



# **You did the research – now disseminate!**

Quick guide to scientific posters

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# Developing and Designing Posters

The background features abstract geometric shapes. A solid yellow horizontal bar is at the bottom left. A large dark blue triangle points upwards from the bottom right towards the top right. A smaller, lighter blue triangle is nested within the dark blue triangle, pointing downwards.

# Poster Goals

- **Clarity of content.** Get the most important points across – be clear and concise
  - Why is the topic important? (background)
  - What did you do? (methods)
  - **What did you find? (results)**
  - Why does it matter? (discussion/conclusion)

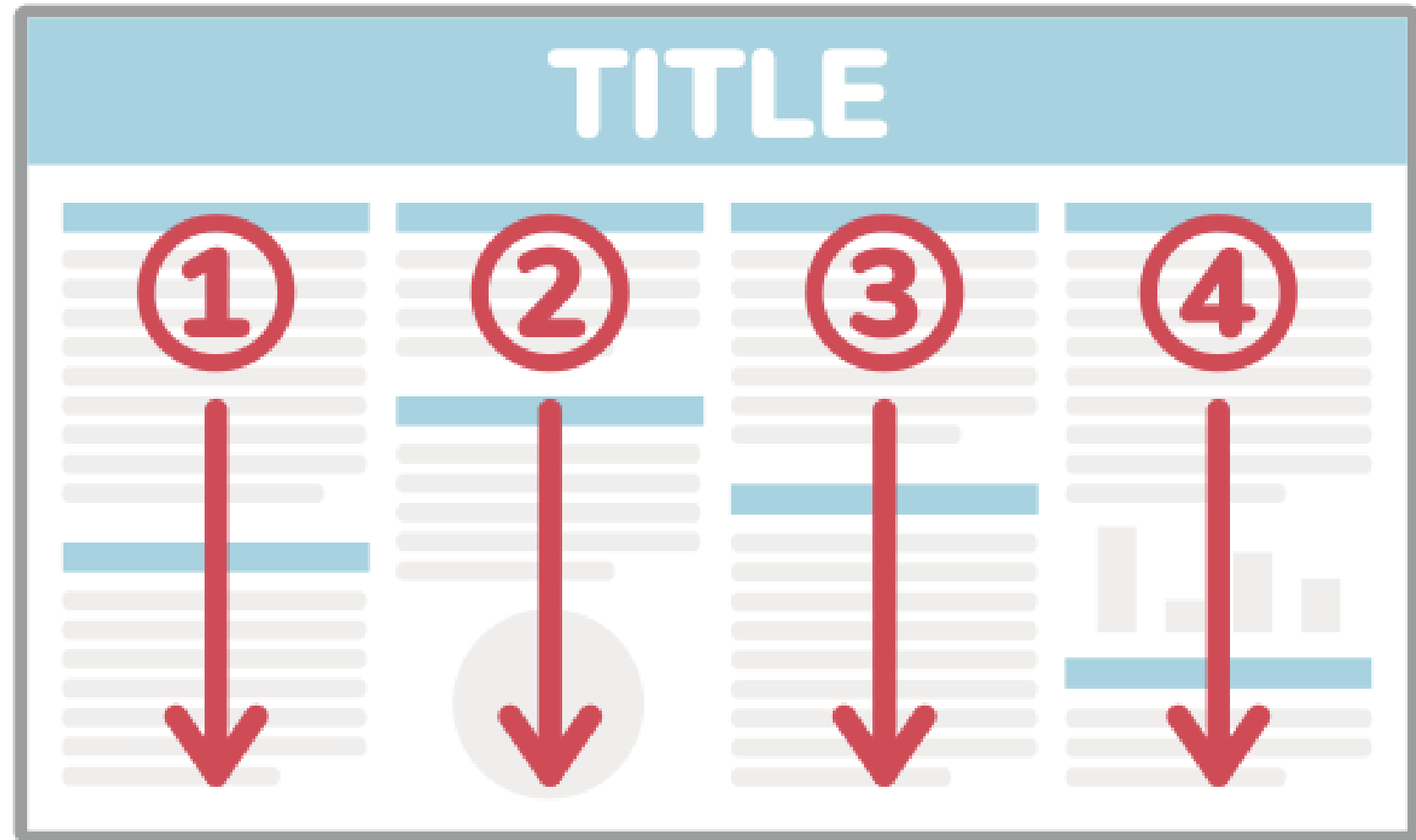
Try to have ~2 points for background, methods, and discussion. 2-4 points for results  
Results should be your STAR
- **Visual interest and accessibility.** Design your poster so it's catchy and easy for readers to get your main points (above)

# Poster Layout

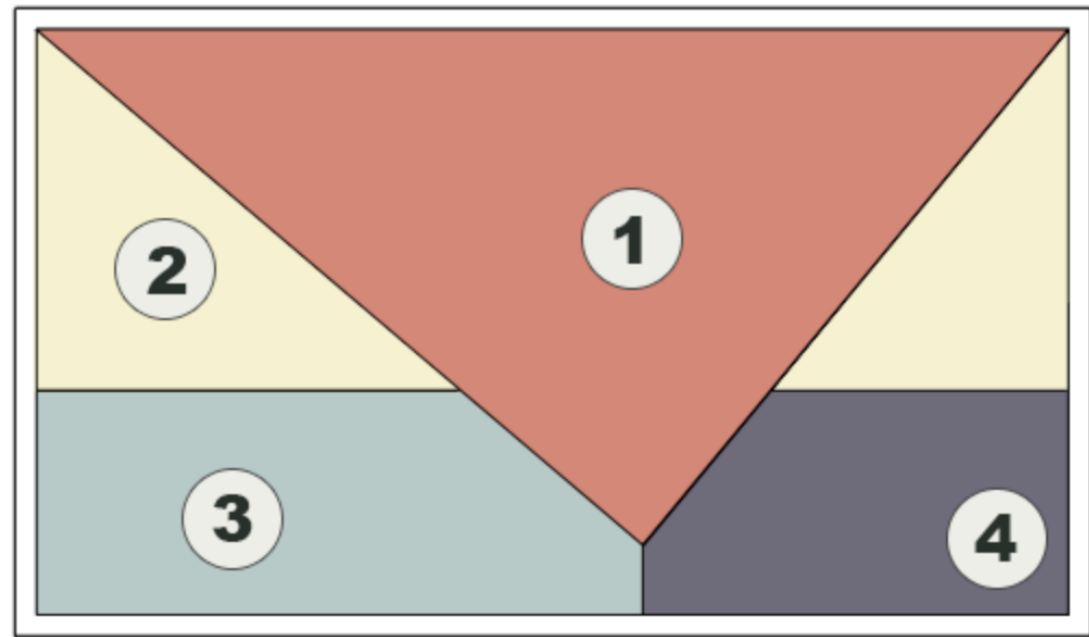
- Title
- Authors and affiliation
- Background/intro (brief)
- Setting (super brief) / Methods
- Results (at least one graphic/table)
  - Should take up the majority of the poster
- Discussion/conclusion (same or less text than background)
- References/funding

