TUPEE309

Health System Responsiveness: Lessons from the SOLTHIS-EMPOWER Project End Line Survey of Experiences of Patients Receiving Care in Sierra Leone

Ngwatu Kermu Brian[1], Konteh Fred Hassan[2], Amahowe Franck[1], Kibe Pauline[1], Ellie Martin[3], Vandy Alren[4]

[1]SOLTHIS Sierra Leone, Freetown, Sierra Leone, [2]University of Sierra Leone, Statistics, Freetown, Sierra Leone, [3]Network of HIV Positives in Sierra Leone, Freetown, Sierra Leone, [4]National Agency for Control of AIDS Control Programme, Sierra Leone, Freetown, Sierra Leone

Issues: Health system responsiveness, its ability to respond to the needs and expectations of patients, should be considered as an intrinsic goal of health service delivery. It is measured across eight domains themed on aspects of health systems related to the rights of patients as human beings.This study aimed to investigate the end-project responsiveness at 12 facilities supported by the three-year EMPOWER project in Sierra Leone which pursued a human rights based approach towards
a) empowering people living with HIV (PLHIV) to demand for and receive quality health services, and
b) capacity building of health workers at the facilities.
Descriptions: The cross-sectional and explanatory study investigated 2080 outpatients (1048 PLHIV and 1032 non-PLHIV) selected using convenience sampling method. Respondents were randomly selected for both patient groups. Standard responsiveness questionnaire applied at baseline was used for data collection. Data analysis was done applying descriptive statistics, Pearson Chi-square tests, and SPSS 16 at significance level of 0.05 to compare baseline and endline results.
Lessons learned: Favorability across most domains at endline was higher for PLHIV. Composite indices showed generally improved favorability at endline from baseline for both patient populations. Significantly, at end line, communication was reported as "the most important domain" by both patient groups (26.9% of PLHIV v 24.2% for non-PLHIV).
Next steps: The EMPOWER project´s approach improved the health responsiveness domains for PLHIV and non-PLHIV patients at the facilities it covered. We recommended sustained resource allocation/investments towards building systems and the capacity of health workers in the non-clinical aspects of care of both PLHIV and non-PLHIV (e.g. communication skills) for desired uptake and execution of quality health services for PLHIV and non-PLHIV patients in Sierra Leone.

TUPEE310

The Young People and Adolescent Peer Support (YAPS) Model: A South-to-South Adaptation of the Zvandiri CATS Model to Improve Outcomes for Adolescents and Young People in Uganda

Chimulwa Teddy Nabwire[1], Katureebe Cordelia[1], Namusoke Magongo Eleanor[1], Lukabwe Ivan[1], Kiggundu Josen[1], Nasaba Rosemary[2], Asire Barbara[3], Nabitaka Vennie[4], Nazziwa Esther[5], Kabanda Joseph[5], Muwanga Catherine[6], Tsitsi Apollo[7], Mushavi Angella[7], Willis Nicola[8], Ricotta April[8], Musinguzi Joshua[1]
[1]Ministry of Health, AIDS Control Program, Kampala, Uganda, [2]ANECCA, Kampala, Uganda, [3]UNICEF, Kampala, Uganda, [4]Clinton Health Access Initiative, Kampala, Uganda, [5]Centers for Disease Control and Prevention, Kampala, Uganda, [6]USAID, Kampala, Uganda, [7]Ministry of Health and Child Care Zimabwe, Harare, Zimbabwe, [8]AFRICAID Zvandiri Programme, Harare, Zimbabwe

Issues: Outcomes of viral load suppression and retention among Adolescents and Young people living with HIV (AYPLHIV) continue to lag behind worldwide. In Uganda, these remain sub-optimal with less than 77% of adolescents living with HIV being identified, linked and retained in care and virally suppressed. The World Health Organization has recommended Peer engagement as a key strategy in improving these outcomes. Uganda adapted the Zvandiri CATS model of Zimbabwe and developed the young people and adolescent peer support (YAPS) model in an attempt to improve these outcomes.
Descriptions: Between July 2018 and April 2019, MOH together with its Partners embarked on a south-to-south learning process to adapt a Peer led model following a benchmarking visit to the Zvandiri CATS model of Zimbabwe that works with AYPLHIV. Lessons learnt and a draft implementation plan was shared with Key stakeholders including senior MOH leadership, AIDS Development partners, Young people networks, Key line ministries engaged in Young people care and District Leadership. A series of planned workshops and consultative meetings supported development of guiding documents including: Implementation plan, Training materials, Mentors guide, and a monitoring and evaluation plan. Engagement of the Zimbabwe Zvandiri programme to peer review the YAPS materials was conducted to validate the materials. Training of trainers was done to field test developed tools and materials. Lessons learnt together with stakeholder engagement supported development of Pilot plan to guide national scale up.
Lessons learned: Government leadership through multi-sectoral collaborations with relevant sectors and development partners is the springboard to successful adaptation and implementation of innovative models of care. Involvement of young people throughout the adaptation and implementation processes ensures responsiveness, learning and empowerment for the participating parties. Engagement with AFRICAID and Zimbabwe MOHCC technical teams and young people enhanced the YAPS model standardization drawing from the accumulated lessons learned over more than a decade of scaling up the CATS model.
Next steps: The 12 months Pilot implemented in 9 districts covering 52 health facilitieswill be evaluated to inform feasibility and effectiveness of the model. Thereafter, a national scale up plan will be developed for full implementation across 45 high burden districts in the country by September 2020.

TUPEE311

Du VIH à l´Accès aux Soins en Général: Evolution Diachronique de l´Observatoire Citoyen sur l´Accès aux Services de Santé (OCASS) du RAME au Burkina Faso

Ouédraogo Hamidou, Simon Kabore
Réseau Accès aux Médicaments Essentiels (RAME), Direction Exécutive, Ouagadougou, Burkina Faso

Notre résumé veut répondre aux questions: Comment le RAME est passé du VIH,aux autres questions de santé dans son dispositif de veille citoyenne? Quels ont été les défis et les stratégies d'adaptation?
le Réseau Accès aux Médicaments Essentiels (RAME) est né dans le contexte de l'implication des communautés dans la lutte contre le VIH/SIDA à la fin des années 1990. Depuis sa création en 2003, le RAME a mis en place un dispositif de veille au Burkina Faso. Ce dispositif naissant en 2003 est le coeur de l´action du RAME et a connu plusieurs phases d´évolution sur le plan thématique et spatiale. Ce sont:

- 2003 à 2007, le début de l´observatoire consacré au suivi des ARV en termes de disponibilité et de coût ;
- 2007 à 2010 l'observatoire évolue pour prendre en compte la veille et le plaidoyer pour l´accès aux examens de suivi biologiques des patients PvVIH;
- 2010 à 2014, une extension spatiale du dispositif de veille a été faite pour passer de 07 à 13 régions du pays;
- 2014-2017, sur financement de l'Initiative 5%, le dispositif de veille a été formalisé en Observatoire Communautaire sur l'Accès aux Services de Santé (OCASS). Aussi, en plus de la prise en charge du VIH, l'OCASS a intégré le suivi de l'accès aux services pour les patients de paludisme et de tuberculose dans 40 centres de santé publics du pays. l'OCASS a également ajouté le renforcement des capacités des usagers sur leurs droits et devoirs en matière de santé à partir de 2014;
- En 2016, la prise en compte du suivi de la mesure de gratuité des soins, décrétée par le gouvernement au profit des femmes enceintes et les enfants de moins de cinq.
- A partir de 2018, l´OCASS est devenu l'Observatoire Citoyen sur l´Accès aux services de Santé (OCASS) et a intégré le suivi des violences basées sur le genre et a certification communauté des centres de santé . Aussi, l'OCASS couvre désormais tous les 70 districts sanitaires avec 73 associations points focaux.
- En 2019, sur un financement de la Banque Mondiale, l'OCASS intègre le suivi citoyen de la réalisation des infrastructures et équipements sanitaires et le suivi des interventions des agents de santé communautaires.

La leçon principale de cette évolution est la reconnaissance continue du leadership du RAME au plan national et international au fur et à mesure de l´évolution de l´observatoire. Pour les prochaines étapes les défis sont entre autres le renforcement de l´engagement citoyen et la diffusion de l´observatoire dans d´autres pays.

TUPEE313

Pragmatic Approach to Strengthening the Capacity of Healthcare Workers to Provide Quality HIV Care: Experience of SOLTHIS from Sierra Leone

Amahowe Franck[1], Ngwatu Brian[1], Guillard Etienne[2], Kafkova Jirina[1], Vandy Alren[3], Jalloh Memuna[1]
[1]SOLTHIS Sierra Leone, Freetown, Sierra Leone, [2]SOLTHIS, Paris, France, [3]National AIDS Control Program (NACP), Freetown, Sierra Leone

Background: Quality of Care (QoC) delivery is a concept at the forefront of health promotion and wellness. It has practical benefit in the context of HIV care in resource-limited setting where uptake of HIV services is faced issues like stigma, inadequate environment for services delivery and limited therapy arsenal.
Sierra Leone's meagre health worker, exacerbated by the devastating Ebola Outbreak between 2014 and 2016, posed a significant barrier to achieving globally recommended quality of care standards. The last 3 years have therefore seen SOLTHIS collaborate with the National AIDS Control Program (NACP) in HIV response through implementation of Empower project that aimed to strengthen capacity of HCWs to provide quality HIV care to users.
Descriptions: Intervention included integrated, multifaceted approaches of participatory needs assessments (PA), classroom trainings, on-site clinical mentoring, provision of tools (job aids, posters). The PA is conducted once yearly at each supported facility to identify gaps & challenges in HIV care and to plan adapted solutions to address them.
The QoC score template comprised 15 indicators to monitor the quality of ART service delivery at 11HFs. The indicators include: Prescription of non-recommended ARV regimens; start of ART in line with national guidelines; CD4 monitoring; clinical staging; use of registers; timely reporting; documentation; adherence assessment; TB screening; and retention in care. Each indicator is given a score of 0, 0.5 or 1 based on a defined criterion of measurement. QoC assessed 4 times: in May 2016 (Baseline); November 2016; November 2017 and November 2018 (end-line).
Lessons learned: Over time, all HFs gradually improved QoC and outpassed project target improvement (60%). Importantly 91% (10 out of 11) of supported-sites reached 80%. Collated, an average of 52 point of percentage (from 33% to 85%) of improvement was achieved. Significantly, poor CD4 count monitoring, hemoglobin assessment, patient adherence assessment and patient retention in care were drawback factors for HFs to reach 100% score.
Conclusion & Recommendations: Supporting and strengthening capacity of HCWs through integrated approaches, cross-cutting, multi-faceted interventions is critical intervention that leads to provision of quality of care delivery.
QoC score tool adapted could serve as a key tool to assess the quality of care.
Keywords: HIV care, capacity-building, quality-of-care, SOLTHIS, Sierra Leone

TUPEE314

The Influence of Institutional Factors on Willingness to Participate in HIV Clinical Trials: Experiences from the Infectious Diseases Institute Mulago National Referral Hospital, Kampala Uganda

Ekusai Sebatta Deborah[1], Bukenya Badru[2], Walimbwa Stephen[3], Kambugu Andrew[3], Siu Godfrey[4]
[1]Infectious Disease Research Collaboration, Research, Kampala, Uganda, [2]Makere University, Social work and social administration, Kampala, Uganda, [3]Infectious Diseases Institute, Makerere University College Of Health Sciences, Research, Kampala, Uganda, [4]Makerere University College of Health Sciences, Child Health and Development Centre, Kampala, Uganda

Background: The number of HIV clinical trials conducted in resource limited settings is increasing but few studies have examined factors associated with participants' willingness to participate in trials. We explored the influence of institutional factors on willingness to participate in clinical trials in an HIV specialized clinic in a national referral hospital in Uganda.
Methods: We conducted a qualitative study at the Infectious Diseases Institute (IDI), with adult HIV patients and staff in July to December 2016. We conducted 4focus group discussions with participants who had previously participated or never participated in clinical trials, and 05 interviews with providers. The data were analyzed using thematic content approach.
Results: A total of 45 participants took part in the study, 24 (53%) of them female. We identified seven themes to explain how institutional factors positively willingness to participate in HIV clinical trials. 1) Ongoing consent processes that facilitate understanding of the research influence participation in clinical trials , 2) Categorization of clinics as 'adult and adolescent clinics which created a conducive atmosphere , 3) the fair selection process of patients joining clinical trials 4), the snack, compensation and transport reimbursement provided to participants was described as 'being treated well, 5) the transfer out policy which created more dedicated time for research, 6) Willingness to participate was also attributed to the reputation of the institution, judged largely by how well resourced it was and 7) proximity to the national referral hospital with access to drugs and specialized doctors. Institutional factors negatively affect willingness to participate in clinical trials by: 2) Policy of no recruitment of new HIV patients in the general pool leaving a research fatigued population, conduct of culturally unacceptable studies that don't allow for people to have children over a long period of time, 3) language barrier that limits patient understanding of the consent process and 4) many numbers of clinic visits during clinical trials negatively affects participation.
Conclusions and Recommendations: This qualitative study suggests that institutional reputation with emphasis on ongoing consent processes influence willingness to participate in HIV clinical trials. Similar research in diverse settings with large samples may provide more insights regarding the pattern of such institutional influences.
Key words: Institutional, willingness to participate, clinical trials, HIV.

TUPEE315

Working Together through Leadership/Partnerships to Improve the Use of Strategic Information for Optimal Performance of the National Wellness Campaign "Cheka Impilo"

Motsieloa Lifutso
South African National AIDS Council, Pretoria, South Africa

Issue: SANAC has played a significant role in the coordination of HIV, TB, and STIs through supporting all spheres of government and stakeholders from Civil Society as represented in the implementation of NSP. In 2010, president Mr Jacob Zuma launched the HIV and treatment expansion campaign. Since the launch of the campaign there has been an expansion of treatment programs with 600 000 new patients on ART every year.In 2018, another launch to revitalise HIV screening and testing to ensure better linkages to care and strengthening of prevention efforts was initiated by the then deputy president Mr Cyril Ramaphosa.The campaign calls for an initiation of additional 2 million people on ART by December 2020. working with all Stakeholders, the campaign aims at reinforcing implementation of prevention strategies, linkages to care management, treatment and support as well as TB case finding.
Description: Nerve Centres played an important role at the national, provincial, district, municipal and facility levels. It is therefore important that they be revitalised for the current campaign, to monitor performance of all stakeholders. In ensuring better monitoring and reporting, a dashboard tool that includes both biomedical and non-biomedical indicators was developed. The tool supports data collecting domains like the DHIS2. Its annual targets and actions are aligned to the NDoH District Implementation Plans for 90 90 90, and as such will ensure that services provided are met by demand from the relevant populations and communities. The campaign aims to encourage all South Africans to undergo health screening, testing services, provided at various sites across the country. SANAC developed a dashboard tool to determine the progress towards meeting targets to support coordination and decision making for the campaign. The tool is a database for storage, and uses an agile and rapid prototyping with data integration platform. The tool is able to house data from multiple stakeholders, multiple users, with different purposes. The tool provide metadata by implementer, location, interventions and time, to meet the who, where, what and when.
Lessons learned: The dashboard allows for data analysis per programme area i.e. HIV, TB, and NCDs of data including the demand generation outs for the civil society sector.
Next steps: The dashboard will use sustainable technologies supported by free and open source software to support use of data for decision making by all role players.

TUPEE316

Partner Perceptions on Effective Capacity Building in HIV/AIDS Biomedical Research in Africa

Yebei Thomas
International AIDS Vaccine Initiative (IAVI), Clinical Development, Nairobi, Kenya

Background: Addressing the HIV/AIDS pandemic in Africa requires adequate scientific capacity to conceptualize, conduct, analyze and publish research by African scientists. High-quality research capacity requires a significant commitment of resources over time. IAVI through its "*Accelerate the Development of Vaccines and New Technologies to Combat the AIDS Epidemic"* (ADVANCE) supports initiatives to strengthen research capacity of African scientists and institutions.
Methods: An assessment of the understanding of effective capacity building strategies through beneficiary selection process, mentorship and institutional support mechanisms was undertaken. The mixed methods approach was used in the study with research staff from Kenya, Uganda, Rwanda, Zambia and South Africa. Key informant face to face interviews with IAVI staff and semi-structured telephone interviews with Principal Investigators (PIs) of IAVI-partner Clinical Research Centers (CRCs) implementing ADVANCE program. Structured questionnaires were administered to advanced degree students and mid-level investigators at the CRCs. Reviewers, mentors and budget managers completed online structured questionnaires.
Results: Interviews included 8 PIs,10 IAVI staff, 15 advanced degree students, 6 mid-level investigators, 4 mentors, 6 reviewers and 6 budget managers. 90% of the respondents highlighted the importance of a transparent selection process in attracting quality applicants. IAVI's selection process for all available programs was found to be fair and transparent and attracted great interest across the IAVI partner network among the applicants.
75% agreed that a successful mentorship program is driven by a clear framework coupled with a pool of committed mentors. Proactive mentees, right selection of the mentors, cordial mentor-mentee relationships and regular interaction provided the right environment for effective mentorship.
Strong institutional support was identified as contributing to successful research capacity building. 80% acknowledged that support from their institutions through protected time, payment of tuition fees, accessibility in the use of institutional facilities and facilitation in procurement of research inputs was important.
Conclusions: Designing an effective capacity building program is complex. We found that participants felt that transparent selection process of the beneficiaries, structured mentorship program, and institutional support programs were all important.

TUPEE317

The Effects of Antiretroviral Therapy on Quality of Life of Patients on Antiretroviral Therapy at Katutura ART Clinic-Namibia

Iyambo Emma Nelago Marlon[1,2]
[1]Ministry of Health and Social Services, Namibia, HIV/STI-Subdivision, Windhoek, Namibia, [2]Stellenbosch University, Africa Centre for HIV/AIDS Management, Stellenbosch, South Africa

Background:The effects of antiretroviral therapy on HIV are well established. Most patients are now able to live longer and live productive lives. As patients stay longer on Antiretroviral therapy, monitoring their quality of life (QoL) becomes critical as they cope with living with HIV or AIDS, however QoL monitoring rarely gets implemented.There is dearth of literature on the effects of ARVs on the quality of life for PLWHA in Namibia and elsewhere. No quality of life studies amongst PLWHA conducted before in Namibia.
Methods:A qualitative study was conducted amongst 30 respondents who actively on ART for a minimum of 12 months or more. Participants were 16 years and above. Purposeful sampling was utilized. Participants were recruited in the study as they walked in the facility for follow ups. Modified and pre-tested SF-36 version 2.0 health survey questionnaire from RAND organization was self-administered. Questionnaires consisted of socio-demographic components and 36 structured questions measuring quality of life (QoL) on 8 domains/scales namely; physical functioning, role limitation due to physical health, role limitation due to emotional problems,energy/fatigue, emotional well-being, social functioning, pain and general health, of which each has a set of sub questions. Data was analyzed using Microsoft Excel and Statistical Package for the Social Sciences (SPSS) software version 21.0.
Results: Thirty respondents were randomly recruited ,56.6% females and 43.3% males. QoL scores were high in; physical functioning (92.16), role limitation due to emotional problems (91.66) and pain (89.66) domains . Quality of life scores were notably low in the domains of energy/fatigue (69.33), Social functioning (79.66) and emotional well-being (77.2). Over 56% patients reported to be underweight, obese or overweight. High blood pressure, Diabetes Mellitus and TB were prevalent amongst PLWHA on ART. The study indicates 33.3% consume alcohol and 76.7% achieved viral load suppression of which was highly among male respondents (43.3%) compared to female (33.3%).
Conclusions and Recommendations: Low scores on QoL were observed in the 3 domains. Study findings recommends psycho-social support services , quality of life assessment offer and intensive screening for non-communicable diseases among PLWHA in ART care despite them clinically doing well, e.g. having achieved viral load suppression.
Keywords: Quality of Life, Effects, Antiretroviral Therapy, PLWHA, Domain Scores.

TUPEE318

Conformité des Laboratoires des Centres de Transfusion Sanguine (LCTS) au Processus SLIPTA OMS-AFRO Basée sur la Norme ISO 15189: 2012

Yao Asseke Pierre[1], Kone Sylvestre[2], Abiola Nadine[3], Sadate-Ngatchou Patricia[4], Perone Lucy A[4], Siransy Liliane[5], Ouattara Ramatou[4]

[1]I-TECH Cote d'Ivoire, Blood Safety System, Abidjan, Côte d'Ivoire, [2]I-TECH Cote d'Ivoire, QMS, Abidjan, Côte d'Ivoire, [3]I-TECH Cote d'Ivoire, Abidjan, Côte d'Ivoire, [4]I-TECH, Seattle , Washington University, Department of Global Health, Seattle, United States, [5]NCTS, Laboratoire de Qualification Biologique du Don de Sang, Abidjan, Côte d'Ivoire

Contexte: En Côte d'ivoire, près de 10 % des dons de sang contaminés par le VIH/Sida (0.8%), l'hépatite C (2.2%), l'hépatite B (6.9%) et la Syphilis (0.2%) sont rejetés. Pour garantir la sécurité des patients transfusés, les Laboratoires des Centres de Transfusion Sanguine (LCTS) doivent produire des résultats fiables pour qualifier biologiquement des dons. En conséquence, sous un finacement de trois ans de CDC/PEPFAR en partenariat avec le Ministère de la Santé et exécuté par l'International Training and Education center for Heath, ceux-ci sont entrés en démarche qualité selon le processus SLIPTA (Stepwise Laboratory Improvement Process Towards Accréditation) de l'OMS-AFRO basée sur la norme ISO 15189 :2012, évaluant les niveaux de conformité des laboratoires de 0 à 5 étoiles soit 0 à 275 points. Les trois LCTS (Abidjan, Daloa, Yamoussoukro) avaient pour objectif de passer de zéro à trois étoiles de 07/2018 à 06/2019.
Méthodologie: Les objectifs étaient de former et encadrer le personnel en gestion de la qualité, améliorer les conditions/environnement de travail et renforcer le matériel. La méthode utilisée est basée sur la roue de Deming (Plan Do Check Act). Un audit initial fut effectué en 04/2018. Avec les non-conformités constatées, une analyse des causes fut faite, un objectif spécifique fixé et des solutions proposées dans un plan d'action. Des documents qualité fut rédigés sur la base de modèle pré établi, le personnel formé et du matériel pourvu. Des indicateurs fut définis pour surveiller et améliorer le système
Résultats: 6 personnes de laboratoire ont été formés à la rédaction de procédure et à la maîtrise de ISO15189 : 2012, 7 formés à la maintenance préventive des équipements et gestion des intrants, 4 en biosécurité et 22 à la collecte et gestion client. 36 coachings réalisés, 843 documents rédigés. Aucune rupture d'intrant et aucun retour de poche pour erreur de diagnostic. Un audit sécurité (08/ 2018) et 2 audits internes (09/2018 et 04/2019) ont été également réalisés.
L´ audit externe réalisé en 05/2019 a montré que les CTS Abidjan est passé de 140 à 213 (77.4%), Yamoussoukro de 92 à 215 (78.18%) et Daloa ; de 92 à 218 sur 275 points (79.2%)
Conclusion: 13 mois après l'audit initial, les 3 LCTS ont réussi leur démarche qualité en améliorant leur niveau de qualité de 0 à 3 étoiles.
Prochaine étape: Ce résultat ouvre la voie pour la préparation de l'accréditation dans 6 à 12 mois.
Mots clés: Qualité, transfusion sanguine, étoiles

TUPEE319

Développement d'un Plan Stratégique Intégré: Vers L'élimination du VIH/Sida, la Tuberculose, le Paludisme, les Hépatites Virales, les IST et les Maladies Épidémiques au Bénin à L'horizon 2030

Aissi Melchior[1], Medegan-Kiki Valentine[2], Agbla Félix[2], Affédjou Bertin S.[2], Molnar Marie-Margarète[3], Houansou Télesphore[4]

[1]Conseil National de Lutte contre le VIH/Sida, la Tuberculose, le Paludisme, les Hépatites, les IST et les Epidémies (CNLS-TP), Cotonou, Benin, [2]Conseil National de Lutte contre le VIH/Sida, la Tuberculose, le Paludisme, les Hépatites, les IST et les Epidémies (CNLS-TP) Bénin, Cotonou, Benin, [3]Onusida, Bénin, Cotonou, Benin, [4]OMS, Bénin, Cotonou, Benin

Questions: Selon les résultats des Enquêtes Démographiques et de Santé successives 2006, 2012 et 2018, le Bénin connait une lente amélioration des indicateurs sanitaires en général et ceux liés aux maladies prioritaires en particulier. La riposte à ces maladies se fait à travers différents programmes, l'analyse de la riposte telle qu'elle est organisée a permis de noter une gestion verticale et couteuse s'appuyant plus sur le processus que sur les résultats ainsi que de faibles couvertures dans la mobilisation des ressources et des interventions fragmentées à faible impact avec peu de retours sur investissement. Comment optimiser alors la riposte à ces maladies pour plus d'efficience et aller vers leur élimination à l'horizon 2030?

Description: L'objectif est de réaliser l'intégration des programmes pour plus d'efficacité et d'efficience grâce aux économies d'échelle dans un contexte d'amenuisement des ressources. Ceci a été possible grâce à la création du Conseil National de Lutte contre le VIH/Sida, la Tuberculose, le Paludisme, les Hépatites, les Infections Sexuellement Transmissibles et les Epidémies. Ce cadre favorise le développement d'approches transversales afin de faire face aux défis structurels du système de santé pour atteindre la Couverture Santé Universelle et « *en finir avec les épidémies à l'horizon 2030* ». Le processus d'intégration de la réponse à ces maladies prioritaires contribue à les sortir de leur isolement avec l'implication des acteurs du système de santé des secteurs public et privé, des autres secteurs de développement et la société civile selon l'approche « Une seule santé ».

Leçons apprises: Il est possible dans le contexte africain de faire travailler les acteurs de différents programmes sous une seule instance de coordination pour développer des stratégies intégrées et transversales sur le système santé visant à éliminer les maladies prioritaires. Au Bénin, ce processus permet la mise en place d'un système unique de gestion des produits de santé, d'une politique harmonisée de santé communautaire et une intégration des co-infection VIH/TB/Hépatites virales dans le protocole de prise en charge des patients récemment mis à jour avec les acteurs des 3 programmes.

Prochaines étapes: Il importe de la mener jusqu'au bout en procédant au réinvestissement des économies d'échelle provenant de l'intégration des interventions. Son évaluation permettra de tirer les leçons et améliorer l'exercice lors des prochains cycles de planification.

TUPEE320

Community Health Volunteers and their Role in Strengthening HIV/AIDS Healthcare Delivery Systems in Low Income Peri-urban Areas: An Exploratory Study of Epworth, Zimbabwe

Taderera Bernard
University of Johannesburg, Department of Environmental Health, Johannesburg, South Africa

Background: Community health volunteers have emerged as an increasingly important avenue through which to address global health workforce challenge in strengthening peri-urban health systems towards delivering HIV/AIDS healthcare in low and middle-income areas. The aim of this study was to explore community health workers and their role in strengthening HIV/AIDS healthcare delivery towards health welfare for all in Epworth, a peri-urban community in Zimbabwe.
Methods: A cross-sectional research design was used for an exploratory qualitative study within which data were collected through a documentary search, key informant interviews, focus group discussions and non-participant observation. Data were transcribed into narratives that were then subjected to interpretive thematic analysis.
Results: Findings from this study showed that there were two main categories of Community Health Volunteers in Epworth peri-urban area, namely Community Health Workers/ Village Health Workers and Peer Educators. Community Health Workers helped mitigate healthcare worker shortages by performing outreach work whilst Peer Educators were HIV patients that played a supportive role to healthcare workers and other HIV patients onsite. Findings also revealed that health volunteers were a source of local knowledge that helped foster acceptance, knowledge sharing and adoption, reduction of stigma, navigation of the local physical and cultural barriers and facilitated HIV/AIDS healthcare delivery through the provision of counseling, coordinating home-based care, patient follow-ups and defaulter tracings. Local health volunteers were also an important link between the local clinics and the community and facilitated beneficial interaction.
Conclusions and Recommendations: Community health volunteers have emerged as an important resource not only to mitigate healthcare worker challenges but also as avenues through which to strengthen HIV/AIDS healthcare delivery systems in resource limited peri-urban areas. The sustainability of local health voluntary work in peri-urban communities is however undermined by capacity constraints which in turn undermines the sustainability of interventions to tap onto the community as a human resource for HIV/AIDS healthcare in low-income peri-urban areas.

TUPEE321

Strengthening Human Resources for Health to Achieve Epidemic Control: A Case Study of the Democratic Republic of the Congo

Michaels-Strasser Susan[1], Lubunda Noe[2], Kayembe Serge[3], Lukeni Beatrice[2], Bazola Faustin[3], Khanyola Judy[4], Parmley Lauren[1], Thurman Paul[1]

[1]ICAP at Columbia University, New York, United States, [2]ICAP at Columbia University, Lubumbashi, Congo, the Democratic Republic of the, [3]ICAP at Columbia University, Kinshasa, Congo, the Democratic Republic of the, [4]ICAP at Columbia University, Nairobi, Kenya

Issue: PEPFAR in the Democratic Republic of the Congo (DRC) continues to fund a robust portfolio of programs aimed at achieving epidemic control in three provinces, where 30% of the total number of people living with HIV/AIDS in the country reside. Challenges around human resources for health (HRH), including inadequate staffing and limited capacity, impede the delivery of quality HIV services in the country.

Description: ICAP at Columbia University, in partnership with the United States Health Resources and Services Administration (HRSA), identified 16 priority health facilities (HFs) in DRC and developed HRH-specific interventions to address challenges in achieving 95-95-95 targets using a criteria-driven prioritization. Through interviews with leadership at all 16 HFs, ICAP developed an intervention framework, determined key short-term priorities, and prepared to implement short-term HRH improvements to reach 95-95-95 targets across all HFs. Site-level interviews occurred in April 2019. Interviews used an adapted version of the PEPFAR HRH Rapid Assessment tool to capture key HRH information including staffing levels by type of clinical or administrative position, key barriers to achieving 95-95-95 metric attainment, and perceptions of needed HRH-specific improvements. The ICAP team then created a list of possible interventions across 6 domains: staffing, training, workplace environment, medical supplies and equipment, and monitoring and evaluation. Thirty-five interventions were hypothesized and prioritized into short, medium, and long-term priorities using a prioritization framework focused on desirability, feasibility, viability, and time-to-impact. Some interventions were applicable to all HFs while others applied only to selected HFs, the national Ministry of Health, or to ICAP. Twelve interventions were selected as highest priority, and budget allocations and task planning were developed for each of the high-priority interventions.

Lessons learned: The supply and quality of HRH is critical to achieving epidemic control. This assessment delineated necessary interventions to address site-specific HRH barriers. HRH interventions focused on ensuring adequate staffing, optimal utilization of health workers, and identifying and strengthening health workers' capacity to provide quality HIV services to achieve epidemic control.

Next steps: Downstream tracking and reporting of key PEPFAR metrics to ensure documentation of PEPFAR and PNLS targets.

TUPEE322

"We Just Need to Continue": Youth Peer Mentors' Experiences Implementing Project YES! in Ndola, Zambia

Burke Virginia M.[1], Frimpong Christiana[2], Abrams Elizabeth A.[1], Merrill Katherine G.[1], Miti Sam[2], Mwansa Jonathan K.[2], Denison Julie A.[1]

[1]Johns Hopkins Bloomberg School of Public Health, Baltimore, United States, [2]Arthur Davison Children's Hospital, Ndola, Zambia

Background: Little is known about youth-led approaches to addressing HIV-related outcomes among adolescents and young adults (AYA) living with HIV. In response, Project YES! trained and hired youth peer mentors (YPMs) living with HIV as paid staff and placed them in four HIV clinics in Ndola, Zambia to hold one-on-one and small group meetings with 276 (60% female) 15-24-year-old youth living with HIV. Within this randomized controlled trial, a qualitative analysis was conducted to explore YPMs' implementing experiences.

Methods: In-depth interviews were conducted with the eight YPMs (50% female) ages 21-26 who implemented the Project YES! intervention. YPMs were asked about their experiences working with clients, their feedback on program components, and what the experience meant to them personally and professionally. Data were analyzed for key themes.

Results: YPMs connected with both male and female AYA clients by discussing their shared struggles, role modeling positive health behaviors, and establishing confidential, judgement-free environments for clients: *"[It's] not like just talking maybe from a booklet. I'm giving myself as an example … you're helping someone from true life experiences*." Additionally, YPMs' experiences resulted in powerful personal transformations in HIV-related health behaviors, conceptions of self, and plans for the future. Many expressed seeing themselves now as community leaders - "*ambassadors*", "*game changers*" - and "*not just alone in this world.*" They described moving from feeling hopeless about their futures to excited and confident about reaching personal and professional goals: *"I also have the right to think ahead and think about my future."* YPMs were adamant that Project YES! should expand so other HIV-positive AYA might benefit: "*[If] we continue talking to them, they will change their mentality. … The more we do this, the more we see our community having healthy people… So we just need to continue*."

Conclusions and Recommendations: Well-trained YPMs can communicate and support HIV-positive AYA in unique and important ways due to their shared experiences. The transformational experience of becoming YPMs empowers youth to be leaders in their communities. Future programs should engage youth living with HIV as partners in efforts to end the HIV epidemic.

adolescent health, youth empowerment, Zambia, peer-mentoring, qualitative

TUPEE323

Nurses Initiated Management of ART (NIMART) Training as a Tool to Strengthen Task Shifting and Increase Treatment Access in Nigeria

Popoola Victor Oluwatobi[1], Ijezie Echey[2], Nwabueze Emmanuel[3], Lubanga Augustine[4], Buzaalirwa Lydia[5], Lutung Penninah[5]

[1]AIDS Healthcare Foundation-Nigeria, Training and Quality Services Unit, Abuja, Nigeria, [2]AIDS Healthcare Foundation-Nigeria, Abuja, Nigeria, [3]AIDS Healthcare Foundation., Abuja, Nigeria, [4]AIDS Healthcare Foundation, Kampal, Uganda, [5]AIDS Healthcare Foundation, Kampala, Uganda

Issues: Reaching the required threshold of health workforce needed to improve treatment access and deliver quality HIV services towards ending HIV as an epidemic, will take many years, in the light of the present human resources for health (HRH) situation in Nigeria. NIMART training for Nurses and Community Health officers was used as a short term intervention to bridge this gap.

Descriptions: A comprehensive 3-phase training package consisting of 6-days didactic training, coaching and mentoring as well as continuous follow up, was delivered to 16 healthcare workers consisting of Nurses and Community health workers, drawn from 6 States of operation of AIDS Healthcare Foundation-Nigeria. The training ensured that participants were equipped with the appropriate knowledge, skills and attitudes to initiate and maintain PLHIVs on lifelong treatment They were given activity logbooks to record the relevant activities including the form of mentorship received and the type of clinical services offered, over a period of 18 months. Charts review were carried to assess performance, and interviews were conducted to get feedback from the trainees.

Lessons learned: 16 participants (15 Nurses and 1 CHO) were trained and followed up.They all received face-face mentorship, 8 received telephone mentorship and another 6 received mentorship during support supervision visits. All the trainees had clinical case management logbooks with an average of 15 cases per trainee and the types of cases recorded in the logbooks included ART initiation, opportunistic infection management and ART toxicity management. During the follow up period, Trainees initiated 36% of the 2,320 people living with HIV initiated on ART in the health facilities that had a trainee.171 charts of clients initiated on ART by the trainees were reviewed and it was observed that all the clients started on ART by trainees were eligible,91% had a baseline CD4 count, 97% were assessed for Tuberculosis at the start of ART, 99% were assessed for WHO staging, 99% were prescribed cotrimoxazole, and 100% of ARV medicine prescriptions were made correctly. All clients were started on the preferred 1st line regimens for the age.

Next steps: When properly implemented with adequate follow up, NiMART training can serve as comprehensive stop-gap measure to bridge the HRH challenges in the country, and ensure increased access to treatment services even in the primary health centers, without compromising quality.

TUPEE324

Addressing Health Workforce Financing Barriers toward HIV/AIDS Epidemic Control in Uganda

Agaba Allan, Hamdi Hana T., Kikomeko Steven, Kibiye Dennis
IntraHealth International, Kampala, Uganda

Background: In 2012, Uganda's health sector financing was UGX 799 billion (US$216 million), about 8.3% of the national budget or slightly more than half of the 15% pledged in the 2001 Abuja Declaration. Human resources for health (HRH) accounted for 27% of the health budget, an insufficient amount to fill the 42% staffing gap required for scaling-up health and HIV/AIDS services. With USAID funding, IntraHealth International invested in developing policies and tools, generating evidence on HRH funding gaps, and advocating with the Government of Uganda (GOU) to increase HRH funding. The urgency to address the staffing shortage compelled GOU, PEPFAR, Global Fund, and others to increase HRH investments. In 2013, GOU allocated UGX 49.5 billion (US$16 million) for a massive recruitment of 7,211 health workers for health center (HC) levels III (sub-county-level clinics) and IV (county-level mini-hospitals). In 2012 and 2015, PEPFAR supported recruitment of over 3,000 health workers toward achieving the global 90:90:90 targets.
Methods: IntraHealth developed tools for conducting routine HRH needs analysis, budgeting, and advocacy for financing. HRH planning guidelines, the integrated HRH Information System (iHRIS), and WHO's Workload Indicators of Staffing Need (WISN) were deployed to determine staffing needs, prioritizing HIV high-burden areas. iHRIS and DHIS-2 data on transitioning 2,212 PEPFAR staff onto GOU payroll were analyzed to validate the shift toward sustainable financing.
Results: Evidence from WISN and other tools influenced a more than doubling of the health budget from 2012-2018 (UGX 1,950 billion) with increased GOU and external financing. The massive recruitment resulted in increased staffing at HCIII (76%) and HCIV (78%) (2013-14) from 56% and 60% in 2011-12, respectively. Increased access to HIV/AIDS services contributed to HIV prevalence declining from 7.3% (2011) to 6% (2016). Absorption of PEPFAR staff has almost tripled from 280 in 2015 to 805 in 2018; however, overall absorption remains low at 36%. Additionally, ART health service delivery has remained consistent through the staffing transition.
Conclusions and Recommendations: Pooling HRH investments has accelerated reduction of Uganda's HIV epidemic. To sustain these gains, concerted effort is needed to transition contract HRH onto local payroll.

TUPEE325

Factors Associated with Motivation of Healthcare Workers in Primary Healthcare Facilities in Mombasa County

Shamsudin Abbasali[1], Waga Grace[2]
[1]Jomo Kenyatta University of Agriculture and Technology, Nairobi, Kenya, [2]Technical University of Mombasa, Mombasa, Kenya

Background: Recurrent health staff unrest has been witnessed in Mombasa County and Kenya in general since healthcare was devolved. Low level of health worker motivation has often been identified as a central problem in health service delivery.The aim of this study was to explore the factors associated with motivation of healthcare workers in primary healthcare facilities in Mombasa County.
Method: This was a cross-sectional study of 33 primary healthcare facilities in Mombasa County. All government-employed health workers in these facilities were eligible to participate in this study. A validated structured questionnaire was used to collect data on predefined variables based on Herzberg´s two-factor theory of motivation. Quantitative data analysis was undertaken using SPSS version 24. Strict ethical measures were taken to safeguard the confidentiality of the study subjects.
Results: A total of 102 health workers distributed across the 33 facilities consented to participate in the study. More than 50% of these were nurses. The rest were laboratory personnel, clinical officers, pharmaceutical technologists, nutritionists and counsellors. More than 85% of the respondents cited poor remuneration as a demotivating factor. Other key demotivating factors included high workload (71%), poor working conditions (66%), unclear career and development prospects (53%), lack of appreciation and recognition of their efforts (51%). Among the key motivating factors identified by the respondents included regular supportive supervision (69%), job security (65%) and peer support (50%).
Conclusion: The study findings indicated that primary healthcare workers in Mombasa County were mostly demotivated. A prerequisite for a well-functioning health system is motivated staff. To achieve this, both hygiene and motivator factors should be considered and incorporated into the motivation strategies used by the primary healthcare managers.

TUPEE326

Accès aux ARV Pédiatriques et Analyses Virologiques. Etat des Lieux dans 38 Sites de Prise en Charge du VIH Pédiatrique de 11 Pays d'Afrique

Zio Réjane, Saint-Gal Anaïs
Sidaction, Paris, France

Suite à la fin du programme Grandir (programme de renforcement des capacités des acteurs de prévention et prise en charge du VIH pédiatrique en Afrique), Sidaction a analysé 10 années de données sur l'accès aux ARV pédiatriques dans 38 sites de prise en charge de 11 pays d'Afrique.
Méthode: Via un questionnaire informatique, chaque année entre 2007 et 2018, Sidaction a enquêté auprès des 17 associations du programme Grandir sur la disponibilité sur leurs sites de dispensation et au niveau central des ARV pédiatriques, du diagnostic précoce, de l'examen de la charge virale et du test de résistance. Les réponses au questionnaire ont été complétées et affinées par des échanges emails avec les associations afin d'identifier les freins et blocages expliquant l'indisponibilité.
Résultats: Progression de l'accès aux ARV pédiatriques de 1ère ligne : 95 % des sites disposent de ABC/3TC 30/60 mg en 2018, contre moins de 10 % avant 2014 ; 90 % des sites disposent de l'AZT/3TC 60/30 mg, AZT/3TC/NVP 60/30/50 mg et EFV 200 mg en 2018 contre 50% en 2013 ; 92 % des sites disposent du LPV/r 100/25 mg en 2018, contre moins de 10 % avant 2014.
Mais, indisponibilité du RAL (1ère ligne) et des ARV de 2ème et 3ème lignes (hormis le LPV/r) pour les enfants de 10-25 kg en 2018 dans l'ensemble des sites interrogés; Et sous-évaluation des besoins en ARV de 2ème et 3ème ligne (taux d'échecs de 1ère ligne estimé à 20-30 % parmi les enfants et adolescents de 0-19 ans).
Progression de la disponibilité du diagnostic précoce rendu en moins de 3 mois (100% des sites y avaient accès en 2016 contre 60% en 2008) et de l'examen de la charge virale en moins de 10 mois (84% en 2018 contre 10% en 2008). Mais un écart entre les capitales et les sites décentralisés et des contraintes d'accessibilité aux examens (frais annexes, ruptures de réactifs, mauvaise maintenance des appareils, etc.).
Conclusion: Amélioration de l'accès aux ARV pédiatriques dans les 11 pays concernés. Mais un retard persistant dans l'accès aux ARV pédiatriques (comparé aux ARV pour adultes) et au suivi virologique. Des freins techniques mais surtout un manque de volonté politique et stratégique de faire de l'accès aux traitements pour les enfants une réelle priorité.. L'application des recommandations OMS et leurs transpositions au niveau national restent impossibles sur le terrain. Les enfants de moins de 25 kg ne disposent pas d'ARV suffisamment diversifiés, adaptés et disponibles pour être suivis efficacement.

TUPEE327

The Impact of Collaboration with Global Fund and USAID on Distribution of HIV Commodities in Ghana

Owusu Kwadwo Koduah[1], Armah Catherine[2], Opare Frank[2], Adu-Gyamfi Raphael[1], Boakye-Yiadom Emmanuel Sefah[3], Asare Edna Nana Yaa[4], Addo Stephen Ayisi[1], Nyiligira Eric[5], Kudiabor Araba[4], Kimera Deo[6]

[1]National AIDS/STI Control Programme, Accra, Ghana, [2]Regional Health Directorate, Sunyani, Ghana, [3]MOH/GF Logistics Support, Chemonics International, Accra, Ghana, [4]Supplies, Stores and Drug Management Division, Ghana Health Service, Accra, Ghana, [5]The Global Fund to Fight HIV/AIDS, Tuberculosis, and Malaria, Geneva, Switzerland, [6]Contractor for USAID Global Health Supply Chain Program, Procurement and Supply Management, Accra, Ghana

Issues: Prior to 2015, challenges in the health commodity supply chain distribution system particularly at the last mile impeded access to life-saving medications and disrupted service delivery at antiretroviral therapy (ART) sites in Ghana. Some ART staff had to travel to the regional medical stores (RMS) and nearby facilities to obtain antiretroviral medicines (ARVs) for patients.In 2002, the Ghana Health Service adopted a policy to ensure the delivery of commodities from the RMS to the service delivery points. However, the implementation was confronted with challenges, ranging from inadequate transportation resources to lack of appropriate tools and data. Following a fire incident that destroyed the Central Medical Stores (CMS) in January 2015, the need for an efficient distribution system to all levels of the supply chain was further highlighted.

Descriptions: The Government of Ghana (GoG) reached an agreement with the Global Fund (GF) to implement supply chain reforms, including last mile distribution (LMD) in all regions. Per the agreement, the GoG could avoid the refund of $9.5million GF investments that were burnt in the inferno if the agreed milestones were achieved. The milestone for LMD was in three phases. Phase one was to deliver commodities to 50% of facilities up to the sub-district level by June 2017, 75% by June 2018 and 100% by September 2018.

Therefore, in the first quarter of 2017, the GHS in collaboration with the GF and USAID began a comprehensive programme to support the RMS to deliver commodities to the last mile in a coordinated manner. As a result, a structured, regular LMD of commodities was implemented in all ten (10) regions with two regions being funded by GoG, four by the GF and the remaining four by the USAID.

Lessons learned: By September 2018, ARVs and other health commodities were delivered through the LMD to 100% of the sub-districts including all ART sites. This resulted in the reduction of the average stock-out rate of tracer commodities by 10%. In the post-implementation assessment report, facility managers expressed satisfaction with the implementation as the costs of transportation and the stress of staff travelling to pick up commodities from the RMS were taken away. Therefore, GF waived the refund of the $9.5million.

Next steps: To sustain these gains, all stakeholders must continue to collaborate to guarantee uninterrupted service to HIV clients across Ghana.

Keywords: LMD, distribution, medicines, ARVs, commodities

TUPEE328

Leveraging Existing Systems to Ensure Continued Availability of Antiretrovirals and Prophylaxis Commodities during the Implementation of the Differentiated Service Delivery Model

Musafiri Cyprien[1], Uwizeye Mutanguha William[2], Kabalisa Max[2], G Buki Ines[2], Ribakare Dr Muhayimpundu[3]

[1]Rwanda Biomedical Center, IHDPC, Kigali, Rwanda, [2]GHSC-PSM, Kigali, Rwanda, [3]Rwanda Biomedical Center, Kigali, Rwanda

Context: In Rwanda, July 2016 marked the launch of the "Treat All" strategy for getting people living with HIV on treatment. This added more people to antiretroviral treatment (ART). With the initial service delivery model, patients had monthly trips for medicines pick up and quarterly clinical visits. "Treat All", by moving all patients on Pre-ART (Receiving only Cotrimoxazole) onto Anti-retroviral Treatment irrespective of the CD4 count, increased the workload for healthcare providers in HIV services.

Motivation: To cope with the increase in number of clients, the Differentiated Service Delivery Model (DSDM) was introduced. This model categorizes patients into Stable clients (who need less clinical attention) and unstable group (who need more regular clinical follow up). The move to treat all and to multi-month prescriptions for stable patients required careful planning in the implementation of associated supply chain activities to avoid shortages and expiries of antiretrovirals (ARVs) and medicines to treat opportunistic infections (OIs).

Methodology: Through a routine quarterly supply plan review exercise, shipments already in pipeline for concerned molecules were pulled forward and additional shipments procured to ensure optimal stock levels are met across the supply chain.

Maximum stock levels were redefined for specific commodities to accommodate 3 months being made available to stable clients.

Key supply chain staffs were trained on the importance of DSDM in achieving program and global targets.

A distribution plan was developed based on reported patients' numbers.

To ensure subsequent orders are accurate, an ARV and OIs re-supply calculator and DSDM Patient Reporting Form were developed.

The Ministry of Health carried out supportive supervision and mentorship to District Pharmacies and Service Delivery Points.

The number of stable and unstable patients being reported is continuously monitored and orders are validated accordingly to ensure availability of commodities.

Results: The program has been able to achieve full supply of ARVs and OIs throughout the implementation of DSDM. Over the course of the implementation of the DSDM strategy, the stock-out rate across the system has been held below 5%. Successful roll-out of this kind of system requires close collaboration among partners, effective planning, efficiency in storage and most notably clinical support must go hand-in-hand with the supply chain.

TUPEE329

Successful Introduction of Tenofovir/Lamivudine/Dolutegravir (TLD) into the Rwandan Supply Chain to Attain Zero Expiries and Wastage of Existing Legacy Commodities

Musafiri Cyprien[1], Icyimpaye Joyce[2], Uwizeye Mutanguha William[2], G Buki Ines[2], Ribakare Dr Muhayimpundu[3]

[1]Rwanda Biomedical Center, IHDPC, Kigali, Rwanda, [2]GHSC-PSM, Kigali, Rwanda, [3]Rwanda Biomedical Center, Kigali, Rwanda

Context: The continued success of HIV treatment has historically been built on the supply chain's ability to actively incorporate new molecules. In country supply chain technicians designed a two-phase approach to introduce Tenofovir/Lamivudine/Dolutegravir 300/300/50mg into the Rwandan supply chain. By June 2018, Rwanda had 92.3% PLHIV on treatment and 91% of these virally suppressing. This achievement is associated, among other parameters, to full supply of ARVs. The introduction of TLD and Dolutegravir 50mg will result in more rapid suppression of viral load.

Motivation: The overall goal of a two-phase approach was to ensure that appropriate quantities of TLD are available at treatment sites to achieve zero stock-outs and Zero wastage.

Methodology: Through the supply chain subgroup of the Care and Treatment technical working group, the introduction of TLD was considered during the annual quantification exercise held in November 2017. Quantities of TLD were identified based on the number of existing patients, projected new patients, and their regimen profiles. During phase one, only New patients across the country were eligible to receive TLD starting July 2018. Phase two was initiated in April 2019 with existing eligible patients transitioning to TLD.

Based on historical new patient numbers, the supply chain team allocated quantities to 561 treatment sites for phase one. For phase two, quantity allocation was based on existing patients' regimen breakdown, the estimated number of patients eligible to shift.

To initiate the 1st phase, 4,515 packs of TLD and 2865 packs of DTG were distributed to treatment sites and District Pharmacies. During Phase-one, approximately 3622 and 567 patients-initiated ARV treatment on TLD and DTG based regimens. 418,004 and 74,383 packs of TLD and DTG were allocated to district pharmacies and treatment sites to facilitate the transition of 68,217 and 12,994 patients onto TLD and Abacavir/Lamivudine 600/300+Dolutegravir 50mg.

Results: By June 30th, 2019, approximately 34,962 (51% of the total eligible) and 4,875 (38%) clients had transitioned to TLD and DTG respectively.

The two-phase approach has shown a gradual reduction in stock levels of legacy commodities that are to be phased out from treatment options.

The approach has also allowed gradual increase in TLD and DTG uptake with consideration of stock levels for other legacy molecules such as TLE that will remain in the treatment protocol.

TUPEE330

Evaluating the Implementation of the Appointment Spacing Model, Multi-month Dispensing and ART Pharmacy Services in Ethiopia

Derib Yalemsew[1], Ayalneh Belete[2]
[1]USAID Global Health Supply Chain Program - Procurement and Supply Management (GHSC-PSM) Project, Addis Ababa, Ethiopia, [2]USAID Global Health Supply Chain Program -Procurement and Supply Management (GHSC-PSM) project, Ethiopia, Addis Ababa, Ethiopia

Issues: In 2017, Ethiopia began implementing an appointment spacing model (ASM), which requires multi-month dispensing (MMD) to HIV patients on antiretroviral treatment (ART). This service delivery model can reduce burden for patients, ART pharmacies, and clinics while maintaining high retention in care.
A successful transition to ASM/MMD in Ethiopia requires:

- **Patient enrollment in ASM/MMD**
- **ART pharmacies capacity for new responsibilities** (inventory management, proper medication use, adverse drug event monitoring)

Description: The USAID Global Health Supply Chain Program-Procurement and Supply Management (GHSC-PSM) project partnered with the Ethiopia Ministry of Health (MOH) to conduct two assessments evaluating the adoption of ASM/MMD, and the performance of ART pharmacies in adopting ASM/MMD.
Patient enrollment assessment: conducted in 88 ART facilities in April 2018, examined enrollment rates and reasons for low enrollment. Data was collected by reviewing relevant records and interviewing health professionals working in ART clinics and pharmacies.
ART pharmacy services assessment: conducted in 205 randomly selected ART pharmacies in May and June 2018. Key informant interviews were conducted with government stakeholders, selected ART sites and partners.
Lessons learned: Results from the first assessment showed patient enrollment significantly below expectations:

- Of the 70% of adult first-line clients expected to enroll, only 36% were enrolled as of April 2018
- Patient refusal of ASM/MMD was reported by 65.5% of the visited facilities

Factors for patient refusal included

- Problems with home storage of medicines
- Fear of stigma for carrying large quantities of ARVs
- Too frequent provider consultations required

The second assessment showed challenges and shortcomings at pharmacies:

- 40% of health facilities didn´t have separate rooms for one-to-one ART dispensing and adherence counselling services
- 50% of ART pharmacies did not meet Ethiopian Food and Drug Administration readiness and suitability criteria
- Only 40% of ART pharmacies complied with WHO good dispensing practices

Next steps: To address patient enrollment challenges and ART pharmacy service shortcomings, GHSC-PSM and the MOH have begun to

- Provide ART in-service trainings and added an ART pharmacy checklist to national ART mentoring guidelines
- Conduct support and supervision visits

- Develop recording and documentation tools for ART pharmacies

These lessons may also inform ASMs and MMD in other countries.

TUPEE331

Plaidoyer pour un Acces des PVVIH aux Soins de Qualite: Plus-value de l'Observatoire VIH/TB en RD-Congo

Mavula Ange[1], Maheshe Gaudens[2], Kalume Whisky[2]
[1]UCOP+ (Union Congolaise des Organisations des PvVIH), Kinshasa, Congo, the Democratic Republic of the, [2]UCOP+ (Union Congolaise des Organisations des PvVIH), Goma, Congo, the Democratic Republic of the

Contexte/Objectif: Les organisations de la Société Civile à travers UCOP+ mettent en œuvre les activités communautaires fondées sur les collectes mensuelles des données dans les formations sanitaires. Ces activités passent par la mise en place, au niveau de la Société Civile VIH Congolaise (RD), d'un dispositif pouvant apporter des informations alternatives en temps réel. Il s'agit de l'Observatoire VIH/TB. L'objectif est d'avoir un bon accès aux soins pour les PvVIH et une bonne qualité de la prise en charge.
Méthodologie: Des collecteurs d'informations ont été formés pour la remontée des informations dans 3 provinces du pays. Des questionnaires électroniques pour la collecte des données relatives à l'accessibilité aux soins, à la qualité (disponibilité des médicaments et autres intrants VIH/TB) des prestations VIH/TB sont intégrés dans les Smartphones. Ils remontent hebdomadairement les informations grâce à la téléphonie mobile via internet. Lesquelles informations sont stockées dans un serveur pour toute fin utile. En dehors des informations fournies par ces collecteurs, une « *Ligne Verte* » est aussi utilisée pour la remontée des informations complémentaires par les usagers eux-mêmes, voir les prestataires. L'équipe de coordination et le « Noyau Plaidoyer » mis en place, traitent les informations reçues et les consolide. Il s'en suit alors une définition des enjeux de plaidoyer.
Résultats: Grâce aux alertes émises sur la situation de l'offre des services VIH, l'Observatoire a contribué à la réduction de certains cas de ruptures des médicaments et autres intrants VIH constatées dans les formations sanitaires et à la réduction de certains coûts d'accès aux soins. La multiplication des actions de plaidoyer au sein des instances décisionnelles (Gouvernement provincial et national, Ministères, Assemblées provinciales, Programmes spécialisés : PNLS, PNLT) a permis aux autorités politico-administratives de replacer la société civile au centre de la lutte.
Conclusion: L'Observatoire VIH/TB, comme dispositif de veille, est un outil capital dans la stratégie de mise en œuvre de plaidoyer qui intègre une double dimension d´observation et de participation active des PvVIH dans le processus des soins de qualité et de traitements leur offerts, incluant les pratiques réelles dans les formations sanitaires de prise en charge. Ainsi, la conformité de sa mise en œuvre s´est révélé un facteur constant de la réussite de l´innovation.

TUPEE332

Utilizing the Community Based Organisations´ Strategy to Overcome Health System Barriers in the Delivery of HIV and Harm Reduction Services to People who Inject Drugs in Uganda

Edward Magomu, Muganda John, S'Diq Abubakar Ali, Ema Twizukye, Shakira Tumuhirwe, Kerion Wanjuzi
Mbale Youth Community Empowerment Group, Mbale, Uganda

Issues: PWIDs (People Who Inject Drugs) are often hidden and hard to reach people due to punitive laws ,stigma and discrimination .PWIDs are 22times likely to acquire HIV than the general public and with 6% of 42,000 new HIV infection in Uganda .(UNAIDS 2018) HIV and HR(Harm Reduction) services have not been scaled up to PWIDs due to CBOs' (Community Based Organizations) inability to support public HSs(Health Systems) by filling critical gaps through providing supportive services that buttress clinical-based care or extend the reach of services to them due to resource constraints,limited knowledge and centralized services . With an HIV prevalence of 16.7% compared to 6.2% among the general population, this situation calls for a model with decentralized HIV and HR services to PWIDs.
Description: HIV/TB(Tuberculosis) (UGA-C-TASO (The AIDS Support Organization)) and Health System Strengthening-HSS(UGA-S-TASO) project which had a goal of increasing the uptake of HIV/TB services among key populations. This was done through empowerment of their communities with engagements of advocacy for PWIDs to access quality health services including within policy design, legal frame work review and their participation in national policy debates to fight against stigma and discrimination. Implementation of the HR client strategy for mobilization; follow up PWIDs for adherence support and education on care and treatment for those living with HIV. And community-based service delivery system which designed peer outreach programs that delivered HIV services like condom distribution, voluntary HIV testing and counselling . Development of CBOs' capacities through training in community-based financing and referral system . (Uganda Harm Reduction Network Annual Report 2017)
Lessons learned: The project reached 1,893 PWIDs with 25.9% being females which developed a Good practice guide for HSs for PWIDs. The HR client strategy is a Differentiated Service Delivery Model which has increased the number of PWIDs initiated into care, adherence to treatment, adaptation to safe injecting practices and decentralization of HIV and HR services to CBOs for easy access to PWIDs.
Next steps: HIV services must be resourced sufficiently and scaled up, it will require a transformation of how community-based services are linked and work with HSs through improved linkages and synergies.
Keywords: HIV services, CBOs, PWIDs, Health Systems, HR client strategy

TUPEE333

Retention in Care for Clients Initiated on ART in the Community at Health Facility in a Rural Setting in Zimbabwe

Muchedzi Auxilia, Mudzengerere Fungai H, Mahachi Nyika, Tafuma Taurayi, Dhliwayo Rumbidzai, Mawora Peter, Zulu Tinashe, Basopo Beloved, Mangena Loveness
FHI360, Harare, Zimbabwe

Background: Zimbabwe has made significant progress towards attaining the UNAIDS 90-90-90 targets. However, ensuring timeous ART initiation for people newly diagnosed with HIV at community levels remains a challenge. FHI 360-Zimbabwe's HIV Care and Treatment (ZHCT) Project provides community-index-testing and facilitates differentiated ART initiation at the nearest facility or though community ART initiation as a strategy to increase uptake of antiretroviral therapy (ART) initiation. For the project to understand the retention rates among clients initiated on ART in the community and those initiated at health facilities, an assessment was conducted to compare retention rates on ART of these two populations.
Methods: A retrospective review of programme data was conducted to determine the retention rates on ART for all people newly diagnosed through community-index-testing in one rural District. People that were initiated on ART in the community or at a health facility between April 2016 to December 2017 on the FHI 360 project were followed-up. Data on retention up to 12 months after ART initiation were collected from the health facility registers. The data were entered and analysed using SPSS version 24.
Results: Of the 441 participants tested through community index testing, 180 (40.8%) were initiated on ART in the community. A total of 153(85%) and 209 (80%) of those initiated in the community and heath facility respectively were retained in care at 12months. There was no statistical difference in clients initiated in the community compared with those initiated at the facility at 3 and 12 months, but the difference was significant at 6 months [OR=2.487 (95%CI: 1.303, 4.746), with a p=0.006].
Conclusions and Recommendations: This study shows that although most of the clients preferred initiation of ART at the nearest health facility, a significant proportion preferred and was initiated on ART in the community. There was a significant difference in the retention rates at 6 months after ART initiation among those initiated in the community and at the health facility. For epidemic control in Zimbabwe, we recommend scaling up of ART initiation delivery models that increase uptake of ART initiation among people diagnosed of HIV.

TUPEE334

Community Improvement Team: A Hidden Resource for Achieving UNAIDS 90:90:90 Targets in a Low Resource Setting

Oke Olufemi[1,2], Awotunde Williams[3], Olashore Emmanuel[3], Nwaonye Paul[3], Oke Rebecca Oluwaseun[4]
[1]Catholic Relief Services, Abuja, Nigeria, [2]Ladoke Akintola University of Technology Teaching Hospital, Department of Community Medicine, Ogbomoso, Nigeria, [3]Catholic Relief Services, Health, Lafia, Nigeria, [4]Ekiti State University, Ado-Ekiti, Department of Nursing, Ado-Ekiti, Nigeria

Issues: The UNAIDS 90:90:90 goal aimed at ensuring 90% of all living with HIV know their HIV status, 90% diagnosed HIV infection placed on antiretroviral therapy (ART) and 90% of all people receiving ART will achieved viral suppression by 2020. This strategy is promising to yield a huge success in HIV programing, however the scarcity of resources posed a threat to its realization. Concerted effort of community stakeholders in mobilizing resources is recommended for the attainment of this target. This abstract aimed at explaining the role of Community Improvement Team (CIT) in achieving the UNAIDS targets.
Descriptions: Sustainable Mechanism for Improving Livelihoods and Household Empowerment (SMILE) project implemented by a consortium led by Catholic Relief Services (CRS) through the funding support of USAID. CIT is a body established by SMILE in 2017 to bring together already existing community structures. Through advocacy and orientation meeting, gate keepers of the different community structures were sensitized on the goal and responsibility of CIT by SMILE team. Thus, the CIT serves as a structure for dissemination of information and mobilization of community members for HIV Testing and Counselling (HTC), complement SMILE in the mobilization of resources for referral and linkage to treatment, reduce stigma and discrimination through education and regular community dialogue. The CIT also provided resources for PLHIV support group meetings to improve adherence to ART.
Lessons learned: Due to the wide engagement of stakeholders through the CIT in Nasarawa State, Nigeria, 108,703 (82,996[76.3%] children; 25,707[23.7%] caregivers) beneficiaries were mobilized to access HTC, out of which 1420 (1.3%) tested positive comprising of 130(M:63; F:67) children and 1290(M:79; F:1211) caregivers were linked to treatment. Thus, CIT helped to increase the number of PLHIV that know their status, number of people on ART and number of people achieving viral load suppression through their various activities.
Next steps: The CIT creates an avenue to increasingly mobilize domestic resources towards ending HIV/AIDS epidemic and related social barriers to household resilience because of their full participation and ownership of the project. The CIT is a valuable structure to be leverage upon in the communities by all IPs to achieve immense result with little resources.

TUPEE335

Scaling up Treatment Access among Pregnant Women and Lactating Mothers in the Western Area and Portloko District

Jimmy Musu Anthonia
Institute of Advance Management and Technology, Development and Economics, Freetown, Sierra Leone

Issues:

▪ Coverage is limited to 12 healthcare facilities in the western Area, and Port Loko;
▪ Delay on the part of Counsellors in collating reports at the end of month;
▪ Availability of IEC materials and baby packs to promote institutional delivery;
▪ Stipend and transportation for supervisors and volunteers not sustainable and motivational;
▪ Stigma and discrimination at service delivery points for pregnant women and lactating mothers.

Descriptions:

▪ M2M programme started in 2017 under the Simplified Approach Process (SAP) grant and continued in 2019 under the Programme Continuation Request (PCR) grant supported by Global Fund/NAS and SOLTHIS.
▪ Mother to Mother (M2M) programme works with volunteers who were trained and attached to healthcare facilities ▪The Mother to Mother program works to strengthen healthcare delivery systems, while creating empowerment for HIV positive women.
▪ Volunteers work in the Western Area (Urban and Rural) and Port Loko district to provide counselling, support infant and young child feeding practices and the elimination of mother to child transmission of HIV
▪ The program targets HIV positive pregnant women and lactating mothers.

Lessons learned:

▪ Programme demonstrates positive trajectory in scaling up HIV service uptake among pregnant and lactating mothers in the Western Area and Portloko district; ▪Promoted solidarity among women living with HIV;
▪ The good practices of this initiative should be shared and possibly adopted to promote the Elimination of Mother to child Transmission of HIV agenda.

Next steps: Partners and Government of Sierra Leone to ensure the availability of Information Education and Communication tools and baby packs to promote institutional delivery; To extend coverage to other health facilities around the country; To ensure that stigma and discrimination is reduced or eliminated at service delivery sites for pregnant and lactating mothers; Provision of other facilities to motivate volunteers.

TUPEE336

Dispensation Communautaire des ARV comme Réponse pour la Rétention: Expérience de Humanity First Cameroon avec les HSH à Yaoundé

Tchombe Yemy Antoine Herve
Humanity First Cameroon, Yaoundé, Cameroon

Issues: Au Cameroun, seulement 40% des personnes éligibles au traitement antirétroviraux (ARV) y ont accès à cause de l'engorgement des structures sanitaires. Face à la discrimination, les populations clés (PC) ne sont pas toujours confortables à utiliser les services de soins. En réponse à ces constats, la dispensation communautaire des ARV a été initiée depuis 2016.(HFC) a évalué la rétention dans les soins des hommes ayant les rapports sexuels avec d'autres hommes (HSH) sous ARV en stratégie de dispensation communautaire.
Descriptions: Dans le cadre de l'enquête de satisfaction qui s'est tenue à HFC,au mois de mai 2017,ou il a été utilisé les questions ouvertes et fermées, les différentes thématiques étaient les suivantes : l'accueil au centre d'écoute, le temps d'attente (retrait des médicaments), le circuit de ravitaillement, et le suivi des personnes sous traitement ARV. Le recrutement des patients s'est fait selon l'algorithme national de dispensation communautaire des ARV : être dans une formation sanitaire, avoir 2 charges virales (CV) indétectables, être observant, ne pas développer les maladies opportunistes, et être en 1ère ligne de traitement ARV. La rétention a été évalué selon le nombre de patients qui respectent leur rendez-vous chaque mois, par rapport aux années antérieures.
Les patients ont reçu au centre d'écoute de HFC chaque mois leur ARV par une équipe de 4 conseillers psychosociaux formés par le comité national de lutte contre le SIDA (CNLS) et le groupement technique régionale (GTR). Ces patients ont aussi bénéficiés des : conseils en éducation thérapeutique, les groupes de soutien pour l'aide à l'observance et les activités de ressourcement pour le bien-être des patients.
Lessons learned: Entre Juillet 2017 et Juin 2019, nous avons enrôlé 242 HSH. L'âge des bénéficiaires varie entre 18 et 50 ans. Nous avons un taux de rétention de 96% (par rapport à 87% avant la mise en place de cette stratégie). L'enquête de satisfaction montre que les bénéficiaires sont satisfaits du service communautaire très «gay friendly » (par rapport aux structures sanitaire). Le taux de suppression virale est de 91,21% (187 sur 205).
Next steps: Il serait intéressant de pérenniser et étendre cette stratégie afin de : - désengorger les unités de prise en charge ;
- offrir un service rapide, convivial dénué de stigmatisation aux PC;
- améliorer la rétention et l'observance thérapeutique des bénéficiaires ;
- Supprimer la CV.

TUPEE337

Dépistage Communautaire et Démédicalisation en RCA : Impact des Actions Coordonnées de Renforcement de Capacités et de Plaidoyer Menées par la Plateforme Coalition PLUS Afrique Centrale et Est (PACE)

Sikitu Ingrid-Zaïre[1], Rwimo Patricia[2], Ngombe Cyriaque[3], Mommessin Stanislas[4]
[1]ANSS, Membre de Coalition PLUS, PACE, Bujumbura, Burundi, [2]ANSS, Membre de Coalition PLUS, Coordination Natinale, Bujumbura, Burundi, [3]ANJFAS, Membre de la PACE, Bangui, Central African Republic, [4]Coalition Internationale Sida, Pôle des Plateformes, Paris, France

Questions: La prévalence nationale du VIH était estimée à 4% au Centrafrique en 2017, avec des taux de 28,6% pour les hommes ayant des rapports sexuels avec des hommes (HSH) et 9% pour les travailleuses du sexe (TS). Seul 53% des personnes vivant avec le VIH connaissent leur statut sérologique. Face à ces enjeux, le Gouvernement a autorisé le partage des tâches aux agents de santé communautaire depuis 2018. Pour concrétiser cette décision, la PACE avec l'Association Nationale des Jeunes Femmes Actives pour la Solidarité/ANJFAS, son partenaire centrafricain, s'est engagée dans un processus alliant renforcement de capacités (RC) et plaidoyer pour obtenir le déploiement effectif du dépistage communautaire.
Description: La PACE a organisé une formation au dépistage démédicalisé pour 27 pairs-éducateurs issus des communautés vulnérables (HSH, TS, militaires, jeunes, femmes infectées). Afin de rendre le dépistage communautaire opérationnel, la PACE a également inclus un volet de plaidoyer ciblant les partenaires techniques et financiers/PTF influents : le Ministère de la Santé, le Conseil National de lutte contre le Sida, les agences des Nations-Unies (ONUSIDA, UNICEF et UNFPA), Croix Rouge France et CORDAID (récipiendaire principal et sous récipiendaire du Fonds Mondial en RCA) et la Première Dame. Les PTF furent conviés à l'ouverture de la formation, à la conférence de presse tenue en marge de l'atelier et rencontrés individuellement par les chargés de plaidoyer.
Leçons apprises: Associer le RC et le Plaidoyer est une approche efficace pour obtenir des engagements concrets. A l'issue de la mission, le gouvernement et les PTF ont soutenu la mise en œuvre de la démédicalisation. ANJFAS bénéficie l'appui financier de l'ONUSIDA, des intrants de CORDAID et a été sollicitée par la Première Dame pour réaliser une activité de dépistage démédicalisé. Trois mois après la formation, ANJFAS a dépisté 796 personnes dont 3,14% ont reçu un résultat positif, 92% d'entre elles ont été accompagnées et mises sous traitement.
Prochaines étapes: Ce travail en RCA fait l'objet d'un suivi afin que les efforts déployés se poursuivent, et sera dupliqué dans d'autres pays de la région tels que le Congo. Néanmoins, la mobilisation de moyens matériels et financiers reste indispensable pour le déploiement des pairs éducateurs dans les communautés vulnérables et la mise à échelle des activités en RCA.
But : Démédicalisation est réelle, Cible: Vulnérables au VIH, Lieu : Bangui en RCA

TUPEE338

Les Plateformes Africaines de Coalition PLUS : Des Socles d'Expertise Communautaire pour la Démédicalisation du Dépistage

Sylla Aliou[1], Mommessin Stanislas[1], Bennani Fouzia[2], Dembele Bintou[3], Gapiya Jeanne[4], Antoine Melissa[5], Alliou Sylla[6]

[1]Coalition Plus Afrique, Reseaux, Dakar, Senegal, [2]ALCS, Casablanca, Morocco, [3]ARCAD-SIDA, Bamako, Mali, [4]ANSS, Bujumbura, Burundi, [5]PILS, Port-Louis, Mauritius, [6]Coalition PLUS Afrique, Dakar, Senegal

Background: Le dépistage du VIH reste la condition *sine qua non* à l'atteinte des 90-90-90. Dans des contextes africains d'épidémies concentrées aux populations clés (PC), les organisations communautaires réunies au sein des Plateformes africaines de Coalition PLUS (PF) ont développé des activités de dépistage communautaire, dans des contextes nationaux parfois hostiles à la démédicalisation. Pour ce faire, les PF ont mis en place un paquet cohérent d'appuis techniques (AT) qui visent à améliorer la qualité du dépistage démédicalisé.

Methods: Ce paquet minimum d'activités comprend :

- L'élaboration de cartographie des lieux de vulnérabilité par PC
- Les formations de pairs-éducateurs au dépistage démédicalisé
- Les appuis en S&E afin de suivre et mesurer l'impact des activités et la contribution des organisations communautaires au dépistage
- La mise en place de stratégies de plaidoyer dans les contextes nationaux réticents

Entre 2017 et 2019, 23 appuis techniques ont été délivrés envers 13 associations dans 9 pays (Mauritanie, Maroc, Madagascar, Maurice, Togo, RCA, Burundi, Niger, Sénégal et Cameroun).

Results: A l'échelle de ces 9 pays, le nombre de dispositifs de dépistage communautaire est passé de 16 à 40 en 2019. Au total, 60 000 personnes issues des PC, majoritairement HSH et TS, ont été dépistées avec un taux moyen de détection des cas positifs de 2.1%. Au Togo, Niger, Sénégal et Cameroun, ce taux moyen de détection de cas positifs culmine à 8.9% chez les TS et à 12.3% chez les HSH. Ainsi, les dispositifs de dépistage communautaires renforcés ou créés par les PF parviennent à déployer des activités de dépistage parfaitement ciblées.

Ainsi les PF Océan Indien et Afrique de l'Ouest sont aussi parvenues à être identifiées comme des socles d'expertise communautaire légitimes, en investissant notamment des canaux d'AT traditionnellement attribués aux experts internationaux parmi les bailleurs tels que l'initiative 5%.

Conclusions and Recommendations: Dans des contextes où le manque de ressources humaines en santé empêche de relever le défi de la fin de l'épidémie d'ici 2030, l'implication des agents communautaires dans le dépistage, mais également dans tout le continuum de soin devient nécessaire. Dans cette perspective, les modèles innovants de réseaux qui concentrent les expertises communautaires, telles que les PF de Coalition PLUS, doivent être positionnées comme prestataires d'AT dans la mise en œuvre de politiques nationales de partage des tâches.

TUPEE339

"Scoping and Scoring": Building Evidence for Community-led Advocacy for HIV Services in Zimbabwe

Mlambo-Chimombe Loveness[1], Webb Karen[1], Page-Mtongwiza Sara[1], Masiye Kenneth[1], Mbetu Patricia[1], Mashoko Chamunorwa[2], Chinyanga Tinashe[1]
[1]OPHID, Harare, Zimbabwe, [2]Advocacy Core Team, Harare, Zimbabwe

Issues: In high HIV prevalence settings, advocacy remains crucial for ensuring resources are directed to where they will have the greatest impact. Civil Society Organizations (CSOs) and communities play an important role in monitoring HIV programs and advocating for improved service quality. While community response is recognised as a "critical enabler", CSOs are too often mobilizing communities with limited access to data and program evidence to inform their actions.
Descriptions: The Evidence for Advocacy project developed a model for enhanced civil society engagement at service delivery level, focused on accountability for quality health services as a shared responsibility between communities and health facilities. CSOs in 5 Districts of Zimbabwe were supported to develop data-driven strategies and documentation of input and outcome advocacy focusing on 1) HIV testing; 2) Viral load monitoring; 3) Drug availability & identifying and reporting adverse drug reactions. Using a Community Scoping tool, CSOs identified geographic locations of interest, defined community composition,community needs and documented gaps in HIV service provision. The Community Scorecard documented baseline perceptions of key affected groups on HIV services.
Lessons learned: From Feb-Mar 2019, Community Scoping responses identified adolescents (27%), female sex workers (18%) and artisanal miners (11%) as subgroups most affected by HIV in participating communities. Men (26%) and adolescents (24%) were identified as groups with greatest unmet testing needs. HIV self-testing and service access among the most affected had highest rates of 'very bad' on likert-scale community scorecard responses (39% and 15% respectively). Key gaps identified through community scoping and scoring informed project activities, monitored in collaboration with facility-based Health Centre Committees, interrogating facility data.
Next steps: The Evidence for Advocacy project demonstrates capacity of CSOs to transcend anecdotal evidence and accelerate quality of HIV services through robust facility and community monitoring. A well-structured, participatory monitoring system enables CSOs and affected communities to reflect on differentiated strategies required, design context specific strategies, co-create messages and advocacy actions to close gaps in the HIV treatment cascade. CSOs will repeat the evidence exercise at project end to provide outcome evidence for advocacy activities upon quality of HIV services.

TUPEE340

Strengthening the Capacity of Civil Society Organizations Using Embedded Advisors: Evidence from the USAID Care Continuum Project

Avle-Gavo Rita Emefa[1], Adiibokah Edward[2], Rahman Yussif Ahmed Abdul[1], Tun Waimar[3], Kye-Mensah Ebenezer[1], Weiss Ellen[4], Nagai Henry[1]

[1]JSI Research and Training Institute Inc., Accra, Ghana, [2]Population Council, Accra, Ghana, [3]Population Council, Washington, Ghana, [4]Population Council, New York, United States

Issues: The global response to the HIV epidemic is rapidly changing, with more emphasis on high-impact and scalable interventions, within the context of dwindling resources. Although local civil society organizations (CSOs) play a pivotal role in HIV epidemic control, many CSOs lack the needed capacity to fulfill their potential. The USAID Strengthening the Care Continuum project embedded HIV knowledge experts - Embedded Advisors (EAs) as a capacity-building strategy into select CSOs in Ghana in response to this need

Descriptions: In 2017,18 EA, (2 Monitoring and evaluation, 7 technical, 4 financial, 6 administrative experts) were embedded into seven CSOs for at most 45 days to provide mentorship and capacity building of CSO staff in order for the CSOs to identify, adopt and implement effective and sustainable interventions across the HIV treatment cascade for key Populations (KPs). CSOs were assisted to conduct technical capacity assessment (TCA) of their organization this was used to develop action plans for technical assistance (TA). To sustain the gains, the EAs supported CSOs to document their innovative strategies and formalize their management information systems. Post-intervention technical capacity assessments were also conducted and data triangulated with pre- and post-intervention TCAs, meeting reports, job descriptions, terms of reference, end of contract reports, and 20 in-depth interviews with staff and executives of the CSOs. Data were analyzed using content and thematic framework analysis.

