You did the research – now disseminate!

Quick guide to scientific posters

Kate Dovel
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Developing and Designing Posters
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

https://www.makesigns.com/tutorials/
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

https://writing.wisc.edu/handbook/assignments/posterpresentations/
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
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.

Aims of study

• Define the ideal wheelchair pressure mapping system
• Design a new system to meet these specifications
Designing the layout of your poster

https://www.linkedin.com/pulse/10-simple-steps-create-awesome-scientific-poster-van-den-eekhout
Examples of Challenged Posters

https://guides.nyu.edu/posters
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

https://www.uclan.ac.uk/students/assets/QRG-MS-PPT-Creating-Academic-Posters.pdf
Examples of Challenged Posters

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

https://www.uclan.ac.uk/students/assets/QRG-MS-PPT-Creating-Academic-Posters.pdf
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

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, where 0 was “not at all” and 3 was “very” effective.

SAMPLE CHARACTERISTICS n (%) DEMOGRAPHIC MEASURES

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Range</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>11 (84.6)</td>
<td>65.33 (15.67)</td>
</tr>
<tr>
<td>Other</td>
<td>1 (7.7)</td>
<td></td>
</tr>
</tbody>
</table>

| Gender | Male | 11 (84.6) |
|        | Female | 2 (15.4) |

<table>
<thead>
<tr>
<th>Level of Education</th>
<th>High School/GED</th>
<th>College (Partially completed)</th>
<th>Complete</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3 (23.1)</td>
<td>10 (76.9)</td>
<td></td>
</tr>
</tbody>
</table>

| Relationship Status | Single | 2 (15.4) |
|                    | Married | 11 (84.6) |

<table>
<thead>
<tr>
<th>Annual Household Income</th>
<th>≤ $25K</th>
<th>&gt; $25K</th>
<th>Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3 (23.1)</td>
<td>7 (53.8)</td>
<td>3 (23.1)</td>
</tr>
</tbody>
</table>

CLINICAL MEASURES

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Lymphoma</th>
<th>Leukemia</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>9 (69.2)</td>
<td>4 (30.8)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chemotherapy Emergencier G5 Rating</th>
<th>Moderate (e.g., 5-FD).</th>
<th>High (e.g., CHOP)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10 (76.9)</td>
<td>3 (23.1)</td>
</tr>
</tbody>
</table>

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 herpess), 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. Kristin Bieber, the Kelkeleborn and the Kelkeleborn Research Group for their contributions to this study. This work was supported by the Doctoral Degree Scholarship in Cancer Nursing. Grant number 37350-01-0178-0347 from the American Cancer Society, National Research Service Award Award number T32NR010826-01 from National Institute of Nursing Research, and by the fellowship award.

https://writing.wisc.edu/handbook/assignments/posterpresentations/
Examples of Posters

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.
- Interventions targeting men are expanding, however, there is very little understanding of how health care workers (HCW) perceive men, and how this influences the type and quality of care provided.
- Extensive research from the U.S. shows that HCW perceptions and harmful stereotypes toward racial and ethnic minority populations negatively influence health outcomes. It’s becoming clearer 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 (FGIDs) with HCWs from 15 health facilities across Malawi and Mozambique (15 FGID in Malawi and 6 FGID in Mozambique). 154 HCW participants.
- FGID were conducted in 2018 to evaluate barriers and facilitators to ART initiation under new universal treatment policies.
- FGID were conducted in the local language (Chichewa) and included 5-12 HCW each, lasting approximately 1-2 hours each.
- FGIDs were recorded, translated into English, and transcribed.
- We applied deductive and inductive coding using Atlas.ti. 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 (1) Barriers/Obstacles/Interventions for ART initiation (2) HCW perceptions of men as clients (3) Findings on HCW perceptions of men as clients.

Results/Discussion

Perpetrators of the epidemic
Men infect women with HIV and interfere with women seeking treatment.

"It is difficult for men to accept (their status) but when women are told you have tested HIV positive they accept easily because they just put all blame on the HIV - they complain that they have always been faithful and have (fellow wives)." Provider in Malawi.

"There are women who are taking ART in hiding, and this influences her treatment adherence. Other wives do not want (these status) because they fear that the partner will lose them or they will be divorced. Nowadays, the men, but not (about) their positive status, they abandon the family." Provider in Mozambique.

Difficult clients
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.

"Men are more selfish and proud than women and as a result they end up missing ART." Provider in Malawi.