# Example of possible layout

1. Background/Methods
2. Results
3. Results
4. Discussion / References & funding



# Example of possible layout



- 1. Main Focus Area**  
Location of research fundamentals: Title, Authors, Institution, Abstract, Results, Conclusion
- 2. Secondary Emphasis**  
Location of important info: Intro, Results or Findings, Summary
- 3. Supporting Area**  
Location of supporting info: Methods, Discussion
- 4. Final Info Area**  
Location of supplemental info: References, Acknowledgments

# What makes a good poster – Less is More!

- Title is short and draws interest
- Important information should be readable from about 10 feet away
  - = limited text that is clear and to the point
    - NO PARAGRAPHS!
    - Word count ~ 300 to 800 words
    - 10-30% white space
- Use of bullets, numbering, and headlines make it easy to read
- Effective use of graphics, color and fonts:
  - 1-3 graphics/pictures tops – but absolutely need at least 1
- Consistent and clean layout
- Includes acknowledgments, authors name and institutional affiliations
  - And [EMAIL!](#) You want people to be able to contact you

# Example: Brief wording

- **Wording in a paper:**

This project sought to establish the ideal specifications for clinically useful wheelchair pressure mapping systems, and to use these specifications to influence the design of an innovative wheelchair pressure mapping system.

- **Wording on a poster:**

## Aims of study

- Define the ideal wheelchair pressure mapping system
- Design a new system to meet these specifications



# Designing the layout of your poster



# Examples of Challenged Posters

**Q<sup>4</sup>-Benzylguanine Inhibits Tamoxifen Resistant Breast Cancer Cell Growth and Resensitizes Breast Cancer Cells to Anti-Estrogen Therapy**

Juliana Smith, George C. Roberts, Rafael Muñoz-Vidal, Jessica Cohen, Beth Isley, Jonathan Toker, Kalkunte S. Shivamogal and Neelil Kundoor

Tamoxifen Research Institute of St. Andrew's Cancer Center, Stony Brook University Health Science Center, Stony Brook, NY

**Abstract**

Abstracts are rarely needed for posters. This is a common mistake. Posters rarely need abstracts.

**Introduction**

Text dissolves into intimidating, boring gray.

**Results**

Too small and too much.

Caption not aligned with figure.

