Coverage of Key Populations at the 2012 International AIDS Conference

Findings from a Program Audit and Implications for Leadership in the Global AIDS Response

nswp Global Network of Sex Work Projects
INPUD International Network of People who Use Drugs
Global Action for Trans Equality
harm reduction coalition
Different Aves
center of excellence for transgender health
MSMGF

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This report was jointly produced by the Global Forum on MSM & HIV (MSMGF), Global Action for Trans* Equality (GATE), the Center of Excellence for Transgender Health, the Harm Reduction Coalition, the International Network of People Who Use Drugs (INPUD), Different Avenues, and the Global Network of Sex Work Projects (NSWP).

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Executive Summary

The International AIDS Conference (IAC) is the world's premier AIDS event. The stated goal of the conference is "to promote scientific excellence and inquiry, encourage individual and collective action, foster multisectoral dialogue and constructive debate, and reinforce accountability amongst all stakeholders."

The IAC is especially important for addressing the HIV epidemic among key populations, including gay men and other men who have sex with men (MSM), transgender people, people who inject drugs (PWID), and sex workers. These populations face significantly higher rates of HIV infection compared to the general population in nearly every country around the world, and mounting evidence argues that addressing HIV among key populations is central to ending the global AIDS crisis.

Despite the need for scientific inquiry and a multisectoral response to the epidemic among key populations, research focused on the needs and concerns of these groups has been markedly underrepresented in program content presented at past IACs. In 2010, the Global Forum on MSM & HIV (MSMGF) conducted a systematic review to determine the proportion of abstracts and abstract sessions[i] dedicated to each key population at the 2010 IAC (also known as AIDS 2010). The analysis revealed that only 17% of all abstracts at the conference exclusively focused on MSM, transgender people, PWID, or sex workers. The percentage of all abstract sessions at the conference exclusively focused on each key population was limited to 3% for MSM, 1% for transgender people, 5% for PWID, and 3% for sex workers. These findings were published by the MSMGF in a full-length report, calling on the organizers of the IAC to increase program coverage focused on key populations at the next IAC, AIDS 2012.

To determine whether the organizers of the IAC made any improvements in program coverage of key populations from AIDS 2010 to AIDS 2012, the MSMGF partnered with Global Action for Trans* Equality (GATE), the Center of Excellence for Transgender Health, the Harm Reduction Coalition, the International Network of People Who Use Drugs (INPUD), Different Avenues, and the Global Network of Sex Work Projects (NSWP) to provide an assessment of key population representation in the AIDS 2012 program. This report presents the results of that assessment, featuring a quantitative audit to determine the number and proportion of abstracts dedicated to key populations. Expanding beyond the parameters of the 2010 review, this report also includes qualitative and geographic analyses to identify the topics and countries covered by abstracts exclusively dedicated to MSM, transgender people, PWID, or sex workers at AIDS 2012.

The quantitative audit showed that there was little improvement in program coverage of these populations at AIDS 2012. Once again, only 17% of all abstracts at AIDS 2012 were exclusively focused on MSM, transgender people, PWID, or sex workers. The percentage of all abstract sessions exclusively focused on each key population was limited to 3% for MSM, less than 1% for transgender people, 5% for PWID, and 5% for sex workers.

Only 17% of all abstracts at AIDS 2012 were exclusively focused on MSM, transgender people, PWID, or sex workers.

i An abstract session is composed of 2 or more abstracts or posters put together to create a session.

The qualitative analysis was even more revealing, indicating a significant disconnect between topics represented at the conference and topics that stakeholders working directly with key populations believe are most important to address. More abstracts on key populations focused on individual risk factors than any other topic, outstripping structural factors; primary prevention; surveillance; and testing, care, and treatment. While each global network involved with this report believes that individual risk factors are important to understand, none feels that risk factor research merits such a large proportion of the IAC program at this point in the epidemic.

Additional qualitative analyses revealed that only 14% of abstracts exclusively focused on key populations used community-based research methods, and only 29% focused on interventions to address vulnerabilities; over 70% of abstracts described vulnerabilities without offering any detailed solutions.

Over 70% of abstracts described vulnerabilities without offering any detailed solutions.

Finally, nearly two-thirds of key population-exclusive abstracts were concentrated in 10 countries alone: United States, India, China, Canada, South Africa, Thailand, Mexico, Russia, Nigeria, and Vietnam. Of the remaining 79 countries represented in key population-exclusive abstracts, 32 of them had only 1 abstract on 1 key population. Numerous regions and countries with concentrated epidemics among key populations were either underrepresented at the conference or entirely absent.

Beyond program content, AIDS 2012 was held in the United States, a country whose visa laws effectively blocked many PWID and sex workers based in countries outside of the United States from attending the conference at all. Transgender advocates also expressed concern that strict US visa laws prevented the attendance of transgender participants from outside the United States due to issues concerning gender and identification documents. Not only did this prevent a significant number of frontline stakeholders serving these hard-hit populations from gaining the benefits of participation in the conference, it also resulted in the absence of key PWID, sex worker, and transgender stakeholders in numerous influential dialogues that took place on site. Without the strong participation of these respected PWID, sex worker, and transgender advocates, the IAC's content, meetings, and outcomes skew away from realistic understandings of key population needs and the prioritization of effective interventions to address them.

These findings beg the question of whether the IAC really does offer an adequate "chance to assess where we are, evaluate recent scientific developments, and collectively chart a course forward"[ii] to address HIV epidemics among these 4 key populations. In the conference's current form, the answer is no.

The lack of appropriate coverage of these 4 key populations at the world's premier AIDS event is as much a reflection of the current state of inequitable global funding and support for research on key populations as it is a reflection of the IAC's processes that reinforce these inequities. As a world leader in the promotion and dissemination of the latest research on HIV and AIDS, the IAC is uniquely positioned to guide the field toward a more appropriate, equitable, and evidence-based approach to the urgent epidemics among key populations.

By taking several concrete steps, the IAC's organizers can update the conference's processes to: A) increase the number and quality of abstracts on key populations that are submitted to the conference; and B) ensure that quality abstracts submitted on key populations

ii The overarching goal of the International AIDS Conference as stated by conference organizers on the AIDS 2012 website: http://www.aids2012.org/Default.aspx?pageId=369.

are not rejected from inclusion in the conference. This will enhance the relevance of the conference to key populations, leveraging the IAC's high added value to strengthen the response to HIV among MSM, transgender people, PWID, and sex workers.

Recommendations

1. **Community Consultations**
    a. Conduct community consultations with each key population to determine program topics that would be most valuable to community members, advocates, and service providers working with key populations in the lead-up to AIDS 2014.

2. **Targeted Call for Abstracts**
    a. Use the results from the community consultations to inform the conference's call for abstracts, explicitly stating that the topics identified through community consultations will be prioritized for acceptance.
    b. Explicitly encourage abstracts that are developed using a community-based approach.

3. **Match Abstracts with Reviewers Based on Expertise**
    a. Develop a system for matching abstracts on key populations with reviewers who have expertise on the population and related issues in question.
    b. Ensure reviewers have a strong understanding of the nature and value of community-based research and programming.

4. **Advocate for Better Funding and Support for Research on Key Populations**
    a. As a leader in the field, the IAC and the International AIDS Society (IAS) that organizes it are well positioned to advocate with large funders and research institutions for more appropriate funding and support for research on key populations that responds to community needs.

5. **Increase Conference Accessibility for Key Populations**
    a. Choose a location that is accessible to MSM, transgender people, PWID, sex workers, and people living with HIV to encourage more balanced program content and conference deliberations.
    b. Create a scholarship fund to support the attendance of key population leaders, helping to ensure they gain the full range of benefits of participation in the conference and that the voices of key populations are represented at influential dialogues on site.

The IAC presents a unique and powerful opportunity to impact the global HIV epidemic by promoting exchange of the most up-to-date research and implementation practices, as well as influencing the industry's discourse, funding priorities, and locus of scientific inquiry. By adopting these measures, the IAC will greatly enhance its relevance to key populations worldwide. This will not only foster the development of more effective strategies to address the needs of key populations, it will also bring the global AIDS response closer to developing the comprehensive approaches we need to end the epidemic.

The IAC is uniquely positioned to guide the field toward a more appropriate, equitable, and evidence-based approach to the urgent epidemics among key populations.

Context

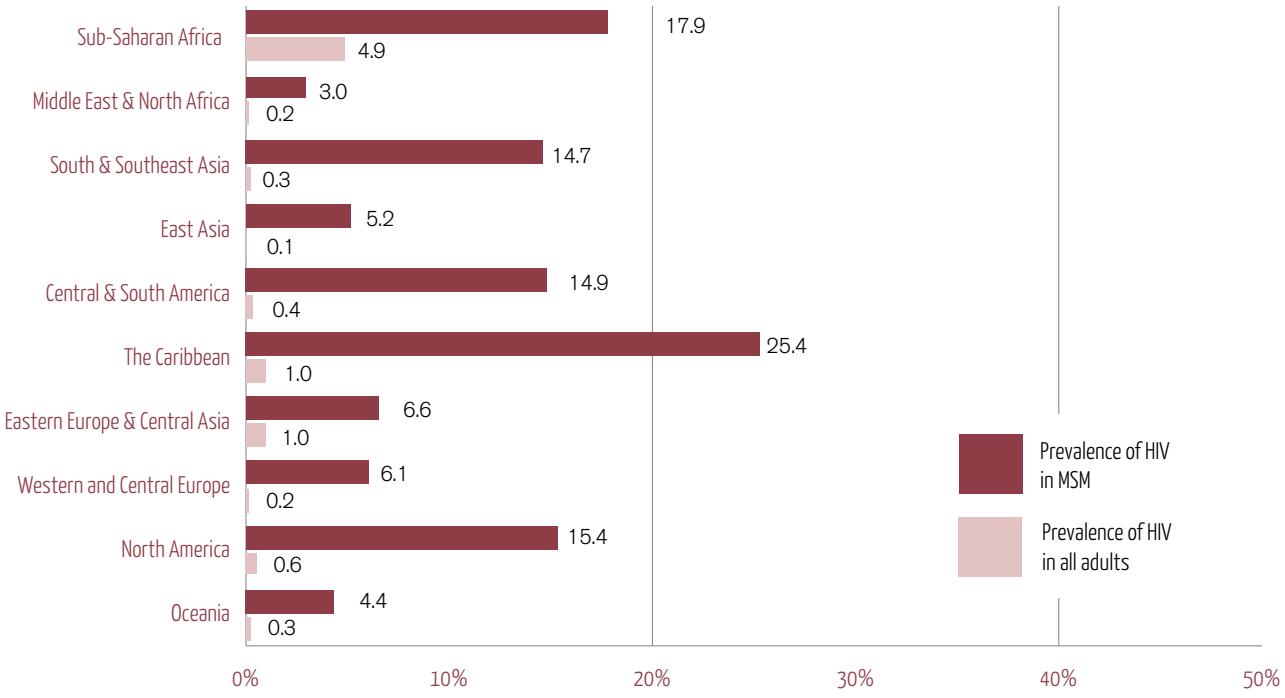
Epidemiological evidence indicates that MSM, transgender people, PWID, and sex workers are at higher risk for HIV infection than the general population in nearly every country around the world. These groups are defined as "key populations" because they are both key to the epidemic's dynamics and key to the response.[2]

Despite the centrality of these populations to the HIV epidemic, HIV services and harm reduction programs targeting key populations are grossly under-resourced. Failure to address HIV among key populations continues to undermine the response to HIV at national and international levels.

Men Who Have Sex with Men

Around the world, MSM are at significantly greater risk of acquiring HIV than the general population. This is the case in high-income countries like the United States, which hosted the 2012 International AIDS Conference, where MSM accounted for 63% of all new infections in 2010.[3] It is also the case in low- and middle-income countries, where MSM are on average 19 times more likely to be infected with HIV than members of the general population.[4]

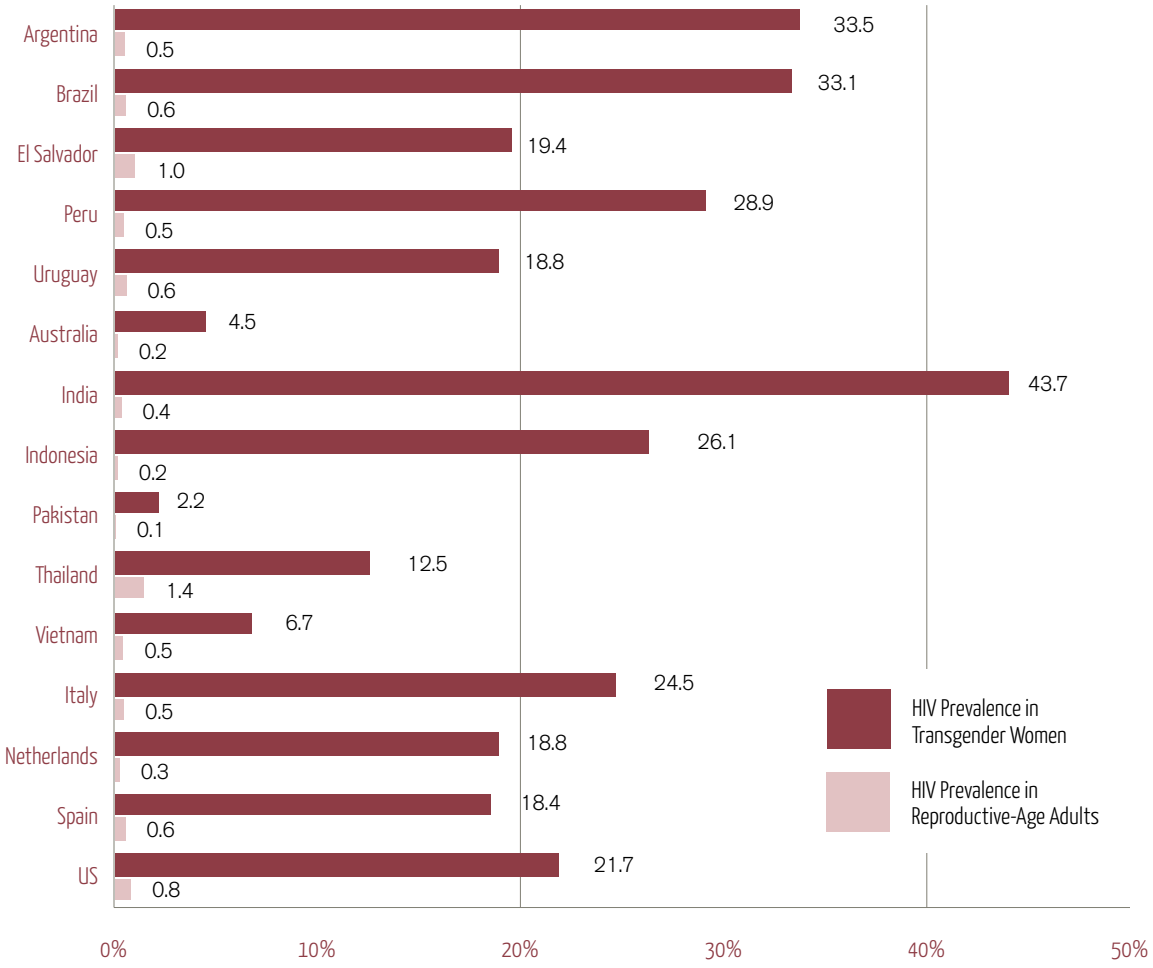
Figure 1. HIV Prevalence for MSM Compared to the General Population as Reported by UNAIDS in 2011[5, 6]