Lessons learned: Key achievements included aligning guidelines for field HIV testing services (HTS) with the National HTS guidelines, developing an outreach HTS checklist for adherence to standardized practices, and integrating social media as a tool for linking hidden KPs to HTS. The result of using social media by a CSO lead to reach and testing 27 MSM with 16 testing positive for HIV. Counterpart staff within the CSOs who worked closely with the EAs are currently playing a lead role in integrating the new learnings. The EA intervention was viewed as a more effective and sustainable alternative to the conventional off-site training or use of consultants.

Next steps:The strategy of EAs shows promise as an effective and acceptable approach to capacity building and institutional strengthening for local CSOs in Ghana. Using short-term embedded advisors, with clear exit strategies may help to sustain knowledge and skills and continued programmatic success

TUPEE341

Integrating High Impact HIV Services in OVC Programming to Contribute to 90-90-90 Targets

Ginindza Bindza, Kisyombe Daisy, Miller Nicole, Wright Molly
Pact Eswatini, Mbabane, Eswatini

Issues: HIV treatment adherence and Viral suppression are not making significant progress for children living with HIV in Eswatini despite the recent success in adult population. Viral suppression among children is less than 75% (SHIMS 2, 2018). One of the aims of the project is to link Orphaned and Vulnerable Children (OVC) living with HIV to care. The project collected data on beneficiaries' HIV and treatment status. Some of the beneficiaries that were identified as living with HIV were not on treatment.
Descriptions: The project used the HIV Testing and Screening tool for eligibility of HIV testing of the beneficiaries. From the HTS screening results; beneficiaries that are HIV positive and not on treatment are identified and linked back into care. The OVCs are also supported and encouraged to join Adolescents Living HIV (ALHIV) support groups that meets at health facilities and jointly facilitated by nurses and project field officers. The support groups are also used for ARV refill and offer psychosocial support to adolescents. This is one way that helps to ensure that the beneficiary is adhering to treatment.
Lessons learned: The project strengthened relationships with the local health facility to ensure that all ALHIV not on treatment are linked back to care. The project trained field officers to conduct teen clubs with the assistance of a local nurse to address the shortage of human resource in the facility. The local clinics uses the project for follow up of children and adolescents that had missed appointments. The community cadre also encourages families and share benefits of adolescents attending teen clubs and ensures linkage to nearest teen club. The project linked 385 newly identified, defaulted, or lost to follow up adolescents living with HIV to HIV care and treatment services (128% of the target of 300). By the end of the project a total of 1257 ALHIV were attending teen clubs and adhering to treatment.
Next steps: The Project has mobile clinics and have recently started initiating beneficiaries into ART. Instead of referring the beneficiaries to the nearest health facility for linkage into care, it will be easy to ensure that they are initiated into treatment. Once a client tests positive the clinical mobile team is able roll out index testing. This will ensure that more people at risk know their status and are initiated into treatment.

TUPEE342

The Language Barrier in delivering Sexual and Reproductive Health Information and Services among hard-to -reach communities, particularly, people in Dzita, Ghana: a qualitative approach

Wayne Naa-Amy[1], Aayire Phylicia[2]
[1]Youth Action Movement & Founder of Faith, Hope &Love Group, Accra, Ghana, [2]Akuse Government Hospital, Nurse, Koforidua, Ghana

Issues: The Volta region has the highest percentage of adolescent mothers in Ghana. About 18% of the adolescent population are mothers, and currently about 4.1% are pregnant with their first child (Ghana Demographic and Health Survey, 2014). One reason for the high fertility rate in Volta region is due to limited access to SRH and services. This is because of a language barrier when it comes to the implementation of SRH information and services in local dialects such as Ewe, which is the predominant language spoken in Dzita, a fishing community in the Volta Region. This study therefore explores insights on barriers, with focus on the extent of language barrier to the utilization of Sexual and Reproductive Health (SRH) Information and Services in Dzita

Descriptions: Focus group discussions (FGDs) and individual assessment interviews were conducted among youth (12-23 years), adults (25-75 years) and key community members (assembly members, the community health nurse and physician's assistant), then grouped into age categories. The interview focused on obtaining insights on the impact of language barrier on the utilization of SRH information and services. This was done concurrently with HIV Testing after a Breast Cancer Screening and checking of general body statistics. The data was written out utilizing a given sequence of information in a matched pattern then aggregated into specific areas for analysis and documentation.

Lessons learned: The study revealed that about 70% of participants did not understand English, and needed constant interpretation during the intervention especially regarding sexual and reproductive health (SRH) language. It was also noticed that, there were no specific words to aptly describe some reproductive health terms in the local dialect, which was a big barrier. Again, young people have limited access to SRH information and services with just those in-school having little information due to some topics treated in school with young girls as young as 14 having birthed their first child. This study has proven that the language barrier remains one key gap in obtaining SRH information and services in hard-to-reach communities.

Next steps: This study has proven that the language barrier remains one key gap in obtaining SRH information and services in hard to reach communities. Thus, it is imperative that SRH is also taught in the local dialects of inhabitants so as to enable understanding and aid them relate to the issues. Consequently, this will aid them in making more informed decisions concerning their RH and help reduce teen pregnancy among the youth.

Keywords: Sexual and Reproductive Health (SRH), Reproductive Health (RH), Health Services, HIV, Breast Cancer Screening, Ghana, Volta Region, Dzita, Family planning, SRH language

TUPEE343

Understanding the Challenges along the HIV Cascade: Key to Addressing and Achieving the Third 90-90-90 Target by 2020

Edison Linda[1], Appiah Patrick[2], Serwaa-Gyamfi Maame[3], Dzitrie Collins[1], Senoo Cecilia[1]
[1]Hope for For Future Generations, Programmes, Greater Accra, Ghana, [2]Hope for For Future Generations, Programmes/M & E, Greater Accra, Ghana, [3]Hope for For Future Generations, M & E, Greater Accra, Ghana

Issues: Many African countries including Ghana are making efforts to achieve the global 90-90-90 target by 2020 through targeted HIV interventions for Key Populations. HIV programs and activities are all skewed towards achieving the 90-90-90 target with emphasis on the second and the third 90. Despite efforts been made, Ghana's achievement stands at 55-61-66. Efforts of Civil Society Organizations (CSOs) to complement government's efforts, the 90-90-90 targets are not been achieved. This abstract tries to understand the challenges in achieving the second and third 90 among Key population in Accra Metropolitan Assembly (AMA).
Descriptions: Hope for Future Generations (HFFG) is partnering four health facilities in implementing the USAID Strengthening the Care Continuum project among Female Sex Workers (FSW) in AMA. During stakeholder's engagement, project managements and review meetings, HFFG tried to identify challenges affecting the progress of the 90-90-90 of targets. Discussions were also made with ART in-charges, Data Officers, Laboratory Technicians and Case Managers in the four health facilities collaborating with HFFG and introduced them to the viral load (VL) google calendar which alert them when a client is due for viral load test. Strategies were developed in solving some of the issues and management started advocating at higher platforms to ensure these challenges are addressed.
Lessons learned: As at December 2018, 432 FSW PLHIV were initiated on ART and 176 were due for VL. 42(24%), tested and received their results out of which 41 (23%) were virally suppressed which is lower than the global target of 90%. Breakdown of viral load (VL) machine, delay in transporting blood samples causes contamination of blood which hinders clients receiving their VL test result. These affect the achievement of the third 90. These challenges which were discussed yielded results such as installment of a new viral load machine at National Public Health and Reference Laboratory, Korle Bu and the introduction of courier service to transport blood samples to the laboratory.
Next steps: All stakeholders, policy makers, health workers, civil society organizations and the private sector all who matter in the provision of HIV services needs to collaborate effectively and efficiently at all level. This will go a long way in addressing the challenges along the HIV cascade which is key to achieving the global 90-90-90 target by 2020.

TUPEE344

Psycho-social Accompaniment of Persons Living with HIV/AIDS in a Community Health Centre in Yaoundé, Cameroon

Ndassie Raissa[1], Katte Jean Claude[2], Loni Ekali Gabriel[3]
[1]3rd Millennium Community Health Center, Yaoundé, Cameroon, [2]Faculty of Medicine and Biomedical Sciences of the University of Yaoundé I, Public Health, Yaoundé, Cameroon, [3]National AiIDS Control Committee, Yaoundé, Cameroon

Background: Psycho-social support is a key aspect of HIV/AIDS management. Grass-root community support has been shown to be pivotal in management people living with HIV/AIDS in low-resource settings. We therefore aimed to describe the psycho-social accompaniment pattern of persons living with HIV/AIDS in a community-based health center in Yaounde, Cameroon.
Methods: We reviewed psycho-social data collection sheet from the 3rd Millennium Community Health Center over a period of one year from January to December 2018. We looked at the number of education talks on personal HIV care, focus group discussion on therapeutic education, numbers lost to follow up, numbers of persons receiving ART and the mode of delivery of ART.
Results: The total number of cases seen at this community health centre was 116. The majority of persons were women (76) representing 65.5%. Total number of educative talks organised throughout the year was 153. Number of focus group discussions on therapeutic education and treatment strengthening was 40. A total of 73 (women representing 65.7%) persons were newly diagnosed during the course of the year. Just 1 case of death from persons regularly coming to the health center was registered. Number of persons on ART after 12 months was 110 representing 94.8%. ART were in the majority of cases delivered at evening/night working sessions in 75% of cases and 25% during the day working sessions. Reasons for this disparity were mainly fear of stigmatisation and nature of jobs/working shifts of the persons living with HIV/AIDS.
Conclusions and Recommendations: Majority of persons receiving treatment and psycho-social support came during the night working shifts for fear of stigmatisation. The number of educative talks and focus group discussions may be the key element for the psycho-social support received at this community health center. Recommend education and therapeutic accompaniment focused on breaking the fear of stigmatisation amongst this group of persons living with HIV/AIDS.

TUPEE345

Linkage to HIV Treatment Services and Retention in Care; Trend in Northern Nigeria

Onu Kema[1], Kolawole Mobolaji[1], Awunor Christie[1], Orisakwe Chigozie[1], Oligbi Suprena[2], Achebe Stella[2]
[1]AIDS Healthcare Foundation, Clinical, Abuja, Nigeria, [2]AIDS Healthcare Foundation, Prevention, Abuja, Nigeria

Background: HIV Testing, linkage to care, treatment adherence and retention remains the major prongs in the continuum of care cascade. Assessing care outcomes among clients engaged into treatment services depends largely on their retention in care (defined as continuous engagement in appropriate medical care). Knowing where the drop-offs are most pronounced, and for what populations, is vital to knowing how, where, and when to intervene to break the cycle of HIV transmission.
Methods: This study examines a cohort 1219 Loss to follow up (LTFU) clients from November 2012 to November 2018. Means and proportions where used to determine the time to LTFU, route of entry into care; HIV Outreach testing model, facility based PITC services, referral services and transfer-in from other facilities. The timing of LTFU from HAART commencement was analyzed 3 monthly for 24 months. All patient who became LTFU were grouped into a cohort using the month of being LTFU and compared with the month of HAART Commencement.
Results: Overall, 663(54%) were lost to follow up from 0-3months, 362(29%) between 4-6months, 117(9.6%) between 7-9months and 35(3%) from 9-12months after the day of HAART start. Out of the total LTFU, 288 (22%) came in from Referral services, 820 (67%) from facility HTS, 107 (9%) from outreaches and 26 (2%) from transfer In. Male 322(26.4%) and female is 897 (73.5%) contributed to LTFU.
Conclusions and recommendations: Client retention rates decreases overtime with a peak within 3 months of HAART commencement, most pronounced in female clients linked to care via facility HTS. A more comprehensive surveillance of these target population within the 3-month timeframe in a cosmopolitan and resource limited setting serves as an intervention strategy. It remains to be established why Facility HTS model generates more LTFU. By identifying gaps and implementing improvements, we can increase the proportion of people living with HIV who are prescribed ART and are able to stay engaged in HIV medical care and adhere to their treatment so that they can achieve viral load suppression.

TUPEE346

Plaidoyer auprès des Décideurs sur le Délai des Rendus de Résultats de la Charge Virale au Mali Basé sur des Évidences Établies en 23 Mois de Collecte Systématique des Données sur 4 Sites à Bamako

Kone Dramane
JUT, Informatique, Baguinéda, Mali

Issues: Le délai de rendu des résultats de la charge est un défis majeur au Mali.
Descriptions: Démarré en janvier 2017 le projet OCT est à sa dernière année de mise en œuvre. Après une phase intense de collecte de données de juillet 2017 à juin 2019, il entre dans sa phase de plaidoyer basée sur les preuves établies par l'analyse des données collectées.
Les indicateurs de la charge virale de juillet 2017 à juin 2019:Nombre de PVVIH ayant reçu le test de charge virale:297 USH; 620 TS; 00 UDI; 91 femmes enceintes; 876 JH (15-24 ans);316 JF (15-24 ans) pour un total de 5558 PVVIH. Nombre de PVVIH qui ont reçus les résultats dans deux semaines: 213 HSH; 3 TS; 0 UDI; 64 Femmes enceintes; 363 JH(15-24ans); 78 JF(15-24ans) pour un total de 1612 PVVIH. Nombre de PVVIH qui ont reçu les résultats entre 15 jours et 3 mois: 30 HSH; 15 TS; 0 UDI; 1 femme enceinte; 149JH (15-24ans); 160JF (15-24ans); pour un total de 2316 PVVIH. Nombre de résultats non rendus: *54 HSH;44 TS; 0 UDI; 26 femmes enceintes;364 JH(15-24ans);78 JF(15-24ans) pour un total de 1630 résultats de CV non rendus.*
Lessons learned: La contre-performance du rendu des résultats de la CV entraine la démotivation des médecins à donner le test de la charge virale; les problèmes d´éthique (on me prélève pourquoi faire avec mon sang ?); le problème de la conservation des échantillons s´il faut attendre des mois pour les traiter; le risque de destruction des échantillons de sang (problème de conservation); le gaspillage de ressources tant matériels que d´efforts humains; le risque de perdre des vies humaines pour manque de suivi efficace.
Next steps: Signature d´un contrat tripartite RMAP+; SE/HCNLS-CSLS/MSAS sur l´implication du RMAP+ dans l´offre de service de CV. Signature d´un contrat de maintenance avec ASL dont les termes seront connus de tous les laboratoires de CV. Elaboration d´un plan opérationnel national d´accès à l´offre de service de charge virale à court terme.

TUPEE347

Effects of HIV/AIDS Donor Funding on Primary Healthcare Delivery in Southwest Nigeria

Awolaran Olusegun[1,2], Adefemi Kazeem[3], Yates Caroline[3], Bakare Joseph[4]
[1]West African Health Organization, Primary Healthcare Services, Bobo Dioulasso, Burkina Faso, [2]University of Ibadan, Community Medicine, Ibadan, Nigeria, [3]Curtin University, Department of Health Policy and Management, School of Public Health, Perth, Australia, [4]Damien Foundation, Ibadan, Nigeria

Background: Over the last couple of decades, this has resulted in large influx of funds made available to developing countries like Nigeria. This qualitative research explores the effect of more than a decade of HIV/AIDS donor funding on health services in southwest Nigeria, through the experiences of hospital administrators.
Methods: This qualitative study was conducted among twelve senior healthcare professionals who worked in facilities running HIV/AIDS funded programs in both rural and urban communities in Southwest Nigeria. Data collection was done over a 3-month period via in-depth and semi-structured interviews. Transcription of data was done by professional service and data analysis was aided with the use of QSR Nvivo 10.
Results: The findings from this study showed that healthcare providers' experience with donor funded HIV/AIDS programs has been largely diverse and varied. On the positive note, it has promoted professional development with the extra skills the health workers had gained through training and capacity building. The provision of laboratory equipment has also empowered many facilities, enabling them to perform tests, and offer services that were hitherto impossible. On the other hand, the study found that there has been increase in workload to unbearable levels partly due to the multiple roles the health workers have to play to satisfy donor requirements, this has not necessarily translated to increase in remuneration or extra incentives. There is also the differential incentives given to health workers who participated in HIV/AIDS programs which those who are not on the program do not get, this can negatively affect moral and commitment of staff, and this could erode some of the gains of the program. Furthermore, there is a reduction in number of staffs available due to the fact that some health workers have gotten employment with better paying donor funded non-governmental organizations (NGOs).
Conclusion and Recommendations: The findings from this study support previous contention that HIV/AIDS funding improves professional development, contributes toward infrastructural upgrade, and improves the quality and coverage of HIV services. These are hitherto unreported effects of HIV programs on health services that need to be further explored for their impacts on primary healthcare delivery in beneficiary countries and in designing potential strategies to confront these challenges and to ensure a more positive program experience.

TUPEE348

Economic and Public Health Impact of Decentralized HIV Viral Load Testing in Kenya

de Necker Margreet[1], de Beer Janetta Catharina[1], Stander Marthinus Petrus[1], Connell Craig Duane[1], Mwai Daniel[2], Mhazo Tinashe[3]

[1]TCD Global, TCD Outcomes Research, Centurion, South Africa, [2]University of Nairobi, School of Economics, Nairobi, Kenya, [3]Value in Research, Centurion, South Africa

Background: The HIV Epidemic is a global health challenge and Kenya has the fourth largest HIV burden in the world. Several strategies have been adopted to control the epidemic, including the implementation of viral load (VL) testing to monitor HIV patients on ARV treatment. Funding for the HIV response in Kenya continues to be a challenge and though impressive gains have been made resulting in fewer new infections and improved access to Antiretroviral therapy, more still needs to be done to achieve the UNAIDS 90:90:90 goals. This study aimed to estimate the economic and public health impact of incorporating HIV viral load testing on the existing GeneXpert install base. The GeneXpert system is a state-of-the-art diagnostic platform that can measure, amongst others, HIV VL and at present is extensively used in Kenya for diagnosis of tuberculosis.

Methods: Markov models were built for the following three populations: non-pregnant women, pregnant women and children. The scenarios analysed were 100% centralized VL testing compared to 50% GeneXpert plus 50% centralized VL testing, with time intervals of 5 years for the adult and child populations, and 31 months for the pregnant population. Incremental effectiveness was estimated in terms of the number of HIV transmissions or opportunistic infections avoided when implementing the GeneXpert scenario compared to a 100% centralized scenario

Results: The model showed that, for all three populations combined, the GeneXpert scenario resulted in 117 less HIV transmissions and 393 less opportunistic infections. The decrease in cost was $21,978,755 for the non-pregnant and pregnant adults and $22,808,533 for the combined population.

Conclusions and Recommendations: The model demonstrated that decentralising 50% of HIV VL testing with GeneXpert would cost less and will be more viable in terms of total cost per HIV transmission avoided and the total cost per opportunistic infection avoided, except for the pregnant population, when considered independently. From a policy perspective, we believe that the results obtained from this study would be relevant to stakeholders when considering adoption and country implementation of the WHO guidelines for monitoring of people living with HIV.

TUPEE349

Attitude of Nurses Towards Management of HIV/AIDS Patients in a Resource Limited Setting: Implication for General Care

Igumbor Eunice, Agofure Otovwe
Novena University, Public and Community Health, Ogume, Nigeria

Background: The fundamental responsibility of a nurse is to promote health, prevent illness, restore health and alleviate suffering of ailing patients. This unique role of the nurse has however, conflicted with the attitude of some nurses in different health institutions, and especially as it concerns management of patients with infectious diseases such as HIV/AIDS. This study was designed to assess the attitude of Nurses towards management of HIV/AIDS in Obiaruku General Hospital in Ukwuani Local Government Area of Delta State, Nigeria.
Methods: The study adopted a cross sectional design among 100 nurses at the Obiaruku General hospital selected purposively. The instrument for data collection was a structured questionnaire which comprised of socio-demographic characteristics, knowledge of HIV/AIDS and attitude towards HIV/AIDS patients. The collected data was analysed using SPSS Version 21. Descriptive statistics and Chi-Square test were used for analysis at level of significance at $P< 0.05$.
Results: The mean age of the respondents was 38.33 ± 8.22 years and 80.0% were female nurses. Seventy two percent demonstrated good knowledge of HIV/AIDS with a mean knowledge score of 6.33 ± 1.33 while 55% exhibited poor attitude towards HIV/AIDS patients. About 28.0% disagreed that HIV/AIDS patients should be given total nursing care and 70.0% agreed that HIV/AIDS patient should be isolated with empathy. Age of the Nurses, Designation of the Nurses, Knowledge of HIV/AIDS all showed a significant relationship with the attitude of the respondents towards HIV/AIDS patients at ($P< 0.05$). However, sex did not show a significant association with the attitude of the respondents towards HIV/AIDS patients at ($P>0.05$).
Conclusions and Recommendations: Poor attitude of nurses towards HIV/AIDS patients remains a critical factor militating against improving the management and care for HIV/AIDS patients. Therefore, strategic programmes proffering solution to this problem should be implemented among nurses and other health workers at all levels of health institutions to improve the level of care received by HIV/AIDS patients.
Keywords: Knowledge, Attitude, HIV/AIDS, Patients, Nurses, Obiaruku General Hospital

TUPEE351

Factors Affecting Quality of the ART Pharmacy Services in the Health Facilities of North Western Ethiopia

Silesh Asmamaw[1], Asmamaw Endalew[2], Mergia Maru[3], Bekele Eshetu[4]
[1]Clinton Health Access Initiative Ethiopia, HIV, Addis Ababa, Ethiopia, [2]Ethiopian Pharmaceuticals Supply Agency, Gondar, Ethiopia, [3]Clinton Health Access Initiative, HIV, Addis Ababa, Ethiopia, [4]Clinton Health Access Initiative, Addis Ababa, Ethiopia

Background: Currently over 474, 000 patients are receiving ART in Ethiopia. However, stakeholders have reflected their concerns at various in-country HIV forums regarding the ART pharmacy service quality and inadequacy of quality data. Considering such concerns, the Ethiopian Pharmaceuticals Supply Agency (EPSA) and the Clinton Health Access Initiative (CHAI), Ethiopia office, jointly conducted a rapid assessment on the ART pharmacy services in the health facilities of the North Western Ethiopia. The purpose of this assessment was therefore to identify factors affecting ART pharmacy service qualities and data management practice, and to establish a clear set of recommendations based on the results.
Methods: The study was a cross sectional assessment conducted in 47 ART health facilities of the North Western Ethiopia. A structured interview questionnaire was used to collect quantitative and qualitative data from currently practicing ART pharmacy staff during October 16 to November 15, 2018. Every interviewee was requested for his/her consent before starting the interview. Records were also reviewed to complement the responses of interviewees. The quantitative data was analyzed using SPSS version 21.
Results: The assessment showed that 97.9% of ART pharmacy staff are non-pharmacists such as pharmacy technicians; Nurses; and health officers. It was also found that 89.4% of the assessed ART pharmacies are not properly storing their pharmaceutical products. Besides, 76.6% of the ART dispensaries have shortage of dispensing aids such as tablet counters, dispensing envelopes, bottles, and other job aids. Further, the proportion of assessed ART pharmacies with access to functional computer and internet are 19.2% and 4.3%, respectively.
Only 42.6% of the ART pharmacies are capturing, but not regularly, patient and product information during drug dispensing. The assessment also found that 84.2% of adult ART clients in the assessed health facilities are being treated using combination of Tenofovir, lamivudine and efavirenz (TDF+3TC+EFV), which is in line with the 2014 guidelines of Ethiopia.
Conclusions and Recommendations: Inappropriate product handling and poor data management would be attributed to shortage of pharmacists, dispensing aids, and computers. Proper staffing, capacity building, and data system strengthening would help to improve service quality and data management. We also recommend accelerated transition from TDF+3TC+EFV to TDF+3TC+DTG.

TUPEE352

Experience with an mHealth Symptom Reporting Service in People Living with HIV in Uganda

Oseku Elizabeth[1], Mubiru Frank[1], Naggirinya Agnes Bwanika[1], Akirana Josephine[1], Kiragga Agnes[1], Byonanebye Dathan[1], Parkes-Ratanshi Rosalind[1,2]

[1]Ugandan Academy for Health Innovations and Impact, Infectious Diseases Institute, Makerere University College Of Health Sciences, Kampala, Uganda, [2]Institute of Public Health, University of Cambridge, Cambridge, United Kingdom

Background: Symptom surveillance with response is key for increasing quality of care among People Living with HIV (PLHIV). MHealth applications provide cheap and efficient platforms for symptom reporting in PLHIV. We describe the experience of a remote symptom reporting Mhealth tool using Interactive Voice Response (IVR), within a randomised control trial that sought to determine its impact on quality of life.
Methods: PLHIV at two urban Kampala clinics (Infectious Diseases Institute and Kasangati HC) were enrolled into Call for Life™ Uganda (CFLU). They were randomised (1:1 ratio) to intervention (remote symptom reporting, appointments and daily pill reminders and health tips) or control arm (standard of care). CFLU operated in three common languages and prompted patients to report symptoms at the end of adherence reminders and health tip calls or to call in via a toll-free number. Study staff received symptom alerts in real-time and responded via calls. Control patients did not receive reminders, health tips or symptom reporting. We determined the rate of remote symptom reporting and used chi-square test to determine differences in reporting in patients using CFLU.
Results: From August 2016 to November 2018, CFLU enrolled 600 participants (intervention=300). In the intervention arm, 210(70%) were female and 174(58%) had minimum secondary level education. The median age (IQR) was 32(25-40) years. Overall, 243(81.0%) participants placed 1863 symptom alerts. The median (IQR) symptom reporting frequency was 6(2-18) calls per patient. Participants with primary level education were more likely to report symptoms compared to patients with no education or secondary-level education (p=0.017). There were no differences in proportions for gender interactions (p=0.773) or age (age< 25years versus >25years) (p=0.925). Of the 1863 alerts, 921(58.7%) concerned urgent care issues (1248 symptoms); 70(3.7%) clinic appointments, lab results, unwell family members, missed doses, service settings; 116(6.2%) accidental alerts and 756(40.6%) were unverifiable because patients were unreachable. The most reported symptoms were respiratory (27.5%).
Conclusions and Recommendations: Remote symptom reporting using mHealth tools is feasible. Patients with low education were able to use the tool and reporting rates were similar by age and gender. Majority of alerts were urgent care issues. mHealth tools are viable symptom surveillance platforms in resource limited settings.

TUPEE353

Assessing Competencies and Training Needs in Implementing Task Sharing in HIV Care: An Exploratory Study in Ghana

Stephen Ayisi Addo[1], Mageret Chebere[2], Marijanatu Abdulai[1], Anthony Ashinyo[1], Raphael Adu Gyamfi[1], James Avoka[3], Akosua N Baddoo[4], Irene Lansah A.[4], Dassah Zanu[2]
[1]Ghana Health Services/ National AIDS/STI Control Programme, Public Health Division, Accra, Ghana, [2]Ghana Health Service, Human Resource Division, Accra, Ghana, [3]Ghana heath services, Human Resource Division, Accra, Ghana, [4]Ghana Health Services/ National AIDS/STI Control Programme, Accra, Ghana

Background:Ghana has made significant strides in key health targets including access to healthcare and a general improvement in life expectancy. Despite these improvements, the country's ARV coverage for diagnosed PLHIV was 48% as of December 2017 and this is affecting the country's progress towards attainment of the 90 90 90 targets. Ghana developed a framework to use task sharing as an intervention to scale up access to HIV/AIDS and related care. This survey aimed at identifying service delivery capacity and training needs to be addressed in this initiative for a successful roll out.
Methods:The National AIDS/STI Control Programme in collaboration with the Human Resource Division of the Ghana Health Service surveyed health professionals in 40 purposively selected ART clinics in four regions from June to December 2017. The regions were selected to represent the geographical zones of the country. A structured questionnaire was used to obtain information from service providers on their competencies, and training needs in critical areas of HIV care. Data was analysed using stata version 14.
Results: Three hundred and fifty-four (354) service providers from thirty -nine (39) facilities responded to the questionnaires. On capacity for service provision, 74% of respondents acknowledged that they could conduct HIV testing, 70% could perform HIV/TB counselling, 68% could under take laboratory monitoring, 64% were competent in both PMTCT/EID and reporting on HIV/TB data. In addition, 63% rated themselves as being competent in following up on HIV/TB co- infected patients, 62% in providing HIV education and 55% could initiate antiretroviral treatment.With respect to training needs, majority (86%) indicated they required training in all specified areas in HIV care. The unmet need for training ranged from 42.8% in HIV testing and counselling to 73.8% in laboratory monitoring. Participants also reported unmet training needs in treatment initiation (61.5%), treatment continuation (60.5%), data management (57.0%), proving PMTCT/EID services (56.0%), screening for TB and HIV (55.4%) and public education on HIV (54.8%).
Conclusions and Recommendations: Even though task sharing has proven to be effective in expanding access to HIV services, poor capacity and knowledge of service providers in HIV testing and counselling, treatment initiation, provision of PMTCT/EID services and data management need to be addressed for its successful implementation in Ghana.

TUPEE354

Impact of Viral Laod Sample Management System to Improve HIV Viral Load Results Turnaround Time in Rwanda

Nirere Jean Damascene, Ribakare Muhayimpundu, Serumondo Janvier, Mwikarago Ivan, Rwizibuka Fred, Mpabuka Etienne, Munana Jean Pierre, Ndacyayisenga Jean Claude, Nsanzimana Sabin
Rwanda Biomedical Center (RBC), Kigali, Rwanda

Introduction: The Viral Load Sample Management System (VLSMS) and Laboratory Information System (LIS) are web based applications introduced in HIV VL testing as a contribution to improve sample management, Turn Around Time (TAT) for HIV Viral Load results and other logistics related to HIV VL testing. VLSMS has a potential to contribute to the increase of HIV VL coverage and monitor viral suppression for all patients on treatment. It was introduced in 2016 on seven HIV VL testing in Rwanda.
Descriptions: HIV VL is the main biomarker for monitoring response to ARV treatment. When used correctly, it can assist in make clinical decision that are helpful to the health benefits of the patients. Significant efforts have been implemented to reduce TAT of HIV VL results by decentralizing HIV VL Testing supported by national sample transportation system.
LIS and VLSMS system were introduced in HIV VL testing to assess as a remedy to delays in return of HIV VL results and identify associate issues. After installation, all testing sites were trained according to the platform used (VLSMS or LIS), Initially, samples were transported to testing sites and logged in the system once reached the sites. This created long pre-analytical procedures and resulted to an increase of clients complaints. Extension of VLSMS and LIS at testing sites and referral sites and transformation of VLSMS to web based has make a positive impact where each sites can login their samples to system at Health Facility level and samples are sent to testing sites through sample transportation with manifest sheet produced by VLSMS or LIS system. with synchronization update, results are generated in the system and all referral sites can remotely access HIV VL results in system.
Achievment: HIV VL Results and sample status are easily retrievable in the system at all level; TAT has reduced from 90 days to 21days and patient information is accessible. Lost samples, lost results and patients lost to follow up has reduced.
Lessons learnt: Extension of VLSMS, LIS, refresher training, Increase users of VLSMS /LIS at all level has contribute to reduce TAT and other issues in pre analytical phases. Targeted mentorship by program managers for identified issues is a way to fix and address gaps.
Next step: Sustain VLSMS and LIS in HIV VL testing and ensure its usage effectively. Monitor VL Testing coverage and suppression rate using VLSMS and LIS. Sustain the achievement and the teamwork at all level.

TUPEE355

Impact of Hands-on-Mentorship in Strengthening the Viral Load Testing Capacity at Public Sector Laboratories in Zambia

Mulenga Namwaka Mungandi[1], Bansal Namita[2], Ramamurti Gita[3], Haimbe Prudence[4], Shibemba Lunda[5]
[1]Clinton Health Access Initiative, Laboratory Systems, Lusaka, Zambia, [2]Clinton Health Access Initiative, Abuja, Nigeria, [3]Clinton Health Access Initiative, Kigali, Rwanda, [4]Clinton Health Access Initiative, Lusaka, Zambia, [5]Ministry of Health, Laboratory Services, Lusaka, Zambia

Issues: Zambia is striving to achieve 90% of people on antiretroviral therapy accessing viral load (VL) testing by the end of 2020. To reach these targets, Zambia has scaled up public-sector VL testing capacity by deploying six Hologic Panther instruments at public-sector laboratories across the country. During the first months after installation, high error rates were observed which often halted testing and threatened the country's ability to meet national VL testing targets. To mitigate this threat, the Clinton Health Access Initiative (CHAI) on behalf of the MoH engaged the Centre of Infectious Disease Research in Zambia (CIDRZ), a private-sector laboratory with extensive experience using the Panther, to mentor the first four (4) public-sector Panther sites.
Descriptions: The mentorship aimed to 1) correct early on any technical issues that laboratory staff were having with the Panther and 2) adjust laboratory workflow to support optimal usage of the Panther. A CIDRZ laboratory staff member with extensive experience working with the instrument mentored the laboratory staff at each site for one (1) week using a hands-on mentoring approach. At the end of the mentorship week, the CIDRZ mentor shared a summary of key recommendations with the MoH.
Lessons learned: An impact assessment administered to the laboratory staff pre- and post-mentorship captured data over a period of 3 weeks. Daily VL testing volumes increased in 3 sites by an average of 66%. VL testing volumes reduced in one (1) site by 51% due to testing VL backlog samples during the pre-mentorship period. Calibrator failure rate reduced from an average 20% pre-mentorship to 12% post-mentorship. Interpretation of log10 results was a major concern for laboratory staff pre-mentorship but staff reported this issue as resolved post-mentorship. Finally, 80% of the laboratory staff stated they were extremely comfortable using the Panther for VL testing pre-mentorship, and this increased to 95% post-mentorship.
Next steps: In order to maintain improved testing volumes, Panther technical issues will be monitored closely by MoH, CHAI and CIDRZ. A "frequently asked questions" section was shared with Hologic in the hopes that these technical issues can be emphasized in future Panther trainings. MoH has recommended the mentorship be implemented in the remaining two Panther laboratories in country, with shadowing by high-performing laboratory staff to bolster the internal mentorship capabilities within the MoH.

TUPEE356

Reducing Lead Time for HIV Prevention Commodities with Vendor Managed Inventory (VMI)

Sagana Reden[1], Wynn Stephen[2], Borse Nagesh[2]
[1]USAID Bureau of Global Health - Office of HIV/AIDS, Supply Chain for Health Division, Washington, United States, [2]USAID Global Health Supply Chain-Procurement and Supply Management Project, Arlington, United States

Issues: Given the ever-changing landscapes and timelines of condom and Voluntary Medical Male Circumcision (VMMC) implementation campaigns conducted by the U.S. President´s Emergency Plan for AIDS Relief (PEPFAR) program, it has become increasingly important to reduce the time between when an HIV prevention program (typically a national government) identifies product needs and when the product arrives, specifically for the delivery of VMMC kits and condoms. This time period is called "lead time". Prior to the implementation of vendor managed inventory (VMI), vendors would manufacture these products or they would be shipped from a costly regional distribution center (RDC). The lead time for manufacture and delivery was at times more than three months, leaving many PEPFAR-supported country programs scrambling for both condoms and VMMC kits when sudden campaigns arose.
Descriptions: In order to address long lead times, the USAID Global Health Supply Chain Program-Procurement and Supply Management (GHSC-PSM) project worked, on behalf of PEPFAR, with both condoms and VMMC vendors to establish VMI. Under this initiative, two VMMC manufacturers and one condom manufacturer agreed to have readily available up to 35% of GHSC-PSM's global demand for (the highest-demand) condoms and VMMC kits. These items are fully manufactured, sterilized and can be shipped anywhere in the world in under two weeks. This requires a nominal 2% price increase on the product, but with VMI, this is far cheaper than purchasing stock and holding it in a regional warehouse.
Lessons learned: With the implementation of VMI, lead times for delivery have been reduced by an average of 11 weeks for condoms and 12 weeks for VMMC kits. A key component of this is the time saved in manufacturing and sterilization with VMI. This has allowed GHSC-PSM to both save money on storage costs and react more quickly to unforeseen changes in HIV prevention campaigns, allowing programming to proceed uninterrupted.
Next steps: Going forward, GHSC-PSM will expand this program in both the condoms portfolio-- identifying more vendors and including female condoms-- and the VMMC portfolio-- adding vendors and increasing percentage of the global demand covered. This will allow GHSC-PSM to reduce cost and lead time on a broader array of HIV prevention commodities.

TUPEE358

Strengthening National Capacity to Mitigate the Impact of International Social Marketing Organizations Transitioning on Condom Programming in East and Southern Africa

Modisaotsile Innocent[1], Musembi Veronica[2]
[1]UNFPA East and Southern Africa Regional Office, Johannesburg, South Africa, [2]Independent Consultant, Nairobi, Kenya

Issues: Female and male condoms play a unique role of triple protection against HIV infections, STIs and unintended pregnancy. Condoms are estimated to have averted 50 million new HIV infections since the beginning of the epidemic globally. Most countries in East and Southern Africa (ESA) have historically depended on three major sources of condoms; public, private and social marketing sectors. However, with International Social Marketing Organizations (SMOs) transitioning in East and Southern Africa, gaps are emerging in national condom programming that if not adequately addressed could undermine access to condoms despite their triple protection role.
Descriptions: The transitioning of international SMOs has negatively impacted condom programming in many countries in ESA. Consequently, UNFPA regional office of East and Southern Africa organized a regional consultation meeting in March 2019 to discuss ways to mitigate the impact of SMOs transitioning to HIV prevention and family planning. Participants discussed how to ensure sustained access to condoms despite SMOs transitioning so that historical gains are not lost. The meeting confirmed that the landscape for condom social marketing has been shifting in recent years, and that this is largely due to reduction in funding for SMOs by traditional international development partners. The most impacted areas include reduced investment in demand generation, decline in socially marketed condoms contribution to total market volumes, reduction in condom brands available to consumers as well as condom outlets, and reduced distribution channels and efforts to gather market intelligence. In some cases, the volumes of condoms in the country (supply) have dropped. In response to these challenges, UNFPA regional office has developed a framework to support countries in the region to mitigate the impact of SMOs transitioning. The Framework proposes strategic responses linked to the different stages of transitioning that different countries are in: pre-transition, in-transition and post-transition.
Lessons learned: Transitioning of SMOs is inevitable. However, its impact to national condom programming can be reduced if transitions are planned. Transition planning pre-transition assessments, transition road maps, robust monitoring frameworks, and technical support throughout the process.
Next steps: Strengthen capacity of countries in the region to operationalize the Framework.

TUPEE359

Improving Laboratory Quality and Capacity through Leadership and Management Training: Lessons from Zambia 2016-18

Gopolang Felicity[1], Zulu-Mwamba Fales[2], Nsama Davy[2], Kruuner Annika[3], Kasvosve Ishmael[4], Gomo Royce[5], Motlhabane Tiny[6], Chohan Bhavna[7], Soge Olusegun[7], Osterhage Daniel[7], Campbell Nancy[7], Noble Michael[8], Downer Ann[1], Flandin Jean-Frederic[1], Nartker Anya[7], Koehn Cat[1], Nonde Linda[9], Shibemba Aaron[2], Perrone Lucy[1]

[1]Internatiional Training and Education Center for Health, Schools of Public Health and Medicine, University of Washington, Department of Global Health, Seattle, United States, [2]Ministry of Health Zambia, Directorate of Clinical Care and Diagnostic Services, Laboratory Services Unit, Lusaka, Zambia, [3]ZAMBART, Lusaka, Zambia, [4]University of Botswana, Faculty of Health Sciences, Gaborone, Botswana, [5]ImmunoGene Labs, Ruwe, Zimbabwe, [6]Institute of Health Sciences, Medical Laboratory Technology, Gaborone, Botswana, [7]University of Washington, Seattle, United States, [8]University of British Columbia, Department of Pathology and Laboratory Medicine, Vancouver, Canada, [9]American International Health Alliance, HIV/AIDS Twinning Center, Lusaka, Zambia

Background: Competent leadership and management are imperative for quality medical laboratory services essential for provision of critical data for effective HIV patient care, pathogen detection, disease surveillance and monitoring, and rapid response. However, few laboratory managers receive job-specific training in management and leadership.The University of Washington's Certificate Program in Laboratory Leadership and Management was developed in 2013 to address this gap.The program goal is to develop competencies in leadership, public health communication, policy development, data analysis, and quality management systems for laboratory personnel working in resource-limited settings.
Methods: The program was implemented in 16 public and military hospital laboratories across Zambia in 2016 (17 laboratory managers participation) and 2017-2018 (16 laboratory managers and 15 laboratory quality officers) with additional collaboration from the University of British Columbia. The nine-month long program employed a mentored, blended learning approach, utilizing both in-person didactic and online training, with practical application through the Capstone Project implementation at the laboratories.
Results: Both cohorts achieved a high graduation rate:16/17 (94%) participants in 2016, and 26/31 (84%) in 2017-2018. All laboratories increased compliance to the International Organisation for Standardisation (ISO) 15189 standard.Thirty-one participants completed quality improvement (Capstone) projects. Fourteen of 16 (87.5%) participating laboratories increased their SLIPTA audit scores, with nine also improving their SLIPTA star rating. Six other laboratories maintained their star rating and one lost a star.Three laboratories subsequently achieved ISO 15189 accreditation in July 2018. Of the 92% of 26 graduates participating in the post-course survey, 58% reported supervising more staff after graduating,11% less staff, and 31% the same staff numbers, whereas, 38% reported receiving a leadership promotion and/or greater leadership responsibilities, with 88% attributing their promotion to participation in the course.
Conclusions and recommendations: The program enables improved laboratory management capacity to apply functional practices of laboratory quality and management for improved patient care and public health services, and it effectively complements quality management training programs such as the Strengthening Laboratory Management Towards Accreditation (SLMTA).

TUPEE360

Analysis of Antiretroviral Therapy (ART) Medication Errors among People Living with HIV Accessing Care at Mpilo Centre of Excellence, Bulawayo, Zimbabwe

Saruchera Samson[1], Sibanda Tafadzwa[1], Sinoia Faith[2], Ndlovu Mbongeni[3], Chikwati Enerst[1]
[1]AIDS Healthcare Foundation, Zimbabwe, Bulawayo, Zimbabwe, [2]Ministry of Health and Child Care, Bulawayo, Zimbabwe, [3]Nationa University of Science and Technology, School of Medicine, Bulawayo, Zimbabwe

Issues: Lifelong antiretroviral therapy has revolutionised the HIV epidemic with PLHIV who are adherent to treatment now living normal lives. However, medication errors can occur among PLHIV on ART and these medication errors to treatment failure, drug resistance, or drug toxicity which may be life threatening. We investigated ART medication errors reported at Mpilo HIV clinic.
Descriptions: A medication error register was introduced at the Mpilo centre in October 2018 to monitor medication after a somewhat increase in medication errors had been noted. The register was kept in the clinic pharmacy. Information captured included the patient demographic characeristics, the health worker reporting the error, timeframe between error occurrence and being reported. We also reported on the effect of the error on the patient and the intervention taken for each case.
Lessons learned: Between October 2018 and June 2019 a total of 64 medication errors were reported against 19 342 ART prescriptions giving a reporting incidence of 3 errors per 1000 prescriptions. The 64 errors occurred among 58 clients of whom 55% were females and the median age was 23 (Q1=14, Q3=39). The majority (64%) of the errors were prescriber errors and 53% were identified and reported by pharmacy staff and only 10% were identified by the patients. The median time between error occurrence and error identification was 5 days (Q1=1, Q3= 27). In 35/58 (61%) the errors were identified before the patient had left the clinic. Sixteen(27%) patients took the wrong medication and three (5.1%) of the patients had to be hospitalized after developing side effects related to overdosing.
Next steps: The pharmacy department and clinicians should work closely together to come up with interventions to reduce ART medication errors. Recipients of care need to be educated about their ART medication so that they can easily identify any errors in their medications.

TUPEE361

Low-cost, Integrated Model for Sex Work Programming in South Africa Key Words - Sex Workers, Public Health Facilities, Integrated Model

Schultz Lebogang[1], Shilubane Tlangelani[2], Modisaotsile Innocent[3], Mutali Beatrice[4]
[1]UNFPA, SRH, Pretoria, South Africa, [2]UNFPA South Africa, Co, Pretoria, South Africa, [3]UNFPA East and Southern Africa Regional Office, ESARO, Sunninghill, South Africa, [4]UNFPA South Africa, Pretoria, South Africa

Issues: Delivering standalone sex workers programmes in SA is a common practice. The services are supported by development partners and have proven to be effective but expensive and difficult to sustain. SA as a middle income country has had difficulties attracting donor funding for standalone projects. To address the SRH challenges of sex workers who remain disproportionately affected by HIV, UNFPA in collaboration with Sex Work Education Advocacy Task Force opted for a low cost integrated model in the public health sector.
Descriptions: Peer education package, aligned with the SA National Sex Worker HIV Plan, is at the centre of this model. This low cost integrated model is implemented in Chris-Hani district in the Eastern Cape and aims to reach a significant number of sex workers. A peer led model which emphasises peer education and support as well as linkage to care is utilised to map sex work hot spots within communities, as well as identify health facilities that could provide services to sex workers. The health care workers in those selected facilities are capacitated to provide stigma free integrated SRH and HIV services to sex workers. Peer educators conduct day and night outreach in communities, provide peer counselling and safe spaces. In addition, they run adherence and risk reduction workshops. The services provided include family planning, cervical cancer screening, STI and TB screening, HIV Test and counselling as well as linkages to HIV care and treatment. In addition, Gender based violence victims are referred to the department of social development for support. Between 2016 and 2018, over 10 000 sex workers were reached with services. The range of services sex workers have received go beyond HIV testing and treatment. Some of the services include FP, cervical cancer screening, psychosocial support and risk reduction. The model has also made inroads in reaching clients of sex workers.
Lessons learned: The model reached 70% of the target population of sex workers in the year and half of implementation. This model has proven to be a sustainable to providing comprehensive SRH services to sex workers and linking them to community based health services. The model, if scaled-up, especially in similar moderate-density settings, has the potential to increase the number of sex workers reached with services, in a low-cost and sustainable fashion.
Next steps: Promote and disseminate the model nationallyScale up the implementation of the model nationally.

TUPEE362

South Sudanese Refugees in Ethiopia towards 90-90-90 in an Unstable Security Situation

Sultana Zinia[1], Das Asis K.[2], Burton Ann[3], Schulte-Hillen Catrin[3]
[1]UNHCR, Public Health, Gambella, Ethiopia, [2]UNHCR, Public Health, Addis Ababa, Ethiopia, [3]UNHCR, Public Health, Geneva, Switzerland

Issues: South Sudanese are the largest refugee population in Ethiopia numbering 293,978. The general security situation of Gambella is constantly challenged by eruptions of inter-ethnic violence. The incidents have increased apprehension between communities and disrupted humanitarian activities inside and outside camps. Refugees´ displacement from camps due to insecurity caused defaulters in HIV program. UNHCR with its Partners adapted strategies for reaching towards 90-90-90 targets even when faced with security challenges.
Descriptions: HIV prevalence is highest (4.8%) among 15-49 years men and women in Gambella compared to other regions in Ethiopia. HIV program for refugees is implemented both at facility and community level. Facility-based services include Provider Initiated Counselling and Testing (PICT), Prevention of Mother to Child Transmission (PMTCT), HIV Counselling and Testing (HCT), Antiretroviral Therapy (ART), treatment for Opportunistic Infection (OI) and Voluntary Medical Male Circumcision (VMMC). Community-based services include awareness raising through outreach workers, mother support groups, adherence supporters and peer group associations.
Lessons learned: Data from October 2018 to March 2019 have been analysed to estimate the progress towards 90-90-90 for seven camps in Gambella. Using ANC prevalence (0.83%) as a proxy for prevalence in general population, it is estimated that the number of PLHIV is 2,440. Total number of PLHIV identified is 1,964 (female 1,404; male 560); 80% of the estimated PLHIV know their status. Following the test and treat protocol, 100% diagnosed positive were initiated on ART. Among the total number of PLHIV who initiated ART, 1467 (75%) received viral load testing. Of those tested for viral load, 905 (62%) have viral load suppressed. Based on data over six months, Gambella refugee camps have achieved 80-100-62. Low viral load suppression seems to indicate low adherence to medication possibly due to service disruptions for insecurity, high mobility, drug resistance, stigma and inadequate care.
Next steps: Continue empowering community groups, regular supply of commodities, new first line ART regimen, scale up viral load testing and service continuity even during insecurity will be key. Focus group discussions with PLHIV will be conducted to understand and address adherence issues. As donor support gradually reduces, coordination with stakeholders will be strengthened for smooth transition of essential activities.

TUPEE363

Integrating Mental Health into HIV Care in Refugee Settings: Evaluation of the Impacts of a Settlement-level Integrated HIV Care Plan on Treatment Coverage, Detection and Individual Outcomes in Uganda

Nalwadda Oliva[1], Ayikoru Daisy[2]
[1]Makerere University, Population and Reproductive Health, Kampala, Uganda, [2]Office of the Prime Minister, Department of Refugees, Kampala, Uganda

Background and introduction: Refugees constitute a large invisible population. The growing numbers of refugees living with HIV estimated at 10.5% in Uganda is a significant public health concern since ART uptake and adherence is startlingly low among this vulnerable group. Poor ART uptake and adherence has largely been attributed to common mental disorders such as depression, however, integration of mental health interventions into HIV care for new arrivals is largely lacking. MIND HEALTH project in Uganda developed and implemented a settlement HIV care plan in one rural refugee settlement to attempt to address this gap.
Methods: Mixed methods were used to evaluate the implementation and impact of the MIND HEALTH initiative. Refugees attending HIV care clinics in Nakivale settlement were consecutively interviewed in a facility-based cross-sectional study. A structured questionnaire was administered, which included the Alcohol Use Disorder Identification Test (AUDIT) to screen for AUD, the 9-item patient health questionnaire to screen for depression as well as sections about demographic characteristics, internalized stigma for HIV and treatment-seeking / adherence. Repeated cross sectional health facility based surveys were conducted at baseline, and 12 months in 2 primary care facilities to identify change in uptake and adherence to ART.
Results: Among the 351 HIV positive refugees (201 female and 150 male) enrolled in the study, 21.8% had suffered from at least one common mental disorder in the past 12 months. The proportion of HIV positive refugees who screened positive for HIV-related stigma was 5.8% ($P< 0.05$) while 4.1% reported non-adherence in the past three months. Non adherence was higher among women with depression ($p>0.05$), men with alcohol use disorders. At end line, uptake of ART among refugees enrolled in the MIND HEALTH intervention significantly increased from baseline to endline by 8.6% (95%CI 0.8-16.4, $p=0.0351$). Adherence to ART increased from 0 to 12.5% at 12 months.Majority of refugees living with HIV (75.0%) reported that participation in group psycho-social interventions has improved their functionality.
Conclusions: It was feasible to integrate mental health care into HIV care in refugee settings in a manner that improves ART uptake and adherence, as well as clinical and functioning outcomes. Challenges remain in sustaining the gains in integrative HIV care and creating demand for integrated services in refugee settings.

TUPEE364

Effects of War on HIV Service Delivery and Antiretroviral Adherence amongst Antenatal Care Women in South West Region of Cameroon

Paulette Ngum Fru[1,2]

[1]University of Buea/Faculty of Health Sciences, Public Health and Hygiene, Buea, Cameroon, [2]District Health Service, Tiko, Cameroon

Background: Since November 2016, the two English speaking regions of Cameroon are experiencing a serious sociopolitical crises which has deteriorated to unimaginable proportions; mass killings, burning of houses, hospitals, schools, killing of some health personnel, thousands of internally displaced persons, some living in the bushes and refugees in Nigeria. This study aimed at assessing the effects of war on Prevention from Mother- to Child Transmission (PMTCT) and antiretroviral (ARV) adherence amongst Antenatal Care women in the South West Region of Cameroon.

Methods: This study was a descriptive study of existing data from the South West Regional Delegation of Public Health. PMTCT monthly reports and statistics from the 300 health facilities engaged in option B^+ in the 18 health districts were used for the study. Results were analysed with SPSS version 21 for univariate, bivariate analysis and data interpretation. Odd ratios and chi square were used to determine the significance between ARV adherence on PMTCT.

Results: 303 HIV positive pregnant women were on ARV out of 410 pregnant women identified positive. This gives a coverage rate of 74% which is far lower than 97.8% recorded before the onset of the war. This was statistically significant at $P \leq 0.05$. Challenges identified by the health districts for this drop were; shutdown/destruction of some health facilities, instability of personnel due to insecurity such as kidnaps and high intimidation from both military and secessionist fighters, no fixed mechanism put in place for transporting dry blood samples, ARV stock outs, pregnant women have flee into the bushes and others displaced internally to other regions, high insecurity on the highway especially for personnel found transporting drugs or commodities.

Conclusions and Recommendations: PMTCT uptake services has dropped drastically in the South West Region due to the ongoing crises. There is a strong need to strengthen collaboration with existing community based organisations, Non-governmental organisations (Medecins sans Frontier, Caritas, Danish Council for Refugees) and some United Nations agencies (UNHCR, WHO, WFP, UNFPA) now based in the South West Region who go to the field. They could help transport ARVs and commodities to health facilities. The government of Cameroon needs to do everything possible to call for a cease fire and end the crises so that things can return to normalcy.

Keywords: Antiretroviral, Adherence, PMTCT

TUPEE365

Outcomes of Preventing Mother to Child Transmission (PMTCT) Program in Imvepi Refugee Settlement, Uganda

van Boekholt Tessa Anne[1], Twebaze Jedah[2], Kerukadho Emmanuel[1], Iname Harouna[1], Nyakoojo Ronald[3], Kazosi Julius[3], Yiweza Dieudonne[4], Burton Ann[5]

[1]UNHCR, Public Health, Arua, Uganda, [2]Medical Teams International, Arua, Uganda, [3]UNHCR, Public Health, Kampala, Uganda, [4]UNHCR, Public Health, Nairobi, Kenya, [5]UNHCR, Public Health, Geneva, Switzerland

Issues: PMTCT programs have successfully reduced transmissions. In Uganda coverage increased from 27% in 2009 to >95% in 2015, with subsequent reduced transmission of 29% to 3%. During 2017 Uganda experienced an influx of refugees from South-Sudan and now hosts 800,000 refugees in the North, with 59,799 in Imvepi. The country has a favourable policy with freedom of movement and the right to live in settlements rather than confined camps. This context could bring specific challenges and potentially impact the PMTCT program. Therefore, an assessment was done to evaluate the outcomes of the program in this setting and highlight the challenges.

Description: Due to the short existence of the settlement (2years), normal cohort analysis was not possible. As a mitigation, individual data collection of the registers was done of all HIV+ women in the PMTCT program during the last 2 years. These data were analysed on the outcomes already available. 56 refugee mother-baby pairs were included. 1 positive case was identified by PCR at 4-6 weeks. Analysis showed an improvement in the time of identification of HIV+ women, from 32% during breastfeeding in 2017, to 8% in 2019. Early initiation on NVP improved from 67% in 2017 to 92% in 2019, and loss to follow-up at the 2nd PCR at 9-13 months decreased from 37% in 2017 to 7% in 2018. Interventions that contributed to this were the establishment of clinics, integrated outreaches and pregnancy mapping, which enabled early identification of the HIV+ women and encouraged facility deliveries. Village health teams (VHT) contributed to lower numbers of loss to follow-up, since missed appointments could be traced in the community and linked back to care. Family support groups (FSG) also greatly contributed to the follow up of the women. FSGs serve as a platform for counselling and until recently, members of these groups were supported with transport refunds.

Lessons learned: Effective PMTCT programming in an emergency setting is challenging. Integrated health and nutrition services and community-based interventions, such as VHTs and pregnancy mapping, can aid in ensuring early identification of HIV+ women and therefore linkage to care. Loss to follow-up remains a big challenge in this setting and is explained by stigma and self-relocation for family reunification.

Next steps: Linkage to livelihood projects, establishing saving groups and transport facilitation for clients could be successful interventions to ensure follow up of clients.

TUPEE366

Gauging the Implementation of Youth Friendly Health Services (YFHS) among Key and Vulnerable Populations in Four Districts of Malawi

Mafiala Foster[1], Gondwe Peter[2], Ngwira Matchona[3], Nyoni Philip[4]
[1]Sexual Reproductive Health and Rights Africa Trust (SAT), Youth Programs, Lilongwe, Malawi, [2]Life Concern (LICO), Lilongwe, Malawi, [3]Kachila Youth Initiative (KAYI), Lilongwe, Malawi, [4]Centre for Youth Development and Transformation (CYDT), Lilongwe, Malawi

Issues: Lack of equitable youth friendly health services among key and vulnerable populations in Malawi.
Descriptions: SAT Malawi's Youth led platform namely Youth Hub facilitated the implementation of youth friendly targeted scorecard assessment among the key and vulnerable population premised on HIV and AIDS and SRHR for a period of 3 years (2016-2018). The project was implemented in four districts in the three regions of Malawi. The project was dubbed Health Systems for Gender Transformative on SRHR, HIV and AIDS in Malawi, targeting young key and vulnerable populations, specifically; young Female Sex Workers (FSW), young Men having Sex with Men (MSM). The goal of the project contributed to strengthening capacity of key national, district and community level actors to promote and support equitable access to youth friendly SRHR, HIV and AIDS related health services by young key and vulnerable populations through rights based and gender transformative approaches. The project trained 40 health care workers from hotspot districts were trained on health care provision targeting key and vulnerable population. 144 community leaders were reached on the rights of key and vulnerable population. 43 peer educators or MSM and sex workers were trained and 120 civil society representatives were reached and 150 young key and vulnerable population were reached with information on their rights and available health services and where to access them in all the four districts.
Lessons learned: Despite creating an enabling environment for key and vulnerable populations as indicated above, In Malawi sexual minorities are afraid to access health services or are denied access to health services because of stigma and discrimination or judgmental attitudes of health service providers and social protection workers. In addition, the whole criminalization of homosexuality makes it difficult for people to access services in fear of being reported to the police. Lack and unavailability of lubricants for MSM including their condoms. Lack of harmonization for age consent for adolescent SRHR restrict adolescents access SRHR.
Next steps: There´s need for harmonization of laws that restrict key and young vulnerable populations from accessing SRHR services. In collaboration with government and other stakeholders, service providers in the hotspots district are being trained on social behavior change communication to address the attitude barrier.

TUPEE367

Integration of Sexual and Reproductive Health Information into Adolescent Girls Livelihood Program; Potential Game Changer from 'Better Life for Girls, Eastern and Karamoja Regions in Uganda

Ogolla Rachel, Kareodu Ronald, Kindyomunda Rosemary
United Nation Population Fund Uganda, HIV/AIDS and SRH, Kampala, Uganda

Background: The *'Better Life for Girls'* (BL4G) project was implemented by United Nations Populations Fund (UNFPA) from 2016 to 2018 in 14 districts in Eastern Uganda and Karamoja regions to accelerate action in preventing teenage pregnancy and child marriage by mobilizing communities, strengthening youth friendly service provision and skills based SRHR education including HIV prevention for adolescent girls aged 10-19 years. The project used a holistic and gender-focused approach to empower girls and reinforce their position in order to put them on the path to sustainable empowerment by; supporting girl clubs in schools to improve menstrual hygiene management, trained health workers on provision of youth friendly Sexual Reproductive Health and Rights(SRHR) information and services, supported the integration of SRHR , life skills, financial literacy and mentorship into Empowerment and Livelihood for Adolescents (ELA) clubs, established Male Action Groups for dialogue on prevention of teenage pregnancy and child marriage.
Methods: A cross sectional design study was used to assess the extent which BL4G program outcomes were achieved. Cochran (1977) formula with correction was used to obtain 1,540 adolescent girls. Multi-stage sampling method was used, 14 districts were randomly selected from Karamoja and Eastern Uganda. Systematic sampling technique was used to sample pupils and students and 632 out of school adolescent girls were sampled. Qualitative data was collected using Key informants Interview Guide among key partners and Focus Group Discussions Guide among programme beneficiaries.
Results: Majority 84.8% of the girls accessed SRHR information. Access and utilization of SRHR services increased by 9% and 8% respectively. Prevalence of teenage pregnancy reduced from 7% at baseline in 2016 to 3.9% in 2019. A 2% reduction in menstrual related absenteeism was recorded among schoolgirls and 40% of out-of-school adolescent girls who completed the ELA clubs owned 'small business enterprises' far beyond the target of 15%.
Conclusion and Recommendation: Integration of HIV and SRH information into Adolescent's livelihood programs (LP) led to increase in access and utilization of SRHR information. This is a promising approach of addressing multiple vulnerabilities that expose adolescent girls to HIV infection. Increased investment is required in strengthening advocacy efforts to scale it up.
Keywords: Sexual and Reproductive Health and Rights, Adolescent girls, empowerment

TUPEE368

Factors Influencing Gender Integration in Planning, Implementing and Documenting HIV Prevention Research in Eastern and Southern Africa (ESA)

Makila Ethel[1], Grewal Gulraj[2], Mshai Mercy[1], Bahati Prince[2]
[1]International AIDS Vaccine Initiative, Nairobi, Kenya, [2]Internaional AIDS vaccine Initiative, Nairobi, Kenya

Background: Gender is a determinant of HIV infection, symptoms and disease progression. Furthermore, gender differences in socio-economic autonomy and education are linked to access of sexual health services and health seeking behavior.In Sub-Saharan Africa, adolescent girls and young women aged are three to four times more likely to be infected than their male peers.
Despite gender differences in risk for infection, HIV prevention clinical trials rely heavily on participation of men. A study was conducted to identify factors influencing gender integration in HIV prevention research in selected Clinical Research Centres (CRCs) in ESA; and identify key gaps in planning and implementing gender responsive approaches
Methods: A rapid literature review contextualized gender integration in biomedical HIV prevention research globally and regionally. A cross-sectional mixed methods approach study was undertaken. Purposive sampling was used to select responding organisations and snowball sampling to select respondents including principal investigators; trial physicians; nurse counsellors; and community engagement staff from 10 participating CRCs in Kenya, Uganda, South Africa and Zambia. Data was collected from 38 respondents through paper-based and electronic surveys. Responses to closed ended questions were coded and analysed using descriptive and inferential statistics. Responses to open-ended questions were analysed deductively using a theoretical thematic approach.
Results: Literature review showed that gender integration approaches were not as well documented in clinical trials as they are in behavioural prevention and treatment and care programs. Respondents working with adolescents and youth; sex workers; lesbian, gay, bisexual, transgender and queer communities; mobile populations and migrants; and discordant couples said gender responsiveness was integral to their research design. Those working with injecting drug users disagreed. 69% said their knowledge of gender issues is high or medium. 78.9% said there is a lack of grass-roots advocacy; 71.1% said the benefits for gender integration in research are unclear.
Recommendations: To enhance implementation of gender transformative processes in HIV biomedical research, the following priorities were identified: more training in gender issues for clinical trials staff; increased advocacy at all levels; donor requirement for gender integration; and requirement for gender-disaggregated data in publication.

TUPEE369

Stemming HIV/AIDS Surge among the Adolescents and Youth through Gender Socialization, Children's Rights, in Context of Early Childhood Development

Nuwoha Ignatius
Anppcan Uganda Chapter, Kampala, Uganda

Issues: In 2013 ANPPCAN (NGO) commissioned a study in Rakai district, to investigate the relationship between gender socialization, children's rights and vulnerability to HIV/AID in context of ECD, which was followed up with a three year project to implement the study findings. Rakai was a more complex society. Family based gender socialization patterns were under pressure from poverty, changing livelihoods and HIV/AIDS. Community parenting had tremendously declined. The media was exerting its influence on children and adults through FM radio stations while HIV/AIDS posed a serious threat to children too.
Descriptions: The project was designed and implemented geared at reversing the then gender socialization approaches which were believed to predispose children to abuse and HIV/AIDS. Those were especially the gender socialization approaches which were devoid of adequate values and skills that could protect children from contracting HIV/AIDS. The implemented activities meant to inculcate into children psycho-social competencies that would enable them to know and live with themselves, know and live with others and finally enable them to make effective decisions. The skill included among others self control and expectations of more fulfilling rewards if present gratification (including sexual) were postponed. Formal education system that prioritized knowledge at the expense of other aspects of children's behavior and attitudinal traits was challenged in advocacy campaign engagements.
Lessons learned: Diffusing gender roles that induce "learned helplessness" in context of family based care for the children through gender socialization succeeded. Socialization agents need to be awakened about the limitations of then gender socialization approaches in protecting children from HIV/AIDS, given the complexity of communities in contemporary time. They need also to be impressed upon of the subtle but existing dangers in then gender socialization approaches that predisposed children to abuse and HIV/AIDS and the significance of inculcating into children psycho-social competences.
Next steps: Exploration the possibility of creating conditions for community development by reinforcing the value of Indigenous knowledge, rekindling processes of inter-generational teaching and learning. A need to filter the traditional values carefully so that the positive and functional aspects that upheld child resilience are enhanced.

TUPEE370

Barriers to HIV Testing and Linkage among Young Men in Mpumalanga and KwaZulu-Natal, South Africa: A Market Segmentation Approach to Differentiated Service Delivery

Bell James[1], Sharma Sunny[1], Malone Shawn[2], Levy Melissa[1], Reast Jemma[1], Little Kristen[3], Hasen Nina[3]
[1]Ipsos Healthcare, London, United Kingdom, [2]PSI, Johannesburg, South Africa, [3]PSI, Washington, United States

Background: Men in South Africa are less likely than women to know their status and link to treatment. While other studies have analysed men's barriers broadly, this study aimed to identify distinct segments of men based on unique barriers to HIV testing and linkage.
Methods: A qualitative phase informed development of a mental model of barriers across the journey, while a quantitative phase mathematically segmented men within that model. We conducted in-depth interviews with purposively recruited men (n=58), analysed thematically. We then administered a quantitative survey with randomly selected men (n=2019), analysed using canonical correlations and hierarchical clustering techniques. Eligibility criteria included age (20-34), ethnicity (African), education (high school or less), and medical circumcision (20% cap).
Results: We found a range of barriers to services, rooted in fear and anticipated loss, and compounded by an environment of chronic stress and uncertainty, as well as negative perceptions of the health system and rigid masculine norms. We then identified five distinct segments, each experiencing a unique set of barriers and requiring different approaches.
Mr Green (15%) and Mr Blue (22%) share traits of pessimism, disconnection, and aversion to health-seeking. Mr Green also has low HIV knowledge and high levels of depression, alcohol use and intimate partner violence, and sees HIV as yet another failure in life. Mr Blue is more stable but also has a bleak outlook and low motivation, and fears HIV as yet another burden in a burdensome life.
Mr Teal (23%) and Mr Rose (25%) share traits of confidence, optimism, and openness to health-seeking but fear the impact of HIV on their identity and lifestyle. Mr Teal identifies as reliable and responsible and fears HIV would harm his self-image and reputation. Mr Rose identifies as fun-loving and fears that HIV would mean a loss of pleasure and lifestyle. Mr Grey (16%) is more traditional, rooted in family and community, and fears HIV would diminish his standing.
Conclusions: Approaches that recognize different segments and address unique barriers are more likely to be effective in increasing uptake of services. For example, Mr Green may need a peer-led approach that creates a safe space and community-based services that make treatment easier, whereas Mr Teal may need support in retaining his identity and community stigma reduction to counter the image of PLHIV as irresponsible.

TUPEE371

Social and Attitudinal Factors Affecting Art Initiation among Young Men Diagnosed with HIV in Mpumalanga and Kwa-Zulu Natal, South Africa

Bell James[1], Sharma Sunny[1], Malone Shawn[2], Levy Melissa[1], Reast Jemma[1], Little Kristen[3], Hasen Nina[3]
[1]Ipsos Healthcare, London, United Kingdom, [2]PSI, Johannesburg, South Africa, [3]PSI, Washington, United States

Background: Men in South Africa are less likely than women to know their status and link to treatment and more likely start ART at a later stage of infection. This study aimed to understand factors influencing whether a newly diagnosed man will initiate ART.
Methods: A qualitative phase informed development of a mental model of barriers in the testing and linkage journey, while a quantitative phase mathematically segmented men within that model. We first conducted interviews with purposively recruited men (n=58, of which n=8 HIV-positive linked and n=9 HIV-positive non-linked), analysed thematically. We then administered a quantitative survey with randomly selected men (n=2019, of which n=202 HIV-positive linked and n=67 HIV-positive non-linked) via a multi-stage household survey, and analysed the data using descriptive and inferential statistics. Eligibility criteria included age (20-34), ethnicity (African), education (high school or below), and circumcision (20% cap on respondents medically circumcised).
Results: We analysed data from HIV-positive linked and unlinked men and found significant differences in their attitudes towards treatment, with linked men exhibiting more trust in ART and better understanding of the reasons to use it. Linked men were also less likely to feel the need to hide ART use from people in their household and community.
Unlinked men were significantly more likely than those who linked to state that they did not trust ARVs (42% vs 17%, p=< 0.001), that they did not understand how ARVs help with HIV (39% vs 22%, p=0.008), that only people who have symptoms of illness need to take ARVs (42% vs 23%, p=0.005), and that ARVs would help them live for a long time (61% vs 74%, p=0.056).
Men who had not linked were also more likely to state that they needed to hide ARVs from people in their household (57% vs 32%, p=< 0.001), that they preferred to test for HIV away from where they live (64% vs 41%, p=0.001), and that they didn't want to test in case they were HIV positive (46% vs 35%, p=< 0.001).
Conclusions: This study highlighted two key factors correlated to newly diagnosed men's decisions on whether to initiate treatment: 1) trust in and understanding of ART and 2) the desire to hide ART (and thus HIV status) from family and community. Policies, strategies and interventions should address the trustworthiness and efficacy of treatment as well as supporting disclosure and reducing stigma.

TUPEE372

The Zambia Male Characterization Study: Why Do Some Men Access HIV Services and Sustain Use?

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

[1]JSI Research & Training Institute Inc., Lusaka, Zambia, [2]John Snow Inc, Boston, United States, [3]USAID Zambia, Lusaka, Zambia

Background: Male HIV service access/utilization is low in Zambia. The purpose of the Zambia male characterization study (MCS), conducted by the USAID DISCOVER-Health project implemented by JSI, was to characterize and understand the male sexual partners of adolescent girls and young women (AGYW) at risk of HIV, in order to better target and improve HIV programs for males, and reduce HIV transmission among AGYW.

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

Results:

A) Individual factors/support networks and

B) Health-system enablers drive men's HIV service access/use.

These men report little/no contact with the health system. Most of them worry about HIV due to past/current high-risk behaviours, but delay seeking services for fear of a positive test/living with HIV, until

(1) persistent ill-health compels them.

(2) Peer support/influence is very important in decision-making about health and using HIV services. Peers are the primary source of HIV/health opinion that shapes individual health-seeking behavior. These men find it difficult to discuss HIV with family members, but when illness becomes obvious/serious,

(3) family support becomes available and is important for initial access/sustaining use.

(4) Positive health staff attitude is a very important health system determinant.

Men access and sustain use of HIV services if health staff are respectful, non-judgmental, professional, and welcoming. Men who feel respected and well-treated tell other men, who also then access services from the facility.

Conclusions and Recommendations: For Zambia to achieve HIV epidemic control by 2020, a key gap needs to be addressed: finding, engaging and sustaining the missing men, particularly men 20-34 (among the least virally-suppressed) in HIV services. The MCS provides insights about the factors that facilitate HIV service access/utilization by men that should be harnessed to increase HIV-program effectiveness in engaging men for their own health, for the health of their partners and families, and towards HIV epidemic control.

TUPEE373

Zambia Male Characterization Study: Unblocking Health System 'Shut-out' to Increase Men's HIV Service Utilization

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

[1]JSI Research & Training Institute Inc., Lusaka, Zambia, [2]John Snow Inc, Boston, United States, [3]USAID Zambia, Lusaka, Zambia

Background: Male HIV service access/utilization is low in Zambia. The purpose of the Zambia male characterization study (MCS), conducted by the USAID DISCOVER-Health project implemented by JSI, was to characterize and understand the male sexual partners of adolescent girls and young women (AGYW) at risk of HIV, in order to better target and improve HIV programs for males, and reduce HIV transmission among AGYW.

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

Results: Most men in the study feared HIV testing/living with HIV, had low HIV knowledge-levels, had limited access to credible HIV information, trusted peers, felt shut-out of clinics, and had low HIV service use. Most were 'well' men, but some may have undiagnosed HIV. The key health system fixes that emerged to improve HIV service access/use are:

1) address poor staff attitudes, a significant barrier to both access and use, through staff training/orientation;
2) assign male providers or provide choice-female providers are a major cultural barrier;
3) differentiate service delivery through evening/weekend clinics to open access for men who are unable to leave work;
4) establish male-friendly services and tailor, e.g. label a clinic space/time slot 'Men's Clinic';
5) provide integrated health services to de-stigmatize HIV services-avoid designated ART pick-up points/days; and
6) address real/perceived lack of confidentiality through provider orientation/space reconfiguration to improve privacy.

Conclusions and Recommendations: For Zambia to achieve HIV epidemic control by 2020, a key gap must be addressed: finding, engaging, and sustaining the missing men, particularly men 20-34 (among the least virally-suppressed) in HIV services. The Zambia MCS reveals that most of these men feel well and won't access/utilize services unless we redesign them and address some of the health system barriers they face. If we do nothing, men will continue to be diagnosed late, resulting in poor health outcomes and limiting Zambia's ability to achieve HIV epidemic control.

TUPEE374

Assessment of Quality of Integrated Family Planning and HIV Services in Luapula Province Zambia

Manda Handson[1], Mwale Mwanjinga[1], Nqumayo Masauso[1], Moono Hastings[1], Smith Gina[2]
[1]Society for Family Health (SFH) Zambia, Research Monitoring and Evaluation, Lusaka, Zambia, [2]Society for Family Health (SFH) Zambia, Programs, Lusaka, Zambia

Issues: There has been a policy shift by development agencies and donors in support of integrating SRH and HIV services. To reach HIV/AIDS epidemic control and achieve the 90-90-90 goals, SRH/HIV integration plays a critical role especially in Zambia which has an estimated adult (15-49 years) HIV prevalence of 12.3% and high unmet need in family planning of 20% as resources may be limited to implement each program independently. According to Zambian guidelines HIV must be fully integrated with SRH. However there is no clear guidance on how this should be done. Society for Family Health (SFH) Zambia, through the USAID funded the Sexual and Reproductive Health for All Initiative (SARAI) piloted an integration assessment tool in order to measure the quality of integrated SRH/HIV services in public health facilities.
Descriptions: In 2016, the SARAI trained 167 public sector health care providers in FP integration service delivery and oriented provincial and district health management teams on family planning integration. Population Services International (PSI), developed an assessment tool for the monitoring of integration of family planning into HIV services to ensure the provision of high quality integrated services that adhere to principles of human rights, informed choice and evidence based programming. The tool scores on Services, staffing and training, Supervision, Facility infrastructure, Referrals, and Drugs and supplies. A total of 40 public health facilities in Luapula province were assessed in June, 2019.
Lessons learned: The results show that; Counselling: 37 (92.5%) facilities scored above average and 3 (7.5%) scored average; Services: 30 (75%) scored above average and 10 (25%) scored average; Staffing and Training: 5 (12.5%) scored above average and 35 (87.5%) below average; Supervision: 40 (100%) scored above average; Infrastructure: 26 (65%) scored above average and 14 (35%) scored average; Drugs and Supply: 4 (10%) scored above average, 22 (55%) scored average and 14 (35%). 95% of facilities were rural. Staffing and Training posed the largest challenge due to staffing shortages.
Next steps: Integration is happening in Zambia however quality of the services provided vary. For quality integrated services to be achieved, there is need for deliberate focus on quality of SRH/HIV integration services and scaled-up to support advancement toward reaching the HIV treatment cascade goals and improving family planning access.

TUPEE375

Adolescent and Youth Sexual Reproductive Health/HIV Programming in Hard-to-Reach Uganda: Determinants of Services Utilization in Amudat District

Ssebadduka Bernadette[1], Nanyingi Miisa[2]
[1]United Nation Population Fund Uganda, Integrated Field Program Support, Moroto, Uganda, [2]Uganda Martyrs University (UMU), Kampala, Uganda

Background: Uganda has one of the highest youth populations globally, yet adolescent and youth sexual reproductive health (AYSRH)[1] services remain inadequate. Supporting AYSRH utilization needs contextual understanding of key determinants of utilization and yet few studies have focused on hotspots with poor AYSRH indicators among hard-to-reach populations in Uganda. This study sought to assess determinants of AYSRH utilization in Amudat District, Uganda.
Methods: An analytical cross-sectional study employing quantitative and qualitative methods. Data was collected from random and purposively selected respondents in June 2018 using structured questionnaires, key informant interviews and focus group discussions. Univariate analysis of the distribution of determinants and level of AYSRH utilization determined as proportions. Bivariate analyses for association between AYSRH utilization and each of the independent variables were assessed using STATA version 12. For all variables which showed association at bivariate level, adjusted prevalence ratios (APRs) and 95% confidence intervals were computed using logistic regression. A pvalue of $\leq$0.05 was considered statistically significant.
Results: 503 adolescents and youth were interviewed. 82.3% having got first marriage before 19 years. Routine facility-based services were underutilized. Respondents aged 20-24 were 10 percent (APR=0.90, CI=0.83-0.97, p=0.01) more likely to utilize AYSRH services compared to those aged 15-19. Respondents out-of school had utilized AYSRH services more than those in-school (APR=1.12, CI=0.91-1.37, p=0.03). Youth who disagreed that religion approves youth to seek AYSRH services had five percent less chance to have utilized services (APR=0.95, CI=0.91-0.99, p=0.003) and respondents who agreed that contraceptives encourages promiscuity were less likely to have utilized AYSRH service (APR=0.95, CI=0.91-0.99, p-value=0.03).
Conclusions: Use of AYSRH services in hard-to-reach hotspots can be improved by offering integrated SRH/HIV/GBV outreach services; training health workers in youth friendly services; community engagement through youth gatekeepers particularly youth religious and cultural leaders plus youth champions; fostering family values that favor AYSRH discussions; culturally adapted sexuality education in schools; preventing child marriage; providing quality AYSRH services
References: [1] AYSRH services in Uganda includes HIV services
Keywords: Hard-to-reach, integrated AYSRH, AYSRH hotspots

WEPEE314

Economic Empowerment as a Tool for Positive and Healthy Living in East and Adamawa Regions, Cameroon

Mbazoa Sabine[1], Ngwenyi Eveline[1], Le Quere Lise-Marie[2], Rebena Agathe[2], Stevens Briony[3], Takpa Vincent[4], Dr Ousmanou Lyli[5], Ymele Aime Juste[6]

[1]World Food Programme Country Office, Yaounde, Cameroon, [2]World Food Programme Regional Bureau, Dakar, Senegal, [3]World Food Programme, Rome, Italy, [4]UNAIDS Country Office, Yaounde, Cameroon, [5]Centre de Traitement Agréé, Bertoua, Cameroon, [6]Association d'Assistance au Développement (ASAD), Bertoua, Cameroon

Issues: In Cameroon, the HIV prevalence is 3.7%. 14% of people living with HIV are malnourished. Of those who have access to WFP nutrition support programmes in East and Adamawa regions, 25% were food insecure after being discharged and 33% relapsed into malnutrition.

