The International AIDS Society

Educational Fund meeting: Outcome report
30 November 2019
Rwanda

From global to regional: Science, youth and community in HIV response in East Africa
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This report was developed in collaboration with the Rwanda Biomedical Centre. The views expressed in the report do not necessarily reflect the view of the International AIDS Society.
## 2. List of abbreviations and acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AGYW</td>
<td>Adolescent girls and young women</td>
</tr>
<tr>
<td>AMICAALL</td>
<td>The Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<td>ART</td>
<td>Antiretroviral therapy</td>
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<tr>
<td>CATS</td>
<td>Community Adolescent Treatment Supporters</td>
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<td>CYSRA-Uganda</td>
<td>Uganda Youth Coalition on Adolescent Sexual and Reproductive Health Rights and HIV</td>
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<tr>
<td>DMPA</td>
<td>Depo-Provera</td>
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<td>DREAMS</td>
<td>Determined, Resilient, Empowered, AIDS-free, Mentored and Safe Districts</td>
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<tr>
<td>DTG</td>
<td>Dolutegravir</td>
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<td>GBV</td>
<td>Gender Based Violence</td>
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<td>IAS</td>
<td>International AIDS Society</td>
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<tr>
<td>MSF</td>
<td>Médecins Sans Frontières</td>
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<td>MSM</td>
<td>Men who have sex with men</td>
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<tr>
<td>PrEP</td>
<td>Pre-exposure Prophylaxis</td>
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<td>SRH</td>
<td>Sexual and reproductive health</td>
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<td>STI</td>
<td>Sexual transmitted infections</td>
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<tr>
<td>TDD/FTC</td>
<td>Tenofovir/emtricitabine</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV and AIDS</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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3. Introduction

The Educational Fund of the International AIDS Society (IAS) was established in 2016 to provide educational and training opportunities to frontline HIV professionals. In its aim to provide direct support to clinicians and healthcare providers, there are smaller scientific symposia/meetings held around the world, which target healthcare workers, advocates and policy makers. IAS Educational Fund meetings give participants an opportunity to hear the latest science and a platform to reflect and inquire on the impact on local epidemics. Eight IAS meetings have previously been held in Africa.

On 30 November 2019, a scientific symposium was held in partnership with Rwanda Biomedical Center in Kigali, Rwanda, under the theme, From global to regional: Science, youth and community in the HIV response in East Africa. Participants ranged from clinicians to healthcare workers, policymakers, and international organizations’ staff, civil society and representatives of key and vulnerable populations. The meeting was co-chaired by Linda-Gail Bekker (IAS Immediate Past President) and Dominique Savio Habimana (Rwanda Biomedical Center).

The IAS Educational Fund symposium objective was to present key scientific and policy content from the 10th IAS Conference on HIV Science (IAS 2019), and how to effectively translate this into local policy and practice in the East African region context. The aim of the symposium was to provide participants with better understanding of HIV science and new developments. It also gave them the opportunity to share ideas, experience and solutions linked to the challenges they face in their day-to-day work and apply the learnings to regional and local issues. Lastly, the attendees had the opportunities to create new contacts and collaborations thanks to the networking opportunities offered to them.

The meeting highlighted four main topics: 1) Fast-Track Cities, 2) Sexual and reproductive health and rights (SRHR) of adolescents girls and young women, 3) HIV testing, linkage to treatment and retention in care of adolescents and young adults, and 4) Access to key populations to comprehensive HIV health services. In each of the four sessions, researchers, healthcare workers, activists and policymakers were brought together to present their work and discuss the challenges linked to these issues.

![Scientific symposium participants, Kigali, Rwanda, 30 November 2019](image)
4. Background and context

Sub-Saharan Africa has just over 10% of the world’s population, but is home to more than 60% of all people living with HIV and more than 85% of all children under 15 living with the disease.

From 1990 to 2003, the number of children in Sub-Saharan Africa who had lost at least one parent to HIV and AIDS grew from less than one million to more than 12 million, and eight out of 10 children orphaned by AIDS live in sub-Saharan Africa.