Transgender People

Despite a comparative lack of data on HIV among transgender populations globally, a systematic review and meta-analysis of transgender women in 10 low- and middle-income countries and 5 high-income countries found a pooled HIV prevalence of 19%. The study found that transgender women in these 15 countries were on average 49 times more likely to be infected with HIV than the general population.[7]

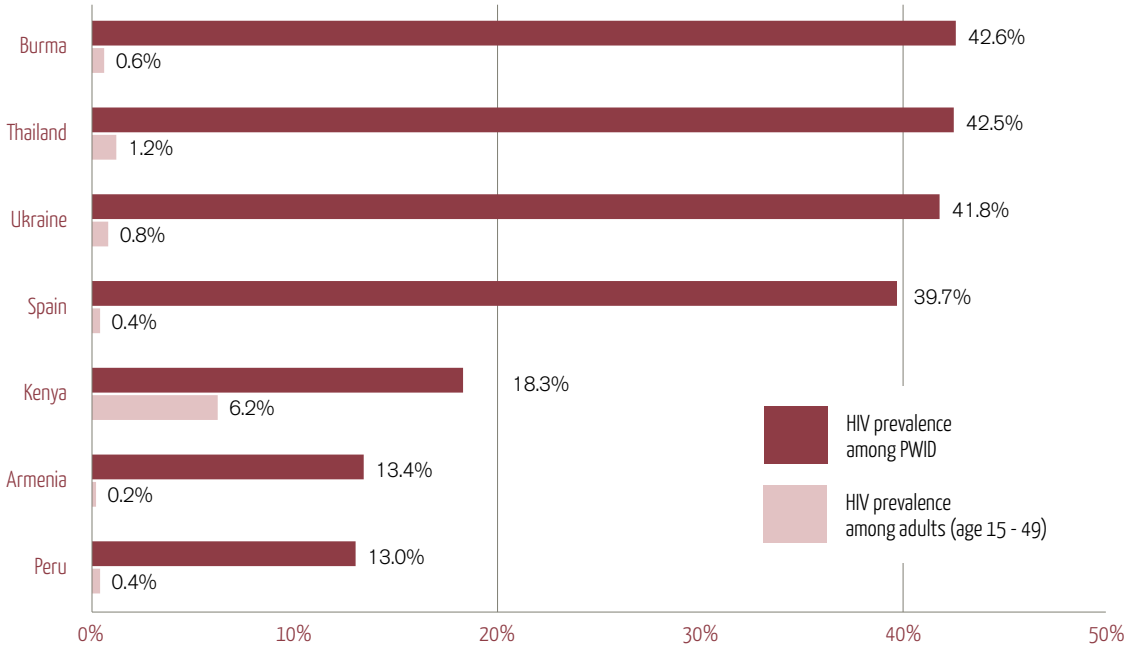
Figure 2. HIV Prevalence for Transgender Women Compared to the General Population[7]



People Who Inject Drugs

It is estimated that there are approximately 16 million people who inject drugs globally, 3 million of whom are living with HIV.[8] Outside of Sub-Saharan Africa, 1 in 3 new HIV cases occur in PWID.[9] HIV prevalence among PWID has been documented above 40% in 9 different countries.[10] In parts of Eastern Europe and Central Asia, over 80% of all HIV infections are attributed to injection drug use.[8] As many as two-thirds of PWID are co-infected with Hepatitis C, which alongside tuberculosis and drug overdose is a leading cause of death among PWID in many countries.[11, 12, 13]

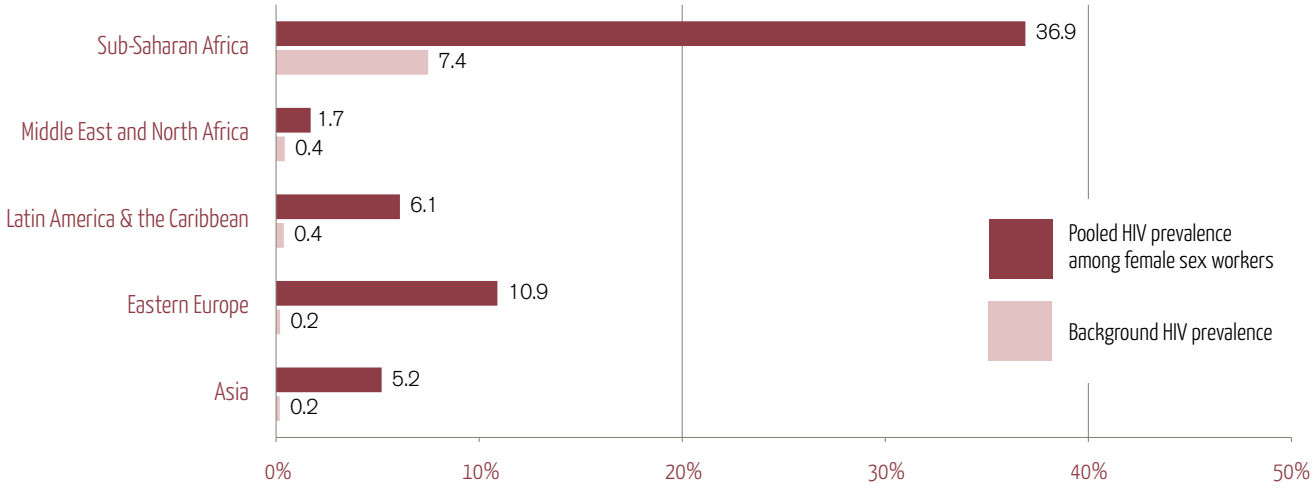
Figure 3. HIV Prevalence for People Who Inject Drugs Compared to the General Population as Reported by UNAIDS in 2011, Selected Countries[10, 14]



Sex Workers

A recent review of HIV burden among female sex workers in low- and middle-income countries showed that overall HIV prevalence was 12%. Representing nearly 100,000 sex workers in 50 countries, the study showed that, on average, sex workers in these countries are 14 times more likely to be infected with HIV than the general population. In 26 countries with medium and high background HIV prevalence, sex workers had an overall HIV prevalence of 31% and were 12 times more likely to be infected with HIV than the general population.[15]

Figure 4. HIV Prevalence for Female Sex Workers Compared to the General Population[15]



Key Populations and the International AIDS Conference

Members of these populations are among those most severely impacted by the global HIV epidemic. The principles of public health and human rights dictate that HIV-focused institutions devote equitable resources to addressing these epidemics and their underlying causes.[16, 17] Beyond benefiting members of these groups themselves, research has shown that addressing HIV among key populations has the potential to impact the trajectory of national epidemics, greatly reducing infection rates among the general population as well.[18]

The history of the global AIDS response has been characterized by broad-scale denial of issues concerning key populations, with governments and international institutions often ignoring the role of key populations because it requires addressing issues that are politically or socially challenging. In recent years, increased recognition of the importance of key populations has been accompanied by progress within some global institutions, including PEPFAR's MSM Guidance, the Global Fund's Strategy in Relation to Sexual Orientation and Gender Identity (SOGI Strategy), and the World Health Organization's guidance documents on key populations. However, many current efforts to address HIV among key populations remain tokenistic, limited in scale, based on fundamental misunderstandings, or developed with a lack of respect for the agency of key populations.

Winning the global fight against AIDS will require explicitly and sensitively addressing HIV among key populations—including the issues that underpin increased vulnerability among these communities.

The International AIDS Conference represents an unparalleled opportunity to influence the course of international funding, research, and policy agendas to meet the needs of communities most affected by HIV. The organizers of the International AIDS Conference correctly describe the event as "the premier gathering for those working in the field of HIV, as well as policy makers, persons living with HIV and other individuals committed to ending the pandemic. It is a chance to assess where we are, evaluate recent scientific developments and lessons learnt, and collectively chart a course forward."[19]

With the increasing recognition of the disproportionate impact of HIV on key populations and a greater understanding of the pivotal role played by key populations in the global epidemic, it is incumbent upon the International AIDS Conference to achieve its stated objectives when it comes to MSM, transgender people, PWID, and sex workers. The IAC's organizers and other global institutions must lead the field toward a more appropriate and effective approach to HIV among key populations. Our collective victory over AIDS depends on it.

The Anatomy of the International AIDS Conference

Content presented at the IAC is divided into abstracts, abstract sessions, non-abstract driven sessions, activities, and workshops. Abstracts and abstract sessions represent the vast majority of content presented at the IAC. The question at the heart of this report is whether or not issues concerning key populations are adequately addressed in the IAC program. As such, an understanding of the IAC's content selection systems is central to this analysis.

How Content is Selected

As the highest governing body of the IAC, the Conference Coordinating Committee (CCC) takes ultimate responsibility for conference policies, priorities, and programming. The CCC is also responsible for selecting the people who serve on the IAC's 3 program committees, which are responsible for determining the content of the conference: the Scientific Program Committee, the Leadership & Accountability Program Committee, and the Community Program Committee.[20]

- **The Scientific Program Committee** is responsible for final selection of all abstracts that will be included in the conference.[21] The stated goal of the Scientific Program Committee is to provide "a dynamic, interactive forum for the presentation, debate and validation of the latest, state-of-the-art research, policy and programme evidence that will inform and guide the global response."[22]
- **The Leadership & Accountability Program Committee** is tasked with "engaging new, non-traditional and existing leaders, for rapid and measurable progress against HIV," and works to "identify, address and debate political, legal, financial, scientific, social and institutional challenges and solutions."[23]
- **The Community Program Committee** aims to foster meaningful involvement of communities affected by HIV to address "the economic and political relevance of stopping HIV and AIDS; the linkages with other pressing social issues; increasing access to integrated HIV prevention, care and support, health, and treatment services based on the best science and practice in public health; and achieving an equitable access to resources to bring proven practice to scale for the most impacted groups." [24]

Abstracts

Anyone working in the field of HIV can submit an abstract for potential inclusion in the IAC. Authors who wish to submit abstracts for consideration are required to place them in 1 of the following 5 tracks: Basic Science; Clinical Science; Epidemiology and Prevention Science; Social Science, Human Rights and Political Science; and Implementation Science, Health Systems and Economics. Each track has a Track Committee that helps plan and finalize that track's program content.

Abstracts are selected for inclusion in the conference through a combination of peer review and decisions made by the Scientific Program Committee and the Track Committees. At AIDS 2012, abstracts were reviewed and scored by 1358 external peer reviewers from 94 nations using a blind peer-reviewed process. Each abstract was scored by at least 3 reviewers.[25] After initial scoring, 40 members of the Scientific Program Committee and the Track Committees met to review the highest-scoring abstracts, select abstracts for inclusion in the program, and create 65 oral abstract sessions and 40 oral poster discussion sessions.[21]

Each oral abstract session and oral poster discussion session is composed of several oral abstracts or oral poster discussion abstracts, respectively. Abstracts selected for presentation in oral abstract sessions or oral poster discussion sessions are among the highest-scoring abstracts and receive the highest visibility at the conference; the remaining abstracts are exhibited among thousands of other posters in large exhibition halls.

At AIDS 2012, each category had the following number of abstracts:

- Oral Abstracts (n=379)
    - Oral Abstract Sessions[iii] (n=65)
- Oral Posters (n=254)
    - Oral Poster Discussion Sessions[iv] (n=40)
- Posters Exhibitions (n=3590)[26]

Other Program Content

The conference also features content that is not submitted and approved through the abstract review process. This includes non-abstract driven sessions, which are developed by all 3 program committees. Non-abstract driven sessions are divided into 3 categories: symposia sessions (speeches that address a single, defined issue), bridging sessions (multidisciplinary dialogues), and special sessions (60-minute lunchtime feature presentations by key leaders).[27]

Additional program content also includes capacity-building workshops,[28] plenary sessions,[29] global village sessions,[30] and independently produced satellites that are approved for official affiliation with the conference.[31]

iii An Oral Abstract Session is composed of 2 or more oral abstracts put together to create a session.
iv An Oral Poster Discussion Session is composed of 2 or more oral posters put together to create a session.

Methods

In order to determine the extent to which AIDS 2012 addressed issues concerning MSM, transgender people, PWID, and sex workers, a consortium of advocacy organizations focused on these key populations conducted an audit of content presented at the conference. The consortium included the MSMGF, Global Action for Trans* Equality (GATE), the Center of Excellence for Transgender Health, the Harm Reduction Coalition, the International Network of People Who Use Drugs (INPUD), Different Avenues, and the Global Network of Sex Work Projects (NSWP). Beyond quantifying the number of abstracts presented, the content of abstracts was also examined to assess relevance and value to addressing HIV among each key population of focus.

Quantitative Audit

The quantitative audit was conducted by counting the number of abstracts and abstract sessions at the conference focused on each key population, respectively. Abstracts on key populations were identified through a systematic review of the AIDS 2012 program, available online at http://pag.aids2012.org. Four different sets of keywords were used to search the AIDS 2012 program for abstracts focused on each of the 4 key populations; keyword lists for each population are available in Appendix A. All abstracts identified through the keyword searches were reviewed for relevance, and only abstracts that explicitly focused on 1 or more of the 4 key populations were included in this audit.

Abstracts and abstract sessions that focused exclusively on 1 key population were counted separately from abstracts that focused on more than 1 key population. For example, if an abstract examined a prevention program designed for sex workers and no other population, it would be counted toward the total number of sex worker-exclusive abstracts. If an abstract examined risk factors for sex workers and MSM, it would be counted as a non-exclusive abstract and added once toward the total count of non-exclusive sex worker abstracts and once toward the total count of non-exclusive MSM abstracts. If an abstract examined violence among male sex workers who have sex with men, it would be counted once toward the total number of MSM-exclusive abstracts and once toward the total number of sex worker-exclusive abstracts. An abstract session was considered exclusive if all abstracts included in the session were focused on the same key population.

Qualitative Analysis

While the quantitative audit included both exclusive and non-exclusive abstracts, the qualitative analysis was only conducted on abstracts that focused exclusively on 1 of the 4 key populations.

