Coverage of Four Key Populations at the 2010 International AIDS Conference

IAC 2010

Implications for Leadership and Accountability in the Global AIDS Response

MSMGF

The Global Forum on MSM and HIV (MSMGF) is an expanding network of AIDS organizations, MSM networks, and advocates committed to ensuring robust coverage of and equitable access to effective HIV prevention, care, treatment, and support services tailored to the needs of gay men and other MSM. Guided by a Steering Committee of 20 members from 17 countries situated mainly in the Global South, and with administrative and fiscal support from AIDS Project Los Angeles (APLA), the MSMGF works to promote MSM health and human rights worldwide through advocacy, information exchange, knowledge production, networking, and capacity building.

MSMGF
Executive Office
436 14th Street, Suite 1500
Oakland, CA 94612
United States

www.msmgf.org

For more information, please contact us at +1.510.271.1950 or contact@msmgf.org.

Coverage of Four Key Populations at the 2010 International AIDS Conference: Implications for Leadership and Accountability in the Global AIDS Response
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Authors

George Ayala, Psy.D., MSMGF Executive Officer
Jack Beck, MSMGF Communications Associate
Pato Hebert, M.F.A., MSMGF Senior Education Associate
Laurence A. Padua, MSMGF Consultant
Mohan Sundararaj M.B.B.S., M.P.H., MSMGF Policy Associate

Credits

Lily Catanes, M.B.A., MSMGF Operations Associate
Krista Lauer, M.Sc., MSMGF Policy Associate

We would also like to acknowledge JoAnne Keatley (Center of Excellence for Transgender Health at University of California, San Francisco), Mat Southwell (International Network of People Who Use Drugs), and Ruth Morgan Thomas (Global Network of Sex Worker Projects) for their expertise and support during the preparation of this document.

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EXECUTIVE SUMMARY

The International AIDS Conference (IAC), organized by the International AIDS Society (IAS), is the world's premier gathering for HIV professionals and people living with HIV. In the past, numerous advocates and networks, including *the Global Forum on MSM & HIV (MSMGF), International Network of People Who Use Drugs (INPUD), the Global Network of Sex Work Projects (NSWP)* and key transgender activists have shared increasing concern over the poor program coverage of their respective constituencies at each IAC. This long-standing frustration stems from the discrepancy between IAC programming and on-the-ground realities. This disconnect is particularly concerning when available and accurate epidemiological data reveals the disproportionate burden that HIV is having on these vulnerable groups.

In an effort to quantify program coverage of men who have sex with men (MSM), people who use drugs, sex workers and transgender people at the IAC in 2010, the MSMGF undertook an analysis independent from and unsolicited by the IAS. The analysis features a review of every abstract and session[a] programmed, drawing a distinction between *non-exclusive and exclusive* coverage of the key populations.[b] By non-exclusive we mean an abstract or a session that focused on two or more key populations. By exclusive, we mean an abstract or a session that focused solely on one key population. Non-exclusive coverage therefore also includes exclusive abstracts and sessions.

Our analysis revealed a gross underrepresentation of the key populations across the 2010 conference program. The major findings of the analysis are as follows:

(1) 6.6%, 5.7%, 3.5% and 0.6% of all **abstracts** *exclusively* focused on MSM, people who use drugs, sex workers, and transgender people respectively.
(2) 3.8%, 5.1%, 2.5%, and 0% of all **non-abstract driven sessions** exclusively focused on MSM, people who use drugs, sex workers and transgender people respectively.
(3) 3.7%, 6.4%, 0% and 0% of all **workshops** exclusively focused on MSM, people who use drugs, sex workers and transgender people respectively.
(4) 558, 442, 338 and 134 of all 4,661 **abstracts** made any mention whatsoever of MSM, people who use drugs, sex workers or transgender people
(5) 2.6%, 4.5%, 3.0% and 1.1% of **all sessions** from the entire IAC program taken together *exclusively* focused on MSM, people who use drugs, sex workers and transgender people respectively.