"Sometimes also when a woman is positive and everyone at home even the men will not want her to accept the HIV status. We will say you go and see a doctor. But they don’t want to see the doctor. Provider in Malawi.

"Men are usually declared and therefore are not doing anything wrong with not taking ART, while women think about their families. As a result the women are often the ones to take ART because they always consider the responsibilities they have. Men are too selfish, such that they don’t care even when their ART positive." Provider in Malawi.

Absent from health facilities and ill-informed
Men lack HIV education. Women visit clinics more frequently and therefore have the knowledge necessary to initiate HIV treatment.

"A lot of programs do not accommodate male involvement. For example under-five, antenatal, family planning of which are attended almost exclusively by women. Men only have a chance to come to the hospital when they are sick and then it is too difficult for them to accept that they are really HIV positive since their (women’s) family with hospitals is already very well." Provider in Malawi.

"If a man cares for the health unit it is because he has something (sexual). They are cuddling. We don’t even believe they can get sick. They don’t want to show weakness." Provider in Mozambique.

Men are not always the source of HIV in stable relationships
There are evidence that HIV epidemics in sub-Saharan Africa are driven and impacted by multiple partners by both sexes and females. Women are just as likely to be the index partner in sero-discordant, stable relationships.

Men often control or influence women’s health-seeking behavior
Men frequently dominate health-care decision-making for the family: the healthcare system may require women to seek permission from men prior to testing or treatment.

Men are motivated by family wellness
People on lifelong ART to prevent and detect family’s well-being and to improve the future of their children is a strong motivator for engaging in HIV care.

Men are not compliant patients
Men do not fit standard characteristics of "ideal clients" and often need to be convinced to follow health guidelines.

Health systems do not engage men
However, health systems are largely designed for women without properly addressing male-specific needs, inaccessible clinic hours, feminized clinic spaces and HIV programs, and the lack of privacy with increased risks of other disclosure for men limit male engagement with HIV services.

Mozambique health service guidelines recommend that women receive routine health services between 176 and 433 times during reproductive lifespan compared to 30 services for men.

Men Visit Facilities Frequently
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.

Men have basic HIV knowledge, but are unfamiliar with HIV programs and in-depth HIV knowledge
A higher proportion of all men in Malawi compared to women have a basic understanding of HIV according to DHA data from studies in 2004, 2016, and 2018. 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.

Discussion

- HCWs hold 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 systematic and institutional barriers men face when accessing care.

- Beliefs about clients influence HIV care quality and service prioritization.

- Studies within the US have indicated that negative provider perceptions of stigmatizing racial and ethnic minorities results in poorer health outcomes for those populations.

- Male focused interventions may need to incorporate and address negative provider perceptions in order to improve outcomes.

Conclusion

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

Acknowledgements

Collaborating Institutions:
- 1. University of California, Los Angeles David Geffen School of Medicine
- 2. Partners in Hope Medical Center, Livingston, Malawi

Funding:
- This project was supported by the Bill and Melinda Gates Foundation and the UCLA GSSTP

Acknowledgements:
- We gratefully acknowledge the providers who participated in this study.

References
- None provided in the image.
Partner-delivered HIV self-testing increases the perceived acceptability of index partner testing among HIV-positive clients in Malawi

O. Agatha Offorjebe1,2, Frackson Shaba1, Kelvin Balakasi1, Mike Nyirenda1, Risa Hoffman1, Kathryn Dowell1,3 on behalf of EQUIP Innovation for Health