Each population-exclusive abstract was analyzed to identify themes and regions addressed, which were then compared to current priority areas identified by each respective global advocacy organization. After reading all exclusive abstracts across each target

population, 5 discrete content categories were identified:

- Surveillance
- Individual-Level Risk Factors
- Primary Prevention
- Testing, Treatment, and Care
- Structural Factors

Most abstracts focused primarily on 1 category, while information concerning other categories took a secondary position. In these cases, we placed the abstract in the category that reflected its primary focus. For example, an abstract that focuses on stigma and its consequences would be counted under "Structural Factors," even if 1 of the consequences was increased individual risk behaviors. In cases where an abstract gave equal weight to information from 2 different categories, it was counted once toward each.

Each global network organization felt strongly that community-based abstracts and abstracts focused on interventions would be highly valuable to key population advocates and service providers. Therefore, in addition to coding all exclusive abstracts using the 5 overarching content categories, we also quantified: A) abstracts that explicitly employed community-based methods; and B) abstracts that described interventions for addressing vulnerabilities rather than simply describing vulnerabilities without offering detailed solutions.

Descriptions of the criteria we used to categorize the population-exclusive abstracts in the qualitative analysis are available in Appendix B.

Geographic Analysis

The key population-exclusive abstracts also underwent a geographic analysis to identify the regions and countries of focus. Abstracts that focused on more than one region were counted once under each region of focus, and abstracts that focused on more than one country were counted once under each country of focus. A catalogue of countries and the regional classifications used for this report is available in Appendix C.

Exclusive vs. Non-Exclusive: Why It Matters

Historically, the global AIDS response has largely failed to employ strategies that explicitly include key populations. Instead of addressing key populations directly, many leaders have relied on research, prevention, and treatment initiatives designed for the general population to meet the needs of key populations. After 30 years of this approach, HIV incidence and prevalence among key populations continue to soar far above those of general populations, while levels of service access remain unacceptably low. It is clear that this strategy does not work. Key populations must be addressed directly, explicitly, and with a great degree of sensitivity if research, programs, and services are to be effective.

While MSM, transgender people, PWID, and sex workers all face stigma and discrimination, their respective vulnerabilities to HIV are often rooted in different structural barriers, psychosocial systems, power dynamics, and historical contexts. This necessitates the development of research initiatives and programs tailored to the unique needs of each population. For this reason, the qualitative analysis in this report focused on exclusive abstracts only.

Results

The results of both the quantitative audits and the qualitative analyses are presented in the following section. The section begins with results for all key populations combined, followed by an in-depth look at each key population individually.

All Key Populations

The percentage of all abstracts at AIDS 2012 devoted exclusively to MSM, transgender people, PWID, or sex workers was 17% (n=732). The percentage of abstract sessions at AIDS 2012 devoted exclusively to any of these populations was 13% (n=14).

Some key populations were much better represented than others. The percentage of abstracts at the conference exclusively dedicated to MSM was 8% (n=329), while the percentage of abstracts exclusively dedicated to transgender people was less than 1% (n=31).

Figure 5. Total Number of Abstracts Compared to Total Number of Key Population-exclusive Abstracts

All Abstracts	All	Exclusively Key Pop.
Oral Abstracts	379	71
Oral Poster Discussion	254	37
Poster Exhibition	3590	624
Total	***4223***	***732***

Abstract Sessions	All	Exclusively Key Pop.
Oral Abstract Sessions	65	9
Oral Poster Discussion Session	40	5
Total	***105***	***14***

By far, more key population-exclusive abstracts focused on individual risk factors than any other theme used in this analysis. The vast majority of key population-exclusive abstracts were not community-based, and comparatively few contained detailed information on interventions.

Figure 6. Thematic Breakdown of All Key Population-exclusive Abstracts

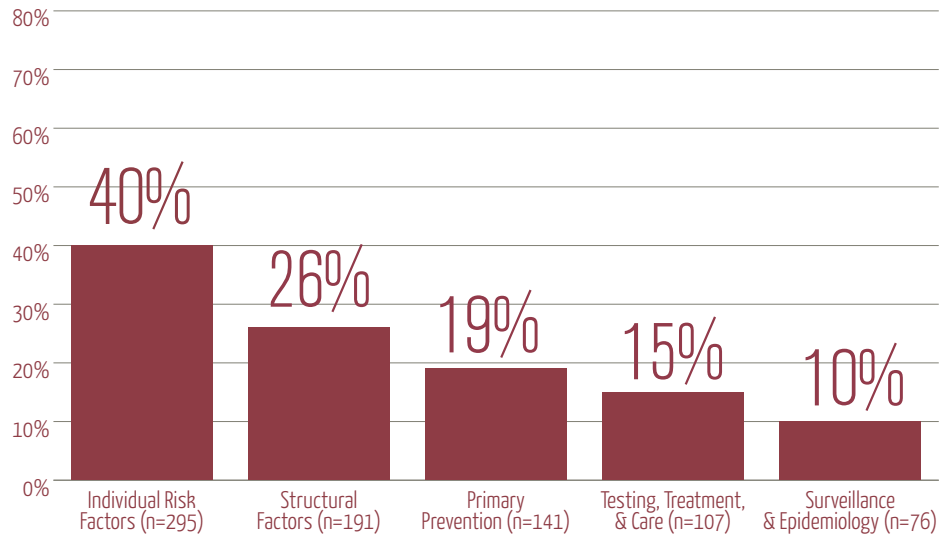


Figure 7. Representation of Community-Based Abstracts and Abstracts on Interventions, All Key Populations

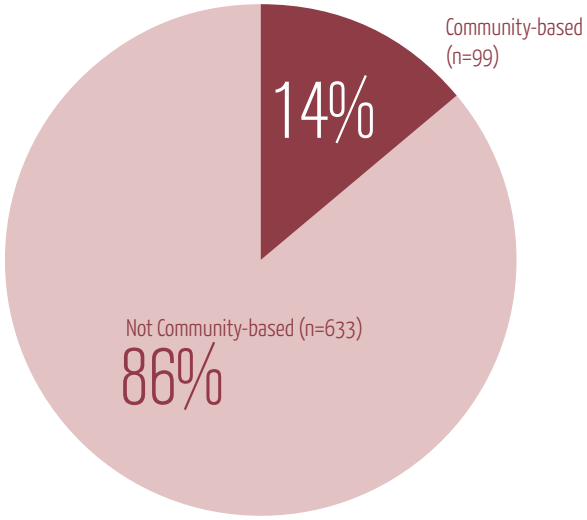
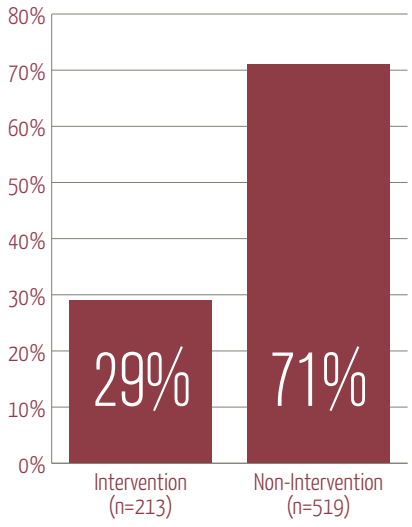
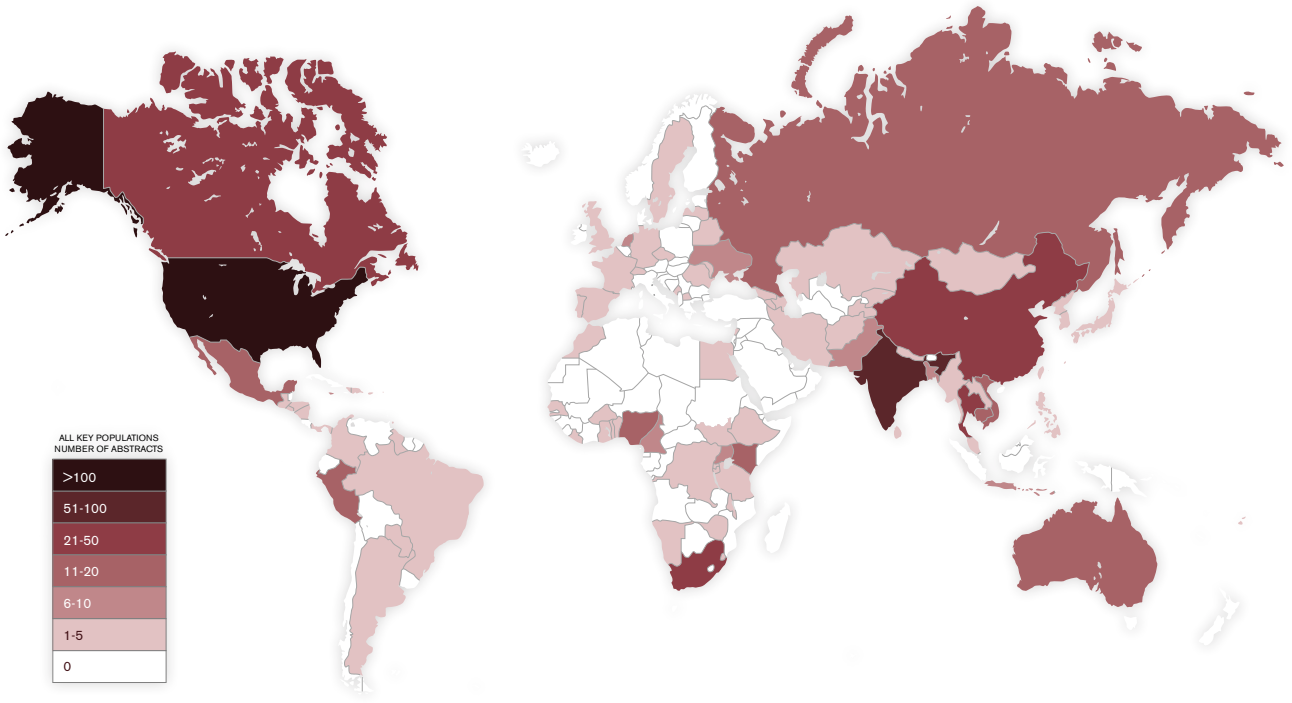


Figure 8: Representation of Abstracts on Interventions, All Key Populations



Of the 732 abstracts exclusively focused on any key population, nearly two-thirds (n=467) were concentrated in 10 countries alone: the United States (n=213), India (n=63), China (n=45), Canada (n=31), South Africa (n=25), Thailand (n=25), Mexico (n=18), Russia (n=17), Nigeria (n=15), and Vietnam (n=15).. Of the remaining 79 countries that had any exclusive abstracts on a key population, 32 of them only had 1 abstract on 1 key population. Numerous regions and countries with concentrated epidemics among key populations were either underrepresented at the conference or entirely absent.

Figure 9. Number of Exclusive Abstracts on Any Key Population by Country



Afghanistan 2	Colombia 3	Honduras 4	Malawi 3	Peru 11	Sweden 1
Argentina 1	Czech Republic 1	India 63	Malaysia 5	Philippines 3	Switzerland 5
Armenia 1	Dominican Republic 4	Indonesia 9	Mexico 18	Portugal 5	Taiwan 4
Australia 11	DRC 2	Iran 1	Moldova 1	Puerto Rico 1	Tajikistan 1
Azerbaijan 1	Egypt 3	Jamaica 6	Mongolia 1	Romania 1	Tanzania 5
Bangladesh 7	El Salvador 2	Japan 1	Morocco 3	Russia 17	Thailand 25
Belarus 2	Ethiopia 1	Kazakhstan 4	Myanmar 1	Rwanda 2	Togo 1
Benin 1	Fiji 1	Kenya 14	Namibia 3	Senegal 4	Trinidad & Tobago 1
Brazil 5	France 5	Korea 1	Nepal 1	Serbia 2	Uganda 7
Burkina Faso 1	Georgia 2	Kyrgyzstan 2	Netherlands 8	South Africa 25	UK 4
Burundi 2	Germany 1	Laos 1	Nicaragua 3	South Sudan 1	Ukraine 7
Cambodia 11	Ghana 5	Latvia 1	Nigeria 15	Spain 2	US 213
Cameroon 8	Guatemala 5	Lebanon 1	Pakistan 7	Sri Lanka 1	Vietnam 15
Canada 31	Guyana 2	Liberia 1	Panama 1	St. Martin 1	Zimbabwe 3
China 45	Haiti 2	Macedonia 1	Paraguay 1	Swaziland 2	

Men Who Have Sex with Men

Quantitative Audit

The percentage of all abstracts at the conference focused exclusively on MSM, including less visible poster exhibitions, was 8%. The percentage of abstract sessions focused exclusively on MSM was 3%.

Figure 10. Total Number of Abstracts Compared to Total Number of MSM Abstracts

All Abstracts	All	MSM-exclusive	MSM Non-exclusive
Oral Abstracts	379	28	19
Oral Poster Discussion	254	14	17
Poster Exhibition	3590	287	225
Total	***4223***	***329***	***261***

Abstract Sessions	All	MSM-exclusive	MSM Non-exclusive
Oral Abstract Sessions	65	2	21
Oral Poster Discussion Session	40	1	14
Total	***105***	***3***	***35***

Overall, this represents little improvement over MSM program coverage at AIDS 2010, where the percentages of total MSM-exclusive abstracts and MSM-exclusive abstract sessions were 7% and 3%, respectively.

Qualitative Analysis

The number of abstracts that focused on the 5 overarching themes used in this analysis is indicated in Figure 11, represented as a percentage of 329 (the total number of MSM-exclusive abstracts at the conference). Of all 329 MSM-exclusive abstracts, 31 gave equal weight to 2 different themes and were counted once under each theme. Four MSM-exclusive abstracts were focused only on research methods and thus were not counted under any category.

More MSM-exclusive abstracts at AIDS 2012 focused on identifying and describing individual risk factors than on any other theme. These abstracts focused on a wide variety of risk factors and vulnerabilities, including sexual networks, drug use, transactional sex, relationship status, rates of STI infection, perceived risk, and mental health. Only 13% of these abstracts used community-based methods, and only 26% included detailed information about interventions.