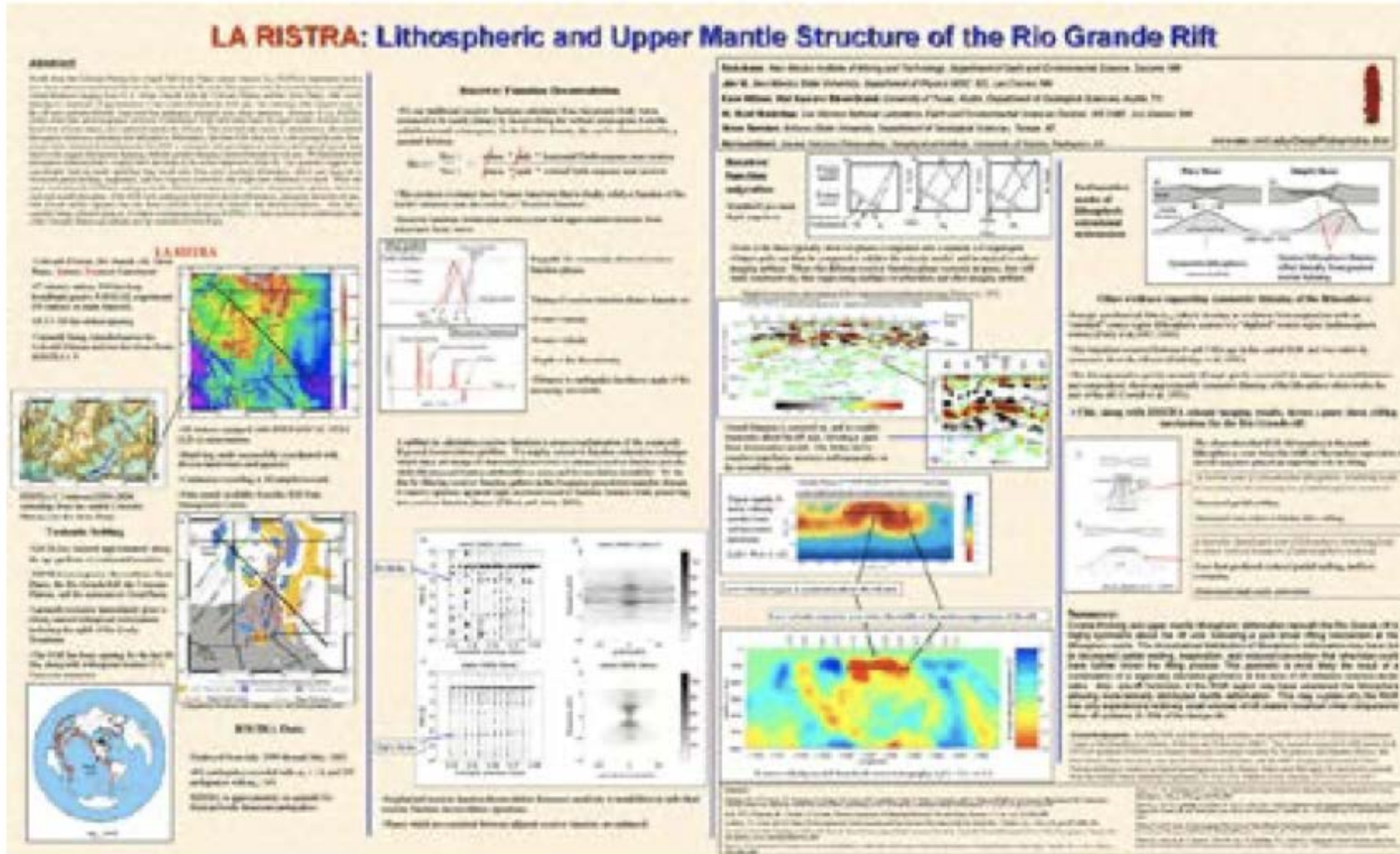
**Conclusion**

Crammed!

**Acknowledgements**

Crammed!

# Examples of Challenged Posters



Avoid any confusion...

- Don't have large amounts of text – be concise
- If your text is too small, your audience won't read it
- Avoid complex graphics and charts
- Don't mix justified, centred and left aligned text
- Use headings



# Examples of Challenged Posters

## Trace Elements and Your Health

- **Sources:** iodine alcohol, iodized table salt, seafood, kelp & other seaweed (raw or processed in items like ice cream)
- **Benefits:** helps metabolize fats, produce energy, and keep thyroid glands healthy
- **Hazards:** too little can result in hypothyroidism, causing weight gain, lack of energy, reduced mental focus, and in some cases Goiter
- Estimated 10-20% of women over age 50 have a thyroid disease

Trace elements are those which we encounter in small quantities, typically 10 to 100 ppm

- We absorb them into our bodies through all means of contact
- Our bodies need small amounts of trace elements to remain healthy, but excessive doses of the same element can harm us
- The right dose for healthy living depends on a person's locale and habits
- The FDA tries to regulate the dosages we encounter in foods, soaps, and other commodities
- Three of the trace elements which we best understand are iodine (I), Fluorine (F), and Selenium (Se)

Regularly added to drinking water and toothpaste for its proven ability to reduce the formation of dental cavities by up to 70%

- **Sources:** drinking water, seafood, tea
- **Benefits:** required to maintain strong bones and teeth
- **Hazards:** excessive amounts can result in mottled teeth, too little can cause osteoporosis

**FOODS RICH IN FLUORINE**

Water/Milk (liters)	Estimated Total Amount (mg/kg)	Physiological Functions
Calcium	1000.00	Energy release, electrolyte
Phosphorus	700.00	Fluids and structure
Potassium	180.00	Fluids, electrolyte
Sodium	80.00	Water & electrolyte balance
Magnesium	20.00	Energy release, electrolyte
Iron	5.00	Metabolism, enzyme
Zinc	4.00	Metabolism, enzyme
Copper	0.10	Metabolism
Manganese	0.02	Metabolism, enzyme
Selenium	0.01	Metabolism, enzyme
Vanadium	0.00	Metabolism, enzyme

Carefully consider colours and images...

- Avoid rainbow colours - always use solid colours and not more than two or three in the poster
- Avoid clipart and cartoon images
- Don't place images (or in this case) letters behind text
- Use clear headings

# Examples of Posters

## Self-Care Interventions for the Management of Mouth Sores in Hematology Patients Receiving Chemotherapy



Stephanie L. Dinse, BSN Candidate & Catherine Cherwin, MS, RN, PhD Candidate

### BACKGROUND

- Patients with hematologic cancers often need large doses of highly toxic chemotherapy, and as a result, experience many severely debilitating side effects, including mouth sores.
- Little research has been done regarding the use of self-care interventions for mouth sores and their perceived efficacy in outpatient hematologic cancer populations.

### PURPOSE

To describe hematology patients' knowledge, use, and perceived effectiveness of preventative and treatment interventions for mouth sores.

### DESIGN & SAMPLE

The study used a descriptive design. A convenience sample of 13 adult hematology patients were recruited from the UW Carbone Cancer Center (UWCCC) as part of a parent study to examine symptom clusters in hematologic cancer patients receiving chemotherapy. Inclusion criteria were:

- Age 18 or older
- Diagnosis of a leukemia or lymphoma
- Beginning at least the third cycle of moderately to highly emetogenic intravenous chemotherapy in 3-week or 4-week cycles
- Able to read and write in English

### PROCEDURE



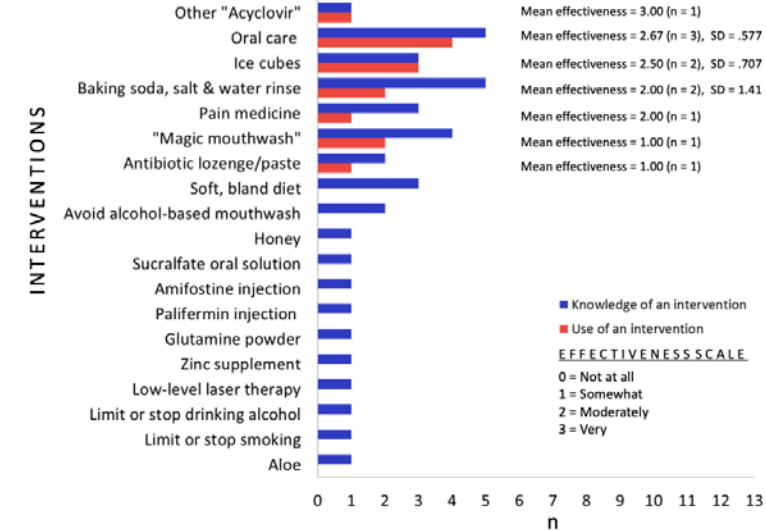
On Day 21 of a chemotherapy cycle, participants reported their knowledge of 18 interventions identified in the literature for mouth sores, described if they used each intervention in the last three weeks, and if so, rated its effectiveness from 0 to 3, 0 being "not at all" and 3 being "very" effective.