A complete analysis of both non-exclusive and exclusive program coverage is contained in this report. A set of key recommendations are provided to underscore the need for robust leadership, transparency and accountability processes at the level of the Conference Coordinating Committee, (CCC) the highest governing body of the IAC. We propose a comprehensive review of IAC governance processes and operations, to be held immediately and in advance of programming decisions for the IAC in Washington DC in 2012. The complete analysis with additional data sets is attached to the Appendix section.

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[a] Session = affiliated events, bridging sessions, commercial satellite, cultural activity, global village sessions, non-commercial satellites, plenary, special session, symposium, community skills development workshops, leadership and accountability development workshops, and professional development workshops. Sessions also include panel presentations where multiple abstracts are presented together.
[b] Key Populations is defined as MSM, people who use drugs, sex workers and transgender people.

ABOUT THE INTERNATIONAL AIDS CONFERENCE

The International AIDS Society (IAS), the world's largest group of HIV professionals with a membership of over 16,000 individuals from 198 countries, convenes the *International AIDS Conference (IAC)* biennially.[1] The IAC is regarded as the world's premier and largest gathering for people working in the field of HIV.[2] Conference delegates, including field advocates and people living with HIV, travel to and participate in the IAC at locations worldwide and use this platform to access cutting-edge knowledge and tools to inform and resource their respective local response efforts on the ground. The IAC in turn drives collaborative and novel research agendas, instigates knowledge production and provides opportunities for grassroots activism that are necessary to halt and reverse the AIDS pandemic.

The IAC is uniquely positioned to influence and shape global HIV discourses and decision-making processes around priorities for the allocation of resources for research and AIDS programming at all levels. The magnitude of the IAC is perhaps best described by enumerating the costs spent on convening such an event, its attendance statistics and the diversity of its programming. In August 2008, the IAS spent over 26 million US dollars to convene the 17th IAC in Mexico City, Mexico.[3] In July 2010, the 18th IAC titled *AIDS 2010 Rights Here, Right Now,* took place in Vienna, Austria with an estimated 25,000 people in attendance and attracted an additional 2,000 personnel from the media. Program content of each IAC includes a range of eclectic activities from didactic presentations and skills-building workshops to entertainment and networking activities. Select sessions are webcast for those delegates who are unable to travel to conference locations. The IAS in collaboration with other partners also provides numerous full and partial scholarships to increase attendance thereby diversifying and affording participation from global HIV constituencies.

KEY POPULATIONS

Available epidemiological data has consistently shown that the AIDS epidemic has had a disproportionate burden on men who have sex with men (MSM), people who use drugs, sex workers and transgender people.[4] [5] [6] [7] These four populations have been historically neglected by donor and other stakeholder agencies, further undermining their capacity to contribute more meaningfully to the AIDS response. These populations are stigmatized at every level and consequently underrepresented in research, policy, advocacy and programmatic responses. Criminalization and punitive policies worsen the situation rendering these structural barriers an impediment to robust and sensitive public health responses targeting MSM, people who use drugs, sex workers and transgender people. This has resulted in a serious lack of data, knowledge, services and resources to meet their HIV prevention, treatment, care and support needs. Given the disproportionate impact that HIV is having in these groups, it is imperative that new information and strategies to disseminate knowledge at various fora are linked to the gravity of the epidemic experienced by these populations.

Demonstrations and side-events led by sex worker networks, networks of people who use drugs and transgender activists have repeatedly reflected these groups' concerns over historically inadequate IAC program coverage. Inadequate coverage of MSM issues has led the MSMGF to plan and convene additional programming under the auspices of an MSM pre-conference. For example, we found that only 6.7% of all abstracts programmed at the IAC in 2008 in Mexico City exclusively focused on MSM. The pre-conferences

have typically been organized since 2004 to occur a day before the opening of the main conference, and have only been available to a small fraction of IAC delegates. Moreover, the MSM pre-conference event is largely attended by MSM activists and workers who may be criminalized and marginalized in their home countries. These activists therefore view the MSM pre-conference as a safe space for them to gather.

Despite its shortcomings, the IAC continues to be the major platform for mainstream HIV professionals to access knowledge and skills to address the needs of key populations. Thus the lack of robust program coverage of key populations at the IAC greatly limits the ability of these professionals to respond more effectively in concert with MSM, people who use drugs, sex workers and transgender people. This ultimately undermines the overall global AIDS response.