Figure 11. Thematic Breakdown for MSM-exclusive Abstracts

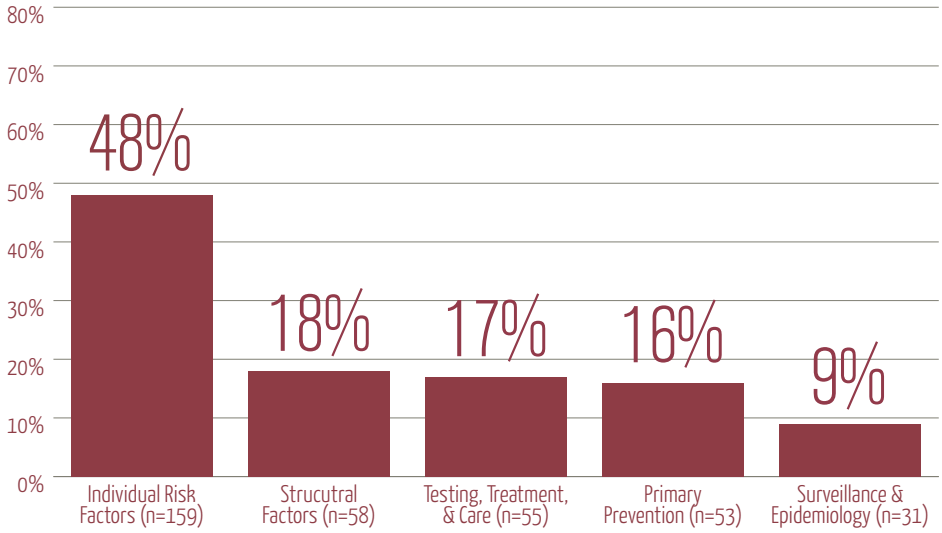


Figure 12. Representation of Community-Based Abstracts, MSM-exclusive Abstracts

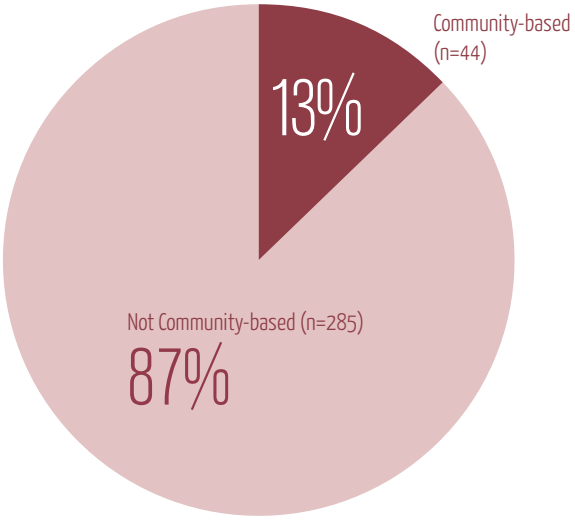
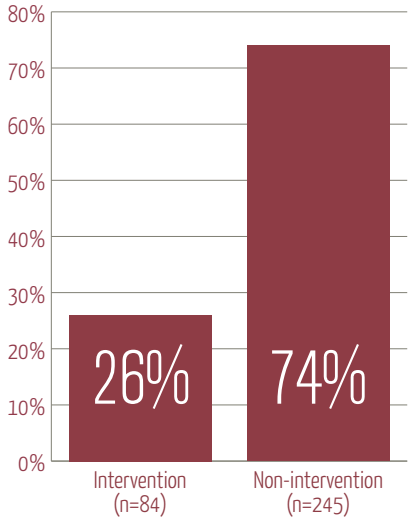


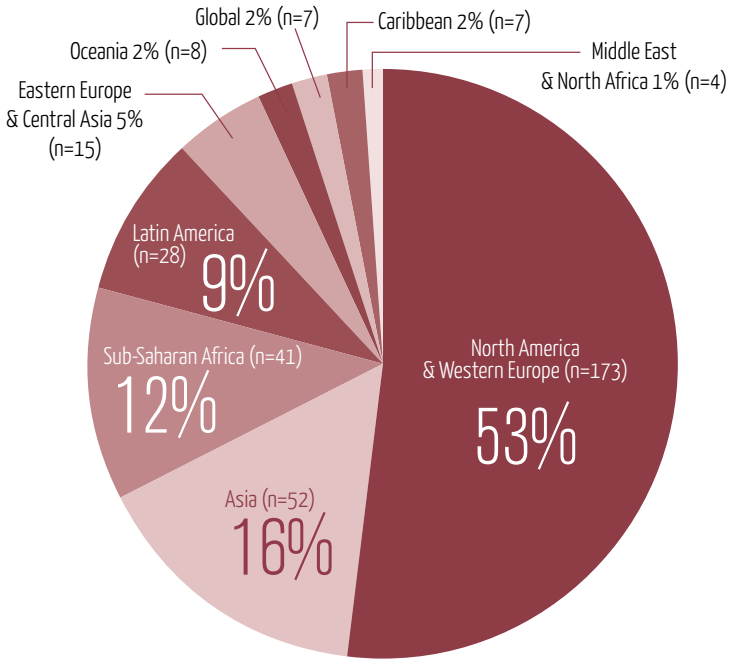
Figure 13. Representation of Abstracts on Interventions, MSM-exclusive Abstracts



Geographic Analysis

The number of MSM-exclusive abstracts that focused on countries in each major world region is indicated in Figure 14, represented as a percentage of the total number of MSM-exclusive abstracts at the conference. Of all 329 MSM-exclusive abstracts, 6 covered countries in more than 1 region and were counted once under each region accordingly.

Figure 14. Regional Breakdown for MSM-exclusive Abstracts

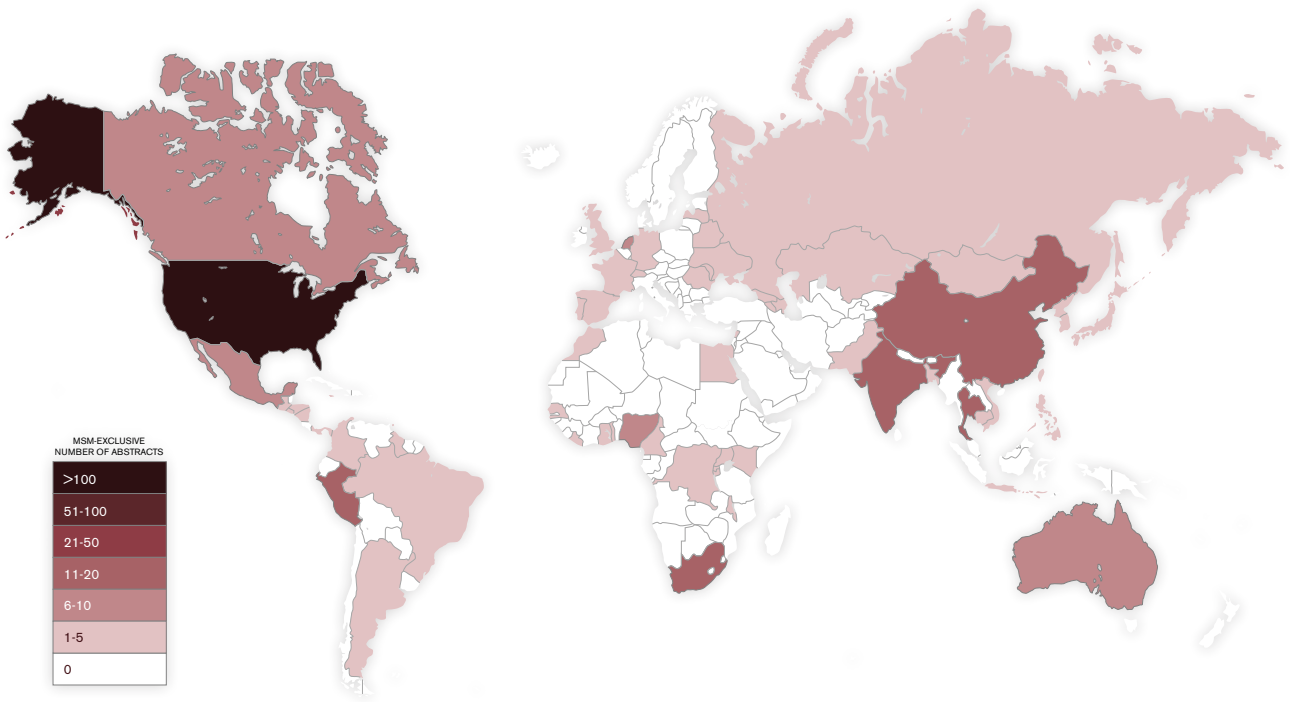


More than half of all MSM-exclusive abstracts were dedicated to North America and Western Europe, while several regions with significant HIV epidemics among MSM were left underrepresented, including Eastern Europe and Central Asia (EECA) and the Caribbean. All abstracts from Oceania focused on Australia, with no MSM-exclusive abstracts from the Pacific Islands included in the conference program.

Within regions, there was great disparity in country coverage. A total of 62 countries were represented in MSM-exclusive abstracts. Roughly two-thirds of all MSM-exclusive abstracts were focused on 1 of 6 countries: the United States (n= 144), South Africa (n=15), China (n=15), India (n=14), Peru (n=11), and Thailand (n=11). Fifteen abstracts were focused globally or regionally and mentioned no specific countries. Six abstracts focused on more than 1 country, with a total of 20 countries represented in these abstracts (ranging from 2-6 countries per abstract). Abstracts that focused on more than 1 country were counted once under each country represented.

Most countries represented had 1 or 2 abstracts only, and many countries that have documented high HIV prevalence rates among MSM had no abstracts at all. These include Bolivia, Botswana, Uruguay, Ecuador, Namibia, Tanzania, Serbia, and Poland, with HIV prevalence among MSM in these countries ranging from 5% to 21%.[32]

Figure 15. Number of MSM-exclusive Abstracts by Country



Argentina....1	China....15	Honduras....2	Malawi....3	Philippines....1	Togo....1
Armenia....1	Colombia....3	India....14	Mexico....6	Portugal....1	Trinidad & Tobago....1
Australia....8	DRC....1	Indonesia....4	Moldova....1	Romania....1	Uganda....2
Azerbaijan....1	Egypt....1	Jamaica....4	Mongolia....1	Russia....4	UK....4
Bangladesh....1	El Salvador....2	Japan....1	Morocco....2	Rwanda....1	Ukraine....1
Belarus....1	France....2	Kazakhstan....2	Netherlands....6	Senegal....1	US....144
Brazil....3	Georgia....1	Kenya....3	Nicaragua....2	South Africa....15	Vietnam....1
Burundi....1	Germany....1	Korea....1	Nigeria....7	Spain....1	
Cambodia....1	Ghana....1	Latvia....1	Pakistan....1	Switzerland....2	
Cameroon....4	Guatemala....3	Lebanon....1	Panama....1	Taiwan....2	
Canada....6	Guyana....1	Liberia....1	Peru....11	Thailand....11	

Transgender People

Quantitative Audit

The percentage of all abstracts at the conference focused exclusively on transgender people, including less visible poster exhibitions, was less than 1% (n=31). The percentage of abstract sessions focused exclusively on transgender people was also less than 1% (n=1).

Figure 16. Total Number of Abstracts Compared to Total Number of Transgender Abstracts

All Abstracts	All	Trans-exclusive	Trans Non-exclusive
Oral Abstracts	379	2	7
Oral Poster Discussion	254	4	5
Poster Exhibition	3590	25	106
Total	***4223***	***31***	***118***

Abstract Sessions	All	Trans-exclusive	Trans Non-exclusive
Oral Abstract Sessions	65	0	8
Oral Poster Discussion Session	40	1	5
Total	***105***	***1***	***13***

Overall, this represents little improvement over transgender program coverage at AIDS 2010, where the percentages of total transgender-exclusive abstracts and transgender-exclusive abstract sessions were less than 1% (n=32) and 1%, respectively.

Qualitative Analysis

The number of abstracts that focused on the 5 overarching themes used in this analysis is indicated in Figure 17, represented as a percentage of 31 (the total number of transgender-exclusive abstracts at the conference).

More abstracts focused on structural factors than any other theme (n=16). These abstracts focused on a variety of structural risk factors, such as stigma, discrimination, violence, housing status, and legal barriers. Only 19% of transgender-exclusive abstracts used community-based methods, and only 39% included detailed information about interventions.

Figure 17: Thematic Breakdown for Transgender-exclusive Abstracts

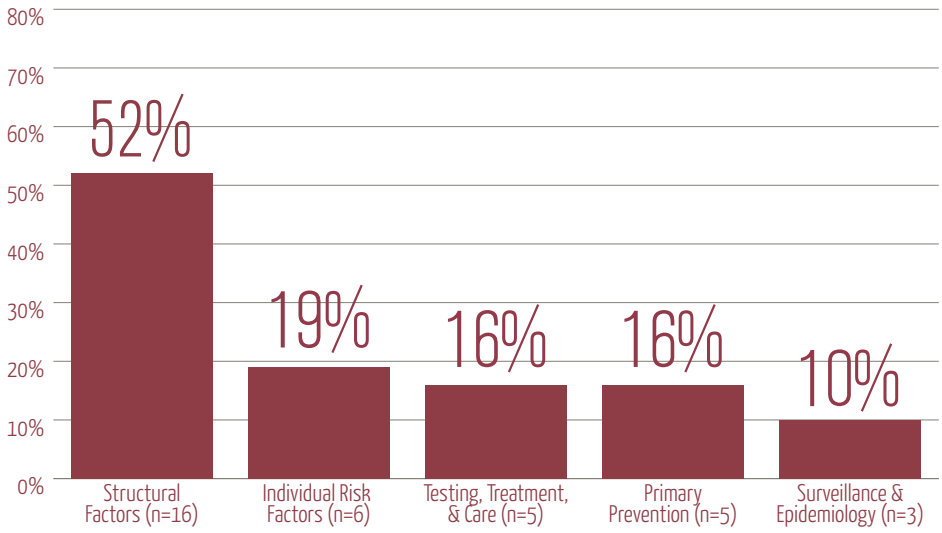


Figure 18. Representation of Community-Based Abstracts, Transgender-exclusive Abstracts

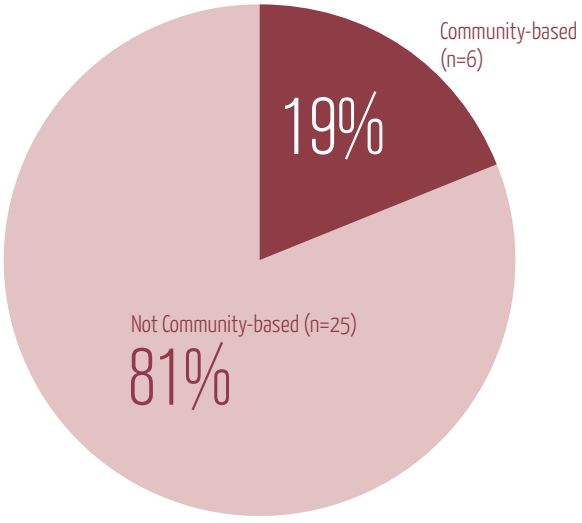
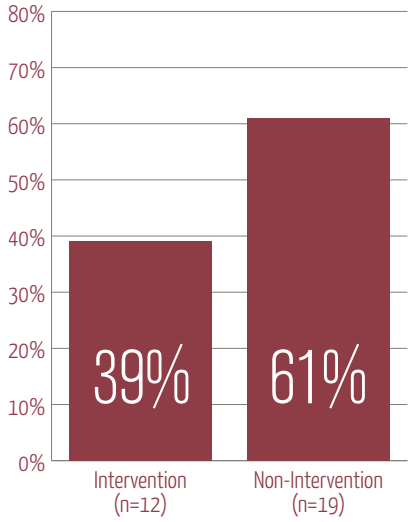