### SAMPLE CHARACTERISTICS

DEMOGRAPHIC MEASURES	n (%)
Age (years)	
Range	25 - 83
Mean (SD)	65.31 (15.67)
Race	
White	11 (84.6%)
Other	2 (15.4%)
Gender	
Male	11 (84.6%)
Level of Education	
High School/GED	3 (23.1%)
College (Partial or completed)	10 (76.9%)
Relationship Status	
Single	2 (15.4%)
Married	11 (84.6%)
Annual Household Income	
≤ \$50 K	3 (23.1%)
> \$50 K	7 (53.8%)
Missing	3 (23.1%)
CLINICAL MEASURES	
Diagnosis	
Lymphoma	9 (69.2%)
Leukemia	4 (30.8%)
Chemotherapy Emetogenicity Rating	
Moderate (e.g. R-Bendamustine)	10 (76.9%)
High (e.g. CHOP)	3 (23.1%)

### RESULTS

#### Knowledge, Use, & Effectiveness



### CONCLUSIONS & IMPLICATIONS

- Participants were most aware of interventions that were recommended in UWCCC patient education materials (oral care, baking soda-salt water rinses, pain medication, ice cubes, soft bland diet), or that were prescribed by a care provider (magic mouthwash, topical antibiotics, acyclovir).
- Very few participants (< 25%) actually used any of the self-care interventions, but among those used, most were rated as at least moderately effective.
- Study limitations include the small sample size, inclusion of participants who may not have experienced mucositis, potential confusion between mouth sores and cold sores (oral herpes), and uncertainty in whether or not participants had received mucositis education from the clinical care providers.
- Further research is needed to document the effectiveness of various self-care interventions for mucositis. Nurse clinicians can provide targeted education to increase patients' awareness and use of strategies found to be effective.

Acknowledgments: The authors would like to thank Dr. Kristine L. Kwekkeboom and the Kwekkeboom Research Group for their contributions to this study. This work was supported by the Doctoral Degree Scholarship in Cancer Nursing Grant number 121310-DSCH-11-278-01-SCN from the American Cancer Society, National Research Service Award number 1F31NR014062-01A1 from the National Institute of Nursing Research, and by the Eckburg Research Award.



# Examples of Posters



## Provider Perceptions of HIV-Positive Men in Malawi and Mozambique

Rose Paneno<sup>1</sup>, Julie Hubbard<sup>1</sup>, Khumbo Phiri<sup>2</sup>, Kelvin Balakasi<sup>2</sup>, Thomas Coates<sup>1</sup>, Kathryn Dovel<sup>1,2</sup>



### Background

- Men in sub-Saharan Africa are less likely than women to test for HIV and, if positive, initiate and be retained in HIV care.<sup>1,2</sup>
- Interventions targeting men are expanding, however, there is very little understanding of how health care workers (HCWs) perceive men, and how this influences the type and quality of care provided.<sup>3</sup>
- Extensive research from the U.S. shows that HCW perceptions and harmful stereotypes toward racial and ethnic minority populations negatively influences health outcomes.<sup>4</sup> It's becoming clear the same may also be true for African men in need of HIV services

### Objectives

- Explore HCW perceptions of HIV positive men as clients in Malawi, and reasons why men may not engage in HIV care
- Findings will inform the development of provider training materials for a large intervention targeting men's engagement in HIV services in Malawi

### Methods

- We conducted a secondary analysis of 21 focus group discussions (FGDs) with HCWs from 15 health facilities across Malawi and Mozambique (12 FGD in Malawi and 8FGD in Mozambique, 154 HCWs total)
- FGDs were originally conducted in 2016 to evaluate barriers and facilitators to ART initiation under new universal treatment policies
  - FGDs were conducted in the local language (Chichewa) and included 6-12 HCWs each, lasting approximately 1-2 hours each
  - FGDs were recorded, translated into English, and transcribed
- We applied deductive and inductive coding using Atlas.ti v.8. Existing literature on men and HIV services provided the basis of deductive codes.
  - We used constant comparison methods to analyze codes and focused on three overarching themes:
    - Barriers to men's ART initiation and retention
    - Facilitators/possible interventions for ART initiation
    - HCW perceptions of men as clients
- Findings on HCW perceptions of men as clients were then analyzed alongside relevant literature to explore areas of discrepancy and convergence.