EPIDEMIOLOGICAL BACKGROUND

To help better contextualize and clarify our concern about inadequate IAC programming for vulnerable populations, we offer the following epidemiological background on HIV among MSM, people who use drugs, sex workers and transgender people. HIV seroprevalence rates among these groups continue to remain alarmingly and disproportionately high when compared to rates in the general population.[8 9] This is true for almost every country with reliable reporting mechanisms.[10 11] Snapshots of available data from around the world are provided here.

Men Who Have Sex With Men

Research indicates that in 2009 MSM represented an estimated 25% of the 1.7 million people living with HIV in Latin America and the Caribbean[12]. In 2008 several countries in southeastern Europe reported that MSM account for a majority of HIV infections (Serbia, 71% in Slovenia, and 76% in Croatia).[13] In Japan in 2007, 66% of the 1,126 newly diagnosed people were MSM.[14] Recent estimates of HIV prevalence among MSM in India have indicated a rate of 16.5%.[15] In sub-Saharan Africa, a meta-analysis of available prevalence data in Senegal, Kenya and Sudan between 2000 and 2006 revealed that MSM are more likely to be infected with HIV when compared to adults in the general population.[16] Traditionally, these African countries have been known to carry heterosexually driven epidemics. UNAIDS recently reported that in Ghana, HIV prevalence among MSM is 9.6 % while adults in the general population recorded a prevalence rate of 2%.[17] Similarly, HIV prevalence figures in Rwanda were recorded at 15% for MSM and 3% for the general population.

People Who Use Drugs

According to the World Health Organization, there are around 16 million people who inject drugs globally, and 3 million of them are also living with HIV.[18] In Eastern Europe and Central Asia, over 80% of HIV infections were reported among people who inject drugs.[19] Injection drug use has been recorded in at least 148 countries and high HIV rates have been reported in many of these countries. HIV infection rates among people who use drugs range between 20% to 40% in Russia, Spain, Cambodia, Vietnam and Libya and over 40% in Estonia, Ukraine, Burma, Indonesia, Thailand, Nepal, Argentina, Brazil and Kenya.[11 20] Regions that previously have had lower HIV prevalence rates among people who inject drugs are now experiencing higher

rates as seen in Kenya, Malawi, Namibia, Botswana, Libya, Tanzania, Zanzibar and South Africa.[21] [22] [23] The correlation between drug use and high-risk sexual behavior in certain populations has also been documented with regard to various recreational substances and modes of consumption.[24]

Sex Workers

In sub-Saharan Africa, prevalence of HIV among sex workers is at a median rate of 19% (ranging from zero to 49.4%).[10] Several countries in this region reported high rates of new infections linked to sex work (32% in Ghana, 14% in Kenya, and 10% in Uganda).[17] In Myanmar, 18% of all sex workers are reportedly living with HIV, while 4 states in southern India report 14.5% HIV prevalence among female sex workers.[10] Togo and Burkina Faso have recorded rates as high as 53.9% and 20.8% among sex workers. It is worse in Ethiopia (73%) and Zambia (63%). In a study conducted in Spain, male sex workers who tested for HIV for the first time recorded an HIV prevalence rate of 16.9%.[25] Laws criminalizing sex work drive sex workers and their clients away from access to necessary HIV prevention programs. Reports indicate that only 22% to 35% of sex workers in Africa and Latin America respectively have access to these programs.[26]

Transgender People

There is a global lack of epidemiological data available among transgender populations, especially in low- and middle-income countries. When available, data shows that transgender people are disproportionately impacted by HIV. A recent meta-analysis estimates the average HIV prevalence rate of the transgender population in the United States at 27.7% but only 12% of these individuals reported that they were living with HIV.[27] In a span of seven years from 1995 to 2002, HIV prevalence among the *waria*[c] communities rose from 7.9% to 22.0% in Jakarta, Indonesia.[28] In India, a surveillance study conducted in Mumbai revealed an HIV prevalence rate of 42% among transgender women who have sex with men.[29] Similarly high rates have been noted in Argentina where a study conducted across several centers revealed a prevalence rate of 35%.[30] Transgender people additionally face challenges when engaging with an HIV and AIDS sector, which is completely ill-equipped to effectively address transgender bodies, sexuality, mental health and legal rights in the context of gender identity and recognition.