There is great diversity throughout Africa in the levels and trends of HIV infection. Across the region, women are disproportionately affected by HIV where on average there are 13 women living with HIV for every 10 infected men and the gap continues to grow. Additionally, African women tend to become infected with HIV at earlier ages than men. The difference in infection levels between women and men are most pronounced among young people (aged 15–24 years).

In countries in the Middle East and North Africa, potential epidemics are being overlooked, in part because of cultural inhibitions against discussing sexual and reproductive health. With the exception of a few countries, systematic surveillance of the epidemic is not well developed, particularly among high-risk groups such as injecting drug users. Yet in some countries, HIV infection appears concentrated among this group. There is also concern that HIV may be spreading undetected among men who have sex with men, as it is illegal and widely condemned in the region.

East and Southern Africa is the region hardest hit by HIV in the world. It is home to around 6.2% of the world’s population (510 million) but hosts over half (54%) of the total number of people living with HIV worldwide (20.6 million people). In 2018, there were 800,000 new HIV infections, just under half of the global total.¹

South Africa accounted for more than a quarter (240,000) of the region’s new infections in 2018. Seven other countries accounted for more than 50% of new infections namely: Mozambique (150,000), Tanzania (72,000), Uganda (53,000), Zambia (48,000), Kenya (46,000), Malawi (38,000), and Zimbabwe (38,000).² Overall, new infections in the region have declined by 28% since 2010.³ In 2018, approximately 310,000 people died of AIDS-related illnesses in the region, although the number of deaths has dropped by 44% since 2010.⁴

Despite the continued severity of HIV, significant strides have been made towards meeting the UNAIDS 90-90-90 targets. In 2018, 85% of people living with HIV were aware of their status, 79% of them were on treatment and 87% of those on treatment achieved viral suppression.⁵

Currently, three countries (Botswana, Eswatini and Namibia) have achieved the UNAIDS targets and Rwanda is close, yet progress remains poor in other countries. For instance, in Madagascar, Mauritius and South Sudan, less than 25% of people living with HIV are aware of their status, and eight countries in the region are not reporting data on viral suppression.⁶ Undoubtedly, some successes have been achieved, however, more work remains to be done.

Rwanda has a generalized epidemic, with 2.5% of the adult population (220,000 individuals) living with HIV, with women displaying higher prevalence levels compared to men (3.2% vs.
Although 65% of new infections occur in stable heterosexual couples, key populations remain affected with 45.8% of female sex workers living with HIV.

Linda-Gail Bekker presenting the overview of the day
5. Meeting report

5.1. Key messages from IAS 2019

Kenneth Ngure (School of Public Health, Jomo Kenyatta University of Agriculture and Technology, Kenya, and IAS Regional Representative for Africa) presented key messages from the IAS 2019 conference held in Mexico City in July 2019.

**Track A: Basic Science**

The presentation began with a discussion on vaginal microbiome, immune activation and hormonal contraceptives. The vaginal microbiome can be categorized into two broad types, namely those with *Lactobacillus* and those where *Lactobacillus* is displaced for anaerobic and facultative bacteria. A study conducted by Noel Romas et al. analysed mucosal specimen and found an association between Depo-Provera (DMPA) and increased vaginal immune activation in women with *Lactobacillus* dominant microbiome. Specifically, these recipients showed a three-fold higher risk of HIV acquisition.

The next topic touched was primary infection and early treatment. A presentation by John Frater at IAS 2019 indicated that very early treatment of HIV such as less than 14 days following infection is associated with better immunity.

The presentation continued with discussion of fourth generation of HIV testing that is currently available and aim to reduce infection during 14 to 20 days following infection. It is important that a person living with HIV starts treatment soon after diagnosis.

**Track B: Clinical Science**

Multiple studies showed that there was an increased risk of neural tube defects for women of childbearing age who take dolutegravir (DTG). Analysis revealed that the risk was two per 1,000 persons who could experience these neural tube defects. WHO guidelines recommend DTG for adults and adolescents.