### Results/Discussion

HCW perceive men as ... (Results)	Documented Reality (Discussion)
<p><b>Perpetrators of the epidemic</b></p> <p>Men infect women with HIV and interfere with women seeking treatment</p> <p><i>"It is difficult for men to accept (their status) but when women are told you have tested HIV positive they accept easily because they usually just fall victim of this (HIV) - they complain that they have always been faithful and have fallen victim."</i>- Provider in Malawi</p> <p><i>"There are wives who are (taking ART) in hiding, and this influences her treatment adherence. Other wives do not reveal (their status) because they fear that the partner will beat them or they will get divorced. Nowadays, when the men find out (about their partners positive status), they abandon the family."</i>-Provider in Mozambique</p>	<p><b>Men are not always the source of HIV in stable relationships</b></p> <p>There is evidence that epidemics in sub-Saharan Africa are dynamic and impacted by multiple partners by both males and females<sup>2</sup>. Women are just as likely to be the index partner in sero-discordant, stable relationships.<sup>5</sup></p> <p><b>Men often control or influence women's health seeking behavior:</b></p> <p>Men frequently dominate health care decision-making for the household, and the healthcare system may require women to seek permission from men prior to testing or treatment.<sup>6</sup></p> <p><b>Men can be supportive</b></p> <p>In a study on PMTCT and status disclosure in Kenya, most women (85%) reported positive, supportive male partner reactions to HIV status disclosure.<sup>7</sup></p>
<p><b>Difficult clients</b></p> <p>Men are too lazy, stubborn, and proud to seek HIV care. Men are selfish and do not consider the wellbeing of their family when seeking care, whereas a woman will seek care to protect her family.</p> <p><i>"Men are more selfish and proud than women are and as a result they end up resisting ART."</i>- Provider in Malawi</p> <p><i>"Sometimes also when the woman is positive and explains at home the man will never appear at the health facility. He will say "you go alone, I'm still not sick."</i>- Provider in Mozambique</p> <p><i>"Men are usually self-centered and therefore do not see anything wrong with not taking ARVs, while women think about their families...As a result they [women] are not shy to take ARVs because they always consider the responsibilities they have. While men are too selfish, such that they don't care even when they are HIV positive."</i>- Provider in Malawi</p>	<p><b>Men are motivated by family wellness</b></p> <p>A father's feelings of duty to protect and defend his family's wellbeing and to improve the future of his children is a strong motivator for engaging in HIV care.<sup>8</sup></p> <p><b>Men are not compliant patients</b></p> <p>Men do not fit standard characteristics of "ideal clients"<sup>9</sup> and often need to be convinced to follow health guidelines.</p> <p><b>Health systems do not engage men</b></p> <p>However, health systems are largely designed for women without catering to male-specific needs. Inaccessible clinic hours, feminized clinic spaces and HIV programs, and the lack of privacy with increased risk of status disclosure for men limit male engagement with HIV services.<sup>1,10,11</sup> Malawi health service guidelines recommend that women receive routine health services between 176 and 433 times during reproductive lifespan compared to 30 services for men.<sup>9</sup></p>
<p><b>Absent from health facilities and ill-informed</b></p> <p>Men lack HIV education. Women visit clinics more frequently and therefore have the knowledge necessary to initiate HIV treatment</p> <p><i>"A lot of programs do not accommodate male involvement. For example under-five, antenatal, family planning all of which are attended almost exclusively by women. Men only have a chance to come to the hospital when they are sick and it becomes very difficult for them to accept that they are really HIV positive since their familiarity with hospitals is always very low."</i>-Provider in Malawi</p> <p><i>"If a man comes to the health unit it is because he has something (serious). They are confusing. I think men never believe they can get sick. They don't want to show weakness"</i>-Provider in Mozambique</p>	<p><b>Men Visit Facilities Frequently</b></p> <p>In a recent study of 1400 Malawian men, 80% of all men visited a health facility within the past 12-months and 90% within the past 24-months. The vast majority attended outpatient departments for acute care.<sup>12</sup></p> <p><b>Men have basic HIV knowledge, but are unfamiliar with HIV programs and in-depth HIV knowledge</b></p> <p>A higher proportion of men in Malawi compared to women have a basic understanding of HIV according to DHS data from studies in 2004, 2010, and 2016.<sup>13</sup> However, men are less familiar with the health system and have less in-depth knowledge about HIV, such as side effects of medications, benefits of early treatment, and details of long-term treatment adherence.<sup>10,11</sup></p>

### Discussion

- HCWs held overall negative perceptions of HIV positive men, portraying them as ill-informed, difficult clients who are largely absent from the health care system, and perpetuate the HIV epidemic with irresponsible sexual behavior.
- Most of these negative perceptions are not well supported by the existing literature regarding HIV positive men in the region, although some perceptions are corroborated.
- Negative perceptions place an undue burden of individual responsibility on men with HIV, while undermining the impact of the systemic and institutional barriers men face when accessing HIV care.
  - Beliefs about clients influence HCW values and service prioritization.<sup>14</sup>
  - Studies within the US have indicated that negative provider perceptions of ethnic and racial minorities results in poorer health outcomes for these populations<sup>4</sup>
  - Male focused interventions may need to incorporate and address negative provider perceptions in order to improve outcomes.

### Conclusion

- In order to ensure improved HIV outcomes for men, it is critical to understand HCW perceptions of men, identify areas of misconceptions, and develop strategies to address HCW stereotypes and improve men's engagement in HIV services.

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- Partners in Hope Medical Center, Lilongwe, Malawi

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# Partner-delivered HIV self-testing increases the perceived acceptability of index partner testing among HIV-positive clients in Malawi

O. Agatha Offorjebe<sup>1,2</sup>, Frackson Shaba<sup>3</sup>, Kelvin Balakasi<sup>3</sup>, Mike Nyirenda<sup>3</sup>, Risa Hoffman<sup>1</sup>, Kathryn Dovel<sup>1,3</sup> on behalf of EQUIP Innovation for Health

<sup>1</sup>David Geffen School of Medicine, University of California, Los Angeles; <sup>2</sup>School of Medicine, Charles R. Drew University of Medicine and Science; <sup>3</sup>Partners in Hope, Lilongwe, Malawi; <sup>4</sup>Division of Infectious Diseases, Department of Medicine, University of California, Los Angeles

## Objective

- To assess perceived feasibility and acceptability of index partner HIV self-testing versus partner referral slip (standard of care) among HIV-positive clients in Malawi