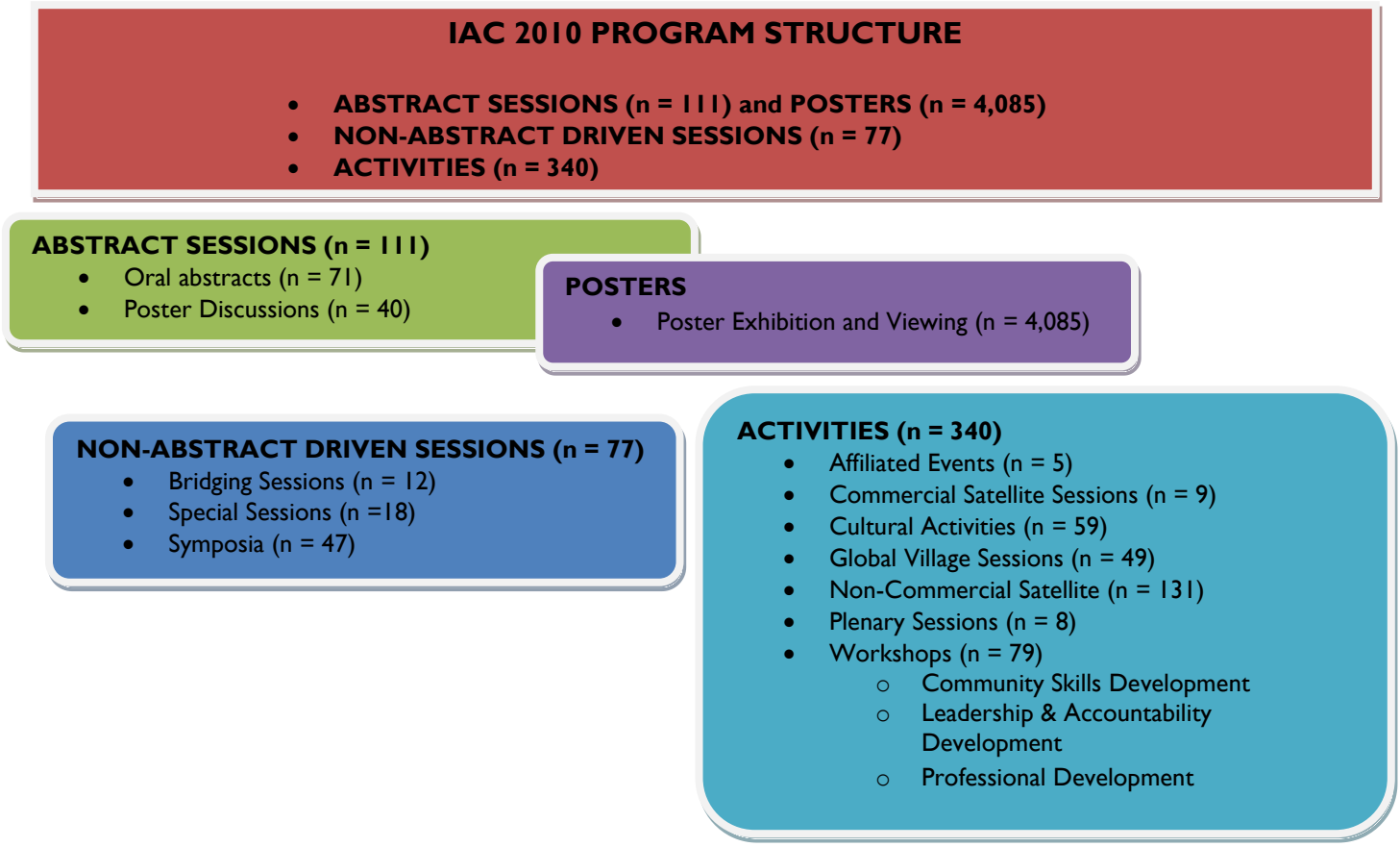
In light of such compelling epidemiological reality, it is imperative that we rethink the programmatic priorities and considerable opportunities presented by the IAC.