**Track C: Prevention Science**

At present, there is a need to integrate contraceptives into HIV prevention strategies, together with the need to integrate sexually transmitted infections (STIs) diagnosis and treatment within pre-exposure prophylaxis (PrEP) programmes. This is dictated by studies indicating an increase in STIs (especially bacterial in nature) for people who use PrEP.

A study conducted in France among men who have sex with men showed no difference in uptake between on demand PrEP and daily PrEP.
A discover trial based on a new product, Tenofovir/emtricitabine (TDD/FTC) was conducted by Spinner et al. on men who have sex with men and transgender women and it showed higher efficacy due to higher concentration shown to be four to six times higher. Dapivarine ring trial conducted by Baeten et al. showed a 30% efficacy. Additionally, 73% of women accepted the ring at all follow-up visits and the observed HIV incidence was lower than in the placebo group in ASPIRE.

IAS 2019 included, for the first time, a discussion of a prevention implant, namely the Islavir implant, developed by Merck, which is currently under trial.

Lastly, HIV self-testing has been used as a way to engage men in HIV testing and care. Besides, peer distribution of self-testing kits show promising potentials to reach key populations as demonstrated by Shapiro et al.

**Track D: Social, Behavioural and Implementation Science**

The presentation of track D entailed the discussion of the Determined, Resilient, Empowered, AIDS-free, Mentored and Safe (DREAMS) partnership, active in 15 countries in Africa and the Caribbean. At IAS 2019, Deborah Birx, highlighted that more than 60% of DREAMS districts led to a decline in HIV diagnoses among girls and young women attending antenatal clinics. Research conducted in Kenya by Were at al. showed that stigma led to low PrEP uptake and highlighting the need to continue adjust programmes based on local dynamics.

5.2. Fast-Track Cities

The examples of two fast-track cities were discussed during the symposium. The Kampala (Uganda) experience was presented by Titus Twesige (Country Director; AMICAALL) and the Durban (South Africa) experience was presented by Hope Ngobese (Senior Manager – Primary Health Care and Ethewkini Municipality). In Uganda, AMICAALL was founded with an aim of engaging the elected leaders in integrated and sustainable service delivery interventions on HIV and AIDS. Overall, the AMICAALL reached 11,063 individuals with different services during sensitization and campaign activities. Some of the activities included mayors publicly taking an HIV test, radio mobilization and sanitation improvement in communities. Reports showed that prevalence was always high in urban areas and in order to achieve the UNAIDS targets the efforts should be focused there. Furthermore, Uganda adopted an urban-tailored fast-track framework which aligned with the Presidential Fast-Track Initiative on Ending AIDS as a Public Health Threat in Uganda.

The main challenge of this programme in Uganda was that urban areas were often forgotten due to the assumptions that they had all they needed and therefore not prioritized. As a result,
statistics on urban areas to inform programming remain inadequate. Additionally, human rights and legal issues relating to key populations remain, as well as material, human and financial resources constraints.

For the Durban experience, the city hosts a high number of people living with HIV, amounting to 652,952 people in a population of 3,702,231. The HIV prevalence of 17.6% exceeds the national of 13.1% for the general population and 53.5% for sex workers. The modes of transmission there were mainly heterosexual. The most at risk and affected were adolescent girls and young women. Different measures have been adapted for Durban as a fast-track city which include:

- HIV prevention Interventions such as PrEP; SHE conquers programme which targets adolescent girls and young women (AGYW) adolescent and youth friendly services, medical male circumcision, elimination of mother to child transmission (from 0.75% to <0.5% by 2020) and HIV testing services targeting high risk individuals
- Treatment and retention in care; active linkage to care and offering same day treatment, treatment buddy, SMS reminders for ART patients; Welcome Back Campaign to track and trace defaulters; Decanting of stable clients to collect from external pick up points, and community clubs
- Close monitoring of performance; daily reporting against targets, weekly meetings, quarterly performance reviews and monitoring of individual performance, facilities and outreach programmes.