1David Geffen School of Medicine, University of California, Los Angeles; 2School of Medicine, Charles R. Drew University of Medicine and Science; 3Partners in Hope, Lilongwe, Malawi; 4Division 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 (standart 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
➢ Barriers to index partner testing include travel to testing sites, long waiting times, inconvenient testing hours, and concerns about confidentiality and privacy
➢ Oral-based HIV self-testing (OHST) 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
➢ 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.
➢ Feasibility indicator: Outpatients ≥ 15 years
➢ Exit survey questions: Demographic; 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 literate (p-value = 0.001)
➢ Male clients were more likely to be married (49% 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)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Men (%)</th>
<th>Women (%)</th>
<th>p-value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (yr)</td>
<td>35.0 (10-51)</td>
<td>34.1 (17-40)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Literacy (%)</td>
<td>42 (26)</td>
<td>153 (59)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Relationship Status (%)</td>
<td>Married 149 (94)</td>
<td>109 (79)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Married (%)</td>
<td>53 (8)</td>
<td>52 (21)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Marital status</td>
<td>43.3 (5-51)</td>
<td>51.0 (3-60)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Marital status of current sexual partner (%)</td>
<td>Married 3 (33)</td>
<td>13 (12)</td>
<td>0.19</td>
</tr>
<tr>
<td>Diagnosis within the past 12 months (%)</td>
<td>No 31 (31)</td>
<td>33 (32)</td>
<td>0.79</td>
</tr>
<tr>
<td>Diagnosis within 1 yr (%)</td>
<td>3 (33)</td>
<td>208 (88)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>1 (1)</td>
<td>4 (4)</td>
<td>0.51</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Men (%)</th>
<th>Women (%)</th>
<th>p-value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feasible HIVST test kits</td>
<td>147 (92)</td>
<td>218 (88)</td>
<td>0.25</td>
</tr>
<tr>
<td>Partner referral slips</td>
<td>140 (88)</td>
<td>189 (77)</td>
<td>0.007</td>
</tr>
<tr>
<td>Predictive distribution of test kits over partner referral slips</td>
<td>97 (64)</td>
<td>164 (64)</td>
<td>0.90</td>
</tr>
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Table 2. Acceptability and feasibility of index partner HIVST vs. partner referral slips (n=404)

<table>
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<tr>
<th>Characteristic</th>
<th>Men (%)</th>
<th>Women (%)</th>
<th>p-value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comfort delivering HIVST kits did differ by sex (p-value = 0.25)</td>
<td>63% of male and 67% of female clients preferred to deliver HIVST over PRS.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comfort delivering HIVST kits did not differ by sex (p-value = 0.007)</td>
<td>56% of male and 62% of female clients believed their partner would prefer testing with HIVST over PRS.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partner testing with HIVST did not differ by sex (p-value = 0.59)</td>
<td>79% of male and 76% of female clients believed their partner would test using HIVST</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male index clients were more likely to believe their partner would use HIVST compared to females (p-value = 0.007)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

References


Contact: O. Agatha Offorjebe
David Geffen School of Medicine at UCLA
Los Angeles, CA, USA
Email: oofforjebe@mednet.ucla.edu

Collaborating Institutions and Acknowledgements

➢ Funding: This study is funded by the US Agency for International Development (USAID) and the President’s Emergency Plan for AIDS Relief (PEPFAR) under Cooperative Agreement Number U01-AIDSO-00416-15-00737.79% was partially funded by the National Institute of Mental Health (NIMH) through P50MH075726-10 KO 1 and MH44492 support from the UCCL (CSIR grant 2013/09/18) and the UCASR Institute.

➢ Acknowledgements: We are grateful to Sindy Guapa and Alan Schofield for feedback on study design. We are grateful to the teams for assisting with data collection and training, and to the facility staff and clients who participated in the study. NO is also grateful for the support of GisCo health fellowship and the Fogarty International Center.

*Values calculated using independent t-tests

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

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<th>Characteristic</th>
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<td>0.90</td>
</tr>
</tbody>
</table>
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 Daws1,2 and Julie Hubbard1,2

Background

- Harmful gender norms negatively impact on a range of health outcomes for both men and women.1
- Numerous qualitative studies have identified harmful gender norms as a primary barrier to men’s use of HIV treatment services in sub-Saharan Africa.2
- 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.
- It is important since behavioral interventions to improve ART initiation in sub-Saharan Africa are ART-centric—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 3 health facilities in Malawi diagnosed with HIV between July 2018 – December 2017
- Cases: Women (179), Men (153)
- Controls: Women (139), Men (148)
- Key variables included: a domain 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 FPA and belief that men should be the sole decision-maker)
- Unnecessary decision making in the household (OHS)
- Analysis: We use multiple logistic regression models, presenting crude and adjusted odds ratios for each variable of interest. All models are run separately by sex.

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

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Initiator</th>
<th>Non-initiator</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV diagnosis</td>
<td>0.11</td>
<td>0.11</td>
<td>0.11</td>
</tr>
<tr>
<td>Average duration of ART</td>
<td>39.6</td>
<td>39.6</td>
<td>0.11</td>
</tr>
<tr>
<td>Number of visits to clinic</td>
<td>12.6</td>
<td>12.6</td>
<td>0.11</td>
</tr>
<tr>
<td>Women’s role is as caregiver</td>
<td>0.11</td>
<td>0.11</td>
<td>0.11</td>
</tr>
<tr>
<td>Men should be tough and independent</td>
<td>0.11</td>
<td>0.11</td>
<td>0.11</td>
</tr>
<tr>
<td>Acceptance of gender inequality</td>
<td>0.11</td>
<td>0.11</td>
<td>0.11</td>
</tr>
<tr>
<td>Unnecessary decision making</td>
<td>0.11</td>
<td>0.11</td>
<td>0.11</td>
</tr>
</tbody>
</table>