[c] A cultural term denoting certain transgender women in Indonesia

IAC PROGRAM STRUCTURE

The IAC program is divided into abstract-driven sessions, non-abstract driven sessions and activities. The overall program is presented in a chart (see Chart I below), providing an eagle-eye view of conference structure.

Chart I – Overall IAC 2010 Program Structure



Our analysis highlights program coverage of MSM, people who use drugs, sex workers and transgender people in three specific components of the program namely:

(1) Abstracts;
(2) Non-abstract driven sessions; and
(3) Workshops.

An additional indicator of program coverage, **(4) all sessions**, includes a collective estimate of exclusive program coverage of the four key populations in every session programmed across the conference. An analysis of all other sections of the program is found in the Appendix Section.

IAC GOVERNANCE STRUCTURES

The Conference Coordinating Committee (CCC) is the highest governing body of the IAC. The CCC is ultimately responsible for the "theme, vision, policies, budget guidelines and overall program of the conference."[31] There are three program committees governing the IAC and together with the CCC, these form the core components of the conference structure. The three program committees[d] are:

(1) Community Program Committee;
(2) Leadership and Accountability Program Committee; and
(3) Scientific Program Committee.

The following table describes the relevant IAC processes for developing, reviewing and programming these sessions.

Table I – Governance Structures That Program Abstracts, Non-Abstract Driven Sessions and Workshops

Program Session	Developed by	Reviewed by	Programmed by
Abstracts	Prospective IAC Presenters	Blinded review panel	Scientific Program Committee
Non-abstract driven sessions	Three Program Committees and Conference Coordinating Committee with stakeholder input[e]		
50% of workshops	Conference Coordinating Committee	Workshop Working Group[e] (Select Members of Program Committees)	
50% of workshops	Prospective IAC Presenters	Independent Reviewing Committee[e]	Workshop Working Group (Select Members of Conference Program Committees)

[d] Each of these committees serves specific functions that are described online at www.aids2010.org. An open call for nominations for committee leadership and membership (approximately 14-17 members including 2-3 Co-Chairs) is typically followed by a selection process influenced by members of the CCC, the three program committees, and local and international partners to the IAC and the IAS. UNAIDS nominates one member each to the Community Program and Leadership and Accountability Program Committees.
[e] We were unable to access any information regarding individuals serving on the Stakeholder Input Group, Workshop Working Group or the Independent Reviewing Committee.

HOW THE ANALYSIS WAS CONDUCTED

The analysis for our report was conducted by two independent auditors who verified their results subsequent to their individual findings. Conducting the analysis with the help of two independent auditors enhanced the credibility of the analysis. When comparing the two-person audit, only two discrepancies were identified. These were reconciled when the audits were completed.

The auditors accessed the abstracts and sessions online at http://pag.aids2010.org/ and reviewed them each by day and category. Each abstract (n = 4,661) and session description (n = 528) was read and reviewed one by one, using terms that alluded to the four key populations and related issues as a broad guideline. These terms helped each auditor make a decision about whether or not to include a given abstract in the summary. These included for MSM: "men who have sex with men, gay, homosexual, homophobia, LGBT, sexual minority, queer, bisexual;" for transgender people: "transgender, transsexual, transphobia, LGBT, gender-variant people, gender identity, transmen, transwomen, cross-dressers, trans persons;" for sex workers: "sex work(er), transactional sex, commercial sex work, prostitution;" and for people who use drugs: "injecting(ion) drug use, needle/syringe exchange, substance use/abuse, intravenous, amphetamine, opioid, methadone, harm reduction, drug law, drug policy." Abbreviated or minor variations of the above terms also aided decisions regarding the inclusion of abstracts and sessions in the summary of the analysis. When abstracts or session descriptions contained terms such as "most-at-risk populations, key populations, or key populations of higher risk" they were counted under all of the categories unless there were other reasons for not doing so after reading the abstract in its entirety. Abstracts containing terms like "human rights" or "vulnerable" were studied to ascertain their relevance to any one of the four key populations studied and then included as appropriate.