Key recommendations:

- It is critical to engage the male population so that they can play a positive role in protecting women
- Resources should be evenly distributed, especially to rural areas
- There is a need to involve local resource mobilization
- There is need for creativity in adjusting programmes and services to be convenient for users to increase uptake of services
- As Africa is soon to be the continent with the youngest population in the world, we need to ensure that their needs are met.

5.3. Panel discussion: Sexual and reproductive health and rights of adolescent girls and young women

Allen Kyendikuwa (CYSRA - Uganda) was the keynote speaker of the panel. Other panelists included Leonidah Wangara (Kenya), Eric Baganizi (Senior Technical Advisor for Health Promotion, USAID/Twiyubake Program, Global) and Barbara Kemigisa (Founder, Pillpower, Uganda). The panel first discussed the importance of involving young adolescent girls in sexual and reproductive health (SRH) programmes. It was highlighted that there is a need for enhanced sexual education, so that girls can make informed decisions about their SRH. They especially need to be an active part of decision-making processes at initial stages such as during policymaking, and the design of interventions to collaboratively create interventions that are relevant and will be absorbed by them. For example, it has been found that the policy of mandatory HIV testing has withdrawn many young girls from using clinical services which is an unintended consequence of lack of their engagement in policy development processes.
As per usual for any programme, it is important to pay attention to the users’ (young adolescent girls) experience with services offered to them. This can be done through online surveys to further explore their experience and challenges for insight into improving future interventions. For instance, it was found that some girls do not use PrEP simply because the partners will not let them; tracking this feedback is useful to inform future interventions.

Subsequently, the skills needed for young girls to uphold the fight against HIV were discussed. It was highlighted that they should be equipped with skills of self-awareness, confidence and negotiation; this especially gives them knowledge on how to handle ‘blessors’ or sponsors that tempt them. Additionally, continuous teaching is needed to ensure knowledge of having safe sex and protecting themselves. Finally, strategies are still needed to bridge the gap between parent and adolescent communication, as they are in best positions to talk to their children about SRH. This remains a challenge as sexual education remains a taboo in African culture.

**Key recommendations:**

- Leadership is important in fostering safe environments for HIV testing and services for populations <18 years. For example, in Rwanda consent for HIV testing is 12 years.
- Men and young boys should be equally involved and targeted in SRH interventions and HIV prevention services.
- There is a need for innovative strategies to address misconceptions about family planning methods or practicing safe sex; for instance, condom use is perceived as being unfaithful in parts of Kenya.
- Advocacy and testimonies by people living with HIV are key in reducing stigma and teaching about HIV prevention to the youth.
- Education systems should be improved to provide space for teachings to be effective for youth.
- Religious leaders should be engaged in the process of SRH education as they have substantial influence on youth.

### 5.4. Panel discussion: HIV testing, linkage to treatment and retention in care of adolescents and young adults

Laurie Gulaid (UNICEF, Kenya) was the panel’s keynote speaker. The rest of the panel included Jeffrey Walimbwa (Ishtar MSM, Kenya), Lucy O’Connel (MSF Khayelitsha; South Africa), Brenda Kateera (AIDS Health Foundation, Rwanda), Manzi Norman (Dream Village, Rwanda) and Phyllis Mavushe (Zvandiri, Zimbabwe). In this session, HIV programmes providing prevention and treatment services shared their work and some of their key challenges and how they approach them in their respective countries. First, a testimony from a man who have sex with men representative shared that the lack of structures to reach men...
who have sex with men were not previously available. However, once men who have sex with men collaborated with health providers, the environment was friendlier and hence increase of those seeking services here. Social media was key in helping reach more key populations. For nurses, availing the HIV services based on the best times for the youth was efficient. Their community youth programmes paid attention to the voices of the youth and tailoring programmes accordingly came a long way. In addition to care and treatment services, psychological support where needed was noted as an essential need that should be increasingly provided to the youth groups seen. HIV Programmes additionally have incorporated gender-based violence (GBV) services, expanding scope to cover children and adolescents as is done in CATS (Community Adolescent Treatment Supporters) covering until the age of 27. Helping peers understand the care they are given was effective, including explanation of their specific treatment regimens and discussing the challenges they face. Support groups tremendously helped as they allow peer exchange of experiences and reception of information is much more conducive than the alternative a non-peer educating the youth groups.