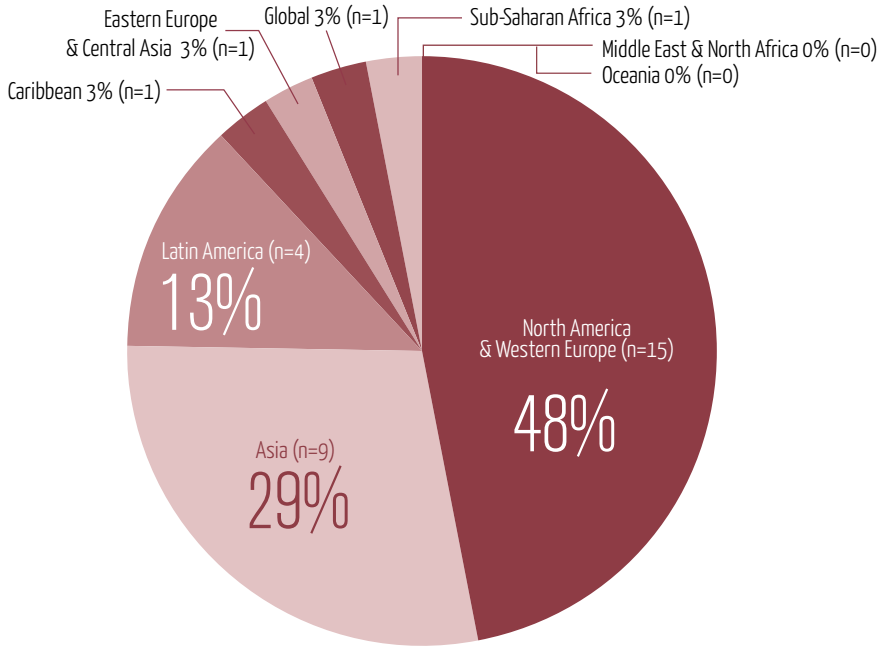
Figure 19. Representation of Abstracts on Interventions, Transgender-exclusive Abstracts



Geographic Analysis

The number of transgender-exclusive abstracts that focused on countries in each major world region is indicated in Figure 20, represented as a percentage of the total number of transgender-exclusive abstracts at the conference. Of all 31 transgender-exclusive abstracts, 1 covered countries in more than 1 region and was counted once under each region accordingly.

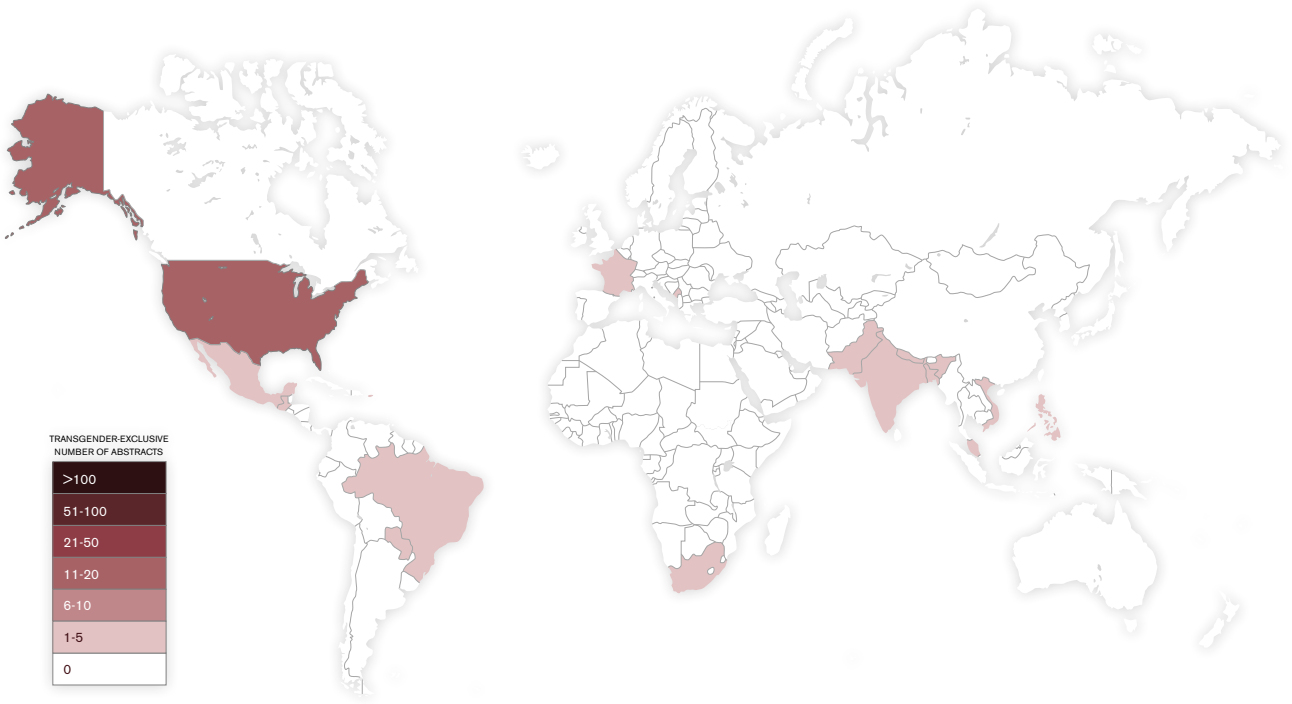
Figure 20. Regional Breakdown for Transgender-exclusive Abstracts



More transgender-exclusive abstracts were focused on North America and Western Europe than any other region. While Asia and Latin America had significant representation comparatively, the conference included only 1 transgender-exclusive abstract focused on EECA, the Caribbean, and Sub-Saharan Africa, respectively. There were no abstracts on transgender people living in MENA or Oceania.

A total of 16 countries were represented in transgender-exclusive abstracts. Only 2 countries had more than 1 transgender-exclusive abstract in the conference: the United States (n=14) and India (n=3). The remaining 14 countries with transgender-exclusive abstracts in the conference all had 1 abstract each. One transgender-exclusive abstract was focused globally, and 1 focused on 2 different countries and was counted once under each.

Figure 21. Number of Transgender-exclusive Abstracts by Country



Bangladesh 1	Guatemala 1	Mexico 1	Paraguay 1	Serbia 1	Vietnam 1
Brazil 1	India 3	Nepal 1	Philippines 1	South Africa 1	
France 1	Malaysia 1	Pakistan 1	Puerto Rico 1	US 14	

People Who Inject Drugs

Quantitative Audit

The percentage of all abstracts at the conference focused exclusively on PWID, including less visible poster exhibitions, was 5%. The percentage of abstract sessions focused exclusively on PWID was also 5%.

Figure 22. Total Number of Abstracts Compared to Total Number of PWID Abstracts

All Abstracts	All	PWID-exclusive	PWID Non-exclusive
Oral Abstracts	379	28	14
Oral Poster Discussion	254	8	9
Poster Exhibition	3590	163	147
Total	***4223***	***199***	***170***

Abstract Sessions	All	PWID-exclusive	PWID Non-exclusive
Oral Abstract Sessions	65	4	7
Oral Poster Discussion Session	40	1	5
Total	***105***	***5***	***12***

Overall, this represents little improvement over PWID program coverage at AIDS 2010, where the percentages of total PWID-exclusive abstracts and PWID-exclusive abstract sessions were 6% and 5%, respectively.

Qualitative Analysis

The number of abstracts that focused on the 5 overarching themes used in this analysis is indicated in Figure 23, represented as a percentage of 199 (the total number of PWID-exclusive abstracts at the conference). Of all 199 PWID-exclusive abstracts, 23 gave equal weight to 2 different themes and were counted once under each theme.

More PWID-exclusive abstracts focused on individual risk factors than any other theme. These abstracts focused on a range of topics, including substance use patterns, drug choice, needle sharing, sexual behavior, STI infection, mental health, and attitudes toward various interventions. Only 14% of PWID-exclusive abstracts used community-based methods, and only 36% included detailed information about interventions.

Figure 23. Thematic Breakdown for PWID-exclusive Abstracts

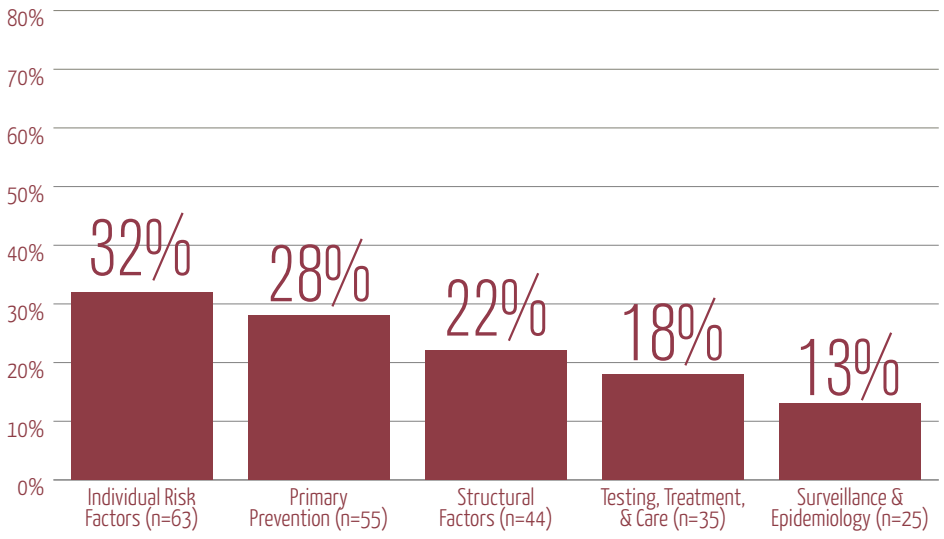


Figure 24. Representation of Community-Based Abstracts, PWID-exclusive Abstracts

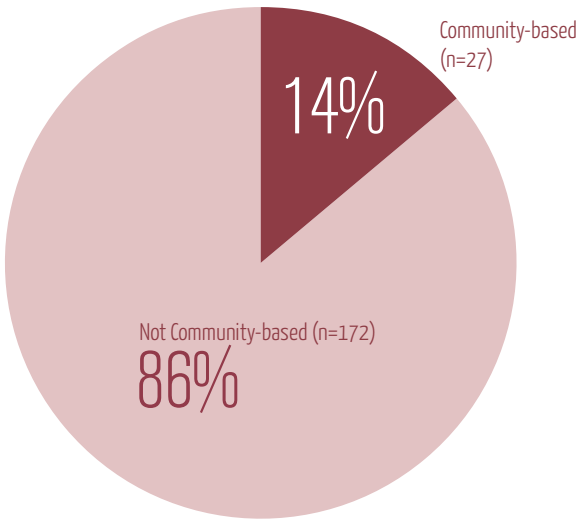
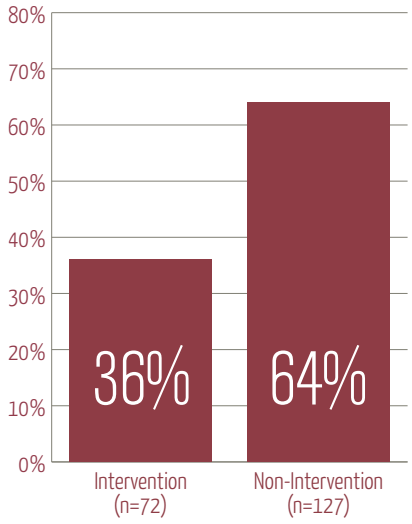


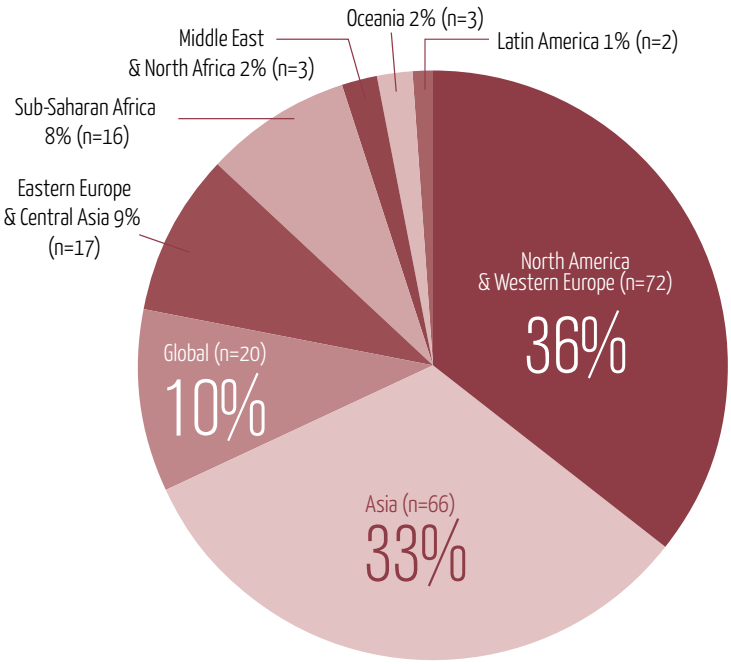
Figure 25. Representation of Abstracts on Interventions, PWID-exclusive Abstracts



Geographic Analysis

The number of PWID-exclusive abstracts that focused on countries in each major world region is indicated in Figure 26, represented as a percentage of the total number of PWID-exclusive abstracts at the conference. Of all 199 PWID-exclusive abstracts, 1 covered countries in more than 1 region and was counted once under each region accordingly.