Results: Respondent Characteristics

- We find a nuanced relationship between gender norms, unequal decision-making, and ART initiation
- Among MEN:
  - Men who believe that gender inequality is acceptable (p = 0.01) and that men should be tough and independent (p = 0.02) 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 (p = 0.01)
- Among WOMEN:
  - Women who believe that gender inequality is unacceptable (p = 0.01) and that men should be tough and independent (p = 0.01) are less likely to initiate ART
  - Women who believe women’s primary responsibility is as a caregiver are more likely to initiate ART (p = 0.01)

- 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

References


Affiliations & Acknowledgements

- Partners in Hope, Lilongwe, Malawi
- University of California, Los Angeles, David Geffen School of Medicine, Division of Infectious Diseases, Los Angeles, California
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- Acknowledgements: We gratefully acknowledge the research assistants who collected data and the clients who participated in the study.
A COMMUNITY-BASED INTERVENTION (MEN’S SPACES) TO ENGAGE MEN IN HIV AND SEXUAL HEALTH SERVICES IN MALAWI: A PILOT STUDY


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. ¹
- Preventive health services and education largely focus on women and children with little educational material targeting men and men’s health. ²
- Community HIV testing strategies have been shown to increase male engagement in care.³
- 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 aged 25-40 years (n=20) ⁴
- Focus group discussions with married women (n=3) and Health Advisory Committees in same villages (n=2) ⁵
- 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. ⁶
- 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

Key components for Community Health events recommended by men
- Peer-led Group discussion not classroom lecture
- Men only
- Onsite health services
- Sessions ≤3 hrs

Results
Developing Intervention: Qualitative Data
- Key topics desired by men for Community Health Events
  - Overcoming barriers and challenges to service utilization
  - Strengthening intimate relationships
  - Health seeking behavior facilitating income generation
  - Improving their own sexual health

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 (HVST) was high. Among those who disclosed their test results, 7% were newly HIV-positive and 83% Initiated ART (Fig 1)
- Highly acceptable: 100% of men surveyed (n=75) would attend again

<table>
<thead>
<tr>
<th>Table 1. Participant demographics (n=75)</th>
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<tr>
<td>Demographics</td>
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<tr>
<td>n (%)</td>
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<tr>
<td>Age in years, mean (SD)</td>
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<tr>
<td>Worked for pay in last week (n=75)</td>
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<tr>
<td>&gt;2 partners in past 12 months (n=75)</td>
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<tr>
<td>Never tested or tested&gt;12 months ago</td>
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<th>Table 2. Top recommendations for future activities (n=75)</th>
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<tr>
<td>Top favorite component of the meeting</td>
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<td>It was men only</td>
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<td>I learnt something about my own health</td>
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<tr>
<td>Understanding men’s struggles with health care and what to do</td>
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<tr>
<td>The opportunity to test for HIV</td>
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<tr>
<td>The opportunity to have access to NCD screening services</td>
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<tr>
<td>The most important/valueable thing learned from the meeting</td>
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<tr>
<td>What to do once tested HIV-positive</td>
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<td>Universal treatment and benefits of early initiation</td>
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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 HVST use and linkage among those who reported a positive test.
- Interactive health services 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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References
Resources

- Mind the graph – support for developing poster design and graphics
  - Free for beginner level
  - [https://mindthegraph.com/usecases/poster?gclid=CjwKCAjwz_WGBhA1EiwAUAxlcRZwkMHB4-l-59QmrBVI6OBSEy_U_A55zwJxQJPl18qFZutbunkerVRoC6pwQAyD_BwE](https://mindthegraph.com/usecases/poster?gclid=CjwKCAjwz_WGBhA1EiwAUAxlcRZwkMHB4-l-59QmrBVI6OBSEy_U_A55zwJxQJPl18qFZutbunkerVRoC6pwQAyD_BwE)

- Linkedin tips
  - [https://www.linkedin.com/pulse/10-simple-steps-create-awesome-scientific-poster-van-den-eeckhout](https://www.linkedin.com/pulse/10-simple-steps-create-awesome-scientific-poster-van-den-eeckhout)
  - [https://www.makesigns.com/tutorials/](https://www.makesigns.com/tutorials/)
Delivering Scientific Posters at Conferences
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....