Phyllis Mavushe shared that advantages lie where programmes can be taken up by a Ministry of Health as their coordination allows the programmes to thrive. She also emphasized the use of differentiated service delivery models which are being developed in Zimbabwe. She finally noted that training, mentorship and supervision need to be integrated within the national systems.

Key recommendations:

- Key and vulnerable populations need to be involved (or reached by) our services as the majority of them reside in urban areas
- More outreach activities are needed to capture those that are not coming to the health facilities
- Considering the gap in interventions targeting people in the 25-35 age group, when planning new interventions, we should ensure their involvement
- For child consent to get tested, it was agreed upon that consent is still needed by the guardian or parent
- A final note to desegregate the data (understand our outcomes and the impact we are at); define packages of services that can be taken up at national level and are differentiated for the different groups.
5.5. Panel discussion: Access for key populations to comprehensive HIV health services

Kenneth Ngure (IAS Governing Council Representative) moderated the panel. Panelists included Karita Etienne (Emory University, Project San Francisco, Rwanda), Sheila Tlou (Global HIV Prevention Coalition, Botswana), Njambi Njuguna (FHI 360, Kenya), Maureen Musimbi Akolo (Partners in Health and Development in Africa, Kenya) and Kagaba Afrodis (Health Development Initiative, Rwanda).

This session started by looking at how success has been possible in ensuring programmes to reach key and vulnerable populations. At the initial stages of some of the programmes targeting men who have sex with men, there was a question about whether there was enough data to support the intervention considering the persisting belief by some people that there are no men who have sex with men in their countries. After meeting with men who have sex with men groups and collaboratively discussing the kinds of services they needed for HIV prevention, interventions were designed. These mostly included training health providers on giving care to men who have sex with men. For instance, an STI such as rectal gonorrhea can be awkward to discuss with a health provider when they ask them how they got this condition.

A recurring issue was that nurses dealing with key populations worried more about changing the patients’ ways of life rather than providing services. They were in denial of the patients’ lifestyles which created a barrier in giving them services. Therefore, ensuring a friendly environment for key populations was key to get them to seek healthcare services.

Success stories in Rwanda mentioned that 2,400 of 6,000 men who have sex with men in the last four years were reached in Kigali and given HIV services such as testing and treatment but more work remained to be done with bridging gaps of stigma and reaching the unreached groups.

Programmes incorporating essential services such as testing, condom and lubricant distribution, PrEP and health education, resulted in an increase in the use of health facilities more among key populations. The programmes also aimed to identify those who are positive, link them to care, and offering preventive services to HIV negative individuals. Main barriers included issues of stigmatizing key populations at the health facilities.
Advocacy and integration of HIV services and care in school curriculums is key in managing HIV as mentioned by Sheila Tlou, the former Minister of Health of Botswana. For instance, bringing key populations to medical students’ classes to teach students who they are and what health services they need was fruitful in Botswana.

Navigating around sexual education being a taboo in many African cultures should be tapped into to promote prevention services as needed.

Key recommendations

- Policies should be inclusive to support teen mothers who are rejected by their families
- As youth can easily access a lot of their information on online platforms, we need to maximize use of these channels to reach them
- It is important to use respectful and non-discriminatory language when dealing with key and vulnerable populations
- Visit www.youngpeople.org for more information about comprehensive sex education; a curriculum created by 20+ Ministers of Health in Africa with human rights, gender equality, keeping girls in school, free education, ending child marriages; call to support this movement as it is helping rates of HIV infection and teen pregnancy decline.
6. Conclusion

The IAS Educational Fund symposium in Kigali, Rwanda was successful in bringing together researchers, healthcare workers, activists and policymakers to discuss HIV and sexual and reproductive health rights of adolescents, testing and linkage to treatment and access for key populations. The meeting provided an excellent platform to hear the voices of key populations, youth and adolescents and people living with HIV.