## Background

- Index partner testing is critical for reaching the UNAIDS 90-90-90 goals
- Partner referral slip (PRS) is the primary strategy for testing partners throughout sub-Saharan Africa, however uptake of this strategy has limited success, with male partners less likely to test than female partners<sup>1</sup>
  - Barriers to index partner testing include travel to testing sites, long waiting times, inconvenient testing hours, and concerns about confidentiality and privacy<sup>2</sup>
- Oral based HIV self-testing (HIVST) may overcome these barriers.
  - Multiple studies show that clients who are HIV-negative or of unknown status are comfortable and able to deliver HIVST kits to their sexual partners<sup>3</sup>
- To date, there is no data on the acceptability of index partner HIVST among HIV-positive clients
  - We define index partner HIVST as giving HIV-positive clients HIVST kits to take home to their sexual partners

## Methods

### Study Design

- This study is nested within a cluster randomized control trial (cRCT) aimed to increase HIV testing among outpatients in high-burden health facilities in Malawi.
  - Data collection: September 2017 - February 2018
  - Sites: 15 large and mid-level health facilities in Malawi
  - Sample size: 5,885 outpatients

### Study procedures

- Exit surveys were conducted with a random sub-set of outpatients after routine consultations.
  - Eligibility criteria:** Outpatients ≥ 15 years
  - Survey questions:** Demographics; HIV-positive clients were asked about the feasibility and acceptability of delivering HIVST versus PRS to their sexual partners

### Analyses

- Clients were eligible for this sub-analysis if they met the following criteria:
  - Ever received an HIV-positive test result
  - Currently in at least 1 sexual relationship
- We use independent t-tests to examine gender differences in the acceptability and feasibility of HIV self-testing and partner referral slips

## Results

- 404 individuals were eligible and included in the analysis (Table 1)
- 26% of male versus 50% of female index clients were illiterate (p-value=<0.001)
- Male clients were more likely to be married (94% vs. 79%; p-value=<0.001)
- 13% of both men and women were diagnosed with HIV within the past 3-months

**Table 1. Baseline characteristics of HIV-positive clients with an active sexual partner (n= 404)**

Characteristic	Men n(%)	Women n(%)	p-value*
Mean age, years (IQR)	42.4 (35-50)	34.4 (27-40)	<0.001
Illiterate (%)	42 (26)	122 (50)	<0.001
Relationship Status (%)			
Married	149 (94)	193 (79)	<0.001
Non-married partner	10 (6)	52 (21)	<0.001
Mean number of children living in the home (IQR)	4.1 (2-5)	3 (2-4)	<0.001
Mean number of current sexual partners (IQR)	2 (1-2)	1.3 (1-1)	<0.001
Diagnosed HIV+ within the past 3months (%)	20 (13)	33 (13)	0.79
Currently on ART (%)	139 (87)	226 (92)	0.11
Region			
Central Malawi	36 (23)	62 (26)	(ref)
Southern Malawi	123 (77)	183 (75)	0.54
Total	159	245	-

\*p-value calculated using independent t-tests

### Delivering index testing strategies (Table 2)

- 92% of male and 89% of female clients were comfortable delivering HIVST kits
  - 61% of male and 67% of female clients preferred to deliver HIVST over PRS
- Comfort delivering HIVST kits did not differ by sex (p-value=0.25)
  - Male clients were more comfortable delivering PRS compared to female clients (p-value=0.007)

### Using index testing strategies (Table 2)

- 79% of male and 76% of female clients believed their partner would test using HIVST
  - 65% of male and 62% of female clients believed their partner would prefer testing with HIVST over PRS
- Partner testing with HIVST did not differ by sex (p-value=0.59)
  - Male index clients were more likely to believe their partners would use PRS compared to partners of female index clients (p-value=0.007)

**Table 2. Acceptability and feasibility of index partner HIVST vs. partner referral slips (n= 404)**

Characteristic	Men n(%)	Women n(%)	p-value*
Comfortable distributing the following index testing strategies			
HIV self-test kits	147 (92)	218 (89)	0.25
Partner referral slips	140 (88)	189 (77)	0.007
Prefer distributing self-test kits over partner referral slips	97 (61)	164 (67)	0.22
Believe their primary sexual partner would test using the following strategies			
HIV self-test kits	125 (79)	187 (76)	0.59
Partner referral slips	117 (74)	148 (60)	0.007
Believe their primary sexual partner would prefer using self-test kits over partner referral slips	104 (65)	152 (62)	0.49

\*p-value calculated using independent t-tests

## Conclusion

- Index partner HIVST was perceived as acceptable among HIV-positive clients in Malawi
- HIVST may close gender-specific gaps in male partner testing
- Additional studies are needed to assess actual use of HIVST and ART linkage

### Collaborating Institutions and Acknowledgements

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# Examples of Posters

## Gender and HIV services: The role of gender norms and gender inequality on ART initiation among men and women in Malawi

Kathryn Dove<sup>1,2</sup> and Julie Hubbard<sup>1,2</sup>

### Background

- Harmful gender norms negatively impact an array of health outcomes for both men and women.<sup>1</sup>
- Numerous qualitative studies have identified harmful gender norms as a primary barrier to men's use of HIV treatment services in sub-Saharan Africa.<sup>2</sup>
- However, the relationship is rarely tested with quantitative methods. Further, little research has examined the role of harmful gender norms on women's use of antiretroviral therapy (ART).
- Understanding the relationship between various gender norms and ART initiation for both men and women can inform innovative behavioral interventions for ART initiation.
  - This is important since behavioral interventions to improve ART initiation in sub-Saharan Africa are still unclear – presenting a significant challenge to reaching UNAIDS 90-90-90 goals.

### Objectives

- Test the association between harmful gender norms and ART initiation among men and women
- Understand the role of the various domains of harmful gender norms on ART initiation for men and women

### Methods

- Data come from a case-control study with clients from 8 facilities in Malawi diagnosed with HIV between July 2016 – December 2017
  - Cases: Women=178; Men=153
  - Controls: Women=40; Men=68
- Key variables include:
  - 4 domains measuring harmful gender norms (Gender Equitable Masculinity Scale)
    - Women's role is as a caregiver
    - Men should be sexually aggressive
    - Men should be tough and independent
    - Acceptance of gender inequality (acceptance of IPV and belief that men should be the sole decision-maker)
  - Unequal decision-making in the household (DHS)
- Analysis: We use multiple logistic regression models, presenting unadjusted and adjusted odds ratio for each variable of interest. All models are run separately by sex.