Description: In November 2017, a social protection intervention was initiated to complement nutrition support for malnourished antiretroviral therapy clients with livelihood activities in the food insecure districts of Batouri and Belabo, and then expanded in 4 other districts in 2018. Selection criteria was based on a vulnerability assessment of ART clients discharged from nutrition support programmes. Criteria included readmission after relapse, being a female head of household, from a household with no economic activities or with vulnerable people. Selected ART clients were gathered into savings and loan associations (15-25 members). Weekly meetings and visits helped to follow-up on treatment adherence. Members were encouraged to save a minimum amount each week and could take loans with minimum interest rates. Based on needs and interest, they received start-up kits and were trained on agricultural techniques, livestock rearing, petty trade or food transformation. Sessions on healthy living including gender, protection, nutrition and hygiene were also provided. The cooperating partner and decentralized services of the Ministries of Agriculture and Rural Development, Livestock and Fishery, Vocational training, or Social affairs facilitated the sessions.

Lessons learnt: 30 village savings and loan associations were created, reaching 675 beneficiaries (62 men; 613 women). 11.7 tons of food (maize, peanuts, soybeans) were produced: 6.8 tons consumed by beneficiary households and 4.9 tons sold. 19.546 USD were earned as benefit and 4.510 USD saved, with 1.814 USD mobilized for solidarity and 435 USD used to assist members suffering hardship. Beneficiaries shared that the programme contributed to an improvement in their quality of life: economic empowerment, improved food diversity, strengthened social cohesion, and the reduction of discriminatory practices by helping members work collaboratively with others, selling and buying essential goods, and having new clients and social networks.

Next steps: Additional work is required to scale-up the programme and build evidence on the impact of integrating nutrition support and economic strengthening on treatment adherence and viral suppression.

WEPEE315

Micronutrient Intake Adequacy among Women of Reproductive Age Living with HIV in Three Arid and Semi-arid Counties in Kenya

Mwema Josephine[1], Ouma Cyprian[2], Mumma Manaan[3], Giordana Giovanni[3]
[1]World Food Programme Kenya Country Office, Nutrition, Nairobi, Kenya, [2]World Food Programme Regional Bureau, Nairobi, Kenya, [3]World Food Programme Regional Bureau, Nairobi, Nairobi, Kenya

Background: Kenya is a UNAIDS Fast-Track country, with the 4th highest HIV burden globally. Despite tremendous achievements, women continue to be disproportionately affected by the AIDS epidemic. The HIV response in the arid and semi-arid lands (ASAL) remains a concern, with gaps persisting in the prevention of mother-to-child transmission, antiretroviral treatment coverage, health facility access and skilled personnel.

Chronic food insecurity compounds vulnerabilities among the most vulnerable, including women living with HIV. Food insecurity and undernutrition hinder the HIV response by undermining adherence to treatment and retention in care while exacerbating the socio-economic impact of the virus, reducing work capacity and productivity, and endangering household livelihoods.

Methods: A cross-sectional study was conducted in three ASAL counties (Turkana, Kitui and Kilifi). The rapid assessment sought to establish the effects of drought on the health, livelihoods and wellbeing of people living with HIV, and to explore the complex and interacting mechanisms that enhance or impede HIV response in ASALs in Kenya.

Geographical targeting was based on a composite score of drought severity, HIV prevalence, poverty index and malnutrition. A total of 775 adults were selected from three comprehensive care clinics in each county. The Statistical Package for Social Sciences Software v.23 was used to conduct the analyses. Minimum dietary diversity for women (MDD-W) was assessed using one 24-hour recall period.

Results: Of a total 775 cases, 69.6% did not meet the MDD-W $\geq$ 5 food group and 30.4% had MDD-W of $\leq$ 4 food groups. Grains, white roots, tubers and milk were the only two food groups consumed by more than 50% of the sample, at 98.9% and 51.7% respectively. Majority had low consumption of Eggs (5.8%), meat, poultry and fish (23%), and vitamin A rich fruits and vegetables (8.6%). In Turkana, Kilifi and Kitui counties 87%, 72% and 54% respectively did not achieve MDD-W

Conclusions and Recommendations: Poor consumption of animal source foods and inadequate micronutrient intake among women of reproductive age who live with HIV remain high in the ASAL, critically below the recommended threshold. Nutrition-sensitive interventions such as cash transfer and food security targeted to women of reproductive age living with HIV can improve programme effectiveness; and health and nutrition outcomes

WEPEE316

Integration of Chronic Care for HIV Positive Patients and HIV Negative Patients with Non-communicable Diseases (NCDs) in Primary Health Care Facilities in Uganda- Lessons Learned

Birungi Josephine[1,2], Namakoola Ivan[1], Lesikari Sokoine[3], Garrib Anupam[4], Snells Hazel[4], Bukenya Dominic[1], Shayo Elizabeth[3], Mutungi Gerald[5], Musinguzi Joshua[6], Mfinanga Sayoki G[3], Nyirenda Moffat Joha[1], Shabbar Jaffar[4]

[1]Medical Research Council/Uganda Virus Research Institute& London School of Hygiene and Tropical Medicine Uganda Research Unit, Entebbe, Uganda, [2]The AIDS Support Organisation(TASO), Kampala, Uganda, [3]National Institute for Medical Research- Muhimbili Medical Research Centre, Dar es Salaam, Tanzania, United Republic of, [4]Liverpool School of Tropical Medicine (LSTM), Liverpool, United Kingdom, [5]Ministry of Health, Non-Communicable Diseases, Kampala, Uganda, [6]Ministry of Health, AIDS Control Program, Kampala, Uganda

Issue: In Africa, the burden of and deaths due to non-communicable diseases has risen sharply alongside a continuing high burden of infectious diseases. The control of NCDs therefore represents one of the biggest health challenges of our time. Unlike for HIV, the coverage of services for NCDs remains very low across Africa and increasing coverage of services will be challenging. We have an opportunity to learn from and use the platforms developed for HIV-infection. We describe the lessons learned during the implementation of a pilot study; MOCCA on integration of care for HIV and NCDs (specifically diabetes and hypertension) in primary care health facilities in Uganda.

Description: Working with the Ministry of Health, the facility healthcare providers and other stakeholders, we set up an integrated chronic care clinic for patients with HIV and/or NCDs (specifically diabetes and hypertension) in 10 primary health care facilities in Uganda and Tanzania. Patients receiving HIV or NCD services were invited and consented to join this new integrated clinic. In this clinic both HIV infected and uninfected patients were clinically evaluated by one clinician as opposed to the previous arrangement where HIV patients attended a stand-alone clinic. We conducted a refresher training for all health care providers and introduced a common triage point for chronic conditions only. We also provided necessary equipment, guidelines, mentorship and coaching sessions. We held series of meetings to discuss the patient flow, data management and quality of care. The individual health workers engaged in additional data collection for study purposes received financial compensation for their time. We documented the lessons learned using the log.

Lessons learned: Engagement of all stakeholders; policy makers, patients, health workers, health unit management committees and the other facility collaborators in all stages of implementation enabled smooth transition from stand-alone clinics to an integrated one. A group incentive as opposed to individual one is better for sustained motivation of bigger proportion of health workers at the facility. On-site continuous educations sessions, mentorship and coaching and peer to peer discussion of patient management enhance learning and builds confidence of the health workers.

Next steps: We will continue to follow up the MOCCA cohort of patients in the integrated chronic care clinics for the next 3 years, looking at retention in care.

WEPEE317

Improved Case Detection and Management of Advanced HIV Disease through TB Contact Risk Stratification and Implementation of a Package of Interventions in a Rural District of Mozambique

Izco Santiago[1,2], Murias Adria[1], Jordan Alexander[3], Greene Gregory[3], Catorze Nteruma[2], Xirinda Lucinda[2], Jeco Espiwa[2], Garcia Juan-Ignacio[1,2,4], Garcia-Basteiro Alberto[1,2], Nhampossa Tacilta[2], Letang Emilio[1,5]
[1]ISGlobal, Hospital Clínic-Universitat de Barcelona, Barcelona, Spain, [2]Centro de Investigação em Saude de Manhica (CISM), Maputo, Mozambique, [3]Centers for Disease Control and Prevention, Mycotic Diseases Branch, Atlanta, United States, [4]PhD Program in Methodology of Biomedical Research, Faculty of Medicine, University of Barcelona, Barcelona, Spain, [5]Hospital del Mar Research Institute (IMIM), Department of Infectious Diseases, Barcelona, Spain

Background: One third of people living with HIV (PLHIV) present to care with advanced HIV disease (AHD) globally. Innovative strategies are needed to increase earlier HIV diagnosis and to improve outcomes, particularly in sub-Saharan Africa.
Methods: An active tuberculosis (TB) case finding study was implemented in the Manhiça district, Mozambique (population ~180,000). Community workers reached all household and community contacts of every new TB case reported during the study period. Participants were tested for HIV and for TB (Xpert® MTB/RIF Ultra in induced sputum). All PLHIV identified who were ART-naïve or had evidence of poor antiretroviral therapy (ART)-adherence were invited to be referred to the Manhiça Health Research Centre and screened for AHD. Patients with AHD (CD4 counts < 200 cells/mm3or WHO stage 3 or 4), were offered a package of interventions recommended by the WHO including screening, treatment and/or prophylaxis for opportunistic infections, rapid ART initiation and adherence support.
Results: Between June and December 2018, 589 adult TB-index cases and 2172 of their contacts were identified. HIV serology was positive in 653 participants, including 371/589 (63%) TB-cases and 282/2172 (13%) contacts. Overall, 181/653 (28%) were either ART-naïve or had documented poor ART-adherence, and 154/181 (85%) accepted being tested for AHD (125 TB- cases and 29 contacts).88/125 (70%) TB-cases had CD4< 200 cells/mm3 and6/29 (21%) contacts had AHD. Among the 92 patients with CD4 < 200 cells/mm3,plasma cryptococcal antigen was positive in 4.3% (4/92, 2 meningitis) and TB-lipoarabinomannan (TB-LAM), in 62% (57/92). TB-LAM was the only confirmatory TB test in 19/65 (29%) of LAM-positive cases. Secondary TB was found in 2/29 contacts (7%). 93% of asymptomatic, CrAg-negative, LAM- negative contacts (25/27) started ART during the first week, 23/25 within 48 hours. Among the remainder, ART timing was tailored to the presence of TB and cryptococcosis. Mortality was 15% in the TB group and zero among contacts.
Conclusions and Recommendations: This innovative community strategy to identify AHD among contacts of notified TB cases was feasible in this rural district of Mozambique. The study resulted in a prompt identification of co-infections and a safe, timely ART initiation in the vast majority of participants.

WEPEE318

Contribution of Community Health Systems Strengthening towards Viral Suppression among Orphans and Vulnerable Children

Kimutai Elizabeth[1], Yienya Nancy[1], Amolo Dorcas[1], Githui James[1], Oindo Clement[1], Okoth George[1], Oyaro Patrick[2]
[1]MWENDO OVC Project, Kisumu, Kenya, [2]Health Innovation Kenya (HIK), Kisumu, Kenya

Background: In achieving UNAIDS goal 3rd 95, MWENDO used a three-prong approach to improve Viral load (VL) Access and suppression;
i) systemic access to viral load results
ii) child-focused, family centered service delivery approach in case-management and
iii) activated community-facility based support systems to improve child´s well-being and mitigate the impact of HIV and AIDS on children and families.
These approaches enhanced multi-sectorial collaboration, strengthened involvement and partnership with the Households to achieve specified goals and build resilience among Orphans and Vulnerable Children (OVC) and their household.
Methods: MWENDO adopted the Ministry of Health 2018 Ante-retroviral Therapy (ART) guideline and sensitized 34 Local Implementing partners (LIPs) to provide a road map for interventions for HIV positive OVC in the project. The project then developed standard operating procedures (SOPs) and further came up with an OVC HIV monitoring tools to guide suppression by LIP staff. Once the Viral Load (VL) results were obtained, the project worked in collaboration with the households and the clinical partners to explore reasons for high VL for OVC through case management approach and designed specific interventions to enhance viral load suppression. The project further supported initiatives to achieve viral load suppression amongst CLHIV with detectable viral load through
i) referrals for enhanced adherence counseling to the facility
ii) linkage of OVC to special OTZ support groups for VL suppression,
iii) Supported Direct Observed Ingestion (DOI)
iv) Conducted Case conferencing
v) Provided pill boxes to OVC vi) Faciliated disclosure of HIV status by care-givers to trusted teachers in schools,
vii) Enrolled care-givers in m-Health platform and
viii) Conducted joint treatment literacy sessions with clinical partners at the community level with caregivers of HIV+ OVC.
Results: As a result of the interventions, the project documented a tremendous improvement on Viral suppression from 69% in Jan-March 017, to 82% in Jan-March 019 ,where 6889 of the CLHIV had VL < 1000cp/ml of 8,471 VL results accessed while only while 1582 (18%) had VL>1000cp/ml.
Conclusions: Efforts geared towards achieving viral load suppression is contributed through a coordinated effort on Continous capacity building of LIPs and project beneficiaries and provision of targeted interventions to address non-suppression issues through community-facility linkages.

WEPEE319

Assessing Access to Optimal ART and Integrated Family Planning (FP) Services for Women Living with HIV in Zambia

Barrett Caroline[1], Carmone Andy[2], Nyambe Lubinda[3], McGovern Shaun[4], Bhebhe Moyo Anita[5], Kasonde Maxwell[5], Mulenga Lloyd[6]

[1]Clinton Health Access Initiative (CHAI), Kigali, Rwanda, [2]Clinton Health Access Initiative (CHAI), Boston, United States, [3]Clinton Health Access Initiative (CHAI), Lusaka, Zambia, [4]Clinton Health Access Initiative (CHAI), Pretoria, South Africa, [5]Zambia Ministry of Health, Lusaka, Zambia, [6]Catholic Relief Services, Lusaka, Zambia

Issue: In July 2018 Zambia began rollout of dolutegravir (DTG)-based antiretroviral therapy (ART). Preliminary data from Botswana suggested a fetal safety concern for women on DTG at peri-conception so Zambia recommended that to be eligible for DTG, women of childbearing potential must use 'reliable contraception.' By May 2019, 28% of 141,000 on DTG were women, a low proportion as 63% of ART patients in Zambia are women. To better understand the situation, Zambia MOH and CHAI conducted a rapid assessment of integration and access to DTG-ART and FP for women living with HIV (WLHIV).
Description: The May 2019 assessment included stakeholder interviews, facility assessments (4 urban, 3 rural), and desk review of national data. 25 healthcare workers (HCWs) and 4 clients were interviewed using standardized questionnaires. Leaders from 8 stakeholder organizations including implementing partners were also interviewed. Lastly, national program data (DHIS2 and SmartCare), survey data (DHS) and national stock data was analyzed.
Learnings: National data suggests FP prevalence among WLHIV is 62.5% but highly variable (28% to 90% across the 7 facilities visited). All had at least one FP method of pills, injectables, or implants available. Supply chain did not appear to be a barrier. Gender disparity in DTG access is driven by poor provider understanding of the benefits of DTG and women's eligibility; only 3/18 HCWs correctly identified Zambia's DTG guidance. Multiple changes in Zambia's guidance may have caused this. ARV and FP interactions are poorly understood; only 5/24 HCWs knew that DTG has no documented interactions. HCWs did not report routinely asking clients about desire for pregnancy or FP. Finally HCWs are unaware that they can use SmartCare (SC), an electronic records system, to query WLHIV's FP uptake; data on method choice among WLHIV is not collected or utilized efficiently.
Next steps: The assessment provided a snapshot of current practice and potential to improve integration and access. Recommendations include: clarifying new guidance; moving all women on hormonal contraception to DTG now; optimizing SC to understand WLHIV's FP choices; re-orienting ART providers to see safe conception and FP as integral to HIV care; ensuring that women do not have to make multiple visits for ART and FP; training lay counselors to adapt FP messaging to adolescent, young, and unmarried women; and storing injectables and pills at ART pharmacies and regional resupply hubs.

WEPEE320

Assessment of the Contribution of Mobile Health (Mhealth) in Re-shaping HIV/AIDS Services in Tanzania: Review from Njombe Region, Tanzania

Nachenga Ferdinand
Deloitte Consulting Ltd, Strategic and Information, Njombe Tanzania, Tanzania, United Republic of

Background: The application of mobile technologies, 'Mobile Health' (mHealth), in the health care industry is increasingly seen as a way to provide high quality and easily accessible care at lower costs. mHealth is the practice of medical and public health supported by mobile devices, such as mobile phones, patient monitoring devices, personal digital assistants (PDAs), and other wireless devices. Under the USAID Boresha Afya, the primary focus of the program is on reducing health care costs, delivering higher quality of care, and improving patient experience and access to basic health care.
SMS Reminder system is one among a number of digital health initiatives that the program supports the government to address missed appointment and lost to follow up among CTC clients and also aiming to improve HIV client adherence to treatment and retention in care. USAID Boresha Afya decided to conduct an analysis on the contribution of the system to retain HIV/AIDS patients to treatment in Njombe region for the period of nine (9) months (from July 2017 to March 2018).
Methods: In July 2017, thirty eight (38) health facilities (with high volume HIV/AIDS clients) were selected and installed the SMS reminder systems in all six councils in the region. The system sends a one-way text notification (JALI AFYA YAKO) three days before the appointment date with a follow-up reminder at 6 AM on the day of the appointment. The data for nine months on running and using this system in the region was analysed to determine the contribution of the systems in reducing missed appointment of clients and increase adherence among PLHIV.
Results: A total of 153,875 clients were expected to attend their visits and 126,220 clients attended their visits as scheduled at these 38 facilities, and 27,655 (*18% of the total appointments*) missed their appointment as scheduled. When compared the same data in the past nine months back (*before the introduction of SMS remainder systems*), the expected clients were 27,398 and only 17,327 attended and a total of 10,071 (*36% of the total appointments*) missed their appointments.
Conclusions and Recommendations: Using the mHealth and the SMS Reminder System actively in this perspective, it's probably the best approach to reducing the LTF clients and a good way to motivate people with HIV/AIDS to go to health facilities for their scheduled visits and other services, and this might make it easier for the program and country to reach to reach 95-95-95 goals.

WEPEE321

Engaging Community Health Workers to Improve Health Outcomes and Retention in Care among Pregnant Women in Tabora, Tanzania

Jahanpour Ola, Antelman Gretchen, Machalo Thomas, Mbogo Naimi, van de Ven Roland
Elizabeth Glaser Pediatric AIDS Foundation, Dar es Salaam, Tanzania, United Republic of

Background: The use of community health workers (CHW), lay health providers linking communities to health services, is a public health strategy applied to bolster support in health services in sub-Saharan Africa. This study assessed the effectiveness of three CHW integration models in improving retention in antenatal care clinic (ANC) attendance and HIV-related services.
Methods: The evaluation design was a mixed-methods cluster-randomized longitudinal observational study of clinic and person-level patient outcomes. The intervention was launched in 2016 at 15 sites and had three study arms (5 sites per arm): 1) case-management, where CHWs are trained to follow up women/infants with elevated pregnant related-risk factors such as prior miscarriages (case-management arm); 2) inclusion of CHW in improving the quality of services provided at facilities by being involved in Planning, Doing, Studying and Acting cycle at facilities (quality improvement-QI arm); and 3) standard of care (SOC). Two evaluation cohorts were created: (1) all women who started ANC in March 2017 (1-month cohort) and (2) all HIV-positive women seen at study facilities in April 2016-March 2017 (1-year cohort). Data were abstracted from national registers and medical records. Chi-square testing was used to test for differences in proportions.
Results: In March 2017, 882 women attended services at clinic sites (1-month cohort): 26%, 39% and 35% from case-management, QI and SOC arms respectively. ANC attendance 4 or more times was found in 38% of case-management and 43% of QI intervention arms compared to 30% in the SOC arm ($p< 0.001$). During the one-year 2016-2017 period, 406 HIV-positive women were seen at the facilities, 26%, 39% and 35% from case-management, QI and SOC arms respectively. In the case-management and QI arms, 40% and 45%, respectively, attended ANC 4 or more times, compared to 18% in the SOC arm ($p< 0.0001$). Significantly lower LTFU was observed in the case-management arm (4%) compared to the QI (16%) and standard of care (16%) arms ($p=0.004$).
Conclusions and Recommendations: Interventions to support integration of CHWs in activities at a health facility contributes to improved patient outcomes. There is merit in both interventions, suggesting that CHWs can play an important role in supporting patients individually, as well as working within the health provider team to monitor reportable indicators and quality improvement.

WEPEE322

Optimizing Treatment Outcomes through Implementation of Regional HIV Technical Working Groups in Kenya - A Case Study of LAKATI Technical Working Group in Central Kenya

Kisio Julius[1], Ndomoto L.N.[2], Irungu K[3], Maina P[4], Kibubu G[5], Sasya J[6], Gichuhi J. K.[7], Mithamo A[3], Kinyanjui D. G.[1], Kariba H[8], Mwangi S[9], Mwangi L[10]

[1]Murang'a County Government, Health Department, Murang'a, Kenya, [2]Africa Mission Healthcare (AMH), Kijabe, Kenya, [3]Nyeri County Government, Health Department, Nyeri, Kenya, [4]Kirinyaga County Government, Health Department, Kirinyaga, Kenya, [5]Kiambu County Government, Kiambu, Kenya, [6]Laikipia County Government, Laikipia, Kenya, [7]Nyandarua County Government, Health Department, Nyandarua, Kenya, [8]Afya Kamilisha/Jhpiego, Nairobi, Kenya, [9]Crissp plus, Nairobi, Kenya, [10]Center for Health Solutions (CHS), Nairobi, Kenya

Background: The Kenya´s 2010 new constituition created a devolved system of government and established 47 county governments. Health became a devolved function creating a need for shifting some of the national tasks to the counties. The Kenya´s National AIDS and STI control program(NASCOP) is a unit within the ministry of health whose mandate is to offer technical co-ordination of HIV programs, provide strategic information and develop policy guidelines for implementation to ensure quality HIV/STI service delivery and complex HIV cases discussions through its national HIV technical working group.
Methods: NASCOP through its mentorship program trained a pool of HIV experts from the counties whom it designated as county lead mentors, in collaboration with counties and local HIV implementing partners, regional techinical working groups were created with a mandate of discussing complex treatment failures and recommending appropriate management including 3rd line(salvage therapies) to consulting health facilities. The county lead mentors key role is offering clinical HIV mentorships to health workers in HIV clinics,helps clinicians in summarizing confirmed 2nd line treatment failure using a national standardized summary form for submission to the regional technical working groups for deliberations and recommendations.
Results: LAKATI technical working group serves 6 counties in central Kenya and has received over 100 complex cases from its various facilities for discussions and deliberations since it was launched in October 2017. The technical team (physcian,pediatrician,HIV experts, and county lead mentors) meets monthly to discuss these cases and draw recommendations which are then cascaded back to the facilities for implementations. Facilities are then required to report back to the TWG the status of their patients wellbeing icluding viral loads results 3 months after implementing the recommendations. 70% of the patients achieved viral suppressions, 30% did not suppress and the technical team recommended drug resistance testing (DRT). The DRTs results revealed various major and minor mutations guiding the team in reconstituting appropriate 3rd line/salvage regimens to the patients who achieved viral suppression on the new regimens.
Conclusions and Recommendations: Task shifting and service decentralization is key in strengthening HIV service delivery and improving patient outcomes as demonstrated through regional technical working groups in Kenya.

WEPEE323

Achieving Elimination of Mother to Child Transmission of HIV Using Peer Education in Rwanda"

Akimana Rachel[1], Mukamurara Rutamu Helene[1], Grace Muriisa[2], Ng'oma Kondwani[2], Umutoni Sandrine[1]
[1]Imbuto Foundation, Kigali, Rwanda, [2]UNICEF, Kigali, Rwanda

Issues: Access to PMTCT services in Rwanda has reached near universal coverage; and the rate of mother to child transmission of HIV (MTCT) has been maintained at 1.5% over the last three years. However, available data show that some women and children are lost follow up and do not adequately utilize PMTCT services. While ART initiation among HIV positive pregnant mothers is >95%, retention during post-partum period diminishes and loss to follow up is estimated to be 7.6% by 18 months. Imbuto Foundation (IF) and Rwanda Network of people living with HIV (RRP+) implemented an innovative peer-based education project to identify acceptable options for psychosocial care, ART adherence and retention

Descriptions: A strategic partnership between IF and RRP+ was established to strengthen coordination and involvement of PLHIV as peer educators for clients receiving PMTCT services from 32 health centers in Bugesera, Musanze, Rubavu, Gatsibo and Huye districts. Sixty Four PMTCT service providers and 320 peer educators were trained to improve their knowledge and skills in HIV counselling and psychosocial support. Regular home visits and adherence counseling sessions were conducted to their clients. Process indicators adopted to track implementation of planned activities. Health care workers trained on data collection on monthly basis using M&E tools. Data analysis done using SPSS.

Lessons learned: Among the 26,647 PMTCT clients, 57% preferred to disclose their status to peer educators and receive counseling support. 93% were able to attend all clinic appointments during the project period, 88% of those linked to peer educators returned to care. 91% and 93.4% achieved optimal viral load suppression (< 20 RNA copies/ml) at 6 and 12 months respectively. Over 90% of the mothers attended clinic appointments according to schedule, and those who missed appointments returned to clinic with the help of peer educators. Reasons for non-adherence to clinic appointments relate to self-stigma, inadequate knowledge and migration. Of the 1,311 HIV exposed infants received at 18 months, only 1.3% were HIV positive. The low level of HIV-positivity observed among these infants is due to high adherence to ART by their mothers.

Next steps: More resources are required to scale up the peer approach including unique identifier systems to track women living with HIV who migrate from one location to the other.

WEPEE324

Community Worker Characteristics Associated with Referral Success in a Multisectoral Bi-directional Referral System for OVC and their Caregivers in Tanzania

Bajaria Shraddha[1], Abdul Ramadhani[1], Exavery Amon[2], Minja Epifania[2], Mtenga Sally[1], Geubbels Eveline[1]
[1]Ifakara Health Institute, Dar Es Salaam, Tanzania, United Republic of, [2]Pact, Dar Es Salaam, Tanzania, United Republic of

Background: Trained community workers (CWs) successfully deliver health and social services especially due to greater community acceptance. Orphans, vulnerable children (OVC) and their caregivers (CG) often need support from several sectors. Although CWs efficiently link multiple facilities, cross-sectoral bi-directional referral systems increase their ability to address these needs. Few studies have explored provider-side determinants for successful implementation of multisectoral programs. This study identified CW and referral characteristics that influenced success of referrals provided to OVC and their CG in Tanzania.
Methods: Data for this secondary analysis come from the first two years (October 2016- September 2018) of USAID funded Kizazi Kipya project. Referral success was defined as feedback and service received 90 days post-referral provision. Generalized estimating equation models with logit link function utilizing an exchangeable correlation structure were used to analyze the factors that influence referral success of HIV, education, nutrition, parenting, economic strengthening and child protection services among OVC and CG.
Results: Majority of the CWs were between 26-49 years (70.0%), 59.4% were females. About half had received primary education. Most (64.5%) had at least one year of work experience in the project. In the study period, 146996 referrals had been provided to 132640 beneficiaries. OVC had much lower referral success for HIV services than CG, 47% and 83% respectively. Adjusted for other covariates, CW age (26-49 vs 18-25 OR=0.83, 95%CI 0.78,0.88; OR=1.19, 95%CI 1.08,1.32) and gender (male vs female OR=1.13, 95%CI 1.09,1.17; OR=0.89, 95%CI 0.82,0.96) were significantly associated with referral success for OVC and CG. CWs with secondary education compared to primary less successfully referred CG. CWs with more than one year of experience in the program were more likely to successfully refer OVC (OR=1.58, 95%CI 1.52,1.65). Referrals for OVC of HIV positive CG were also more successful (OR=1.38, 95%CI 1.33,1.44). Compared to HIV referrals provided to OVC, referrals for all other services were significantly more successful.
Conclusions and Recommendations: CWs' age, gender, education, work experience and CG HIV status significantly influenced referral success. Our findings could help policymakers in low resource-high burden settings decide on the level of involvement of CWs in community based multi-sectoral intervention programs.

WEPEE325

"Dispense ARVs Daily!": Preferences of Men in Optimizing ART Initiation in Malawi

Nyondo-Mipando Alinane Linda[1], Suwedi-Kapesa Leticia Chimwemwe[1], Salimu Sangwani[1], Kazuma Thokozani[1], Mwapasa Victor[2]

[1]University of Malawi, College of Medicine, Health Systems and Policy, Blantyre, Malawi, [2]University of Malawi, College of Medicine, Public health, Blantyre, Malawi

Background: Gender disparities exist in the scale up and uptake of HIV services with men being disproportionately under-represented in the services. In Eastern and Southern Africa, of the people living with HIV infection, more adult women (59%) than men (44%) were on treatment highlighting the disparities in HIV services. A delayed access to HIV testing potentially results in a delay with initiation of antiretroviral therapy (ART) thus increasing HIV and AIDS associated morbidity and mortality. The main objective of this study was to assess the strategies that men prefer for ART initiation in Blantyre, Malawi.

Methods: This was a qualitative study conducted in 7 Health facilities in Blantyre and was guided by the Andersen and Newman Framework of Health Services Utilization. We conducted 20 in-depth interviews with men of different HIV statuses, 16 interviews with Health care workers and 14 Focus group discussions among men of varying HIV statuses. All data were digitally recorded and transcribed verbatim and were thematically analysed.

Results: The broader themes on strategies for ART initiation for men were: Accessibility of ART services and Availability of ART services and were largely influenced by the individual's context as they interface with ART services. Accessibility included restructuring of the health system by offering ARVs on a daily basis, extending the hours of operation and dispensing ARVs from the main pharmacy of the facility. Availability encompassed establishment of community based approaches to ART such as Mobile ART clinics, strong partnerships with privately owned facilities for ART provision, increasing the number of work-based ART centres and establishment of male specific clinics.

Conclusions and Recommendations: The success in ART initiation among men will require a restructuring of the current ART services to make them accessible and available for men to initiate on treatment. Inclusion of people-centred approaches will ensure that individual preferences have been incorporated in the initiation of ARVs.

WEPEE326

ART Differentiated Care for Stable HIV Positive Patients; Perspectives of Patients and Providers across ART Clinics in Nigeria

Chizoba Amara Frances[1], Ichima Oche[2], Kehinde Nike[1], Saliu Idris[1], Ifedigbo Alfred[1], Nzeako Amara[2]
[1]Center for Clinical Care and Clinical Research Nigeria, Clinical, Makurdi, Nigeria, [2]Center for Clinical Care and Clinical Research Nigeria, Pharmacy, Makurdi, Nigeria

Background: Nigeria has the second largest HIV burden globally. As ART need increases in Nigeria, provider-patient ratio decreases, resulting to increased workload for providers, increased patients' clinic time and decreased satisfaction among providers and patients. To bridge this gap, ART differentiated care (ADC) through multi-month script (MMS)- entailing 3 monthly hospital visit with 6 monthly clinical consultation of stable patient- was adopted in ART clinics to reduce patients' wait time and staff workload thus improving patients and providers' satisfaction. We aimed to assess patients and providers perspective on effect of ADC on clinic satisfaction.
Methods: We adopted a cross sectional study design using an interviewer guided questionnaire to elicit responses on effect of ART differentiated care among patients and providers. Data was analyzed using frequency distribution and percentages
Results: Fourteen (14) patients and 19 providers (4 Physicians, 5 pharmacists, 5 Nurses and 5 Health volunteers) participated in the study across 3 large ART clinics implementing ADC in Benue Nigeria. Questionnaires contained ten questions aimed at evaluating impact of the ADC on clinic time, adherence, providers' workload and satisfaction for patients and providers. 100% of patients expressed satisfaction with ADC program. 79% (11/14) stated reduction in clinic time from average of 7 hours to 2 hours, 57%(8/14) agreed to it reducing missed-appointment/non-adherence and 93%(13/14) of the patients prefer to remain in ADC. All 100% of service providers expressed very satisfied with ADC. While 100% of providers agreed to ADC being effective in reduction of patients' clinic time, 73%(14/19) agreed to ADC reducing workload, and only 63% (12/19) agreed to it reducing missed appointment and non-adherence.
Conclusions and Recommendations: ADC is effective in reducing patients' clinic time and providers' workload while improving patients and providers' satisfaction. It is recommended to be adopted in ART programs to bridge gaps in low providers- patients' ratio.

WEPEE327

Post-training and Mentorship Experiences of Child-friendly Champions Implementing the KidzAlive Intervention at Primary Healthcare Facilities in Kwazulu-Natal, South Africa

Mutambo Chipo[1], Hlongwana Khumbulani[2], Shumba Kemist[2]
[1]Zoe-Life Innovative Solutions, Durban, South Africa, [2]University of KwaZulu-Natal, Public Health Medicine, Durban, South Africa

Background: Introduced in 2009, the KidzAlive Intervention promotes the use of child-friendly approaches to improve the quality of HIV care among children in South Africa. In September 2018, 80 healthcare workers (HCWs) were trained and mentored on this the child-friendly approach. They became child-friendly champions, integrating child-friendly approaches into their routine functions in primary healthcare (PHC) facilities. This study explored their post-training and mentorship experiences after a 6-month implementation period.
Setting: We conducted qualitative interviews with twenty purposively selected child-friendly champions across four districts in KwaZulu-Natal.
Methods: We used an interview guide, audio-recorded interviews, transcribed verbatim, and imported data into NVivo 10 for analysis. Thematic analysis was used to develop a coding framework from the research questions.
Findings: The analysis process yielded six themes. These include; Healthcare worker knowledge, skills and confidence to provide child-friendly HIV services; Children's participation in own healthcare journey; Involvement of primary caregivers (PCGs) in children's healthcare journey; Health outcomes of children living with HIV; Transformation of the PHC environment towards being child-friendly, and Barriers to implementing child-friendly approaches.
Conclusions and Recommendations: The findings present evidence of successful stakeholder (child-friendly champions, HIV seropositive children and PCGs) buy-in of the Intervention, at least from the perspectives of the child-friendly champions. The Intervention seems to have been well integrated into current service delivery processes in PHC facilities. The findings make a strong case for scale-up of the Intervention and make the barriers to its success explicit to the Intervention developers and future funders.

WEPEE328

Mise à l'echelle de la Décentralisation des ARV au Sénégal pour l'Atteinte des 90-90-90 : L'Exemple Réussi de la Région Aurifère de Kédougou

Konate Abdoulaye[1], Senghor Cheikh Sadibou[2], Ndiaye Moussa[3], Diene Djibril[4], Ndiaye Ismaila[2]
[1]Conseiller VIH - CNLS Kédougou, Kédougou, Senegal, [2]Region Médicale, Kédougou, Senegal, [3]District Sanitaire de Kédougou, Kédougou, Senegal, [4]District Sanitaire de Salémata, Salémata, Senegal

Questions: Au Sénégal, les efforts consentis depuis le début de la riposte ont abouti à une stabilisation, voire une baisse de l'épidémie, avec une prévalence de 0,5 %, selon l'ONUSIDA, une baisse de 50,0 % des nouvelles infections est notée entre 2001 et 2016. Ces résultats sont liés à l'accès aux ARV, qui a réduit le taux de décès à 3,5%, avec une couverture nationale de 63,0 %. Ces résultats encourageant pourraient être meilleurs avec une décentralisation des ARV, jusque dans les structures sanitaires les plus reculées du pays, avec des prestataires formés sur la dispensation

Description: Rendre effectifs le traitement et la dispensation des ARV dans les postes de santé de la région de Kédougou par la formation des prestataires sur le modèle de prise en charge (PEC) adaptée, associant la décentralisation des ARV et le suivi différencié des PVVIH sous traitement

·Cartographie des offres des services

·Répartition des prestataires (Infirmiers-chef de poste, Sages-femmes et assistants sociaux) en 3 groupes

·Acheminement des ARV dans les postes de santé

Période : Janvier 2018 à mars 2019

Leçons apprises: Ce procédé contribue à apporter une amélioration dans le dispositif de PEC des PVVIH. Au total, 37 postes de santé sur 39 ont été enrôlés avec 70 prestataires formés sur la dispensation des ARV et le suivi des PVVIH.

Le nombre de PVVIH suivies dans les sites décentralisés est de 224 (164 à Kédougou, 35 à Salémata et 25 à Saraya) en janvier 2018. Au bout de 15 mois,300 PVVIHs ont régulièrement suivies(228 à Kédougou, 35 à Salémata, 37 à Saraya) avec les décès qui passent de 0.6% à 00% et les PDV de 3.3% à 0.33%. Globalement, le taux de rétention de la région est passé de 78.2% avant la décentralisation à 84.3% en 2018.

Réduction du taux d'abandons du traitement

Traitement précoce

Confiance accrue aux ARV

Prochaines étapes: Le traitement se fait sur place, avec un suivi constant. La décentralisation des ARV facilite l'accès aux soins et réduit le nombre de perdus de vue. Elle permet d'asseoir une communication soutenue avec les patients et encourage le partage du statut au sein du couple

La décentralisation des ARVconstitue une priorité pour le traitement et la PEC des PVVIH et suppose relever ces défis pour l'atteinte des 90-90-90 :

- Disponibilité permanente des ARV et des machines charge virale
- Formation des prestataires sur le Counselling etla dispensation des ARV
- Prise en compte des préoccupations des PVVIH

WEPEE329

Adolescents Friendly Sexual Reproductive Health Services in Selected Cities of Rwanda: A Service Providers Cross Sectional Study

Niyonzima Jean De la Croix[1], Nyandwi Jean Baptiste[2,3], Uwase Rosine[4], Biracyaza Emmanuel[1,5], Ndayishimiye Pacifique[1], Kubwimana Isabelle[4], Kadima Ntokamunda Justin[6], Jansen Stefan[7]
[1]Youth Service Organization (YSO), Public Health, Huye, Rwanda, [2]University of Rwanda, Pharmacy, Huye, Rwanda, [3]Gyeongsang National University, department of pharmacology, Jinju, Korea, Republic of, [4]Youth Service Organization (YSO), Huye, Rwanda, [5]University of Rwanda, Public Health, Kigali, Rwanda, [6]University of Rwanda, Pharmacy, Kigali, Rwanda, [7]University of Rwanda, Directorate of Research and Innovation, Kigali, Rwanda

Background: Sexual Reproductive Health services are provided to adolescents' to meet their needs according to the Rwandan Ministry of Health. However access to these services is challenged by various reasons. The study assessed the friendliness of adolescents' sexual and reproductive Health services in six selected Rwandan cities according to the indicators of World Health Organization.
Methods: This was a descriptive cross sectional study. The study cities were selected purposively and stratified sampling methods were used to select health facilities, and youth centers, while eligible respondents were selected randomly within SRH departments. Data collection was done using a structured questionnaire. SPSS version 23 was used for data analysis.
Results: We are reporting the preliminary findings of our study. Out of 147 health care providers interviewed, 78 (58.1%) were male and the majority 64 (43.5%) were in the age range of 26-35 years old followed with those of 36-45 making 54 (36.7%). The majority 118 (80.3%) of respondents were general nurses . On the services provided, we have found that, 125 (85.0%) of facilities provide HIV testing services, 133 (90.5%) STIs testing, 48 (32.7%) HIV treatment, 115 (78.2%) HIV counselling, 107 (72.8%) male condoms while 31 (21.1%) provide female condoms. 22 (15%) of the facility are able to provide the lubricants, 138 (93.9%) provide further information on SRH services provided, and 87 (59.2%) reported to have permanent staff in SRH units. It was documented that the majority 88 (59.9%) of adolescents access the services from below 30min walkable distance and 91 (61.9%) of respondents felt that there was a reasonable waiting time of 30min to access the services and 111 (75.5%) responded that they operate within suitable hours for young people. The community 62 (42.2%), the family 96 (65.3%) and the religious leaders 92 (62.7% were reported as barriers toward access to SRH services and information for adolescents.
Conclusions and Recommendations: Our results showed that the SRH services for adolescents were accessible and available. Efforts to eradicate stigma associated with seeking SRH and HIV services should be considered.
Keywords: Accessibility; Availability; SRH; Adolescents; HIV

WEPEE330

Community-based Strategies to Strengthen Retention in HIV Care and Suppressed Viral Load Using Community ART Refill Groups

Mudzengerere Fungai Hamilton, Muchedzi Auxilia, Mawora Peter, Zulu Tinashe, Harbick Don, Tafuma Taurayi
FHI 360, Harare, Zimbabwe

Issues: Zimbabwe has scaled up coverage of Antiretroviral Therapy (ART) with 86.8% of identified people living with HIV (PLHIV) on treatment. This is a significant improvement from 56.1% in 2009. Despite these great strides, the rapid expansion of ART programmes in low-income settings with weak health systems is associated with loss of patients to follow up. To attain the 3rd 90, the country is scaling up Direct Service Delivery (DSD) initiatives to improve long term retention on ART. One such initiative is community ART refill Groups (CARGs). This assessment highlights outcomes for viral load suppression and retention in care of clients in CARGs.
Descriptions: The FHI360 team works closely with health facility nurses to support formation of CARGS, in accordance to national guidance, with clearly defined eligibility criteria. The self-forming groups of 4-12 stable PLHIV on ART take turns to: pick up antiretroviral (ARVs) at the health-facility; get clinical assessment and monitoring and distribute ARVS among other group members in the community. CARGs outcomes that is retention in care, adherence to treatment, and viral load suppression were tracked for a year. A retrospective assessment of clients who enrolled in CARGs between October 2017 and September 2018 in Makoni district of Zimbabwe was conducted
Lessons learned: A total of 388 CARGs were formed in one year in Makoni district with 3,375 (1,060 males and 2,315 females) members receiving ART. Of these, 91% (3095/3375) clients had documented VL and 95.5% (2956/3095) had suppressed VL (VL< 1000 copies/ml). Retention of clients in CARGs was 99% (3343/3375) with 3 members having relocated, 21 females falling pregnant and 8 members died.
Next steps: The CARGs model had shown a high retention rate of clients and suppressed VL. FHI 360 will continue to encourage clients to be in CARGs and ensure they have access to viral load testing to closely monitor quality of care.

WEPEE332

DECPOST: Impact de la Décentralisation de la Prise en Charge des PVVIH au Niveau des Postes de Santé dans les Régions de Tambacounda et de Saint-Louis (Sénégal)

Fortes Déguénonvo Louise[1], Dia Badiane Ndeye Mery[2], Diouf Assane[1], Massaly Aminata[1], Diop Ndiaga Mactar[3], Ndione Albert Gautier[4], Ndiaye Coulibaly Ndeye Binta[5], Bocoum Mamadou[6], Diouf Amadou Mactar[7], Ndiaye Abib[7], Ndiaye Seynabou[6], Niasse Fatou[3], Thiam Safiatou[3], Ndour Cheikh Tidiane[5], Seydi Moussa[1]

[1]Service des Maladies Infectieuses et Tropicales CHNU Fann (Dakar), Dakar, Senegal, [2]UFR des Sciences de la Santé, Université Gaston Berger/ CHR de Saint Louis, Saint-Louis, Senegal, [3]Conseil National de Lutte Contre le SIDA (CNLS), Dakar, Senegal, [4]Centre Régional de Recherche et de Formation du CHNU Fann (Dakar), Dakar, Senegal, [5]Division de Lutte Contre le Sida et les IST (DLSI), Dakar, Senegal, [6]Région Médicale de Saint-Louis, Saint-Louis, Senegal, [7]Région Médicale de Tambacounda, Tambacounda, Senegal

Objectifs: L'étude « DECPOST » avait comme objectif principal d'évaluer l'impact de la décentralisation de la prise en charge de l'infection à VIH au niveau des postes de santé sur l'accès au traitement ARV et la rétention.
Méthodologie: il s'agit d'un essai communautaire randomisé avec deux groupes de comparaison : groupe A « intervention » et le groupe B « sans intervention». Cette étude s'est déroulée de janvier 2017 à Juillet 2018. Les courbes de survie ont été estimées par la méthode de Kaplan-Meier et le test de Log-Rank a été utilisé pour comparer les taux de mortalité et de rétention entre 2 groupes.
Résultats: Nous avons inclus 1014 patients vivant avec le VIH répartis comme suit : Groupe A : 429 patients (42,3%) et Groupe B : 585 patients (57,7%). Il s'agissait majoritairement de patients sous ARV depuis une durée médiane de 37 mois [11-78,4] et sous TDF+3TC/FTC+EFV dans 63,8% des cas. Sur les 113 postes de santé, 53 ont démarré la prise en charge de l'infection à VIH. Le taux d'acceptation de transfert par les patients était de 50,8% et il était plus élevé dans la région de Tambacounda (80,7% contre 27,7% Saint-Louis ; p< 10-6). Le taux global de rétention était de 94,38% et il n'y avait pas de différence entre les deux groupes (HRa : 1,20 [0,68 - 2,14] p= 0,53). Le taux de mortalité était de 1,58 % ; sans différence entre les deux groupes (HRa : 1,81 [0,64 - 5,13] ; p=0,26). La rétention était plus élevée chez les patients stables par rapport aux patients Naïfs (HRa : 3,69 [1,92 - 7,10] ; $p< 10^{-6}$). Le taux de suppression virale était de 79,6% et il n'y avait pas de différence entre les 2 groupes de randomisation (A : 83,4% versus B : 76,5% ; p=0,08). L'enquête médico-économique a retrouvé une baisse de la proportion de patients qui payaient un frais de transport (97,6% versus 40,6%, $p< 10^{-6}$), de la durée moyenne de transport (120 ± 68 minutes à 29 ± 31 mintues, $p< 10^{-6}$ soit une baisse de 75%), du coût moyen de transport (3114 ± 2616 F CFA à 495 ± 924 CFA, p< 10-6 soit une baisse de 84%) mais également du temps moyen passé dans la structure sanitaire (89 ± 91 minutes à 25 ± 23 minutes, $p< 10^{-6}$).
Conclusion: Cette étude a montré que la décentralisation au niveau des postes de santé améliorait significativement la qualité des services VIH et les rends plus accessibles aux populations. Ce modèle de prise en charge pourra être mis à l'échelle en tenant en compte des spécificités régionales.

WEPEE333

Involvement of Expert Patients in HIV Self-testing: Models for Optimizing Targeted Testing in Zimbabwe

Mugwagwa Rumbidzai, Page- Mtongwiza Sara, Webb Karen, Patel Diana, Mhlanga Trudy, Chinyanga Tinashe
OPHID, Harare, Zimbabwe

Issues: The impact of human resource constraints upon HIV service quality in high burden,resource-limited settings is well documented, particularly in large urban health facilities with high patient volume.Zimbabwe is such a setting, with an adult HIV prevalence of 14.1%.To meet program targets and optimize HIV testing towards attainment of the first 90 in Zimbabwe,PEPFAR-partners are implementing an integrated HIV Testing (iHTS) model that includes HIV self-testing (HIVST) in public health facilities.Despite HIVST kit stocks,HIVST distribution was low due to human resource constraints, creating missed opportunities for providing HIV testing.
Descriptions: From Jan-June 2019, a learning phase model was implemented to task shift HIVST distribution to expert patients at health facilities in Bulawayo urban.A total of 36 expert patients were trained on HIVST distribution, documentation and reporting. Experts patients mobilised clients for HIV testing through group education, and interpersonal communication, offered lay counselling and distributed HIVST kits to eligible clients using MoHCC adult HIV screening tools. A flipchart with key messages supported client education on HIVST. HIV implementing partners and site level nurses mentored experts patients at site level.
Lessons learned: We demonstrated significant increases in number of HIVST kits distributed and test yield using the facility-based experts patient model.There was a threefold increase in the number of test kits distributed after the introduction of the expert patients .Increased HIVST distribution, improved use of the nation adult HIV screening tool and weekly performance monitoring led to a notable increase in HIV test yield and absolute number of new positives identified over the period of interest. The proportion of clients with a reactive test increased significantly from5% to11% in Jan-March 2019 to Apr-June 2019.The number of new positives identified through HIVST rose from 41 to 588 over the same period.
Next steps: Meaningful involvement of expert patients in HIV programming improves program performance and contributes to the de-stigmatization of people living with HIV within facility environment.Training to expert patients in other districts, specifically targeting high volume facilities, to support over-burdened health facility staff. Future research will be on introducing other self- care approaches to beneficiaries through expert patients such as screening for mental health,Hepatitis B,C

WEPEE334

Community Adherence Group (CAG) for HIV Viremic Patients: Early Lessons Learnt from Lusaka, Zambia

Mwamba Daniel
Centre for Infectious Disease Research in Zambia (CIDRZ), Lusaka, Zambia

Background: Despite progress with ART scale up, 10.8% of HIV patients on treatment do not achieve virologic suppression in Zambia. While most differentiated service delivery (DSD) models are tailored to fit the need of stable patients, unstable (i.e. viremic) patients receiving the standard of care face increased clinic visit frequency and longer wait times. This constitute a barrier to patient engagement in care and, ultimately, viral load (VL) suppression. We developed a novel viremic patient DSD model offering combined community- and clinic-based services including: 1) inviting them to join a routine CAG; 2) close clinical follow up in a dedicated "Viral Load" clinic. We conducted a retrospective cohort study to test the hypothesis that our model would help viremic patients achieve viral suppression.
Methods: We implemented our DSD model at one first-level hospital in Lusaka to accommodate patients with viral load >1,000 copies/ml. To assess uptake of viremic DSD services and the proportion of beneficiaries who re-suppress, we reviewed all patient records for patients who received the intervention from the model's inception, October 2017, to May 2019. We calculated descriptive statistics for baseline clinical & demographic variables and describe the care continuum for viremic patients in the model.
Results: We approached 386 patients to join the model who had a routine monitoring VL >1,000 copies/ml. Table 1 presents clinical and demographic characteristics of patients approached. All 386 (100%) patients accepted to attend the high VL clinic day and 346 (89.6%) accepted to join both CAG and high VL clinic. Of those accepting, 119/386 (30.8%) have completed Enhanced Adherence Counselling (EAC) and had their VL test repeated. Of 119 samples collected, 97 (81.5%) VL results were received, of which 27 (27.8%) suppressed (VL< 1000).
Discussion: Introducing a dedicated DSD for viremic patients is a feasible intervention in urban Zambia and results in high patient uptake of services, particularly "fast track" clinical care in a dedicate clinic. Despite high uptake, only 27% of viremic patients with a documented repeat VL result achieved virologic suppression. Further research, including genotype testing and adherence monitoring, is needed to understand reasons for failed re-suppression after DSD model enrolment.

WEPEE335

Proportions of HIV Patients with Advanced HIV Disease Remain Consistently High at Primary Health Care Facilities across Four High HIV Burden Countries

Lamp Katherine[1], McGovern Seth[2], Fong Youyi[3], Atem Charles Diko[4], Nfetam Jean Bosco Elat[5], Nzuobontane Divine[4], Bollinger Timothy[6], Jani Ilesh[7], Sitoe Nadia[7], Kiyaga Charles[8], Senyama George[9], Mangwendeza Phibeon M.[10], Mtapuri-Zinyowera Sekesai[11], Doi Naoko[2], Peter Trevor F.[2], Sacks Jilian A.[2], Vojnov Lara[2]

[1]Clinton Health Access Initiative, Laboratory Services Team, Boston, United States, [2]Clinton Health Access Initiative, Boston, United States, [3]Fred Hutchinson Cancer Research Center, Seattle, United States, [4]Clinton Health Access Initiative, Yaoundé, Cameroon, [5]National AIDS Control Committee (NACC/CNLS), Yaoundé, Cameroon, [6]Clinton Health Access Initiative, Maputo, Mozambique, [7]Instituto Nacional de Saúde, Maputo, Mozambique, [8]Central Public Health Laboratory, Kampala, Uganda, [9]Clinton Health Access Initiative, Kampala, Uganda, [10]Clinton Health Access Initiative, Harare, Zimbabwe, [11]Ministory of Health and Child Care, Harare, Zimbabwe

Background: Globally, nearly 22 million HIV-infected patients are currently accessing antiretroviral treatment; however, almost one million people living with HIV died of AIDS-related illnesses in 2018. Advanced HIV disease remains a significant issue to curb HIV-related mortality.

Methods: We analyzed 864,389 CD4 testing records collected by 1,016 Alere PimaTM Analyzers implemented at a variety of facilities, including peripheral facilities, between January 2012 and December 2016 across four countries in sub-Saharan Africa. Routinely collected data and programmatic records were used to analyze the median CD4 counts and proportions of patients with advanced HIV disease by country, facility type, and year.

Results: Median CD4 counts were between 409 - 444 cells/ul each year since 2012 with a median in 2016 of 444 cells/ul (n=319,829). The proportion of patients with CD4 counts above 500 cells/ul has increased slowly each year with 41.8% (95% CI: 41.6 - 41.9%) of patients having a CD4 count above 500 cells/ul in 2016. Median CD4 counts were similar across facility types. The proportion of patients with advanced HIV disease has remained fairly consistent: 19.4% (95% CI: 18.8 - 20.1%) in 2012 compared to 16.1% (95% CI: 16.0 - 16.3%) in 2016. The proportion of patients with advanced HIV disease ranged from 14.0% in Uganda to 28.8% in Cameroon. 6.9% (95% CI: 6.8 - 7.0%) of patients had very advanced HIV disease (CD4< 100 cells/ul) in 2016.

Conclusions and Recommendations: The proportion of patients living with HIV and presenting to primary health care facilities with advanced HIV disease, regardless of whether treatment naïve or experienced, was relatively high and consistent across four high HIV burden countries, despite increases in treatment coverage and adoption of Treat All policies during the time period. CD4 testing supports identification of patients with advanced HIV disease in need of follow-up care and a suggested package of interventions in order to minimize HIV-related morbidity and mortality. Management for patients identified with advanced HIV disease, including in peripheral facilities and using point-of-care technologies to support faster identification, should be a priority in order to support sick patients and reduce HIV-related morbidity and mortality.

WEPEE336

Lay Counsellors (LCs) Fill in the Gap towards Ghana's Full Attainment of the Global Fast Track Targets in HIV and AIDS

Gyamfi Maame Serwaa[1], Senoo Cecilia[1], Ampong D. A.[1], Adiibokah E.[2], Edison , L.[1], Appiah P. K.[1], Eifler Kristin[3]

[1]Hope for Future Generations, Accra, Ghana, [2]Population Council, Accra, Ghana, [3]JSI Research and Training Institute Inc., Boston, United States

Issues: According to the 2017 integrated biological and behavioral surveillance survey (IBBSS) among female sex workers (FSWs) in Ghana, 30% have never tested for HIV. This low- HIV testing service (HTS) uptake is driven by structural barriers like stigma and discrimination and criminalization of sex work, resulting in FSWs driven to dangerous and hard-to-reach locations. Health workers (nurses) who provide HTS often avoid outreach to such areas due to security concerns. To achieve the 90-90-90 targets, innovative HTS outreach strategies are needed. We describe an effective task-shifting strategy with persons living with HIV (PLHIV) lay counsellors (LCs) to provide HST in difficult outreach areas for FSW in Ghana

Descriptions: In November 2017, Hope for Future Generations, a non-governmental organization in Ghana supported by the JSI-implemented USAID Strengthening the Care Continuum Project, trained six PLHIV as LCs, with support from the National AIDs Control Programme, to provide quality outreach HTS using the national Key Population Standard Operating Procedure, to FSW the Accra Metropolis Area (AMA). The training included HIV testing and counselling skills, disclosure and partner notification, positive living, antiretroviral therapy (ART) adherence, HTS legal and ethical issues, and safety precautions. PLHIV LCs provide HTS through targeted door-to-door outreach by Peer Educators (PEs). HIV positive FSWs identified given a laboratory test initiated on ART and are tracked through the continuum of care. The LCs are also case managers to the FWS-PLHIV, by following them up through home visits, phone calls and texts.

Lessons learned: The PEs reached 6123 FSW in AMA with HIV preventive messages between November 2017 and June 2019. Of these, 38 percent were reached and tested by LCs through targeted outreach approaches in 32 hard-to-reach slums and ghettos. Four percent of FSWs tested by PLHIV LCs were diagnosed positive with 95 percent of those enrolled and sustained on ART. FSW PLHIV trust the LCs and disclose sensitive and confidential information because they are also PLHIV and understand the needs without stigma.

Next steps: The PLHIV LCs are effective in providing differentiated services, breaking distance, language and stigma barriers that challenge activities of the health care workers. Based on the evidence, the authors recommend a scaling up of the PLHIV LCs HTS model to fill in the gap to provide service to underserved and hard to reach populations.

WEPEE337

MSM Case Managers a Vital Strategy to Achieve the 2nd and 3rd 90 of the UNAIDS 90-90-90 HIV Treatment Targets

Ekem-Ferguson George, Owusu Asante Mark K, Kwofie Edward, Pious Awuzu Gideon, Acquah Robert, Wosornu Senyo
Maritime Life Precious Foundation, Tarkoradi, Ghana

I**ssues:** Enrolment in care and initiation on ART of HIV-positive men who have sex with men (MSM) is low in Ghana. High rates of denial of HIV infection, fear of stigmatization, and myths around the side effects of antiretroviral drugs (ART) drastically affect the treatment initiation rate of HIV-positive MSM and also can result in loss-to-follow-up and defaulting from treatment. Case managers (CM) can play an effective role in successfully increasing the rate of treatment initiation of HIV-positive MSM.
Descriptions: Maritime Life Precious Foundation (MLPF), in partnership with the USAID Strengthening the Care Continuum project, implemented by JSI, trained five HIV-positive MSM CM to bridge the gap between HIV diagnosis and ART enrolment in two administrative districts in Ghana. The CM offered services ranging from supporting their clients to complete all the required lab tests, ART literacy including adherence, positive living, and disclosure to their partners. They were integrated into the health facilities to support the work of nurses, trace positive cases and link them to care and follow up with services to ensure that they do not default or get lost to follow-up
Lessons learned: The CM introduced from July 2017 to January 2018 were successful in facilitating the initiation and retention of HIV-positive MSM on ART. Prior to the introduction of case managers (January - June 2017), 38 MSM were diagnosed positive in Sekondi-Takoradi Metro Area (STMA) and Shama and 20 (53%) were initiated on ART, out of which 13 (65%) defaulted. After the CM commenced working, 98 MSM were diagnosed positive, out of which 79 (77%) have been initiated on ART with only 13 defaulters (16%). 10 MSM PLHIV were virally suppressed after 6 months of treatment. Between February 2018 to May 2019, more MSM have been initiated on treatment through the assistance of MSM CM. A total of 304 MSM were diagnosed HIV+ within the period out of which 286 (94.1%) were initiated on treatment. Viral load results for 141 clients were received with 116 (82.3%) being virally suppressed. These findings suggest that MSM CM are vital in enhancing client-centered friendly services for HIV-positive MSM and increasing retention rates.
Next steps: Case management is a vital strategy to increase initiation on ART and reduction in defaulters or lost to follow up among MSM PLHIV. Additional CM should be trained to improve efficiency considering the number of positive patients to be managed.

WEPEE338

Quality of ART Services Are Perceived to Be Better with Community-based Antiretroviral Therapy (ART) Provision for Female Sex Workers in Tanzania: Qualitative Findings

Tun Waimar[1], Conserve Donaldson[2], Bunga Catherine[3], Jeremiah Kidola[3], Apicella Lou[4], Vu Lung[1]
[1]Population Council, HIV and AIDS Program, Washington, United States, [2]University of South Carolina, Arnold School of Public Health, Columbia, United States, [3]National Institute for Medical Research (NIMR), Mwanza, Tanzania, United Republic of, [4]Population Council, Dar es Salaam, Tanzania, United Republic of

Background: To increase linkages to and retention in ART, we piloted the delivery of community-based ART services to female sex workers (FSWs) using community-based HIV testing and counseling platforms.
Methods: FSWs in the intervention arm (Njombe; N=309) were enrolled into community-based ART and immediately received 1-month supply of antiretroviral (ARV) drugs. At first refill, FSWs received a 2-month supply, followed by 3-month supply. FSWs in the comparison arm (Mbeya; N=308) were referred to public ART facilities, following national guidelines (fixed refill date, 1 month of ARVs). Upon completion of the 12-month pilot, we conducted in-depth interviews with 12 participants in each arm (in addition to quantitative survey interviews) to understand their perspective on the quality of the ART services they received (using the quality of service framework).
Results: Findings were categorized around the themes of: accessibility, privacy, service efficiency, and perceived technical competency of staff. Better accessibility was reported by intervention FSWs primarily for two reasons: 1) the drugs are delivered to them at a convenient time and place; and 2) they do not have to worry about transport costs unlike their counterparts in the comparison arm who struggled with transportation costs to reach ART facilities. Intervention participants valued the high level of privacy they had as compared to what they would have received in the government ART clinics. Participants indicated that they did not want to be seen by other people at the ART clinics. The efficiency of services was reported to be better in the intervention arm. In particular, comparison participants reported long queues to be seen by the provider and not having their viral load tested regularly. The majority of those in the intervention arm reported having been tested regularly and knowing their VL status. Participants in both arms perceived that their providers were competent and very knowledgeable about how to treat them for HIV. Participants in both arms were very satisfied with their interactions with the service providers. They felt that the providers treated them with respect.
Conclusions: Given the better perceived quality of services, and taken together with increased initiation and retention rates (based on quantitative data) in the community-based ART services compared to standard services, expanding community-based ART for FSWs may improve HIV treatment access and outcomes for FSWs.

WEPEE339

"Caring for the Caregiver"- Providing Counseling, Care and Support to Helpline Counselors (HLCs) on the Care Continuum Project

Kodua Nyano Angelina[1], Bruce Egbert K[1], Rahman Yussif Ahmed Abdul[1], Mensah Ebenezer K[1], Benefour Samuel[2], Nagai Henry[1]

[1]JSI Research and Training Institute Inc., Accra, Ghana, [2]Population Council, Accra, Ghana

Issues: HIV and AIDS care and treatment requires extensive supportive supervision to help clients adhere strictly to protocols to achieve viral suppression (VS). Factors such as HIV related stigma and social and economic burden on affected families, constrains client support which strains professional and lay counsellors, including helpline counsellors (HLCs). These care providers need care to manage the psychosocial demands of their work. We present an innovative intervention focused on providing care for HLCs in Ghana

Descriptions: The USAID Strengthening the Care Continuum Project is Ghana's flagship key population-focused HIV program. The Project partners with 10 civil society organizations (CSOs) to provide direct HIV and other STI related services in (4) implementing regions across Ghana. In 2018 the project trained and certified 19 HLCs to offer key populations (KPs) information on quality HIV-related services. The HLCs operates 24/7 service for KPs. The project's interaction with the HLCs indicated that they were highly stressed and at risk of burn out. As a result, 5 of the nineteen trained HLC who were trained drop out of the work. The Care Continuum technical team in response took steps to help the HLCs bear with the burden and to avoid burn out. We first organized a training for all the fourteen (14) HLCs to help them better manage burnout, and emotional drain, and also refresh their memory on HIV related issues. Some of the issues discussed were how to identify burn out (signs and symptoms), how to manage it, risks of getting personal with clients, client dependency management (to reduce emotional drain due to over exposure to horrifying stories), and updates on HIV/AIDS and STIs (nationally and internationally)

Lessons learned: The intervention was timely and acceptable to the HLCs for support to prevent, identify and manage burn out from their stressful work, such as. 2) Outlining the risks associated with being too personal or emotionally involved with clients is a must for counsellors before they start work. 3) Counselors and all staff cadres working on HIV/AIDS and STI need breaks and flexible schedules to prevent burn out. 4) Meeting other HLCs to share experiences and success stories were refreshing and added new knowledge to the other counselors

Next steps: We intend to extend the support to other health care cadres working with the project and to continue to offer refresher training and support to the HLCS

WEPEE340

Increased Access of HIV Testing and Treatment by Men Reduces New HIV Infections among the Adolescent Girls and Young Women

Simonda Mubita, Kapalaula Gershom, Mwansa Ethel
Afya Mzuri, Lusaka, Zambia

Background: Despite sound behaviour change interventions used in over 20 years now for HIV prevention, there has been no decrease in HIV infection rates but increase in new HIV new infections in all categories of people with the adolescent girls and young women the most at risk. This challenge is due to the fact that male involvement in sexual reproductive health (SRH) and HIV prevention has continued to be a public health challenge resulting in increase in HIV infections amongst the adolescent girls and young women.

In order to provide solution to the reduction of new HIV infections, Male Involvement in SRH and HIV prevention as well as utilization of positive traditional learning system for HIV prevention is vital to contribute to reduction of new HIV infections in adolescent girls and young women. Afya Mzuri is implementing a male involvement project called Insaka focusing on HIV Prevention.

The men's Insaka is a traditional learning system for the male gender in an African set up and Zambia in particular. The Insaka is held every weekend in selected communities and is conducted by champions, elders and health experts. Through this process the men; Men gain comprehensive knowledge on HIV Prevention and sexual reproductive health, Men have access to health services such as counseling, HIV testing, Voluntary Medical Male Circumcision and condoms and Men be exposed to positive attitudes towards HIV Prevention.

Methods: Baseline study conducted in bars and night clubs targeting male clients.

Identified and trained outreach workers who recruit the men from bars and night clubs to the weekly Insaka.

Mapping of SRH, HIV and AIDS service providers in the district and developing of a referral list.

Results: Since the onset of the project 2017, 3311 men have been invited from the bars to the men's Insaka, with 1987 directly accessing information on the broad topic of SRH and HIV Prevention. Through the Insaka, 202 men tested HIV with 15 going for voluntary male circumcision and 20 screening for sexually transmitted infections.

Conclusion and Recommendations: In conclusion, this innovation of male involvement in SRH and HIV prevention is unique because most of the current HIV interventions are centered around women living out men hence increasing the HIV knowledge gaps between men and women. It is therefore, important for donors, both public and private sector, the civil society to design HIV intervention that fully involve men.

WEPEE341

Group Care Model versus Individualized Care; A Comparative Analysis of Treatment Outcomes amongst Pediatrics on ART in Northern Nigeria

Orisakwe Chigozie Maria-Gorathy[1], Onu Kema Anthony[2], Oluwasina Folajinmi[3], Awunor Christy[4], Kolawale Mobolaji[3], Nwabueze Emmanuel[5], Popoola Victor[6]

[1]AIDS Healthcare Foundation Nigeria, Treatment, Jabi, Nigeria, [2]AIDS Healthcare Foundation, Treatment, Jabi, Nigeria, [3]AIDS Healthcare Foundation Nigeria, Monitoring and Evaluation, Jabi, Nigeria, [4]AIDS Healthcare Foundation Nigeria, Nursing and Treatment, Jabi, Nigeria, [5]AHF Abuja, Treatment, Jabi, Nigeria, [6]AHF Abuja, Quality Assurance, Jabi, Nigeria

Background: Several approaches are under consideration in the bid to upscale ART services and adherence in pediatric age group in low income countries. Group care model has experienced great acceptance and has positive impact in adult ART services but its significant on pediatrics is still unclear. This study aims to ascertain the superiority of pediatric group care over individualized care.
Methods: A retrospective study was done, using a cluster sampling on 235 Pediatrics receiving ART in AHF facilities, between the year 2015 to 2019. Outcomes measured includes: Adherence to medication, retention in care, clinic visits, viral loads and CD4.
Results: 4.3% of the pediatric population under review were managed under a group care model because they lived in a foster home and accessed care together under an experienced retired nurse. 80% of these were virally suppressed, all had a mean CD4 of 500ul,1 child left the foster home while 3 are now above the pediatrics age. Medications are administered at same time eliminating time challenge and poor adherence. Stigmatization is assumed minimal because they lived in same home and attended same schools. Clinic visits and investigations where collectively done.
Conclusions and recommendations: Our findings summarized a better ART services uptake of the children under a group care model as compared with individualized-based system. Therefore, we advocate that policies geared at creating pediatric clubs and support group which can function as group care model for children living with HIV be looked into.

WEPEE342

Assessment of the Quality of HIV Testing & Counselling in Antenatal Clinics in Private Health Facilities in Ayawaso Sub-metro, Accra Ghana

Osei-Ofei Yaa Adwo[1], Esena Reuben[2], Coleman-Sarfo Kate[1,3]
[1]37 Military Hospital, Pharmacy Department, Accra, Ghana, [2]University of Ghana, School of Public Health, Accra, Ghana, [3]University of Ghana, Pharmacy Department, Accra, Ghana

Introduction: Eliminating Mother-to-Child-Transmission (MTCT) of HIV is a global health priority. Advances in the Prevention of Mother-to-Child Transmission (PMTCT) program have provided the means to drastically reduce infant morbidity and mortality associated with HIV/AIDS. Quality HIV testing and counselling (HTC) is an important gateway to PMTCT services and concerted effort has been made by the National AIDS Control Program (NACP) to scale up the provision of antenatal HTC in Ghana. Some concerns have been raised about the quality of HTC provided in antenatal clinics (ANC) especially in the context of rapid scale-up programs. Greater Accra was one of three regions that recorded an increase in ANC HIV in 2013. Ayawaso, a densely populated sub-metro in Accra has the highest concentration of private health facilities, however, the quality of HTC in antenatal clinics in private health facilities within the sub-metro is unknown.
Methods: A descriptive, cross sectional, mixed methods research was carried out in purposively selected private health facilities in Ayawaso. Quantitative data were collected using a health facility assessment tool and client exit questionnaires; qualitative data were collected using observations and interviews with key HTC staff.
Findings: There were inadequate structures in place for the provision of quality HTC. While some aspects of the HTC process were adhered to, principles of informed consent and confidentiality were breached. In spite of this observation, both healthcare workers and clients expressed satisfaction with quality of HTC.
Conclusions: Private health facilities in Ayawaso have weak structures for the provision of quality HTC. Private health facilities adhere in part to the National Policy guidelines with deviations in obtaining informed consent and communicating confidentiality to the clients. In the perception of the clients and healthcare workers however, quality of HTC was good.
Keywords: Quality, Antenatal, HIV, Testing, Counselling.

WEPEE343

PMTCT Service Uptake among Pregnant Women in 3 IDPs Camps in Borno State

Affiah Nsikan[1], Fadoju Sunkanmi[2], Dickson Peter[3], Jasini Joseph[3], Opada Toluwase[3], John Jonah[3], Yunana Paul[3]

[1]Achieving Health Nigeria Initiative (Affiliate of FHI 360), Program, Borno, Nigeria, [2]Achieving Health Nigeria Initiative (Affiliate of FHI 360), Program, Maiduguri, Nigeria, [3]Achieving Health Nigeria Initiative (Affiliate of FHI 360), Maiduguri, Nigeria

Background: Humanitarian emergencies upset and wreck existing healthcare services and systems. Pregnant women and infant are incredibly defenseless, as these infants are exposed to the risk of preventable childhood disease which include HIV that is transmitted from their HIV positive mother. In the absence of any intervention, the risk of HIV transmission increases to about 40% among infant born to HIV positive mothers. The goal of this paper is to examine the prevalence and uptake of HIV service among pregnant women and to access the level of PCR uptake for children under 2 months born to HIV positive mothers.

Methods: A sentinel case study approach was adopted. The study was conducted in 3 IDP camps across 3 LGAs (Banki, Dikwa and Ngala) of Borno state between January 2018 to May 2019. Data were collected on HIV prevalence, PMTCT service uptake and PCR optimization using standard service registered across PMTCT service delivery sites in the 3 camps. DHIS 2.0 was used for data extraction and analyzed using Microsoft Excel 2016 software.

Results: The findings revealed that the prevalence of HIV among pregnant women clients (1st ANC Visits) in the 3 IDP camps were 1.22% (Ngala), 0.44% (Banki) and 0.16% (Dikwa). The average HIV prevalence rate among pregnant women in the 3 IDP camps is 0.61% compared to the National strategic framework for HIV/AIDs the prevalence among pregnant women is 1.1%. Also, the uptake of HIV testing service among pregnant women in the 3 IDP camps were 90.65% (Ngala), 100% (Banki) and 100% (Dikwa), with an average uptake of 96.9%. Th study shows PCR uptake for children within 2 months of age delivered by HIV infected mothers to be 50.0% (Dikwa), 12.5% (Banki) and 0% (Ngala). By implication, in Ngala, none of the HIV exposed children received PCR test earlier than 2 months of birth during the period under review. However, the study observed that there is strong negative correlation (r=-0.98) between prevalence and uptake of HIV services among pregnant women in the 3 IDP camps.

Conclusions: In this study, Banki and Dikwa IDP camps achieved One Hundred Percent optimization of PMTCT services compared to Ngala, although Ngala had the highest prevalence among pregnant women that access HIV Testing service. The study also shows that none of the 3 IDP camps were able to optimize Early Infant Diagnosis at 2 months of birth. It is hereby recommended that Care-giver Focused Approach should be prioritized in PMTCT service delivery.

WEPEE344

Improving Patient Satisfaction in PMTCT Services through the Community Score Card Approach in Malawi

Chauwa Felluna[1], Sampathkumar Veena[1], Ahimbisibwe Allan[1], Katirayi Leila[2], Kays Megan[2], Latera Anne[3], Msiska Thumbiko[4], Kudiabor Kwashie[1], Kayira Dumbani[5], Callahan Tegan[6], Montandon Michelle[6], Modi Surbhi[2], Kalua Thokozani[7], Woelk Godfrey[2]

[1]Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), Lilongwe, Malawi, [2]Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), Washington DC, United States, [3]CARE International, Atlanta, United States, [4]CARE Malawi, Lilongwe, Malawi, [5]Center for Disease Control and Prevention, Lilongwe, Malawi, [6]Center for Diseases Prevention and Control, CDC-Atlanta, Atlanta, United States, [7]Ministry of Health and Populations, Lilongwe, Malawi

Background: Malawi faces challenges with retention in prevention of mother-to-child transmission (PMTCT) services. Lack of trust and low satisfaction with patient-provider relationships can be reasons for poor retention. The Community Score Card (CSC) is an approach that uses a perception-based scorecard to facilitate dialogue between healthcare workers (HCWs) and their patients. This study adapted the CSC intervention for PMTCT and evaluated its effect on satisfaction with PMTCT services and trust in HCWs.
Methods: From September 2017 to August 2018, HCWs and HIV-positive women were recruited from 11 high-volume health facilities in Dedza and Ntcheu districts. Women and HCWs separately identified perceived challenges with PMTCT services; they selected final indicators for the scorecard in a joint meeting. Differences between indicator scores (absolute percentages) aggregated across all sites at baseline and at the end of the intervention were assessed using a Z-test. We evaluated patient-provider relationships through focus group discussions (FGDs) and key informant interviews before and after the CSC intervention. Finally, we abstracted medical record data on infant HIV testing and maternal retention at 3 and 6 months.
Results: A total of 485 HIV-positive women (102 pregnant women and 383 postpartum mothers) and 120 HCWs participated. Eight of 15 scorecard indicators improved significantly after the intervention ($p \leq 0.05$), including indicators such as level of male involvement, availability of trained workers, level of stigma and discrimination, and availability of disclosure support and confidentiality. In post-intervention FGDs, women and HCWs both reported improved relationships. In structured interviews, HCWs reported significant improvement in self-efficacy, particularly their ability to improve PMTCT services (81% pre-intervention vs. 96% post-intervention, $p < 0.009$), and their ability to advocate in the community for service improvements (79% pre-intervention vs. 98% post-intervention, $p < 0.001$). No significant difference was identified in maternal retention or infant HIV testing rates.
Conclusion: While the CSC did not improve individual patient outcomes, analysis of scorecard indicators, FGDs and interviews demonstrated improved patient-provider relationships, patient satisfaction, and HCW self-efficacy after CSC implementation. The CSC may be a useful tool to increase engagement of women and HCWs in quality improvement of PMTCT services.

WEPEE345

Volunteerism at International AIDS Conferences: Impact and Implications for Youth of Botswana

Morake Fhikile[1,2]

[1]Volunteers Network for Global Change Association, Communication, Gaborone, Botswana, [2]Superhero Dialogue Series, Communication, Gaborone, Botswana

Issues: Botswana is one of the countries highly affected by HIV and AIDS, and new infections among youth continue to pose a challenge to ending AIDS as a public health threat by 2030. There is limited data on the impact that the engagement of young people as volunteers has on their future participation in HIV/AIDS activities for Sustainable development, therefore, there is need to encourage exposure of youth to AIDS volunteerism and to increase their engagement in subsequent activities related to the AIDS response in Africa.

Descriptions: A survey was conducted among young volunteers who had participated in the 18th International Conference on AIDS and STI's in Africa (ICASA 2015), Zimbabwe, the 21st International AIDS Conference, 2016, Durban, South Africa, and the 22nd International AIDS Conference 2018, Amsterdam, Netherlands. Among the 56 volunteers who are members of VNGCA, a sample of 20 volunteers, was randomly chosen to answer an open-ended questionnaire that collected demographical data, previous history of volunteering at International AIDS Conferences, reasons for volunteering, and the self-reported impact on their current and future life. Participants' ages ranged from 22.5 to 27.3 years. They had all volunteered in at least two conferences. Reasons for volunteering included: to increase knowledge about HIV and AIDS (76%), interest in a career in the field of HIV (70%), to assist in ending AIDS (60%), to meet famous AIDS activists and researchers (45%), to meet other young people in the AIDS response (45%).

Lessons learned: On personal impact, 3 non-governmental organizations were established by some of the volunteers after attending the conferences, and these provided support platforms for youth empowerment and engagement on social, behavioral and economic issues in Botswana. At least 7 young people were now pursuing further studies in Medicine and Nursing, and some 3 others plan to go into politics for better decision-making about the AIDS response.