The scientific symposium provided different perspectives and stimulated the discussion not only among the participants but also with the speakers. HIV programmes and activities should be driven by the goal to provide services for the target population services, engaging them in the process. Subsequently, it is important to equally allocate resources to both urban and rural areas, and not neglect one over the other in order to equally manage the epidemic. A constant question of who has not been reached with HIV services will help keep improving the programmes’ reach, and leave no one behind. As the youth actively uses social media platforms, it is crucial to maximize this space to circulate services available to them as well as teach them. Finally, government leadership is at the heart of programmes being successful, so it is important to continue to advocate for the rights of people living with HIV in terms of acquiring the basic services that they need.
7. References

1. UNAIDS ‘AIDSinfo’ (accessed July 2019)
2. UNAIDS ‘AIDSinfo’ (accessed July 2019)
5. UNAIDS ‘AIDSinfo’ (accessed July 2019)
8. UNAIDS ‘AIDSinfo’ (accessed July 2019)
9. UNAIDS ‘AIDSinfo’ (accessed July 2019)
8. Acknowledgments

The International AIDS Society (IAS), in collaboration with the Rwanda Biomedical Center would like to acknowledge and thank all participants and stakeholders for their contribution to making the IAS Educational Fund symposium on 30 November 2019 at Hôtel des Mille Collines in Kigali, Rwanda the huge success that it was.

The IAS would like to extend its appreciation to Swiss Development Cooperation (SDC) and Merck for their financial support for the meeting.
9. Appendices

9.1. IAS Educational Fund meeting detailed programme

30 November 2019

Chairs: Linda-Gail Bekker, IAS Immediate Past President and Dominique Savio Habimana, Rwanda Biomedical Center

11:00-12.00 Registration & Networking

12:00-12:10 Official comments and welcome / Overview of the day
- Linda-Gail Bekker, IAS Immediate Past President
- Dominique Savio Habimana, Rwanda Biomedical Center

12:10-12:40 Key messages from IAS 2019
- Kenneth Ngure, IAS Governing Council Representative

12:40-13:40 Lunch

13:40-14:40 Fast-Track Cities

Speakers:
- Titus Twesige, AMICAALL, Kampala, Uganda
- Hope Ngobese, Ethewkini Municipality, Durban

14:40-16:00 Panel discussion: Sexual and reproductive health and rights of adolescent girls and young women

Keynote speaker: Allen Kyendikuwa, Uganda Youth Coalition on Adolescent SRHR and HIV

Panellists:
- Leonidah Wangaram, Kenya
- Eric Baganizi, DREAM project, Global Communities, Rwanda
- Barbara Kemigisa, Pillpower, Uganda

16:00-16:15 Coffee break

16:15-17:35 Panel discussion: HIV testing, linkage to treatment and retention in care of adolescents and young adults

Keynote speaker: Laurie Gulaid, UNICEF, Kenya

Panellists:
- Jeffrey Walimbwa, Isthar MSM, Kenya
- Lucy O’Connell, MSF, Khayelitsha
- Brenda Kateera, AIDS Health Foundation, Rwanda
- Manzi Norman, Dream Village, Rwanda
- Phyllis Mavushe, Zanidiri, CATS, Zimbabwe

17:35-18:45  Panel discussion: Access for key populations to comprehensive HIV health services

Moderator: Kenneth Ngure, IAS Governing Council Representative

Panellists:
- Karita Etienne, Emory University, Rwanda
- Sheila Tlou, Global HIV Prevention Coalition, Botswana
- Njambi Njuguna, FHI 360, Kenya
- Maureen Musimbi Akolo, Partners in Health and Development in Africa, Kenya
- Kagaba Afrodis, Health Development Initiative Rwanda

18:45-19:00  Closing remarks and evaluation

Chairs

19:00-20:00  Networking cocktail