Figure 26. Regional Breakdown for PWID-exclusive Abstracts

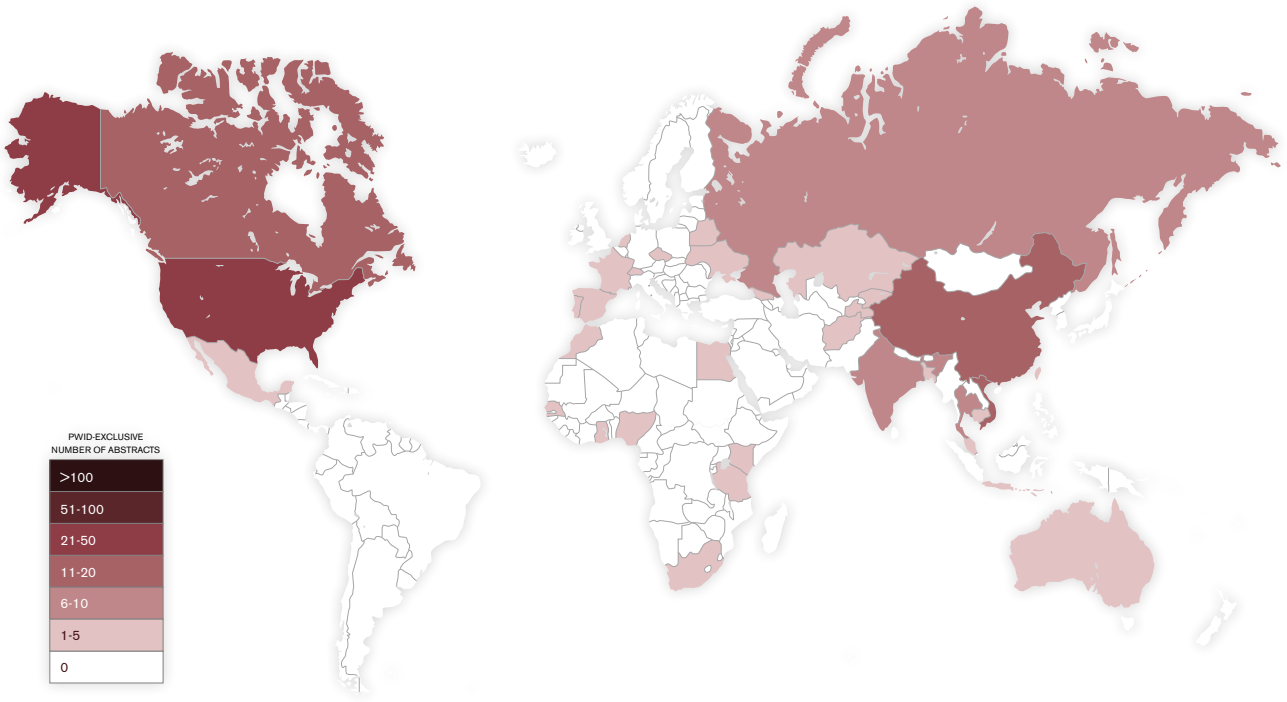


Two-thirds of all PWID-exclusive abstracts were devoted to North America and Western Europe or Asia, while abstracts on PWID in MENA, Latin America, and the Caribbean were almost entirely absent. The underrepresentation of EECA is particularly surprising, considering that over 80% of infections in parts of EECA can be attributed to injection drug use.

A total of 35 countries were represented in PWID-exclusive abstracts. More than half of all PWID-exclusive abstracts were focused on 1 of 5 countries: the United States (n=47), China (n=20), Canada (n=15), Vietnam (n=12), and Thailand (n=10). Twenty-four abstracts were focused globally or regionally and mentioned no specific countries. Four abstracts focused on more than 1 country, with a total of 12 countries represented in these abstracts (ranging from 2-4 countries per abstract). Abstracts that focused on more than 1 country were counted once under each country represented.

Numerous countries with high estimates of HIV prevalence among PWID were not represented, including Iran, Nepal, Pakistan, Uzbekistan, Puerto Rico, Argentina, Paraguay, and Peru, with HIV prevalence rates among PWID in these countries ranging from 9% to 50%.[10]

Figure 27. Number of PWID-exclusive Abstracts by Country



Afghanistan....2	China....20	India....8	Mexico....2	Senegal....2	Tanzania....4
Australia....3	Czech Republic....1	Indonesia....5	Morocco....1	South Africa....4	Thailand....10
Bangladesh....1	Egypt....2	Kazakhstan....2	Netherlands....2	Spain....1	Ukraine....4
Belarus....1	France....1	Kenya....5	Nigeria....3	Switzerland....3	US....47
Cambodia....3	Georgia....1	Kyrgyzstan....2	Portugal....3	Taiwan....1	Vietnam....12
Canada....15	Ghana....1	Malaysia....4	Russia....6	Tajikistan....1	

Sex Workers

Quantitative Audit

The percentage of all abstracts at the conference focused exclusively on sex workers, including less visible poster exhibitions, was 4%. The percentage of abstract sessions focused exclusively on sex workers was 5%.

Figure 28. Total Number of Abstracts Compared to Total Number of Sex Worker Abstracts

All Abstracts	All	Sex Work-exclusive	Sex Work Non-exclusive
Oral Abstracts	379	13	17
Oral Poster Discussion	254	11	0
Poster Exhibition	3590	149	115
Total	***4223***	***173***	***132***

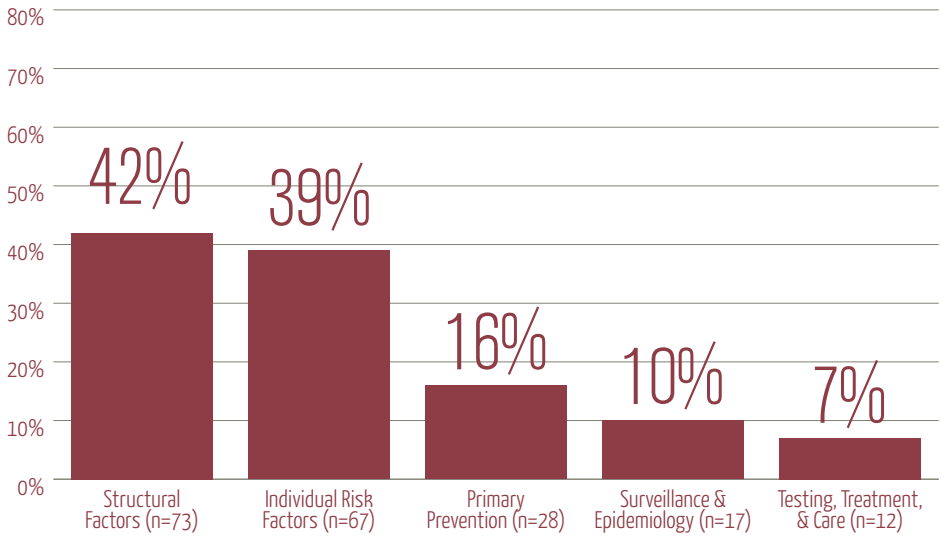
Abstract Sessions	All	Sex Work-exclusive	Sex Work Non-exclusive
Oral Abstract Sessions	65	3	16
Oral Poster Discussion Session	40	2	12
Total	***105***	***5***	***28***

Overall, this represents little improvement over sex worker program coverage at AIDS 2010, where the percentages of total sex worker-exclusive abstracts and sex worker-exclusive abstract sessions were 4% and 3%, respectively.

Qualitative Analysis

The number of abstracts that focused on the 5 overarching themes used in this analysis is indicated in Figure 29, represented as a percentage of 173 (the total number of sex worker-exclusive abstracts at the conference). Of all 173 sex worker-exclusive abstracts, 26 gave equal weight to 2 different themes and were counted once under each theme. Two sex worker-exclusive abstracts were focused on research methods only and thus were not counted under any category.

Figure 29. Thematic Breakdown for Sex Worker-exclusive Abstracts



Over 80% of sex worker-exclusive abstracts focused on either structural factors or individual risk factors, with nearly equal weight given to both categories. Abstracts on structural factors focused on a number of different topics, including violence, police abuse, human rights violations, sex worker empowerment, criminalization of sex work, and criminalization of carrying condoms. Abstracts on individual risk factors also focused on a range of topics, including drug use, partner concurrency, anal sex, risk perception, mental health, and STI infection. Only 13% of sex worker-exclusive abstracts used community-based methods and only 26% included detailed information on interventions.

Figure 30. Representation of Community-Based Abstracts, Sex Worker-exclusive Abstracts

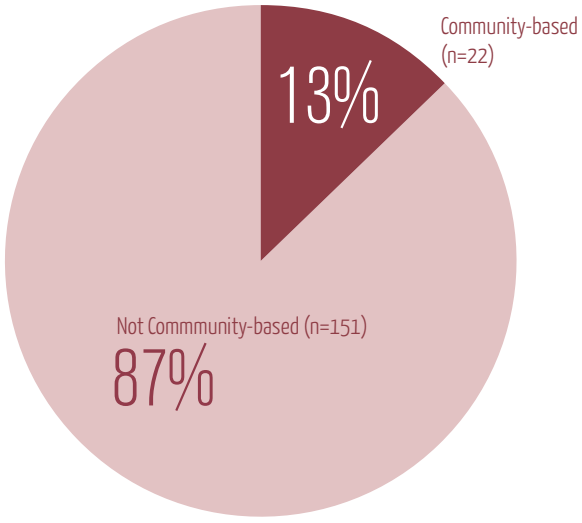
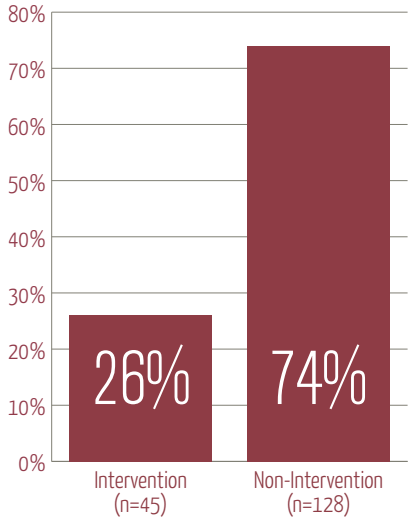


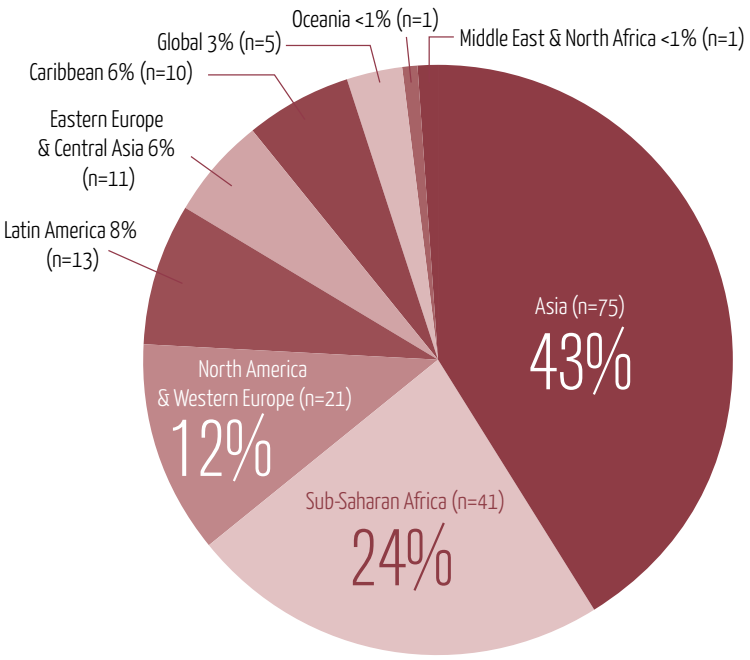
Figure 31. Representation of Abstracts on Interventions, Sex Worker-exclusive Abstracts



Geographic Analysis

The number of sex worker-exclusive abstracts that focused on countries in each major world region is indicated in Figure 32, represented as a percentage of the total number of sex worker-exclusive abstracts at the conference. Of all 173 sex worker-exclusive abstracts, 2 covered countries in more than 1 region, with a total of 7 regions represented in these 2 abstracts (ranging from 3-4 regions per abstract).

Figure 32. Regional Breakdown for Sex Worker-exclusive Abstracts

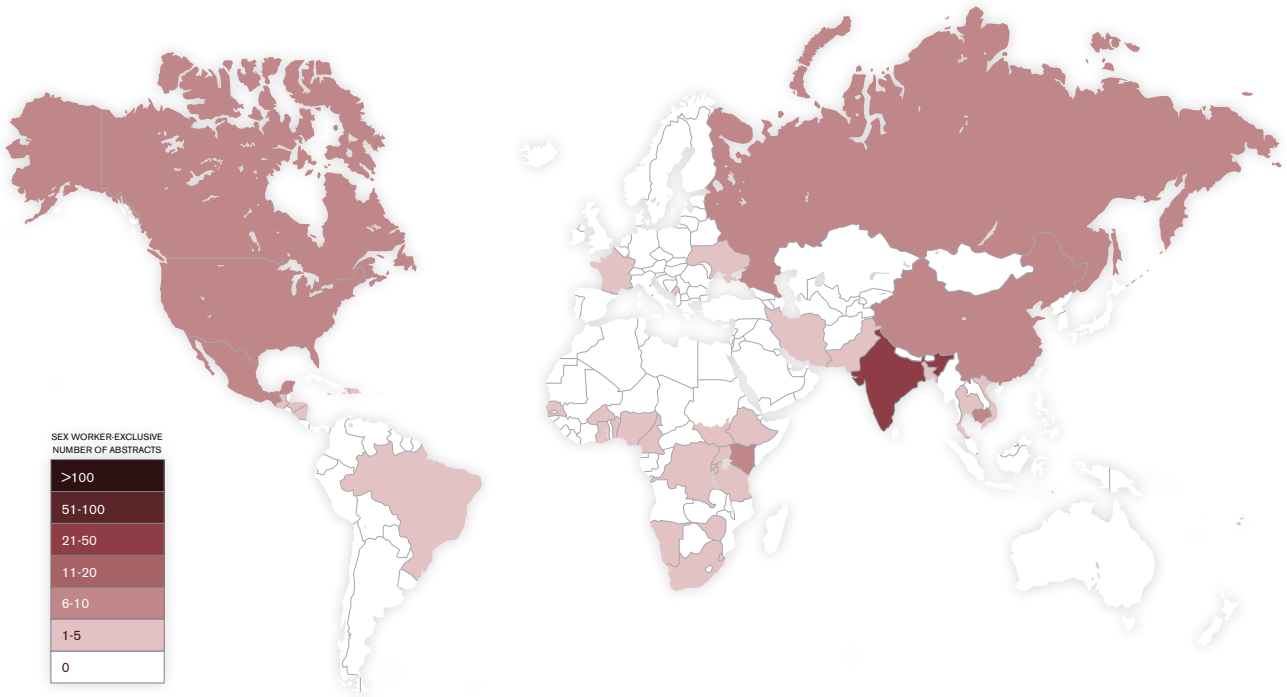


Most sex worker-exclusive abstracts focused on Asia and Sub-Saharan Africa, while other regions had far fewer abstracts represented. The low number of abstracts focused on EECA and the Caribbean is particularly surprising, considering that the pooled HIV prevalence among female sex workers in these regions is 11% and 6%,[v] respectively.[15]

A total of 51 countries were represented in sex worker-exclusive abstracts. Nearly half of all sex worker-exclusive abstracts were focused on 1 of 5 countries: India (n=38), China (n=10), Canada (n=10), Mexico (n=9), and the United States (n=8). Eight abstracts were focused globally or regionally and mentioned no specific countries. Five abstracts focused on more than 1 country, with a total of 17 countries represented in these abstracts (ranging from 2-6 countries per abstract). Abstracts that focused on more than 1 country were counted once under each country represented.

v Pooled HIV prevalence of 6% represents the figure for Latin America and the Caribbean.