Next steps: The findings highlight a positive change by volunteers through the organizations they have formed in Botswana after participating in the AIDS conferences. The importance of encouraging young people, as future leaders in the AIDS response, to participate in these conferences cannot be overemphasized. It is therefore crucial that efforts be made to provide youth volunteers with financial and other support so that they empower themselves and their peers in the continent of Africa.

WEPEE346

Les observatoires Communautaires en Santé: Savoirs Issus d'une Capitalisation Collective

Duroyaume Perrine[1], Gombert Hélène[1], Beuret Jean-Eudes[2], Noseda Veronica[1], Fleutelot Eric[1]
[1]Expertise France, Paris, France, [2]Consultant, Rennes, France

Contexte: Depuis une quinzaine d'années, plusieurs observatoires de veille citoyenne et communautaire ont vu le jour, sous l'impulsion notamment de l'émergence des « patient.e.s-expert.e.s » dans la lutte contre le sida et de la promotion de la santé communautaire. A la fois dispositifs de suivi-évaluation des systèmes de santé et mouvements citoyens qui donnent une voix aux patient.e.s, les observatoires suscitent un intérêt croissant concernant l'amélioration de la lutte contre le VIH, le paludisme et la tuberculose.
Activités: A partir des expériences de 14 observatoires qu'elle a soutenus au Bénin, Burkina Faso, Cameroun, Centrafrique, Égypte, Guinée, Liban, Madagascar, Maroc, Mauritanie, Niger, République démocratique du Congo, Tchad et Tunisie, l'Initiative 5% a initié depuis 2018 une capitalisation collective afin d'éclairer leurs points communs, axes de différenciation et défis à relever.
Résultats: Points communs :

1. Les observatoires se fondent sur une implication communautaire, locale et citoyenne
2. Ils visent à alerter sur les dysfonctionnements, à collecter des informations fiables sur l'état des services de santé qu'ils diffusent de façon régulière à différentes échelles
3. Ils créent du dialogue entre les acteurs et renforcent les plaidoyers à tous les niveaux de la pyramide sanitaire
4. Ils contribuent à l'amélioration des systèmes de santé en mettant en avant la redevabilité de chaque acteur
5. Ils sont une alternative complémentaire aux systèmes d'informations institutionnels

Axes de différenciation:
La diversité des formes des observatoires s'explique par une variété de facteurs et résulte de tensions entre :

- **Le maintien de leur indépendance et le besoin d'un dialogue avec les autorités sanitaires.** Selon le positionnement adopté, les observatoires s´orientent vers une observation assurée par la communauté ou par des collecteurs spécialisés, une remontée des informations ouverte (ligne verte, application...) ou par des collectes de données systématiques et régulières

- **Des contextes de naissance différents** entre des observatoires initiés localement par des associations de patient.e.s et des observatoires portés par des bailleurs de fonds/des ONG internationales, sur la base d'expériences préalables

Malgré l'intérêt croissant pour ces dispositifs, du côté des autorités de santé et du Fonds mondial, la question de la pérennité des observatoires et de leur intégration dans l'environnement sanitaire reste d'actualité.

WEPEE347

In Ethiopia, Enhancing Supply Chain Management of Viral Load (VL) Commodities to Improve Service and Accelerate Progress towards Achieving the 3rd 90 Target

Tesfahunegn Zeamanuel[1], Alemu Fikreslassie[1], Ejigu Edmealem[1], Demissie Daniel[2], Endalew Kassahun[3]
[1]USAID Global Health Supply Chain Program: Procurement and Supply Management, Ethiopia, Addis Ababa, Ethiopia, [2]Ethiopian Public Health Institute, National Laboratory Capacity-Building Directorate, Ethiopia, Addis Ababa, Ethiopia, [3]Ethiopian Pharmaceuticals Supply Agency (EPSA), Quantification and Market Shaping Directorate, Ethiopia, Addis Ababa, Ethiopia

Issues: The Ethiopian national HIV guidelines recommend VL testing to monitor HIV treatment response and diagnose treatment failures to address the 3rd 90. Eighteen VL testing sites serve 1,200 HIV/AIDS treatment centers providing service to over 453,152 people. Yet VL commodity forecasting, procurement, distribution, storage, recoding and reporting challenges resulted in service breaks, impeding realization of national programmatic goals.

Descriptions: The USAID Global Health Supply Chain Program-Procurement and Supply Management (GHSC-PSM) project performed an assessment at 18 VL testing sites with the Ethiopian Pharmaceuticals Supply Agency (EPSA) and Ethiopian Public Health Institute (EPHI) in Dec. 2017 to understand the root causes. Results showed stockouts at 21% of facilities and repeated machine failure causing testing service interruption. Poor recording and reporting practices also revealed: 5.6% of testing sites had updated bin cards and 38.9% had complete logistics reports. Findings from regular assessments to identify VL commodity bottlenecks and supply gaps were used to update VL commodity supply plans, coordinate procurement, facilitate timely distribution and redistribution and improve reporting timeliness and quality. Based on findings, the FMoH integrated VL commodities into the national supply chain system. To assess intervention impacts, GHSC-PSM, EPHI and EPSA evaluated all VL testing sites in May 2019: 8 (44.4%) were hospitals, 9 (50%) regional labs and 1 (5.6%) was a national reference lab.

Lessons learned: Results included: stockout rate reduced to zero, backlog samples decreased by 80%, storage-space adequacy increased to 44.4%, bin card utilization improved to 72.2%, and reporting rate reached 100% with elevated data accuracy (66.7%) and validity (83.3%). GHSC-PSM interventions ensured nonstop service provision, informing decisions on treatment adjustments and the ability to assess treatment efficacy (based on VL). As of May 2019, 62% of the total number of people on ARTs were tested for VL. Of those, 88.6% had their VL suppressed, bringing Ethiopia close to achieving the 3rd 90 target.

Next steps: Assessments should not stand alone but applied to inform and evaluate interventions to address service-related challenges ensuring consistent product availability. For added improvement and sustainability, similar practices will continue for product management of other health programs.

WEPEE349

Analysis of Antiretroviral Therapy (ART) Pharmacy Data on Medicine Possession Ratio and Multi-month Dispensing Informs Future Program Policy Strategy on Multi-month Scripting in Namibia

Mazibuko Greatjoy Njabulo[1], Nghishekwa Naita[2], Indongo Lazarus[3], Ongeri Benjamin[1], Mwinga Samson[1], Phulu Bayobuya[3], Zeleke Wuletaw[4], Tuchman Jodarn[5]

[1]USAID Global Health Supply Chain Project - Procurement Supply Management (GHSC-PSM) Project, Windhoek, Namibia, [2]National Medicines Policy Co-ordination, Namibia, Windhoek, Namibia, [3]Pharmaceutical Services, Windhoek, Namibia, [4]Ministry of Health and Social Services, Windhoek, Namibia, [5]USAID Namibia, Windhoek, Namibia

Issues: Namibia has rapidly scaled up ART resulting in coverage of over 84%, with 93% of patients enrolled in care and leading healthy productive lives. Core to reducing facility congestion and ensuring patients' medicinal needs is a simplified model of Differentiated ART Services Delivery. Each model requires that stable patients meet strict criterion to benefit from multi-month scripting and dispensing. The goal of the program is give patients 6-month supplies of ART if they meet the HIV program criteria.
Description: In December 2018, the USAID Global Health Supply Chain Program-Procurement and Supply Management (GHSC-PSM) project working with the Ministry of Health and Social Services (MoHSS) ART Logistics Pharmacist analyzed patient-level data from the Electronic Dispensing Tool (EDT) National Database (NDB) for 44 main ART sites countrywide to assess refills, medicine possession ratio (MPR) and cross-sectional analysis of number of refills per month. The period analyzed was September 2017 to October 2018. A minimum MPR of 80% and max MPR of 130% were determined to be acceptable measures of pill coverage for this analysis, considering the patient may have picked ARVs up right before or at the end of the analysis period.
Lessons learned: Most patients (45%) are getting their refills every 4-5 months annually. Regional analysis indicates that over 65% of patients in remote and highly populated regions are getting their refills every 4 months possibly due to the need to reduce frequency of patient visits and decongest facilities. The total number of patients to achieve a medicines possession ration of >80%-< 130% was 69,891 (64%) out of the total measured population of 109,048 active patients. The majority (35%) of patients to achieve the acceptable MPR picked up their medicines 4-5 times a year. As MPR is a measure of adherence this indicates a potential for stable patients to achieve higher MPR rates if their frequency of refill visits to facilities is reduced.
Next steps: GHSC-PSM in Namibia is working closely with the Ministry of Health to develop standard operating procedures for phased implementation of 6-month dispensing. The MoHSS is also reviewing ART guidelines and are considering the evidence from this analysis to reduce patient visits to facilities. Simulated supply chain considerations for 6-month dispensing implementation have been presented to the MoHSS as well as quality control measures for proper medicine management.

WEPEE350

Utilizing a Web-based Anti-retro-Viral (ARV) Dispensing Tool to Estimate Pre-exposure Prophylaxis (PrEP) Dispensing Patterns in Kenya

Musau Abednego[1], Muchiri Philip[2], Wanjohi Victoria[2], Were Daniel[1], Imbuki Evans[3], Anyona Micah[1]
[1]Jilinde (JHPIEGO), Nairobi, Kenya, [2]Clinton Health Access Initiative (CHAI), Nairobi, Kenya, [3]National AIDS and STI Control Programme (NASCOP), Nairobi, Kenya

Issues: Kenya has implemented PrEP as part of HIV prevention package since its adoption in the national guidelines and official launch in 2017. The PrEP implementation framework provides for monthly prescriptions and dispensing. In a facility, data on dispensed PrEP is captured manually onto a daily activity register or electronically through a web-based ARVs dispensing tool (web ADT). During PrEP implementation, there has been doubts whether facilities maintain fidelity to existing prescribing and dispensing guidance. We describe a national web ADT roll-out and its utility in establishing PrEP dispensing patterns in Kenya.

Description: National roll-out of web ADT began with a collaborative effort consisting Clinton Health Access Initiative and Jilinde project (with funding from Bill & Melinda Gates Foundation), and National AIDS and STIs Control Program (NASCOP) from October 2018.This process included software development, setting up a networked infrastructure, software installation, training service providers, field support and monitoring. The software aids to generate facility-level reports and computes stock needs which are submitted to Kenya's drug supplies agency. Analysis of extracted and cleaned Web ADT outputs was conducted using Epi INFO and Microsoft excel to generate PrEP dispensing patterns.

Lessons Learnt: Between October 2018 and June 2019, 236 (15.8%) of 1,494 PrEP sites in Kenya employed web ADT for PrEP dispensing serving 10,727 clients. Majority (56%) were sub-county facilities. Two-thirds of clients served were female. Duration of PrEP use ranged between 0.01 to 2.82 years; the earliest client dispensed to PrEP in December 2015 during PrEP demonstration studies. The median age for clients initiated on PrEP was 31 (range 13-87) years. Majority (52.6%) of clients received PrEP doses lasting for one month as recommended, 16.0% for 60 days, 12.2% for 90 days and 19.2% received doses beyond 90 days.

Next steps: The roll-out of a web ADT for PrEP has been feasible and provided reliable, timely and easily available client-level PrEP dispensing data. Implementing systems similar to web ADT requires collaboration between partners with diverse expertise and pooling of resources to build synergy and maximize utilization of resources. Findings from the analysis imply that circumstances resulting to multi-month doses need to be examined. This can inform review of current prescription guidelines to guarantee a secure supply chain system.

WEPEE352

Approche Novatrice de Priorisation des Propositions Soumises au Fonds Mondial par le Tchad et le Gabon

Manzengo Casimir[1], Lago Hugues[2]
[1]World Health Organisation, Libreville, Gabon, [2]WHO, Afro Regional Office, Brazzaville, Congo, the Democratic Republic of the

Issues: Au cours de l'année 2018, le Tchad et le Gabon ont été appelés à re-soumettre les notes conceptuelles au Fonds Mondial car les premières n'étaient pas stratégiquement ciblées. L'effort de priorisation est indispensable pour optimiser l'impact des interventions mises en œuvre, surtout dans un contexte de rareté des ressources financières.
Descriptions: L'approche de priorisation a consisté en plusieurs étapes suivantes :

- Pour commencer, la cascade du traitement a été analysée, ainsi que les faiblesses identifiées au niveau national et régional.
- La deuxième étape fût celle de l'identification de 20% des régions qui seraient susceptibles de contribuer à l'atteinte de 80% des résultats attendus. (Loi de Pareto)
- La troisième étape a consisté à l'identification des interventions à haut impact à mettre en œuvre dans les régions prioritaires (bonnes pratiques à expérimenter). Le reste de 80% des régions bénéficient de la continuité des services (approvisionnement des médicaments). Ceci est présenté dans une feuille de route
- Lorsque la priorisation est bien conduite et exécutée après la période de l'échéance de la feuille de route, l'indice de l'efficacité de ciblage stratégique devra être supérieur à un ((dt-d0)/(et-e0)>1).
- Interprétation de l'Indice d'efficacité de ciblage stratégique : dt= performances réalisées dans les régions prioritaires au temps fixé; d0= performances initiales des régions prioritaires ; et= performances réalisées par les régions non prioritaires au temps t; e0= performances initiales des régions non prioritaires. Si I=1 : efficacité nulle, Si I< 1 : efficacité inversée, Si I>1 : efficacité effective

Lessons learned: L'approche qui consiste à prioriser les régions géographiques selon leur contribution potentielle à l'atteinte des résultats renforce la planification axée sur les résultats.
Au Tchad, l'exercice de priorisation a permis de tirer à partir de 23 régions, sept d'entre elles qui couvraient 71% des patients PVV attendues et 74% des cas de tuberculose attendus. Ensuite, de 10 régions sanitaires du Gabon, l'exercice de priorisation a permis de concentrer les efforts dans deux régions qui portent 64% des cas de Tuberculose attendus et 61% des issues non favorables du traitement.
Next steps: De ce qui précède, les prochaines étapes consistent essentiellement à appuyer les pays dans l'exercice de la priorisation et le déroulement de la feuille de route dans les régions prioritaires.

WEPEE353

Investing in HIV the Journey So Far: Expenditure Analysis of the National Aids Spending Assessment (2007 - 2016)

Annang Dennis[1], Epeh Daniel[2], Kpogo Daniel[2], Ayamah Paul[3]
[1]Ghana AIDS Commission, Research Monitoring and Evaluation, Accra, Ghana, [2]Ghana AIDS Commission, Finance, Accra, Ghana, [3]Ghana AIDS Commission, Technical Services, Accra, Ghana

Background: Expenditure analysis of HIV and AIDS activities are essential strategic information tools which can influence HIV programming and policy decisions. In addition, it sets the agenda for prioritizing cost effective HIV interventions by making optimal use of available funds for HIV programmes. In effect an expenditure analysis was conducted using the findings from Ghana's National AIDS Spending Assessments (NASA) with the aim of deriving expenditure patterns that will support current HIV programming decisions.
Methods: Expenditure patterns by funding sources and spending categories from 2007 to 2016 was obtained from the Resource Tracking Software (RTS) developed by UNAIDS which was used for each round of the NASA process. Summaries and trends were obtained through aggregation of the data in Microsoft Excel.
Results: Overall, total expenditure on HIV and AIDS activities in Ghana from 2007 to 2016 is estimated at US$652,322,871 with funding from international organizations (71%) being the largest contributors. The ten year period saw a systematic increase in funding with an average growth rate of 31%. Out of the eight spending categories, Treatment and Care, Prevention Programmes and Programme Management were the 3 largest spending categories with each accounting for 38%, 25% and 22% respectively of the total expenditure. Majority of the public sector, private sector and international organizations funds were spent on Programme Management, Care and Treatment and Prevention Programmes respectively. Though there was significant increase in funding over the period, 2008, 2013 and 2015 experienced sharp declines in total expenditure due to significant drop in expenditure for the 3 largest spending categories. These falloffs can be attributed to significant drop in expenditure in Antiretroviral therapy for 2008, Prevention programmes for youth in school for 2013 and Nutritional support associated to ARV therapy for 2015.
Conclusions and Recommendation: Ghana's national HIV and AIDS response over the ten year period was largely dependent on donor support with 3 key spending categories. The data presented can inform which areas under the 3 spending categories can be prioritized through optimization models to ensure the impact of current HIV interventions. Key spending areas that should be increased and sustained over the next ten years should include expenditure on Prevention of mother-to-child transmission (PMTCT) and Antiretroviral therapy

WEPEE354

La Mobilisation des Ressources Autrement: Expérience de l'ONG Espoir Vie-Togo

Alégah Kpantchala
Espoir Vie-Togo, Lomé, Togo

Questions: La majorité des associations du Sud se focalisent sur les appels à projets et autres possibilités de financement des partenaires du Nord au point de passer à côté des opportunités qui s'offrent dans leur propre pays. Aujourd'hui, le contexte d'amenuisement des ressources rend difficile l'accès aux financements internationaux. Il est donc important de repenser les stratégies actuelles de mobilisation de ressources pour développer des approches qui permettent de mettre à contribution les ressources endogènes et minimiser les dépenses.

Description: EVT, grâce au programme Autonomisation initié par Solidarité Sida s'est engagée depuis 2012 à diversifier ses ressources en mettant un accent particulier sur les ressources endogènes, dans un esprit de « faire plus avec moins ». Elle a donc intégré à la fiche de poste de certains membres de son personnel la tâche de faire la prospection.

Sur la base des besoins opérationnels et de fonctionnement de la structure, des démarches ont été effectuées auprès des fournisseurs locaux pour la réduction des coûts, voire l'obtention de prestations gratuites, afin de dégager des économies sur certaines lignes budgétaires des projets existants pour faire face à d'autres besoins.

Leçons apprises: Ces démarches ont permis entre autres de :

- Supprimer les frais bancaires de 10 des 11 comptes dont dispose EVT auprès de sa banque ;
- Disposer de l'accord programme du Ministère de la Planification pour être dispensée des impôts lors de l'acquisition de matériels ;
- Avoir gratuitement des salles pour des formations et réunions et organisation des évènements ;
- Disposer d'une dizaine de volontaires à plein temps à travers le Programme de Volontariat National.

Plus globalement, ces démarches montrent que mobiliser des ressources passe aussi par la réduction des coûts et qu'il existe des opportunités de soutien aux ONG qui sont sous exploitées au plan local.

Prochaines étapes: EVT prévoit de poursuivre ces démarches en vue de réduire d'autres coûts comme les frais d'électricité, de communication, le carburant, etc. et de capitaliser cette expérience pour la partager avec d'autres structures.

WEPEE355

"No Such Accountability Is Available on the Ground": A Review of Community Engagement in Malawi´s Global Fund Processes

Oberth Gemma[1,2], Gausi Emma[3], Matemba Maziko[4], Torres Mary Ann[5], Dzimadzi Abigail[6]
[1]Centre for Social Science Research (CSSR), University of Cape Town (UCT), AIDS and Society Research Unit (ASRU), Cape Town, South Africa, [2]International Council of AIDS Service Organizations (ICASO), Cape Town, South Africa, [3]Independent Consultant, Lilongwe, Malawi, [4]Health and Rights Education Programme (HREP), Lilongwe, Malawi, [5]International Council of AIDS Service Organizations (ICASO), Toronto, Canada, [6]The Malawi Network of AIDS Service Organisations (MANASO), Lilongwe, Malawi

Background: Development partners contribute more than 80% of all HIV funding in Malawi. One million people living with HIV depend on these partners for sustained access to antiretroviral therapy and treatment monitoring. With 39,000 new HIV infections a year, strategic prevention investments are also critical. For the 2017-2019 funding cycle, the Global Fund to Fight AIDS, Tuberculosis and Malaria made $450.5 million available to support Malawi´s national response. Engagement of communities most affected by the diseases is vital to ensure effective and efficient use of these resources.
Methods: In 2017, ICASO supported a local partner—Health and Rights Education Programme (HREP)—to facilitate meaningful and impactful community engagement in Global Fund processes in Malawi. Using data from a desk review of national Global Fund documents and 13 key informant interviews in Lilongwe, Blantyre and Zomba, conducted in April 2018, this review assesses: (1) The level of funding requested for key program areas; (2) The quality of program design; (3) The inclusion of community-articulated priorities in the funding request; and (4) Community-identified successes, challenges, and opportunities to improve their Global Fund engagement.
Results: Funding requested for HIV prevention among key populations increased more than 8-fold from the last funding cycle (from $1.23m to $10.28m), but funding for community systems strengthening significantly decreased (from $9.95m to $2.00m). There are improvements in program quality, with tailored service packages for key populations clearly defined, and an augmented basket of services offered to adolescent girls and young women. Of the 26 priorities set by communities, 16 were either fully or partially included in the final submission to the Global Fund. Many priorities related to key and vulnerable populations were included, however, priorities to monitor treatment stock outs and develop community scorecards were not taken on board. The involvement of women- and prison-focused civil society organizations contributed to the inclusion of these communities´ priorities in the grant. Yet, there is a dire need for improved coordination and community monitoring to increase accountability during grant implementation.
Conclusions and Recommendations: As the 2020-2022 funding cycle approaches, communities in Malawi should take stock of these lessons and prepare to engage. Investments in community systems strengthening should be prioritized.

WEPEE356

Global Fund Achievements for Matching Funds on Community, Rights and Gender Components in the Response to HIV/TB in Anglophone Africa

Murenga Maurine, Mumba Olive
EANNASO, Technical Support Center, Arusha, Tanzania, United Republic of

Issues: The study aimed at generating evidence on how the Global Fund catalytic funding through matching grant for Key Vulnerable population has impacted on Community, Rights and Gender aspects of HIV/TB in Anglophone Africa with in the period of 2017- 2019 grant cycle.
Descriptions: The "matching funds" were designed to inspire innovation and ambitious programming approaches driven by evidence in order to maximize impact in specific strategic priority areas which are HIV.
Methodology and Sample size: The study was a desk-review from GF country data reports and survey monkey questionnaire was administered to a total of 179
Results: The study focused on 5 priority areas which results were derived from as: Programs to remove human rights-related barriers to health services, Adolescent girls and young women, Finding missing TB cases, Resilient and sustainable systems for health with 85% men, 67% women, and 18% queer respondents.
Matching funds accelerated increase in investments in the priority areas at country level, Some countries increased investments in priority areas by more than 100%, "Eswatini increased funding for HIV prevention among AGYW by 172% (From $2,800,000 to $4,824,823). Zambia increased funding requested for HIV prevention among AGYW by 25% (from 3,428,516.60 to $4,298,059. South Africa increased funding requests for HIV prevention among AGYW by 52% (From $55,689,088 to $84, 609,774) and funding for removing human rights-related barriers to access by 188% (from 1,962,000 to (5,655,649). Zimbabwe increased funding for key populations and AGYW by 650% (from $858,262 to % $5,619,260)" Results showed that 94% of civil society strongly agree, 90% agree, 55% neither agree nor disagree, 45% disagree while 13% strongly disagree on Scale-up of Evidence-Informed HIV programs for Key Populations.
Lessons learned: Despite acknowledging the importance of matching funds, limited resources pushed countries to make hard decisions between investing in catalytic programs vis -a- vis procurement of life saving commodities, This affected investment in some of the matching fund priorities as some countries could not match the required amounts to choose between treatment and prevention as all of them are essential in the fight.
Next steps: To Create community networks for learning and sharing platform to ensure maximizing the use of existing good practices and tools and fund for core functions of community-based organizations transparent accountability framework

WEPEE357

Cost of Providing Prevention of Mother to Child Transmission (PMTCT) and Antiretroviral Treatment (ART) Services in Zimbabwe

Chingombe Innocent[1], Mapingure Munyaradzi P.[1], Balachandra Shirish[2], Chipango Tendayi N.[1], Gambanga Fiona[1], Mushavi Angela[3], Apollo Tsitsi[3], Suraratdecha Chutima[4], Rogers John H.[2], Ruangtragool Leala[4], Gonese Elizabeth[2], Musuka Godfrey N.[1], Mugurungi Owen M.[3], Harris Tiffany G.[1]
[1]ICAP at Columbia University, New York, United States, [2]CDC Zimbabwe, Harare, Zimbabwe, [3]Ministry of Health and Child Care, Government of Zimbabwe, Harare, Zimbabwe, [4]CDC, Atlanta, United States

Background: Zimbabwe has made large strides in addressing HIV. To ensure a continued robust response, a clear understanding of costs associated with its HIV program is critical.
Methods: Data on 2016 PMTCT and ART economic and financial health system program costs, descriptive information and patient volume were collected at 20 randomly selected public health facilities (HF) and 2 national laboratories providing HIV services. Standard data collection instruments used in previous CDC-supported costing evaluations were adapted and collected costs related to staffing, laboratory and other supplies, ARVs and other drugs, equipment, and other costs related to ART and PMTCT care. Additional data were collected from central government, funders and partners. The analysis included measuring the overall total program costs and the average per person costs for both service types, disaggregating by HF level and exploring cost drivers. All costs are annual costs in 2016 USD.
Results: The average per HF costs for PMTCT and ART were $234,778 and $377,823. For both groups the average per HF costs increased with increasing level. Costs at the primary, secondary, tertiary and quaternary levels were $58,125, $193,340, $364,876 and $935,036 for PMTCT and $116,097, $300,162, $613,558 and $1,394,125 for ART, respectively. The average annual per patient cost of providing PMTCT services was $703 and ranged from $195-$1,761. The average annual per patient cost of providing ART services was $196 and ranged from $28-$469. For both PMTCT and ART the per patient costs were lower at primary versus quaternary HF ($546 vs. $2,127, $79 vs. $308) and rural versus urban HF ($579 vs. $1011, $181 vs. $194). For both PMTCT and ART, the largest HF cost drivers were personnel (annual average of $446 and $66 per patient) followed by ARVs ($101 and $82). Average per patient costs were generally higher for PMTCT versus ART due to costs being averaged across a lower # of patients at the included HF (2,072 vs. 38,496). The annual costs of providing PMTCT and ART services at national laboratories were $911,342 and $1,367,652, with supplies and personnel the majority of costs.
Conclusions: Our analysis revealed that average per patient costs increased for both ART and PMTCT with increasing HF level. Ongoing decentralization and emphasis on robust primary care may encourage efficiencies and sustainability for HIV services in Zimbabwe.
Key words: Costs, HIV services, Zimbabwe

WEPEE359

Financement du VIH en République du Congo: Évaluation du Coût Direct de la Prise en Charge

Ebourombi Dagène Fruinovy[1], Boukaka Kaled[1], Mahambou Dominique[2], Diafouka Merlin[3], Mapapa Miakassissa Cécile[4]

[1]Programme National de Lutte Contre le SIDA, Planification, Suivi et Évaluation, Brazzaville, Congo, [2]Centre de Traitement Ambulatoire de Brazzaville, Coordinateur Médical, Brazzaville, Congo, [3]Centre de Traitement Ambulatoire de Brazzaville, Direction, Brazzaville, Congo, [4]Programme National de Lutte Contre le SIDA, Coordination, Brazzaville, Congo

Contexte: L'année 2007 a été celle de l'annonce de la gratuité de la prise en charge pour des PVVIH en République du Congo. Depuis la mise en œuvre de cette politique de santé, aucune évaluation économique n'est réalisée afin d'établir le coût moyen de prise en charge par patient/année de traitement. La non maîtrise de ce coût est aujourd'hui l'une des causes des ruptures répétées des antirétroviraux et des intrants de laboratoire et qui fait qu'une part importante des dépenses de santé liées à la prise en charge du VIH reste à la charge des patients VIH+ qui à leur tour sont confrontées aux dépenses dont la capacité à y faire face est moins évidente dans la durée surtout dans ce contexte de crise économique majeure. Ceci a impact négatif direct sur l'atteinte des objectif 90 90 90 de l'ONUSIDA. Ce présent travail contribuera sans doute au renforcement de l'efficacité des politiques de financement du VIH en établissant le coût réel de la prise en charge des patients/année de traitement.
Méthodes: il s'agit d'une étude transversale et descriptive menée entre Mai et Novembre 2018 chez 52 patients consultant le CTA de Brazzaville. Les variables étudiées ont porté sur les aspects épidémiologiques, cliniques, biologiques, psychologiques et monétaires. Les données ont été analysées par le logiciel Epi info 7. L'unité monétaire est le dollar US.
Résultats: l'âge moyen des patients est de 41,71 ±10,08 ans. A l'initiation de traitement, 69% de nos patients ont bénéficié en moyenne d'un bilan biologique complet. Cependant, ils étaient au nombre de 34/52 soit 64,5% avoir réalisé leur bilan au douzième mois de traitement conformément aux lignes directrices en vigueur. Chaque patient a bénéficié en moyenne de 8,9 consultations médicales et d'une consultation psychologique. Le suivi biologique a constitué la composante qui a la plus grande charge soit 140,15$ représentant ainsi 53,30% du coût moyen couvert par la gratuité (262,95$), suivi des médicaments (108,74$). Le coût moyen global de prise en charge d'un patient en République du Congo est de 328,5$ par/an et 20% de ce coût soit 65,55$ reste à la charge des patients.
Conclusion et Recommandation: L´étude montre une part importante de l'ordre de 20% reste à couvrir. les politiques doivent élargir cette gratuité à d´autres médicaments non ARV pour pouvoir atteindre les trois 90 de l´ONUSIDA.
Mots Clés: Financement, Coût, Prise en charge et VIH

WEPEE360

Are the Patients Happy? Findings from a Patient Satisfaction Survey of Psycho-social Influencers in a Large HIV Program in Nigeria

Tony-Monye Ifeoma[1], Fadare Olawale[1], Esin Sandra[1], Balogun Kehinde[1], Sunday Johnny[1], Onuzulike Tochukwu[1], Odo Juliet[1], Terwase Joy[1], Nwosu Derick[2], Olayiwola Olarenwaju[1], Enegela Joseph[2], Effiong Amana[1], Oko John Okpanachi[1]

[1]Caritas Nigeria, Abuja, Nigeria, [2]ProHealth International, Abuja, Nigeria

Background: The Nigerian HIV response supports over a million persons living with HIV (PLHIV) and its performance is key in assessing the fight against HIV in Sub Saharan Africa. Patient satisfaction plays a crucial role in medication adherence, retention in care and viral suppression of PLHIVs on anti-retroviral therapy (ART) across hospitals offering HIV Care & Treatment services. Caritas Nigeria supports 93 Comprehensive Care & Treatment (CCT) and 103 PMTCT/ART Stand-alone facilities in Delta, Ebonyi, Enugu and Imo States to provide HIV Care & Treatment services for 54,251 PLHIVs. A Patient Satisfaction Survey was conducted in all 4 states.

Methods: The Picker Patient Experience questionnaire was adapted to assess patients' perception of quality of ART received at 69 CCTs with an intended 7,645 respondents. The tool (available as both electronic and paper tools for ease of administration and collation) had 11 sections and 42 questions covering accessibility & convenience, provider behavior/attitude, facility & confidentiality, respect & caring, payment, integration of services and spiritual support. An online web portal was created for real time and off-line data capture and synchronization. Trained data abstractors administered the questionnaires from July to October 2018. 7,376 PLHIVs (F- 5,068; M- 2,189; Not indicated (NI) 119) responded and results were analyzed using Microsoft Excel software.

Results: 45% (F-2238; M-914; NI-53) of PLHIVs noticed their paper medical records were different from regular patients. 25% (F-1184; M-582; NI-35) felt counselor was judgmental about their HIV status. 22% (F-1092; M-487; NI-16) noticed they don´t access services in the same place as regular patients. 20% (F-1054; M-366; NI-25) felt the home-clinic distance was inconvenient. 19% (F-906; M-385; NI-35) thought of stopping their ARVS due to their beliefs to seek spiritual healing. 17% (F-840; M-374; NI-28) missed getting Medicare because they could not afford it. 15% (F-732; M-313; NI-24) did not get explanation for services that are free or to be paid for.

Conclusions and Recommendations: The range of discontent with ART services in the hospitals assessed is enough basis for concern and engagement of HIV service providers has been initiated. However, further investments and a multi-stakeholder commitment to routine Patient Satisfaction Surveys in the future can guide the program optimization and monitor improvements in quality of care across all affected hospitals.

WEPEE361

Domestic Resource Mobilization for Sustainable Health Financing in Africa

Rusimbi John
Rwanda NGOs Forum on HIV/AIDS and Health Promotion, Programs Manager, Kigali, Rwanda

Issues: Africa is home to 16% of the world's population and accounts for 24% of the world's disease burden. 50% of under-five deaths and 70% of people living with HIV are in Africa and more than half the population lacks access to essential health services. The infectious diseases that have declined elsewhere - lower respiratory infections, HIV/AIDS, TB, malaria - remain leading causes of mortality. Despite the progress made towards implementing the Abuja Declaration, Africa still has a lengthy path to traverse in order to sustain economic growth, mobilize increased domestic resources and ensure sustainable long term financing for health. The ever declining donor support also require member states to increase sustainable financing and ownership of health services delivery.
Descriptions: Rwanda NGOs forum on HIV/AIDS and Health promotion in collaboration with member CSOs in Rwanda, GFAN Africa and Global Fund Geneva have been involved in Advocacy for Global fund Replenishment every three years. The CSOs Global advocacy efforts placed specific emphasis on increased Donor and country contributions to the Global Fund as well as increased domestic resources to strengthen national health systems.
Lessons learned: Some Countries and Donors have responded positively and increased their contributions to the global fund as well as their national GDP for health. National efforts to fundraise for HTC, and HIV coinfections including TB and Hepatitis has been producing results in Rwanda.
Next steps: ϖ Strengthen advocacy efforts on increased commitment of funds by governments, donors and the private sector on a fully funded Global Fund at every replenishment.
ϖ Accelerate momentum in increased Domestic Resource Mobilization (DRM) for sustainable national Health Financing.

WEPEE362

Economic Empowerment (SILC) in Fight against HIV/AIDS

Ncube Edwin Augustine
Jointed Hands Welfare Organisation, Gweru, Zimbabwe

Issues: As a measure to combat financially-induced albatross, households have resorted to form various SILC groups as a pathway to mobilize money to keep their children in school and to meet households essentials. These groups act as social banking and borrowing groups that depend on social capital and members' commitment and stewardship. In Gweru district, households have received training to start out SILC groups as a way of building community/household resilience and keeping children in school. Keeping children in school is a method of breaking the cycle of the girl child's cultural norm of early marriage, sex work, and abuse.

Descriptions: Against this background, households are training that boost financial literacy, investment and entrepreneurship skill set. The program's main targets are the households with girls who are in the school going age but facing a daunting task of keeping them in school. For groups to be formed, each group should have between 15 and 25 members and go through rigorous 9 module training before they start saving and lending activities. The group comes up with its own rules and regulations that best suit their way of operation. In each group, there are two accounts; savings and borrowing account and social account. In the former account, members meet regularly and deposit money into the account and those who might want to borrow at an interest rate and the latter is where group members and other community people can receive some money from in the event that there is loss of property, emergency support and funeral costs among other things but without interest rate.

Lessons learned: To date, there are 144 SILC groups in Gweru in various wards which are home to 2814 members. These groups are helping 1845 children to pay school fees and meeting other household essentials. This has resulted in 357 children being sent back to school.

Next steps: Given the strides made by the first wave of community SILC training, the program must be scaled up at grass roots level to ensure that many households are reached out. Household members must be equipped with financial literacy skills as it is a pathway to boost household livelihoods. Future training must equip people with financial literacy skills so that they can be able navigate through in turbulent economic situations.

WEPEE363

Strengthening the Capacity of Supreme Audit Institutions (SAIs) to Audit Global Fund Grants in Sub-Saharan Africa

Ithibu Ann, Amendah Djesika
Aidspan, Nairobi, Kenya

Issues: The Global Fund to fight AIDS, Tuberculosis (TB) and malaria spends nearly $4 billion per year fighting those diseases. Approximately 65% of funds are invested in sub-Saharan Africa (SSA) where government Principal Recipients manage the largest proportion of the grants. Supreme audit institutions (SAIs) have the mandate to audit all public funds. However, only eight supreme audit institutions (SAIs), all from English-speaking countries, audit annually Global Fund grants in their countries. Instead, government implementers in most countries contract private audit firms. Lack of independence, limited capacity in terms of staff, and limited knowledge about the Global Fund procedures are the key barriers to SAIs auditing Global Fund grants. While these current audit arrangements solve short-term problems, they are not be cost-effective and do not promote country ownership, accountability or sustainability.
It is against this background that Aidspan is implementing the Supreme Audit Institutions audit Global Fund grants project.
Descriptions: The project aims to enable SAIs to audit government implementers recipients through tailored support, capacity building and peer learning among SAIs. Key interventions include:
1) document best practices and lessons learned from SAIs that already audit government implementers, and
2) train the SAIs on financial, compliance and performance audits of Global Fund grants.
The 13-month project targets eight sub-Saharan African countries: Burkina Faso, Ghana, Kenya, Liberia, Malawi, Rwanda, Sierra Leone and Togo.
Lessons learned: SAIs that audit Global Fund grants have legal status which guarantees them independence. The SAIs have invested in attracting and retaining competent staff. However, they still face inadequate resources, limited knowledge of the programmatic aspects of the grants and limited collaboration with other Global Fund oversight bodies.
All the SAIs that do not currently audit Global Fund grants expressed interest and willingness to receive training and start auditing grants. So far, Aidspan has trained two of the eight SAIs on financial, compliance and performance audits. One of the two SAIs has collaborated with the Global Fund's Office of the Inspector General in audit of Global Fund grants in their countries post-training.
Next steps: Aidspan plans to build on the project's early successes. The training sessions for the remaining six SAIs will be informed by the lessons learned in the first two.

WEPEE364

Evaluation of the Concordance of the Results of the Dried Plasma Spot and Liquid Plasma for the Determination of the Viral Load of the HIV in Kinshasa: Preliminary Study

Bulanda Ben[1], Bongenia Berry[1], Lepira François[2], Kamangu Erick[3], FOCUS HIV/DRC
[1]Research Group "Focus HIV/AIDS", Kinshasa-Democratic Republic of Congo, Kinshasa, Congo, the Democratic Republic of the, [2]Service of Nephrology, University Clinics of Kinshasa, Faculty of Medicine, University of Kinshasa (UNIKIN), Department of Internal Medicine, Kinshasa, Congo, the Democratic Republic of the, [3]Service of Molecular Biochemistry, Faculty of Medicine, University of Kinshasa (UNIKIN), Department of Basic Sciences, Kinshasa, Congo, the Democratic Republic of the

Background: This study aims to compare the determination of the Viral Load of HIV using plasma samples and Dried Plasma Spots (DPS) in the context of Biological Monitoring in Kinshasa.
Methods: An experimental study was conducted to determine patients´ Viral Load (VL) on liquid plasma and DPS. It was performed at the Molecular Biology Laboratory of the UNIKIN Faculty of Medicine. The size of the population was 48 ARV-naive patients in a reasoned manner in the various selected centers. Five milliliters of blood were collected in a tube with EDTA anticoagulant from the vein of the elbow crease. The collected blood was centrifuged at 1000 g for 10 minutes to obtain the plasma. The blotting paper was prepared from 140 µl of plasma. After extraction of the RNA, the VLs were carried out on different algorithms for DPS and liquid plasma.
Results: Forty-eight (48) plasma samples and DPS were analyzed simultaneously for the determination of the VL. All samples were successfully extracted and amplified. At 60 Cycles, the results reveal 100% amplification for liquid plasma and DPS. The median values of VLs were respectively 4.68 log10RNA copies/ml on plasma and 4.52 log10 RNA copies/ml onDPS.The correlation between the 2 methods was strong and the coefficient R2 was of 0.9452($p < 0.001$).The approved limits for both samples are between -1.20 and 0.80 log10 copies/ml and the 30% confidence interval is -0.2 to 0.2.
Conclusions and Recommendations: The results found for the viral load on DPS and liquid plasma had shown that the results were consistent and correlated.
Keywords: Viral load; Dried Plasma Spot; HIV; PCR; Kinshasa

WEPEE365

Le Test et le Traitement Sont Réalisables pour les Pays Pauvres en Ressources en Afrique

Esangowale Yangala Nadege[1,2], Mulaja Jean Paul[3], Loi, Droits Humain, Sciences Sociales, et Sciences Politiques

[1]Equilibre International, SANTE, Kinshasa, Congo, the Democratic Republic of the, [2]Equilibre International, VIH/IST, Lubumbashi, Congo, the Democratic Republic of the, [3]Equilibre International, VIH/IST, Kananga, Congo, the Democratic Republic of the

Problèmes: Le débat sur le contenu de la PTME soulève la question de savoir pourquoi, dans les pays pauvres en ressources, nous traitons toutes les femmes atteintes du VIH avec un traitement antirétroviral, alors nous fournissons le traitement ARV uniquement avec d´autres patients séropositifs Leur compte de CD4 + est inférieur à 350.

Description: Nous avons examiné la faisabilité de «tester et traiter» tous les individus séropositifs en Éthiopie, un pays pauvre en ressources avec une prévalence du VIH estimée à 1,5%.

En utilisant les données actuelles sur le volume des patients séropositifs, la distribution des chiffres de CD4 et les coûts des tests ARV et CD4, nous avons redéfini le nombre de patients sous traitement antirétroviral et le nombre de tests CD4 résumés par: «Testeur et traitement »Est adopté.

Leçons Apprises: Passer de «tester et traiter» tous les individus séropositifs en Ethiopie augmentée à 29%, le nombre de patients sous ART. En vertu de la politique actuelle, un test de routine des CD4 est requis pour tous les patients atteints du VIH, tous les 6 mois.

Ensemble, la police actuelle coûte 90 667 400 dollars. Si le patient est CD4, il est supprimé pour les patients recevant un traitement antirétroviral (et ensuite une résistance aux ARV ou autres complications), le coût annuel de la mise sous traitement antirétroviral de tous les patients séropositifs en Ethiopie serait de 100 890 200 $. Adopter «tester et traiter», élimine les exigences actuelles en matière de test initial de CD4 et limite les tests de routine de CD4 pour les écuries de patients entraînés étaient d'un coût supplémentaire de 6 222 800 $, soit une augmentation de 13% par rapport au coût actuel politique.

Ce coût supplémentaire a été testé et traité. Il a amélioré la qualité et prolongé la vie des patients VIH actuels.

Le travail dans le test et le traitement »en éthique est le plus rentable et le plus éthique. «Tester et traiter» a déjà été adopté comme pratique standard en Europe et aux États-Unis; C´est une prochaine étape pour les pays pauvres en Afrique.

WEPEE367

A Two-layered HIV Screening Approach in Identification of New HIV Positives under the PEPFAR Surge Performance in Rwenzori Region, Uganda

Kekitiinwa Adeodata[1], Ssebunya Rogers[1], Mugisa Emmanuel[1], Ajuna Patrick[1], Tumbu Paul[1], Maganda Albert[1], Bitimwine Harriet[2]

[1]Baylor College of Medicine Children's Foundation Uganda, Kampala, Uganda, [2]Ministry of Health, HIV Testing Services Program, Kampala, Uganda

Background: Knowledge of HIV status is critical to meeting the UNAIDS 95-95-95 targets. We assessed the effectiveness of a two-layered HIV screening approach (first level - eligibility screening by lay providers, second level - professional health workers) in efficiently identifying new positive individuals and their positivity characteristics in public health facilities in Rwenzori region, western Uganda.

Methods: Abstraction of routinely captured data was conducted using an open data kit (ODK) based platform in six public health facilities between 1st October and 9th November 2018. All evaluation sites had screening forms for the two levels. Clients attending the out-patient departments (OPDs) were screened for HIV testing eligibility. Those eligible at level one were rescreened at level two and only those eligible at this level were offered HIV testing as part of routine services under the "Surge implementation". Number of HIV positive clients identified and their characteristics, HIV tests and costs saved (US dollars) were computed.

Results: Of the 11,061 clients who attended OPDs, 7,105 (64.2%) were females, 9,562 (86.4%) were screened at level one, among whom 2,174 (22.7%) were eligible. Of those eligible at level 1, 1,215 (55.9%) were considered eligible at level two, and 81/1215 (6.7%) tested HIV positive. Without the second level screening HIV positivity yield would have been 3.7% (81/2,174) assuming all were tested. A total of 959 HIV tests were saved, translating into US$ 653 saved within the six evaluation sites. Being a key population and having sex with someone of unknown HIV status were common characteristics among those testing positive for HIV.

Conclusions: The two-layered HIV screening approach increases the HIV positive yield, minimises wastage of test kits while reducing work load for testers. We recommend operationalisation of this approach in all health facility entry points including HTS outreaches

WEPEE368

The Costs of Implementing HIV Viral Load Point of Care Testing in South Africa

Cassim Naseem[1,2], Makhuraj Abel Luke[2], Sarang Somayya[2], Hans Lucia[1,2], Carmona Sergio[1,2], Stevens Wendy Susan[1,2]

[1]University of the Witwatersrand, Johannesburg, South Africa, [2]National Health Laboratory Service, National Priority Programme, Johannesburg, South Africa

Background: The relatively rapid turnaround-time of point-of-care (POC) assays have been advocated to improve clinical management and patient retention. A local based study reported significantly improved HIV viral suppression and retention in care, attributable by some degree, to rapid provision of viral load (VL) results. The limitation of POC platforms is the high cost. The m-PIMA™ HIV-1/2 VL (Alere Technologies GmbH, Germany) POC assay has been pre-qualified, capable of producing a result within 70 minutes. This will expedite roll-out in low and middle-income countries (LIMC). The study aims to evaluate the cost per result for POC HIV VL testing in South Africa.

Methods: A bottom-up costing approach was used to determine the cost per result. The ingredients-based costing approach established annual equivalent costs for the following categories; (i) laboratory equipment, (ii) staff, (iii) reagents, (iv) external quality assurance (EQA), (v) furniture and (vi) costs of a POCT coordinator for support visits. The annual cost-to-company salary of a C2 technologist and D1 grade coordinator were used. The C2 grade is for a middle-level medical technologist and the D1 grade is for entry-level management. Laboratory equipment includes the m-PIMA™ analyzer, micro-centrifuge and barcode scanner. The accounting stance was as a provider of testing assuming an outright purchase for 3 years (1300 tests p/annum or 5 p/day). Costs were collected from quotations, invoices and estimates, collected in ZAR and reported in USD (exchange rate of 14.92).

Results: The cost per result was $58.75. The incremental cost per result was $36.00 compared to conventional laboratory testing using the VL state price. Staff contributed 52 % of the cost per result ($30.52) followed by reagents at 35% ($20.80). Laboratory equipment contributed 7% of the cost per result ($3.87). The EQA, furniture, and coordinator collectively contributed 6.1 % to the cost per result ($3.56). The annual equivalent cost was $76,370.65. An annual incremental cost over laboratory-based testing was $46,801.71.

Conclusions and Recommendations: The POC VL assay is substantially more expensive than traditional laboratory-based testing. A use case needs to be developed to identify the appropriate setting where VL POC would improve clinical outcome. Using a public health approach, a more expensive POC assay could be implemented in a scenario where the benefits are demonstrated by a cost-effectiveness analysis.

WEPEE369

Estimating the Cost-effectiveness of HIV Pre-exposure Prophylaxisand its Impact on HIV Transmission in Zimbabwe

Schillings Tobias[1], Mpofu Amon[2], Taramusi Isaac[2], Cheluget Boaz Kiprop[3], Sithole Ngwarai[4]
[1]Independent Economic Consultant & Researcher, Oxford, United Kingdom, [2]National AIDS Council of Zimbabwe, Harare, Zimbabwe, [3]UNAIDS, Harare, Zimbabwe, [4]Ministry of Health and Child Care, Government of Zimbabwe, Harare, Zimbabwe

Issues: HIV pre-exposure prophylaxis (PrEP) plays an important role in Zimbabwe's HIV prevention strategy. As part of the national combination prevention approach, PrEP is targeted at vulnerable population groups at high risk of infection. To ensure efficient programme implementation, economic analysis is necessary to identify key target groups and evaluate the cost-effectiveness of PrEP.
Descriptions: The "PrEP Economic Analysis" project has been commissioned by UNDP and conducted in cooperation with the National AIDS Council to inform the national roll-out of oral PrEP in Zimbabwe. A dynamic, deterministic transmission model was developed and combined with a cost-benefit analysis to simulate different scenarios of PrEP implementation among high risk groups. The model enables the estimation of the direct and indirect protection impact, as well as the cost-effectiveness of PrEP under different combination strategies, behavioural adjustments, and cost considerations. Modelled scenarios include the achievement of the 90-90-90 goals, scale-up of VMMC, the introduction of adherence support, and the engagement in riskier behaviour of clients due to the use of PrEP. Designed as an accessible Excel workbook, the tool allows to customize and visualize a range of different results and scenarios.
Lessons learned: Calibrated based on available national data and stakeholder consultations, the analysis indicates that PrEP can have a significant impact on HIV transmission in Zimbabwe and can be shown to be cost-effective for men who have sex with men, female sex workers, and serodiscordant couples. This result does not preclude implementation among other target groups, but it emphasises the need for close monitoring and reporting. Furthermore, cost-effectiveness deteriorates significantly with the scale-up of other prevention strategies suggesting that PrEP might be a mid-term strategy for HIV prevention rather than a permanent solution. Overall, the model shows that the key determinants for cost-effectiveness are adherence, programme targeting, HIV risk levels, and procurement costs.
Next steps: The results of the PrEP Economic Model are used to support programme targeting and implementation in Zimbabwe. Furthermore, the model will be made available on the UNAIDS website to enable other users to employ, customise, and adapt the model for their purposes.
Keywords: PrEP, pre-exposure prophylaxis, cost-effectiveness, Zimbabwe, mathematical model

WEPEE370

Did Treatment Costs Increase after the Introduction of Treat All (TA) in Namibia?

Schutte Carl[1], Forsythe Steven[2], Mdala Johnface[3], Zieman Brady[4], Linder Rachael[5], Vu Lung[4]
[1]Genesis Analytics, Johannesburg, South Africa, [2]Avenir Health, Fountain Hills, United States, [3]Intrahealth, Windhoek, Namibia, [4]Population Council, Washington, United States, [5]Avenir Health, Washington, United States

Background: To reach the WHO/UNAIDS 90-90-90 targets, the government of Namibia started implementing TA guidelines in April 2017. TA has been promoted worldwide as trials have found that getting people on treatment early will reduce loss to follow up and increase viral suppression, which will ultimately improve health outcomes and reduce HIV transmission. However, the impact of introducing TA on costs is largely unknown. We investigated how costs changed after Namibia's introduction of TA.
Methods: We collected and compared costs of providing antiretroviral therapy (ART) services during the 12 months before TA (Phase I) and the 12 months following (Phase II). We collected cost data from 10 large and medium size ART facilities in Northern Namibia. Data collection included interviewing facility staff and collecting accounting data on resources utilized to treat ART patients (drugs, laboratory, operational, and personnel). Data were cleaned and checked for consistency and validity. We calculated annual ART unit cost as well as cost per cost component for the year prior to TA and the year after TA was introduced nationwide.
Results: We found a 16% reduction of ART unit cost from US$360 per patient per year for the one-year period prior to TA to US$301 per patient per year one-year post-TA. The reduction was driven by 3 factors:
1) shifts in ARV regimens that resulted in lower costs for drugs and consumables,
2) reduced costs for viral load tests
3) decline in personnel costs. It is unclear how the first two factors were significantly influenced by the introduction of TA.
The reduction in personnel costs may have either represented a positive development (fewer personnel costs associated with increased numbers of healthier patients and fewer visits required) or alternatively may reflect constraints in Namibia's staffing. Prior to this study, it was expected that the introduction of TA would lead to a significant increase in the number of ART patients. However, there was less than a 4% increase in the number of adult patients at the 10 sampled facilities, although patient numbers were influenced by an ongoing process of decentralization.
Conclusions and Recommendations: From a financial point of view, TA did not increase the resources required in the 10 sampled facilities, either by raising unit costs or significantly increasing the number of ART patients.

WEPEE371

What Would Kenyans Pay to Reduce their Risk of HIV Infection? An Analysis of Willingness to Pay for PrEP

Forsythe Steven[1], Kioko Urbanus[2,3], Glaubius Robert[4]
[1]Avenir Health, Fountain Hills, United States, [2]University of Nairobi, Nairobi, Kenya, [3]Avenir Health, Nairobi, Kenya, [4]Avenir Health, Glastonbury, United States

Background: Pre-exposure prophylaxis (PrEP) significantly reduces the risk of HIV infection. In higher prevalence countries such as Kenya, providing access to PrEP is particularly important for those at a high risk of infection, including female sex workers (FSW), men who have sex with men (MSM) and adolescent girls and young women (AGYW). Kenya has been the first country to formally scale-up PrEP as a part of the country's prevention strategy. While there has been a significant uptake of PrEP, the poor retention on PrEP raises concerns about PrEP's overall impact. Contingent valuation can assist in understanding the strength of people's motivation to use PrEP, as well as providing information about potentially sustaining access to PrEP.
Methods: A total of 1,830 PrEP clients were interviewed, as well as 309 key population members who had not adopted PrEP. Respondents were asked if they would be willing to pay for PrEP on a monthly basis, and if so, what would be the maximum amount they would pay. Characteristics of individuals were then related to their willingness to pay.
Results: Forty-two percent of respondents were unwilling to pay for PrEP (as expected, current clients were more willing to pay than non-clients), although this declined to only 29% when excluding "protest zeros" (individuals who objected to the idea of having to pay, as opposed to revealing their true valuation of PrEP). Overall about half of clients would be willing to pay $2 per month for PrEP. Only 11% of clients indicated they would pay $7 per month, which would fully cover the cost of the medication. WTP was highest in Nairobi and on the Coast and was the lowest in the Lake region. WTP was highest among MSM ($5) and FSW ($3) and was lowest for AGYW (less than $1). As expected, respondents with higher monthly incomes were willing to pay more than those with lower incomes. MSM were willing to pay 2.1% of their monthly income for PrEP, while FSW were willing to pay only 1.3% and AGYW were willing to pay only 1.0%.
Conclusions and Recommendations: While there appears to be some willingness to pay for PrEP, the extent to which key populations in Kenya can pay for PrEP is relatively small. MSM appear to be most motivated to adopt PrEP, as indicated by their higher WTP. Conversely, AGYW indicate the lowest WTP for PrEP, which is in part driven by their low incomes. This suggests that AGYW may be more influenced by financial incentives provided to maintain their use of PrEP.

WEPEE372

Will the Daily Dose Methadone Assisted Therapy (MAT) Affordable? The Economic Evidence from 3 MAT Clinics in Tanzania

Mnzava Thomas[1], Suraratdecha Chutima[2], Springstubb Nora[3], Matiko Eva[3], Mbwambo Jessie[4], Bwogi David[3], Mbaraka Amuri[5], Kazaura Koku[6], Bingham Trista[7]

[1]US Centers for Disease Control and Prevention, Dar es Salaam, Tanzania, United Republic of, [2]US Centers for Disease Control and Prevention, Atlanta, United States, [3]US Centers for Disease Control and Prevention, Dar es salaam, Tanzania, United Republic of, [4]Muhimbili National Hospital, Dar es Salaam, Tanzania, United Republic of, [5]U.S Centers for Disease Control and Prevention, Dar es Salaam, Tanzania, United Republic of, [6]U.S Centers for Disease Control and Prevention, Dar es salaam, Tanzania, United Republic of, [7]U.S Centers for Disease Control and Prevention, Atlanta, United States

Background: An estimated 30,000 people in Tanzania are people who inject drugs (PWID), and 35% of those in Dar es Salaam are estimated to be HIV infected compared to 4.7% in the general population. Evidence supports the use of methadone to assist people with heroin dependence and to reduce their associated injecting, sexual risk behaviors and HIV risk. In response to the HIV epidemic among PWID. The Tanzanian government launched the first publicly daily dose methadone program on mainland Tanzania in sub-Saharan Africa in 2011. MAT program is integrating methadone, HIV/AIDS and tuberculosis services at 3 health facilities in Dar es Salaam in 2011. A plan to scale-up MAT program nationally are in development. Understanding the costs of MAT will be essential to inform the program scale-up and management.

Methods: This study used the micro-costing method, and time and motion approach to collect program costs for MAT services offered at Temeke, Mwananyala and Muhimbili clinics. Costs per client were estimated per client registered to MAT, per client adhered to MAT, per client receiving daily dose methadone, and per client receiving services. Total costs collected included capital costs (training, equipment and new infrastructure) and recurrent costs (personnel, drugs, supplies, travel and transport, building, contracted services and utilities). Data were collected from May 1, 2017 to April 30, 2018 in local currency and converted to 2018 USD.

Results: The average costs per client registered, per client received daily dose methadone, and per client adhered to MAT integrated services were $148.08 (Range:$97.05 to $198.64)), $134.86 (Range: $89.30 to $183.85) and $192.68 (Range: $122.87 to $273.84), respectively. The largest input type for MAT services was personnel (42%) followed by drugs (18%) and equipment (16%).

Conclusions and Recommendations: The costs per client were driven by the volume and attrition rate. The sites that have relatively lower unit costs tend to deliver services in an integrated way. The service delivery model tended to affect personnel costs. Since the cost per client adhered to MAT integrated services ($192.68) is comparable to the ART cost per patient year ($197.27) derived from an ART study conducted in Tanzania in 2016, the effective MAT program in preventing HIV infection would potentially generate savings and be affordable to the HIV program.

WEPEE373

A Systematic Literature Review of Costs and Cost-effectiveness Analyses of HIV Testing Services in Sub-Saharan Africa

Ahmed Nurilign[1], Terris-Prestholt Fern[1], J.Ong Jason[1,2], d'Elbée Marc[1], Rotolo Stephanie[1], Maheswaran Hendramoorthy[3]

[1]London School of Hygiene and Tropical Medicine, London, United Kingdom, [2]Monash University, Melbourne, Australia, [3]University of Liverpool, Liverpool, United Kingdom

Objective: To review the costs and cost-effectiveness of HIV testing services (HTS) in sub-Saharan Africa.

Design: A systematic literature review of costing and cost-effectiveness studies reported since January 2006.

Methods: We searched ten electronic databases for studies that reported estimates for cost per person tested (US$pptested), cost per HIV-positive identified (US$ppositive), and cost-effectiveness (CE) analysis where health outcomes were quantified in quality-adjusted life years (QALYs) disability-adjusted life years (DALYs), HIV infections averted, or life-years gained. We explored variations in costs and CE estimates by different testing modalities and size of the HTS. All costs are presented in 2017 US$.

Results: Fifty-five studies were identified: cost studies (*n*=43), CE studies (*n*=15), both cost and CE studies (*n*=5), reporting estimates for six HIV testing modalities: health facility, home-based, mobile-service, self-testing, campaign-style and stand-alone. The mean US$pptested was lowest with self-testing services (US$12.39, range:US$8.15-US$16.42) and highest with campaign-style (US$53.48, range:US$14.25-US$89.66). The mean US$ppositive was lowest with self-testing services (US$76.06, range:US$31.94-US$110.05) and highest with campaign-style (US$852.21). The 15 CE studies reported 31 estimates. For facility-based testing, the cost per HIV infection averted ranged from US$122.76 to US$68,213.13. Additional, mobile-service compared to standard of care testing would cost US$2,936.80 per life-year saved. An additional provision of self-testing to the standard of care would result in ICER of US$286.59 and US$296.50 from a provider and societal perspectives, respectively. We observed economies of scale with lower US$pptested and US$ppositive at larger testing sites.

Conclusion: HIV testing and self-testing in the community and through existing health facilities were the least costly approaches. Providing a combination of these modalities is more likely to achieve universal awareness of HIV status, but will result in the loss of economies of scale achievable through larger single modality testing service.

WEPEE374

Evaluation of the Quality Improvement Support to Differentiated Care Models for Anti-retroviral Therapy in Kenya

Obare Valerie[1], Kimani Maureen[1], Ngugi Catherine[1], Chepkorir Milcah[1], Ombam Regina[2], Inimah Maureen[1], Opanga Brenda[1], Sewe Nicholas[1], Chi Y Ling[3], Chola Lumbwe[3], Memiah Peter[4], Muiyoro Mburu[1], Asiimwe Sarah[5]

[1]Ministry of Health, NASCOP, Nairobi, Kenya, [2]Ministry of Health, NACC, Nairobi, Kenya, [3]Imperial College London, London, United Kingdom, [4]University of West Florida, Florida, United States, [5]Global Fund, Geneva, Switzerland

Background: The Kenya ART Guidelines 2016 was the introduced policy for differentiated care models (DC) for clients on anti-retroviral therapy (ART). DC is a patient-centred approach which seeks to provide services based on individual needs of clients. The National AIDS and STI Control Program has been piloting a Quality Improvement (QI) programme to explicitly support DC implementation (DC+QI) in 7 counties in Kenya. Our study sought to establish how the intervention, DC+QI, compares with DC alone (without QI support), in terms of client experience (i.e. client journey in the healthcare system, self-reported health and satisfaction) and provider experience (i.e. satisfaction, knowledge of guidelines, workload).

Methods: A patient survey was administered to 1,409 clients and a provider experience survey was administered to 56 health providers in 30 facilities across 12 counties in Kenya. Facilities were case-matched using baseline characteristics resulting in 15 interventions (DC+QI) and 15 control facilities (only DC) Bivariate models were used to estimate the difference in client and healthcare experience and satisfaction in facilities implementing DC+QI versus DC alone.

Results: From the patient survey there was a significant difference between the control and intervention facilities by type of health facility ($p < 0.001$); marital status ($p=0.043$); monthly income ($p < 0.001$); in regards to patient experience there was a significant difference between the intervention and control facilities in regards to self-reported viral suppression ($p=0.007$); Hospitalization ($p=0.016$); consultation experience ($p < 0.001$); recommending DC models to other patients ($p < 0.001$); convenience of time appointment ($p=0.013$); Findings from the provider survey there was a significant difference in those who had QI training ($p < 0.001$); contribution of QI to the practices at the clinic ($p < 0.001$) and number of meetings related to QI ($p < 0.001$).

Conclusions: Across the world, DC pathways have been implemented, in line with global guidelines (as issued by the WHO). However, the evidence on the extent of the guideline implementation in non-trial settings on the ground is limited. This present work will provide valuable insights on DC implementation on the ground, and the contribution of quality improvement programmes.

Key Words: Differentiated Care, Quality Improvement, patient and provider satisfaction.

WEPEE375

Financial Flows in the Fight against AIDS in Cameroon, 2016, 2017: Discrepancy between Resources, Expenditures Orientation and Epidemiological Trends

Billong Serge-Clotaire[1], Messeh Arlette[2], Penda Calixte Ida[3], Owona Natacha[4], Anoubissie Jean De Dieu[4], Moutapam Pamela Reine[5], Fokam Joseph[6], Billong Edson-Joan[7], Evouna Armel[8], Bohimbo Carole[9], Thome Lutresse[10], Takpa Vincent[11], Bissek Anne-Cecile[12], Bonono Leonard[4], Elat Jean-Bosco[4], Essi Marie-José[13]

[1]University of Yaoundé 1, Public Health, Yaoundé, Cameroon, [2]CNLS Cameroun, Public Health, Yaoundé, Cameroon, [3]Université de Douala, Pediatrie, Douala, Cameroon, [4]CNLS Cameroun, Yaoundé, Cameroon, [5]Cabinet de Recherche Afrique en Marche, Yaoundé, Cameroon, [6]CIRCB: Chantal Biya International Reference Center for HIV Prevention and Management, Yaoundé, Cameroon, [7]Cabinet de Recherche Afrique en Marche, Public Health, Yaoundé, Cameroon, [8]MOH Cameroun, DLM, Yaoundé, Cameroon, [9]MOH Cameroun, Yaoundé, Cameroon, [10]Université de Yaoundé 1, Yaoundé, Cameroon, [11]ONUSIDA, Yaoundé, Cameroon, [12]MOH Cameroun, DROSS, Yaoundé, Cameroon, [13]Université de Yaoundé 1, Public Health, Yaoundé, Cameroon

Background: The HIV epidemic in Cameroon shows significant disparities across regions and population subgroups. It is known that funding for programmatic responses influences epidemiological outcomes. Cameroon had planned to invest 88.1 billion CFA francs and 98.6 billion CFA francs for HIV in 2016 and 2017 respectively. Our study aimed to describe at the national level the financial flows with regard to populations and identified priority interventions.

Methods: We conducted a retrospective study over a period from January 2016-December 2017. We systematically identified resources and expenditures in the fight against AIDS according to the UNAIDS methodological model of tracing financial flows from different sources to financial agents towards service providers and final beneficiaries. We also collected information on epidemiological trends (HIV incidence and prevalence).

Results: In 2016 expenditures in the fight against AIDS were estimated at 44 999 675 860 FCFA against 65 620 341 631 FCFA in 2017 representing half of forecasts. The sources of funding came mainly from international funds 87.5% (2016) and 83.5% (2017). Orientation was primarily focused on treatment at 55.7% in 2016 and 63.4% in 2017 and not taking into account the prevalence or incidence of HIV.

Conclusions and recommendations: People living with HIV were the main beneficiaries with more than 50% of the funds invested. Adolescents and youth have benefited from lower funding for prevention yet they have the highest incidence of HIV. These results suggest a strengthening of domestic funding and the reorientation of spending towards prevention and adolescent youth.

Keywords: HIV - AIDS - Resources - expenditures, - Epidemiology - Cameroon

WEPEE376

Coûts Élevés pour les Patients et Faible Efficience des Dispositifs de Protection Sociale: Une Étude sur le Reste-à-charge des PVVIH lors d'une Consultation de Suivi au CRCF-CHU Fann

Laborde-Balen Gabrièle[1,2], Taverne Bernard[1,2], Gueye Madjiguene[2,3], Sow Khoudia[2,4], UNISSAHEL-Sénégal Study Group

[1]IRD UMI 233 TransVIHMI/ INSERM U1175/ Université de Montpellier, Montpellier, France, [2]Centre Régional de Recherche et de Formation à la Prise en Charge Clinique de Fann, Dakar, Senegal, [3]Réseau National des Associations de Personnes Vivant avec le VIH du Sénégal (RNP+), Dakar, Senegal, [4]Ministère de la Sante et de l'action Sociale, Dakar, Senegal

Contexte et Objectifs: Au Sénégal les ARV, les CD4 et la charge virale (CV), sont gratuits depuis 2003, mais une part des soins reste à la charge des patients. Diverses études ont montré que les « Reste-à-Charge » (part payée par le patient) élevés réduisent l'accès aux soins en favorisant le renoncement. Depuis 2015, un dispositif de couverture médicale se développe au Sénégal. Dans le cadre du programme UNISSAHEL-Sénégal de l'IRD/CRCF, l'étude évalue l'efficacité de ce dispositif et le Reste-à-Charge pour une consultation de routine des PVVIH au CRCF (CHU de Fann, Dakar).
Méthode: Enquête transversale réalisée au CRCF en 2018, par questionnaire à la sortie de la consultation. Des informations socio-démographiques et médico-économiques ont été enregistrées à l'aide du logiciel Open Data Kit (ODK).
Résultats: l'étude porte sur 344 personnes (69% de femmes), traitées par ARV avec une durée médiane de 6 ans [max 20] . L'âge moyen est de 46 ans [18-74].
82% des personnes sont sans protection sociale, 12% affiliées à une assurance liée à l'emploi ou à la vieillesse, 6% à une mutuelle de santé (MS) communautaire.
Le coût moyen (hors ARV et CV) est de 33 USD/personne/consultation [9 -375]. Il se répartit en : bilan biologique 36%, consultation 26%, déplacement 18%, médicaments 10%, imagerie et autres 10%.
38% des dépenses (≈ 12 USD) sont couvertes par le patient ; 34% (≈ 11 USD) par le programme national, 27% (≈ 9 USD) par la structure sanitaire et seulement 1% (< 1USD) par les MS ou assurances.
Le Reste-à-charge moyen est ≈ 12 USD (médiane : 8 USD). Aucune des 16 personnes affiliées à une MS n'a eu de prise en charge (PEC) et seulement 3 parmi les 33 affiliées à une assurance.
124 personnes (36%) ont bénéficié d'une PEC par le Programme national VIH de leur examen biologique. Sur les 47 personnes de plus de 60 ans, 6 ont été eu une PEC partielle par le plan Sésame (programme national personnes âgées).
Conclusion: Le Reste-à-Charge d'une consultation de routine reste élevé.
Le dispositif le plus efficient est l'achat de service par le programme national. Le recours aux dispositifs existants reste faible du fait de l'inadaptation des procédures. Dans un contexte de pauvreté aggravé par la maladie, leur simplification et le développement des systèmes de gratuité au point de consommation pourraient prévenir le renoncement aux soins et favoriser la rétention.
Mots clés : Reste-à-charge, VIH, protection sociale, Sénégal

WEPEE377

A Community-based Participatory Research Process to Improve HIV Prevention and the 90-90-90 UNAIDS Outcomes among Female Sex Workers in Burkina Faso

Tassembedo Souleymane[1], Traore Isidore Tiandiogo[1,2], Millogo Adjara[1], W.Wilfried Bazie[1], De Rekeneire Nathalie[1]

[1]Centre MURAZ Research Institute, Department of Clinical Research, Bobo-Dioulasso, Burkina Faso,
[2]University Nazi Boni, Department of Public Health, Bobo-Dioulasso, Burkina Faso

Background: Despite recent progresses in curbing HIV incidence in sub-Saharan African, female sex workers are highly burdened by HIV/AIDS. This group is highly covered by HIV counseling and testing services but its linkage and access to care are still challenging. Innovative comprehensive approaches involving all stakeholders are needed to boost this side. Interventions were largely based on literature reviews and theoretical concepts. This study aimed at collecting stakeholders (FSW, CBO, government and global agencies) inputs on the bottlenecks and the potential solutions to improve HIV care cascade in Bobo-Dioulasso in this group.
Methods: Individual interviews and Focus group discussions have been conducted with government and global health agencies, members of FSW´ CBOs operating in Burkina Faso between February and March 2019.
Results: Regarding HIV prevention in this group the gaps noticed by stakeholders include: awareness messages are not done optimally and new targets have to be considered (residencies being illegally transformed into motels, FSW working only through internet). For the HIV cascade the extreme mobility including travel abroad, alcohol substance abuse, poverty foreign FSW have been of concern. FSW had poor knowledge of PrEP, PEP and same day ART initiation. Stigmatization including within the community members exist and could jeopardize HIV prevention and care seeking. Propositions for more personalized and aggressive awareness messages, touching hidden FSW through social media, going to illegal motels (private houses turned into motels) and with MSM help have been made. Other propositions include: addressing intra community stigma have been made, implementing a trans-border referral system to tackle mobility issue, improving follow up outcomes by setting a digital imprints identification system and tackling substance abuse (alcohol and drugs) and violence in this vulnerable group. All stakeholders are committed to be partners in the implementation of the research project that will be derived from.
Conclusions and Recommendations: Putting together decisions makers and community member's views yield information about real bottlenecks in HIV prevention and care cascade and pathways to be taking into account by researchers in order to improve the HIV care Cascade among Female sex workers in Burkina Faso. Whenever possible this might be the step when designing a research project involving various stakeholders.

WEPEE378

An NGO's Efforts in the Central African Republic to Help HIV Patients Support Themselves through Agriculture

Okabe Kiyoko[1], Takatsuka Ayako[2], Kono Sayoko[1], Kato Shoko[3], Numakura Kazumi[4], Mbongndo Sophie[5], Tokunaga Mizuko[1]

[1]NGO Amis d`Afrique, Tokyo, Japan, [2]The Jikei University School of Nursing, Tokyo, Japan, [3]Miyazaki Prefectural Nursing University, Miyazaki, Japan, [4]Health Care Center HEALTH CHECK, Tokyo, Japan, [5]NGO Amis d`Afrique, Bangui, Central African Republic

Background: Amis d´Afrique is a Japanese NGO that has been providing medical support to people with HIV in Bangui, capital of the Central African Republic, since 1993. While antiretroviral treatment has been provided free since 2006 with support from the Global Fund, helping AIDS patients to support themselves has become a significant medical issue. Some 500 AIDS patients are registered with us, of which about 80% are unemployed. In June 2012, the NGO borrowed farmland as part of a program to help support those patients wishing to establish their economic independence through agriculture. As of August 2017, the NGO has purchased 2.6 hectares of land, supporting 50 such patients.
Methods: AIDS patients who wished to start agriculture became cultivators. Each person was allotted 0.05 hectares of land to grow crops of their choice. An agricultural technician visited the land weekly to provide technical guidance. The cultivators reported their yields monthly.
Results: All 50 cultivators (5 males, 45 females) planted cassava, which could be harvested after a year, along with crops such as peanuts, corn, and pumpkin, which were planted between the stems. By the second year, about half of the participants were self-sufficient in their staple food, cassava; by 2016, all but one, who was in bad health and lived far from the land, were self-sufficient. Since 2016, 80% of the cultivators have earned cash income from selling surplus crops. Of these, 30% have an annual income of 100,000XAF or more, 30% have earned 50,000-100,000XAF, and 30% earn up to $50,000XAF. The program has also enhanced family cooperation and strengthened family ties, given unemployed AIDS patients a new-found reason for living, increased caloric intake leading to improved health, and provided income that has enabled families to send their children to school.
Conclusions: Because of the positive effects of agriculture, we intend to expand the available farmland and increase the number of cultivators. However, only 10% of the patients are engaged in agriculture, and there are many who prefer not to be. We need to develop other projects to help such patients support themselves.
Keywords: people with HIV, self-reliance support, agriculture

THPEE307

Innovative Approaches at TEBA Points of Care to Provide Comprehensive TB and HIV Services to Miners and Their Families

Lebelo Limakatso[1], Frederix Koen[2], Maraisane Reaboka[2], Tsoeu Silane[2], Ndagije Felix[2], Maama Llang[3], Howard Andrea A[4]

[1]ICAP at Columbia University Lesotho Lesotho, Maseru, Lesotho, [2]ICAP at Columbia University Lesotho, Maseru, Lesotho, [3]Ministry of Health, Lesotho, Maseru, Lesotho, [4]ICAP at Columbia University, New York, USA, New York, United States

Issues: Lesotho is severely affected by HIV and tuberculosis (TB), with an HIV prevalence of 25.6% and TB incidence of 655 per 100,000. Migrant miners and their families are at high risk for HIV infection and TB, yet testing, engagement, and retention in care and treatment are suboptimal. Innovative strategies to treatment outcomes in this population are needed.

Description: As part of a public-private partnership between Lesotho's Ministry of Health (MOH) and TEBA, the sole recruitment agency for Basotho miners working in South Africa, ICAP provided technical assistance to establish Points of Care (POC) that offer integrated TB and HIV services 6 days/week to miners, ex-miners and their families within three regional TEBA offices that provide pre-employment health screening and dispense deferred pay to over 20,000 miners. Services include: TB screening, sputum collection for same-day GeneXpert testing, TB treatment, documentation of TB treatment outcomes, HIV testing and antiretroviral therapy (ART). Since November 2017, with funding from World Bank under the Southern Africa Tuberculosis Health Systems Support (SATBHSS) project, additional interventions were implemented to improve access and adherence to TB and HIV services.

Lessons learned: Integrating TB/HIV diagnosis and treatment services with banking and administrative services in mining employment offices resulted in high uptake of health services by miners and their families. Between November 2017 and December 2018, 118,622 clients were screened for TB, 2,847 screened positive and 138 (4.8%) were diagnosed with TB. A total of 3,295 clients were tested for HIV, among whom 171 (5.2%) were HIV-positive and all were linked to care and treatment. The project demonstrated excellent TB treatment outcomes with 93% treatment success overall and 95% among miners, (compared to 77% nationally) and high 12-month retention in HIV care (88%). Among 902 people provided with HIV self-testing kits, 32 (3.5%) were found to be HIV-positive.

Next steps: Absorption of TEBA POCs by the MOH-supported health system is crucial for program sustainability. Inclusion of the POCs in MOH budget and facility structure is needed to continue their work. Expansion of the model to other high-volume TEBA offices and planned integration of other health services including screening for sexually transmitted infections and voluntary medical male circumcision will further contribute to sustainability of the POCs.

THPEE308

The "Frenzy" of Finding the Missing Cases of HIV/AIDS

Fawole Adefolarin Ayotunde
Department of Health Kwazulunatal, Pietermaritzburg, South Africa

Issues: Imbalenhle Community Health Centre (CHC) is a Primary Care Center in Kwazulu Natal province of South Africa with a high prevalence of Human Immunodeficiency Virus / Autoimmune Deficiency Syndrome (HIV/AIDS). Imbalenhle CHC usually surpasses the target of testing (250 patients per week). As for initiating patients on Antiretoviral Treatment (ART), target is not met. Nerve Centre committees in partnership with an NGO (MATCH) are tasked to address inabilities to meet this target. Reasons include:
(1) Newly diagnosed HIV patients ´´not ready´´ to be initiated.
(2) Some patients prefer to take treatment elsewhere.
(3) Some newly diagnosed patients are also diagnosed with Pulmonary Tuberculosis (PTB). These patients will only be initiated on ARTs after 2 weeks as per guidelines.
(4) HIV Positive patients returning to test.
Descriptions: For intervention in the under-performance of ART initiations, Universal Test and Treat (UTT) approach was reemphasized, hence same day initiations should be encouraged.
A framework of efficient flow of patients was developed. Patients are mostly tested by lay counselors. Those who test positive and are not PTB suspects are then counseled on starting treatment. These same patients are subsequently linked to a Professional nurse or a doctor for initiation.
For those patients with stigmatization fears, counseling is reinforced by clinicians to allay their anxieties. If a patient prefers to take treatment elsewhere, they are initiated on site before being transferred out.
Lessons learned: After the interventions, the number of patients not initiated decreased from 72 in January to 16 in June 2019, showing a huge improvement. The majority of patients still not initiated on the same day are those who insist that they are not ready or those with PTB. Quite a number of patients have been previously diagnosed at some point, but they come to the facility to be tested without disclosing their status. For every patient that the counselors test positive, before they are linked to the clinicians, the counselors check with the data capturers if such patients are not already appearing on the database as already collecting ARTs.
Next steps: Recommendations will be laying emphasis on linkage to care. Contact details of all patients are to be painstakingly collected by linkage officers so that follow ups can be done.