### Results: Respondent Characteristics

Table 1. Characteristics of initiates and non-initiates, by sex

Characteristic	Men		Women	
	Initiate	Non-Initiate	Initiate	Non-Initiate
Mean age, years (IQR)	39.72 (32-46)	38.03 (29-45)	37.06 (28-45)	33.58 (22-47)
Mean years of school completed (IQR)	5.29 (3-8)	4.78 (2-7.5)	3.75 (0-6)	3.75 (0-7)
No current sexual partner(s) (%)	19.61	8.82	33.71	22.50
Household Assets Scale (IQR)	1.89 (0-3)	2 (1-3)	1.51 (0-2)	1.46 (0-2)
Mean score of Gender Norm Domains:				
Men's sexual performance (IQR)	1.31 (1-2)	1.5 (1-2)	1.53 (1-2)	1.83 (2-2)
Men's toughness (IQR)	1.39 (1-2)	1.29 (1-2)	0.46 (0-3)	0.7 (0-1)
Women's role is the caregiver (IQR)	3.26 (3-4)	3.35 (3-4)	3.67 (3-4)	3.55 (3-4)
Gender inequality (IQR)	0.65 (0-1)	1.29 (1-2)	1.75 (1-2)	2.1 (1-3)
Respondent is the Primary Decision-Maker for:				
Money earned by respondent (%)	84	82	44	40
Household earnings (%)	75	69	34	30
Major household purchases (%)	71	65	31	25
Respondent's healthcare (%)	45	57	51	50
Total	153	68	178	40

### Results: Respondent Characteristics

Table 2. Multivariate adjusted odds ratio for timely ART initiation, by sex\*

Characteristic	Men		Women	
	Model 1	Model 2	Model 1	Model 2
Mean score of Gender Norm Domains				
Men's sexual performance	0.63	0.15	0.64	0.103
Men's toughness	1.71	0.052	1.80	0.042
Women's role is the caregiver	1.21	0.350	1.26	0.286
Gender inequality	0.36	<0.001	0.33	<0.001
Respondent is the Primary Decision-Maker for:				
Money earned by respondent	-	-	0.45	0.159
Household earnings	-	-	2.74	0.033
Major household purchases	-	-	1.25	0.612
Respondent's healthcare	-	-	0.51	0.059
No current sexual partner	4.522	0.008	6.27	0.002
Constant	0.18	0.325	0.26	0.473

\*All models adjust for age, age-squared, years of education completed, and a household assets scale



### Conclusions

- We find a nuanced relationship between gender norms, unequal decision-making, and ART initiation
- Among MEN:
  - Men who believe that gender inequality acceptable (AOR: 0.33; p-value<0.001) and are the primary decision-maker for their own health care (AOR: 0.51; p-value=0.06) are less likely to initiate ART, although the latter is not significant
  - Men who believe men should be tough and independent are more likely to initiate ART (AOR: 1.80; p-value=0.04)
- Among WOMEN:
  - Women who believe that gender inequality is acceptable (AOR: 0.60; p-value=0.03) and that men should be sexually aggressive (AOR: 0.03; p-value=0.006) are less likely to initiate ART
  - Women who believe women's primary responsibility is as a caregiver are more likely to initiate ART (AOR: 2.61; p-value=0.006)
- Acceptability of gender inequality was a strong predictor of ART initiation for both men and women.

- Strategies to address harmful gender norms specific to gender inequality may be warranted to increase ART initiation in Malawi

### Affiliations & Acknowledgements

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<sup>2</sup>: University of California, Los Angeles, David Geffen School of Medicine, Division of Infectious Diseases, Los Angeles, California

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# A COMMUNITY-BASED INTERVENTION (MEN'S SPACES) TO ENGAGE MEN IN HIV AND SEXUAL HEALTH SERVICES IN MALAWI: A PILOT STUDY

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## Objective

To develop and pilot a male-focused community intervention, 'Men's Spaces', focused on men's general health and HIV testing, informed by the health-related interests and unmet needs of men in Malawi.

## Background

- Men have worse health outcomes than women, including greater HIV-related morbidity and mortality.<sup>1</sup>
- Preventative health services and education largely focus on women and children with little educational material targeting men and men's health.<sup>2</sup>
- Community HIV testing strategies have been shown to increase male engagement in care.<sup>3</sup>
- Male-focused community spaces providing sexual health education and HIV testing services specifically developed for men may improve sexual health knowledge and use of HIV services.

## Methods

All data collected from 4 villages in Chikwawa District, southern Malawi between October 2018-June 2019.

### Developing Intervention: Qualitative Data

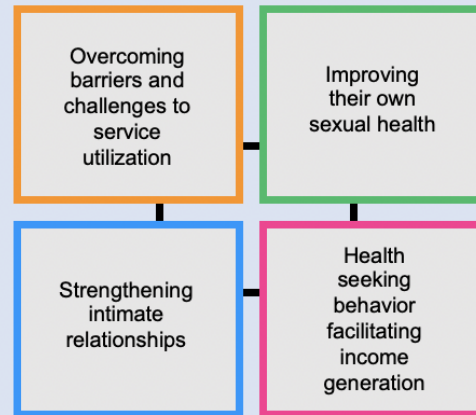
- In-depth interviews with men age 25-40 years (n=20)
- Focus group discussions with married women (n=3) and Health Advisory Committees in same villages (n=2)
- Coded deductive and inductive techniques in Atlas.ti with constant comparison methods used for analysis