Figure 33. Number of Sex Worker-exclusive Abstracts by Country



Bangladesh 4	Dominican Republic 4	Honduras 2	Namibia 3	Serbia 1	Thailand 4
Benin 1	DRC 1	India 38	Nicaragua 1	South Africa 5	Uganda 5
Brazil 1	Ethiopia 1	Iran 1	Nigeria 5	South Sudan 1	Ukraine 2
Burkina Faso 1	Fiji 1	Jamaica 2	Pakistan 5	Sri Lanka 1	US 8
Burundi 1	France 1	Kenya 6	Philippines 1	St. Martin 1	Vietnam 1
Cambodia 7	Ghana 3	Laos 1	Portugal 1	Swaziland 2	Zimbabwe 3
Cameroon 4	Guatemala 1	Macedonia 1	Russia 7	Sweden 1	
Canada 10	Guyana 1	Mexico 9	Rwanda 1	Taiwan 1	
China 10	Haiti 2	Myanmar 1	Senegal 1	Tanzania 1	

Discussion

Prioritizing abstracts on strategies to address risk factors is more valuable than accepting high numbers of abstracts on rates of condomless intercourse and needle sharing year after year.

The organizers of AIDS 2012 set forth 4 "Conference Principles" to guide the conference, the first of which was: "Be inclusive of people living with HIV and key affected populations, and optimize mechanisms for meaningful participation." This principle is echoed by the conference's stated goals, one of which is described as engaging "key, new and non-traditional stakeholders throughout the world in the development of and participation throughout the conference programme."[19]

Our analysis examined the extent to which key populations were meaningfully reflected in the program at AIDS 2012, assessing the number and quality of abstracts at the conference. The quantitative audits and qualitative analyses show that overall program coverage of key populations at AIDS 2012 was poor, and that program content that did concern key populations was skewed away from issues that may be more useful to community members and stakeholders working directly with the groups in question. The percentage of community-based abstracts was low, and geographic distribution was extremely uneven. Overall, the analysis shows that the conference failed to meet the important goals it set for itself concerning key populations.

Of all abstracts presented at AIDS 2012, only 17% (n=732) were exclusively focused on MSM, transgender people, PWID, or sex workers. Of these abstracts, over 40% (n=295) were dedicated to describing individual risk factors. A great deal of the individual risk factor research presented at AIDS 2012 focused on rates of condom use, drug use, and needle sharing, without offering strategies to address associated risks. In fact, more than two-thirds of key population-exclusive abstracts (n=519) offered no detailed information on interventions to address HIV among key populations.

While each global network organization involved with this report believes that individual risk factors are important to understand, none feels that this issue should be the primary focus of the research presented at the conference. After 30 years of the epidemic, we know that key populations are at risk, and we know many of the reasons why. Prioritizing abstracts on strategies for addressing these risk factors is more valuable than accepting high numbers of abstracts that assess rates of condomless intercourse and needle sharing year after year.

The body of abstracts exclusively focused on MSM at AIDS 2012 presents a useful example of the gap between the kind of research key population stakeholders feel would be most valuable and the kind of research that was ultimately presented at the conference. Ahead of AIDS 2012, the MSMGF conducted a global online survey of MSM advocates and service providers to identify the topics they felt would be most important to address at the conference. Nearly 300 participants responded from every major world region, identifying a total of 37 themes they felt were important to address at AIDS 2012.

In order of most-frequently cited, the top 10 themes were: 1) Prevention; 2) Stigma and Discrimination; 3) Law and Criminalization; 4) Human Rights; 5) Locally Tailored Intervention Strategies; 6) Treatment and Care; 7) Advocacy; 8) Holistic Health; 9) Community-Based Approaches; and 10) Funding. Of all abstracts at the conference

(n=4223), the percentage of MSM-exclusive abstracts dedicated to the top 3 priorities most cited by MSM advocates and service providers–Prevention, Stigma and Discrimination, and Law and Criminalization–was 1.6%, 0.5%, and 0.3%, respectively.

In addition, after the IAC's organizers notified abstract authors of the acceptance or rejection of their abstracts for inclusion in the AIDS 2012 program, the MSMGF issued a public call for abstracts on MSM and transgender people that were rejected from the conference. The MSMGF received over 150 rejected abstracts on MSM and transgender people and subjected them to a secondary blind peer-review process using the IAC's own Abstract Review Guidelines. Over 120 abstracts were found to be of high (n=39) or moderate (n=82) quality, and many of them addressed priority issues identified by the MSMGF's global online survey. The full report of this analysis, including all high- and moderate-scoring abstracts, can be found in the MSMGF's report, "Missing Voices from the Field."[33]

Aside from research topics, our examination of research methods revealed that the vast majority of key population-exclusive abstracts made no explicit mention of community-based methodology or community involvement in project development or design (86%; n=633). Community-based research involves members of the study population in all stages of the research process, and the advantages are well documented, including:

- Enhancing the relevance, usefulness, and use of the research data by all parties involved;
- Improving the quality and validity of research by engaging local knowledge and local theory based on the lived experience of the people involved;
- Strengthening research and program development capacity of the partners; and
- Developing culturally appropriate measures and interventions geared toward reducing inequities and promoting social justice.[40]

While the conference organizers state that they work to "ensure that a full range of communities and sectors affected by HIV/AIDS are represented and engaged in the conference planning and delivery process,"[35] it appears that these values do not extend to the actual research featured at the event. IAC organizers could address this gap by explicitly calling for and prioritizing the acceptance of abstracts that report findings from studies that utilize community-based methods.

The regional breakdown of key population-exclusive abstracts revealed a similar disconnect between need and coverage. Nearly two-thirds of all abstracts exclusively dedicated to key populations focused on 10 countries alone, while numerous hard-hit regions and countries remained underrepresented or entirely absent.

It is widely recognized that public health research and interventions carried out in one country will not necessarily apply to another. Research and interventions targeting key populations are no different, especially considering the wide range of cultures, identities, practices, and sexualities represented across these groups internationally. Such uneven regional representation limits the utility of research presented at the conference, particularly for those working in countries where key populations are shouldering a disproportionate HIV disease burden and where the need for evidence-based approaches is especially urgent.

Less than 3% of all abstracts at the conference were dedicated to the top three topics prioritized by MSM advocates and service providers combined.

It must be recognized that the lack of key population-exclusive abstracts on priority topics and countries at AIDS 2012 is not only a reflection of the conference's internal structures, but also a reflection of the current state of global funding and support for research on key populations. While the IAC rejects a significant number of valuable abstracts on key populations, the low number of abstracts on topics and countries prioritized by key populations at AIDS 2012 may also reflect a dearth of funding and support for this kind of research in the first place. As a world leader in the promotion and dissemination of the latest research on HIV and AIDS, the IAC is uniquely positioned to advocate with large funders and research institutions for more and better research on the topics and countries most relevant to key populations. Without engaging in this kind of advocacy, the IAC–and indeed the global AIDS response–will remain of limited relevance and benefit to key populations around the world.

Finally, many members of key populations were unable to access the conference at all due to its location in the United States. People applying for a visa to the United States are asked whether they have ever engaged in drug use or sex work. If an individual answers yes, they may be found inadmissible and their application can be denied on those grounds.[36] Many transgender advocates also expressed concern that their colleagues outside the United States were unable to attend due to strict interpretation of gender on passports and other identifying documents. By choosing the United States as the location for the conference, the CCC effectively prevented many members of key populations outside the United States from participating in the conference.

While conference organizers did provide some support for the development of hubs in Ukraine and India for PWID and sex workers, respectively, this does not constitute a replacement for actual participation in the IAC. Physical presence at the conference is required to gain the full set of benefits that make the IAC such a valuable resource, including trainings, networking, access to the latest research, and the opportunity to help shape influential dialogues that take place on site.

Research has shown that structural barriers have been a powerful driver of HIV among key populations worldwide. Previous International AIDS Conferences themselves have featured research on these issues. Institutions charged with addressing the global HIV epidemic must not only support increased understanding of the factors that perpetuate these epidemics; they must embody that understanding through their organizational structures, processes, and commitments. Without doing so, the International AIDS Conference will remain a part of the structural oppression that fuels these epidemics instead of part of the solution that ends them.

Global AIDS institutions must not only increase understanding of the structural factors that perpetuate AIDS, they must embody that understanding through their organizational structures, processes, and commitments.

Recommendations

The findings of the quantitative audit and qualitative analyses bring us back to the question: Does the IAC offer an adequate "chance to assess where we are, evaluate recent scientific developments, and collectively chart a course forward" to address HIV epidemics among these 4 key populations? In the conference's current form, the answer is no.

However, the IAC's organizers can take several concrete steps to update the conference's processes to: A) increase the number and quality of abstracts on key populations that are submitted to the conference; and B) ensure that quality abstracts submitted on key populations are not rejected from inclusion in the conference. This will enhance the relevance of the conference to key populations, leveraging the IAC's high added value to strengthen the response to HIV among MSM, transgender people, PWID, and sex workers.

1. Community Consultations

Prior to launching the global call for abstracts, conference organizers must conduct systematic consultations focused on each key population to determine priority focus topics for abstracts.

Consultations on each population should include members of that population and advocates and service providers working with that population. Priority should be given to advocates and service providers who identify as members of the key populations with whom they work.

2. Targeted Call for Abstracts

When the call for abstracts is announced, conference organizers should include a list of focus topics that were prioritized by community consultations and indicate that these topics will be prioritized for acceptance into the conference. The call should include an explicit emphasis on the importance of abstracts featuring community-based research and abstracts focused on interventions targeted for MSM, transgender people, PWID, and sex workers.

At present, the only content guidelines for abstract submission are: "We encourage work that introduces new ideas and/or concepts; new research findings and advances to the field, as well as analysis of both success and failure." This guidance is not detailed enough to ensure that the conference program is sufficiently valuable to key populations. Content submission must be guided by actual needs as identified by members of key populations.

3. Match Abstracts with Reviewers Based on Expertise

Abstracts dealing with key populations must be evaluated by reviewers with expertise on the population and topic area in question, and all reviewers should have a basic understanding of the methods and value of community-based research.

At present, there seems to be no system for matching abstracts with reviewers on the basis of expertise. It is therefore not surprising that the abstracts selected for presentation at the conference are largely disconnected from the current needs and priorities of the key populations themselves. Reviewers with appropriate expertise will be better able to determine the relevance of an abstract's subject matter to the population at hand, greatly increasing the value of the conference program on the whole.

4. Advocate for Better Funding and Support for Research on Key Populations

As a leader in the global AIDS field, the IAC and the IAS are well positioned to advocate with large funders and research institutions for more appropriate funding and support for research on key populations that responds to community needs. Without such advocacy, the number of abstracts on key populations that focus on priority topics and countries submitted to the IAC will remain limited. It is incumbent upon the IAS to guide the field to a more equitable, evidence-based, and targeted focus on research concerning key populations.

5. Increase Conference Accessibility for Key Populations

a. The conference must be held in a country with laws that allow entry for MSM, transgender people, PWID, sex workers, and people living with HIV. Participation in conference hubs is not a substitute for participation in the main conference.

b. Year after year, many important key population leaders and stakeholders are unable to attend the conference due to limited resources. A scholarship fund for key populations could support more robust attendance of key populations, helping to ensure they gain the full range of benefits of participation in the conference and that the voices of key populations are represented at influential dialogues on site.

By adopting these measures, the IAC's organizers will greatly enhance the relevance of the conference to addressing HIV among key populations worldwide. This will not only foster the development of more effective strategies to address the needs of key populations, it will also bring the global AIDS response closer to developing the comprehensive approaches we need to end the epidemic.

References

1. International AIDS Society. Conference Programme. AIDS 2012 Web site. http://www.aids2012.org/Default.aspx?pageId=370. Accessed May 24, 2013.
2. UNAIDS. UNAIDS Terminology Guidelines, October 2011. Geneva, Switzerland: UNAIDS; 2011. http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/JC2118_terminology-guidelines_en.pdf. Accessed May 24, 2013.
3. Centers for Disease Control and Prevention. HIV Among Gay and Bisexual Men. Centers for Disease Control and Prevention Web site. http://www.cdc.gov/hiv/risk/gender/msm/facts/index.html. Accessed May 24, 2013.
4. Baral SD, Sifakis F, Cleghorn F, Beyrer C. Elevated Risk for HIV Infection among Men Who Have Sex with Men in Low- and Middle-Income Countries 2000-2006: A Systematic Review. PLoS Med. 2007;4(12):e339.
5. Beyrer C, Baral SD, van Griensven F, et al. Global Epidemiology of HIV Infection in Men Who Have Sex with Men. The Lancet. 2012; 280(9839):367-377.
6. UNAIDS. UNAIDS Report on the Global AIDS Epidemic: 2012. UNAIDS Web site. http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/20121120_UNAIDS_Global_Report_2012_en.pdf. Accessed May 30, 2013.
7. Baral SD, Poteat T, Strömdahl S, Wirtz A, Guadamuz T, Beyrer C. Worldwide Burden of HIV in Transgender Women: A Systematic Review and Meta-Analysis. The Lancet Infectious Diseases. 2012;13(3)214-222.
8. World Health Organization. HIV/AIDS: Injecting Drug Use. World Health Organization Web site. http://www.who.int/hiv/topics/idu/en/index.html. Accessed May 24, 2013.
9. The International Center for Science in Drug Policy. The Vienna Declaration Fact Sheet. The Vienna Declaration Web site. http://www.viennadeclaration.com/wordpress/wp-content/uploads/2011/04/2-VDec-Fact-Sheet-IAS.pdf. Accessed on May 25, 2013.
10. Mathers BM, Degenhardt L, Phillips B, et al. Global Epidemiology of Injecting Drug Use and HIV among People Who Inject Drugs: A Systematic Review. The Lancet. 2008;372(9651)1733-1745.
11. Nelson PK, Mathers BM, Cowie B, et al. Global Epidemiology of Hepatitis B and Hepatitis C in People Who Inject Drugs: Results of Systematic Reviews. The Lancet. 2011;378(9791)571-583.
12. Getahun H, Gunneberg C, Sculier D, Verster A, Reviglione M. Tuberculosis and HIV in People Who Inject Drugs: evidence for Action for Tuberculosis, HIV, Prison and Harm Reduction Services. Curr Opin HIV AIDS. 2012;7(4)345-53.
13. Degenhardt L, Bucello C, Mathers B, et al. Mortality among Regular or Dependent Users of Heroin and Other Opioids: A Systematic Review and Meta-Analysis of Cohort Studies. Addiction. 2011;106(1)32-51.
14. UNAIDS. Countries. UNAIDS Web site. http://www.unaids.org/en/regionscountries/countries/. Access on May 26, 2013.
15. Baral S, Beyrer C, Muessig K, et al. Burden of HIV among Female Sex Workers in Low-Income and Middle-Income Countries: A Systematic Review and Meta-Analysis. The Lancet Infectious Diseases. 2012;12(7)538-549.
16. Commission on Social Determinants of Health. Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health. Geneva, Switzerland: World Health Organization; 2008.
17. Satcher D, Higginbotham E. The Public Health Approach to Eliminating Disparities in Health. American Journal of Public Health. 2008;98(3)400-403.
18. Better HIV/AIDS Programs for Men Who Have Sex with Men Could Significantly Slow Global Epidemic [news release]. World Bank; June 8, 2011. http://web.worldbank.org/WBSITE/EXTERNAL/NEWS/0,,contentMDK:22934648~pagePK:64257043~piPK:437376~theSitePK:4607,00.html. Accessed May 26, 2013.
19. International AIDS Society. Conference Objectives. AIDS 2012 Web site. http://www.aids2012.org/Default.aspx?pageId=434. Accessed May 26, 2013.
20. International AIDS Society. AIDS 2012 Conference Organization, Structures and Process. AIDS 2012 Web site. http://www.aids2012.org/WebContent/File/AIDS2012_Conference_Organization_Structures_and_Process.pdf. Accessed May 26, 2013.