THPEE309

Public Private Potential? Scoping of Private Sector HIV Services and Needs in Zimbabwe

Webb Karen[1], Page-Mtongwiza Sara[1], Mujaranji Grapper[1], Bepe Tafadzwa[1], Trudy Mhlanga[1], Patel Diana[1], Mbetu Patricia[1], Chinyanga Tinashe[1], Mulingwa Albert[2], Choto Regis[2], Apollo Tsitsi[2]
[1]Organisation for Public Health Interventions and Development (OPHID), Harare, Zimbabwe, [2]Ministry of Health and Child Care, AIDS & TB Unit, Harare, Zimbabwe

Issues: The private sector is an important source of HIV testing, care and treatment services in high prevalence countries like Zimbabwe, particularly in urban areas. However, little is known about the coverage and nature of HIV services offered in the private sector to guide priority program actions. Our objective was to establish HIV care and treatment services and needs in the private sector.
Descriptions: Private sector scoping of 22 districts supported by the Families and Communities for Elimination (FACE-HIV) Program in January 2019. Purposive sampling of identified private health providers in each District. Private clinics enumerated using a standardized questionnaire, entered electronically at District-level into MS Forms for centralised analysis. Data analysed descriptively using MS Excel and STATAV12.
Lessons learned: A total of 111 private clinics were enumerated. The majority of private clinics were in the private health sector (60%) followed by industry (10%) and mining (8%). The majority (64%; 71/111) of private sector facilities were providing HIV testing, however, fewer than half were reporting in Ministry of Health and Child Care (MOHCC) health information system. The majority (71.9%; 28/39) of facilities not currently offering HIV services were interested in receiving support in the form of: HIV rapid test training, and IEC and client education on HIV. Overall, only 38% (42/111) of private sector facilities were providing ART initiation services. Among ART initiating sites, 31/42 (74%) indicated they were aware of the number of clients on ART - serving 2847 clients. Less an 1/3 (9/31) of these sites were reporting to MOHCC; with non-reporting sites serving 2612 'uncounted' clients on ART. Of 14 facilities offering neither HIV testing or treatment services, serving +50 clients a week, 13 indicated they were interested in receiving technical support.
Next steps: We document a significant amount of HIV services provided in the private sector that are currently uncounted. The HIV service cascade in the private sector is weak, with high potential for leakage. Private sector companies demonstrate willingness and interest in supporting HIV testing, care and treatment efforts and in aligning with national guidelines and information systems. A tiered approach recognizing complexities and prioritizing 'high volume, high interest' private facilities is required to improve quantification and strengthening of HIV services in the private sector.

THPEE310

Community-facility Services Collaboration: Improved HIV Care and Treatment in Southern Tanzania

Haule Helena[1], Ikonje Albert[1], Njelekela Marina[1], Bisimba Jema[2], Jones Carlton[1]
[1]Deloitte Consulting Ltd, Dar Es Salaam, Tanzania, United Republic of, [2]USAID Country Office, Dar Es salaam, Dar Es Salaam, Tanzania, United Republic of

Background: Collaboration, integration and partnership with key stakeholders is key in improving program implementation in an HIV Care and Treatment program. In Tanzania different community and facility implementing partners coexist in several councils, to ensure care and treatment at facilities as well community access to HIV services is promptly delivered. Without proper collaboration between implementing partners disconnect of services may happen, leading to loss to services by clients. Thus this study is seeking to analyse the effects of integration and collaboration on changes in number of PLHIV on care, yield and new PLHIVs on treatment in five selected councils in Southern Tanzania.
Methods: Five councils of Kilombero DC, Kilosa DC and Mvomero DC from Morogoro, Mafinga TC from Iringa and Wanging'ombe DC from Njombe participated in this study. Data on the number of PLHIV currently on care, focused testing (less testing with high yield) and number of new PLHIV on treatment was collected from all electronic sites in the five councils that had a coexistence of facility and community partner. Chi square test was used to test for the changes of the three selected outcomes for three quarters, (July-September 2018, October - December 2018 and January - March 2019) over time.
Results: There was a significant increase in the number of new PLHIV that are in care from 2,071, 2,495 and 2,768 clients and was statistically significant $p< 0.001$. Yield of those who were positives increased proportionately by quarters from 2.9, 2.7, and 4.3, respectively with $p< 0.001$. No significant difference was observed on the Total increase in total number of PLHIV between the first and second quarters. However, significant difference was observed in total PLHIV from October - December 2018 to January-March 2019.
Conclusions and Recommendations: Collaboration between facility and community implementing HIV partners has improved number of PLHIV in care, number of new PLHIV in care and improved focused testing. More efforts need to be employed to make sure these good practices are withhold.

THPEE311

Partenariat entre Organisation Communautaire-public sur le Référencement, le Maintien dans les Soins des Populations Clés (PC), Hommes Ayant des Rapports avec des Homme (HSH), Travailleuses du Sexe (PS)

Some T Charles[1], Some K Ghislain Victor[2], Kambire Arlette[3], Somda Martine[4], Sawadogo Mahama[4], Traore Lassiné[4]

[1]Centre Médical REVS PLUS, Santé Communautaire, Bobo Dioulasso, Burkina Faso, [2]ONG/REVS+ Burkina-Faso, Santé Communautaire, Bobo Dioulasso, Burkina Faso, [3]Centre Médical de REVS PLUS, Santé Communautaire, Bobo Dioulasso, Burkina Faso, [4]REVS PLUS, Santé Communautaire, Bobo Dioulasso, Burkina Faso

Questions: Au Burkina Faso, la prévalence du VIH a dramatiquement diminué en passant de 7,2% en 1997 à 0,8% en 2017. L'épidémie reste active au sein des PC dont les HSH 1,9%, les PS 5,4%. Malgré une prise en charge du VIH gratuite, les PC ont moins accès au traitement, à la prise en charge comparativement à la population générale. Cette moindre prise en charge s'explique notamment par un environnement hostile aux PC et à l´insuffisance de collaboration entre le secteur communautaire et public.Face à cette insuffisance, REVS PLUS a établi un partenariat avec les structures sanitaires publiques pour améliorer la prise en charge des PC.

Description: 02 rencontres entre les acteurs(pairs éducateurs, le personnel de santé du public) sur la prise en charge des PC ont été initiées au 1er trimestre de l'année 2018 pour susciter la mobilisation, l'implication au dépistage, la référence et le maintien dans les soins. A l´issue de la formalisation du partenariat, il était nécessaire de coconstruire au préalable:1/ une cartographie à destination des PC des sites de dépistage et de prise en charge médicale ; 2/Une fiche de référence suite au dépistage et de contre-référence suite à l'entrée dans les soins pour faciliter la récolte de données. Puis le système de référencement a été mis en place. Premièrement, les pairs éducateurs, font le point au sein de leur structure des PC dépistées positives et référées dans les centres de soins. Secundo, les centres de soins public à leurs tours établissent en retour, une fiche de contre-référence pour confirmer que les PC positives ont été enrôlées dans les soins. Enfin, toutes les parties se réunissent trimestriellement pour faire le point des PC dépistées et enrôlées dans les soins pour éviter les doublons et les déperditions des données. Ce partenariat a permis de dépister 1512 PC en 2018 dont 39 positifs.

Leçons apprises: Tout au long du processus, nous avons rencontré un certain nombre d'obstacles qui ont freiné le bon déroulement et fonctionnement de nos interventions dont entre autres la clandestinité de la cible, la non réactivité à temps pour le feedback du contre-référence. Aussi, l'une des obstacles fut l'utilisation des fiches en support papier qui a occasionné souvent des pertes

Prochaines étapes:

-Développement d'un logiciel de référencement et de contré-référence
-Promotion de cette approche peu coûteuse à l'échelle nationale
-Stratégie de pérennisation du cadre de concertation entre les différentes parties.

THPEE312

Partenariat Association/Service de Santé Public: Expérience de REVS PLUS

Bissinga/Diendéré Christèle, Traore Lassine
REVS PLUS, Santé Communautaire, Bobo Dioulasso, Burkina Faso

Questions: Il est établi que les acteurs de prise en charge des PvVIH ne sont pas suffisamment outillés à la prise en charge mais aussi sur le processus d'accompagnement de la transition enfance à adulte dans les structures de prise en charge médicale du secteur public.Pour mieux accompagner les agents de santé du secteur public et communautaire, REVS PLUS a initié grâce au soutien de Sidaction un projet de renforcement des capacités.

Description: Les enfants que nous avons suivis sont devenus des adolescents et des jeunes. D'où l'idée de cette collaboration avec les formations sanitaires du publique dans les antennes ou REVS PLUS ne dispose pas de centre médical. La formalisation de cette approche a facilité les activités de renforcement de capacité, des stages d'immersion au niveau du siège, des supervisions formatives et des réunions semestrielles.

Pour ces 03 premières années de partenariat, les activités réalisées dans le cadre du projet sont :

-la formation des prestataires des services de santé public et des acteurs de prise en charge psychosociale de REVS PLUS, siège et antennes

-des stages pratiques des prestataires des services de santé public et des acteurs de prise en charge psychosociale des antennes au siège

-04 supervisions formatives dans toutes les antennes

-une évaluation à mi-parcours du projet.

Leçons apprises: C´ est un projet innovant dans l'accompagnement des enfants, adolescents et jeunes infectés et où affectés par le VIH car,Il a connu l'adhésion des premiers responsables des services de santé public et de la chef d'antenne régionale du SP CNLS IST. Il permet de renforcer les compétences des prestataires des services de santé public ainsi que de l'association ce qui améliore la qualité du suivi médical et psychosocial des enfants, des adolescents et jeunes qui sont oubliés dans le continuum de soins et qui ont des besoins spécifiques. Aussi d'améliorer la collaboration avec les services de santé public et de maintenir le contact après la formation.

Prochaines étapes: Notre souhait est que ce modèle de collaboration qui est une réussite, puisse être dupliqué sur le plan national et international afin que nos enfants que nous avons aidé à grandir, puisse continuer à grandir dans un environnement sain, où ils pourront avoir accès aux informations justes faire des projets de vie et ainsi, assurer la relève.

THPEE313

Can We Leverage on Private Pharmacies for HIV Service Delivery in Kenya? Insights from Patients and Pharmacy Providers

Musuva Anne
Population Services Kenya, HIV, Nairobi, Kenya

Issue: Donor funds provide 62% of HIV expenditure in Kenya. In addition, while 40-50% of Kenyans access health services through the public sector, only 5% seek HIV services from the private sector indicating the private sectors under utilization in HIV service delivery. With dwindling donor funding, there is an urgent need to mobilize domestic resources and explore sustainable models.
Descriptions: The HCM project seeks to address this by increasing the participation of the private sector in HIV service delivery. Decentralized ART delivery for stable clients through private pharmacies is an effective model to deliver patient-centred services and to decongest public sector facilities. In order to inform the acceptability and feasibility of such an initiative, HCM carried out a survey among PLHIV and Pharmacy providers.. A cross sectional survey was carried out among 53 private pharmacies in Nairobi that currently stock HIV self-testing kits. 83% were willing to dispense ARVs and 81% were willing to carry out basic screening of clients before giving drugs to them. 90% indicated they would charge a service fee and 48% would charge between $1-3. 83% were be willing to keep records of those collecting drugs. The results of the FGDs carried out among PLHIV were as follows: The PLHIV patients find clinic days stressful due to the amount of time spend commuting to and from the health facility and queuing for drugs.The PLHIV indicated that collecting drugs from a private pharmacy provider near them would be more efficient. However some were not willing to pay a service fee. as they were used to getting their drugs for free at public facilities. They felt confident they would be able to identify and seek medical assistance for any other health issues. Other drug delivery options suggested by the PLHIV would be to have the drugs delivered to their homes or workplaces by a rider.
Lessons learned: There is a high willingness of private pharmacies to be engaged in HIV service delivery through HIV drug collection. While many patients would appreciate the convenience of having the drugs delivered, cost of pick up at a private pharmacy was a barrier.
Next steps: Explore and co-create with PLHIV and MOH efficient models of drug collection that PLHIV would be willing to pay for. Further research among PLHIV and the private sector to determine how the private sector can be more meaningfully engaged to raise domestic resources.

THPEE314

Embracing Technology to Maximize HIV Status Awareness. Introducing OraQuick in Kigali

Nyirinkindi Aime Ernest, Gallican Rwibasira, Beata Sangwayire, Grace Nsabimana, Jean Pierre Ayingoma R, Arlette Nikokeza, Eric Remera, Sabin Nsanzimana, Placidie Mugwaneza
Rwanda Biomedical Center (RBC), Insitute of HIV, Disease Prevention and Control, Kigali, Rwanda

Background: HIV testing package has grown over time in Rwanda, and many different strategies have been developed to increase HIV testing. HIVST is an innovative way to facilitate access to HIV testing. Rwanda launched HIV self-testing in December 2017 as supplement approach to others HIV testing methods and adopted an open HIV self-test kits market through private pharmacies. However, little is known about self-test distribution strategies that are optimal for increasing testing access among individuals who have little time or fear of stigma and/or discrimination. The HIVST using Oraquick was introduced in Rwanda for it easy use and safety.
Description: Our focus is about HIVST Kits distributed in 19 authorized private pharmacies in Kigali. At least one provider has been trained on HIV self-testing and preliminary package on counselling. HIVST kits contains information on usage procedures in 3 languages to include local one. Each pharmacy provides a monthly report. The data do not include personal information. Only age range overtime was considered and categorized into 4age ranges; 1)Pople aged from 18-24Years, 2)People aged between 25-34Years, 3)People aged between 35-44 Years, the last is category of 50Years old and above. The distribution of Oraquick kits was initiated in Kigali as pilot phase, which should provide information on the countrywide scalability. 19 pharmacies were selected to sell HIVST. Pharmacies buy the kits from The Bethlehem-based OraSure Company and sell them to population.
Lessons learnt: From July 2018, 10 pharmacies started to distribute HIVST kits, and 9 pharmacies in February 2019. People aged 25-34years(72,2%) are more likely to demand HIVST kits than other age categories. The men are more likely to buy HIVST kits (53%) than women (47%). People aged from 50years and above are less likely to demand HIVST kits (3,8%). Pharmacists reported that many didn´t want to give details about themselves and some do not accept to be recorded as some are the returning and do not want to be recorded twice. Among who agreed to give feedback after self-test (n=116) only 4 did it.
Conclusion and next steps: HIVST kits distribution in private pharmacies is feasible and may be in high demand. Marketing is needed to make public aware of the providing pharmacies. Recording is also the important part to consider. Continuous monitoring from National HIV program is required to assess uptake, output, and linkage to care on a larger scale.

THPEE315

Meaningful Participation/Engagement of Adolescents and Young People in the HIV Response in Kenya

Moses Gloriah[1,2,3]
[1]NEPHAK, Advocacy and Communications, Nairobi, Kenya, [2]AYARHEP, Board of Directors, Nairobi, Kenya, [3]Kenya Coordinating Mechanism (Global Fund), Adolescent and Young People, Nairobi, Kenya

Issues: Adolescents and young people (AYP) especially young women, bear the brunt of HIV/AIDS epidemic due to limited access to information, services, stigma and discrimination. In Kenya, approximately 29% of all new HIV infections are among AYP. AIDS is the leading cause of death and morbidity among AYP in Kenya: 3,697 adolescents and young people died of AIDS in Kenya in 2017 (NACC 2017).
In the past adolescents and young people have not been engaged in the design of different HIV programs targeted towards them. Their representation was minimal if not absent hence programs set for them haven't worked effectively. Over the recent past, AYP have been involved in different areas of programming in youth focused projects. This has shown effectiveness hence a conclusion that the AYP have the expertise of their own issues.
Descriptions: NEPHAK, a National network that unites people living with HIV and those affected by TB, is implementing an asset based approach model dubbed OTZ (Operation Triple Zero; zero missed appointments, zero missed drugs and zero viral load) in Nairobi county, whose main objective is to help AYP on ART to live healthier lives by achieving complete viral suppression through key motivators of; being a hero, identification with OTZ club, regular motivational messages, ownership of one's health and tailored model of care.
Lessons learned: The model has resulted in increased uptake of HIV services, with more than 47,000 AYP people enrolled in OTZ countrywide. For those enrolled for six months or more, viral suppression has improved from 77% in 2016 when the program began to 82% currently, retention to ART is at 99% and self-reported adherence to treatment is at 95%. Other targets within the program include zero AIDS related deaths, zero TB, zero losses to follow up and zero self-stigma.
Next steps: As a result of operation triple zero successes, the model has been scaled up across 27 high HIV burden counties in Kenya. Program implementers are refining areas of implementation to further explore which best practices offer stronger outcomes while at the same time maintaining the fundamental mechanisms of the program. There is need to scale it to all the counties as this has been successful in the pilot counties.

THPEE316

Patients' Attitudes towards Cash to Incentivize their HIV Care Engagement: Qualitative Insights from a Randomized Trial in Western Kenya

Iguna Sarah[1], Odhiambo Gladys[1], Adhiambo Fridah[1], Akama Eliud[1], Getuhun Monica[2], Kulzer Jayne[2], Geng Elvin[2], Camlin Carol S[2]
[1]KEMRI-CMR, Kisumu, Kenya, [2]University of California San Francisco, San Francisco, United States

Background: Economic incentives can improve medication ownership, appointment attendance, and reduce lost-to- follow-up from HIV care in sub-Saharan Africa. However, little is known about the pathways through which incentives affect care engagement.
Methods: A qualitative study in the ADAPT-R trial explored the influence of cash incentives on HIV care engagement. Newly diagnosed patients received ~$4 (for any use) contingent on clinic attendance within three days of an appointment; a purposive gender and age balanced sample of 39 cash-receiving participants were interviewed within a month of enrollment from July 2016 - June 2017. Interviews were translated and transcribed; a collaboratively developed coding framework was deductively and inductively applied by a six-person team.
Results: Care-seeking often conflicted with livelihoods; patients weighed the costs of clinic attendance (in lost wages) versus benefits. Incentives helped prioritize care-seeking: "in a day, I make a profit of KSH 600; I decided to forgo [work] and attend clinic […] the incentive relieved me." Food insecurity also hindered care seeking ("I had to endure hunger and also walk to the hospital") and adherence. Incentives alleviated food insecurity and anxieties: "I left this [clinic] and went to the market to buy food; I cooked and ate. I felt so good." Care-seeking for many involved borrowing money, which led to worry ("when you want to come to the clinic […] you will be forced to […] borrow money you have difficulty in paying back");many experienced relief and social benefits: "Ijust borrow with confidence that I will pay after [my] appointment",felt less indebted, autonomous, and better able to support their families: "I used the [incentive] to buy clothes and Pampers for the children." Incentives did not influence care seeking for intrinsically motivated patients: "my life depends on the drugs, not the voucher", or for those who mistrusted researchers or health authorities: "they may think that it is from devil worshippers; nothing comes for free."
Conclusions: Findings revealed cash incentives expanded choice and facilitated clinic attendance; incentives permitted care prioritization, alleviated food insecurity and indebtedness, enhanced social role fulfilment, and relieving anxiety. Incentives did not impact intrinsically motivated patients.

THPEE317

The Role of Short Message Service Reminder and Peers' Home Visits in Improving Adherence to Antiretroviral Therapy among HIV-Infected Adolescents in Cameroon

Ketchaji Alice[1,2], Assah Felix[3], Fokam Joseph[4], Fouda Atangana Alain[5], Ngouakam Hermann[1], Amabo Chi Franck[2], Ndongo Ateba Francis[6], Lantche Martial[6], Monebenimp Francisca[3], Ngowe Ngowe Marcelin[1]
[1]Ministry of Public Health, Department for the Control of Disease, Epidemics and Pandemics, Yaoundé, Cameroon, [2]University of Buea, Department of Public Health and Hygiene, Faculty of Health Sciences, Buea, Cameroon, [3]University of Yaoundé 1, Department of Public Health, Faculty of Medicine and Biomedical Sciences, Yaoundé, Cameroon, [4]Chantal BIYA International Reference Centre for Research on HIV/AIDS Prevention and Management, Virology Laboratory, Yaoundé, Cameroon, [5]Cameroonian Network of Positive Youths, Yaoundé, Cameroon, [6]Mother-Child Centre, Chantal BIYA Foundation, Yaounde, Cameroon

Introduction: In Cameroon, very few interventional studies have been conducted in order to improve adherence to antiretroviral treatment (ART) in HIV-infected adolescents. This study aimed to assess the impact of daily Short Message Service (SMS) reminder of drug dosing schedule and peers' home visits on adherence to ART and virologic response in HIV-infected adolescents receiving antiretroviral therapy (ART) in a Cameroonian health facility.
Methods: Two randomized control trial (RCT) were conducted for 6 months (from July through February 2019) among 184 adolescents aged 15 to 19 years old with disclosed HIV status receiving ART at the Mother-Child Centre, Chantal BIYA Foundation, Yaounde. For the first RCT, participants received daily SMS reminder of drug dosing schedule while for the second RCT, participants benefiting weekly home visits from peers whom viral load was already suppressed. Both of control group for each RCT received the standard of care at the healthcare facility. Adherence was measured by using a composite of both self-reported and pill count assessments.
Results: After the interventions, adherence to ART was better in both interventional arm-A (SMS reminder of drug dosing schedule) and arm-B (peer support by home visits), compared to the control arm (OR, 95% Confidence Interval: 5.8[2.3-14.9] and 4.1[1.6-10.9], respectively). Similarly, adolescents in both interventional arms were significantly achieved viral load suppression than those in control arm (OR, 95% Confidence Interval: 15.6[4.2-57.7] and 14.7[4.8-44.6], respectively).
Conclusions: Adherence to ART and virologic response are improved by SMS reminder of drug dosing schedule and peers' home visits. Such interventions should be integrated in the routine monitoring strategy for a better transition of adolescents to adult care in Cameroon.
Keywords: HIV, Adolescents, Short Message Service reminder of drug dosing schedule, peers' home visits, Adherence to ART, Virologic response

THPEE318

Manifestation du Vécu du Deuil Lié au VIH/Sida chez les Patients à l´Hôpital de Zone de Natitingou et à l´Hôpital St Jean de Dieu de Tanguiéta dans l'Atacora, Nord Bénin

Ganlalo Alexis O.[1], Aïtchédji Alvine[2], Agbanoussou Igor[3], Agbassagan Bernys[4], Abiola Souliatou[5], Affoukou Théodi[6], Quenum Hilda[7], Adimi Marie Stella[8], Ogoundélé Sylvain[2], Sodoloufo Odile[2]

[1]Plan International Bénin, Cotonou, BéninI, Cotonou Cadjehoun Rue Aupiais Carré, Benin, [2]Plan International Bénin, Cotonou, Bénin, Littoral, Cotonou Cadjehoun Rue Aupiais Carré, Benin, [3]Plan International Bénin, Cotonou, Bénin, Borgou, Parakou, Benin, [4]Plan International Bénin, Cotonou, Bénin, Ouémé, Porto-Novo, Benin, [5]Plan International Bénin, Cotonou, BéninI, Littoral, Cotonou, Benin, [6]Plan International Bénin; Cotonou, Bénin, Zou-Collines, Dassa, Benin, [7]Plan International Bénin, Cotonou, Bénin, Atlantique, Ouidah, Benin, [8]Plan International Bénin, Cotonou, Bénin, Zou-Collines, Bohicon, Benin

Contexte: Apprendre que l'on est porteur du VIH est déstabilisant. C'est d'une crise de vie qui affecte inévitablement la personne concernée. En effet le deuil dans le contexte du VIH/SIDA est un état affectif douloureux provoqué par la période de souffrance et de chagrin qui suit la découverte de la séropositivité. En dépit de la meilleure amélioration de l'espérance de vie constatée grâce à l'état d'avancement des traitements, le vécu du deuil de l'infection à VIH, pourrait-il être une phase décisive dans leur vie avec le virus ? Ce travail nous permet d'apprécier le processus de deuil de l'infection à VIH chez les patients et d'identifier ses manifestations psychologiques.

Méthodes: Il s´agit d´une étude rétrospective, quantitative et non probabiliste qui porte sur 557 patients infectés par le VIH/Sida et suivis à l'HZ Natitingou et l'HSJD Tanguiéta au Bénin. Nous avons considéré les patients reçus en première consultation et qui ont été référés par un acteur du site de prise en charge dans la période d'avril à décembre 2018. Les données ont été collectées dans les dossiers d'accompagnement psychologique puis traitées avec le logiciel SPSS.

Résultats: (66%) de La population sont des femmes, (4,1%) d'enfants de moins de 15 ans et (7,2%) de jeunes et adolescents âgés de [15 à 24 ans]. Le processus de deuil continue même au-delà de la période de 6 mois après la découverte de statut VIH+ chez (9%) de femmes et (4%) d'hommes et la majorité des patients sont mis sous traitements ARV dans un intervalle de 0 à 6 mois de la découverte du statut VIH+ chez (43,1%) des femmes et (12,1%) d'hommes. On note un taux de désespoir de (31,8%) entre 3 à 6 mois de la découverte du statut. Le détachement se manifeste entre 3 à 6 mois chez (47,8%). Des manifestations dominantes ont été identifiées pour les différentes étapes de deuil chez les patients. A la phase de protestation l'anxiété (10,3%) domine et s'en suit le déni de la maladie (7,8%). Le découragement se remarque chez (12%), les manifestations psychosomatiques sont présentes à (9,9%), la phase de résignation de (7,5%). De plus, l'isolement est constaté chez (9,2%) des patients.

Conclusion: Le deuil est un processus incontournable dans le vécu d'une personne infectée par le VIH. Connaître ces manifestations pour un meilleur accompagnement est un atout capital pour mieux aider les personnes infectées. Cela leur permettra de mieux vivre leur séropositivité et une meilleure réinsertion sociale des patients

THPEE319

Nutrition Support as a Tool for Saving Lives of Malnourished People Living with HIV in Cameroon

Mbazoa Sabine[1], Ngwenyi Eveline[1], Le Quéré Lise-Marie[2], Rebena Agathe[2], Stevens Briony[3], Takpa Vincent[4], Dr Ousmanou Lyli[5], Mamka Nadège Prudence[6]

[1]World Food Programme Country Office, Yaounde, Cameroon, [2]World Food Programme Regional Bureau, Dakar, Senegal, [3]World Food Programme, Rome, Italy, [4]UNAIDS Country Office, Yaounde, Cameroon, [5]Centre de Traitement Agréé, Bertoua, Cameroon, [6]Association d'Assistance au Développement (ASAD), Bertoua, Cameroon

Issues: The East and Adamawa regions are among the most affected by HIV in Cameroon with prevalences of 5.9% and 4.9%. The effects of the epidemic in these regions are compounded by the precarious food security and nutrition situation owing to the influx of refugees fleeing the Central African Republic. A 2011 study revealed that 16% and 18.4% of ART clients were suffering from malnutrition in these two regions and recommended the integration of nutritional care into the HIV response.
Description: In 2013, in collaboration with the Government, WFP started a project on the nutritional rehabilitation of malnourished ART clients in 4 HIV care units (East region). Following a 2014 evaluation, the programme was extended to 9 HIV care units in the two regions. The distribution of specialized nutritious food to malnourished ART clients is part of a cost-effective comprehensive package of interventions that includes nutrition assessment and counselling, sanitation and hygiene sensitization, and home follow-up visits. The programme targeted moderately acute malnourished (MAM) ART clients, including children (6-59 months), pregnant and lactating women and other adults. Nutrition support was provided to approximately 2000 ART clients annually. Nutritional recovery rate among beneficiaries has improved from 63% in 2014 to 95.5% in 2018; mortality rate has decreased from 10.3% in 2015 to 2.1% in 2018; and defaulter rates decreased from 16.7% in 2015 to 0% in 2018. A rapid assessment showed that care units providing nutrition support have better treatment adherence and their ART clients a better nutritional status than those that did not provide such support. Based on the change they see in people attending the programme, more people living with HIV have come to care units to declare their status and start treatment.
Lessons learned: This programme has contributed to HIV testing, treatment initiation and adherence and therefore served a dual role of nutritional rehabilitation and incentive for beneficiary's access to HIV care and treatment. Systematic nutritional screening in HIV care units also permits early detection and treatment of MAM and prevents the deterioration to severe acute malnutrition.
Next steps: WFP is pursuing advocacy and support for the nationwide integration of nutrition assessment, counselling and support into the HIV response and is calling for additional evidence building on the impact of nutrition support on adherence and viral suppression.

THPEE320

Improving Treatment Adherence, Viral Suppression Rates and Retention in Care of Children Living with HIV through KidzClubs in Community-based Organisations in KwaZulu-Natal, South Africa

Mutambo Chipo[1], Heath Dewald[2], Health Nokuthula[3], Chewe Gilbert[3]
[1]Zoe-Life, Durban, South Africa, [2]Zoe-Life Innovative Solutions, Monitoring, Evaluation and Research, Durban, South Africa, [3]Zoe-Life Innovative Solutions, Durban, South Africa

Background: KidzClubs are child-focused support groups for children aged 5-14 years living with HIV. These Kidzclubs are part of the KidzAlive Programme which aims to improve HIV services for children in South Africa by using child-friendly innovations and approaches to train and empower healthcare workers, HIV-exposed and infected children and their caregivers to more confidently overcome barriers that limit children's uptake of HIV testing and treatment. During KidzClub sessions, children are taken through a series of psychosocial educational sessions where they are provided with HIV, adherence and wellness education using play therapy techniques to improve their HIV and treatment literacy. Their primary caregivers (PCGs) are also provided with similar sessions to ensure that they receive adequate psychosocial support and HIV knowledge to care for their children living with HIV.
Methods: Forty-eight (48) HIV positive children and PCG dyads were recruited into KidzClubs by local 4 Community-Based Organisations in KwaZulu-Natal, South Africa. At enrolment, we collected each child's history including last viral load, treatment regimen, disclosure status, age, gender, weight and height. We then ran concurrent KidzClub sessions and PCG Support groups for a 4-month pilot period. At the end of the pilot period, we collected data on the following outcomes: viral suppression rates, adherence to drug collection appointments, children and PCGs knowledge and understanding of their illness, disclosure rates, number of children remaining in care.
Results: We currently have positive preliminary qualitative results because we are still in the follow-up period. We will be able to report on the outcomes of the pilot by November 2019 in time for the ICASA Conference.
Conclusions: Findings from this pilot will be used to motivate for the addition of KidzAClubs to the current National Adherence Guidelines as a differentiated care model for children. This is important as there are limited child-centred differentiated care models for children in South Africa.

THPEE321

Economic Empowerment as a Tool for HIV Treatment and Prevention among a Sex Worker Collective in Nairobi, Kenya

Gathatwa James[1], Mathenge John[1], Kamau Mercy[2], Olawo Alice[3], Groot Anke[4]
[1]Health Options for Young Men on HIV, AIDS and STIs (HOYMAS), Nairobi, Kenya, [2]Jhpiego, Nairobi, Kenya, [3]Linkages, Nairobi, Kenya, [4]AIDS FONDS, Amsterdam, Netherlands

Issues: Male sex workers (MSWs) remain at highest risk for HIV in Kenya. Despite robust HIV prevention and treatment programs, MSWs in Nairobi face structural and social barriers preventing equitable access to health care. Stigma, combined with criminalization of sex work (a primary source of economic support), pushes this population to live in extreme poverty, resulting in diminished health outcomes. Created by MSWs in 2009, Health Options for Young Men on HIV/AIDS and STI (HOYMAS) works to address this gap. One issue that sets HOYMAS apart is its novel approach to economic empowerment.
Descriptions: Big Dreams is an Economic Empowerment Program (EEP) began by HOYMAS in 2015 to address the unique needs of the most vulnerable of MSWs. Many were HIV-positive, living on the street, struggling for food, and leaving antiretroviral treatment (ARV) adherence at a low priority. Substance and alcohol dependence was common and most sex work performed was survival-based, with little opportunity to improve economic situations. By humanizing their situation, peer educators (PE) and participants of Big Dreams were able to agree on key concepts for EEP: Ownership, Inclusivity, and Empowerment. From this place of mutual trust, the participants identified achievable economic, harm reduction, and wellness goals, arriving at a consensus for Empowerment Milestones. As a result, they were able to negotiate with clients for better pay leaving them better equipped to maintain supportive housing, adhere to medication, and improve nutrition.
Lessons learned: Through past initiatives with highly stigmatized populations, PE at HOYMAS knew it was critical to reach people at their level by working in hot spots and pubs frequented by MSWs. Today, Big Dreams has changed the economic future of more than 200 MSWs who had lost hope and given them a reason to dream again. Rates of ARV adherence has improved over 2018 and PrEP uptake for HIV negative MSWs has drastically improved. Most importantly, all have homes and are finally able to negotiate for better pay from clients.
Next steps: This approach of economic empowerment has managed to reach an otherwise inaccessible group of sex workers who avoided accessing services in mainstream clinics due to stigma and low self-esteem.

THPEE323

Contribution of the Free to Shine Campaign to Ending HIV and AIDS among Children in Rwanda

Rurangwa Amanda, Umutoni Sandrine, Kalisa Isabelle, Umutesi Geraldine, Hagenimana Felix, Vugayabagabo Jackson, Mukamurara Helene Rutamu, Kaneza Grace, Akimana Rachel
Imbuto Foundation, Kigali, Rwanda

Issues: Global new HIV infections have declined by 18% in the past 7 years, from 2.2 million in 2010 to 1.8 million in 2017. Although this is half the number of new infections compared to the peak in 1996 (3.4 million), the decline is not enough to reach the target of fewer than 500,000 by 2020. In Rwanda, the rate of Mother to Child transmission(MTCT) of HIV has dramatically reduced to 1.5% by 18 months post-partum.
In 2016, only 43% of HIV-exposed infants were tested within the first two months of life. Similarly, only 43% of the 2.1 million children living with HIV around the world received antiretroviral therapy (ART). Without timely treatment, mortality in children with HIV is very high. To contribute to ending HIV and AIDS in children as well as identifying the remaining 57% of children(1.2million) who are not on treatment, Imbuto Foundation (IF) through an initiative of the Organizations of African First Ladies against HIVand AIDS in Africa(OAFLA)" the Free to shine campaign", partnered with the Ministry of health, to conduct a screening of all children born from HIV positive parents
Descriptions: IF whose primary goal is to reduce mother to child transmission, contributed to this campaign by partnering with all health centers in Nyabihu district to screen all children born from HIV positive parents, and link them to treatment. This was done in 16 health facilities. The district had 4,181 clients on ART and pre-ART , and 1,632 clients reporting to have children aged between 0-19 years old. Data of screened children was collected from health centers and data were analyzed using SPSS.
Lessons learned: Before the screening, there was 779 children that were not previously tested. Among them, 212 were boys and 567 were girls. 412 children were tested during the screening campaign, 408 were tested negative and 4 positive. 1,333 children that were previously tested negative, were also screened again, and among them 1 child was found positive. All 5 children were linked to access treatment.
Next steps: This screening showed that despite the progress made in Rwanda, there is still a large number of children not tested because their parents are not yet comfortable with their HIV status. Parents should be sensitized and counselled to screen their children at an early age to prevent HIV transmission. IF will continue to encourage parents to screen their children and therefore contribute to the Rwandan 95-95-95 strategy to end the AIDS epidemic.

THPEE324

Livelihood Strengthening Activities: An Approach to Bolster the Livelihoods of PLHIV in Poverty-stricken Lesotho

Mokhethi Makhauta
World Food Programme, Maseru, Lesotho

Issues: Lesotho remain vulnerable to the HIV pandemic, with the second highest prevalence in the world at 25.6 percent among adults aged 15-59 years. Another development challenge is high levels of food insecurity with the most food-insecure households especially in the Southern districts headed by women, and people affected by HIV and AIDS, including children, particularly orphans and vulnerable children. Food insecurity has been found to be a critical barrier to adherence to antiretroviral therapy (ART) and retention in care among HIV and TB infected adults, HIV infected pregnant women and their HIV exposed infants. Addressing household food security as part of the AIDS response for vulnerable households hosting clients on antiretroviral treatment is key to increasing adherence to treatment and prevention from malnutrition.

Descriptions: The aim of the programme was to enhance the livelihoods of PLHIV on ART and their families for improved treatment uptake, adherence and retention in care in Mohale's Hoek and Leribe districts. To mitigate against the effects of the 2015/16 El Niño induced drought on PLHIV, WFP Lesotho partnered with local NGOs Thembalethu Development and Phelisanang Bophelong in the establishment of poultry and piggery farming, cash crops and vegetable production. The project supported 150 ART clients and their families. Voluntary Savings and Loans schemes were established with members contributing $14 to promote collective savings. The scheme helped ART clients build financial credence to access loans in big Savings and Credit Cooperative Societies amounting to $140 per person.

Lessons learned: Production of variety of vegetables resulted in improved dietary diversity among ART clients and their households. The generated cash improved client's livelihood and contributed to transport costs to access health services and other nutritious food especially during dry seasons contributing to improved adherence to treatment and nutrition outcomes at household level. The project helped improved household income from 15% to 162%.

Next steps: The success of livelihood strengthening initiatives rely on constant follow-up and solid relationship with multi-sectoral partners including communities. In the absence of social protection policies that put the vulnerable at heart, especially PLHIV, strengthening household food security of PLHIV as part of the AIDS response is key in building resilience at household level

THPEE325

Leaving No One Behind-ENDING AIDS by 2030 in HIV Sensitive Social Protection Programming for Adolescents Living with HIV in Zimbabwe

Sirewu Caroline[1], Senzanje Beula[2], Pierotti Chiara[2]
[1]National AIDS Control Council, Programmes, Harare, Zimbabwe, [2]UNICEF, Harrare, Zimbabwe

Background: Over a million of HIV positive clients in the country including children and adolescents have been put on life saving ARVs. While set targets for retention in care are progressing positively in adults. The HIV Sensitive Social protection programme implemented in 23 districts since 2018 by National AIDS Council (NAC) focused on integrating social and child protection issues within the HIV programme and vice versa to increase services' access and retention in care by adolescents and children living with HIV (ACLHIV)
Methods: Project's beneficiaries are ACLHIV aged between 5 and 24 years. Activities conducted are1. Monthly Support group meetings for at least 20 ACLHIV in each of the 23 districts
2. Quarterly orientation meetings for caregivers of ACLHIV, local teachers, MOPSLSW Case Care Workers and Village Health Workers
3. Quarterly district and biannual national multi stakeholder meetings for HIV and social and child protection implementers
4. Cultivated referral pathways for both HIV, social and child protection problems of ACLHIV
Results: The following outcomes for the ACLHIV were realized through programming
ACLHIV effectively access HIV Sensitive Social Protection programme interventions through multiple stakeholders with over 85% reported problems in ACLHIV resolved
Conclusions and Recommendations: HIV Sensitive Social protection programmes are an effective strategy in care for ACLHIV as they directly impact positively on retention in care & should be replicated

THPEE326

Retention in Care, a Thematic Analysis of Healthcare Workers in Facilities in Abuja, Nigeria

Taofeek Adeleye, Stella Achebe, Oligbi Suprena, Nwabueze Emmanuel, Ijezie Echey
AIDS Healthcare Foundation, Abuja, Nigeria

Issues: HIV treatment facilities continuously records increasingly high number of defaulters in care, which is one of the contributors to unsuppressed viral load and treatment failures. This study examines the effect healthcare worker´s attitude on retention of HIV-Infected patients in care at treatment facilities in Abuja, Nigeria.
Descriptions: Increasing ART defaulters draws back efforts geared towards ending AIDS as a public health disease. This study employed purposive and stratified sampling techniques to get representative samples of ART defaulters drawn from both public and private facilities. Data were collected using in depth interviews and structured questionnaires and presented on tables in line with research objectives. Data coding and management was highly standardized to ensure quality results were obtained. Thematic analysis was used to reveal patterns across data set and findings were presented sequentially and logically to aid conclusion.
Lesson learned: Out of 547 ART defaulters in the treatment facilities. Data showed 69% of the respondents reported poor service delivery by half of the health workers. 72% reported an elongated waiting time caused by sluggishness of almost one third of the healthcare workers. It shows that healthcare worker´s attitudes significantly contribute to the increasing number of ART defaulters/loss to follow-up.
Next steps: It is recommended that the assessment of inherent qualities of healthcare workers to passionately deliver smart quality HIV/AIDS services be made paramount during recruitment rather than only academic qualifications and experiences, while supportive supervision and mentoring should be intensified.

THPEE327

HIV Prevention: Increasing Involvement in HIV Prevention among Bisexual Sex Networks in Uganda

Muyunga-Mukasa Tom
Center For Democratization, Governance, Justice Health & Policy Africa (DGJHAPA), San Francisco, United States

Background: Economic status influences health seeking practices. We tested the extent combination prevention including: comprehensiveness; appropriateness; and applicability could be used among 142 bisexual persons who were economically sound: earned UGX. 500.000.00 ($150.00).
Methods: We identified and disaggregated the beneficiaries to ascertain the environment that influences their practices. We then mapped and identified health facilities they accessed where SRHR/HIV prevention, HIV testing and treatment was provided without user fees. Primary prevention response composed of biomedical, behavioral and structural services closely linked to treatment. We then used Exit key Service User Informant Interviews.
Results: We followed 142 bisexual aged 18-42 years (38 females: 104 males) between 2013-2017. They were provided with trainings in life planning skills and comprehensive sexuality education; addressing harmful masculinity, gender norms and gender-based violence; skills in information and demand generation for HIV prevention; and were trained to demand for sexual and reproductive health services including addressing their wider sexual and reproductive needs. 43 were Boda-boda taxi operators, 10 were foods chefs (4 females: 6 males), 22 were skilled hairdressers (15 females: 7 males), 10 were Uber drivers (3 females: 7 males), 57 worked in the services industry (16 females:41 males). 70 were self-confessed male sex-workers, were trained as designated safer sex promoters; 27 self reported using condoms in the last 2 months for every sexual encounter; and 32 females self reported having multiple partners and used protective dams in all encounters. 73 had tested negative in the past month (35 females: 38 males). 20 candidates were successfully circumcised (VMMC); 120 had HPV immunization (38 females: 82 males).
Conclusions and Recommendations: Targeted service provision including economic improvement makes it easier to address medical needs. These are more manageable and disaggregation enables one to identify vulnerabilities hence ensure risk reduction. Further research into what motivates, demotivates or constitutes barriers faced by beneficiaries in engaging in life preserving practices will influence optimal health outcomes.

THPEE328

Can Key-population Led Community Based Monitoring Contribute to Better Strategic Planning at National Level? The Youth Community Accountability Project (Y-CAP)

Bussmann Sarah[1], Malambo Sibu[2], Bodal Huzeifa[1], Hermanns Sophie[3]
[1]Gesellschaft für Internationale Zusammenarbeit (GIZ), Bonn, Germany, [2]The Zambian Youth Platform, Choma, Zambia, [3]Gesellschaft für Internationale Zusammenarbeit (GIZ), Eschborn, Germany

Issues: The centralized control over service delivery coupled with unclear accountability relationships have been identified as important determinants of poor quality health services in developing countries. CBM leverages user experiences to provide feedback to service providers and increase their accountability. This could be a cost-effective instrument to improve the quality of health services and outcomes through two modes of action:
<ol style="list-style-type: decimal; direction: ltr;">
- The established community ownership increases engagement and consequently better health outcomes
- Service providers become open to public scrutiny and can act more responsively, due to shorter feedback loops

In order to assess the effectiveness of CBM on health outcomes and service delivery in developing countries, we conducted a systematic review and identified the following critical determinants for successful CBM:
<ol style="list-style-type: decimal; direction: ltr;">
- CBM as continous process
- Link to governing bodies to ensure leverage for implementation
- Representation of disadvantaged communities
- Community involvement in the entire process

Descriptions: The Y-CAP was designed based on these determinants and is being implemented in two districts in Zambia. The context in Zambia is representative for countries with a high HIV burden, due to significant gender and age related disparities. AGYW have been defined as a key population in the funding request to the Global Fund to Fights AIDS, TB and Malaria (GFATM), yet the shaping of GFATM programs lack meaningful engagement of adolescents. The objective of the project, which received TA from GIZ, is to build capacity of young people, to monitor grant implementation by means of an Accountability Framework, which generates quantitative and qualitative data in a participatory manner, for all GFATM supported programs in the two districts.

Lessons learned: The Y-CAP is a powerful approach to CBM, as it puts a key population group in charge of the accountability system. The idea is to develop a partnership between young people and the MoH to combine efforts on program review.
The data that, which will be available for presentation complements the global indicators that account for number of people treated and tested, but do not consider perceived service quality.

Next steps: The project will be rolled out over all districts and should form an integral part of informing the CCM as MoH-affiliated national governing structure in the future, to shape programmatic planning of key health investments.

THPEE329

Transfert des Tâches aux Médiateurs de Santé pour un Meilleur Accès aux Services Liés au VIH/SIDA, Expérience de l'Association Nationale de Soutien aux Séropositifs et Malades du Sida au Burundi

Ruvari Sandrine[1,2], Rwimo Patricia[1,2], Kabugubugu Martine[1,2], Umugabekazi Marie-Thérèse[1,2], Sabushimike Janvière[1,2], Kabura Séverienne[1,2], Niragira Sylvain Pagnol[1,2]
[1]Association Nationale de Soutien aux Séropositifs et Malades du Sida (ANSS), Bujumbura, Burundi, [2]Laboratoire de Recherche Communautaire, Coalition PLUS, Pantin, France

Questions: Les nouvelles infections au VIH ont diminué de 55% depuis 2010 au Burundi, pays de l'Afrique de l'Est à faible revenu, notamment grâce au travail effectué par les associations de lutte contre le sida. Dans un contexte de manque de personnels de santé, dès les premiers cas de VIH, des bénévoles, disponibles, motivés se sont engagés pour soutenir les programmes de prévention, de conseils et de dépistage au sein de l'Association National de Soutien aux Séropositifs et Malades du Sida (ANSS). Afin de pérenniser leurs actions et leurs impacts positifs sur le continuum de soins des personnes vivant avec le VIH (PVVIH), l'ANSS s'est engagée dans un processus de valorisation institutionnelle de leurs fonctions.
Description: Depuis 2004, des Médiateurs De Santé « MDS » ont été formés à la prise en charge global du VIH/SIDA pour faire partie intégrante des personnels de santé. L'ANSS a procédé en 2014 à la délégation de tâches aux 23 MDS qui œuvrent en consultation médicale et différentes pharmacies, s'occupent de la référence et contre-référence, animent des groupes de parole sur les thèmes variés, mobilisent les représentants des communes et les pairs-navigateurs pour renforcer la participation des personnes concernées et luttent pour l'appropriation et une ferme responsabilisation de la communauté. Chaque MDS suit entre 100 et 125 patients de la file active totale. De plus, les services de soins VIH se sont coordonnés avec les autres services : prévention de la transmission mère-enfant, dépistage du cancer du col utérin et la stratégie d'indexation.
Leçons apprises: La délégation des tâches à des professionnels non médicaux est faisable et a un impact positif sur la prise en charge des PVVIH, notamment pour les pays en route vers la fin de l'épidémie VIH. Cependant, sans financements nationaux pérennisés pour soutenir ces initiatives, leurs bénéfices sur la vie des personnes concernées seront remis en cause.
Prochaines étapes: Avec son accroissement programmatique, la supervision de l'ANSS ajuste le modèle de prestation par la responsabilisation et l'engagement de la communauté pour mieux progresser vers les objectifs.

THPEE330

Making Civil Society's Contributions in the Fight against HIV Visible with Data in Angola

Francisco Alberto[1], Pinheiro Steven[1], Pinto Laurinda[2], Tulomba Daniel[3], Joaquim Florentino[4], Cristino Giuseppe[5], Cardao Joana[6], Cotrina Armando[6]

[1]Management Sciences for Health (MSH), LINKAGES Project, Maianga, Angola, [2]MWENHO, Luanda, Angola, [3]ASCAM, Luanda, Angola, [4]Cuidados da Infancia, Luanda, Angola, [5]Management Sciences for Health (MSH), Maianga, Angola, [6]USAID, Angola, Luanda, Angola

Issues: Historically in Angola, civil society has been regarded as weak and unable to track nor report accurately on their contributions to HIV prevention, testing, care and treatment. This in turn makes the vulnerable populations they serve invisible.

Descriptions: The LINKAGES project in Angola worked from 2015 to 2019 with 9 civil society partners and 3 key population groups to build a health information system that would track individuals, as opposed to cumulative information, and create a culture of data use within civil society organizations at all levels, ensuring that staff would understand and act upon the data coming in. Additionally, the project promoted a culture of data sharing and discussion among partners.

Lessons learned: Today, the community health information system built holds service records for 59,528 key populations in 3 provinces of Angola and can be used to show the contribution to these services overtime by organization. The system also makes it possible to make key population sub groups (older men who have sex with men for example) not invisible anymore. The system also makes possible to show how 3 civil society organizations in Luanda province were able to contribute 43%, 31% and 17% of the total patients initiated in ART at the largest government health facilities in the capital province.

Next steps: By building an individualized, unique patient-tracking health information system and encouraging a culture of data use and sharing among civil society partners, international projects can contribute to national advocacy efforts, around data transparency, accountability and ensuring that local civil society efforts do not go unnoticed, that the contribution of CSOs to national targets and commitments is recognized and valued.

THPEE331

Use of WhatsApp Technology as a Platform for Improving Timeliness of Data Reporting in a Hard-to-Reach Rural Riverine Health Facilities in South-South Nigeria

Onyedinachi Okezie[1], Odutuga George[1], Atori Costa[2], Daniel Henry[2], Ekanem Stephen[2], Eyo Andy[3], Awa Nneoma[1], Nnaji Chisom[1]

[1]Excellence Community Education Welfare Scheme (ECEWS), Clinical Services Unit, Abuja, Nigeria,
[2]Excellence Community Education Welfare Scheme (ECEWS), Clinical Services Unit, Yenogoa, Nigeria,
[3]Excellence Community Education Welfare Scheme (ECEWS), Clinical Services Unit, Uyo, Nigeria

Background: Excellence Community Education Welfare Scheme (ECEWS) supports 55 health facilities in Bayelsa State, South-South Nigeria to provide HIV Prevention, care and treatment intervention with funding from the Global Fund (GF). Of the 55health facilities, 17 are located in a hard to reach/riverine community. One of the core monitoring and evaluation deliverable of the project is "**To ensure timeliness in validated data reporting on a monthly basis."**
Adopting effectively the National Guideline on HIV for collection of routine monitoring and evaluation data through the local government area (LGA) M&E officials from the facility has been adversely affected by difficulty in accessing the hard to reach/riverine areas. This has continuously caused delay in complete submission of monthly monitoring and evaluation program data.
Methods: ECEWS built capacity of 28 Data Entry Clerks (DECs)/Adhoc Staff supporting monitoring and evaluation activities at the 14 Global Fund HIV Comprehensive care and treatment sites through a 3day on site orientation on the use of WhatsApp technology in collation and reporting data and cluster the other facilities including the riverine facilities to ensure timeliness of data reporting. On monthly basis, each Data Entry Clerk will snap and upload data summaries alongside their key source documentations from Hub and spoke facilities for validation by different staff. With this system in place, the long process of moving across the supported health facilities including the hard to reach/riverine areas to get hard copies of data from facilities is effectively bypassed while ensuring timeliness and data quality issues are resolved real time; through continuous group mentoring.
Results: Retrospective analysis of the monitoring and evaluation monthly data reporting shows that from April 2017 - May, 2018, the ECEWS team struggled with inconsistency in data completeness and timeliness; with the reporting rate stagnated at 55-65% as against the set timeliness target of 90%. The output of this innovation has significantly improved reporting rate from 72% in June 2018, 76% in July and 100% in August 2018 till date.
Conclusion: Building capacity of DECs at Global Fund supported HIV comprehensive care and treatment sites on the use of WhatsApp platform in the areas of data collection reporting and validation has helped to improve not only timeliness but also completeness of monitoring and evaluation monthly data.

THPEE332

Contribution de l'Observatoire Communautaire sur le Traitement dans le Suivi des Résultats de l'Examen de Charge Virale en Vue de l´Atteinte du Troisième 90 en Côte d'Ivoire

Keipo Valentin

Réseau Ivoirien des Organisations de Personnes Vivant Avec le VIH (RIP+), Suivi Évaluation, Abidjan, Côte d'Ivoire

Questions: L'examen de la charge virale recommandé par l'OMS pour le suivi des patients VIH, est relativement récent dans la gamme de services offerts aux PVVIH en côte d'ivoire. En effet, il existe 17 laboratoires sur le plan national pour 250.000 PVVIH estimés . Soit un ratio de 1 laboratoire pour 14706 patients et moins d'un laboratoire pour une région sanitaire. Dans un tel contexte, le Réseau Ivoirien des organisations de personnes vivant avec le VIH à travers l'observatoire communautaire sur le traitement initié par ITPC et financé par le Fonds Mondial, s'est donné pour tâche le suivi des résultats des tests de la charge virale:
Description: l´Objectif de cette activité de suivi est d´améliorer le délai de rendu résultats du test de la charge virale en vue de contribuer à l´atteinte du troisième 90 en Côte d'Ivoire. Pour ce faire, l'observatoire a suivi la disponibilité des résultats de tests de la charge virale d'avril à septembre 2018 sur 27 sites sanitaires représentant 35.000 patients sous traitement soit, 15% de la file active nationale dans 5 régions sanitaires à forte prévalence du VIH. ce suivi a permis de réaliser que 13,37% des résultats étaient disponibles en 14 jours et 83% des résultats dans une moyenne de 55 jours du à certains dysfonctionnements dans le système de prélèvements des échantillons de sang, des laboratoires et du circuit de transmission des résultats.
Leçons Apprises: Le suivi de routine du délai de rendu des résultats de l´examen de la charge virale a permis de relever conséquemment les goulots d´étranglement du système en lien avec l´examen de la charge virale afin de les corriger.
Prochaines Étapes: Ces résultats permettront à l´observatoire et aux acteurs communautaires de mettre en oeuvre des activités de plaidoyer en faveur de l´amélioration des délais de rendu de résultats des tests, par le renforcement des équipements et des services de convoyage des échantillons et des résultats de la charge virale au niveau national.

THPEE333

HIV Mother to Child Data Quality Assement in Cameroon

Youm Eric[1], Anoubissi Jean De Dieu[2,3]
[1]Elizabeth Glaser Pediatric AIDS Foundation, Bastos, Cameroon, [2]National Aids Control Council Comittee, Yaoundé, Cameroon, [3]National Aids Control Comittee, Yaoundé, Cameroon

Background: In order to eliminate MTCT mother-to-child transmission of HIV, the management program has implemented strategies based on routine data. The quality of the interventions adopted depends on the quality of the data collected. The aims of this study was to evaluate the quality of data produced in the context of vertical transmission of HIV in Cameroon West region
Methods: The study was conducted in December 2018 in five high - burden health facilities in terms of pregnant women receiving prenatal consultations during the year. The evaluation focused on the records of prenatal consultation, delivery room of postnatal (mother and child), laboratory and records of children born to HIV positive mothers and plugs monthly statistical summaries of in the field of MTCT. The operational approach consisted in building a quality index based on the availability of the collection tools, the completeness of the data, the coherence in the data, the triangulation and the accuracy of the data transmitted .The score was considered low when it was below 50% average when it was between 50% - 80% and high otherwise. These different data quality elements were put together in a tool designed from Microsoft Excel.
Results: The overall data quality score for the region was medium because it was rated at 63.5 % and varied between 79.3 % and 65 % according to health facilities. Data availability was assessed at 95.8 %, completeness to 79.6 % , consistency at 73.3% while data recount and triangulation of data were 28.2% and 63.5%, respectively. All health facilities had the same weight in the analysis.
Conclusions and Recommendations: The results suggest the need for capacity of the various actors on the filling of collection tools and training on the quality of data in order to limit errors in the recount.

THPEE334

Enhancing Retention Monitoring of Clients on ART through Use of Customized Data Capture Tools for Follow up: A TASO Rukungiri M&E Strategy

Bibohere Jacob, Borobya Beingana Ambrose, Nuwamanya Nicholas, Kateeba Tusiime Agnes
Makerere University, Kampala, Uganda

Issues: Monitoring of retention for clients on ART is a crucial indicator towards achievement of UNAIDS 95-95-95 fast track targets. Clients enrolled on ART are periodically monitored in cohorts to ascertain the retention, lost to follow up rate and mortality rate. High rates of clients lost on ART and missing appointments greatly hinders effective realization of treatment outcomes. It is also associated with poor adherence and also affects viral load coverage and suppression.TASO Rukungiri in a bid to improve retention and sustain clients on ART addressed the challenge through designing a customized client follow up form to track outcomes of clients who miss appointments and those lost on ART.
Descriptions: A client follow up form was designed to document follow up attempts and track outcomes of clients who miss appointments and those lost on ART.A list of missed appointment clients is periodically generated by the M&E officer and clients files are retrieved. The form captures the clients current phone contact, service delivery model, date of three follow up attempts,outcomes and findings of the follow up such as client transferred to another health facility, relocated from the area and others (comments). The form also provides options for documenting plans made by the counselor after a follow up which include making another attempt for clients who couldn't be traced on the first attempt and initiating a physical follow up(home visit). These outcomes are captured for each follow up attempt done and presented for entry into a designed electronic data capture screen by the data clerk.
Results from the analysis form a basis for updating of client information in cases such as a transfer or death and measuring progress on retention
Lessons learned: For the Period Oct-Dec 2018,240 lost clients were followed up and their outcomes captured using the client follow up form. At the end of the Jan-March 2019, 89 clients were returned to care and 151 clients had a documented outcome of at least one follow up attempt.103 clients previously lost to follow were tracked and returned into care at the end of Jan-Mar 2019 period. This led to an increase in active clientele from 7068 in Oct-Dec 2018 to 7096 at the end of the Jan-Mar 2019 reporting period
Next steps: The customized client follow up form and data entry screen has greatly improved documentation of follow up outcomes and is effective in tracking lost clients to improve retention rates for clients on ART

THPEE335

Application of Mobile Data Collection Tool in Multi-center Survey of HIV/AIDs Patients Lost to Follow-up in Nigeria

Ejimkaraonye Evans[1], Kene Terfa[1], Morka Mercy[2], Ude Nancy[1]
[1]Achieving Health Nigeria Initiative (Affiliate of FHI 360), Monitoring and Evaluation, Abuja, Nigeria,
[2]Academic Model Providing Access to Health Care- AMPATH, Monitoring and Evaluation, Abuja, Nigeria

Issues: The complexity of survey data collection increases with the number of respondents and questions and complexity of the questions especially when carried out in multiple locations. For an efficient and quality data collection for surveys, the collection process must be accurate, flexible, cost-effective, and timely.

Mobile data collection tools have been shown to improve the speed, accuracy and flexibility of data collection, while also reducing the cost.

Descriptions: A mobile data collection technique was used to collect data from patients who defaulted from their medication in 22 health facilities across 11 states and the Federal Capital Territory in Nigeria, using a total of 96 interviewers (8 per state) for 10 days. The questionnaire containing 38 questions was coded to a mobile form and loaded on mobile Android tablets. The form was built with validation settings such as skip logics, mandatory questions and GPS tracker.

A pilot was done, the form reviewed, and the interviewers were trained on how to navigate the application before final deployment. Data collected was uploaded to a central server, which was reviewed, and feedback provided to the field team daily.

Lessons learned: The use of a mobile data collection technique improved the collection process in many aspects. Questions that were irrelevant to some respondents due to their response to previous questions were completely avoided with the use of skip logic which reduced the difficulty in navigating through the questions, increasing the speed and accuracy.

The method also enhanced flexibility as data from all locations were immediately available to the survey supervisor for review and errors noted were communicated to the interviewers for review and correction.

A total of 4977 patients were interviewed within the 10 days of the study, and the data was downloaded the following day and was ready for analysis.

Next steps: The use of mobile data collection technique is more efficient in large-scale multi-center surveys than the traditional paper collection system so organizations should provide opportunity for staff to acquire these skills for efficient use of resources.

THPEE336

Monitoring the Transition to New Antiretroviral Treatment Regimens through an Enhanced Data System in Kenya

Lahuerta Maria[1,2], Syowai Maureen[1], Vakil Shobha[1], Odhiambo Jacob[3], Gitonga Mwenda[3], Sugandhi Nandita[1], Odhiambo Stanslaus[1], Kimani Maureen[4], Wamicwe Joyce[4], Batuka James[5], Imbuki Evans[4], Bartilol Kigen[4], Abrams Elaine J.[1,6]

[1]ICAP at Columbia University, New York, United States, [2]Mailman School of Public Health, Columbia University, Department of Epidemiology, New York, United States, [3]Palladium Kenya, Nairobi, Kenya, [4]National AIDS and STI Control Programme (NASCOP), Nairobi, Kenya, [5]United States Agency for International Development (USAID) Kenya, Nairobi, Kenya, [6]Vagelos College of Physicians & Surgeons, Columbia University, Department of Pediatrics, New York, United States

Issues: While the scale-up of HIV services has improved national health management information systems (HMIS), there are still challenges in using routine data to guide the introduction of optimized antiretroviral (ARV) drugs. In 2017, the Kenya National AIDS & STI Control Program (NASCOP) introduced an optimized antiretroviral treatment (ART) regimen, tenofovir (TDF) + lamivudine (3TC) + dolutegravir (DTG) [TLD], which presented an opportunity to document the safety and efficacy of TLD outside a research setting.

Descriptions: Building on the recent enhancements to the HMIS in Kenya and coinciding with the introduction of TLD, we developed and implemented an enhanced data system (EDS) to improve availability of safety and efficacy data among people living with HIV (PLHIV) in Kenya. Using data from one health facility, we showcase how the EDS can be used to monitor ARV transition and identify missed opportunities to transition eligible patients to optimized regimes.

Lessons learned: Four health facilities were prioritized for development and implementation of the EDS in 2018. An adverse event (AE) screening form was developed and integrated into the electronic medical record (EMR) to institute an active approach to toxicity monitoring among PLHIV. An interoperability layer was created to link clinical data from the EMRs, including AE data, with ART dispensing from the ART dispensing database at the pharmacy and viral load (VL) results from VL database. Given the lack of unique patient identifiers, a master person index was developed to link the individual records across all three systems. On a monthly basis, the database is de-identified and uploaded into a national data warehouse, with interactive dashboards. Using the EDS at one facility, we determined that of the 5,500 PLHIV ≥15 years on first-line ART, 4,233 (77%) had transitioned to optimized ARVs. Of the 1,267 still on legacy regimens, 459 (36%) were determined to be eligible and prioritized to switch.

Next steps: This project illustrates how enhancements to the national HMIS can facilitate the use of routine patient-level data to monitor the transition to new ARVs and inform the national HIV response. The facility data presented in this manuscript highlight the progress made to date at rapidly transitioning PLHIV to optimized ARVs in Kenya, a country that has been at the forefront of global optimization efforts.

THPEE337

Tableau to Improve HIV Testing and Coverage and Yield in Tanzania

Verity Jaclyn[1], Steiner Claire[1], Senyana Brenda[1], Maruyama Haruka[2], Franks Julie[1], Anyoti Vanessa[3], Laki Damian[3], Lahuerta Maria[1,4]

[1]Columbia University's Mailman School of Public Health, ICAP, New York, United States, [2]Columbia University, ICAP, Maseru, Lesotho, [3]Columbia University, ICAP, Dar es Salaam, Tanzania, United Republic of, [4]Columbia University's Mailman School of Public Health, Epidemiology, New York, United States

Issues: Undiagnosed HIV infection drives HIV transmission. Targeting HIV testing services (HTS) to localities where transmission is ongoing is crucial to reach epidemic control. Given limited resources, programs need to analyze and visualize data to rapidly optimize the implementation strategy to the regions in need.

Descriptions: ICAP in Tanzania´s FIKIA project provides community-based HTS to identify new HIV cases and initiated on ART. The team uses digital mapping to update, monitor, and share project inputs and outcomes from different regions on a monthly basis, intensifying efforts in areas with elevated yield of HIV-positive cases and ensuring that HTS and ART coverage in all regions progresses as planned. The digital maps were developed as data visualization dashboards through Tableau, an advanced business informatics and analytics platform. The dashboards provide an easily accessible centralized platform for collaboration within and across teams.

Lessons learned: Programs can efficiently identify patterns of testing outcomes and communicate updated strategy to field teams, directing resources to areas with high yield and using HIV treatment coverage trends and population and geographic distribution to monitor and address low coverage. Field teams can also see their work improving over time, link diversified approaches to results, strengthen both coverage and yield of HTS, and ART initiation. Tableau facilitates visualization of service implementation and outcomes, allowing for dynamic adjustments to respond to challenges and meet targets. Tableau allows to harmonize and systematize data visualization across different technical areas and regions. Future updates will move towards real-time review of data, to further reduce the time from data collection to visualisation.

Next steps: As staff proficiency in Tableau is strengthened, real-time data visualization becomes a versatile and powerful tool for program monitoring and improvement. ICAP in Tanzania will incorporate additional data elements to enrich mapping and use the technology to understand how beneficiaries interact with FIKIA services. In light of limited funding, this project highlights how data visualization dashboards can be used to optimize resources, target interventions to geographic needs, increase identification of HIV undiagnosed cases and improve ART coverage, areas of need, which will be crucial for HIV epidemic control.

Keywords: Tanzania, Mapping, Community Testing, Data Visualization

THPEE338

Monitoring Implementation Pace and Quality of Differentiated Services at Scale in Zambia

Mukumbwa-Mwenechanya Mpande, Mulenga Helen Bwalya, Mubiana Muhau, Liyembele Chitalu, Lumpa Mwansa, Somwe Paul, Wa Mwanza Mwanza, Sharma Anjali, Bolton-Moore Carolyn
Centre for Infectious Disease Research in Zambia, Lusaka, Zambia

Introduction: Zambia is scaling up Differentiated Service Delivery (DSD) for all people living with HIV in order to achieve the UNAIDS 90-90-90 targets.[1]DSD model scale up necessitates changes to health systems and challenges the monitoring of services. In the absence of a national framework, we aimed to monitor pace, uptake, outcomes of 2 DSD models and promote comparisons across facilities and provinces using simple and easy indicators.
Methods: We implemented 2 DSD modelsin medium-high ART patient load (>1000) clinics in 3 Provinces. These were 1) Individual facility-based Fast Track model (accelerated ART pickup every 3 months) and 2)individual community-based Health Post model (accelerated ART pickup every 3 months at a Community Health Facility within 2 km walk from patient residence). Models were offered toeligible stable patients (HIV+, on ART > 6 months, not acutely ill, CD4 >200/µl).We developed a model register to capture enrolment and monitor the pace and uptake of DSD. We relied on the existing electronic medical records (EMR) to ascertain the proportion of health facilities (HF) eligible to offer DSD, proportion of HF offering the models, the proportion of patients eligible for the models, and on the register to determine the proportion of eligible patient's enrolled in DSD and proportion of enrolled patients who are retained (defined as drug collection within 7 days of appointment).
Results: From August 2017-2018, 47 facilities met eligibility criteria for model implementation. During this period, 26 (55.3%) had adopted at least one model, mostly from Lusaka (19/73.1%) followed by Western (5/19.2%) and Eastern (2/7.7%). Across the 26 facilities, a total of 126,406(73.3%) patients were determined as eligible of these 33,362(26.4%) patients were enrolled into the models. Lusaka enrolled 31,624 (94.8%), Eastern 704 (2.1%) and Western 1,034 (3. 1%).Timely drug pick up ranged between 70% - 98% with heterogeneity across facilities and provinces.
Conclusion: Paper-based data collection was useful for tracking pace of scale up whilst monitoring the second 90 and to determine further resource allocation and technical support. As scale up of DSD models continues, electronic data recording and reporting should be prioritized in order to have robust information on performance and progress to the global treatment goals.
[1]Consolidated HIV/AIDS Guidelines 2018

THPEE339

Technologie Mobile et Qualité des Données d'un Programme de Santé : Expérience du Projet REVE

Kanon Wakiri Stephane, Boli Jules Renaud Henri, Noba Valentin, Semde Abla Gisele
Save the Children, REVE Project, Abidjan, Côte d'Ivoire

Issues: La qualité de l'information appréciée par l'exactitude, la complétude, la cohérence, la conformité, la duplication et l'intégrité demeure un défi de nombreux programmes de santé. Le projet communautaire « Ressources pour l'Elimination de la Vulnérabilité des Enfants » (REVE) financé par USAID, en Côte d'Ivoire depuis 2015, dans 22 districts sanitaires en partenariat avec 18 organisations de la société civile (OSC) et servant près de 80000 bénéficiaires chaque année, a très vite été confronté au défi de la qualité de l'information avec une base de données partiellement à jour, l'accès à l'information non accessible à tous, et l'analyse des données quasi impossible en temps réel. Ces défis ont conduit depuis fin 2017 à la réflexion et la mise en place d'un système innovant de collecte et de rapportage des données en temps réel via une application mobile gratuite.
Descriptions: En vue de réduire la vulnérabilité au VIH des PVVIH, OEV, et adolescentes, REVE, sous la responsabilité département de l'information stratégique, a entamé une révision de son système d'information avec (1) la redéfinition du rôle des acteurs de première ligne, les conseillers communautaires (CC), assurant une permanence hebdomadaire, au siège de leur OSC, durant laquelle le CC et le superviseur communautaire passent en revue les activités menées la semaine écoulée, vérifient puis valident les outils de collecte renseignés par le CC; (2) la conception d'une application mobile de collecte de données sur un support gratuit, offrant une sécurisation des données via mot de passe, un suivi en temps réel de la saisie par les CC des outils papiers validés, la possibilité de saisir en Offline, puis de soumettre ces données en Online.
Lessons learned: A juin 2019, les données des 83522 bénéficiaires et 13210 ménages identifiés par les CC, sont saisies à 100%, et sont accessibles en temps réel par l'équipe de direction du projet, via la plateforme mobile du projet à l'aide des paramètres administrateurs permettant une prise de décision rapide pour une meilleure performance du programme.
Next steps: En s'appuyant sur la technologie mobile, peu coûteuse, REVE dispose aujourd'hui d'informations de qualité, contribuant ainsi à l'amélioration de ses performances. Cependant, l'engagement et le coaching serré des CC est capital pour garder le cap.
Kay words: Technologie - mobile- collecte- données - qualité

THPEE340

Optimizing Linkage to HIV Treatment through Improved Utilization of Data Tools for Decision Making in North West Nigeria

Etsetowaghan Andrew[1], Onyealisi Kelechi[1], Omoluabi Anddy[1], Suleiman Ibrahim[1], Mairiga Felicia[1], Ogundehin Dolapo[2], Ezekiel James[2]
[1]Management Sciences for Health (MSH), Abuja, Nigeria, [2]USAID Nigeria, Abuja, Nigeria

Issues: Following the full adoption of the test and treat strategy in Nigeria in 2016, the goal of reaching the UNAID 90: 90: 90 target by 2020 remains ever more achievable. One of the key challenges remains linkage to treatment with specific focus in ensuring 90% of identified positive clients are commenced on ART. The abstract reviews the role and impact of improved utilization of data tools for decision making in improving linkage to ART
Descriptions: The USAID-funded CaTSS project implemented by MSH conducted developed in March 2018 billboard, a simple cost-effective, easy to use excel based interactive tool with slicers for granular facility level data analysis and performance measurements. This tool was deployed at National and sub national level to key stakeholders for monitoring of key indicators, performance reviews and data analysis. Following the roll-out of this tool program managers were able to promptly identify the sites contributing to the gaps in linkage by facility type and client demographics. The tool helped to demonstrate a trend that showed over 60 % of the linkage gaps were from non-pregnant HIV positive client identified at PMTCT only site who were initially referred to other comprehensive sites for ART
Lessons learned: The data from the tool provided evidence for developing a family centered centralize approach , where non pregnant client identified at these sites were provided with HIV service directly or actively referred to complete comprehensive site resulting in over 70 % improvement in linkage rates in target facilities.
Next steps: The introduction of simple cost-effective data analytical tools provide a platform for improving service delivery providing program managers with vital information for strategic decision-making. This tool is excel based and can be easily replicated for use by program manager in resource limited setting for program monitoring in reaching epidemic control.

THPEE341

Mobile Technology Enabling Monitoring & Strengthening of Sexual Reproductive Health (SRH) Services: The Case of MobiSAfAIDS

Ngwerume Percy[1], Garanganga Alaric[1], Chomba Chrispin[2], Rusike Chido Kelly Saruh[1]
[1]SAfAIDS, Harare, Zimbabwe, [2]SAfAIDS, Lusaka, Zambia

The abstract presents lessons on integration of mobile technology in monitoring & strengthening Sexual & Reproductive Health (SRH) services. Evidence is drawn from the MobiSAfAIDS application, which was developed by SAfAIDS in partnership with Rhodes University. It is being piloted in 6 SADC countries. SAfAIDS through the Transforming Lives programme seeks to strengthen capacity of youth organisations and networks in Social Accountability Monitoring (SAM) of youth-friendly SRH information and services in southern Africa. This is being done through piloting SAM of young people's SRH services in 6 intervention sites.

The MobiSAfAIDS web and mobile application was developed for young people to monitor provision of SRH services at local health facilities and demand accountability from the state in improving delivery of such services. Services being monitored include SGBV, Contraceptives, HTS, information and counselling. MobiSAfAIDS provides two way communications between young people and health service providers. After young people access SRH services at the health facility they can log in to the app to report service delivery challenges, presented as a ticket. The ticket is assigned to a service provider through a facility administrator, who resolves the challenge and changes the ticket status to resolved. The young person who opened the ticket can close the ticket when satisfied that reported issue has been resolved. If not, he/she can unresolve the ticket.

The use of MobiSAfAIDS has increased interaction between health service providers and young people, who remain anonymous. Of importance is the presence of a feedback mechanism promoting the uptake of quality SRH services. Over the period March - June 2019, 2779 young people registered on the platform; 836 SRH issues were raised and 163 of these were closed The data is also further validated through community score cards, community interface meetings and other advocacy platforms to inform policy shifts. Data generated is then packaged for policy advocacy.

Acceptability of technology integration is not universal as there is resistance in using the app by health staff who fear that it is a policing tool. In resource limited settings there is limited mobile network coverage and access to phones.

Continuous documentation of the pilot process across all six sites to generate evidence on working models for integrating mobile technology in monitoring and strengthening delivery of SRH services by young people.

THPEE342

Using an Integrated Automated Fingerprint Identification System to Bridge the Gap between Treatment New and Treatment Retention through Patient Tracking

Daka Wanzi[1,2]
[1]USAID DISCOVER-Health, Lusaka, Zambia, [2]Texila American University, Lusaka, Zambia

Issues: One of the challenges countries are facing in the HIV care continuum is the ability to track patients across facilities. If a client decides to leave a health facility for another without a documented transfer, there isn't a dependable system in place that can detect a known positive client, which facility they began treatment from, what regime they are on or for how long they have been on treatment. Lack of a system that can capture patient movement across facilities has made it difficult to determine if retention outcomes observed at the facility level are an accurate representation on the national level.
Descriptions: As Anti-retroviral Therapy (ART) services continue to scale-up, patients have more choices on where to access treatment convenient to their situations, whether for reasons of anonymity, migration or perceived quality of service It is difficult to track patients across sites when formal transfers are unavailable. With this gap in the HIV care continuum, there is potential for false estimation in patient retention, a pseudo increase in the number of new patients enrolled on ART and an increase in cases of lost to follow-up. The use of an automated fingerprint identification system (AFIS) presents a solution for this challenge.
Lessons learned: Fingerprint identification systems are being used in large-scale civil identifications to prevent multiple enrollments (ABIS 2019: South Africa).A tablet or laptop set up with an attached fingerprint scanner can be stationed at the facility. When a patient registers, they will be required to scan a finger(s) and provide associated personal information. The fingerprint(s) are stored in a coded form on a secure central database. On each successive visit to the health facility, the fingerprint scan will be required and once provided will be automatically compared with the pre-scanned print in the database thereby providing quick access to their personal and medical information from any ART providing facility in the country.
Next steps: Efficient and effective integrated identifier systems are available but have not been utilized in ART care. Using AFIS in the HIV care continuum will give us the ability to trace patients who move from one HIV treatment site to another. Making it easier to match the patient with an existing enrollment record and conclusively provide a live database with an active estimation on retention in care.

THPEE343

From a Week to a Day: Improved HIV Data Management through Interoperability of DHIS2 and Datim Software

Kasongo Pierre[1], Nguessan Jean[2]
[1]IntraHealth International, Kinsasha, Congo, the Democratic Republic of the, [2]IntraHealth International, Chapel Hill, NC, United States

Issues: In the past, the PEPFAR-funded Integrated HIV/AIDS Project in Haut Katanga and Lualaba (IHAP-HK/L), Democratic Republic of the Congo, manually transferred data between DHIS2, the national health management information system, and DATIM, PEPFAR's health information platform for facility-level HIV service information. Many PEPFAR countries faced the same issue. The indicators generated by DHIS2 were extracted into Excel, then processed and adapted to the appropriate format to be entered in DATIM by 20 data clerks. This process took an entire week per quarter. In addition, the Data Systems Officer's counter-verification process for data quality added about 3 days of work. Following a PEPFAR recommendation to optimize resource use to improve HIV program performance, IHAP-HK/L undertook an initiative to create interoperability between DHIS2 and DATIM.
Description: After evaluating several options, the project team, led by IntraHealth HIS developer, decided on an innovative approach of designing intermediate software between DHIS2 and DATIM. A dictionary was developed to create correspondence between the HIV service indicator codes used in each system. The intermediate software, called DATIM Generator, draws data from DHIS2 in Excel and processes it to match DATIM indicators using the dictionary. Without modifying DHIS2, the team designed a system that quickly generates a file ready for import to DATIM.
Lessons learned: DATIM Generator reduced the time for data transfer from 7 to 1 working day, consisting of data extraction and formatting from DHIS2 by the Data Systems Officer. Data entry errors were eliminated due to automatic data processing, except for any errors that existed in DHIS2. The 20 data clerks, including assistant nurses, nurses, and community workers, were redeployed to assist HIV facilities to improve the quality of service provision. IHAP-HK/L improved the quality and timeliness of data, enabling a more cost-effective decision-making process toward achieving PEPFAR's 95-95-95 goal**.**
Next steps: This experience can be applied to connect DHIS2 and DATIM in the other provinces, and also different databases existing in the country. The opportunity to connect those databases can help to integrate different technical domains (e.g., HR management, malaria, tuberculosis) to improve data quality and optimize resources.