### Implementing Intervention: Quantitative Data

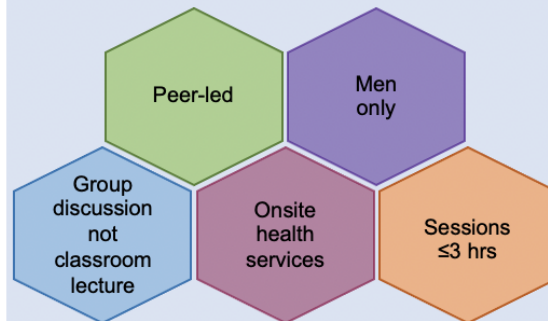
- Men's Spaces was piloted in the same four villages and included a one-time interactive session with men aged 25-45 years
  - Intervention was implemented by routine program staff
- Medical chart reviews and exit surveys using convenience sampling (n=75) were conducted by research staff immediately following each Men's Spaces intervention session.
  - Descriptive statistics used

## Developing Intervention: Qualitative Data

Key topics desired by men for Community Health Events



Key components for Community Health events recommended by men



## Results

### Implementing Intervention: Quantitative Data

- Implemented with 183 men across four villages (7 sessions with ~26 men per session) with an average session length of 2.45 hrs
- Use of HIV Self-Testing (HIVST) was high. Among those who disclosed their test results, 7% were newly HIV-positive and 83% initiated ART same day (Fig 1)
- Highly acceptable: 100% of men surveyed (n=75) would attend again

Table 1. Participant demographics (n=75)

Demographics	n (%)
Age in years, mean (SD)	30 (5.36)
Worked for pay in last week	53 (70%)
>2partners in past 12months	46 (61%)
Never tested or tested >12months ago	47 (62%)

Table 2. Top recommendations for future activities (n=75)

Top favorite component of the meeting
It was men only
I learnt something about my own health
Understanding men's struggles with health care and what to do
The opportunity to test for HIV
The opportunity to have access to NCD screening services
The most important/valuable thing learned from the meeting
What to do once tested HIV-positive
Universal treatment and benefits of early initiation

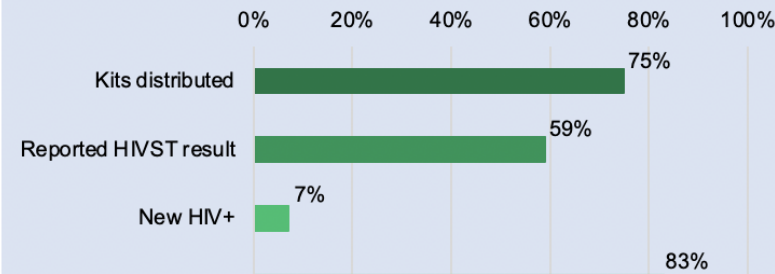


Fig. 1 HIVST at Men's Spaces

## Conclusions

- Men desired interventions that focused on their own sexual health, strengthening romantic relationships, and income generation.
- A community, peer-based intervention was feasible and acceptable among men, with high HIVST use and linkage among those who reported a positive test.
- Interactive health sessions provided alongside HIV testing and NCD services are a practical way to engage men with the health system and improve knowledge about their own health.
- Future studies should consider how a Men's Spaces framework could be integrated into the existing health system, for example in outpatient departments

## Acknowledgements

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# Resources

- Mind the graph – support for developing poster design and graphics
  - Free for beginner level
  - [https://mindthegraph.com/usecases/poster?gclid=CjwKCAjwz\\_WGBhA1EiwAUAXlcRZwkMHB4-I-59QmrBVI6OBSEy\\_U\\_A55zwJxQJPI18qFZutbukerVRoC6pwQAvD\\_BwE](https://mindthegraph.com/usecases/poster?gclid=CjwKCAjwz_WGBhA1EiwAUAXlcRZwkMHB4-I-59QmrBVI6OBSEy_U_A55zwJxQJPI18qFZutbukerVRoC6pwQAvD_BwE)
- LinkedIn tips
  - <https://www.linkedin.com/pulse/10-simple-steps-create-awesome-scientific-poster-van-den-eeckhout>
- <https://www.makesigns.com/tutorials/>



# Delivering Scientific Posters at Conferences

The slide features a white background with a large, abstract graphic on the right side. This graphic consists of several overlapping geometric shapes: a large dark blue triangle pointing towards the top right, a smaller medium blue triangle nested within it, and a yellow trapezoidal shape at the bottom left that overlaps with the dark blue triangle. The text is positioned in the upper left quadrant of the slide.

# Preparing for the presentation

- Have an elevator pitch (30-60 seconds):
  - Goal: Get someone walking by interested and wanting to know more. It should be big picture – not in the details – The pitch should be punchy, intriguing and relevant.
  - Questions answered (1 sentence or less each):
    - What is your research topic?
    - What have you found?
    - Why is that important?
- Develop a script (5-10 min, depending on conference):
  - Tailor to your audience: Don't know? Ask
  - You are the narrator; it is up to you as the story teller to make the content both compelling and exciting. Attendees are not all experts in your field.; if you are unsure how familiar your audience is with your subject area, ask them.

# Preparing for the presentation

- Hand outs: not required, but can be helpful to disseminate your work broadly.
  - To include:
    - Title; Name of authors and affiliations; **your professional email address**;
    - Key information from the poster: couple bullets of background; methods; findings (likely 1 graphic); conclusion/take away
    - Link to any relevant paper or website

# And FINALLY: Delivering your poster

- Practice, practice, practice
    - Work with your mentors to understand likely questions and prepare answers
  - Be approachable / welcoming
    - Sell yourself and your research with the elevator pitch
  - Ask questions
    - Ask if the presentation is making sense or if they need more detail. Questions like: “Have I been clear enough” or “should I go into more detail about.....?”
  - Be flexible
    - Know your script, but be able to deviate based on the conversation and knowledge base of your audience
-

Questions? Let's talk about your  
posters....