21. International AIDS Society. Abstracts. AIDS 2012 Web site. http://www.aids2012.org/Default.aspx?pageId=375. Accessed May 26, 2013.

22. International AIDS Society. Scientific Programme Vision. AIDS 2012 Web site. http://www.aids2012.org/Default.aspx?pageId=418. Accessed May 26, 2013.

23. International AIDS Society. Leadership & Accountability Programme Vision. AIDS 2012 Web site. http://www.aids2012.org/Default.aspx?pageId=420. Accessed May 26, 2013.

24. International AIDS Society. Community Programme Vision. AIDS 2012 Web site. http://www.aids2012.org/Default.aspx?pageId=419. Accessed May 26, 2013.

25. International AIDS Society. Scientific Programme Vision. AIDS 2012 Web site. http://www.aids2012.org/Default.aspx?pageId=418. Accessed May 26, 2013.

26. International AIDS Society. AIDS 2012 – Programme-at-a-Glance. AIDS 2012 Web site. http://pag.aids2012.org/PAGHome.aspx?tab=2. Accessed May 26, 2013.

27. International AIDS Society. Non-Abstract Driven Sessions. AIDS 2012 Web site. http://www.aids2012.org/Default.aspx?pageId=416. Accessed May 26, 2013.

28. International AIDS Society. Workshops. AIDS 2012 Web site. http://www.aids2012.org/Default.aspx?pageId=479. Accessed May 26, 2013.

29. International AIDS Society. Daily Plenary Session. AIDS 2012 Web site. http://www.aids2012.org/Default.aspx?pageId=415. Accessed May 26, 2013.

30. International AIDS Society. Global Village. AIDS 2012 Web site. http://www.aids2012.org/Default.aspx?pageId=429. Accessed May 26, 2013.

31. International AIDS Society. Exhibitions, Satellites & Affiliated Independent Events. AIDS 2012 Web site. http://www.aids2012.org/Default.aspx?pageId=411. Accessed May 26, 2013.

32. Beryer C, Wirtz AL, Walker D, Johns B, Sifakis F, Baral SD. The Global HIV Epidemics among Men Who Have Sex with Men (MSM). World Bank. 2011. http://elibrary.worldbank.org/content/book/9780821387269;jsessionid=26o96h15ujcrm.z-wb-live-01. Accessed May 26, 2013.

33. Global Forum on MSM & HIV (MSMGF). Missing Voices from the Field: A Selection of MSM & Transgender Abstracts Rejected from the 2012 International AIDS Conference. http://www.msmgf.org/files/msmgf//About_Us/MSMGF_RejectedAbstracts2012rev1.pdf. Published July 2012. Accessed May 26, 2013.

34. Israel BA, Schulz AJ, Parker EA, Becker AB. Review of Community-Based Research: Assessing Partnership Approaches to Improve Public Health. Annu. Rev. Public Health. 1998;19:173-202.

35. International AIDS Society. Civil Society and Community Outreach. AIDS 2012 Web site. http://www.aids2012.org/Default.aspx?pageId=470. Accessed May 30, 2013.

36. International AIDS Society. AIDS 2012 Fact Sheet: Travel to the United States – Former and Current Sex Workers and People Who Use Drugs. AIDS 2012 Web site. http://www.aids2012.org/WebContent/File/AIDS2012_Visa_Waiver.pdf. Accessed May 26, 2013.

Appendix A

The systematic analysis of the AIDS 2012 program was conducted using a different set of keywords to identify abstracts on each key population of focus.

- **Keywords: Men Who Have Sex with Men**
    - MSM, Gay, Men Who Have Sex, Homosexual, Homosexuality, Homophobia, Sexual Orientation, LGBT, Bisexual, Same-Sex, Anal Sex, Male Sex Work, Queer, Sexuality, Sexual Minority, Sexual Minorities, Key Populations, Key Affected Populations, Most-at-Risk, Higher Risk / High Risk, Criminal, Sodomy, Human Rights, MARP.
- **Keywords: Transgender People**
    - Transgender, Transsexual, Intersex, Trans Individual, Trans People, Transphobia, Transvestite, LGBT, Gender Identity, Gender Expression, Trans(gender) Youth, Trans(gender) Sex Workers, Gender Variant, Gender Variance, Queer, Hormone, SRS, Sexual Reassignment Surgery, Sex Change, Gender Assigned, Gender Minority, Gender Minorities, Non-conforming, Cross-Dress, Cross-Gender, Key Populations, Key Affected Populations, Most-at-Risk, Higher Risk, Human Rights, MARP.
- **Keywords: People Who Inject Drugs**
    - Drug Use, Substance Use, Drug User, IDU, Injection Drug User, Injecting Drug User, People Who Use Drugs, Syringe Exchange, Needle Exchange, Heroin, Cocaine, Crack, Amphetamine, Methamphetamine, Opioid, Opiate, Club Drugs, Ecstasy, Ketamine, Hepatitis, Overdose, Naloxone, Criminalization, Decriminalization, Drug Policy, Methadone, Buprenorphine, Drug Treatment, Key Affected Population, Most Affected Population, Most-at-Risk Populations, MARPs, Addiction, Dependence, Dependency.
- **Keywords: Sex Workers**
    - Sex Work, Transactional Sex, Sexual Exchange, Exchange Sex, Commercial Sex, Sex Trade, Trade Sex, Sex for Exchange, Sex Industry, Sexual Labor, Key Populations, CSW, Trading Sex.

Appendix B

The section below details the criteria used in the qualitative analysis to categorize key population-exclusive abstracts.

- **Surveillance and Epidemiology**
  - Any abstract that focuses on new surveillance data on the population in question. This includes abstracts focused on HIV prevalence, HIV incidence, HIV transmission routes, and prevalence or incidence of drug resistance or viral strain. This does not include incidence or prevalence of other sexually transmitted infections (STIs), as these were primarily discussed as a risk factor for HIV, and were thus included under "Individual Risk Factors."
- **Individual Risk Factors**
  - Any abstract that describes an individual risk factor for HIV infection or transmission. This includes drug use, rates of condomless sex, rates of STI infection, mental health indicators, partner notification, risk perception, social networks, sexual networks, knowledge, attitudes, and behaviors. This does not include structural factors like violence, discrimination, or policy.
- **Primary Prevention**
  - Any abstract that describes the structure or efficacy of prevention interventions targeting HIV-negative people. This includes behavioral interventions and biomedical interventions like PrEP and PEP, but does not include secondary prevention interventions targeting people living with HIV (PLHIV) like Treatment as Prevention (TasP) and Test and Treat. Knowledge and attitudes concerning prevention interventions were included in "Individual Risk Factors," not in "Primary Prevention."
- **Testing, Treatment, and Care**
  - Any abstract that describes the current state of HIV testing, treatment, or care, as well as any abstract that describes efforts to increase access to these services. This includes abstracts on testing rates, linkage to care, PLHIV health, and secondary prevention interventions focused on PLHIV to prevent forward transmission, including TasP and Test and Treat. It also includes abstracts that address the general health needs of PLHIV, including sexual health, mental health, and substance use. For PWID, abstracts on treatment and care for drug overdose were also included.
- **Structural Factors**
  - Any abstract that focuses on structural factors that impact HIV risk, prevention interventions, or treatment programs, as well as abstracts that detail advocacy initiatives to address structural barriers. This includes abstracts on policy, stigma, violence, funding, housing stability, and incarceration. We did not include abstracts that briefly mentioned structural factors without assessing them in detail, which was common in background and conclusion sections and did not offer any insight into addressing the structural factor cited.

- **Community-Based**
    - Any abstract that explicitly states members of the target community were involved in the design of the project or research described. This includes interventions that were created or co-created through a community-based process, as well as community-based research. We did not include abstracts on programs or research that used community-based organizations to recruit participants but did not explicitly involve them in the project design process.

- **Interventions**
    - Any abstract that described the design or efficacy of an HIV prevention, testing, treatment, or care intervention. This includes assessments of empowerment schemes, methadone clinics, needle exchanges, testing approaches, behavioral interventions, structural interventions, biomedical interventions, and advocacy initiatives. It does not include abstracts that describe risk, vulnerability, or structural factors that make brief suggestions about possible interventions that may be useful to address them, nor does it include abstracts that focus on individual knowledge, attitudes, or behaviors about various interventions.

Appendix C

The regional analysis was conducted by identifying the countries cited in each abstract and then coding them by region. Countries and the corresponding regional categories we used for this report are listed below.

Asia	Caribbean	Eastern Europe & Central Asia	Latin America
Afghanistan	Anguilla	Albania	Argentina
Bangladesh	Antigua and Barbuda	Armenia	Bolivia
Bhutan	Aruba	Azerbaijan	Brazil
Brunei Darussalam	Bahamas	Belarus	Chile
Cambodia	Barbados	Bosnia and Herzegovina	Colombia
China	Belize	Bulgaria	Costa Rica
India	British Virgin Islands	Croatia	Ecuador
Indonesia	Cayman Islands	Cyprus	El Salvador
Japan	Cuba	Czech Republic	Guatemala
Lao	Dominica	Estonia	Honduras
Malaysia	Dominican Republic	Georgia	Mexico
Maldives	Dutch Antilles	Hungary	Nicaragua
Mongolia	French Caribbean	Kazakhstan	Panama
Myanmar	Grenada	Kosovo	Paraguay
Nepal	Guyana	Kyrgyzstan	Peru
North Korea (DPRK)	Haiti	Latvia	Uruguay
Pakistan	Jamaica	Lithuania	Venezuela
Philippines	Montserrat	Macedonia	
Singapore	Netherlands Antilles	Moldova	
South Korea (ROK)	Puerto Rico	Montenegro	
Sri Lanka	Saint Kitts and Nevis	Poland	
Thailand	Saint Lucia	Romania	
Timor-Leste	Saint Vincent and the Grenadines	Russia	
Viet Nam	Saint-Barthelemy	Serbia	
	Suriname	Slovakia	
	Trinidad and Tobago	Slovenia	
	Turks and Caicos Islands	Tajikistan	
	US Virgin Islands	Turkmenistan	
		Ukraine	
		Uzbekistan	

Middle East & North Africa	Oceania	Sub-Saharan Africa	Western Europe & North America
Algeria	Australia	Angola	Andorra
Bahrain	Cook Islands	Benin	Austria
Egypt	Fed. States of Micronesia	Botswana	Belgium
Iran	Fiji	Burkina Faso	Bermuda
Iraq	French Polynesia	Burundi	Canada
Israel	Johnston Island	Cameroon	Denmark
Jordan	Kiribati	Cape Verde	Finland
Kuwait	Nauru	Central African Republic	France
Lebanon	New Caledonia	Chad	Germany
Lybia	New Zealand	Comoros	Greece
Mauritania	Niue	Congo	Greenland
Morocco	Norfolk Island	Côte d'Ivoire	Holy See
Occupied Palestinian Territory	Northern Mariana Islands	Democratic Republic of the Congo	Iceland
Oman	Palau	Djibouti	Ireland
Qatar	Papua New Guinea	Equatorial Guinea	Italy
Saudi Arabia	Pitcairn	Eritrea	Liechtenstein
Sudan	Samoa	Ethiopia	Luxembourg
Syria	Solomon Islands	Gabon	Malta
Tunisia	Tokelau	Gambia	Monaco
Turkey	Tonga	Ghana	Netherlands
United Arab Emirates	Tuvalu	Guinea	Norway
Yemen	Vanuatu	Guinea-Bissau	Portugal
	Wallis and Futuna Islands	Kenya	Saint Pierre and Miquelon
		Lesotho	San Marino
		Liberia	Spain
		Madagascar	Sweden
		Malawi	Switzerland
		Mali	United Kingdom
		Mauritius	United States of America
		Mayotte	
		Mozambique	
		Namibia	
		Niger	
		Nigeria	
		Réunion	
		Rwanda	
		Saint Helena	
		Sao Tome and Principe	
		Senegal	
		Seychelles	
		Sierra Leone	
		Somalia	
		South Africa	
		Swaziland	
		Tanzania	
		Togo	
		Uganda	
		Zambia	
		Zimbabwe	

The Global Forum on MSM & HIV (MSMGF) is a coalition of advocates working to ensure an effective response to HIV among MSM. Our coalition includes a wide range of people, including HIV-positive and HIV-negative gay men directly affected by the HIV epidemic, and other experts in health, human rights, research, and policy work. What we share is our willingness to step forward and act to address the lack of HIV responses targeted to MSM, end AIDS, and promote health and rights for all. We also share a particular concern for the health and rights of gay men/MSM who: are living with HIV; are young; are from low and middle income countries; are poor; are migrant; belong to racial/ethnic minority or indigenous communities; engage in sex work; use drugs; and/or identify as transgender.

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Coverage of Key Populations at the 2012 International AIDS Conference
Findings from a Program Audit and Implications for Leadership in the Global AIDS Response

June 2013

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Design and Layout: Design Action Collective
Copy Editing: Kimmianne Webster