THPEE344

Linkage to Continued ART Care and Subsequent ART Outcomes among PLHIV Lost to Follow-up in the Zimbabwe Antiretroviral Therapy Program, 2018

Takarinda Kudakwashe[1,2], Matare Takura[1], Choto Regis C[1], Dzangare Janet[1], Sithole Ngwarai[1], Mhangara Mutsa[3], Maruva Matthews[3], Nkomo Brilliant[3], Nesara Paul[4], Marisa Chiedza[4], Deda Marsha[4], Tachiwenyika Emmanuel[5], Mabuku Japhet[1], Mbito Cephas[1], Apollo Tsitsi[1], Mugurungi Owen[1]
[1]Ministry of Health and Child Care, AIDS and TB Department, Harare, Zimbabwe, [2]International Union Against TB & Lung Disease, Center for Operational Research, Paris, France, [3]The U.S. Agency for International Development (USAID), Harare, Zimbabwe, [4]The Organization for Public Health Interventions and Development (OPHID), Harare, Zimbabwe, [5]Elisabeth Glaser Pediatric Aids Foundation, Harare, Zimbabwe

Background: Ensuring that PLHIV enrolled in ART are retained in care is vital to achieving viral suppression. Despite this, many countries encounter lost to follow-ups (LTFU) from ART which poses a threat to effectiveness of ART. It is unclear what extent these LTFU patients may be "silent transfers" continuing ART care at other ART sites. In 2018, Zimbabwe conducted a nationwide recount of all PLHIV receiving ART care across 1,560 public ART sites to establish their current ART status. We set to determine among those classified LTFU: i) the proportion linked to continued ART care at another ART site ii) subsequent ART outcomes and associated factors.
Methods: Data abstraction of PLHIV perceived active on ART as at 31/10/18, was done by ART site health workers from 12/12/18-06/05/19. LTFU patients were defined as defaulting their last scheduled clinic visit by >90 days at time of data abstraction. A combination of the unique patient ART number, sex and age was used to match if these LTFU patients were registered in ART care at another ART site.
Results: Of 1,020,820 PLHIV in care, 70,369(6.9%) were classified LTFU of whom 2,140(3%) were linked to continued ART care at another ART site. Among those linked to continued ART care, 1,478 (69.1%) were still active on ART whilst 573(26.8%), 75(3.5%), and 14(< 1%) were transferred-out, LTFUs, and deaths respectively. Linkage to continued ART care increased with being LTFU from sites with >2,000 ART patients [ARR=2.89;95% CI:2.48-3.38] and with >1 year on ART prior to being LTFU [ARR=2.89;95% CI:2.48-3.38], whilst ART initiation in from 2016-2018 reduced chances of linkage to continued care elsewhere [ARR=0.52;95% CI:0.37-0.73]. ART retention among those linked to continued ART was higher among females [ARR=1.42;95% CI:1.10-1.85], those >1 year on ART prior to being LTFU [ARR=2.37;95%CI:1.58-3.57] and lower among those 20-29 years [ARR=0.39;95%CI:0.17-0.86] and on 2nd-line ART [ARR=0.34;95% CI:0.14-0.85].
Conclusions: Overall, few patients classified as LTFU were successfully traced in continued ART care elsewhere within public health facilities of Zimbabwe, particularly those classified LTFU within early months of ART and those from low volume sites. Use of networked electronic systems across all ART sites might help in actively tracking "silent transfers" receiving continued ART care elsewhere and promptly trigger defaulter-tracking mechanisms for re-engagement in ART care for those not traced.

THPEE345

Contribution Empirique à l'Atteinte des Trois 90: Gestion de la File Active à Travers l'Agenda de Rendez-vous Mis en Place par le Centre de Traitement Ambulatoire de Dakar

Konaré Zaccariah[1], Diagne Astou[2], Ndiaye Kiné[2], Ngom Ndeye Fatou[2]
[1]Centre de Traitement Ambulatoire de Dakar, Service des Maladies Infectieuses et Tropicales, Dakar, Senegal, [2]Centre de Traitement Ambulatoire de Dakar, Dakar, Senegal

Introduction: A l'horizon 2020 l'ONUSIDA s'engage à éliminer le VIH à travers la stratégie des 3X90. Seulement pour atteindre le dernier 90, il est nécessaire d'avoir un suivi régulier des patients sous traitement ARV et leur rétention dans les cohortes. L'objectif de cette communication est d'évaluer la gestion de la file active à l'aide d'un agenda de rendez-vous.
Méthodologie: L'agenda permet de répertorier de façon journalière le nombre de patients attendus, ceux qui sont venus, ceux qui se sont absents, ceux qui sont venus en consultation intermédiaire et ceux qui ont rattrapé leurs Rendez-vous dans la même semaine.
A la fin de chaque semaine les patients qui ne sont pas venus sont identifiés et appelés au téléphone. Ceci constitue un dispositif d'alerte précoce afin de réduire au maximum les cas de perdus de vue.
Résultats: Sur une période de six mois d'observation, sur 1469 patients attendus, 62% ont honoré leurs rendez vous. Sur les 38% des patients n'ayant pas respectés leur rendez-vous, 63% ont été rattrapés et sont venus dans le mois. Au bout des six mois, 6% seulement du nombre de patient attendus ont été considéré comme perdus de vue. Des stratégies telles que les appels et messages téléphoniques répétés et les descentes sur le terrain ont été mises en place pour entrer en contact avec eux.
Les relances hebdomadaires ont permis de recenser plusieurs facteurs explicatifs de leur retard: L'absence de moyen pour payer les bilans, le coût du transport, l'éloignement de la structure par rapport au lieu de résidence, l'oubli, la coïncidence du rendez-vous avec un événement social où un rendez-vous médical ont été évoqués.
Des solutions ont été apportées aux différents problèmes soulevés par les patients. Il s'agit du renforcement pour le respect des rendez-vous, de l'appui financier pour le transport et pour les bilans s'il y a des fonds disponibles.
Conclusion: La tenue d'un agenda de Rendez-vous montre son importance à plusieurs niveaux. Il permet de suivre la régularité de chaque patient dans le suivi médical, de connaitre les facteurs liés à son retard et de trouver des solutions appropriées à sa situation. L'agenda de rendez-vous, bien tenu, pourrait permettre de retenir les patients dans les soins afin de maintenir chaque PVVIH dans le troisième 90.

THPEE346

Implémentation d'un Outil de Collecte des Données dans les Sites de Prise en Charge à Grande Cohorte en Guinée: Modèle Simplifié Reproductible (MSR)

Cissé Amadou[1,2], Kadio Kadio Jean-Jacques Olivier[1,3], Daffé Diaraman[1], Guilavogui Foromo[1], Bah Fatoumata Fily[1], Pascal Tiakpacoura Bonimy[4], Koita Youssouf[1]

[1]Programme de Lutte contre le Sida et les Hépatites, Direction Nationale des Grandes Endémies et de la Lutte contre la Maladie, Conakry, Guinea, [2]Centre Informatique, Université Gamal Abdel Nasser de Conakry, Conakry, Guinea, [3]Chaire de Santé Publique, Faculté des Sciences et Techniques de la Santé, Université Gamal Abdel Nasser de Conakry, Conakry, Guinea, [4]ONUSIDA, Conakry, Guinea

Questions: Dans la prise en charge des PVVIH, les responsables de programmes VIH sont confrontés à un manque d´informations pertinentes lorsqu´ils cherchent à offrir un service de qualité ou à élaborer de nouvelles interventions. En guinée, lors de l´audit de la file active en 2017, il a été constaté des insuffisances sur la qualité des données VIH. Suite à cela, le Programme National de lutte contre le Sida et les Hépatites (PNLSH) a opté pour la mise en place d´un outil de collecte de données à savoir le « Modèle Simplifié Reproductible » (MSR) afin de pallier à ces insuffisances.

Description:

- En 2017, la Guinée a acquis 42 kits informatiques qui ont été installés dans les sites de prise en charge. Également, un pool de 96 formateurs et d´utilisateurs a été identifié et formé à l´utilisation du MSR (Version 1.0) pour l´audit de la file active. La dite version n´était dédiée qu´aux données de consommation ARV.
- En 2018, dans l´optique d´améliorer la qualité des données, l´outil MSR a été amélioré et une version plus complète a vu le jour (MSR Version 1.1) comportant des nouveaux items et générant de façon automatique le rapport mensuel PEC.
- Le MSR a été déployé au sein de de 29 sites PEC concentrant 90% de la file active nationale de prise en charge. Un guide d´utilisateur de la version MSR 2.0 fut élaboré, des prestaires et des agents de saisie recrutés pour appuyer la saisie des données de ces 29 sites (15 sites à Conakry et 14 sites dans les autres régions) dit à grande cohorte (nombre PVVIH $\geq$ 200).

Leçons apprises:

- L´utilisation de l´outil MSR a aidé à l´amélioration de la qualité des données des sites à grande cohorte et les données de la file active 2018 ont été approuvé et validé par tous les acteurs de la riposte et par le FM
- Le MSR facilite le rapportage mensuel des données de PEC des sites à grande cohorte
- Le MSR permet une utilisation rationnelle des ARV et aussi de générer les informations nécessaires au calcul des besoins en médicaments et de prendre d´autres décisions en matière de gestion mais aussi un outil facilitant la saisie des données de PEC sur la plateforme DHIS2 en Guinée

Les étapes à suivre:

- Déployer l´outil MSR sur l´ensemble des sites restant du pays (80 sites PEC)
- Renforcer les aptitudes des prestataires à la saisie régulière du MSR et au contrôle de la qualité des données saisies et former les prestaires des sites ne disposant pas du MSR à son utilisation

THPEE347

A Census of Active Clients in HIV Care in Zimbabwe, 2018

Matare Takura[1], Takarinda Kudakwashe C[1], Choto Regis C[1], Sithole Ngwarai[1], Mhangara Mutsa[2], Maruva Matthews[2], Nkomo Brilliant[2], Nesara Paul[3], Marisa Chiedza[3], Deda Marsha[3], Tachiwenyika Emmanuel[4], Dzangare Janet[1], Mabuku Japhet[1], Mbito Cephas[1], Mutasa-Apollo Tsitsi[1], Mugurungi Owen[1]
[1]Ministry of Health and Child Care, AIDS & TB, Harare, Zimbabwe, [2]The U.S. Agency for International Development (USAID), Washington, United States, [3]The Organization for Public Health Interventions and Development (OPHID), Strategic Information, Harare, Zimbabwe, [4]Elizabeth Glazer Paediatric AIDS Foundation (EGPAF), Strategic Information, Harare, Zimbabwe

Background: Zimbabwe has a generalized HIV epidemic, with an estimated 1.3 million People Living with HIV (PLHIV) and an HIV prevalence of 14% among adults aged 15-64 years. In December 2017, the national HIV database [District Health Information System 2 (DHIS 2)] had 1.15 million clients on Antiretroviral Therapy (ART) translating to 87% ART coverage. A data quality audit (DQA) conducted in a subset of facilities in 2017 revealed over-reporting of active ART clients. We conducted a national recount of ART clients across all facilities to determine the 'true' number of active ART clients in the health sector.
Methods: A retrospective assessment was conducted on patient level data of all reported active ART clients in all facilities reporting through DHIS 2. Data were abstracted from facility-held Patient Care Booklets, as at 31 October 2018, using an electronic EpiData form. Active on ART clients were defined as attending their last scheduled visit 'on time' or '< 90 days by date of abstraction'. Clients lost to follow-up (LTFU) were those who defaulted their last scheduled clinic visit date by ≥90 days at time of data abstraction. This was compared to DHIS 2-reported figures. LTFU clients were followed for up to 2 weeks and re-engaged into care where applicable. Data abstraction was conducted by trained facility health workers from 12 November 2018 - 6 May 2019.
Results: Data from 1,508 (95.4%) ART sites were analysed. A total of 967,066 patients were active on ART. The overall percentage variance between DHIS2 (1,157,460) and ART census (967,066) was 16% (n=190,394). Disaggregated by province, variances ranged from 5% in Matabeleland South to 24% in Mashonaland Central. No significant variations were reported between the ART census and DHIS2 for females (63,5% versus 62,2%) and for children (5,3% versus 5,0%). There was a notable shift in age distribution towards older age groups between DHIS2 and ART census, with DHIS2 showing 51% (587,016) of the 30-49 years and 17% (191,781) of the 50+ years age groups being active on ART while ART census showed 57% [548,916] of the 30-49 years and 21% (203,848) of the 50+ years age groups were active on ART.
Conclusions and Recommendations: DHIS 2 was over-reporting on active ART clients, hence the need to invest in routine DQAs and nationwide recounts of ART clients. The observed data quality issues highlight limitations of using paper-based data collection systems and calls for increased investment in electronic systems

THPEE348

Community AIDS Program Reporting - A Case of the Community AIDS Program Reporting System in Kenya

Gitonga Joshua
National AIDS Control Council, Policy Monitoring and Research, Nairobi, Kenya

Issues: In the Kenya context, the Health Sector rely heavily on Health facility based reporting systems for Routine Strategic Information required when making routine decisions for the HIV program. These Routine Systems include the District Health Information System (DHIS-2) and the Logistics Management Information System (LMIS) which routinely collect patient level and bio-medical information. This presented the HIV program with a gap of availing routinized behavioral and structural Strategic Information for monitoring HIV prevention initiatives and determining contribution of Community Based Organizations to the HIV response.
Descriptions: To address this gap, the country through a highly consultative process developed and rolled out a Community Reporting System dubbed the Community AIDS Program Reporting (CAPR) System. About 3,000 Community based Organizations across the country are reporting through CAPR system on their Behavioral and Structural interventions on a monthly basis. The CAPR system which started predominately as a HIV community activity reporting system has attracted attention of other disease areas to include tracking of Community based activities for other Sexually Transmitted Infections, Non-Communicable Diseases, Tuberculosis and Malaria. A CAPR performance report is generated and shared widely every Month to inform routine HIV prevention decisions.
Lessons learned: The CAPR system which has been in use over the last two years has routinized structural and behavioral reporting for the HIV program and facilitated accountability among Community Based Organizations which remain the main channel through which donor support reach the community. Expansion in number of reporting Organizations over time and buy-in from other disease areas underpins the CAPR as a strong Community Reporting System.
Next steps: The roll out of the electronic and online versions of the CAPR tool is ongoing following the initial roll out of paper based version to enhance access and utilization by the policy makers, implementing and development partners. The National AIDS Control Council which coordinates CAPR is working with relevant stakeholders to increase access and utilization of the CAPR system at all levels.
Key words*:* HIV, AIDS,Community, Reporting tool, system

THPEE349

Enhancing HIV Testing and Linkage in HIV Care: Assessing the Utility of a HIV Post-test Checklist in Nairobi, Kenya

Lango Daniel[1], Okal Jerry[1], Matheka James[1], Ngunu Carol[2], Owino Moses[2], Mugambi Mary[3], Sarma Avina[4]

[1]Population Council, Nairobi, Kenya, [2]County Government of Nairobi, Nairobi, Kenya, [3]Ministry Health, Nairobi, Kenya, [4]Population Council, Washington, DC, United States

Background: Initiating ART among people living with HIV (PLHIV) improves individual health outcomes, and prevents onward HIV transmission. The UNAIDS "95-95-95" aims at universal testing, ART access and viral suppression by 2030. However, there are challenges in linking PLHIV from sub-Saharan Africa to continuous care. We describe use of a simple post-HIV testing assessment check list to assist in systematically conducting pre-HIV test preparation, post-test counselling, treatment preparation, linkage to care and support, patient confidentiality, all contributing to improved linkage to treatment, care and other support services for newly diagnosed HIV positive individuals.

Methods: A quasi-experimental prospective study in 10 facilities (intervention, n=5 and comparison, n=5) with 200 newly diagnosed male and female PLHIVs (18-54 years) in Nairobi, Kenya from October 2018 and June 2019. Counselors in the intervention site were trained on the post-test assessment tool and used it with HIV+ clients over two months. Counselors at comparison sites provided routine standard of care. Descriptive analysis was conducted to assess effectiveness in the intervention sites. In-depth interviews with providers (n=8) assessed the acceptability and feasibility of the tool.

Results: Provider Initiated Testing and Counselling was commonly used for clients testing in 4 of 5 intervention facilities (58%), while client initiated testing is common in one facility (88%). Differences between baseline and endline in were observed in the intervention site in terms of

i) pre-HIV test preparation, (92.7% baseline, 98.8% endline),

ii) post-test counselling (80.15% baseline vs 97.6% endline),

iii) treatment preparation (90.53% baseline, 91.9% endline) linkage to care and support (48.4% vs 56.8%).

Other differences were found in patient confidentiality (89.3% baseline vs 94% endline), and risk assessment (65.3% baseline vs 76.5% endline). Qualitative findings show that the checklist was useful in

i) organizing and systematizing steps in providing services to newly diagnosed HIV positive clients,

ii) flagging clients that were at risk of loss to follow-up and

iii) adherence.

Providers agreed that the tool would be useful in contributing to the 95; 95; 95 goals.

Conclusion: The checklist is a useful tool in ensuring providers identify and act on potential challenges to linkage, ART initiation, adherence and follow-up; and in systematically following set HTS procedures.

THPEE350

Tracking Key Population in Ghana: Electronic Management System Approach

Acheampong Nana Amoako, Asante Adobea Cynthia, Annang Dennis
Ghana AIDS Commission, Research, Monitoring and Evaluation, Accra, Ghana

Issues: Ghana's National HIV and AIDS Strategic Plan 2016 - 2020 provides the general framework for interventions for targeting Key Populations (KP). The framework also provides an outlook for the implementation of comprehensive package of services designed specifically to reach the Key Population sub-groups. In tracking these sub-groups and the services provided to them, KP Program Managers are faced with how to effectively monitor these groups and also ensuring that KP programs and interventions achieve the desired results. This was the case during the implementation of the SHARPER and LINKAGES projects, where KP Program Managers were faced with issues of double counting and tracking services provided to KP clients. To address these challenges, the Ghana AIDS Commission (GAC) with in collaboration with its partners developed the Ghana Key Population Unique Identification System (GKPUIS).

Descriptions: GKPUIS is a web based management system developed in 2015 that allow users to login from different locations in Ghana through standard internet browser or using the mobile application. The system which is an innovation tracks individual KP clients by providing a 16 character system generated unique identification code at the point of registration. Additionally, it provides details on services provided to each KP client and implements a role based access control which restricts access to only authorized users.

Lessons learned: The GKPUIS application has become the national repository for data for KP information in Ghana after the system launch in April 2019.

Access to real time data on KP client registered and services provided to them.

Next steps: Ongoing nationwide data entry by KP implementing agencies registering client on the system and services provided to them. GKPUIS linkage with E - Tracker (clinical database) which will ensure monitoring of the 90-90-90 target in KPs.

THPEE351

Adherence and Viral Load Follow up on Patients with Un-suppressed through the Mobile Phone-based Adherence Support "Life Care Platform" at Joint Clinical Research Centre Uganda

Akello Dorothy[1], Kakande Nelson[2], Kityo Mutuuluza Cissy[3], Fortin Anny[4], Ratanshi Parkers Rosalind[5]
[1]Joint Clinical Research Center, Nursing, Kampala, Uganda, [2]Joint Clinical Research Center, Training, Kampala, Uganda, [3]Joint Clinical Research Center, Executive Director, Kampala, Uganda, [4]Johnson & Johnson, Global Public Health, Programme Management Leader, Brussels, Belgium, [5]Uganda Academy for Health Innovation, Director, Kampala, Uganda

Issues: The MOH guidelines state that HIV+ patients with VL ≥ 1,000 copies should receive 3 consecutive intensive adherence sessions monthly for 3 months at the health facility and a repeat VL on the 4th month. The goal of "Life Care program" is to offer a close follow-up of HIV+ patients having un-suppressed VL at JCRC. The objectives are: i) pill and clinic appointment reminder. ii). provide health Education on: HIV, adherence to ART, Viral load, support symptom and critical result reporting.
Descriptions: With support from Johnson and Johnson Global Public Health, JCRC is implementing connect for Life™ m-health tool (CfL). CfL is a mobile phone based health platform that promotes healthy behaviors and adherence to treatment. The CfL was set up and JCRC staff trained on usage Patients with unsuppressed VL are registered on the platform. Each provides a preferred mobile phone number on which to receive automated voice messages. The patient accesses the information by putting in a defined PIN whenever the program prompts. From June 2018 to July 2019, a total of 387 patients are registered. They receive intensive adherence support (IAC) at JCRC physically once in a month for 3 months, coupled with monthly drug refills. In addition, each receive automated daily pill reminders, adherence voice messages, clinic visit reminders and health education messages on HIV and Viral load to help them improve on ART and for proper health care management. The healthcare provider receives feedback by review of patient profile in the platform. Of the 387 patients registered, 42.9% suppressed, 32.8% un-suppressed, 23.3 % still undergoing IAC while 1 % died/transferred to another facility before they had repeat
Lessons learned: Preliminary outcomes indicate that the 3 sessions of IAC coupled with automated daily pill reminders and heath education are promising approach for follow-up of HIV+ patients with un-suppressed VL.
Next steps: Explore the cost-effectiveness of routine use of Life Care program for all HIV+ patients at initiation of ART and continuous follow up of patients regardless of VL.

THPEE352

Mobile Messaging and Voice Call Platforms for Retention of HIV Positive Patients in Care: A Retrospective Review of Records from a Tele-Health Centre in Kampala, Uganda

Ninsiima Sandra, Rusoke Davis, Magambo Stella, Musinguzi Davis, Kamulegeya Louis, Bwanika John Mark
The Medical Concierge Group (TMCG), Kampala, Uganda

Issues: The 2017 Uganda Population HIV Impact Assessment survey reported 1.2 million HIV infected persons aged 15-64 years, with only 73% in care; falling short of the 95% UNAIDS recommendation. A 20-40% lost to follow-up rate within the first year of ART initiation has been reported by many studies; this is fueled by the mobile nature of patients, poor or no functional follow-up systems, large client numbers, and short working hours of the HIV clinics. We evaluated the impact of regular SMS reminders and quarterly voice calls on retention in care of HIV positive patients in a large public health program over a period of 2 years.
Descriptions: Between October 2016 and September 2018, 1,740 HIV positive patients from supported health facilities in different regions of Uganda were consented for the mHealth package. This included; pre-appointment reminders, quarterly voice call follow-ups, mobile SMS content on positive living. There was 24/7 access to a doctor via a toll-free line, contact details (names, age, health facility) were collected and uploaded into the messaging platform (RapidPro). Biweekly messages were scheduled. Honouring hospital appointments and accessing viral load tests was tracked during quarterly calls. All data was analysed using Epi Info 7.
Lessons learned: The median age was 26 years, 22% were females and 68% males. A total of 11,795 calls were made over the 2 years, for which a progressive rise in compliance to honouring hospital appointments from 70% in 2016 to 95% in 2018 was noted. There was a strong correlation between accessing timely viral load testing and honouring health facility appointment dates ($P< 0.000$). The project's viral load suppression rate was 89%, way above national rates at 80.3%.
Next steps: Engagement and follow up of HIV patients using mobile health platforms like SMS and voice call interventions has the potential to improve retention and mitigate loss to follow up. There is need for wider evaluation to generate evidence for scale up and institutionalisation.

THPEE353

Expérience de ALAVI de Ouagadougou, Burkina-Faso dans la Réalisation de la Mesure de Charge Virale Plasmatique (CVP) du VIH 1 des PVVIH

Ouédraogo Pascal Honoré[1,2], Sawadogo Geoffroy[1]
[1]Association Laafi la Viim (ALAVI), Communautaire, Ouagadougou, Burkina Faso, [2]Programme Santé de Lutte Contre le Sida, Ouagadougou, Burkina Faso

Contexte: Depuis 2017, le Burkina Faso, s'est engagé résolument à atteindre les objectifs des trois 90-90-90 décrété par l'ONUSIDA en 2014. Le rapport ONUSIDA 2017 estimait la prévalence de l'infection à VIH dans la population adulte du Burkina Faso à **0,8 %,** soit environ 94000 personnes vivant avec le VIH dont 85000 adultes, 51000 femmes et 9400 enfants). 4300 nouvelles infections et environ 1600 cas de décès. Pour l'atteinte du troisième 90 à l'horizon 2020, le pays doit toucher 68 526 PVVIH.
Selon les normes et protocoles de prise en charge médicale du pays, la charge virale plasmatique est l'un des l'examen spécifique réalisé gratuitement. C'est dans cette optique que «ALAVI» s'est inscrit dans la politique de décentralisation de la réalisation de la charge virale plasmatique du VIH1.
Patients et Méthode: Le Centre Médical effectue des prélèvements sanguins chez les PVVIH pour la CVP; et ces échantillons sanguins sont acheminés une à deux fois par mois par un agent du laboratoire de ladite structure en moto au laboratoire de référence à l'hôpital Saint Camille de Ouagadougou pour être traités selon la répartition des sites «de prise en charge des PVVIH de la charge virale plasmatique du VIH1»; Le retour des résultats se fait par le biais de ce même agent qui procède à l'enlèvement lorsqu'il acheminera de nouveaux échantillons. La lenteur du traitement des échantillons et le faible retour des résultats, constituent un obstacle.
Résultats: Le Centre Médical de l'association a enregistré depuis 2003 à fin 2018, un total de 1109 (féminins : 830, masculins: 279) patients adultes dont 1108 sous traitement ARV (99,90%), ainsi donc, le premier 90 est atteint. Egalement dans la même année, Sur 998 PVVIH attendus pour les prélèvements de la CVP au niveau de l'ALAVI, seulement 575 (H : 141, F: 434) ont pu bénéficier de prélèvement soit un pourcentage de 57,61%; 171 (H: 30, F: 141) résultats obtenus sur les 575 échantillons transmis soit 29,73%. Les détails en termes de résultats obtenus sont : sur les 171 résultats obtenus, 155 PVVIH ont eu leur CVP indétectable (90,64%) contre 16 PVVIH avec une CVP détectable (09,35 %).
Conclusion et Recommandation: La décentralisation de la CVP au niveau de ALAVI a été bénéfique pour les patients depuis sa mise en oeuvre 2018 et ce, malgré les difficultés qui ont émaillé l'activité.La promptitude pour le retour des résultats de la CVP doit être la prochaine bataille à gagner à l'horizon 2020.

THPEE354

L'Observatoire Communautaire de Traitement du Togo: Un Dispositif de Plaidoyer de la Société Civile

Hlomewoo Amen
RAS+ Togo, Lomé, Togo

Questions: Le rendez-vous de 2020 pour l'atteinte des 90*90*90 constitue un défit majeur pour tous les Etats engagés dans la riposte au VIH. Le succès de cet agenda demande un engagement multisectoriel des acteurs investis contre cette pandémie. Au Togo, conformément aux principes de GIPA, RAS+Togo s'est mobilisé pour contribuer à briser les barrières d'accès au dépistage, aux soins et à la charge virale à travers un plaidoyer fort.

Description: RAS+Togo, à l'instar de 11 pays S-B de l´Afrique de l'Ouest, a bénéficié d'un appui financier et technique de ITPC-Afrique de l'Ouest pour initier un Observatoire Communautaire de Traitement (OCT) dont le but est de favoriser un accès optimal aux soins des populations clés (HSH, PS et UDI) et populations vulnérables (Femmes Enceintes et Jeunes). Cet Observatoire repose sur deux modèles. D'abord le modèle Communautaire qui permet de traiter les obstacles structurels le long du continuum de prévention, soins et traitement du VIH. Ensuite, le model opérationnel basé sur la collecte des données qui apportent des réponses aux interrogations soulevées un peu plus haut. Ainsi pour ce faire, l'OCT s'appuie sur la collecte des données quantitatives et qualitatives, suivant les indicateurs de la cascade des soins, de 11 structures de PEC représentant une file active de 24,23% de celle nationale. Les données sont validées par le Groupe Consultatif Communautaire

Leçons Apprises: De juin 2017 à décembre 2018, les activités de l'OCT ont permis :

· de lancer 2 alertes de ruptures nationales d'ARV ;
· de lancer 6 alertes de ruptures régionales d'ARV ;
· de faire le plaidoyer pour le respect de l'offre de service de la PPE dans toutes les structures de PEC et à toute la population alors que le service est offert seulement aux prestataires de soins victimes d'AES et aux victimes de viol ;
· à deux structures de PEC du Projet de démarrer la charge virale
· de recruter des OPS pour alimenter les bases de données au niveau du plus grand Hôpital du pays et d'un autre Hôpital de référence
· de constater que le dépistage est plus organisé dans les structures communautaires que dans les structures publiques

Prochaines Étapes:

· organiser un atelier national de plaidoyer pour l'accès à la charge virale
· augmenter le nombre de structures partenaires du Projet pour atteindre au moins 30% de la file active nationale

THPEE355

Point-of-Care Data Driven Reviews for Improved Retention in Care: Experience of Doctors with Africa CUAMM USAID RHITES Project

Aguze George[1], Jerry Itcho[2], Jasper Abor[1]
[1]Doctors with Africa CUAMM Uganda, Community, Kampala, Uganda, [2]Doctors with Africa CUAMM Kampala, Kampala, Uganda

Issues: Lango sub-region has 2.1 million people living in 9 districts; 80% are rural and 50% below age 15, HIV prevalence at 7.2%, above national average of 6.2%. Doctors with Africa-CUAMM, a consortium partner in the USAID's RHITES-North, Lango is committed to building community health platforms to attain high impact, evidence-based HIV, TB and MNCH outcomes. As countries push towards HIV Epidemic control, retention of client in HIV care remains a challenge. In Uganda, 89% diagnosed, 89% on treatment and 65% Virally suppressed, a performance below the 95-95-95 cascade. In the Lango sub region, retention is even much lower at 62% and 69% for 6 and 12 months' cohorts respectively (January to March 2019) with high volume facilities accounting for a greater number of lost clients in the sub-region. The low retention of clients significantly meant viral load suppression also remained low at 67% critically below the ceiling.

Descriptions: Doctors with Africa-CUAMM as a lead consortium conducted a Point of Care (POC) Data Driven Reviews and Real time client follow up in 23 ART facilities. Data retrieved from DHIS2, reviewed and used to select sites with poor retention focusing at 6, 12 months' cohorts. Health workers, facility based linkage facilitators and counselors updated appointment register, line listed clients lost, developed follow up plan and tracking tools. Follow up were conducted by linkage facilitators and PLHIV groups and outcome documented in the HIV care card, appointment book and ART registers in real time. To reduce the increasing number of lost clients from care, daily tracking of miss appointments at the end of the clinic day was instituted at all ART sites. Pre-appointment reminder messages and phone calls were among the demonstrable efforts for improved retention of clients in care.

Lessons learned: Overall, fifteen health facilities 68% (15/22) had remarkable improvement in retention levels. Of which,60% (9/15) surpassing the 95%, with 33% (5/15) retaining over 90% of the clients. This significant improvement is attributed to real POC data reviews and use- to track clients who are lost and returned to care.

Next steps: Point of Care (POC) data driven reviews and real time follow up significantly improved retention of HIV Client in Care. Therefore, it is critical to provide routine technical support to health facility teams to ensure mechanisms of client tracking and client follow up efforts are done in real time.

THPEE356

A Mixed-methods Evaluation of the Roll Out of Community ART Refill Groups in Zimbabwe

Manyanga Phibion[1], Bochner Aaron F[2], Meacham Elizabeth[2], Mhungu Nathan[1], Petracca Frances[2], Muserere Claudios[1], Gonese Gloria[1], Makunike Batsirai[1], Wazara Blessing[1], Gwanzura Clorata[3], Nyika Ponesai[4], Levine Ruth[2], Mutasa-Apollo Tsitsi[3], Balachandra Shirish[4], Wiktor Stefan Z.[2]
[1]I-TECH, Harare, Zimbabwe, [2]I-TECH, Seattle, United States, [3]Ministry of Health and Child Care Zimbabwe, Harare, Zimbabwe, [4]Centers for Disease Control and Prevention, Harare, Zimbabwe

Background: In late 2016, the Zimbabwe Ministry of Health and Child Care began a nationwide rollout of Community ART Refill Groups (CARGs), an antiretroviral therapy (ART) service delivery model in which clients form into groups and one member visits the clinic quarterly to collect ART on behalf of all members. Resource-intensive pilot programs of similar ART delivery models have been evaluated, but no evaluations of routine nationwide implementation have been disseminated. We conducted a mixed-methods evaluation to assess the acceptability and perceived effects of CARGs under routine implementation conditions.
Methods: From 345 I-TECH supported facilities, we purposely sampled eight facilities implementing the CARG model across four provinces of Zimbabwe. At each facility we administered an individual survey and focus group discussion with healthcare workers (HCWs) and in-depth interviews with three ART clients. Discussions and interviews were audio recorded, transcribed, and translated to English, with thematic coding performed by two analysts
Results: At selected facilities, the number of ART clients ranged from 377-6543 and the proportion of clients in CARGs ranged from 12- 53%. In surveys, 97% (36/37) of HCWs reported that CARGs reduced their workload and 100% (37/37) reported that CARGs improved the quality of care for ART clients. In focus groups, HCWs explained that CARGs made ART distribution faster, and the reduced workload enabled them to provide better care to those clients who did visit the clinic. CARG members reported that the groups saved them time and money by reducing the frequency of clinic visits, facilitating ART collection and improving adherence. CARG members also described receiving emotional and informational support from other members, further supporting their adherence. However, ART clients noted that reluctance to disclose their HIV status and concerns around trusting other group members to collect ART and maintain confidentiality were primary barriers to joining a CARG. Some clients indicated that CARG membership facilitated overcoming their fear of disclosure and led to reduced feelings of isolation
Conclusions and Recommendations: This evaluation demonstrates that the CARG model can be successfully implemented on a national scale and suggests that CARGs may reduce the workload required to distribute ART, reduce costs for clients, and improve clinical outcomes.

THPEE357

Early Results from a Faith Based Strategy for HIV Stigma Reduction & Case Finding Project Targeting Children in Nigeria

Chukwudolue Pauline[1], Azige Alfred[2], Agwom Lucy[3], Obo-Effanga Ijeoma[4], Olayiwola Olanrewaju[5], Fadare Olawale[6], Oko John[4], Obodoechina Uche[4], Nobile Stefano[7]

[1]St. Bernard Comprehensive Health Center, Diocese of Lafia, ART Clinic, Akanga, Nigeria, [2]Parish Priest St Mathew Parish Obi, Diocese of Lafia, Obi, Nigeria, [3]Our Lady of Apostles Hospital, Akwanga, Diocese of Lafia, HIV Testing & Counselling, Akwanga, Nigeria, [4]Caritas Nigeria, Program Management, Abuja, Nigeria, [5]Caritas Nigeria, Clinical Services, Abuja, Nigeria, [6]Caritas Nigeria, Outcomes & Evaluation, Abuja, Nigeria, [7]Caritas Internationalis, Health & HIV, Geneva, Switzerland

Issues: Nigeria is the largest contributor to the global burden of children living with HIV but only 21% of Nigerian children eligible for anti-retroviral therapy (ART) actually receive it. The diocese of Lafia, North Central Nigeria, serves faith communities in Nasarawa State (population 1.9 million). The National AIDS Indicator Impact Survey (NAIIS2018) ranked Nasarawa 9th of 37 states for HIV prevalence (2% for adults 15 - 64 years; less than 1% for 0 - 4 years). Dioces of Lafia implemented the Galvanizing Religious Leaders for Accelerated Identification & Linkage to Pediatric ART (GRAIL) Project; focused on HIV awareness creation, stigma reduction and increased HIV case identification in children through the social capital of clergy.

Descriptions: UNAIDS, Caritas Nigeria and Caritas Internationalis trained 7 Pediatric ART Champions (3F; 4M) from Lafia Diocese who went on to recruit an additional 105 champions, mentoring them on how to organize catalytic activities (like medical fairs, age-appropriate messaging for schools and recruiting parents and teachers) for combating HIV stigma in communities. Champions were also trained on HIV risk profiling for children using the Bandason Screening Tool. Each faith community was linked to a network of HIV treatment centers so referrals for HIV tests could be initiated and monitored.

Lessons learned: Trained champions served 14 parishes, 22 missions and 150 outstations where HIV messaging was delivered during sermons and other activities. Medical fairs (which commenced in December, 2018) resulted in over 1,500 children receiving clinical and nutritional assessments as well as HIV diagnostic tests and treatment of locally endemic diseases. 5,210 children were tested for HIV with 52 HIV cases diagnosed (testing yield of 1%) and linked to ART. Referrals also ensured the early diagnosis of other childhood conditions like febrile diseases, malnutrition, upper respiratory track and gastrointestinal infections in the children.

Next steps: The implementation logic of GRAIL is based on socio-cultural factors like the influence of religious leaders on their faith communities. Community penetration of faith based leaders is guaranteed to deliver accurate information about HIV transmission and combat stigma. More support is however needed to ensure effective health teams in faith communities and consistency in using HIV risk profiling techniques to increase HIV case identification in children.

THPEE358

Quality Improvement Initiatives in Improving Uptake of Tuberculosis Preventive Therapy among ART Clients - Experience from Southern Zone, Tanzania

Kisanga Robert[1], Gamaliel John[1], Okechukwu Emeka[1], Christian Beatrice[2], Mwijarubi Ezra[3], Bisimba Jema[3], Njelekela Marina[4]

[1]FHI 360 (Family Health International), USAID Boresha Afya Southern Zone, Dar es salaam, Tanzania, United Republic of, [2]Management and Development for Health (MDH), USAID Boresha Afya Southern Zone, Dar es salaam, Tanzania, United Republic of, [3]USAID Tanzania, Dar es salaam, Tanzania, United Republic of, [4]Deloitte Consulting Ltd, USAID Boresha Afya Southern Zone, Dar es salaam, Tanzania, United Republic of

Background: TB Preventive Therapy (TPT) reduces the overall risk of active tuberculosis in people living with HIV/AIDS (PLHIV) up to 60%. WHO recommends TPT provision to reduce the prevalence of TB for PLHIV. However, according to the Tanzania National Aids Control Program (NACP), TPT uptake among PLHIV was at 10% by December 2016 while there were no data on completion rate. USAID Boresha Afya-Southern Zone program support TB/HIV interventions at 516 health facilities in southern Tanzania. We followed up a cohort of clients started TPT quarterly and found that by January-March 2018, a total of 6504 clients were expected to finish TPT within that respective period but only 54% of them managed to complete 6 months of TPT as per national guideline. Furthermore, 6097 clients equivalent to 4% of those eligible were initiated TPT during January-March 2018. We document the quality improvement initiatives to improve TPT uptake and completion among ART clients in 516 supported facilities.

Methods: In April 2018, Health facilities were supported by team of mentors to form quality improvement teams. Facility QI teams were trained on QI methodology, assisted to analyze TPT initiation and completion performance, identity reasons for low TPT uptake and set facility TPT initiation and completion improvement goal and targets. Among barriers identified during root cause analysis were; erratic supply of TPT tablets, health providers knowledge and attitude towards TPT provision and poor documentation in the M&E tools. Through PDSA cycle, improvement teams tested changes to improve staff knowledge on TPT provision, acceptability of TPT among ART clients, proper documentation as well as availability of Isoniazid tablets. From April 2018 to March 2019, QI teams were supported to document the improvement plans while monitoring TPT uptake and completion every month and report quarterly using IPT registers and National CTC2 database.

Results: The number of ART clients initiated TPT increased from 5669 clients initiated in January -March 2018 to 37816 clients in January- March 2019. IPT completion rate improved from 54% observed in January-March 2018 to 90% in January-March 2019.

Conclusions and Recommendations: QI initiatives improved TPT initiation as well as completion rate among clients receiving ART at program supported sites. However, robust interventions need to be instituted to address barriers; demand creation, acceptability, supply chain management as well as documentation.

THPEE359

Approche Pluridisciplinaire, Élément-clé de l´accompagnement d´enfants et Adolescents Séropositifs

Nzeyimana Alexis[1], Nimubona Egide[2], Nikuze Fabrice[3]
[1]SEP/CNLS, Bujumbura, Burundi, [2]SWAA-Burundi, Bujumbura, Burundi, [3]ANSS, Bujumbura, Burundi

Questions: Les enfants vivant dans la famille élargie ou dans des familles d'accueil sont moins susceptibles de bénéficier de soins, d'une éducation et d'autres services essentiels. La situation est plus désespérée pour les orphelins de deux parents et vivant dans des ménages gérés par des mineurs. Ils sont exposés aux risques d'exploitation, infection par le VIH, accès insuffisant aux soins de santé, etc.
Description: L'approche mise en place par ANSS et SWAA-Burundi, consiste à impliquer les prestataires ayant des profils différents pour une meilleure observance de soins et amélioration du bien-être. Les deux associations ont réuni, autour des enfants et adolescents, une équipe pluridisciplinaire travaillant de manière complémentaire composée de médecins, infirmiers(ères), assistants(ntes) sociaux(les), les psychologues, les médiateurs(trices) de santé et relais communautaires.
Cette approche utilisée pendant le processus d'annonce de la séropositivité, dans l'observance des ARV, l'animation des groupes de paroles, les visites à domicile, lors des sorties et des week-end thérapeutiques a permis d'inciter parents et tuteurs à assumer leur rôle éducatif. A travers leurs actions d'information, soutien, accompagnement et orientation, les pairs(es) éducateurs(trices) ont établi des liens de confiance entre les enfants et les soignants.
Leçons apprises: L'approche a permis de faire face à la complexité des problèmes, de limiter les risques d'épuisement du personnel. Accessible à 7000 enfants et adolescents, un dispositif de services leur a permis d'être informés à temps de leur statut sérologique, d'accéder rapidement aux ARV. Parmi 1000 enfants dépistés séropositifs, 57% sont des filles, 420 sont orphelins de deux parents et 1250 d'un parent. En meilleure santé, les enfants séropositifs s'épanouissent : 95% sont inscrits dans la file active sous ARV, 68 % de ceux qui sont sous ARV ont une charge virale indétectable, 79% sont informés de leur statut sérologique. 475 ont obtenu leur certificat ou diplôme.
Prochaines étapes: La répartition des tâches et responsabilités doit être clairement définie au sein de l'équipe et des outils mis en place pour faciliter le partage d'informations clés. Il est indispensable que le discours au sein de l'équipe envers l'enfant soit cohérent. Il faudrait prévoir régulièrement des séances de débriefing pour l'équipe pluridisciplinaire. Cette approche devrait être appliquée aux autres sites.

THPEE360

Medicycles: Using Microfinanced Motorcycle Taxis and Community Collection to Serve Remote, Difficult-to-Reach Areas with Sustainable, Integrated Care Outreach Clinics and Continuity of Care

Gibbons Kevin
Health Access Connect, Kampala, Uganda

Issues: Reaching 95-95-95 depends on our health systems' abilities to serve key and priority populations in remote areas. Patients who live over 5km from the nearest facility are much less likely to access health services. The world needs scalable, sustainable solutions to get medicine and health workers to remote areas.
The model of waiting for patients to access treatment at the health facility is broken. We need to bring the health facility to the patients.
Description: Health Access Connect (HAC) is a Ugandan NGO that has been implementing the Medicycles program since August 2015. Monthly, one-day comprehensive health outreach clinics are set up in remote villages with high HIV prevalence.
The HAC model has three components:

1. Partner health facilities use their vehicles or HAC microfinanced motorcycle or boat taxis to transport staff and supplies to remote villages.
2. During monthly outreach clinics, 3-to-5 health workers provide integrated health services, including HIV testing, ART, maternal & child healthcare, family planning, immunizations, and other essential health services.
3. Community oversight and sustainability are achieved through patient contributions of US$0.55 (half for children) to cover transportation expenses (US$22-30 per outreach clinic).

Lessons learned: Between August 2015 and June 2019, HAC achieved these numbers:*
339 outreach clinics
36 remote villages
14,693 total patients (43.5 per outreach, 43.6% male)
4,876 ART clients (14.4 per outreach, 45.6% male)
3,025 tested for HIV (8.9 per outreach, 50.1% male)
We have learned:

- By using local health, transportation, and financial resources, service delivery can sustainably meet patient needs and strengthen the health system.
- Coordination with government health leadership ensures continuity and quality of care.
- Targeted outreach clinics increase numbers of clients accessing HIV testing, receiving treatment, and suppressing viral load.
- Sustainability and improved patient numbers can be achieved through offering integrated services and community collection from Day 1.

Next steps: The HAC model emphasizes providing transportation and community collection to provide continuity of care to difficult-to-reach populations. Expansion to villages in five districts has demonstrated that the model can be scaled and adapted to many contexts. This model can be adapted to help improve the distribution of health services around the globe.
**Reporting data are for patient services distributed. Many patients are repeats.*

THPEE361

Viral Load Suppression by Adolescent through Edutainment by Young Positives Accessing Care and Treatment in St. Francis Health Care Services

Huzairu Nyanzi[1,2,3]

[1]St.Francis Health Care Services Njeru Uganda, Montroing and evaluation, Jinja, Uganda, [2]Uganda Network Of Young People Living With HIV (UNYPA), Social Work, Kampala, Uganda, [3]Sexual Reproductive Health and Rights (SRHRAllianceUg), Social Work, Kampala, Uganda

Issues: Young people have continuously faced frustrations from stigma and discrimination from their families, guardians, potential employers and the general public. This affects their uptake of HIV services at health facilities, adherence and fear to disclose due to fear of violence and rejections. All these are primary indicators to poor viral load suppression. St. Francis Health Care Services addresses this challenge through Edutainment (music, dance and drama.)

Descriptions: St. Francis Health Care Services through the counseling arm in 2018 initiated a group of active positive children to form an infotainment group to create awareness of positive living through music dance and Drama known as the YOUNG POSITIVES. The group started with about ten positive youth who had been on life saving drugs (ARVs) for over five years with good drug adherence and a positive living attitude. These young people are trained to package their successful drug adherence and a positive living attitude into performing Art with support from a choreographer for instance songs dances and drama. These theatrical performances are in turn used to motivate the other peers at the center on every clinical day and breaking barriers in the communities around HIV like denial and stigma thus reviving hopes among young positives empowering them to adhere well leading to viral load suppression

Lessons learned: Currently St. Francis Health Care Services serves a population of 350 young people of which 245 are on ARVs from within the facility and the others receive their drugs from other health centers- of the 245 young people receiving ART from St. Francis Health Care Services, 56% have achieved viral suppression for the last one year

- The group has reached 2000 young people both in and out of school with Psycho-social and SRHR information HIV inclusive through drama plays and skits and peer to peer sessions in the last one year
- Of the 245 young positives 90% is able to meet their appointment dates
- Five of the young positives have contested in the young positive Beauty pageant as a result of risen self-esteem after participation in the drama group

Next steps: There is need to include drama and sports in the provision of comprehensive care to young people living with HIV to eliminate stigma and fear of the inevitable

THPEE362

Contribution des Groupes de Soutien Personnes Vivant avec le VIH à la Rétention dans les Soins dans la Région de San-Pedro, Côte-d´Ivoire, en 2018

Ossohou Bonhon Serge[1], Dan Epse Koffi Dessi Brou[2], Etien Aka Charles[1]
[1]APROSAM, Programme, San Pedro, Côte d'Ivoire, [2]APROSAM, Direction, San Pedro, Côte d'Ivoire

Question: Le maintien dans les soins est important dans la prise en charge des PVVIH. Selon l´OMS, les personnes qui ne viennent pas à leur rendez-vous 90 jours après la date, sont considérées comme perdues de vue. La résistance aux ARV entraîne les échecs thérapeutiques et les traitements de 2ème et 3ème ligne.

Malgré la gratuité des soins, le nombre de perdus de vue est toujours important. Les groupes de soutien ne sont pas régulièrement fréquentés car les thèmes abordés ne sont pas attrayants. Cette situation amène à penser une autre stratégie pour réduire le nombre de perdus de vue et maintenir les malades dans les soins.

L´Association pour la promotion de la santé, de la femme, de la mère, de l´enfant et de la famille (APROSAM) a lancé au Centre Espérance San-Pedro des activités d´auto-support(GAS) où se tissent des relations d'amitié ou de parrainage.

Description de l´intervention: Les activités ont consisté en la mise en place d´un système de parrainage depuis 2017. Chaque client enrôlé se choisit un parrain qui est observant au traitement, ce dernier devient son ami. Cette amitié va au-delà des réunions du GAS. Ils collaborent, se donnent des conseils sur le traitement et s´accompagnent mutuellement.

Le renforcement de l´appui communautaire et l´autonomisation des clients avec la participation aux activités de l´Association Villageoise d´Epargne et du Crédit (AVEC). En effet, L'AVEC permet aux PVVIH d'avoir une activité génératrice de revenus afin qu'ils soient autonomes.

Leçons tirées: Les activités de l´approche AVEC, a permis d´obtenir les résultats suivants: Pour le premier cycle de 2017: sur une cohorte de 25 PVVIH, 24 ont terminé les activités d´AVEC et dans le même temps ont été observant jusqu´en fin de cycle.

Pour le deuxième cycle en 2018: sur une cohorte de 25 PVVIH, 25 ont terminé soit 100% d´observant jusqu´en fin de cycle.

Le système de parrainage a permis d´avoir les données suivantes: En 2017: pour une cohorte de 15 filleuls joints à 15 parrains, 13 soit 86,66% étaient observants.

En 2018: Pour une cohorte de 25 filleuls joints à 25 parrains, 25 soit 100% étaient observants.

Étape à Suivre: Le Parrainage et la participation aux activités d´AVEC participent à la réduction des perdus de vue cette. Cette approche doit être intensifiée dans les activités communautaires pour améliorer la rétention des PVVIH dans les soins

THPEE363

Rwanda's Implementation Process in Integrating Peer Education Strategy into the National HIV/AIDS Program

Elise Mutunge[1], Marie Josee Maliboli[1], Innocent Kamali[1], Muhayimpundu Ribakare[1], Arielle Eagan[2]
[1]Rwanda Biomedical Center (RBC), Kigali, Rwanda, [2]Harvard Medical School, Boston, United States

Issues: To continue to improve patient outcomes and program efficiencies, Rwanda's national HIV guidelines were revised in 2016, defining differentiated service delivery model (DSDM) for care for People Living with HIV (PLHIV). This model has been effective at reducing the frequency of clinical visits and drug pick-ups for patients, while also reducing burden on the health system. Yet if a patient is not well supported in this transition to patient-directed care, the model can create a concerning adherence gap. Peer Education (PE), which empowers a PLHIV to educate and support fellow PLHIVs, is a protective strategy that can be integrated into the DSDM to prevent this adherence gap, ensure strong health facility and community linkage, and improve quality of care.
Descriptions: In 2016, the National HIV Program launched the DSDM nationally. A PE Strategy was developed in 2017 and integrated into national guidelines. To disseminate PE, a 5-day PE training of trainers (TOT) for health care providers (HCP) was conducted. By targeting two HCPs from each facility providing HIV services, the TOT enabled rapid, efficient dissemination. The TOT developed capacity in: PE in HIV services, role of eductor at the health facility and community, supervision and mentorship and PE implementation. In 2018, 1,200 HCPs were trained. Returning to facilities, they disseminated the training to PE selected .With 1 PE for every 50 PLHIV, 4,800 roles were created. Under HCP supervision, PEs began coordinating peer support groups, home visits, and re-linking patients with the HCP at the facility.
Lessons learned:Using a TOT, HCP investment in, and facility-level ownership over, the PE strategy was created; this is critical for effective implementation and sustainability. 4,800 PEs are now building strong patient-centered and patient-led links between the community and facilities. PE is likely contributing to Rwandan's successful control of HIV, with 92.3% of Rwanda's 240,000 PLHIV on ART and 91% with a suppressed viral load. PE's dissemination and sustained early success have taught the National HIV Program an important lesson in its designing and implementing a national strategy through a TOT model.
Next steps:The PE Strategy plays a critical role in improving adherence and retention among PLHIV in DSDM. Looking forward, a monitoring framework is being designed to garner evidence for future policy.
Keywords: Peer Educator, Differentiated Service Delivery Model, adherence

THPEE364

Streamlined Care: Qualitative Insights into Provider and Patient Experiences with a Differentiated HIV Care Model in Rural Kenya and Uganda

Mwangwa Florence[1], Getahun Monica[2], Itiakorit Harriet[1], Koss Catherine A[3], Jain Vivek[3], Owino Lawrence[4], Akatukwasa Cecilia[1], Bukusi Elizabeth A.[4], Kamya Moses R[1,5], Petersen Maya L.[6], Cohen Craig R.[2], Charlebois Edwin D.[7], Havlir Diane V.[3], Camlin Carol S.[3,7], and the SEARCH Collaboration
[1]Infectious Diseases Research Collaboration, Kampala, Uganda, [2]University of California San Francisco, Obstetrics, Gynecology & Reproductive Sciences, San Francisco, United States, [3]University of California San Francisco, HIV, Infectious Disease, and Global Medicine, San Francisco, United States, [4]Kenya Medical Research Institute (KEMRI), Nairobi, Kenya, [5]Makerere University School of Medicine, Kampala, Uganda, [6]University of California Berkeley, Divisions of Biostatistics and Epidemiology, Berkeley, United States, [7]University of California San Francisco, Center for AIDS Prevention Studies, San Francisco, United States

Background: Patient and provider experiences are critical for optimizing Differentiated Care Models (DCMs). The SEARCH trial (NCT01864603) implemented population-based HIV testing in Kenya and Uganda, and its model of differentiated or '*Streamlined Care*', exceeding the UNAIDS 90/90/90 targets in two years. *Streamlined Care* featured a patient-centered approach, immediate linkage to care, individualized counselling, rapid ART start, adherence support, 3-monthly ART refills and structured viral load counselling.
Methods: In-depth semi-structured interviews were conducted at two time points with patients and providers in six sites (2014-16). Participants were randomly selected and providers systematically sampled to include a range of cadres delivering *Streamlined Care*; N=18 patients (60% female) were interviewed at baseline, and n=17 a year later (60% female);n=28 providers were interviewed at baseline and n=21 a year later. Patient interviews explored HIV care and treatment; provider interviews explored factors related to providing *Streamlined Care*. Audio transcriptions were deductively and inductively coded and analysed using a collaboratively developed framework.
Results: Assisted disclosure and individualized counselling motivated patients towards rapid ART start. Assisted disclosure benefited women (who feared negative reactions from partners) and men (who feared accusation/blame). A desire to live longer and reap the benefits of early ART motivated patients towards rapid start. Barriers to rapid ART included repeat HIV testing to disprove results, feeling healthy (high CD4 patients), limited knowledge of early ART, mistrust of researchers, and anticipated ART side-effects. Patients credited individualized support, provider knowledge of their drug schedule and availability of health workers via phone/in-person for their care engagement. Short-and long-term mobility presented care challenges. Viral load counselling served as powerful provider tool to convince high CD4 patients to initiate ART.
Conclusion: A patient-centered approach, individualized counselling and assisted disclosure facilitated *Streamlined Care*. Despite the success of *Streamlined Care* in achieving high levels of linkage, retention and viral suppression, barriers included misconceptions about ART, fear of side effects, HIV-related stigma and disclosure and mobility. DCM design and implementation should build on the successes of *Streamlined Care*, while addressing persistent care barriers.

THPEE365

Increasing the Uptake on Condom Use: The Role of the Condom Vending Machine (CVM) in Ghana

Okai Kwasi Gyimah[1], Larbi Emmanuel[1], Dowouna Ellis[2], Adobea Cynthia[1]
[1]Ghana AIDS Commission, Research Monitoring and Evaluation, Accra, Ghana, [2]Ghana AIDS Commission, Finance Division, Accra, Ghana

Issues: Condom promotion and distribution as a preventive measure continue to receive widespread publicity to encourage safe sex practices among the target group in the general and key population. Comprehensive knowledge of HIV and AIDS is important for an effective implementation of a Behavior Change Communication strategy for access to and utilization of condom. Civil society organisations undertaking HIV interventions over the years are adopting innovative strategies like condom activation sessions to distribute condoms.
Descriptions: The low use of condoms in Ghana are attributed to challenges with regard to the availability,accessibility and misconceptions surrounding its use. In response to this, the Government of Ghana through the Ministry of Health (MOH), developed the National Condom and Lubricant Strategy (NCLS 2016-2020) to improve access and use of quality condoms and lubricants in Ghana. In 2014, 500 CVM were installed as a strategy to increase access and use of condom.
Lessons learned: The CVMs provides convenient outlets to accessing condoms particularly in places that have non-existing stores and pharmacies selling condoms. 2016 recorded 201,188 pieces of condoms distributed through CVM. 182,600 and 199,102 male condoms were distributed through CVM in 2017 and 2018 respectively. The introduction of CVM reduced the level of stigma and embarrassment attached to the purchase of condoms from third parties. Access to condoms through CVM's are affordable than those sold at the pharmacies, groceries and supermarkets. The CVM's increased the availability and accessibility of condoms and fostered a supportive social environment for HIV prevention especially among Key Population (KP).
Next steps: Create a leadership, coordination, and policy environment that supports and ensures availability of condoms and lubricants for HIV interventions. Consider expansion of CVMs services to underserved districts, defined by high numbers of Population reached through previous HIV programming. Develop new CVM's, to distribute both condoms and lubricants simultaneously to enhance KP interventions in the country. Pilot KP-specific condom promotion and distribution strategy which will make condoms available at any time. Intensify outreach services at hot spots to provide education on access to condom use. Map out and involve key stakeholders within the community in condom programming. Create sustained nation-wide generic condom mass media campaigns on the use of CVM.

THPEE366

Solutions for Getting Older Men into Voluntary Medical Male Circumcision Services: Field Lessons from Malawi

Musiige Adrian[1,2], Gold Elizabeth[3,4], Sallet Jackie[3,4], Twahirwa William[1,2], Mwandi Zebedee[2,3], Chilembo Austin[1,2], Seifert-Ahanda Kim[5], Carrasco Maria[5], Gibson Hannah[1,2], Odek James[6], Kapito Martin[7], Kiggundu Valerian[5]

[1]AIDSFree Malawi, Blantyre, Malawi, [2]Jhpiego Malawi, Blantyre, Malawi, [3]AIDSFree, Washington, United States, [4]JSI Research & Training Institute Inc., Arlington, United States, [5]United States Agency for International Development (USAID), Washington, United States, [6]United States Agency for International Development (USAID), Blantyre, Malawi, [7]Ministry of Health, Blantyre, Malawi

Issues: In 2012, the Government of Malawi rolled out voluntary medical male circumcision (VMMC) as one of the priority interventions for combination HIV prevention for quicker epidemic control, with an aim that 70% of program clients are 15 to 29 years old. The program, however, attracted mainly younger boys aged 10 to 14 years, instead of the sexually active, older adolescents and men of age 15 years or older who have a more immediate risk of acquiring HIV. At the same time, many districts were not meeting annual targets.

Descriptions: During the period from October 2017 to September 2018 (FY18), the USAID-funded AIDSFree project in Thyolo, Chikwawa, and Zomba districts of Malawi launched coordinated demand creation and service delivery approaches which rapidly increased uptake of VMMC services. These approaches involved investing in community mobilization (training, compensation, and equipment), providing transport refund to clients, and using data to inform decision-making for immediate course correction. We used satisfied clients as community mobilizers for advocacy and peer referrals, and improved follow-up on prospective VMMC clients. The districts effected these changes during the first quarter of FY18, leading to unprecedented uptake in these districts, specifically among the priority age group 15 to 29 years. A retrospective review of the data from October 2016 to September 2018 (FY17) showed a significant increase in uptake of VMMC services by clients aged 15 years, from 36.9% (9,176 of 24,881) in FY17 to 61.3% (22,152 of 36,153). There was also an overall increase in uptake of VMMC services during the same period, from 24,881 (80.5% of 30,894 target) in FY17 to 36,153 (100.1% of 36,014 target) in FY18.

Lessons learned: This work illustrated the importance of demand creation approaches, which addressed critical gaps and increased uptake of VMMC among men and adolescents age 15 years or older. Translating these solutions into program success requires systematic assessment of gaps, developing an appropriate set of actions, and implementing the actions with fidelity.

Next steps: Whereas country contexts differ, the solutions that these districts implemented can apply to other VMMC programs that are aiming to increase uptake of VMMC among older men. Programs looking to increase VMMC uptake among older adolescents and men can consider applying these tested approaches.

Key words: VMMC, increasing uptake, older men, priority age, Malawi

THPEE367

#End Adolescents AIDS: Bottlenecks Limiting Coverage and Impact of Priority HIV Interventions among Adolescents and Young People in 5 High HIV Burden Districts in Zimbabwe

Komu Patricia[1], Senzanje Beula[2], Ncube Getrude[3], Sithole Ngwarai[3], Choto Regis[3], Pierotti Chiara[2], Murimwa Tonderayi[2]
[1]UNICEF Consultant, Windhoek, Namibia, [2]UNICEF Zimbabwe, Programmes, Harare, Zimbabwe, [3]Ministry of Health and Child Care, AIDS & TB Department, Harare, Zimbabwe

Issues: In Zimbabwe, adolescents and young people ADYP (15-24) comprise 19% of population and 20% of PLHIV but have made less progress than adults towards the 90-90-90 goals. Zimbabwe adopted the #EndAdolescentsAIDS initiative to accelerate HIV response to ending AIDS by 2030.
Descriptions: In 2018 Ministry of Health and UNICEF conducted a participatory, multi-sector in-depth bottleneck analysis (BNA) using Adolescents Assessment and Decision Maker's tool involving ADYP on three HIV interventions for ADYP (HIV testing services HTS, Antiretroviral Treatment ART, Life skills-based education LSBE) using disaggregated data on determinant indicators or proxies of supply (commodities, human resources, accessibility), demand (coverage on initial utilization and continuity) and quality for each intervention in five districts with high adolescent HIV burden, followed by identification of underlying causes and formulation of corresponding corrective actions.
Lessons learned: The BNA approach facilitated identification of factors and their causes that impact three key interventions for ADYP. It identified disparities across districts and highlighted gender and age differences. Major findings were: 100% availability of LSBE commodities, utilization and continuity indicators, but unavailability of trained teachers; absence of data to assess impact of new LSBE curriculum. HIV testing commodities stock outs were linked to poor stock management by health workers and lack of supportive supervision. Low ART initiation (indicator for both HTS quality and ART provision) was associated with lack of integrated services at health facilities and outreach testing services. BN on retention in HIV care were linked to treatment fatigue and fear of disclosure by ADYP. Lack of setting adolescent HIV targets for adolescents HTS at district level resulted there was no relevant data for utilization and continuity indicators. Other data gaps were in AFHS provision and viral load monitoring.
Next steps: BNA should be used routinely to define and monitor over time BNs and their underlying causes in ADYP interventions and to facilitate districts to develop action plans.These should include priority interventions for ADYP with responsibilities and timelines. In-depth analysis will be scaled to all remaining districts in Zimbabwe. Strengthening availability and quality of data and targets and promote ADYP participation in HIV programming should be prioritized at sub-national level.

THPEE368

Text for Adherence (T4A) among People Living with HIV/AIDS: Evidence from a Pilot in Homa Bay County, Kenya

Mwangi Cathy[1], Mudogo Collins[1], Simiyu Rodgers[2]
[1]mHealth Kenya, Nairobi, Kenya, [2]Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), Nairobi, Kenya

Background: Adherence to appointments is a proxy indicator to adherence to treatment which influences viral load suppression among people living with HIV/AIDS (PLHIV). With funding from CDC, mHealth Kenya developed and piloted the Text for Adherence (T4A) system in 3 facilities: Kiasa, Gongo and Ogongo in Homa Bay County in collaboration with Elizabeth Glaser Pediatric AIDS Foundation (EGPAF). A welcoming short text message (SMS) is sent upon consenting, 3 appointment text messages: upon updating of appointment date, one week to the date and on the day of appointment were sent to patients upon consent. The aim was to improve retention in care and adherence to treatment for PLHIV. The piloting started in March 2017 and continued for 12 months when there was an upgrade to version 2 of T4A.
Methodology: A before and after design using both quantitative and qualitative approaches were used to evaluate the influence of T4A system in improving keeping of appointments and reducing unscheduled appointments among participants in the pilot sites. From 1095 clients who had consented, a random sample of records for 558 (349 for females and 209 for males) patients was abstracted from files and T4A data base. Three appointments before and three appointments after consenting into T4A, with 3 months intervals, were analyzed using SPSS version 25.
Results: There was improvement in keeping of appointments from 55.7% before T4A to 63.8%, [α=0.006, CI of 95%]. A steady improvement in keeping appointments (from 55.7%, 58.1% to 63.8%) after T4A the unsteady trend of (58.5%, 58.5% to 55.7%) before T4A were observed. Wilcoxon mean rank of 166.54 before- and 180.68 after-intervention showed an improvement in reducing the unscheduled appointments. The results did not show any major differences in appointment outcomes between females and males. Qualitative findings show that both clients and users liked T4A as a helpful, confidential, private and easy to use system.
Conclusion: T4A has potential to enhance care and treatment among PLHIV in terms of appointment management.
Recommendation: Optimal use of the system by regularly updating required information to avoid possibility of false missed appointments and defaulters on the system is critical among users.

THPEE369

Developing a District-based Comprehensive Approach to the HIV/AIDS Response to Accelerate Progress towards the 90-90-90 Objectives in Cameroon

Keugoung Basile[1], Oloume Beyeme Valentine[1], Muluh Clifford[1], Ebogo Fouda Liliane Estele[2], Tjek Biyaga Paul[3], Zeh Kakanou Florence[4], Fouda Alain Patrick[5], Ngo Ngwe Solange Bernadette[1], Bacha Abdelkader[1], Nduwimana Therese[6], Dongmo Tsague Landry[6]

[1]UNICEF-Cameroon, Yaoundé, Cameroon, [2]CNLS Cameroun, Yaoundé, Cameroon, [3]Ministère de la Santé Publique, Yaoundé, Cameroon, [4]Direction de l'Organisation des Soins et de la Technologie Sanitaire, Yaoundé, Cameroon, [5]RECAJ+, Yaoundé, Cameroon, [6]UNICEF WCARO, Dakar, Senegal

Questions: In Cameroon, only 21% of children and adolescents living with HIV had access to antiretroviral treatment (ART) in 2017. In 2018, to accelerate progress towards the 90-90-90 objectives, UNICEF developed with its implementing partners a comprehensive approach for the children and adolescent's HIV/AIDS response. This study aims to assess the effects of this approach on the HIV/AIDS response.

Description: The UNICEF's support started at the central level by advocating for change from a two-age groups (0-14 and 15-19 years) to five-age groups (0-4, 5-9, 10-14, and 15-19 years) data monitoring system. Then, HIV/AIDS planning changed from centralized to decentralized in each of the 10 districts in the 4 Regions supported by UNICEF.

The Regions quarterly supervised health districts and organized a coordination meeting to review the performance of each district.

At the district level, competencies of staff of 235 primary health care facilities were reinforced through training and supervision and ART delivery was decentralized from district hospitals to health centres. Additionally, the capacities of a community-based organization were strengthened to refill antiretroviral drugs to stable HIV positive patients on ART, trace defaulters and link them to care, and promote HIV prevention especially for young and adolescents. Moreover, other sectors (Ministries in charge of Youth Affairs and of Secondary Education) participated in adolescents' sensitization for HIV prevention and referral for HIV counselling and testing in health facilities. A monitoring tool was developed to monthly follow ART coverage for the five-age groups and take appropriate decision for improvement.

To asses the intervention, data were collected from documentary review of 2018 reports of health facilities and implementing partners at the central, regional, district and community levels as well as the online HIV/AIDS reports on DHIS2.

Lessons learnt: In the 10-supported health districts, ART coverage for children and adolescents (0-19 years) living with HIV increased from 21% in 2017 to 53% in 2018. Specifically, the ART coverages were 63% in the age group 0-4 years, 29% for 5-9 years, 48% for 10-14 years, and 72% for 15-19 years. Nationally, the ART coverages were 20% for children 0-9 years and 29.5% for adolescents 10-19 years.

Next steps: Scaling up this comprehensive approach to all health districts will contribute to close the gaps and reach the 90-90-90 goals.

THPEE370

Digitalization of Community Involvement in HIV Commodity Monitoring and Reporting of State of Services: Learning from NEPHAK's GlobalFund I-Monitor Project

Okello Victor[1], Kimono Nickson[2]
[1]National Empowerment Network of People Living with HIV/AIDS in Kenya - NEPHAK, Nairobi, Kenya, [2]NEPHAK, Nairobi, Kenya

While the importance of community participation in the health service development and the fact that it is its backbone is uncontested, there is need of paradigm shift from exclusively vertical, top-down and curative approach to local people driven health service if we are to achieve and sustain SDGs goals. As Kenyan government through the implementation of universal health care aims at ensuring that Kenyans have access to an explicit unified progressive health benefit package, there is need of empowering its citizens to become an integral part of the decision making and action process.
With the aim of enhancing community participation in health services, NEPHAK has been piloting in Vihiga,Homa Bay and Kwale counties I-monitor+ATM Kenya - a community owned,innovative solution tool that leverages the use of technology to enable monitoring, recording and reporting the state of services, as experienced by people themselves, thereby enabling a dialogue for transformation. The project aims at driving public accountability. The concept involves sensitizing PLHIVs group leaders, community leaders, activists and general community on the use of I-monitor in monitoring HIV commodities and reporting of state of services at the local health facilities. The chosen leaders are given phones and are provided with data bundles monthly to enable them access and use I-monitor. Users can choose to report an incidence as anonymous or use their real names.
The project has created impact within 10 months of its implementation. A total of 218 community cases were reported,31.2% were on commodities, service delivery 32.6%, human rights issues 15.6% and 6.4% treatment literacy. Successfully resolved cases were 67%, 31.7% are still open and 0.01% cases remain unresolved.
As a result of the project, there has been increase public accountability in government health facilities, improved quality of services offered by health care workers, improved hygiene and sanitation in the health facilities, good networking with facility in charges due to the resourceful I-Monitor ATM+ App utilization in raising cases like stock out of health commodities and improved relationship between service providers and the community.
This concept that can be relied upon in enhancing community participation in health services, monitoring health commodities, widening and strengthening of real-time collection of reliable and verifiable data from the community, measuring and evaluating community participation.

THPEE371

Ready to Lead: Understanding the Pathways to Leadership among Young Women Supporting their Peers to Advocate for their Needs and Rights

Dziwa Chengetai[1], Schlosser Delphine[1], Sango Annah[2], Gumbo Gladys[2]
[1]Frontline AIDS, Cape Town, South Africa, [2]Zimbabwe Youth Positives, Harare, Zimbabwe

Issues: Adolescent girls and young women (AGYW) are facing a huge burden of HIV in East and Southern Africa. This group is still disproportionally affected by HIV and in 2017, 79% of new HIV infections were among adolescent girls while an estimated 50 adolescent girls die every day from AIDS-related illnesses and 460 adolescent girls become infected with HIV within this region. While there is increased levels of understanding of the epidemic which has increased the awareness on the need to prioritise this group, there is still need to capacitate them to engage in advocacy spaces. Establishing leadership pathways required to build capacity of young women to support their peers to express their rights is key.
Descriptions: READY to Lead focuses on young women's leadership in Zimbabwe and aims to to hone their leadership skills through training and mentorship. As the project progresses, young women mentees also grow into mentors to create a sustainable model of young female leadership. The project target is to mentor 1,000 young women in four districts namely Masvingo, Bulawayo, Gutu and Chitungwiza in Zimbabwe. A total of 100 young women leaders were trained and supported to lead community and advocacy activities and each mentors at least 10 young women. The mentors act as role models to their mentees and use their technical knowledge to act as experts and champions in their communities. In order to have an in-depth understanding of the pathways to leadership a four case studies were documented with four selected mentors.
Lessons learned: Leadership increases awareness of the self within the mentors, and the need for their roles in the communities. With increased self-awareness, comes increased self-agency and confidence. Additionally, mentors have learnt the value of advocating both at personal level and at household and community level for her mentees. However, leadership pathways are constantly tested as the young leaders live their lives within the same community they served. Stigma around HIV and negative social norms within the communities also interferes with the pathways of leadership.
Next steps: Leadership and sustained mentorship helps young women leaders succeed in engaging their peers, their families, the community, service providers and decision makers in advocating for their priorities. As the young women increase their self-awareness they are empowered to express their needs and rights and also support their peers to do the same.

THPEE372

Differentiated ART Care Models; A Strategy for Improving Retention and Viral Suppression among People Living with HIV/AIDS in Conflict Zones

Nitah Eleanor[1], Desembuin Felix[2], Atanga Paul[2], Banlack Ernest[2], Atembe Bernard[2], Tih Pius[2]
[1]Cameroon Baptist Convention Health Services, HIV Free, Mutengene, Cameroon, [2]Cameroon Baptist Convention Health Services, Mutengene, Cameroon

Background: There is the need to improve on retention and viral suppression amongst people living with HIV (PLWH) in conflict areas where access to care is a challenge. This has led to innovative methods of ART service delivery. The Differentiated ART Care Model (DACM) is a client-centred approach of provided services particularly but not limited to stable clients who have challenges accessing ART services. It comes as a response to specific barriers and or challenges faced by clients as a result of the ongoing socio political crises in the South West Region (SWR) of Cameroon.
Methods: DACM was applied in some 26 health facilities in the crises hit areas of the SWR of Cameroon over a three month period, April to June 2019. The models include; Family ART model; A family member picks up medication for self and any other family member on ART, Community ART groups (CAGs); Clients in a community received their ART refills in a group. Usually, a group member who is due viral load monitoring or needed some form of clinical help, came to the facility and collected pre-packaged medication for self and other group members. Extended working hours; facility staff stayed back after official closing hours or holidays to deliver ART services for clients making impromptu visits. VIP/ Private services; drugs and other ART services were taken to some clients at designated locations, such clients avoided coming to the health facility (HF) due to their social status in the society or busy schedule. Community dispensation; A healthcare worker (HCW) took drugs and /or a few basic ART services to a group of people in a community or cluster. These models were all used simultaneously and in parallel during this period.
Results: During this period, April to June 2019, 36% (7336) of those currently on treatment in 36 health facilities were served. The breakdown is as follows: Community ART dispensation, 15%(3031), Community ART groups, 8%(1637), Extended working hours, 7% (1344), VIP/ Private services, 4% (857) and the Family model, 2% (467).
Conclusions and recommendations: Differentiated ART Care Model is a client-centred strategy which allows for effective decentralization of ART service delivery and increased access to care in a crises zone. These models take ART closer to the people, reduce number of trips clients make to the health facility, reduce unnecessary burden on health systems, help improve on retention which consequently leads to viral suppression among PLWH.

THPEE373

Harmonization of HIV Migration Management across National Borders in Selected SADC Countries

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

Issues: The contribution of migration to the spread of HIV has long been recognized. Countries within SADC have identified type and scale of approaches geared on how to mount a formidable response to the HIV epidemic within national borders. Cross-country comparison suggests that development is associated with more rapid and extensive spread of HIV in Africa. However, a response to HIV across international borders is poorly understood. Such national responses do not present epidemic response strategies for continuity of care across national borders. This paper describes cross border collaboration's to promote HIV referrals and adherence in cross border communities.
Descriptions: The intervention is implemented in cross border districts of Eswatini, Lesotho, Malawi, Mozambique, South Africa and Zambia. The intervention works at three outcome levels. Increased Service providers, from each of the six countries; both health and non-health, were trained to provide AYPs, migrant and sex worker rEnabling Environment by conducting advocacy engagements at district, national and regional levels. Program data was analysed for migrant referrals and access to HIV antiretroviral treatment. Cross border collaboration forums were established across national borders.
Lessons learned: Migrants and sex workers have trouble in accessing ART outside countries of origin. This assertion is also true for internal migrants who have moved outside districts of origin. Migrants and sex workers make use of aliases or simply register themselves for services as first time clients. In some cases the nearest cross border facility is located within the adjacent country on the other side of the border. Established cross border forums effective in increasing access to HIV treatment and care. Two SRHR HIV tripartite functional cross border forums have been established (- Malawi, Mozambique and Zambia - and Eswatini, Mozambique and South Africa) to discuss cross border referrals, creating Sex Worker and migration responsive services.
Next steps: Effective continuity of care for migrants across national borders may be realized through participation of beneficiaries, civil society, non governmental organizations, traditional and religious leaders and highly placed influential government officials. Sustain cross border forums with recognized secritariats with fund raising capabilities. Promote pooled procurement of pharmaceuticals, especially ARVs to limit brand differences across national borders.

FRPEE309

Repenser les Approches du Partenariat pour Favoriser l´Empowerment des Associations de Personnes Séropositives dans le Contexte de Crise de Financement: Le Programme « Autonomisation » de Bokk Yakaar

Ndiaye Oumy[1], Ba Ibrahima[1], Paulmier Aude[2], Marchal Florent[2]
[1]Association Bokk Yakaar des Personnes Vivant avec le VIH de Fatick, Fatick, Senegal, [2]Solidarité Sida, Paris, France

Les questions: Les associations des PVVIH rencontrent des difficultés pour financer leurs programmes, dans un contexte de demande croissante des services. Pour augmenter et sécuriser leurs ressources, elles acceptent des conditions défavorables à leur autonomie, notamment l´imposition de thématiques ou d´outils de suivi qui complexifient leur travail. Ces contraintes influent sur leurs stratégies et priorités en les réduisant à un rôle de prestataire. Bokk Yakaar Fatick, crée 2005, cherche à répondre à 2 questions : Comment l'association peut-elle contrer les effets de la crise de financement sur son autonomie? Quel rôle les bailleurs peuvent-ils jouer pour favoriser son autonomie?
Description: Bokk Yakaar met en œuvre un programme triennal (2016-2019), financé par Solidarité Sida en partenariat avec la Ville de Paris et l'Agence Française de Développement (AFD), pour accompagner son autonomisation pour qu´elle gère stratégiquement sa dépendance tout en développant des ressources diversifiées. Cette autonomisation consiste à diagnostiquer les manques, puis à amener un changement de posture et d´approche partenariale à travers un coaching, le financement d´investissements stratégiques et d´appuis techniques et l´organisation de renforcements de capacités.
Leçons Tirées: En replaçant le projet associatif au cœur des stratégies partenariales, Bokk Yakaar a pu piloter son évolution dans le contexte de crise de financement. Ainsi, Bokk Yakaar a pu acquérir des motos pour ses cellules pour faciliter les visites à domicile et les recherches de perdus de vue. L'association a organisé avec la Gouvernance un Comité Régional de Développement (CRD) qui a permis d'obtenir un terrain pour le siège de 1000m^2, un appui financier de 450 000f pour l'inscription des membres aux mutuelles de santé. Des Comités départementaux de développement (CDD) sont organisés dans les départements sur engagement du Gouverneur. Un gala de lutte pour collecter des fonds a été organisé au mois de novembre a généré plusieurs ressources pour l'association. Des parrainages des OEV sont faits lors du CRD et des CDD.
Prochaines Étapes: Dans un but de poursuivre l'autonomisation de Bokk Yakaar, des stratégies innovantes de mobilisation de ressources ou d'accompagnement des PVVIH seront développés. Il s'agira d'un recrutement de bénévoles pour l'association dans les lycées pour les journées de collecte, de la mise en place de l'approche famille dans la prise en charge des PVVIH.

FRPEE310

Reaching the Unreached Children of Female Sex Workers through Innovative Partnership with Other Implementing Partner for Enrollment into OVC Program

Oke Olufemi[1,2], Anoje Emeka[3], Efuntoye Adeola[3], Osisami Olukayode[4], Oke Rebecca Oluwaseun[5]
[1]Catholic Relief Services, Abuja, Nigeria, [2]Ladoke Akintola University of Technology Teaching Hospital, Department of Community Medicine, Ogbomoso, Nigeria, [3]Catholic Relief Services, Health, Abuja, Nigeria, [4]Heartland Alliance Int'l, Nigeria, Health, Abuja, Nigeria, [5]Ekiti State University, Ado-Ekiti, Department of Nursing, Ado-Ekiti, Nigeria

Issues: The attainment of the UNAIDS 90-90-90 target may be derailed if efforts are not harnessed in a concerted and strategic manner to reach the key population with disproportionate high burden of HIV. Even though four in ten female sex workers (FSWs) in sub-Saharan Africa are infected with HIV, only a small proportion have access to HIV prevention and treatment programs. Reaching the key population especially the FSWs and their children is hampered with a lot of barriers among which are high mobility, societal stigma and discrimination and potential for breach of confidentiality. Following the new PEPFAR OVC target streams for enrolment, children of FSWs occupied a central tenet within the OVC program. Enrolling children of FSWs for service provision is often challenging. This study aimed at describing the gains of engagement and partnership with other IPs working with FSWs.
Descriptions: Sustainable Mechanism for Improving Livelihoods and Household Empowerment (SMILE) project implemented by a consortium led by Catholic Relief Services (CRS) with USAID funding. In the face of daunting challenges of reaching these FSWs and their children, SMILE approached Heartland Alliance International in Nigeria (HAI-N) who are already implementing project among the key populations but with no specific provision to cater for their children. SMILE signed MoU with HAI-N on terms of engagement and linked all the children of FSWs on their program to SMILE for enrollment and service provision.
Lessons learned: The engagement and partnership with HAI started begins in November,2017 and was consolidated in March 2018.At the end of the engagement process HAI linked to SMILE through their Community Facilitators who worked with SMILE Community Volunteers to enrolled 1002 households with 2442 VC (M= 1180; F= 1262) out of this 2442 VC we identified 54 adolescents FSWs among them. These children were provided with services based on their identified need.
Next steps: Engagement and partnership with other IPs within the HIV programming is essential for maximizing the gains of various USAID funded project. There exist within each program a low hanging fruits that IPs can explore among themselves. This provided new insight that collaboration can be effective with minimal resources utilization.

FRPEE311

Engagement of and Collaboration with State Stakeholders: Key to the Success of the Nigerian AIDS Indicator and Impact Survey

Aguolu Rose, Edward Chigozie, Ashefor Gregory
National Agency for the Control of AIDS, Abuja, Nigeria

Issues: Obtaining good responses for household interviews and sample collection in population-based surveys is essential to having good statistical outcome. The Nigerian AIDS Indicator and Impact Survey (NAIIS) was a population-based household survey conducted in all the 36 states of Nigeria, and the Federal Capital Territory in 2018. This paper showcases how states' stakeholder's participation in NAIIS led to the success of the survey field implementation in five months.
Descriptions: State stakeholders were engaged at different levels. The state implementation team (SIT) was the main NAIIS organizational structure of engagement at the state level. The SIT comprised of officials from the State Ministry of Health, State Agency for the Control of AIDS and civil society groups. This team was inaugurated and conducted their affairs in line with their terms of reference. They participated in planning meetings, state advocacy visits to top influential state stakeholders, recruitment of field data collectors and community mobilizers, state stakeholders' engagement and entry meetings and monitoring of field data collection. They also participated in state exit meetings, data validation exercise and dissemination of results.
Lessons learned: Engaging these stakeholders facilitated ease in states' entry and survey implementation. Their participation in advocacy visits to key state actors- commissioners of health, traditional and religious rulers, and security agencies facilitated state approvals, community acceptance and logistic assistance. They provided very useful information on security, religious and socio-cultural events that guided the timing and location of field data collection in the state, which led to very minimal casualties and timely collection of data. The state and local governments committed resources to support the survey. The presence of the SIT as field monitors enhanced quick resolution of socio-cultural challenges that arose during the process of field data collection.
Next steps: Engagement of and collaboration with state stakeholders throughout the planning and the different stages of field implementation of NAIIS facilitated quick survey acceptance, excellent response rates and state ownership of NAIIS results. Involving these stakeholders in the review of HIV program interventions and policies will further consolidate on the gains from NAIIS.

FRPEE312

Scaling-up Viral Load Testing in Treatment Monitoring of HIV/AIDS Clients on Combined Antiretroviral Therapy in Project Concern International Supported Defense Force Zambia Health Facilities

Tembo Aaron K.[1], Musonda Shebba E.[1], Kafweta Cunningham[1], Mulenga Yvonne[1], Chungu Bernard B.[2], Banda Chibeza[2], Simenti Emmanuel[2]
[1]Project Concern International, Laboratory Technical Unit, Lusaka, Zambia, [2]Defense Force Medical Services, Laboratory Technical Unit, Lusaka, Zambia

Background: Viral load (VL) is recommended as the preferred monitoring approach to determine the performance of Combined Antiretroviral Therapy (cART) in HIV-infected individuals. According to the Zambia Consolidated Guidelines for Treatment and Prevention of HIV Infection (ZCG) 2018, the first VL is done at 6-months post-initiation, and if VL is less than 1000 copies/ml, 12-months post-initiation and every 12 months, if it remains below 1000 copies/ml. VL monitoring for HIV-infected pregnant and breastfeeding women is done at baseline for known HIV positives. Henceforth, VL is done at month 6 of pregnancy and 2 to 4 weeks before labor and delivery, and every 6 months during breastfeeding. However, if VL is greater than 1000 copies, a repeat VL is done at 3 months following enhanced adherence counseling, until suppression is achieved or the cART regimen is switched preferably after conducting HIV Drug Resistance (HIV-DR) test. The objective of this study was to assess the impact of PCI DOD/PEPFAR DLAB Project in scaling up VL in DFZ health facilities.
Methods: An additional third and higher throughput PCR equipment was placed at Zambia Air Force Headquarters Hospital. PCI supported DFZ health facilities were mapped using the 'hub and spoke' model to take samples to the 3 DZF PCR Laboratories; and of course to closest Ministry of Health (MOH) PCR Laboratories. Based on the proximity of the facilities, central facilities (also known as sample Hubs) were identified and supported to receive VL samples from surrounding facilities (also known as spoke sites). Hubs prepare the samples and transport them to the PCR Laboratory. Each time the Hubs deliver VL samples to the PCR Laboratory, they collect results for last batch of samples. In turn, each time the spoke sites deliver samples to the Hubs, they collect the results of the last batch.
Results: With addition of the higher capacity PCR equipment and strengthening of the sample and results courier system in DFZ health facilities using the 'Hub and Spoke' model, the average VL results turnaround time (TAT) has reduced from an average of 90 days to an average 14 days. Additionally, the number of VL samples submitted has increased by almost 25% from 50% to 75 %.
Conclusions and Recommendations: Scaling-up VL require consented effort - from demand creation, strengthening the sample courier system and empowering PCR Laboratories including the hubs and spoke sites.

FRPEE313

Stakeholder Engagement in Changing the Narratives around Issues Affecting Lesbian Gay Bisexual Transgender and Intersex (LGBTI) Communities in Nigeria

Nnolum Chukwuebuka[1], Aka Abayomi[2], Alubumgu Basiru[1]
[1]International Center for Advocacy on Right to Health, Programs, Abuja, Nigeria, [2]International Center for Advocacy on Right to Health, Management, Abuja, Nigeria

Issues: Over 286 LGBTI persons face different types of human right violation annually ranging from Murder, arbitrary arrests/unlawful detention, blackmail and extortion and battery based on perceived or real sexual orientation and gender identity in 2018. This is due to existing laws that prohibit and criminalize affairs and activities of LGBTI persons in Nigeria.
Description: In 2018, the International Center for Advocacy on Right to Health (ICARH) with support from Frontline AIDS, celebrated humanity by joining the world in commemorating the International Worlds AIDS Day, and the International Human Rights Day through the PITCH PhotoVoice Project. The event aims promoting human rights regardless of race, sex, gender and to encourage people to know their HIV status, and also access HIV prevention, treatment and care services.
Lessons learned: ICARH community centre served as the venue for the event, holding a capacity of about fifty participants in attendance ranging from partner NGO's, LGBTI community members, representative from national human right commission, media representatives, healthcare providers, police and vigilantes. The event had a photo exhibition of images expressing instances of human rights violations against sexual minorities and LGBTI persons from arbitrary arrest, to denial of access to healthcare services, panel discussions on the themes "#knowyourstatus and #standupforhumanrights with technical experts in areas of LGBTI human rights advocacy and HIV prevention services for men, a short movie screening titled "Hell or High Water" that relates the realities of LGBTI persons in Nigeria and their ordeal with religion and societal expectations and a candle light procession in memories of those lost to the HIV virus. Evidently, the event brought together relevant stakeholders who admitted thy impacted their perception towards LGBTI community and also willingness to support community based organizations in ensuring the rights of LGBTI persons are protected.
Next steps: ICARH will build up on the success and continue to work with stakeholders and allies at different levels within the state to promote visibility and proactively on issues relating to sexual minorities and LGBTI persons.
Keywords: LGBTI, Human Rights,

FRPEE314

Strengthening Collaborative Partnerships: Role and Impact of Research Partners in Creating a Conducive Policy Environment for Key Populations in Kenya

Owino George Victor[1], Bhattacharjee Parinita[2], Ominde Henry[3], Musyoki Helgar[4]
[1]International AIDS Vaccine Initiative (IAVI), Global Affairs, Nairobi, Kenya, [2]Partners for Health and Development in Africa (PHDA), Nairobi, Kenya, [3]PEMA Kenya, Mombasa, Kenya, [4]National AIDS and STI Control Programme (NASCOP), Nairobi, Kenya

Issues: Young Key Populations (YKPs) aged 15 to 24 years are particularly vulnerable as there are structural barriers that hinder their involvement in research, and access to appropriate sexual reproductive health (SRH), including HIV prevention services. HIV prevention services remain inaccessible to key populations, i.e. Female Sex Workers (FSW), Men Who Have Sex with Men (MSM) and People who Inject Drugs (PWID). Some of these barriers are violence, stigma and discrimination. Researchers working in Kenya and around Africa play a critical role in contributing to science to address HIV and AIDS.
Descriptions: Through a collaborative partnership between IAVI, NASCOP, PHDA and Community Based Organizations (CBOs), one community-driven needs assessment to investigate the needs of YKPs was conducted in 2017. 4 YKP community researchers; 2 FSWs and two MSM were identified and trained in qualitative research methods, data collection and analysis. The needs assessment was conducted in Mombasa and explored risk, vulnerability and needs of young women who sell sex (YWSS) and young MSM (YMSM) in the context of HIV prevention to inform the development of policy guidelines and programmes for YKP in Kenya.
Community researchers conducted Focus Group Discussions (FGD) with 72 YWSS and YMSM and in-depth interviews (IDI) with 12 service providers. The collected data was transcribed and analyzed in a 5-day workshop by a team of community researchers and experts from other partner organizations. The analysis included coding based on recurrent themes and then documenting the emerging issues.
Lessons learned: Results show that collaborative partnership can result in in-depth understanding of issues, leading to development of policy and programmes. The need for implementing partners to provide comprehensive SRH services, sexual health education, safe spaces, mental health services, violence and stigma reduction services, skill-based job training, social protection and information about research using a peer-to-peer approach, emerged. The need to develop policies that create an enabling environment for YKPs to access comprehensive services identified.
Next steps: National Implementation Guidelines for HIV and STI Programming among Young Key Populations was developed, launched and disseminated in 2018, following this collaborative assessment. This emerged as a best practice model for strengthening collaborative partnerships with researchers to influence policy and practice.

FRPEE315

Evidence-based Behavioral Change Communication Materials as Effective HIV Peer Education Interventions among Female Sex Workers

Addison-Fynn Mary[1], Appiah Evans[1], Adiibokah Edward[2], Nartey David Tetteh[3], Eifler Kristin[4]
[1]Hope For All, Takoradi, Ghana, [2]Population Council, Accra, Ghana, [3]JSI Research and Training Institute Inc., Accra, Ghana, [4]JSI Research and Training Institute Inc., Boston, United States

Issues: Peer education remains a popular strategy to reach epidemic control by 2030 due to shared background, experience, interest, language of peers involved. While the typical informal and unstructured approach used in peer education can be more effective with female sex workers (FSWs), evidence around this is limited. We highlight the key ingredients that engender success for a peer education intervention to prevent HIV among FSWs using programmatic data from an FSW friendly Civil Society Organization (CSO) in Ghana

Descriptions: Hope For ALL (HOFA), an FSW friendly CSO, under the USAID Strengthening the Care Continuum project, has been implementing a peer education intervention for FSWs in two administrative districts of the Western region of Ghana since 2016. The Peer Education intervention involved demarcation of micro-sites, selection of Peer Educator (PEs) based on typology and leadership and communication skills. In January 2019, we introduce an evidence -based, audio-visual behavioral change communication (BCC) manual. PEs were trained and monitored and supervised to use the BCC materials to reach out to their peers. The manual was developed in partnership with the Ghana AIDS Commission, FSWs were purposively selected to represent diversity of FSWs in the country both in typology geographical coverage and put in a focused ground discussion to develop the content of the BCC materials

Lessons learned: The audio-visual BCC material led to a spike in the number of FSWs reached with HIV education, screened for gender-based violence and referred for STI, and HIV testing services (HTS). PEs ability to reach and link FSWs who are at elevated risk of HIV infections because of condom-less sex, STI infections and illicit drug use increased. During the period July-September 2018, the number of KPs tested for HIV was 168 of which 6 tested HIV positives. Following the full deployment of the BCC materials in October-December 2018, 200 KPs were reached and tested, with 15 testing positive. Peer educators indicated that the BCC materials made them appear more credible to their peers as they were able to explain issues more eloquently

Next steps: While other factors remain important to the effectiveness of peer education interventions for FSWs, the use of evidence-based audio visual BCC material play a critical role for success. This is especially pertinent in low-literacy settings like Ghana. This approach will be useful in similar settings.

FRPEE316

Management Stratégique du Programme de Lutte contre le VIH/SIDA dans les Forces Armées au Sénégal

Toure Mor Talla[1], Faye Babacar[2,3], Diallo Gorgui Sene[1], Grillo Michael[4], Sherif Joanna F[4]
[1]ONG Africare, Dakar, Senegal, [2]Programme Sida des Forces Armées Senegal, Dakar, Dakar, Senegal, [3]Université Cheikh Anta Diop de Dakar, Dakar, Dakar, Senegal, [4]DHAPP, San Diego, United States

Contexte: L'épidémie VIH au Sénégal est de type concentré avec une prévalence basse dans la population générale, estimée à 0,5% en 2016 *(Spectrum ONUSIDA, 2017)* et élevée chez les populations clés.
Certains facteurs liés à leur statut ou à leur mobilité, rendent vulnérables les militaires. La mobilité étant corrélée à plusieurs facteurs de vulnérabilité dont le recours des rapports sexuels.
Les données programmatiques du Sénégal révèlent des performances de 69-57-19 par rapport au 3 "90" témoignant de gaps observés à tous les niveaux de la cascade.
Au regard des résultats obtenus en 2016, beaucoup de défis sont à relever.
Pour gérer la cible militaire et appuyer le niveau national à atteindre cet objectif en 2020, un programme de lutte contre le VIH/SIDA a été mis en place dans les forces armées Sénégalaises.
Objectifs: Réduire le nombre de nouvelles infections à VIH parmi les militaires, leurs familles et les communautés civiles desservies, réduire le nombre de décès liés au VIH et améliorer la qualité de vie des PVVIH.
Méthodologie: Elaboration d'un plan stratégique et opérationnel par SAF et validé par DHAPP et Africare. Mise en œuvre des activités VIH par SAF dans les structures militaires à travers le pays.
Un management stratégique tripartite (DHAPP, SAF et Africare) dans les interventions aidant à renforcer les capacités institutionnelles, techniques et administratives des services sanitaires des forces armées sénégalaises.
Résultats: D'une prévalence de 0,3 % à la fois chez les gendarmes et les militaires *(ENSC 2015), on est passé à un* taux de positivité de 0,18% chez les militaires en 2018. 11 895 dépistés, 23 142 personnes touchées et recevant un paquet complet de prévention du VIH/SIDA ; 64 156 préservatifs distribués. 2 715 femmes enceintes ont bénéficié de la PTME avec un taux de positivité de 0, 3%, 100% des patients sous ARV,
Une cohorte en moyenne de 2000 PVVIH suivis au niveau des structures militaires avec 95% de civils.
Le Labo de référence du programme aide le niveau national dans le suivi immuno virologique (1634 Charges virales effectuées, 491 CD4) et 214 PCR VIH pour Bébés.
Conclusion: Cette collaboration tripartite a permis d'avoir un des taux les plus faibles dans les armées africaines et la mise en place d'un système de prévention, de suivi clinique et biologique des PVVIH.

FRPEE317

Domestic Financing towards Ending HIV&AIDS in Uganda through Voluntary Contribution of One Dollar to the Private Sector Led Fund

Tamale George[1,2]
[1]One Dollar HIV&AIDS Initiative Uganda, Kampala, Uganda, [2]Federation of Uganda Employers, Workplace Health, Kampala, Uganda

Issues: Since 1982, Uganda has been devastated by HIV&AIDS massively impacting individuals, communities, businesses and economy. Uganda Aids Commission's Multisectoral approach coordinates all stakeholders including the private sector towards three ones' principle in coordination of the national response. Because of the negative impact of HIV&AIDS on businesses through increased costs, declining profits and productivity coupled with reduced external donor funding, establishment of the private sector One Dollar HIV&AIDS Initiative (ODI) was inevitable in 2017

Descriptions: Under the trusteeship of Federation of Uganda Employers and Uganda Manufacturers Association ODI mobilizes domestic financial/in-kind resource contributions minimum of four thousand Uganda shillings equivalent to ONE DOLLAR annually from the private corporate sector, business entities, professional associations, Rotary clubs, Lions clubs, NGOs/CSOs, religious institutions, Ugandans in the diaspora, other well-wishers and also through special fundraising events into a fund. Resources mobilized support critical gaps in national HIV&AIDS prevention, treatment and care interventions guided by the national HIV&AIDS strategic plan motivated by the need for business sustainability through the increased purchasing power of healthy communities.

Lessons learned: U$25,000 (In-kind and financial) has been voluntarily, locally raised since 2017 into ODI.

Partnerships and community involvement to responding to common critical challenges and financing is attainable. Both financial/in-kind resources are needed and significantly contribute towards ending the epidemic in targeted grouping and settings. Simple innovative local approaches in mobilizing HIV&AIDS resource can substantially generate tangible resources for HIV prevention, treatment and care interventions.

Next steps: Involving the private sector in multisectoral response and their effective coordination harnesses leverages on resources for HIV&AIDS.

Good governance such as independence, transparency and accountability of resources for HIV&AIDS motivates and encourages contributions.

Engaging the private sector in corporate sustainability approaches can support critical HIV and AIDS gaps and challenges that accrue benefits to business community.

Demonstrating its impact to company´s bottom -line and competitiveness are vital and effective to get workable solutions and buy-in to support HIV&AIDS prevention initiatives in their workplaces

FRPEE318

The Impact of PMTCT Intervention in Private Health Facilities Rivers State Nigeria, in Reducing Mother to Child Transmission of HIV

Aneke Chukwunonye[1], Ugwoeruchukwu Wilfred[2], Adebiyi Olubunmi[2], Terfa Kene[3]
[1]Independent Researcher, Port Harcourt, Nigeria, [2]Prime Health Response Initiative, Lagos, Nigeria, [3]Achieving Health Nigeria Initiative (Affiliate of FHI 360), Abuja, Nigeria

Issues: The PMTCT intervention was majorly being carried out in the public facilities and a few faith-based private organizations in Nigeria as at 2011. Many HIV positive pregnant women and infants were still did not have access to quality HIV services despite the global goal of eliminating mother to child transmission and improving maternal and child health overall by 2015[1]. Following the realization that 60% of the Nigerian population access health care from the private owned facilities, the private for-profit health facilities were involved in the intervention in 2013[2]. Under the SIDHAS project through PEPFER funds, ninety-four (94) PFP health facilities were supported to offer PMTCT services.
The study showed the impact of PMTCT scale up to private sector in reducing childhood morbidity and mortality by HIV infection
Descriptions: 94 Private health facilities in Rivers State that provided PMTCT services between January 2014 and December 2015, and the live births to the identified HIV pregnant women between October 2015 and September 2016 who were 18months and above, were selected for the study.
The design was a retrospective cohort analysis of secondary data from the FHI360 SIDHAS project in the state. The collected data was analyzed on MS excel
Lessons learned: Within this period, 25,544 pregnant women accessed quality HIV testing services. 2.4% (608) of this population was identified HIV positive, 99% (604) of which were placed on Antiretroviral drug. All HIV exposed babies received ARV prophylaxis. Out of these 274 live births, 150 received PCR test for early infant diagnosis. 95.33% (143) of them had a negative result at 6weeks while 4.67%(7) were infected and thus refereed for further care. 90 out of the 150 babies completed the PMTCT program and had a documented report of the PMTCT out come at 18months. All the 90 had either a record of the rapid HIV test or a second PCR result. These results were all HIV negative
Next steps: The PMTCT intervention in private facilities reduced mother to child transmission of HIV. There is need to strengthen the model of intervention to ensure retention of mother baby pair in the program. It is therefore recommended that the private for-profit health sector be more engaged and supported to carryout standard PMTCT interventions.

FRPEE319

Leveraging Mobile Technology & Creative Storytelling to Enhance HIV Prevention, Care and Treatment for Children and Adolescents Using the Kidzalive Talk Tool Mobile Application

Mutambo Chipo[1], Heath Dewald[2,3], Heath Nokuthula[3], Des Fontaine Natalie[3]
[1]Zoe-Life, Monitoring, Evaluation and Research, Durban, South Africa, [2]Zoe-Life Innovative Solutions, Monitoring, Evaluation and Research, Durban, South Africa, [3]Zoe-Life Innovative Solutions, Durban, South Africa

Background: Evidence suggests that healthcare workers (HCWs) are reluctant to provide HIV services to children including HIV Counselling and Testing (HCT) and status disclosure, as they are not well equipped with child-friendly job aids. As a countermeasure, the KidzAlive Talk-Tool App, originally a paper-based job-aid that is widely used by the National Department of Health; was developed as a child-friendly job-aid for assisting HCWs to provide HCT, assist with disclosure and link HIV positive children to care. We present findings from pilot sites where this App was tested in Gauteng and KZN in 2018.
Methods: The KidzAlive Talk-Tool App was installed on tablets and phones and given to HCWs to use in place of the paper-based tool. We also provided HCWs with training and mentorship on using the App. During service provision, the HCW and child follow along with the story in the app about an animated frog, Sibusiso, as he learns about HIV, coping with stigma, and the importance of adhering to his treatment.
Findings: Playing interactive games on the App keeps children engaged throughout the counselling sessions and increases children's ability to understand and retain age-appropriate HIV information. 33 HCWs at pilot sites had a 62% increase in confidence and competence in providing age-appropriate, children-centred HIV services to children after receiving training on the App; the Increased willingness of caregivers to have their children tested for HIV. Of the 280 children that were tested using the app and 7% tested positive indicating the effectiveness of the approach in HIV case finding. Improved Access to care and treatment**:**100% of children that tested positive in the pilot were initiated on treatment.
Conclusion: Use of mobile technology was welcomed by HCWs, children and their primary caregivers. Next steps involve further development of the KidzAlive Mobilised Brand apps to support adherence at home.

FRPEE321

Empowering Zambia Millennials: Tapping into Technology to Meet their Sexual Reproductive Health and Rights/ HIV Needs

Meda Kudzai[1], Chomba Chrispin[2]
[1]SAfAIDS, Programmes, Lusaka, Zambia, [2]SAfAIDS, Deputy Programmes Director, Harare, Zimbabwe

Background: Zambia is one of the ten countries in the world hardest hit by the HIV epidemic according to the study conducted by UNAIDS in 2015.HIV prevalence among girls & boys aged 15-19 years is 6% and 4% respectively, among young people aged 15-24, only 34% females & 37% males have comprehensive knowledge about HIV/AIDS.While some young people rely on SRH information from teachers and elders in communities, most of them regard, in the highest esteem, platforms created by modern Information and Communication Technologies (ICTs) .With this understanding, Praekeit with funding from UNFPA planned, designed and developed a SRHR platform that incorporates ICT-Tune Me. Tune Me empowers adolescents and young people to make informed decisions around their bodies.
Methods: SAfAIDS popularised the Tune Me mobile site in Western Province in order to increase the number of user profiles & also increase influx onto the site by the adolescents and young people. To achieve this, key activities were conducted such as the High Volume Street Bashes, Radio series, peer-to-peer outreach activities &conduct weekly Facebook give aways and outreach activities. SAfAIDS trained a critical mass of Tune Me champions to aid in popularisation of the Tune Me MobiSite.
Results: The young people managed to have duo sources of accessing information that subsequently informed their decision-making processes to accessing SRH & HIV services. The live call-in radio program was conducted and a total of 1300 new users were successfully linked through the Facebook page as was seen by the increase of number of likes from 64,178 before the activity to 70, 381. Through the strong referral system using the peer-to-peer approach a total of over 200,000 adolescents and young people were reached with SRH information. It can be noted that 572,074 New sessions accounting for 97.96% of the total sessions have been conducted and 99.3% of the users had direct access of the Tune Me Mobisite.
Conclusion: There is need for a continuation of the popularisation of the Tune Me Mobisite through the already established government facilities and infrastructures.This has ensured that the platform is integrated into existing youth, health and education referral systems.The use of demand creating activities in popularisation of Tune Me activities has resulted in the increase in young people's knowledge & skills to promote the adoption of protective sexual behaviours.

FRPEE322

Artificial Intelligence to Improve Access and Task Shifting for HIV Services

Popoola Victor Oluwatobi[1], Popoola Eunice Oluwadamilola[1], Abikoye Oluwakemi Christiana[1], Morakinyo Akinkunmi[2]
[1]University of Ilorin, Ilorin, Nigeria, [2]Seamfix Nigeria Limited, Lagos, Nigeria

Issues: Significant challenges still exist in the HIV continuum of care regardless of the epidemic context or the level of achievement of UNAIDS 90-90-90. In the face of these challenges, artificial intelligence can be valuable in making services smarter and improving clinical decision making even among lower cadre of health workers as a way of strengthening task shifting and improving treatment access. The aim of the research was to model an HIV/AIDS diagnosis, Clinical Staging, and Regimen prescription system using artificial intelligence.
Descriptions: The experimental setup was carried out and developed with MATLAB programming language and the employment of various developed functions and class which were used to develop a graphic user interface for user interactivity and responsiveness. The system was built based on dataset obtained from national treatment guidelines and HIV experts through interview sessions that helped to develop training rules. The steps and process involved were Loading of the trained dataset, selecting the hybrid model for the training model and validating the developed model.
Lessons learned: A total database of three hundred was arrived at with the HIV/AIDS experts and the data was grouped to nineteen attributes and three classes namely; HIV Status Conclusion, Clinical Stage Interpretation and prescription of appropriate antiretroviral regimen. The data obtained was split into two; 70 % of the dataset was used for training and 30% for testing. The 70% of the data was supplied to the system so as to create a learning process as it will help the system to keep good experimental brain knowledge while the remaining 30% was used for validating the system. The resulting test carried on the systems shows a very good predictive model with an accuracy of 93.33% and the system was also able to manage medical records.
Next steps: The ability of the system to smartly tap into the extensive database in an adaptive way that mirrors expert thoughts and decision making process holds huge promise to support targeted testing, improve treatment access and serve as a means to strengthen task shifting towards improved efficiency of the available and overwhelmed human resource for health. It is recommended that this system should be made more robust, pilot in clinical settings and possibly scaled up to address the current challenges facing HIV programs.

FRPEE323

Impact of Provision of Mobile Phones for Communication Between Healthcare Workers and People Living with HIV in Sierra Leone

Amahowe Franck[1], Ngwatu Brian[1], Jalloh Memuna[1], Guillard Etienne[2], Vandy Alren[3]
[1]SOLTHIS Sierra Leone, Freetown, Sierra Leone, [2]SOLTHIS France, Paris, France, [3]National AIDS Control Program (NACP), Freetown, Sierra Leone

Background: HIV care in Sierra Leone is significantly impeded by patient stigma and gaps in availability of an environment that provides for quality patients-health workers communication. This, in addition to the low human resource coverage to attend to the increasingly high patient volume as Sierra Leone implements the "Test All, Treat All, Retain All" policy to increase HIV treatment access, has led to setbacks in the smooth continuity of HIV service delivery, affecting both the HIV service providers and beneficiaries.
An intervention to support and encourage communication between HealthCare Workers (HCW) and People Living with HIV **(**PLHIVs) via routine phone calls, deemed pragmatic in a country with low literacy and high mobile phone usage was therefore undertaken. This study aims to evaluate the use and impact of phone calls in PLHIV care at 11 facilities in Sierra Leone.
Methods: A telephone, monthly credit of 50,000 SLL (~5.76 USD), a facility-specific business card indicating the clinic telephone number (to be given to PLHIV at enrollment into care), and a call log register to capture metrics related to PLHIV/HCW phone calls were provided to 11 facilities in December 2017.
In this mixed methods study, reason for communication, associated costs, and outcome of attrition from chronic HIV care pre and post intervention (one year before and after intervention) were assessed. Data collected from call log and Antiretroviral Therapy registers were analyzed using descriptive statistics, independent t-tests and SPSS at significance level of 0.05.
Results: 61% (n=574) of all patient-health worker phone calls (n=939) were towards management of medical Care e.g. Side Effects and other medical condition. 22 % (n=211) of phone calls were for laboratory investigation (e.g. VL test, CD4 count, GeneXpert referral) and 5 % to follow themes of PMTCT/EID follow up & defaulter tracing. Average duration of calls was 1.27 minutes, with average cost of 773.74 SLL (~0.09 USD).
Pooled 6 months retention rate improved by 15% [95% CI (5.29, 20.5), $p < 0.01$], and by 18% at 12 months [95% CI (9.93, 22.07), $p < 0.01$].
Conclusions: Routine phone calls is an important way to address real time patient and programmatic needs and improve retention of PLHIV as HIV programs pursue the UNAIDS 90-90-90 targets.
Keywords: Mobile phone, communication, phone call, Solthis, Sierra Leone

FRPEE324

Unlocking Rwanda's Genomic Research Potential towards Delivery of Individualised HIV Diagnosis, Treatment and Surveillance: Bio Banking, Genomics and Virtual Sequences Model (BRT BioGenomics)

Karame Prosper, Ndishimye Pacifique
Rwanda Biomedical Center (RBC), Rwanda Medical Research Center, Kigali, Rwanda

Issues: Medical advances have enabled sound preventive, diagnostic, care and treatment approaches and largely influenced the improvement of health outcomes for people with life-threatening and lifelong conditions. HIV/AIDS has been particularly prioritised and individually customised diagnostic tools and treatments algorithms have supported tremendous achievements in patients' outcomes, especially with engagement in genomics and big data analytics.
Descriptions: This paper exploits the challenge posed by lack of bio-banking and virtual sequences data repository and loopholes in currently available leadership, scientific, ethics and financial barriers that must be overcome to propel genomics, especially the genomics research-based HIV precision medicine. It discusses the fundamental role of genomics research while exploiting bio bank data and appraising disease-drug interactions and health outcomes and related socio-economic implications; the model incorporates the most relevant opportunities, risks and paradigms complementing the the 2015's pillars of genomics research expressed in the Human Health and Heredity - Africa. The proposed model, Build, Run and Transfer Bio banking and Genomics Model (BRT+ BioGenomics) conceptualizes a Rwanda-operated HIV bio-specimen repository and virtual sequences databases for HIV research.
Lessons learnt: BRT+ BioGenomics Model reflects the needs for shifting the paradigm in prioritising research and investments plans for HIV precision medicine research. Featured applications demonstrate how bio-banking and genomics could drive some innovative African-tailored research projects and corresponding healthcare services. Typically, pharmacokinetic and pharmacodynamic-based characterisation of clinical first line drugs which may elucidate the most relevant guidance for anti retro-viral precision medicine. Genomics provides a sophisticated approach featuring the applications of structure-guided drug designs, basis for promising HIV-suppressing molecules and epigenetically targeted therapies.
Next steps: In-house bio banking and genomics research would save approximately 69% of funding compared to when done oversees, this adds to local infrastructure and human capacity and customisation of research per country. While on good track on leadership and ethics compliance, planning and funding strategies for bio banking and genomics should be redirected , accordingly.
Keywords: Africa, genomics, HIV, precision, medicine

FRPEE325

Continuous HIV Data Quality Improvement through Use of Facility Champions and Adoption of Electronic Medical Records in EMR Supported Hospitals in Kericho County, Kenya

Ronoh Patrick[1], Sambu Cheruiyot[2]
[1]Kapkatet Hospital, ICT Department, Kapkatet, Kenya, [2]Kapkatet County Hospital, IT Department, Kericho, Kenya

Background: HIV care and management of patients on Antiretroviral Therapy requires complete and reliable documentation of patient demographics and clinical information. Before some facilities such as Kapkatet Sub-County Hospital in Kericho county utilized electronic medical record system, challenges on accurate documentation of patient's records were experienced while using paper records systems. Data collected were prone to poor documentation as result of human errors which couldn't be noted down immediately unlike when using electronic medical record system which has inbuilt validations and aid in data collection and storage of complete patient information. One strategy employed by the health facility is on use of Facility Champion whose role is to ensure that the EMR is available and reliable in the health facility. The Champion is a super user with passion, technical capabilities and interest to drive the use and adoption of EMR.
Method: After Retrospective data entry that was done in the year 2014. The end-user trainings and technical trainings for champions were done on technical aspect of maintaining IQCare with the support from Palladium. Most of the health facilities in Kericho County completed data migration into IQCare amongst was Kapkatet Sub-County hospital. Later, subsequent Supervision and Data Quality Assessments were done in the years, 2015, 2016 and 2017 to assess the progress of the implementation of IQCare in each facility within the Kericho County. Routine Data Quality Assessment Tool was used to evaluate data entered.
Results: After every Supervision and Data Quality Assessments for the three years in Kericho County, Kapkatet Sub-County Hospital emerged the best and since then left usage of files and moved to paperless using the system fully on August 2015 to date due to the presence of champions in the facility unlike other neighboring facilities where they do not have champions.
Conclusion: For the EMR Implementation to be successful in our country we need to have more trained champions in our facilities to boost EMR performance. Champions should consist of physicians/clinicians, nurses and IT because an EMR implementation will affect nearly all aspects of a hospital or clinic's operations. Implementing an EMR without one or more physician champions can be disastrous.

FRPEE326

Impact of Electronic HIV Testing Services (eHTS) on Uptake and Documentation of HIV Testing Services; A Data Quality Assessment of Electronic Data in Kisumu, Western Kenya

Omondi Felix[1], Obado Valary[2], Mando Raphael[3]

[1]Kenya Medical Research Institute-Centre for Microbial Research-Research Care Training and Practice., KIsumu, Kenya, [2]Ministry of Health, Kisumu, Kenya, [3]Kenya Medical Research Institute-Centre for Microbial Research-Research Care Training and Practice., Kisumu, Kenya

Introduction: Early HIV testing services is among the best strategies in slowing HIV transmission. However, incorrect documentation and reporting of paper-based records affect testing coverage. eHTS reduces errors and improves complete and correct client documentation improves documentation and reporting. Full transition from paper to electronic reporting platform remains a challenge among most HTS service provider.

Methods: We performed a retrospective comparative data quality assessment of all hard copy HIV Testing Records from the HIV Testing Register -MOH 362 collected from Railways Dispensary between January 2018 to March 2018 and electronic records from Lumumba Sub County Hospital -a high volume testing site implementing electronic HIV Testing Services (eHTS) system between October 2018 and December 2018. Electronic HIV screening and testing services is the use of a digital platform to capture the digital version of real-time, patient centred HIV screening and testing records and make them instantly available securely to authorised users. We used a data quality assessment score to compute and compare a DQA score for electronic and hardcopy records from the two sites. The score was computed by assessing the proportion of complete, accurate and properly documented data points in each of the following variables; patient type/population type; ever tested; facility department conducting testing; client tested as(individual/couple); linkage status; test kit expiry date.

Results: We performed a DQA on 5388 records of which 5362(99.5%) of the records were unique while only 26(0.5%) were duplicates from the eHTS site vs. 395 records from non-eHTS site of which we could not assess duplicates; the DQA-score for patient type/population type was 100% for eHTS site while the non eHTS was 0%; the ever tested status was 100% for the eHTS and 95% for non-HTS; the facility department from where the patient is tested score was 100% and 0% for non-HTS; the client tested as(individual/couple) score for both eHTS and non-eHTS site was 100%; Linkages status was filled for 189/5388 (3.5%) vs 5/395 (1.3%) for non-eHTS sites.

Conclusion: Proportion of patients in the eHTS site was higher than those from the non-eHTS site. eHTS produced superior quality records of HIV testing service provision. eHTS system also gave better accountability for HIV testing kits and patients compared to non-eHTS and therefore should be adopted as the standard documentation technique.

FRPEE327

Experience from Scale-up Integrated Testing of HIV-1 Qual and MTRIF GeneXpert Assays in 69 Health Facilities in Ethiopia

Abate Zelalem[1], Anbesa Adisu[2], Assaye Biruhtesfa[1], Bellete Bahrie[1], Mekonennen Wondimeneh[2], Juhar Shemsu[2], Zealiyas Kidist[2]

[1]Clinton Health Access Initiative Ethiopia, Addis Ababa, Ethiopia, [2]Ethiopian Public Health Institute, Addis Ababa, Ethiopia

Issues: Expensive and technically complex diagnostics for Early Infant Diagnosis have put appropriate staging, treatment monitoring and infant diagnosis out of reach for many patients in resource-limited settings. Simplified diagnostic tools, especially point-of-care (POC) technology, have been shown to further expand access to early diagnosis and treatment. Ethiopia has started rolling out integrated testing of HIV-1 Qual GeneXpert assay and MTBRIF assay using the existing GeneXpert devices being used for MTBRIF testing to improve turn-around time and early initiation of treatment for HIV exposed infants.
Descriptions: GeneXpert IV sites used for MTBRIF testing were selected for phase one national scale-up based on distance from conventional testing (VL/EID) laboratories and spare capacity to accommodate additional EID testing. 69 health facilities were selected by Ethiopian Public Health Institute and Ministry of Health. Off-site training was provided for PMTCT, Laboratory, Pediatric inpatient, and nutrition department from each facility. On-site training was also provided . Logbooks, flowcharts, SOPs, job aids and other materials were provided.
Lessons learned: Number of tests done and positive infants linked to treatment increased from the baseline, due to increase in access to testing on-site. Out of the 68 sites which receive QASI panels the participation rate was 75%. 16 sites were unable to report due to internet connection and other related issues such as, instrument out of service, Xeprt HIV-1 cartridges not available and inappropriate sample transportation.
Phase one scale-up of integrated GeneXpert HIV-1 Qual assay with MTBRIF testing showed improved access to same day testing of HIV Exposed Infants and facilitated putting them on ART as soon as possible, if they tested positive and had no negative impact on MTBRIF testing. The practicability of this assay makes it suitable for health facilities far from DNA PCR testing labs with high case load.
Next steps: Based on the phase one scale-up experience Ministry of Health of Ethiopia has decided to scale-up to additional 50 sites as phase two scale-up.

FRPEE328

Using RADA Mobile App to Reduce the Rates of HIV Prevention among University Students: A Case of University of Nairobi, Kenya

Kivuvani Mwikali[1], Kibagendi Mogaka Julius[2], Kingori Ndungu Joseph[2], Kamau Jane[3]
[1]Sexual Reproductive Health and Rights (SRHR) Kenya, Nairobi, Kenya, [2]University of Nairobi, Humanity and Social Science, Nairobi, Kenya, [3]UNESCO, Regional Office for Eastern Africa, Nairobi, Kenya

Issues: Young people are exposed to various unique sexual and reproductive health risks worldwide and are often faced with many vulnerabilities. Despite the country making many investments in the HIV response, HIV remains the leading cause of death and morbidity among adolescents and young people in Kenya with approximately 29% of all new HIV infections in Kenya are among adolescents and youth. Thirty percent of new HIV infections in adults are among youth below 24 years. The attainment of Kenya's Vision 2030 is dependent on harnessing dividends from the youth and their health status directly impacts on the country's socio-economic status

Descriptions: A survey conducted by University of Nairobi, UNESCO, I choose life and SRHR Alliance showed an increase in *new HIV infections, non-adherence to ART, unwanted pregnancies and increased frequency of PEP uptake,* The survey showed university students had little and incorrect knowledge on various SRH topics. With the advent use of mobile phone technology, and social media, UoN students in collaboration with UNESCO, Sexual and Reproductive Health Alliance (SRHA) and I Choose Life (ICL) developed RADA, an innovative mobile application developed that aims at improving student's well-being to empower students and other young people in Kenya and beyond with correct and relevant information so that they can make informed decisions. The app provides a safe space using themes and videos for students to access information on Sexual and reproductive health

Lessons learned: Access to technology is unequal however, the increasing spread and sophistication of technology means the landscape of e-health is constantly evolving with the potential to improve HIV prevention, care and treatment services. Social media brings people most affected by HIV together to share information and campaign for their rights. Demand-driven and culturally-relevant information will enhance the uptake of SRH services among the youth in Kenya and globally with technology helping people affected by HIV access information about HIV prevention or adhere to treatment

Next steps: The University is seeking partnerships to upscale RADA to include other youth outside the formal education system to create awareness on the various health issues and provide psycho-social support to students. RADA is open source however, health and counseling services features and facilities are limited to the University of Nairobi student's facilities.

FRPEE329

Impact of Prioritized Community Symptomatic Testing (P-COST) Model; An Approach for Improving HIV Fast Track Strategy (FTS) in Rural Communities in North-Central Nigeria

Nwabueze Emmanuel[1], Poopola Victor[1], Ijezie Echey[2], Nedu Austin[1], Abiaziem Greg[1], Buzaarlirwa Lydia[3], Lutung Penninah[3]

[1]AIDS Healthcare Foundation, Medical, Abuja, Nigeria, [2]AIDS Healthcare Foundation, Abuja, Nigeria, [3]AIDS Healthcare Foundation, Kampala, Uganda

Issues: HIV services are limited across rural, hard to reach communities. Within such communities, people ignorantly live with symptomatic HIV diseases. Meeting the global targets towards eliminating HIV remain ambitious especially in the face of several challenges to HIV services especially within these rural settings.

This retrospective study reviews the impact of "P-COST model" implemented by AIDS Healthcare Foundation in such settings after 6 months.

Descriptions: AIDS Healthcare Foundation Nigeria, ensures provision of cutting edge medicine with most of her supported facilities in rural communities. The P-COST model utilizes pictorial HIV symptomatic tool to increase index of identification and ensure prioritized referral for HIV Testing Services. To ensure acceptability and understanding of the model, focal group discussions was carried out in 4 different rural facilities with a total of 66 peoples (42 women and 24 men) including HCWs, clients and community stakeholders in attendance. Community catchment area for each facility was distributed for trained focal persons residing in these communities. They conduct test for all people sent to them and link positives to HIV care. Within the referred facility, clients were retested and testing yield increased through Index case finding and partner notification.

Lessons learned: Combined with partner notification services for a period of 6-month, there were a greater client yield, RTK usage maximized resulting to increased client enrollment and prioritized HIV testing services. Client volume in these facilities increased from 34 to 278 (4 to 55, 6 to 63, 5 to 68 and 19 to 92). The P-COST model increased community participation and acceptability, treatment awareness, access to HIV services and testing yields, leading to optimized client volume and increased overall quality of care. Clients from key population were also identified and linked.

Next steps: It is recommended to be adopted and expanded as part of the FTS to optimize the treatment gap in rural areas to ultimately end the HIV epidemic.

FRPEE330

Enhancing Transmission of Laboratory Results Using Mobile Technology to Reduce Turnaround Time for Delivery of Care to People Living with HIV/AIDS: Experience from SMS Printers to mLab in Kenya

Mudogo Collins, Mwangi Cathy
mHealth Kenya, Nairobi, Kenya

Issue: Early infant diagnosis (EID) is critical for reducing infant morbidity and mortality due to HIV. To achieve the third 90 UNAIDS target, viral load (VL) testing results for people living with HIV (PLHIV) is an essential indicator. A challenge to providing effective HIV testing and treatment services in most low-to-middle income countries is the timeliness with which test results are returned to health facilities from the few available central reference laboratories (CRL) for clinical decision making.
Description: In 2012, mHealth Kenya distributed 299 SMS printers in health facilities in Kenya. The SMS printers were standalone devices that were customizable to receive EID and VL results from the CRL and enable remote health facilities print via the Global System for Mobile Communications (GSM) network for SMS. The implementation process and findings from the 2018 evaluation of the SMS Printers project showed that it was faced with many challenges including maintenance of the devices; thus, did not significantly reduce the turnaround time for EID and VL results transmission. With funding from CDC, mHealth Kenya has developed the mobile laboratory (mLab) an Android-based application that enables health facilities to access real-time VL and EID results through a secure and confidential platform from CRL. The system notifies patients and/or caregivers when results are available at the facility and can send results directly to the patients upon consent. The system was rolled out in 2017 in Kenya and is currently in 31 counties, and is being implemented by 17-CDC and USAID- supported implementing partners in 825 health facilities and has transmitted over 1.6 million VL and more than 79,000 EID results.
Lessons Learnt: Simple, easy to use, locally developed technologies are highly effective and have a high likelihood to be accepted, adopted and integrated into health systems.
Next Steps: Key enhancements on the system include modules for remote log-in of samples, transmission of inconclusive results and Tuberculosis results are ongoing based on user needs. Further scale-up of the system to be the main platform for transfer of results and sustainability plans are the key areas of priority.

FRPEE331

Application of Mobile Money Payment Solutions in HIV/AIDS Program Management: Community Health Workers in Zambia

Mulumba Clive, Monze Muleya, Francis Kasonde
JSI Research & Training Institute Inc., Lusaka, Zambia

Issues: In resource-limited settings like Zambia, community health worker (CHW) volunteers who are paid a stipend, are an essential part of the health service delivery system. Trained CHWs bring different skillsets, supporting facility health service delivery activities (registry duties, HIV testing, group counseling, etc.) and serving as the backbone of community-based client support. We present the experience of the USAID DISCOVER-Health project (DISCOVER) implemented by JSI, in managing stipend payments for over 1000 CHWs who support the delivery of Project HIV, family planning and reproductive health, maternal and child health, and general out-patient services in the country.
Description: DISCOVER uses a hub and spoke model, to support health service delivery in 150 sites across Zambia. The Project's 1000+ CHWs who volunteer to support service delivery, receive stipends using Mobile Money (MOMO) solutions the Project has helped pioneer in the country. MOMO payments contribute to prudent management of funds, avoid financial waste and help to ensure all CHWs receive their payments on time, so that they remain engaged and motivated to contribute to Project objectives. CHW performance is tracked through site-level timesheets entered into an electronic system. Data from this system informs the disbursement of an average of $100,000 monthly in MOMO payments to recipients. Once approved in the MOMO payment platform, the beneficiary immediately receives mobile phone notification, enabling withdrawal of funds from an authorized agent. To deliver timely/secure payments to CHWs, the Project leverages its strong financial systems/team, Zambia's robust cellphone networks, as well as effective central bank oversight of mobile payments systems in the country.
Lessons learned: 1) Strong finance and admin internal systems are highly essential to buttress electronic payments; 2) correct/timely stipend payments motivate the CHWs, which aids the Project to achieve its goals; 3) tracking performance/work completion through secure electronic systems avoids inefficient paper-based systems/errors; and 4) MOMO systems should continually be improved to ensure effectiveness and efficiency in getting payments to intended recipients, and periodically reviewed to identify gaps/vulnerabilities.
Next steps: Continue use of MOMO electronic payments for CHWs, while fully engaging with regulators, telecommunications companies and financial institutions, to better these platforms.

FRPEE332

Mobile Clinic Reaches Men who Have Sex with Men (MSM) with HIV Testing and Linkage to Care: A Case Study from Ghana

Darko Mensah Matilda, Vanderpuye Naa Ashiley, Sorensen Guro, Ayeh Kissedu Phinehas, Cole Jazmin, Effah Solomon, Kowalski Mark
West Africa AIDS Foundation, Accra, Ghana

Issues: Men who have sex with men (MSM) are at an increased risk of contracting HIV and other STIs. Unfortunately, they are less likely to access testing, care or treatment services due to multiple socio-cultural barriers. Such barriers include stigma, discrimination and oppression from society and health care providers. To reach MSM, culturally appropriate and creative strategies are needed. WAAF used a mobile clinic to deliver HIV testing service (HTS) and prevention services targeted at MSM in the Accra Metropolitan Assembly.
Descriptions: WAAF provides full-scale HIV testing and care services using a customized vehicle that parks at strategic hotspots. Comprehensive package of services delivered include STI and TB screening, body mass index and HIV services. MSM are individually able to receive confidential pre-and post-test counseling and HTS in the van where results are also disclosed to the client. Free condoms and lubricants are provided. HIV negative clients are empowered to stay negative through education on safer sexual practices whilst HIV positive clients are able to immediately begin treatment or are linked to case managers who assist them with enrollment into HIV care at the health facility level.
Lessons learned: From October 2017 to January 2019, this intervention resulted in a total of 530 MSM receiving an HTS with 43 (8%) tested positive, a figure nearly five-time HIV prevalence in the general population in Ghana. HIV positive clients were able to start treatment in the van, and then asked to visit WAAF's clinic within two weeks. MSM who chose not to begin treatment in the van were connected to case managers or health service providers for follow up counseling. Delivery of HTSs in combination with other health services through a mobile van can reach a large proportion of MSM and remove barriers to HIV testing, care and treatment for MSM. The mobile van proved to be feasible to implement and is acceptable to the MSM community. However, the sustainability of the program is still an issue as it requires a number of clinical staff, a van, fuel, and a driver.
Next steps: Immediate next steps are to collaborate with WAAF branches in other regions of the country to bring this service to their communities. Locally, WAAF will continue to increase awareness of this service in the Accra metropolis by partnering with public and private health facilities. All these steps will work towards the goal of enhancing linkages to care for MSM.

FRPEE333

Leveraging Online Spaces to Increase MSM HIV Program Access: Lessons Learnt from Key Population Virtual Mapping Study in Nigeria

Ezirim Idoteyin[1], Adebanjo Tosin[1], Chukuebuka Ejeckam[2], Kalada Green[2], Ashefor Greg[1]
[1]National Agency for the Control of AIDS, Strategic Knowledge Management Department, Abuja, Nigeria, [2]University of Manitoba, Abuja, Nigeria

Background: The increase in information technology and mobile internet has given MSMs the opportunity to connect online. Therefore, it is important to map virtual sites, estimate and profile MSMs in virtual spaces who meet partners in these spaces to gain insight for planning HIV interventions. Hence Nigeria conducted its first virtual mapping in 2018.
Methods: Virtual mapping was done in 9 Nigerian states. In each state, MSM Key informants (KIs), knowledgeable about websites/apps used by MSMs to meet sexual partners were identified and focus group discussions (FGDs) were conducted. During FGDs, KIs mentioned virtual sites used by MSMs in the state and selected a maximum of 15 frequently used sites for mapping. 2 MSMs were engaged as virtual mappers in each state (18 virtual mappers) and they moved from Local government (LGA) to LGA in the state. In the LGA virtual mappers logged into each website/app at scheduled times daily. Using the GPs function of the websites /apps they recorded, the number of persons registered on the virtual sites and persons active at that time on the virtual site within that LGA. The virtual mappers also discussed with persons on the virtual sites and identified those willing to meet physically for interview. During the interview, information on demographics, other websites/apps the MSM is registered, multiple registrations with different IDs, number of friends on each website, physical locations for picking up other MSM was obtained.
Results: The study revealed that in 6 states more than 1,000 MSMs used websites/apps to connect daily. Also websites/apps used frequently by MSMs in the 9 states were identified. 1,347 MSMs virtual sites users were interviewed in the 9 states. The study showed that in 5 states (Kaduna, Kano, Enugu, Imo and Oyo states) over 90% of MSM virtual users interviewed, also visited physical locations to meet male partners while in 4 states (Abia, Anambra, Edo and Gombe states) it was over 50%.
Conclusions and Recommendations: Since MSMs using virtual sites also visit physical locations, HIV programs can use virtual platforms to disseminate information that will attract more MSMs to access interventions at physical locations.

FRPEE334

The Contribution of Treatment as Prevention among MSMs and Male Sex Workers Living with HIV in Nairobi, Kenya

Gathatwa James[1], Mathenge John[1], Irungu Pascal[1], Olawo Alice[2], Kamau Mercy[3], Angote Priscah[1], Groot Anke[4], Njue Kenneth[1], Maina John[1], Chege Wanjiru[1], Mwaniga Mwavu Shillah[5]
[1]Health Options for Young Men on HIV, AIDS and STIs (HOYMAS), Nairobi, Kenya, [2]Linkages, Nairobi, Kenya, [3]Jhpiego, Nairobi, Kenya, [4]AIDS FONDS, Amsterdam, Netherlands, [5]County Government of Nairobi, Nairobi, Kenya

Issues: HOYMAS clinic opened on APRIL 2015 providing HIV prevention, treatment and care interventions with about 32% of about 1000 male sex workers accessing services receiving HIV positive results. The Treatment as Prevention Approach was inculcated into the programming to ensure 100% adherence. This led reduced viral load among HIV+ clients within 6 - 12 months of being on treatment. Today about 80% of HIV+ MSM(Men who Have Sex With Men) have undetectable viral load. This has also coincided with very low new HIV infections currently recorded at our clinic showing undetectable viral load is actually untransmittable in a real- life setting.
Descriptions: Treatment as prevention method being introduced to HIV+ MSMs and Male Sex Workers. Peer navigators - community led tracing method of clinic appointment defaulters
Support groups formed online via WhatsApp. The use WhatsApp groups for HIV+ clients - open discussion and adherence encouragement resulted in a mutual support system available continuously. Entrepreneurship resulting in economic freedom led to a powerful motivation for peers to adhere to their treatment.
Lessons learned: The use of Treatment and Prevention among MSMs and male sex workers visiting HOYMAS clinic led to reduced viral load among HIV+ clients within 6 - 12 months of being on treatment. Today about 90% of HIV+ MSM have undetectable viral load. This has also coincided with very low new HIV infections currently being recorded. When the program started
Next steps: HOYMAS has been able to demonstrate that undetectable viral load results in a drastic decline in new HIV cases and indeed undetectable = untransimmable in a real life setting. This should be incorporated and scaled up as a strategy to end HIV in the world.

FRPEE336

Leaving Noone Behind: Addressing the Unique Needs of Men who Have Sex with Men in Mutare, Manicaland Province, Zimbabwe

Nyamasoka Moses[1], Shumba Gertrude[2], Tavengerwei Jenifer[2], Takaidza Tinashe[3], Rufurwadzo Tinashe Grateful[3], Madyauta Maxwell[4]

[1]FACT Zimbabwe, Health and HIV, Mutare, Zimbabwe, [2]FACT Zimbabwe, Management, Mutare, Zimbabwe, [3]FACT Zimbabwe, Strategic Information and Research, Mutare, Zimbabwe, [4]Population Services International, Health and HIV, Mutare, Zimbabwe

Issues: Globally, men who have sex with men (MSM) are 28 times more likely to acquire HIV than the general population. Criminalizing this vulnerable group drives it away from accessing HTS. As a result, many do not know their HIV status, let alone access treatment. MSM receives negative attitudes, stigma and discrimination when they are accessing SRH and HIV prevention, treatment, care and support services from public health facilities. It is reported that 28% of MSM are HIV positive (GALZ, 2018). If this group does not receive quality and friendly HIV Testing Services in a conducive environment, ending AIDS will never be a reality.

Descriptions: FACT Zimbabwe with support from USAID/PEPFAR and in partnership with PSI is managing the ART Clinic in Mutare. Fifteen health care workers were trained on delivering quality HIV prevention, treatment, care and support service to key populations including MSM. Since 2016, 140 MSM were initiated on ART at the clinic, of these, as at July 2019, 85 have undetectable viral load.405 MSM accessed PrEP, 178 accessed PEP. MSM living with HIV have their support groups where they discuss various issues which affect their lives and come up with solutions. The trained health care workers offer mental health support to those who are in need. The ART clinic is a one stop center; MSM are tested for HIV, initiated on ART, treated for sexually transmitted infections and have their viral loads tests and results.

Lessons learned: The training of health care workers in service provision for MSM is of paramount significance as they deliver quality and friendly services without prejudice and discrimination. It is of paramount significance to involve MSM in programme designing, implementation, monitoring and evaluation as they know what is best for them. The snow ball methodology has worked so well where MSM will be linking service providers to their peers.

Next steps: There is a need to promote social inclusion and promotion of rights by addressing several issues so as to end AIDS by 2030. While Zimbabwe has made efforts to address MSM and HIV within major cities social inclusion and criminalization is still an impediment to reach out to some hidden groups of MSM. The last mile efforts need to address comprehensive prevention elements as they have mainly address behaviour and biomedical elements in the prevention and limited efforts have been made in addressing structural issue which is not limited to policy but law reform.

FRPEE337

Scaling up HIV Prevention Programmes for and with Adolescent and Young Key Populations through an Online Toolkit

Faugli Bente[1], Zhukov Ilia[1], Balakrishnan Sudha[2], Konstantinov Boyan[3], Baer James[4], Pages Ruben[5], Sanchez Alicia[6], Boborakhimov Sharafdzhon[7]
[1]UNFPA, New York, United States, [2]UNICEF, New York, United States, [3]UNDP, New York, United States, [4]Independent Consultant, London, United Kingdom, [5]UNAIDS, Kingston, Jamaica, [6]UNAIDS, Geneva, Switzerland, [7]Independent Consultant, Bangkok, Thailand

Issues: Adolescents and youth need effective interventions, implemented at scale in countries, in order to address the HIV epidemic in this age group. The need is even more acute for those who are members of key populations, which are disproportionately affected by HIV. Stakeholders at national and sub-national levels require access to guidance documents as well as practical "how-to" tools on HIV prevention programmes with young key populations (YKPs). The toolkit was conceived to fill this resource gap.
Description: UNICEF, UNFPA, UNDP and UNAIDS supported networks of YKPs, and other stakeholders to collate a Toolkit for Scaling Up HIV Prevention Programmes for and with Adolescent and YKPs http://childrenandaids.org/aykpToolkit. The purpose of the Toolkit is to help national programmes choose evidence-based minimum packages and tools to scale up HIV prevention programmes with adolescent and young people (aged 10-24 years) who are sexually exploited or sell sex, who inject drugs, transgender people, and men who have sex with men. The Toolkit is an online resource, presenting a curated collection of 176 tools that are already in use around the world. The modules of the Toolkit cover eight thematic areas: Strategic assessment; Programme planning; Resourcing; Policy, legal and social-norm change; Multi-stakeholder collaboration; Monitoring and social accountability; Innovations and Knowledge exchange. For each tool, notes explain its source and purpose, how it is used, and considerations for adaptation for other contexts or various key populations. The tools were selected by 120 members of a global consultative group, including members of YKPs, experts, policymakers and programme managers. In total 377 tools were submitted for selection (288 documents, websites, and videos; and 89 journal article abstracts). Specific criteria were developed to select tools. It currently includes a limited collection of tools in languages other than English. The online, dynamic nature of the Toolkit presents an opportunity for countries to contribute to the Toolkit as well as drawing upon it for tools.
Lessons learned: The Toolkit was piloted in 2 country consultations, along with a global online questionnaire. The beta version was well received.
Next steps: Plans are underway for a webinar series for wider dissemination of the Toolkit, and support to countries to use it.

FRPEE338

Stratégie d'Approche Communautaire Intégrée dans l'Atteinte des 90-90-90 chez les Usagers de Drogues (UD) Précaires d'Abidjan (Côte-d'Ivoire)

Boulet Renaud, Kouadio Denise, Agnimel Armande, Koné Hamidou, Diomandé Masséni, Toha Marie Julie, Hié Mathieu
Medecins du Monde, Abidjan, Côte d'Ivoire

Contexte et justification: Depuis 2015 Médecins du Monde (MdM) met en œuvre un programme de réduction des risques auprès des UD précaires à Abidjan. Afin d'atteindre l'objectif 90-90-90 chez une population UD, il était impératif de développer une stratégie adaptée pour faire face à deux difficultés majeures : Le faible taux d'UD qui se font dépister en raison d'une forte marginalisation d'une part et, d'autre part, la difficulté de suivi du traitement causé par une forte précarité et une grande mobilité. Afin de pallier ces difficultés MdM a développé une stratégie adaptée basée sur une approche communautaire de sensibilisation, dépistage sur site et accompagnement tout au long du traitement.
Description de la stratégie: La stratégie s'articule autour d'activités de sensibilisation aux risques ainsi que des dépistages menés au sein même des scènes ouvertes de consommation.
La formation d'une équipe d'éducateurs pairs a été nécessaire pour garantir la qualité des interventions. Des outils de sensibilisation adaptés (jeux, dépliants etc.) ont été réalisés en collaboration avec la communauté.
Les EP font le suivi des personnes dépistées positives tout au long du traitement, ils sont à leur coté pour tous les rendez-vous, garantissant un accès aux soins et organisent des visites régulières ainsi que des groupes de soutien. Les EP sont également actifs dans la recherche des patients perdus de vue.
Avantage de la stratégie: Cette stratégie adaptée permet de démontrer que les EP garantissent un accès aux populations cibles et une meilleure adhésion aux principes de dépistage, ils garantissent également un succès dans le suivi du traitement.
En 2018 environs 2 000 dépistages VIH effectués, plus de 35 UD dépistés positifs, mis dans les soins et sous traitement anti rétroviraux (ARV) ; 10 ayant une charge virale indétectable après six (06) mois de traitement et enfin 03 charges virales indétectables après une année de traitement.
Conclusion: Le dispositif ayant démontré son efficacité dans l'atteinte des 90 90 90, une réflexion est menée actuellement sur la mise à l'échelle nationale ainsi que son intégration dans la stratégie nationale de lutte contre le VIH.

FRPEE339

Partnership to Break Structural Barriers to Access to Sexual Reproductive Health /HIV and Gender-based Violence Services: Role of Inter Religious Council of Uganda

Ogolla Rachel[1], Serwanja Charles[2]
[1]United Nation Population Fund Uganda, HIV/AIDS and SRH, Kampala, Uganda, [2]Inter Religious Council of Uganda, HIV/AIDS, Kampala, Uganda

Issue: Socio-cultural norms and religious beliefs are documented major structural barriers to access HIV services and simultaneously act as drivers to new infection in Uganda and other high HIV burden countries. Partnership between United Nations Population Fund (UNFPA) and Inter-Religious Council of Uganda (IRCU) has revealed several positive gains in obtaining religious leaders support around issues related to HIV/SRH/GBV including community mobilization for service uptake as well as providing SRH/HIV/GBV information.
Description: Since 2016, investments in leadership capacity strengthening of IRCU members, advocacy at national and district level and mobilization of populations by IRCU member organizations through their existing platforms led to several positive outcomes. Over 10,000 religious leaders were oriented on SRH/HIV/GBV utilizing standardized leadership manuals and their community messaging skills was enhanced. In 2018, IRCU secretariat passed position papers related to HIV prevention focusing on male engagement, teenage pregnancy, etc. IRCU Secretariat and member denominations used their structures including media stations to communicate harmonized SRH/HIV/GBV messages reaching over 10 million followers monthly.
Lessons learnt:

- Message harmonization by the various denominations is key, lack of commonly agreed messages is potential for conflict and failure to exploit the powerful collective advocacy of IRCU
- Faith based institutions (FBOs) are mainly male led, this provides an advantage in social mobilization to engage men in SRH/HIV/GBV for their own, their partners and families' health.
- IRCU provides a low-cost platform for mobilizing communities to access services which is particularly helpful for programming in resource constrained areas.
- Weak reporting systems is a challenge in quantifying the impact of FBOs work.

Next steps: Religious fraternity in Uganda has transitioned from a target audience to a strong partner in societal transformation addressing structural barriers to access to SRH/HIV/GBV services. To advance this partnership,IRCU will lobby to move high level leadership from position papers to pastoral letters which directly feed into planning at different levels.UNFPA will strengthen IRCU reporting system and referral for specialized SRH/HIV/GBV services and mobilize resources to expand social mobilization through education and social structures of denominations within the 3-point access model.
Keywords: Partnerships, Male engagement, Advocacy

FRPEE340

Violence against Male, Female and Transgender Sex Workers in Kenya; Sex Worker-led Research into Risks, Mitigation and Access to SRHR

Groot Anna Maria[1,2,3], Ndunda Erastus[3], Woensdregt Lise[2]
[1]Soa Aids Nederland/ Aids Fonds, Sex Work Înternational, Amsterdam, Netherlands, [2]Vrije Universiteit Amsterdam, Amsterdam, Netherlands, [3]HOYMAS Kenya, Nairobi, Kenya

Background: This sex-worker-led research documents violence against sex workers in Kenya and identifies strategies for reducing new HIV infections to advocate for human rights in Kenya.
Methods: The research involved 600 surveys, 40 in-depth interviews, 20 FGDs with 170 sex workers (54.8% female, 41.0% male, 3.7% transgender, 0.5% other).
Results: Ninety-six percent of sex workers experienced violence in the last 12 months at an average frequency of 45 times. Such incidents included physical violence (75%), sexual violence (33%), blackmail (57%), and economic and emotional violence (89%). Respondents identified clients (86%), police 63%, sex workers 72%, family 28%, friends 46%, intimate partner 56%, community: 42, pimps 18% and health workers 16% as perpetrators.
HIV+ status correlates with higher incidents of physical violence and 35% less income .
47.5% respondents sought services for ARVs. Of the 11.6% of respondents who shared HIV+ status, 95.5% are on ARVs. Of the 20% who did not share their status, 64% sought ARV services, but only 16% accessed regular ARV treatment. 1 in 3 transgender sex workers is HIV+.
Emotional and economic violence leads to a 10% reduction in condom use.
74% of sex workers always uses a condom. Self agency increases regular condom use.
Seventy-eight percent of respondents test for HIV and 48% for STI every 3 months. Forty percent of sex workers experienced hostility at health clinics, e.g. discrimination (30%), feeling judged (27%) or being yelled at (21%). This is higher for sex workers who seek health services related to anal sex (52%).
Physical violence by police was experienced by 44% of male and 25% of female sex workers. Transgender (32%) and male (16%) sex workers are more likely to have sex with police to prevent arrest than female (9%) sex workers. Immigrant sex workers are at a higher risk (35%) of sexual violence by police than Kenyan sex workers (12%).
43% of sex workers experience discrimination when asking for police assistance.
Conclusions: These are unacceptable high levels of violence against sex workers in Kenya, especially with police officers being regular perpetrators. This affects access to HIV and ARV services. Risk mitigation strategies are still being analysed but include condom use, self agency, mobility, combating alcohol/drug use and addressing a challenging context where sex work, especially sex between men, is criminalised, due to Kenya's Penal Code

FRPEE341

The Nexus: Programming with Legal Facilitators and Improved Overall Case Finding and ART Uptake among Key Populations who Are Victims of Violence in Nasarawa State

Uji Rudolf Oche[1], Trout Clinton[2], Jaiyebo Toluwanimi[3], Odiahi Peter[3], Zakka Timothy[1]
[1]Heartland Alliance International Nigeria, Programs, Abuja, Nigeria, [2]Heartland Alliance International, Programs, Chicago, United States, [3]Health Alliance International Nigeria, Programs, Abuja, Nigeria

Background: Men who have sex with men (MSM), female sex workers (FSW) and people who inject drugs (PWID) are key populations (KPs): highly vulnerable to HIV. In Nasarawa State, HIV prevalence for HIV was 8.1% for MSM, 27% for brothel-based FSW, 7.7% for non-brothel based FSW, and 3.1% for PWID (IBBSS 2014). Gender-based violence (GBV) against KPs is a key driver of low HIV services uptake. And discrimination fear of reprisal and prosecution play a critical role in limiting access to HIV services. We appraised the nexus between the use of legal facilitators and improved uptake of HIV services.

Methods: This phase of the Heartland Alliance program for KPs started in October 2016 and closed in October 2018. The first year of implementation was without the use of legal facilitators. In the second year, legal facilitators were embedded to provide post-GBV care and handle issues of human rights. Program data extracted from the monitoring were compared at the end of each phase. We conducted a before-after analysis of post GBV incidence and human rights.

Results: In the initial period of programming (October 2016-2017) without the use of legal facilitators, HIV positivity yield achieved was 11% (417/3910) with only 56% (234) of clients linked to care.
In the second phase (October 2017-2018) when legal facilitators were used, 4309 (HRM: 1528, PWID: 842, FSW: 1939) human rights violations were handled. The case typology ranged from unlawful arrest, forced abortion, physical, verbal, sexual and emotional abuse by state and non-state actors and community members. Post-GBV care provided ranged from bail, psychosocial support, medical services, and alternative dispute resolution. Thirty-eight community members; (M: 14, F: 24) were also reached with the knowledge on safety and security and were engaged to better respond to safety issues. Forty-two community members (M: 19, F: 23) were trained as paralegal officers to provide legal support and post GBV care to victims of violence. During this period, Case findings improved. Treatment numbers rose to 1010 (FSW: 711, MSM: 195, PWID: 104). Positivity yield rose to (1010/3910) 26% and a 100% linkage rate was achieved.

Conclusions and Recommendations: The findings from the two periods show that Legal support can improve case finding and linkage and treatment uptake among Key Populations. This correlation between HIV service uptake and legal support should be explored further in pursuit of an AIDS-free generation.

FRPEE342

Young Women who Sell Sex (YWWSS) in Bangui, Central African Republic: A Neglected Group Highly Vulnerable to HIV

Longo Jean De Dieu[1,2], Diemer Henri Saint-Calvaire[3], Tépka Gaspard[4], Grésenguet Gérard[5,6], Belec Laurent[7]

[1]Université de Bangui, Santé Publique, Bangui, Central African Republic, [2]Unité de Recherches et d'Intervention sur Département de Santé Publique, Faculté des Sciences de la Santé de Bangui, Central African Republic, Bangui, Central African Republic, [3]Centre National de Référence des Maladies Sexuellement Transmissibles et de la Thérapie Antirétrovirale, Bangui, Central African Republic, Santé Publique, Bangui, Central African Republic, [4]Service des Maladies Infectieuses, Centre Hospitalier Universitaire de l'Amitié, Bangui, Central African Republic, Bangui, Central African Republic, [5]Centre National de Référence des Maladies Sexuellement Transmissibles et de la Thérapie Antirétrovirale, Bangui, Central African Republic, Bangui, Central African Republic, [6]Département de Santé Publique, Faculté des Sciences de la Santé de Bangui, Central African Republic, Bangui, Central African Republic, [7]Laboratoire de Microbiologie, hôpital Européen Georges Pompidou, Assistance Publique-Hôpitaux de Paris, and Faculté de Médecine Paris Descartes, Université Paris Descartes, Sorbonne Paris Cité, Paris, France., Paris, France

Background: The young (15-24 years old) women who sell sex (YWWSS) are less able to negotiate safer sex. The objectives were i) to assess possible association between demographic and behavioral risk variables in YWWSS as compared to older sex workers living in Bangui; and ii) to investigate the YWWSS factors associated with HIV status.
Methods: A cross-sectional study was conducted among female sex workers (FSW) involved in commercial sex transactions living in Bangui the capital city of the CAR and attending the CNRMST/SIDA, the main clinic center of Bangui for HIV counselling and testing. The data were collected during face-to-face interviews. Descriptive, bivariate and multivariate regression models included 4 outcomes.
Results: The overall HIV prevalence was 29.4% among YWWSS as compared to 19.6% in FSW (OR=5.51; 95% CI [1.87 - 12.58]) (P< 0.001). The YWWSS showed low educational level, and had poor knowledge on the transmission modes of HIV (OR= 3.02; 95% [1.41 - 8.12]). Rates of consistent condoms use among YWWSS and FSW were very low at 22.3% and 41.2, respectively. However, FSW had a greater capacity to negotiate condoms than YWWSS (OR =2.69; 95% CI, [1.22 - 4.96]) (P< 0.001). More than half of YWWSS (54.5%) reported regular consumption of alcohol or drug during working as compared to 30.2% of FSW (OR=2.69; 95% [1.22 - 4.96]) (P< 0.001). The multivariate logistic regression model showed potential predictors of five outcomes, which included: Education level, age difference with partner, having been a victim of sexual violence in the last 12 months, having a status of YWWSS and using condoms during the last time of having sex intercourse.
Conclusions: Nearly one-third of YWWSS in Bangui are HIV-infected; YWWSS are vulnerable because they have low educational level and difficulties to negotiate protected sexual intercourse. Their vulnerability is worsened by usual alcohol or drug consumption. Taken together, these findings demonstrate that YWWSS constitute a yet largely neglected group highly vulnerable to HIV and in marked economic precariousness.

FRPEE343

Consistent and Correct Use of Condom Usage as a Factor to Reduce the Spread of New HIV Infections among MSM in Oyo State, Nigeria

Onumabor Jude[1], Alade Olayinka[2], Efa Obono[1], Kingsley Ajana[1], Darlington Adighibe[2]
[1]Initiative for the Advancement of Improved Health and Development, Programmes, Ibadan, Nigeria,
[2]Initiative for the Advancement of Improved Health and Development, Monitoring and Evaluation, Ibadan, Nigeria

Issues: Globally, Key populations are known to be the drivers of HIV epidemic due to some high risks behaviors associated to them. In Nigeria, Men who have Sex with Men (MSM) have the highest rate of HIV with a 22.9% rate according to IBBSS 2014. As a strategic to reduce HIV among MSM in Nigeria, Oyo State was selected as part of the Global Fund HIV Intervention States in Nigeria. This study explored the antecedent factors influencing the practice of condom usage among MSM in Oyo state Nigeria with leverage on the Global Fund New Funding Model HIV Project for MSM in Oyo State.
Descriptions: The study was descriptive cross sectional in design, 2802 MSM who were reached with the Global Fund HIV Intervention in Oyo State from October 2018 to June 2019 were used for the study. Semi structured questionnaire which included knowledge scale on HIV and condom usage was used for data collection. Data were analyzed using descriptive statistics, chi - square test and analysis of variance (ANOVA).
Lessons learned: The mean age was 27.4 ±5. Mean knowledge score on HIV was 8.2±2.9. Age, educational level and occupation were significantly associated with knowledge of HIV ($p < 0.05$). Usage of condoms was significantly more among respondents of 30 to 49 years. 87.6% do not enjoy the usage of condoms during sexual intercourse because they do not find the usage of condom during sexual intercourse pleasurable, 26.2% had challenges with the usage of condoms due to anal pain and 10.2% find the usage of condom pleasurable and enjoyable.
Next steps: Continuous sensitization and training activities are needed to promote the use of condom awareness among MSM. Community Walk-In Centre for MSM can also be used to improve the usage of condoms among MSM in Oyo State. And usage of condoms will help to reduce the spread of HIV and new infections among MSM in Oyo State.

FRPEE344

Involving Grassroots Authorities in Addressing HIV/AIDS and Discrimination against Key Populations

Gapira Jean Faustin
APROFAPER, Kigali, Rwanda

Issues: The evidence on HIV/AIDS infection is progressively showing greater needs of accelerating action on integrated prevention strategies of HIV. There is low uptake of services to key populations in health facilities and other public services such as police stations, etc. There are also reported cases of sexual harassment and abuses against female sex workers in pubs and other gatherings. Their sexual orientation makes them vulnerable to HIV and other infectious diseases and to all forms of discrimination. Officials in grassroots give little attention to those cases and religious leaders treat them as sinners and immoral people in the society.
Descriptions: APROFAPER Organization organized a two day training workshop in Rubavu District for officials in public and private sectors, selected community leaders, representatives of faith-based organizations and representatives of key NGOs. This course was meant to inform the participants on the achievements of APROFAPER in the protection of vulnerable groups namely female sex workers and men who have sex with men. The workshop attracted 79 participants. Discussions turned on (i) the status of HIV in Rwanda (ii) security and gender based violence (iii) country's development through associations/cooperatives (iv) faith based organizations and HIV response in Rwanda.
Lessons learned: Daily anonymous evaluation by participants were overall positive, with especially high ratings for the technical presentations and skills building activities (93% high score against 7% for low score) notably awareness on the danger of HIV/AIDS and its corollary on the development of the country. High scores were also given to the relevance and usefulness of the workshop. The majority (98%) of participants found that the workshop was quite successful, meeting most of the objectives set forward. As training outcome,105 FSWs were sensitized and accepted to join together into associations (5 associations) to generate revenues through handicrafts and exchange them in Goma and Gisenyi via Poids Lourds border.
Next steps: A research is needed to assess the level of compliance of local authorities and the progress made in the protection of FSWs and MSM and the effect their commitments made on these groups. A similar training workshop is needed in Northern Province for engaging local authorities in the fight against HIV/AIDS and the protection of key populations against harassment and abuses.

FRPEE345

Accelerating Viral Load Suppression among Gay Men, Men who Have Sex with Men and Male Sex Workers in Mombasa County through Community Led Initiatives

Kyana Martin[1,2], Adhiambo Esther[3]
[1]HIV/AIDS People Alliance of Kenya (HAPA Kenya), Field Officer, Mombasa, Kenya, [2]Initiative for Equality and Non Discrimination, Mombasa, Kenya, [3]Initiative for Equality and Non Discrimination, Executive Director, Mombasa, Kenya

In Kenya, homosexuality is illegal, this coupled with entrenched social attitudes leads to high levels of stigma. In this context, Men who have sex with men (MSM) living with HIV have faced increased stigma and discrimination pushing them to shy away from taking their Anti-retroviral drugs regularly and adequately. This has led to higher cases of ART defaulting, and high number of MSM succumbing to opportunistic infections. HIV/AID Peoples' Alliance of Kenya, with support from Global Fund through Kenya Red Cross Society, runs a viral load suppression program through its community run clinic.
Description: A description of the intervention, project, experience, service and/or advocacy.
Clients get enrolled into cohorts as per their age brackets, sub counties, hotspots of operations and treatment regimen. Through these cohorts, they share their experiences, and encourage each other to adhere to treatment. In 6 sub Counties within Mombasa the program has a cohort of 246 clients living with HIV. Clients designed their pill packages, as opposed to the Government package which is highly stigmatized. The male sex workers feel comfortable using the package while at work as it carries only 4 tablets. Each sub county has 1 case manager who tracks defaulters, lost to follow up, ensures they attend to their clinic appointments, and counsel clients. This approach has led to MSM specific psychosocial support network which is more focused in addressing their issues.
Lessons learned: Conclusions and implications of the intervention or project. Data that support the lessons learned and evidence must be included.
The percentage of adherence for community members has gone up by 85% in a country where 63% of people living with HIV are virally suppressed.
MSM specific psychosocial network for people living with HIV improves adherence.
Convenient pill package boosts adherence amongst gay men, men who have sex with men and male sex workers.
Next steps: Possible next steps for implementation, or recommendations.
Community initiated programs are more effective and gain more trust among peers.

FRPEE346

Moonlight HCT the Way to Go for MSM in Tororo/Malaba-Uganda Border

Ayoo Proscovia[1,2]
[1]Tororo Forum for People Living with HIV and AIDS Networks (TOFPHANET), Tororo, Uganda,
[2]Tomorrow Vijana, Tororo, Uganda

Issues: Conventional HIV prevention approaches are not friendly to men who have sex with other men(MSM) in terms of hours of operation and accessibility to services.As a result HIV infection rates remain high among MSM. In order to respond o this gap,in 2018,Tororo forum for PLHIV networks came up with the moonlight HIV Counseling and testing outreaches conducted at night to MSM at their workplaces of operation.This aimed at improving uptake of HCT,reported utilization of condoms and treatment of sexually transmitted infections by MSM.
Descriptions: The aim was to assess HIV sero prevalence and condom use among MSM who took up HCT in Malaba.Data for 109 MSM was analysed.Moonlight HCT targets MSM/CSWs and their clients as secondary targets.It involved using brothel leaders as contact persons that mobilized MSM/CSWs in their brothels.Rooms used for HCT and consultations are hired while condoms are distributed in strategic places.
Lessons learned: Moonlgh HCT is perceived as a non-stigmatizing convenient approach which helps MSM to receive HIV prevention services without being recognized in their own locations
Next steps: Moonlight HCT outreaches still offer oppotunities for HIV prevention among MSM as well as general populations.

FRPEE347

HIV Treatment Enrollment and Adherence for Key Populations (SW, MSM, TG and PWID) at the Stand Alone Drop in Center Operated by PSI, Liberia

Freeman, W S Josephine[1,2], Jackson Hokie W[3], Tamba Julius[4], Kreyoh Vivian[5], Kollie Loleyah[6], Lackay Bonah S.[7], Daye Zinnah[8], Jallah Sumo[9], Nyanti Gabriel[10], Dennis Precious[6], Kallon Thomas[11], Nyankun Vivian[1], Joboe Oscar[12], Nyenawo Catherine Djilan[13], Ako Cyriaque Yapo[14], Koikoi Titus K[15], Dua Rajiv[2,16]
[1]United Methodist University, Monrovia, Liberia, [2]Population Services International, Monrovia, Liberia, [3]Cuttington University, Suakoko, Liberia, [4]Adventist University, Advent Hill, Liberia, [5]Liberia Christian Community College, Monrovia, Liberia, [6]Cuttington University, Gbarnga, Liberia, [7]University of Abomey Calavi, Monrovia, Liberia, [8]African Methodist Episcopal Zion University, Monrovia, Liberia, [9]Atlantic International University, Honolulu, United States, [10]Heriot-Watt University, Edinburgh, United Kingdom, [11]Methodist University College Ghana, Accra, Ghana, [12]Stella Maris polytechnic, Monrovia, Liberia, [13]Cuttington University, Suacoco, Liberia, [14]ESARC(Ecole Superieure d'Actions et de Recherches Commerciales), Paris, France, [15]Cuttington University School of Graduate Studies, Suacoco, Liberia, [16]Tata Institute for Social Sciences, Mumbai, India

Background: HIV treatment adherence in Liberia has been a challenge since the introduction of treatment care centers. While the prevalence rate of HIV in Liberia is at 2.1%, the prevalence rate in KP is worrisome; SW 9.8%, MSM TG 19.8% (IBBSS 2013). KPs have drawn PSI's attention in the fight against HIV as Liberia thrive meeting 2020 target. KP remains marginalized, denied access to health, stigmatized and discriminated because of their sexual preferences, hence the continuous increase of HIV rate in their community.
Methods: PSI with funding from GFATM has opened a Drop In Center (DIC) where KPs gather for medical services and free space free of charge by nurses who are community oriented. It provides safe and supportive environments for people labeled as less human and not conforming to societal (Liberia) values. Peer educators (PE) trained by NACP provide HCT for their peers; MSM to MSM, TG to TG, SW to SW. A reactive client is linked to the DIC for confirmatory test. A positive confirmatory client is linked to a treatment buddy or special peer educator (SPE) for counseling and disclosure, sent back to the nurses for enrollment. Counseling is enhanced and the client receives first supply of co pack, ART and home based kit. SPEs regularly visit clients and maintain communication via mobile. Monthly support group meetings for clients are held and at these meetings, they talk about importance and need for treatment adherence, success story and challenges they face and they collectively find solution.
Results: A total of 101 clients (45 MSM/TG and 56 SW) have been enrolled from November 2018 to June 2019 and are still into care with none lost. SPEs and nurses follow up for next refill dates, VLT, support group meetings and other KP activities. The DIC has a network of experienced and professional staff who have understood diversity in health and therefore have an open mind in working with KPs. KPs are more comfortable, safe and also share their experiences with others peers who are now requesting transfer to the DIC. VL results have shown huge success for clients tested.
Conclusions and Recommendations: The DIC is a home away from home and a "go to "place. It provides adequate information on HIV and ART's value, they have motivators of treatment adherence and a continuous counseling, follow up and support network making adherence sustainable. The DIC maintains respect and confidentiality, creating a positive mark on adherence and positive sex practices.

FRPEE348

Increasing Access to HIV, SRHR Andother Healthcare Services for Intersex People in Zimbabwe

Zuze Ronika
Intersex Community of Zimbabwe, Chitungwiza, Zimbabwe

Issues: Zimbabwe has seen intersex issues being misrepresented and excluded from healthcare programming, particularly with regards to SRHR and HIV & AIDS, largely attributable to a lack of knowledge on intersex health needs and service provision modalities, as well as the subsuming of intersex health needs among broader LGBTI health needs and service delivery approaches. As a result, intersex people are unable to take up health services, or access acceptable and appropriate HIV prevention, care, and treatment services.
Descriptions: ICoZ implemented a capacity building program for healthcare workers & intersex community members. At program inception, intersex community members and CBOs were consulted with regards to Advocacy Issues and Needs around access to SRHR and HIV services at the programme pilot site. The following were achieved; an understanding of intersex and the 40+ variations by healthcare professionals. Engaging with intersex people in order to find out their healthcare needs in regards to what suits them best and understand challenges faced in accessing healthcare services.
Lessons learned: Storytelling methodology used is highly effective in mapping community health needs and sensitizing stakeholders.
MSM and LGBTI health programs do not speak to neither do they address intersex health issues, mainly because of the different biological and anatomical differences of these different groups of people. Therefore addressing intersex issues using MSM and LGBTI issues becomes limiting and excluding to the intersex healthcare needs.
A serious and widespread misconceptions within the medical fraternity around intersex identities and health needs.
Self-stigma and isolationist approaches by family members and society are major barriers to service uptake by intersex persons.
Next steps: A statewide policy on intersex health needs and service delivery to be implemented and a proper understanding of intersex sex-education, access to quality mental healthcare services for intersex people which is currently lacking in healthcare service facilities.Apart from SRHR & HIV healthcare needs, there is also need for mental healthcare for intersex people and to have allies who are willing to work on reaching and supporting intersex people, their families and healthcare providers to meet their unique needs. This support should include sensitization on intersex identity and health best practices, psycho-social support, and SRH information.

FRPEE349

Reaching Hard to Reach Men who Have Sex with Men (MSM) in Ghana through Traditional Healers: A Case Study of Maritime Life Precious Foundation

Acquah Robert Kobina[1], Ekem-Ferguson George[1], Owusu Asante Mark K[1], Wosornu Senyo[1], Kwofie , Edward[1], Tagoe Henry[2], Nagai Henry[3], Rahman Yussif Ahmed Abdul[3]
[1]Maritime Life Precious Foundation, Tarkoradi, Ghana, [2]Population Council, Accra, Ghana, [3]JSI Research and Training Institute Inc., Accra, Ghana

Issues: The recent biological and behavioral surveillance survey of men who have sex with men and (MSM) revealed that the prevalence of HIV among MSM is about 16 times higher (18.1%) than the general male population (1.1%). Despite efforts by key population-friendly organizations to reach HIV positive MSM and enroll them into care, some still remain unreached. Preference for traditional/faith healing camps over orthodox health system is relatively high in most rural and peri-urban localities resulting in delays in treatment and other negative health outcomes. In response, Maritime Life Precious Foundation (MLPF) under the USAID Strengthening the Care Continuum Project rolled out a targeted intervention to reach out to traditional healers (THs) to identify and link HIV positive MSM to formal HIV services for care and treatment.
Descriptions: This new approach was streamlined to target only THs who were MSM. This innovative TH-MSM approach was implemented from January to September using multistage systematic approach which first identify MSM who are THs, use them as the index to identify other TH-MSM in the catchment area. The TH-MSM are then trained as lay counselors and case-managers, to identify MSM clients who are positive and link them to MLPF, who in turn ensure that they are linked to treatment. Other duties of the TH-MSM include provision of HIV education and testing services to their MSM clients with unknow HIV status. We conducted a pre-and post-intervention analysis of data (9 months each - January to September 2017 and January to September 2018).
Lessons learned: Fifteen THs were involved in the intervention. We found higher numbers of TH-MSM and a higher proportion of positive cases and a much higher rate of enrollment into treatment in the post-intervention period. In the 9-month period prior to the intervention, 29 TH-MSM and their clients were reached and tested for HIV through a door-to-door strategy with 34.5% testing positive and 20% enrolling into treatment. During the intervention period a total of 147 THs and their clients were tested, 58 (39.5%) tested positive. Almost all 57 (98.3%) positive cases were successfully enrolled onto treatment.
Next steps: Targeting THs who are MSM and their networks is more effective in reaching and linking MSM positives on treatment than the broad brush approach which targets all TH settings regardless of the sexual orientation of the TH. This approach is ideal for scale up to similar settings.

FRPEE350

Etude Pilote sur l'Accès au Dépistage de l'Infection à VIH et au Traitement Antirétroviral chez les Populations Clés dans le District Sanitaire d'Oussouye, Région de Ziguinchor

Diatta Diombraise Gabriel
Distrct Sanitaire Oussouye, Oussouye, Senegal

Contexte et justification: Le dépistage de l'infection à VIH est indispensable chez les populations clés (Professionnels du Sexe, Hommes ayant des rapports Sexuels avec des Hommes, Consommateurs de Drogues Injectables) du fait surtout de leur vulnérabilité face à cette infection
C'est dans ce contexte que nous avons réalisé cette étude dont l'objectif était d'évaluer la faisabilité et les résultats des stratégies de promotion et d'éducation pour la santé au profit des populations clés au niveau du District Sanitaire d'Oussouye ;
Métholodologie: Il s'agissait d'une étude qui a été faite sur la base d'une analyse de toutes les stratégies relatives aux activités de promotion et d'éducation pour la santé (mobilisation sociale suivie de dépistage, entretiens individuels, visites à domicile), des données de routine recueillies entre Janvier 2018 à décembre 2018 ainsi que des résultats issus des entretiens semi-structurés avec trois médiateurs des populations clés et cinq prestataires communautaire impliqués dans les activités de promotion et de prévention pour la sante.
Résultats: A l'issue de la mise en œuvre des stratégies promotionnelles, 20 mobilisations sociales suivies de dépistages ont été effectuées, 50 visites à domiciles réalisées, 300 entretiens individuels menés, 5873 préservatifs distribués, un dépistage de l'infection à VIH effectué chez 200 Professionnels du Sexe et chez 100 Consommateurs de Drogues Injectables. Ainsi, la proportion des populations clés dépistée était de 6, 68% (392/5873).
Par conséquent, la prévalence de l'infection à VIH chez ces populations clés était de 2,33 % (9/39) 2) et 85% (7/9) étaient traitées par les antirétroviraux et régulièrement suivis.
Conclusion: Les campagnes de promotion et d´éducation pour la santé effectuées dans le District Sanitaire de Oussouye ont été efficaces pour identifier les populations clés, leur faire un dépistage de l'infection à VIH et les mettre sous traitement antirétroviral mais ces résultats nécessitent des études complémentaires.
Par ailleurs les résultats de cette étude ont montré l'importance de la synergie entre les organisations communautaires de base, les acteurs communautaires de la promotion de la santé et de la prévention ainsi que les services de santé dans la fourniture de conseils, de tests et de soins appropriés aux populations clés.

FRPEE351

The Uptake of Sexual Reproductive Health and Rights (SRHR) Services among Adolescent Girls and Young Women in Kaduna State, Nigeria

Sunday Haruna Aaron[1,2,3], Udeh Emmanuel[2,4], Baba Idris[3], Umenwobi Anthonia[5]
[1]African Network of Adolescents and Young Persons Development (ANAYD), Prevention, Kaduna, Nigeria, [2]Center for Integrated Health Programs (CIHP), Prevention, Kaduna, Nigeria, [3]United Nations Children Fund (UNICEF), HIV/AYPS, Kaduna, Nigeria, [4]Association of Positive Youth Living with HIV in Nigeria (APYIN), Prevention, Kaduna, Nigeria, [5]African Network of Adolescents and Young Persons Development (ANAYD), Programs, Kaduna, Nigeria

Background: This study aims at assessing the knowledge, experience, and exposure of Adolescent Girls and Young Women on sexual education, condom use and Gender-based Violence (GBV), which results in their poor uptake of Sexual Reproductive Health and Rights (SRHR) services.
Methods: An online study comprising of 88 Adolescent Girls and Young Women, age 10-24 of different ethnic background and religion was conducted, from the 25th of February to the 7th of April 2018, in Kaduna state, Nigeria. A mixed method approach was employed for this study, involving the use of self-administered online questionnaires to elicit information. Data collected was analyzed by Google, and presented graphically, in percentages. https://bit.ly/2HejPPf
Results:
- 48.9% of the respondents got their first knowledge about menstrual cycle from their parent, while 35.2% from school, 18.2% from peer group and 5.7% by self discovery.
- 83% of the respondents know how to track their menstrual cycle, while 17% do not.
- Only 37.5% of respondents have knowledge of their safe period, while 62.5% do not have knowledge of their safe period.
- 76.1% of respondents have heard of female condom, while 23.9% of respondents have not.
- 51.1% of respondents have seen female condom, while 48.9% have not. Of the respondents that have seen a female condom, 53.5% saw it at the health facility/pharmacy, 27.9% saw it with friends, 16.3% saw it in school and 4.7% at home.
- All the respondents have never used a female condom.
- 15.9% of respondents are victims of Gender-based violence (GBV), while 84.1% have never had such experience. Of all the victims, 76.9% did nothing, 15.4% reported to the Police/Authorities and 7.7% reported to their Parent/Guardian.
- Of all the victims that did nothing, 71.4% was because they did not know what to do, 14.3% were threatened and 14.3% were scared of stigma.
Conclusions and Recommendations: Sexual Reproductive Health and Rights (SRHR) are services we must provide to Adolescent Girls and Young Women in other to mitigate unsafe sex, Sexually Transmitted Infections (STI),pregnancy, unsafe abortion and early marriage among this target populations. Its therefore paramount that efforts aimed at addressing these gaps and challenges are made as it will greatly impact on the quality of Sexual reproductive health and right (SRHR) services and it's outcome.

FRPEE352

Le Dépistage du VIH/SIDA Fait par les Communautaires MSM

Bah-Bi Boti Elise, Njaboue Philippe Gesvais
ONG Alternative Côte d'Ivoire, Abidjan, Côte d'Ivoire

Contexe: La Côte d'Ivoire est le pays le plus touché par le VIH de l'Afrique de l'ouest avec un taux de prévalence de 3,7% (EDSCI III 2012) dans la population générale. La communauté MSM en est encore plus exposée avec une prévalence de 18% (Enquête SHARM CI 2012). Cette forte prévalence est dût à insuffisance de messages de sensibilisation, une faible fréquentation des centres de santé par les MSM et la forte stigmatisation dont ils sont victimes dans ces centres de santé. Face à ces difficultés, l'État de Côte d'Ivoire a mis en place une stratégie avancée qui consiste à former les les agents communautaires MSM en dépistage au bout du doigt. Cela à pour objectif de rapprocher des MSM des service de CDV.
Méthodes:

- La formation des agents communautaires se fait en 3 phases: D'abord ils sont formés par le Programme National de Lutte Contre le VIH/sida (PNLS) du Ministère de la Santé et de l'Hygiène Public où ils reçoivent une formation théorique (notion de base , et en bio manipulation), ensuite une phase pratique en clinique .Et enfin une phase de coaching sur le terrain par le personnel soignant . supervisés par le PNLS afin de recevoir un quitus et être opérationnels.

L'activité de dépistage se déroule comme suit. Le conseiller communautaire, à votre écoute, recueille vos attentes, vous conseille et vous explique le déroulement du test. Il échange avec vous sur les différentes possibilités de résultats.

- 1. Prélèvement d'une goutte de sang au bout de votre doigt
- 2. Réalisation du test, le résultat est disponible au bout d'une vingtaine minutes.
- 3. Le pair éducateur dépistage partage avec vous le résultat de façon orale.

Résultats: Au sein de l'ONG Alternative CI, (36) éducateurs et conseillers communautaires ont été formés et (8) sont opérationnels. Pendant 12 mois, de octobre 2017 à septembre 2018, ces 44 éducateurs de pairs et conseillers ont dépistés 5664 MSM et ont accompagné 726 pairs dépistées positives pour une prise en charge médicale et/ou psychosociale.
Conclusion: L'activité de dépistage dans la communauté reste une réussite au delà de nos attentes. Elle a permis aux MSM de se rendre compte par eux-mêmes que le dépistage était un moyen important pour réduire le taux de prévalence. Cette initiative de l'État de Côte d'Ivoire doit être dupliquée afin de réduire considérable les conséquences du VIH/Sida dans les communautés MSM africaines.

FRPEE353

La Problématique de la Grossesse Non Désirée chez les TS a l'USAC de Kayes

Bane A[1], Dembele Bintou[1,2,3], Bah D[1], Fomba Y[1]
[1]Coalition Plus, Kayes, Mali, [2]ARCAD-SIDA, Kayes, Mali, [3]EHESP, Bamako, Mali

Contexte et justification: Au cours des interventions de prévention primaire chez les TS, des cas de grossesse ont été signalé pour mieux décrire le phénomène nous avons mené cette étude.
Objectifs: Analyser les cas de grossesse non désirée chez les TS
Méthodologie: C'est une étude observationnelle descriptive, rétrospective à partir du registre de consultation sur une période de 2 ans.
Les données ont été saisies sur une fiche d'enquête et analysé par le logiciel épi-info 7
Résultats: 23 TS ont contracté une grossesse non désiré pendant les deux ans sur 750 TS enregistré soit un taux de 3.06 %. 65.2 % avait un âge compris entre [21-30]. les âges extrêmes étaient de 17-35 ans. 47.8 % (11) avait consulté au premier trimestre de la grossesse.
L'auteur des grossesses était des boys friend dans 52.2 % contre 43, 5 % pour les clients.
4.3 % des TS ne savaient pas l'auteur de leur grossesse. 56.6 avaient avorté contre 26.1 % qui ont accouché. 4 TS sont restée sans information soit 17,4%.
Le test de l'hépatite B a été réalisé chez 19 TS et 4 sont revenus positifs soit 17.4 %.
15 TS avait une IST soit 65,2% et l'écoulement vaginal était le plus fréquent.
Le test VIH était revenu positif chez 9 TS soit 39.1 %.
La tranche [21-30] a plus avorté avec un P=00025; le VIH est plus fréquent dans cette même tranche d'âge avec P=0.19.
Le taux avortement est plus élevé chez les analphabète P=0.2.
Conclusion: La fréquence des grossesses non désirés constituent un risque de transmission des IST/VIH chez la cible TS; toutes fois des actions doivent être mise en place pour diminuer ce risque.
Mots clé: Problématique, grossesse non désirée, TS

FRPEE355

Sexual and Reproductive Health Knowledge, Attitude and Practice among Young Persons with Disabilities (PWD); A Case Study of Three Clusters in Lagos

Oluwa Enitan Sophie[1], Adebayo Rita Olawunmi[2], Boyo Mayowa Eleanora[3]
[1]*International Youth Alliance For Family Planning, Program Officer / State Coordinator, Lagos, Nigeria,*
[2]*Joint Association of Persons With Disability (JONAPWD) Lagos Chapter, Women Leader, Lagos, Nigeria,*
[3]*House of Eleanora; A Community of DIFFERENTLY Abled Persons., Founder, Lagos, Nigeria*

Background: In Nigeria, 15% representing 25 million people have at least one type of disability. People With Disabilities (PWDs) often perceived to be sexually inactive lack accurate SRH information and are highly vulnerable to sexual and emotional abuse. It is important for young PWDs to have comprehensive sexuality education. This study aims to assess the sexual and reproductive health knowledge, attitude and practice of PWD.
Methods: A hundred and twenty (120) PWDs, male and female, 15 - 29 years old with at least one form of disability *were reached* within a twelve weeks period. Focus Group Discussion, one on one structured discussion and interviews were conducted at agreed location, to collect data on their knowledge of SRHR including attitudes and perception, HIV/AIDS, STIs testing and treatment services.
Results: PWDs like everyone have SRH needs, yet they face heightened barriers to information and services. This survey had a baseline response rate of 89.9% with 69% of the respondents as females whilst 30% were male; 25% of male and 18% of female respondents had knowledge of modern contraceptive methods and have used one form or the other. 85% had issues with accessing these products as they need aid in getting services they would rather was discreet. The ignorance and attitudes of society and individuals, including health-care providers, raise most of these barriers - not the disabilities. The findings confirmed the low level of SRHR knowledge, attitudes and perceptions related to Reproductive Health among young PWDs in Nigeria. As 49% of all respondents admitted they were sexually active. The needs of PWDs are often overlooked in spite their high vulnerability. 91% of all sexually active female have had unprotected sex. 45.2 % of all respondents within the ages of 15 - 29 have had unintended pregnancies in the past. This leaves women facing multiple, intersecting discrimination. PWDs are more likely to become infected with HIV and other STIs; 87.9% of all respondents like many youths have misconceptions about contraceptives and the low use of contraceptives at last sex by many PWDs shows the urgent need for intervention.
Conclusions and Recommendations: There is a need to promote participation of young PWDs, in policy making processes. to develop guidelines to help proper implementation with service providers exposed to other dimension of understanding human sexual orientation and how this come in when designing programs for PWDs.

FRPEE356

Early Changes in Family Planning Uptake among HIV-negative Female Sex Workers Initiating Oral Pre-exposure Prophylaxis (PrEP) in Kenya

Waruguru Gladys[1], Musau Abedenego[2], Kamau Mercy[2], Manguro Griffins[1], Were Daniel[2]
[1]International Center for Reproductive Health, Mombasa, Kenya, [2]Jhpiego Kenya, Nairobi, Kenya

Background: PrEP has proven efficacy to reduce new HIV infection among people with substantial risk, including female sex workers (FSW). Apart from HIV-risk, FSW experience substantial unmet family planning (FP) needs. Studies in Africa have reported reduced condom use by women on PrEP. Reduced condom use, in absence of non-barrier FP use, may result in unwanted pregnancies and pairing PrEP with FP methods may abrogate this risk. FSW in Kenya access PrEP through drop in centers (DICEs) since 2017. We investigated determinants of new FP uptake among FP-naïve FSW when continuing on PrEP.
Methods: We conducted a retrospective analysis of data from 27 DICEs in Jilinde, a project funded by Bill & Melinda Gates Foundation to support PrEP scale-up in Kenya. Providers collected data during visits using a national PrEP tool. Data was entered to a secure database. Analysis was restricted to FSW who did not report FP use at PrEP initiation, described as FP-naïve, and for whom 3-month visit data were available. The outcome variable was reported FP use at the third visit. Bivariate analysis was conducted to determine association between FSW variables and new FP use and multivariate regression analyses isolated predictors of new FP use.
Results: From February 2017-May 2019, 2,291 (17.6%) of 13,327 FSW eligible for a third visit returned. Of returning FSW, 1,190 (51.9%) were FP-naïve at the initial visit, mean age28.2 (SD=7.2) years and 72.2% were unmarried, 25% mobilized by peers and 37% reached via outreaches. At initial visit, 96.7% reported inconsistent condom use and 35.3% had sex under influence of drugs and alcohol. After 3 months, 303 (25.5%) FSW reported FP use, a crude FP incidence of 1.02 per 100 persons' years. On univariate analysis, new FP use was associated with being married (OR 1.52, 95% CI 1.15-2.01), self-reported gender based violence (GBV) (OR 2.99, 95% CI 1.17-7.59) and sex under influence of drugs and alcohol (OR 1.64, 95% CI 1.26-2.15). Being married and reported GBV emerged as predictors of new FP use (AOR 3.29, 95% CI 1.15-9.43).
Conclusions and Recommendations: This study unearthed low FP use among FSW initiating PrEP. We illustrated that 1 in 4 FP-naïve FSW on PrEP will adopt a non-barrier FP method in the course of PrEP revisits. Integrating FP into HIV prevention platforms has potential to address unmet FP needs, including FSW unwilling to use condoms. PrEP programs for FSW should offer comprehensive sexual and reproductive health services.

FRPEE357

Treatment as Prevention and Pre-exposure Prophylaxis for Female Sex Workers: Service User Costs of Care in Cotonou, Benin

Cianci Fiona[1], Behanzin Luc[2,3,4], Kessou Leon[5], Guédou Fernand Aimé[2,3], Zannou Djmon[6,7], Alary Michel[8,9], Terris-Prestholt Fern[10], Vickerman Peter[11]

[1]HSE, Dublin, Ireland, [2]Centre de Santé Communal de Cotonou 1, Dispensaire IST, Cotonou, Benin, [3]Université Laval, Centre de Recherche du CHU de Québec, Québec, Canada, [4]Université de Parakou, Ecole Nationale de Formation des Techniciens Supérieurs en Santé Publique et en Surveillance Epidémiologique, Parakou, Benin, [5]Service de Consultance et Expertise Nouvelle en Afrique, Cotonou, Benin, [6]Université d'Abomey-Calavi, Faculté des Sciences de la Santé, Cotonou, Benin, [7]Centre National Hospitalier Universitaire HMK de Cotonou, Cotonou, Benin, [8]Université Laval, Département de Médecine Sociale et Préventive, Québec, Canada, [9]Institut National de Santé Publique du Québec, Québec, Canada, [10]London School of Hygiene & Tropical Medicine, London, United Kingdom, [11]University of Bristol, School of Social and Community Medicine, Bristol, United Kingdom

Background: Treatment as prevention (TasP) and Pre-exposure prophylaxis (PrEP) are effective forms of HIV prevention but the cost of accessing these treatments for key populations such as female sex workers (FSW) may be a barrier to uptake. The aim was to evaluate the direct and indirect costs to FSWs of accessing PrEP and TasP in a demonstration study in Cotonou, Benin.

Methods: FSW were enrolled into either the PrEP or TasP arm of the study from October 2014 to Dec 2015 and were followed up until December 2016. Self-reported direct and indirect costs incurred by FSW were collected prospectively by questionnaire at each clinic visit attended. Direct costs included the cost of travel and food to attend clinic visits. Indirect costs included lost earnings attributable to clinic attendance. Data on monthly salary was also collected and used to estimate a mean annual salary. Total economic costs for all the women enrolled in the study was calculated. The mean cost per each visit type was calculated and the mean initiation costs and mean annual cost per FSW of full attendance to all clinic visits was derived. This was compared to mean annual salary.

Results: 105 women were recruited to TASP arm with a total follow up of 117.7 person years and 256 to PrEP with a total follow up of 250.1 years. For all women on TasP, the total economic cost of attending the clinic for treatment was $2561 of which $946 (36%) were indirect costs. In the PrEP arm, total economic cost was $6688 for the cohort, of this $3477 (52%) were indirect costs.

For women on TasP, the mean cost of attending initiation visits was $8 and the mean annual cost of full attendance to quarterly scheduled visits was $16. For women on PrEP the mean initiation cost was $11 and the mean annual cost was $21. This represents 0.9% of the mean annual salary reported for FSW on TasP ($125) and 0.5% of the salary of FSW on PrEP ($215).

Conclusions: The economic cost of attending the PrEP or TasP intervention represented a small proportion of the annual salary of FSW and so should not inhibit women accessing care. However, many women reported no monthly income so any costs incurred by attending the clinic could represent a barrier to access.

FRPEE358

Stratégies d'identification et de Rétention des HSH dans les Soins VIH dans un Centre de Traitement Ambulatoire (CTA) en Afrique de l'Ouest

Gueye Mamadou[1], Diagne Astou[1], Diaw Khaly[2], Mboup Ahmadou[3], Ndiaye Kiné[4], Ngom Ndeye Fatou[3]
[1]Centre de Traitement Ambulatoire du CHNU de Fann, Maladies Infectieuses et Tropicales, Dakar, Senegal, [2]Centre de Traitement Ambulatoire du CHNU de Fann, Dakar, Senegal, [3]Centre de Traitement Ambulatoire de Dakar, Dakar, Senegal, [4]Centre de Traitement Ambulatoire, Dakar, Senegal

Contexte: Depuis 2010, le nombre de nouvelles infections à VIH chez les adultes est resté stable dans le monde. Les populations clés et leurs partenaires sexuels représentent 47% de toutes les nouvelles infections en 2017 selon ONUSIDA. L'identification et la rétention dans les soins de ce groupe vulnérable est plus que nécessaire pour l'atteinte des 3*90.
L'objectif de cette recherche action est de tester des stratégies qui améliorent le dépistage et la rétention des HSH au CTA de Dakar.
Méthodologie: Démarrage du processus depuis la réunion de partage du rapport annuel 2018, tenue en janvier 2019. La difficulté d'identification des HSH est ressortie comme contrainte majeure évoquée dans ce rapport. Ainsi un dispositif a été réfléchi et mis en place pour une meilleure identification des populations clé fréquentant la structure. Des lignes directrices et des outils de recueil de données ont été développés. Des interrogatoires minutieux sont menés par les assistants sociaux avec l'appui des médiateurs pendant le counseling dépistage pré et post-test. Dans cet interrogatoire, figurent des rubriques sur l'orientation et les pratiques sexuelles à risque. Dans le suivi routinier des patients, le personnel instaure un climat de confiance. Des questions sur l'orientation sexuelle ne leur sont posées qu'après garantie d'une confidentialité.
Résultats: Du 1er Janvier au 30 juin 2019, nous avons identifié **141 HSH** âge < 25ans **34**, et âge ≥ 25ans **107**. Pour le counseling dépistage, parmi les **49** dépistés, **25** sont revenus positifs **(prévalence chez les HSH dépistés au CTA 68%).** Tous ont bénéficié d'une prise en charge.
Parmi les patients qui sont régulièrement suivis, nous avons pu identifier **92 HSH**, dont **23** ont moins de 25 ans.
Quelques activités ciblées sont déroulées à leur encontre comme la distribution de préservatifs et de lubrifiants, des séances de prévention d´IST et pour la sensibilisation des partenaires au test de dépistage VIH.
Conclusion: La stigmatisation des HSH, et particulièrement de ceux vivant avec le VIH constitue un obstacle à leur identification surtout les plus âgés. La stratégie mise en place au CTA a permis de noter que certains HSH suivis ne bénéficiaient pas d'activité ciblée. Elle a permis de doubler le nombre de HSH identifiés dans la cohorte ainsi que les nouveaux cas dépistés.
Or, les dernières estimations sur la prévalence de ce groupe nécessite un meilleur ciblage des activités pour l´atteinte des 3"90"

FRPEE359

Barriers and Facilitators of HIV Care Provision for HIV-positive Men who Have Sex with Men in Ghana: The Perspectives of HIV Care Providers

Gyamerah Akua O.[1], Sorensen Guro[2], Mensah Matilda D.[2], Vanderpuye Naa Ashiley[2]
[1]University of California, San Francisco, Center for AIDS Prevention Studies, San Francisco, United States, [2]West Africa AIDS Foundation, Accra, Ghana

Introduction: In Ghana, men who have sex with men (MSM) bear the highest HIV burden among key populations, with a prevalence of 18%. The national response has made significant progress to address HIV among MSM, but there remains a treatment gap among MSM living with HIV (MSMLHIV). To address this, we examined the multilevel needs of MSMLHIV along the treatment cascade. This study reports on HIV healthcare workers' (HCWs) perspectives on barriers and facilitators of HIV care provision for MSM clients.
Methods: We conducted in-depth (n=13) and group (n=4) interviews with HCWs (nurses, doctors, and case/lay counselors) in 2019. HCWs were asked about their experiences providing services to MSMLHIV, what factors make it hard or easy to provide services to clients, and how HIV care for MSM can be improved. Interviews were transcribed and analyzed using thematic analysis.
Results: HCWs reported multilevel barriers in providing care to MSMLHIV. Structural barriers included sporadic antiretroviral shortages, inadequate services, and off-site viral load equipment, which prevent/delay HCWs from providing comprehensive services. HCWs also reported labor-related barriers such as inadequate staffing, insufficient wages, and out-of-pocket contributions to support clients' treatment and deliver services. Sociocultural barriers included anti-gay and HIV stigma in clinical settings, with some nurses reporting being stigmatized as the HIV/gay people's nurse. In addition, criminalization and stigma against homosexuality place HCWs at risk of anti-gay violence during community outreach work. MSM's internalization of these stigmas also presents challenges such as having high expectations of HCWs to provide them with care ahead of other clients due to fear of being recognized at an HIV ward. On the individual level, some HCWs discussed feeling morally conflicted about working with MSM due to their beliefs about homosexuality. Facilitators of HIV care were less reported. Of those discussed, HCWs shared that knowing their client's life story facilitated their work. Moreover, working with MSMHLIV helped HCWs better understand MSM´s struggles and support their treatment journey.
Conclusions and Recommendations: HCWs need more resources, labor support, comprehensive care services, and health systems strengthening to improve their working conditions and HIV services to MSMLHIV. Anti-stigma trainings of HCWs and media campaigns are needed to address workplace stigma against MSMLHIV.

FRPEE360

Premières Données sur l'Infection à VIH en Milieu Carcéral à Bangui

Mossoro-Kpindé Christian Diamant[1,2], Dimer Henri[3,4], Gbangba-Ngai Eudes[3,5], Mossoro-Kpindé Hermione Dahlia[1], Bezo Max Elysée Richard[6], Ngaikoumon Gervais[7,8], Mbeko Simaleko Marcel[1,9]

[1]Faculté des Sciences de la Santé, Université de Bangui, Bangui, Central African Republic, [2]Laboratoire de Biologie Clinique et de Santé Publique, Bangui, Central African Republic, [3]Faculté des Sciences de la Santé, Université de Bangui, Bangui, Central African Republic, Bangui, Central African Republic, [4]Direction de Lutte Contre le Sida, les IST et la Tuberculose, Bangui, Central African Republic, [5]Services de Santé des Armées, Bangui, Central African Republic, [6]Centre de Santé Urbain de Ouango, Bangui, Central African Republic, [7]Service de Santé des Armées, Bangui, Central African Republic, [8]Infirmerie de la Prison Centrale de Ngaragba, Bangui, Central African Republic, [9]Direction Générale de Lutte Contre les Endémies Spécifiques, Bangui, Central African Republic

Background: l'élimination de l'infection à VIH requiert une prise en charge particulière des populations-clés. L'objectif de cette étude était de dépister l'infection à VIH à là prison centrale de Ngaragba à Bangui afin d'offrir aux séropositifs un traitement antirétroviral.
Methods: L'étude s'est déroulée du 3 au 7 août 2015 à la prison centrale masculine de Ngaragba. Les détenus volontaires étaient systématiquement inclus dans l'étude. Une fiche standardisée a permis de collecter les données sociodémographiques. La sérologie VIH était réalisée sur place à l'aide d'un algorithme séquentiel utilisant Détermine® VIH 1/2 (Abbott, Japon) et Unigold® VIH 1/2 (Trinity Biotech, Irland). La confirmation des cas positifs ou indéterminés étaient réalisés au Laboratoire National de Biologie Clinique et de Santé Publique à l'aide d'un algorithme parallèle associant les tests ELISA Genscreen® HIV-1/2 Version 2, (Bio-Rad, France) et Vironostika ® HIV 1.2.0 (Biotech limited, Angleterre).
Results: Durant la période de l'étude, 630 personnes étaient détenues à Ngaragba, soit le double de l'effectif moyen habituel des détenus. Sur les 630, 444 détenus ont accepté le dépistage, soit un taux de participation de 70,5%. L'âge moyen était de 25,6 ans. Les détenus (67,8%) provenaient essentiellement de 4 des 8 arrondissements de Bangui : 8ème (26,9%), 5ème (15,8%), 3ème (12,8%) et 4ème (12,3%). Les désœuvrés représentaient 62,5% des prisonniers. L'union libre était le statut matrimonial dominant (60,3%). Soixante-quatorze pourcent des détenus étaient de niveau collège et 55,9% n'ont pas atteint le niveau secondaire. Huit était séropositifs au VIH (1,8%), par les tests rapides, tous confirmés en ELISA. Des 8, 6 étaient anémiés, 5 avaient une hyperleucocytose et 7 un taux de lymphocytes T CD4 < 500 mm^3 et ont bénéficié du traitement antirétroviral.
Conclusions and recommendations: La faible séroprévalence du VIH inférieure à séroprévalence nationale (4,9%) serait liée à la faible participation. Cette faible participation souligne l'importance des activités de sensibilisation à la prévention, au dépistage et au traitement de l'infection à VIH à l'endroit des détenus.

FRPEE361

Delivering Integrated Package of HIV Prevention for Adolescents: Experience from Two Years of First Time Young Mothers Project in Rwanda

Hagenimana Felix[1], Mukamurara Helene R.[1], Musonera Grace Kaneza[1], Akimana Rachel[1], Kalisa Isabelle[1], Moro Liana[2], Siraji Furaha[2], Iryanyawera Marie Claire[2], Karugwiza Therese[2], Umutesi Geraldine[1], Umutoni Sandrine[1]

[1]Imbuto Foundation, Health, Kigali, Rwanda, [2]UNFPA, Adolescents & Youth, Kigali, Rwanda

Issues: In Rwanda, the teenage pregnancy rate increased slightly from 6.1% in 2010 to 7.3% in 2015. About one in five girls in Rwanda become First Time Young Mother (FTYM) at the age of 19. Despite Government efforts, to expand Adolescent friendly Sexual and Reproductive Health (ASRH) services and access to quality services tailored to young people's needs is still limited. As a response, the FTYM project was initiated, providing an integrated package of interventions for effective social re-integration.
Descriptions: Since April 2017, Imbuto Foundation, in collaboration with UNFPA has implemented FTYM project in Rubavu district. The project targets the most vulnerable FTYMs aged between 10 and 19 years and their children. It's implemented through integrated package: psycho-social support counseling provides once a week at health center (HC); 14 Parent Adolescent Communication (PAC) forums sessions to restore the relationship between FTYMs and their parents; 6 community-based outreach campaigns to increase awareness and fight social discrimination, stigma and violence; skills-based training for 166 health care providers aimed at increasing the uptake of contraceptives after delivery and HIV testing; improved child care practices; and 7 groups were formed to promote income generating activities (IGAs). Data were collected using monitoring tools on monthly basis. Descriptive statistics was used to generate findings, using STATA version 14.
Lessons learned: Through psycho-social support counseling, 175 FTYMs were equipped with ASRH information and youth-friendly services. 81% of FTYMs chose to use Family Planning (FP) methods to prevent another pregnancy and risk of HIV. Implants and injectables were the most preferred (64% and 15% respectively). All 175 FTYMs consented to HIV counseling and testing and 2 (1.14%) of them were found HIV positive and subsequently adhered to care and treatment at HCs. Of all FTYMs who were chased out of their homes (25% of the total cohort) were reintegrated back after 2nd PAC sessions involving 260 parents across 7 sectors. Six outreach campaigns increased awareness of 5,850 community members. From IGAs interventions, all 175 FTYMs saved amount of US$7726 and are able to pay their health insurance and cover other basic needs for themselves and their children.
Next steps: With regards to future scale-up, collaborating with similar institutions and government initiatives would facilitate addressing the identified needs.

FRPEE362

Effect of Time Change on Adolescent and Young People Accessibility to AYFHC in Akure, Ondo State, Nigeria

Aiwanfo Onesimus, Young Advocacy Group
Kids & Teens Resource Centre, Monitoring and Evaluation, Ondo State, Nigeria

Issues: Government in Ondo state have made significant effort in establishing youth friendly health care centres to increase young people´s access to health and social services. By it became very frustrating to see very few young people patronizing such centres due 8am-4pm working hours.Change in time to 4pm-8pm showed a significant difference in young people access to AYFHC services.
Descriptions: Using Participatory Learning in action and community engagement We discovered young people 10-35years in Akure either attend school from 8am-4pm or go to centres where they skills from 8am-6pm. With this kind of schedule, it became very difficult for young people to leave school or their skill centres for AYFHC services. In 2017, there was an extension in service time to 8pm, there was a massive increase of young people accessing social and health services at this centre´s from 4pm-8pm from 2persons per day to 12persons per day, and 2018 we had a 50% increase.
Lessons learned: It was observed that the additional 50 persons came between 4pm to 8pm. Most of the young people preferred the evening hours because it was very convenient and it allows them do their daily activities. Also it reduced stigmatization because absence at school or work leads to questions been raised.
Next steps: Provision of AYFHC isn´t enough, passionate Friendly health workers should be employed and Service time should be convenient for young people to come as well as the location should be strategic. Op

FRPEE363

Scaling Up Undetectable = Untransmittable Campaigns within Key Population Drop-in Centers in Kilifi and Mombasa Counties, Kenya

Owira Patricia[1], Manguro Griffins[1], Langat Lillian[2], Okoro Dan[2]
[1]International Centre for Reproductive Health Kenya, Mombasa, Kenya, [2]United Nations Populations Fund Kenya, Nairobi, Kenya

Issues: Educating people that maintaining undetectable viral loads effectively eliminates risk of sexual transmission of HIV, Undetectable = Untransmittable (U=U), greatly optimizes the HIV cascade. Benefits include improved uptake of testing services, linkage to antiretroviral therapy (ART) and viral load (VL) uptake. Key populations (KPs) specifically female sex workers (fsws) and men who have sex with men (msm) are a key driver to HIV in Kenya with 14% new infections attributable to sex work. Undetectable viral loads among key populations living with HIV (KPLHIV) will thus markedly reduce transmission in Kenya. We scaled up U=U campaigns to optimize the HIV cascade among fsws and msm in six drop-in centers in Kilifi and Mombasa counties, Kenya.
Description: Between October 2018 and June 2019, two types of events were organized to sensitize fsws and msm on U=U. The first events were incorporated into routine psychosocial support groups (PSSGs) and were targeted at KPLHIV on ART, defaulters and those not initiated on ART. The second events were independent campaigns that also included KPs within our cohorts who had never been tested. Targeted KPs were then invited via phone calls and short message service. Health talks on the science behind U=U were conducted by trained service providers with the aid of flip charts and videos tailored to KPs. We distributed branded t-shirts and information materials on U=U including posters and brochures. We provided testing to fearful KPs who did not know their status and those testing positive were initiated on ART. VL samples for eligible KPLHIVs were also collected.
Lessons learned: Fsws and msm were encouraged to know their status with increased rates of first-time testers from 0.5% (n=25/4362) to 5.5% (n=312/5697) for fsws and 3% (n=27/900) to 11.2% (n=185/1658) for msm. Improved linkage to antiretroviral therapy for newly diagnosed positives was observed from 72% (n=34/47) to 92% (n=102/111) for fsws and 33% (n=3/9) to 93% (n=25/27) for msm. VL uptake for those eligible also improved from 39% (n=67/173) to 92% (n=222/241) for fsws and 61% (n=22/36) to 91% (n=53/58) for msm.
Recommendations: Targeted U=U campaigns are a cost effective method when integrated into routine PSSGs but since not all KPLHIVs attend PSSGs, independent events still remain necessary. U=U campaigns greatly optimize the HIV cascade among KPs and coupled with oral PrEP could reduce risk of HIV transmission to regular sex partners of KPLHIVs.

FRPEE364

Dépistage Communautaire au Cameroun: La Solution pour Toucher les HSH «Hard to Reach» de la Ville de Yaoundé ?

Olongo Ekani Antoine Silvère[1], Enama Ossomba Jean Paul Bienvenu[2], Betsi Emmanuel[3]
[1]Humanity First Cameroon, Programs, Yaoundé, Cameroon, [2]Humanity First Cameroon, Yaoundé, Cameroon, [3]Ministère de la Sante Publique du Cameroun, Yaoundé, Cameroon

Background: Au Cameroun, la prévalence du VIH reste très concentrée au sein des populations clés et notamment des MSM (44% dans la seule de ville de Yaoundé, selon l'étude IBBS de 2016). Le projet Continuum of Prevention, care and Treatment of HIV/AIDS with Most at Risk Population (CHAMP) du PEPFAR mis en œuvre par Care International Cameroun, qui se déploie dans un contexte politico-juridique peu favorable à l'endroit des populations clés et donc des MSM, a développé avec ses partenaires de mise en œuvre que sont les OBCs, la stratégie de dépistage communautaire du VIH pour offrir le service de dépistage du VIH aux MSM de Yaoundé.
Methods: Ce service est fourni dans le cadre du Projet CHAMP. Il a permis d'avoir au sein des OBCdes laboratoires communautaires, dans les villes de Yaoundé, Douala et Bamenda. Pour rassurer les clients de la fiabilité des dépistages offerts, les OBC mettent à contribution un personnel communautaire. Il s'agit des laborantins, des conseillers psychosociaux et des Conseillers Relais qui sont capacités à cet effet. Un service de supervision et d'assurance qualité a été mis en place pour suivre et garantir la fiabilité des résultats positifs ou négatifs. Le travail consiste ici à aller vers les MSM « Hard to reach » et leur offrir le service de dépistage du VIH et des IST dans les points chauds.
Results: Entre janvier 2015 et Septembre 2018, plus 22 254 MSM ont été touchés au niveau de la prévention (distribution des préservatifs et des gels lubrifiants). Parmi ces derniers, 10 542 ont bénéficiés du dépistage communautaire et 3254 d'entre ceux ayant accepté le dépistage ont été dépistés positif au VIH et, mis sous traitement dans le même intervalle. Selon l'étude IBBS de 2016, on note une grande satisfaction chez les MSM ayant utilisés ce service. Depuis que ces services sont proposés aux MSM au sein de notre Drop in Center, l'on observe une forte demande d'autres services dont voudrait bénéficier les MSM positifs au VIH.
Conclusions and Recommendations: La stigmatisation et la discrimination dont sont souvent victime les MSM dans les services de santé classiques justifient la préférence et l'aisance qu'ils ont à accepter de se faire dépister en communauté. La principale raison de cette acceptation est le fait que ce service leur garanti une certaine confidentialité et une convivialité dont ils ont besoin. Il est donc urgent que soit renforcé le service de dépistage communautaire.

FRPEE365

L'Impact du DIC (Drop in Center) sur la Prise en Charge des LGBTIQ au Togo

Avouglan Kodjo Sena
Association Big Mama, Lomé, Togo

La mise en place du DIC a permis d'organiser et d'offrir une PEC médicale et d'assistance juridique aux victimes de stigmatisation et de discrimination. Le DIC accueil aussi les LGBTIQ sans domicile fixe. La disponibilité gratuite de connexion internet a augmenté la fréquentation du DIC. Il constitue un espace de détente et d'apprentissage.

Questions: L'environnement peu favorable pour l'épanouissement des LGBTIQ a des répercussions sanitaires sur la vie de ces derniers. La peur d'être stigmatisé dans une structure sanitaire est toujours d'actualité et les LGBTIQ préfèrent rester dans la clandestinité; ce qui entraîne pour la plupart des complications voire des cas de décès. Depuis la mise en place du premier DIC au Togo en faveur des LGBTIQ, cette cible est sortie de cette clandestinité.

Description: En 2013, sous l'initiative des membres de la communauté LGBTIQ, et du projet PACTE de l'USAID, le premier DIC a été érigé au Togo et a démarré les activités de permanences médicales, de conseils dépistage volontaires, de permanences juridiques et psychologiques, de loisirs et de convivialité à l'endroit des LGBTIQ,. C'est un cadre d'activités des associations identitaires.

Leçons Apprises: Les LGBTIQ bénéficient d'un cadre convivial loin des regards stigmatisant

Prochaines Étapes: La communauté est toujours dans la dynamique de renforcer les activités du DIC afin de permettre aux LGBTIQ d'avoir une prise en charge adéquate et une vie épanouie.

FRPEE366

Peer-based Distribution of HIV Self-test Kits among Key Population at Work Places in Kampala, Uganda

Kirungi Gloria[1,2], Tanga Erasmus[2], Mukasa Betty[3], Lopez Melanie[4]
[1]Nkumba University, School of Postgraduate Studies and Research, Kampala, Uganda, [2]HIV/Health Initiative in Workplace Activity Project, World Vision Uganda, Kampala, Uganda, [3]Uganda Police Force, Directorate of Police Health Services, Kampala, Uganda, [4]HIV/Health Initiative in Workplace Activity Project, World Vision US, Seattle, United States

Issues: HIV self-testing (HIVST) addresses barriers to HIV diagnosis and is a potential strategy to overcome disparities in access to and uptake of HIV testing among key populations (KP) in Uganda. Lack of privacy, hostile policy environment, and convenience have been reported as key barriers to this vulnerable population hence resulting in significantly low uptake of other testing options. This pilot study aimed to explore the use of KP peers to increase access and uptake of HIV testing services among MSMs and female sex workers living within the workplace which is the police barracks and surrounding communities in Kampala.
Description: Twelve health workers from various service delivery points at Nsambya police health facility were trained in the provision of HIVST services and two KP peers (1 MSM, 1FSW) were trained in sensitization and mobilization of fellow peers for HIVST services. Each KP peer was attached to 6 health workers for additional support in demand creation, thereafter, each KP peer was tasked to sensitize and mobilize at least 10 peers to utilize HIVST services within a period of 2 weeks.
The MSM and FSW peers sensitized and mobilized 28 MSMs and 45 FSWs respectively within 2 weeks, all peers were eligible for HIV testing and accepted voluntary HIV testing using the HIVST kit (OraQuick ADVANCE Rapid HIV-1/2 Antibody Test). 73 kits were distributed, only 40% of the clients reported their test results to the health workers, majority (52%) shared their test results with the trained KP peer. HIV positivity was at 7.1% and 6.6% among MSMs and FSWs respectively. All the individuals with positive result were linked to ART.
Lessons learned: HIVST has offered confidential HIV testing services to key populations hence a potential to ensure that 90% of the key population know their HIV status for epidemic control.
Technical support and attachment of peers to trained health workers is vital in ensuring good quality of services and enrollment of HIV positive clients on ART. There is need to empower KP peers with skill in HIV counselling and support since majority of peers prefer to disclose their test results to the peer rather than the health worker.
Next steps: Scale up peer distribution of HIVST kits among key population within workplaces so as to reach the many margnalized group of people. Explore incorporation of KP peers in the health system to bridge the gap between the health facility and key population.

FRPEE368

Family Characteristics and Health-related Quality of Life of Persons Living with HIV/AIDS Attending a Comprehensive Treatment and Care Centre in Southwest Nigeria

Adebayo Ayodeji[1], Betiku Bamidele[2]
[1]University of Ibadan, Community Medicine, Ibadan, Nigeria, [2]Federal Medical Centre, Owo, Nigeria

Background: The advent of highly active antiretroviral therapy (HAART) has positive effects on health related quality of life (HRQoL) of persons living with HIV/AIDS (PLWHA). However, the effect could be undermined it family correlates are not given due considerations. There is paucity of literature on the relationship between family characteristics and HRQoL of PLHWA in Nigeria, hence the need for this study.
Methods: This data was extracted from a descriptive longitudinal study conducted to test the effect of HAART on the HRQoL of 216 PLWHA who were yet to commence therapy. Family functionality was assessed using a 20-point family APGAR scale. Other family characteristics assessed were marital status, current employment status, occupational class, average monthly income. The WHOQoL-HIV was used to assess HRQoL. Data were analyzed using descriptive statistics, Chi-square and linear logistic regression at p=0.05.
Results: The age of respondents was 38.4±8.5 years**.** About two-third were married, 86.1% were currently employed, 27.0% were in the high occupational class and 53.8% earned below the minimum wage. Over two-third came from functional families. Sixty-two percent perceived their HRQoL as being good and 72.2% were generally satisfied with life. Family predictors of HRQoL were marital status, employment status, average monthly income and family functionality. Respondents from functional families were more likely to have good HRQoL than those from dysfunctional families ($p < 0.001$).
Conclusions and Recommendations: The study revealed positive relationship between family characteristics and HRQoL of PLWHA. Understanding the role of family characteristics and social support is important to combat stigma and discrimination and enhance unrestricted access to HAART.

FRPEE369

Evaluation Quantitative de l'Impact des Médiatrices Communautaires dans l'Atteinte de l'Objectif 90-90-90 chez les Travailleuses du Sexe Séropositives au Centre Médical Oasis au Burkina Faso

Traore Abdoulazziz Soundiata[1], Rajaonarivelo Andriamanana Miorisoa Camille[2], Tiendrebeogo Pascal[2], Ouedraogo Lucille[2], Kindo Safiatou[2], Ouelgo Assita[2], Ros Sanchez Alejandro[3], Annequin Margot[4], Yomb Yves[5], N'Gardoumi Koné Aoua[2], Tiendrebeogo Issoufou[2]

[1]Association African Solidarité, Santé, Ouagadougou, Burkina Faso, [2]Association African Solidarité, Ouagadougou, Burkina Faso, [3]Coalition PLUS, Laboratoire de Recherche Communautaire, Pantin, France, [4]Coalition Plus, Recherche Communautaire, Paris, France, [5]Alternatives Cameroun, Douala, Cameroon

Questions: Les travailleuses du sexe dépistées positives au VIH (TS+) n'acceptent pas de se faire inscrire dans la file active du Centre médical Oasis de l'Association African Solidarité à Ouagadougou (CMO) pour leur prise en charge. En 2015, sur 79 TS dépistées positives, seulement 52 (65,82%) ont intégré la file active. La stigmatisation, le rejet et la crainte de décéder sont des obstacles pour les intégrer dans les soins, les maintenir et obtenir une charge virale indétectable (CVI)

Description: En 2015 au CMO les médiatrices communautaires (MC) étaient chargées d'orienter les TS+ vers les services de soin. Sur les 52 TS+ incluses dans la file active en 2015 39 (75%) ont été maintenues, 27 (69,23%) ont atteint une CVI. Le CMO a adopté en Mars 2016 une nouvelle approche de prise en charge du VIH des TS+ reposant sur une implication des MC .Cette implication commence dès le dépistage en stratégie fixe sur place, en avancée avec une moto et en mobile avec une unité mobile hors du CMO .Les MC deviennent des portes d'entrée dans les soins pour les TS+. Les TS séropositives référées au centre Oasis sont orientées vers une MC qui les rassure de la confidentialité, de la disponibilité des offres de service, de l'efficacité des soins. Cela contribue à dissiper la peur, l'angoisse. La prise de contact entre les MC et la TS+, facilite leur inclusion dans les soins. Les TS+ sous ARV bénéficient d'un suivi individuel psychosocial.

Leçons tirées: Avec cette approche nous avons constaté un maintien et une CVI chez TS+ sous ARV. Sur 217 TS+ référées et suivies au CMO de Mars 2016 à Décembre 2018; 215 (99,07%) ont été inclues dans les soins 214 TS (98,61%) ont initié le traitement ARV et parmi eux 209 (97,66%)sont toujours sous traitement. 206 (98,56%) ont atteint une CVI il faut noter que ses TS+ sont toujours suivi au CMO et l'approche avec les MC continue. L'implication des MC dans la prise en charge des TS+ s'est révélé une bonne approche pour réduire l'inaccessibilité des TS+ aux soins. Avec cette approche la majorité des TS+ sont maintenues dans les soins et évoluent vers une suppression virale. Il faut ajouter les MC deviennent un personnel de l'équipe du dépistage VIH.

Etapes à suivre: L'utilisation des médiatrices a permis de réduire le taux de perdus de vue au traitement ARV et augmenter le nombre de personnes avec des CVI.Cette approche devrait être répliquée dans d'autres structures œuvrant dans la prise en charge des TS+

Mots cles: TS+, MC, 3 X 90

FRPEE370

La Stratégie des Médiateurs : Un Modèle de Participation Communautaire pour Améliorer l'Accès des PVVIH surtout Populations-clé aux Services de Santé

Ndiaye Serigne Cheikh[1], Mané Famara[2]
[1]Alliance Nationale Contre Le Sida, Dakar, Senegal, [2]Alliance Nationale Contre Le Sida Coalition-Plus, Dakar, Senegal

Background: Répondant aux besoins de soutien psychologique et social des personnes vivant avec le VIH (PVVIH) et des populations clés, l´ANCS, a mis en place depuis 2011 le dispositif des médiateurs ou pairs accompagnants. . L´objectif de cette étude est de décrire le travail des médiateurs et d´évaluer leur apport sur la qualité de la prise en charge médicale et psychosociale des PVVIH et des populations clés dans 3 sites.
Methods: Une méthodologie mixte, quantitative-qualitative a été utilisée de novembre à décembre 2017. L'enquête qualitative s'intéressait aux médiateurs et aux bénéficiaires, 33 entretiens semi-directifs ont été effectués avec des médiateurs PVVIH et des médiateurs ainsi que 13 focus groupes dont 4 avec des hommes ayant des rapports sexuels avec des hommes 3 avec des usagers de drogues injectables, 3 avec des travailleuses du sexe et 3 avec des PVVIH. Des questionnaires quantitatifs ont été administrés à 33 médiateurs et 19 professionnels de santé et acteurs institutionnels.
Results: Pour la majorité des médiateurs (61%), ils accompagnent entre 5 et 20 personnes par semaine et 35% plus de 20 personnes. Les tâches effectuées par ces derniers sont : L'accueil, l'orientation des pairs, le counseling, l'éducation thérapeutique, l'aide à l'observance, les visites à domicile. Dans le cadre de la délégation de taches, ces derniers sont également en charge de la dispensation des ARV et du dépistage communautaire.
Conclusions and recommendations: La professionnalisation des médiateurs a permis une amélioration du continuum de services de prévention et de soins auprès des PVVIH dans ces sites, notamment en allégeant le travail des professionnels de santé. Toutefois, en intervenant exclusivement dans les structures de soins, les médiateurs pourraient réduire leur posture d'acteurs communautaires.

FRPEE371

'The Clinics Are Unsafe': Contextualising Access to Healthcare for Young Gay Men in Southwestern Nigeria

Ekerin Olabode[1,2]
[1]The WiseUp Health Initiative, Lagos, Nigeria, [2]Lagos State University College of Medicine, Lagos, Nigeria

Background: young gay men in Nigeria are at increased risk for HIV because of multiple socio-structural barriers and do not have adequate access to appropriate HIV prevention, diagnosis and treatment services. To examine the context of access to healthcare experienced by young gay men, we conducted a qualitative study in a Lagos State, a state in southwestern Nigeria.
Methods: We carried out in-depth interviews with ten healthcare workers purposively sampled from four government health facilities in Lagos, Nigeria to explore healthcare workers' perceptions, beliefs and attitudes towards young gay men. Interviews was also conducted with twenty young gay men who were also purposively sampled and recruited through organizations and networks in the state exploring their experiences of accessing healthcare.
Results: The healthcare workers described their attitudes towards young gay men and demonstrated a lack of relevant information, skills and training to manage the particular health needs and vulnerabilities facing them. Young gay men described their experiences of stigmatization, and of being made to feel guilt, shame and a loss of dignity as a result of the discrimination by healthcare providers and other community. members. Our findings suggest that the uptake and effectiveness of health services amongst young gay men in Southwestern Nigeria is limited by internalized stigma, reluctance to seek care, unwillingness to disclose risk behaviours to healthcare workers, combined with a lack of knowledge and understanding on the part of the broader community members, including healthcare workers.
Conclusions and Recommendations: This study highlights the need to address the broader healthcare provision settings, improving alignment of policies and programming in order to strengthen provision of effective health services.

FRPEE372

Outreach Initiation and Management (OIM): The HIV Care Cascade in the Community

Zokufa Nompumelelo[1], Keene Calire[1], Lebelo Keitumetse[1], Cassidy Tali[1], Gwashu Fanelwa[1], Sibanda Berly[1], Trivino Duran Laura[1], López Paola[1], Katz Ingrid[2], Mc Cloen Sheila[3], Roberts Erin[3], Gerstenhaber Rodd[1]

[1]MSF - Doctors Without Borders South Africa, Cape Town, South Africa, [2]Harvard Medical School, Cape Town, South Africa, [3]Department of Health, Western Cape, Cape Town, South Africa

Issue: To reach the 90-90-90 targets, we need to find and link those not accessing antiretroviral therapy (ART). Community-based services may decant clinics and address some facility barriers to engagement e.g. patient transport costs, long queues and inconvenient opening hours.

Description: Khayelitsha, a large peri-urban settlement outside Cape Town, serves over 40 000 ART patients. With the community and Department of Health (DoH), Médecins Sans Frontières (MSF) designed OIM to evaluate the use of outreach models as a strategy to reach people not engaging with ART services (e.g. males and youth).

OIM offers Saturday services and closes late on weekdays. It is an extension of a DoH clinic, which supplies drugs and laboratory testing. MSF staff (nurse, patient usher and 2 counselors) provide HIV testing and ART, family planning and screen and manage STIs and non-communicable diseases.

Lessons learned: OIM demonstrates feasibility in managing patients in the community as an outreach of a primary facility, with human resources as the main additional cost to the health system.

From quarter 2 (Q2) 2018 to Q2 2019, overall headcount almost doubled (384 to 697 per quarter), of which 80% were tested for HIV. OIM initiated 289 people on ART since Q2 2017, with 12 month retention in care (RIC) for the first year averaging 66%. This is lower than facility-initiated patients, but compares favorably to RIC for people tested in the community. In Q2 2019, 9% of those tested for HIV had not tested in over a year and 2% had never tested (of which 13.5% tested positive and 66.7% of these initiated ART) - people who had not been reached by standard services. After prioritizing youth after 3pm, their proportion rose from 26% to 36%. Responding to the request for male-focused Saturdays made the service more relevant for the community's need.

It takes time for a community to trust new services and for mobilization to gain momentum: after 2 years in the community, 47% of patients surveyed said they first heard of OIM through word-of-mouth. Mobilization is resource intensive, but finding patients that do not access facilities may require a thorough approach, including door-to-door, radio and social media campaigns.

Next steps: Community models show promise to feasibly decant clinics, but also to reach those not accessing current services. Further exploration to optimise this decanting potential would be helpful. Cost efficacy and a qualitative evaluation will also be conducted.

FRPEE373

The First Key Population-competent Healthcare Worker Training in Namibia Improved Knowledge and Attitudes

Abang Roger[1], Goyti Stephen[1], Oladapo Gbenga Austen[1], Trout Clinton[2], Amaambo Taimi[3], Mangwana Hadrian[3], Bouacha Nora[4], Maldonado Brenda[4]

[1]Heartland Alliance International, Calabar, Nigeria, [2]Heartland Alliance International, Los Angeles, United States, [3]Society for Family Health, Windhoek, Namibia, [4]Heartland Alliance International, Chicago, United States

Issues: Adult HIV prevalence in Namibia is 11.5% (14.8% women, 8.0% among men). While treatment coverage is high and the country is making good progress, 5,000 people are newly infected each year and 2,500 die of AIDS. Key populations (KPs) and their partners represent 17% of new infections in Eastern and Southern Africa and report high rates of stigma and discrimination in healthcare settings. As this creates barriers to treatment access and efficacy, healthcare settings must be KP-friendly and competent for Namibia to reach epidemic control.

Descriptions: We designed Namibia's first training KP-competence curriculum for healthcare workers (based on international guidance) which was then edited and validated by the KP-community. The objectives of the trainings were to increase empathy, clinical, and interpersonal skills. Our goal was to build on on participants' existing empathy and skills through the sharing of scientific data, group discussions, role-plays, and interaction with local KPs themselves. The trainers (from Nigeria) included a physician, a nurse, and a KP leader. We measured participant attitudes and knowledge before and after trainings in order to gauge progress.

Lessons learned: In total, 161 training participants (93%) completed both pre and post attitudinal tests with an average of 23 respondents for each training (range 9-34). While 81.3% (131/161; range: 50%-95%) expressed largely positive, non-stigmatizing attitudes on the pre-tests, 93.9% (154/164; range: 88%-100%) did so on the posttests.

In total, 167 participants (97%) completed the 15-question pre-posttest knowledge assessments, with an average of 24.7 respondents across all seven trainings (range: 10-36). The average score rose by 23.4 percentage points: from 55.9% (8.39/15; range: 7.87/15-8.83/15) for the pretest to 79.4% (11.8/15; range: 10.73/15-12.98/15) for the posttest.

Next steps: The training curriculum and two-day training resulted in significant improvement of both KP-friendly attitudes and KP-competent knowledge and participants were overwhelmingly satisfied. Lower knowledge pre and posttest scores were among lower-level health care workers. We recommend expanding the training to three days with the same curriculum, reinforcing the 'train-the-trainer' model by encouraging one to two hour trainings over time at the health centers, and developing an "advanced" training follow-up after most relevant healthcare workers have completed this curriculum.

FRPEE374

Prise en Charge des Pathologies Anales dans le Cadre des Services en Santé Sexuelle chez les HSH au Cameroun. Implications pour la Dé-Stigmatisation de la Santé Anale pour tous

Ntetmen Mbetbo Joachim
Alternatives-Cameroon, Programmes, Douala, Cameroon

Problématique: Un fort tabou entoure les pathologies anales au Cameroun, perçues comme maladies des gays. Comme conséquence, ces pathologies sont longtemps restées peu ou mal connues, encore moins pris en charge, exposant tant de monde à toutes formes de complications. Dans la logique de notre association de lever toutes les barrières à l'accès aux soins pour tous, nous avons investi dans le développement du service de proctologie dans notre centre communautaire depuis 2011.
Description: En 2011, un proctologue de renommée mondiale a formé 5 de nos prestataires, médecins et infirmiers, en couplant la formation à une campagne de diagnostic et de prise en charge des pathologies anales chez 55 bénéficiaires, dont 30 traités. Par la suite, nous pouvions offrir des consultations de proctologie deux fois par semaine, à 75 personnes par an. En 2017, nous avons renouvelé et renforcé l'expérience et renouvelé le matériel. Les pairs éducateurs et les conseillers formés par le proctologue sur la problématique de la prise en charge des maladies anales. Un chirurgien a été contacté pour la prise en charge des cas nécessitant une opération chirurgicale, avec un tarif préférentiel. Nous avons pris contact avec un nutritionniste pour la confection d'un fiche alimentaire devant guider les bénéficiaires dans le choix de aliments pouvant leur permettre de mieux régulariser leur transit, et prévenir ainsi les pathologies anales liées à la difficulté d'évacuation. Au cours cette autre campagne, 64 personnes ont été reçus, 57 cas diagnostiqués, 49 traités surplace et 7 référés au chirurgien.
Leçons apprises: L'offre de services en proctologie n'a cessé d'augmenter depuis les deux campagnes, passant de 2 consultations par semaine à tous les jours, et de 75 bénéficiaires par an à environ 150. Nous proposons désormais les consultations systématiques de proctologie à nos bénéficiaires. Une récente étude communautaire montre que les besoins en services proctologiques sont couverts chez 53% de nos bénéficiaires. S'ils restent majoritairement HSH, ce service est de plus en plus demandé, y compris par la population générale, ce qui signifie que les pathologies anales ont tendance à se déstigmatiser.
Prochaines étapes: Nous sommes bénéficiaires d'un projet qui consistera à former d'autres OBC au Cameroun à ce service. Nous élaborerons un document de référence permettant de vulgariser et structurer ce service à l'échelle nationale.

FRPEE377

Blood Pressure Self-monitoring Is Feasible and Acceptable for Adults with HIV and Hypertension in the Kingdom of Eswatini

Schaaf Andrea[1], Bitchong Raymond[2], Preko Peter[3], Nuwagaba-Biribonwoha Harriet[3], Mthethwa Simangele[4], Nxumalo Sifiso[3], Reidy William[1,5], Shongwe Siphiwe[3], Simelane Samkelo[3], Zech Jennifer[1], Rabkin Miriam[1,5]

[1]ICAP at Columbia University, New York, United States, [2]Raleigh Fitkin Memorial Hospital, Manzini, Eswatini, [3]ICAP at Columbia University, Mbabane, Eswatini, [4]Ministry of Health, Mbabane, Eswatini, [5]Columbia University Mailman School of Public Health, Department of Epidemiology, New York, United States

Background: Eswatini has the world's highest adult HIV prevalence (27%) and a substantial burden of cardiovascular disease. Hypertension (HTN) is common amongst people living with HIV (PLWH); a 2017 study found that, among PLWH receiving antiretroviral therapy (ART) at an urban hospital, 25% of those ≥ 40 years and 42% of those ≥ 60 years had HTN. This presents a challenge to Ministry of Health priorities to shift PLWH who are stable on ART to less-intensive differentiated service delivery models (DSDM), with fewer visits to health facilities. We report results of a proof-of-concept study to assess the feasibility and acceptability of a blood pressure self-monitoring (BPSM) package for people with both HIV and HTN.
Methods: The BPSM package included use of a wrist-worn BP monitor and ongoing contact with a study nurse via text messaging. 26 PLHIV ≥ 40 years on ART with a documented history of HTN were enrolled and completed a baseline questionnaire and training in the use of the BP monitor. Participants (ppts) texted their BP results to study staff 2-3 times per week and staff followed up with ppts with high BP via phone. Ppts returned for a follow-up visit at 2 weeks and a final visit and exit interview at 12 weeks.
Results: Median age was 53 years (range 43-73); 23/26 (88%) had been on ART for > 5 years and 12/26 (46%) reported being on BP medication. At baseline, 16/26 (62%) ppts reported sending or receiving text messages daily, though most (19/26, 73%) had never communicated with a health care provider via text. In the exit interview, 100% of ppts reported feeling confident in their ability to use the BP monitor and 25/26 (96%) were "very satisfied" with the BPSM package. None found BP monitor use negative in any way, although 1 ppt reported technical difficulty and 2 reported that household members had accessed the device without permission. Of the ppts on BP medication, all said the BPSM package made them more likely to take the medication as directed; all 26 ppts said the package improved their ART adherence. All felt the package could improve their health; 11/26 (42%) said it could help "to a great extent" and 15/26 said "to a very great extent."
Conclusions and Recommendations: The BPSM package was feasible and acceptable to ppts in this pilot study. This suggests that BPSM could be used as part of a strategy to reduce the frequency of clinical follow-up for PLWH with HTN. Further research into the use of BPSM in less-intensive DSDM is needed.

FRPEE375

Cartographie et Évaluation des Sites Fréquentés par les Populations Clés en Guinée Bissau

Ba Ibrahima[1], Liestman Benjamin[2], Djalo Aliu[3], Ndiaye Sidy Mokhtar[4], Diouf Daouda[4]
[1]Enda Santé, Suivi Évaluation, Dakar, Senegal, [2]John Hopkins University, Dakar, Senegal, [3]ENDA Guinée Bissau, Bissau, Guinea-Bissau, [4]ENDA Santé, Dakar, Senegal

Contexte: Pour atteindre les objectifs des 90-90-90 de l´ONUSIDA en 2020, le gouvernement de la Guinée-Bissau a identifié les populations clés comme cibles prioritaires dans la riposte nationale au VIH. C'est dans cette optique, qu'une cartographie des sites de socialisation des populations clés et des services a été réalisée à Bissau dans le but de fournir des informations opérationnelles pour faciliter la mise en œuvre des activités de prévention et de prise en charge du VIH/sida auprès chez populations clés.
Méthodes: La méthode PLACE modifiée a été utilisée. Elle s'est faite en trois phases : l'identification des sites avec les informateurs clés, la vérification et l'évaluation des sites. Un questionnaire a été développé avec l'application Survey CTO à chaque étape. La saisie s'est faite sur tablette et le logiciel Stata a permis d'analyser les données.
Résultats: 1195 informateurs clés constitués en majorité d'hommes (70%) ont été interrogés. L'âge médian était de 28 ans. Ils étaient des pécheurs, des artistes, des artisans, des étudiants, des personnels d'ONG, des personnels de santé et des populations clés. 511 points chauds fréquentés par des PS, HSH et UD et 69 services de santé ont été identifiés dont 226 vérifiés et validés. La typologie des points chauds était des bars/restaurants/discothèque (25%), sites virtuels (19%), rues/angles (17%), maisons closes (14%), appartements/hôtels (12%), maisons privées (8%) espaces publiques (3%) etc. Concernant l'accès aux services dans les sites, les données révèlent que 50% des points chauds ne faisaient pas la distribution du préservatif masculin au cours des 6 derniers mois précédant l'enquête. Le lubrifiant n'était accessible que dans 8% des sites. Les activités de sensibilisation étaient plus fréquentes dans les sites de Bissau (24%), Oio (23%) et Bafata (17%). Celles de dépistage étaient plus disponibles dans les sites de Bafata (11%) et Gabu (4%). La plupart des structures sanitaires offraient des appuis à la prise en charge aux PVVIH (65%) et environ la moitié faisait la distribution des ARV (50%). Cependant peu de structures sanitaires fournissaient des services adaptés aux PS (21%), HSH (9%) et UD (17%).
Conclusion: La couverture des points chauds en termes d'offre de service de prévention et la disponibilité des services de prise en charge en direction des populations clés dans les structures de sante constitue un sérieux problème.

FRPEE376

Non-Communicable Diseases and HIV: Costs, Effects and Efficiency of Integrated Screening and Testing Services for Men in Democratic Republic of Congo (DRC)

Adetunji Oluwarantimi[1], Nyombe Cady[2], Gill Michelle[1], Mukherjee Sushant[1], Ingala Dominique[2], Mboma Bina[2], Ditekemena John[2]

[1]Elizabeth Glaser Pediatric AIDS Foundation, Washington, United States, [2]Elizabeth Glaser Pediatric AIDS Foundation, Kinshasa, Congo, the Democratic Republic of the

Background: This analysis aimed to estimate the costs, effectiveness, and efficiency of integrated HIV testing services for men in a resource-limited context.

Methods: A community-based approach, integrating HIV with non-communicable diseases (NCD) testing, was implemented from 2018 in DRC. Activities included education campaigns on HIV/AIDS and NCD, NCD screenings, and targeted HIV testing among consenting individuals. Community workers targeted crowded venues, such as markets, for the campaigns. While the intervention targeted males, services were provided to females who participated. Individuals who tested positive for HIV, hyperglycemia, or hypertension were referred to the health facility for further diagnostics or treatment. The study population were individuals ≥ 20 years of age who participated in a community-based NCD session. We applied micro-costing methods to estimate the quantity and cost of the resources utilized to implement the intervention. Costs in 2018 US dollars and testing data were extracted from financial systems, program records, and interviews.

Results: 3,010 adults were tested in the first 11 months of implementation; 73% were male and 22% were aged 20-29 years. Among those tested, 4.2% were HIV-positive, 92% of whom were linked to care. Among males, those aged 30-39 had the highest proportion of HIV at 6.0%. Among females, those aged 20-29 had the highest proportion of HIV at 5.3%. Among participants screened for NCD, 555 and 316 tested positive for hypertension and hyperglycemia, respectively; 81% and 85% of those who screened positive for hypertension and hyperglycemia were male. Among HIV-positive individuals, 7.9% and 6.4% had high blood pressure and blood sugar respectively. Mean costs were $10 per adult tested, $235 per HIV-positive adult, $326 per HIV-positive male, which were lower than PEPFAR´s average cost of $960 per HIV-positive client identified with community-based strategies in DRC. With outcomes combined, mean cost reduced to $30 per person and $37 per male tested positive for HIV, hypertension or hyperglycemia.

Conclusions and Recommendations: Integrating NCDs with HIV services served more males than women, which may be due to increased accessibility of services. It is a cost-efficient strategy that helps fulfill unmet needs for HIV and NCD screening. Future studies should evaluate the effectiveness of early identification from NCDs and HIV service integration.

Keywords: HIV, integrated screening, NCDs, cost analysis