Non-Exclusive and Exclusive Analysis

Identified abstracts and sessions that referenced any one or more of the key populations were tabulated under two categories based on exclusivity. This allowed the auditors to populate a spreadsheet based on *non-exclusive*[f] *and exclusive* abstracts and sessions. By non-exclusive, we mean abstracts or sessions that focused on two or more key populations. By exclusive, we mean an entire abstract or session that focused solely on one key population. It is therefore important to note that the non-exclusive analysis also includes exclusive abstracts and sessions.

[f] There are two challenges associated with quantifying the non-exclusive findings. First, the non-exclusive analysis allowed for over-reporting and counting more-than-once. Given that certain key populations do bear multiple identities – for example, a sex worker may also carry a transgender identity and vice versa – the non-exclusive analysis is also important. Using the same example, a session focused on both transgender people and sex workers was counted under both these two population categories. Therefore, the non-exclusive analysis does not lend itself to *percentile reporting* when all key populations are reported together. Second, it is difficult to precisely quantify coverage of one key population when two or more key populations were discussed. Non-exclusive findings are therefore presented in this report as a *numerical value*. However, despite the overlap in coverage and counting, the gross underrepresentation of MSM, people who use drugs, sex workers and transgender people remains glaringly evident.

ABSTRACTS

Abstracts submitted to the IAC by prospective conference presenters are either rejected or accepted for inclusion into the conference program. Abstracts are ultimately approved by the Scientific Program Committee pursuant to a blind peer-review process. At the time of application, all applicants indicate that their abstract is intended for presentation in either of two formats: didactic oral presentations or poster exhibitions.

Information regarding the total number of abstracts submitted or rejected is now available publicly on the IAC website.[32] The total number of abstracts subsequently programmed and therefore included in our analysis is 4,661. This was derived directly from the IAC's official online program available at http://pag.aids2010.org/.

The IAC 2010 Program has three categories of abstracts

The three types of abstracts are:

(1) Oral abstracts;
(2) Poster discussion abstracts; and
(3) Poster exhibition abstracts.

Oral abstracts (n = 354) are clustered to form numerous high-level scientific sessions[g] that are presented in panel format. This involves multiple individuals (typically 4-5) talking on topics linked by a common or broad theme. Oral abstracts are presented to an audience in a room with a moderator.

The rest of the abstracts are posters. However, a small number of the posters are chosen for session,[g] using a presentation format similar to oral abstracts. These are the highest scoring poster abstracts that are presented in a panel (typically 4-5 individuals) to an audience. These high-scoring posters are called poster discussion abstracts (n = 222). They are allocated a much shorter duration per presenter (typically 5 minutes) when compared to oral abstracts (typically 15-20 minutes).

Poster exhibition and viewing abstracts (n = 4,085) are displayed among several hundred posters mounted by delegates across many viewing halls throughout the duration of the conference. Several posters may be clustered together by a common theme or topic area. The presenter is invited to stand by the poster for two hours, once during the assigned day to answer any potential questions.[h]

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[g] An entire session where either oral abstracts or poster discussions are conducted is called an **abstract session**. At the IAC 2010, 354 oral abstracts were presented across 71 sessions. There were 222 poster discussion abstracts presented across 40 sessions. This is not applicable to poster exhibition abstracts, described below.

[h] Poster exhibitions allow for some personal interaction yet the transfer of knowledge and skills is presumably diluted given the volume of posters presented throughout the conference. Only delegates who are able to take sufficient time away from the main conference sessions or meetings are able to tour the poster exhibition and viewing halls and therefore benefit from this model. It is clear therefore that oral abstracts are positioned to impart more meaningful learning when compared to poster discussion abstracts and are thus treated with greater esteem.

MSM, people who use drugs, sex workers and transgender people were grossly underrepresented in each abstract category

The following table reports on non-exclusive and exclusive coverage of MSM, people who use drugs, sex workers and transgender people in oral, poster discussion and poster exhibition and viewing abstracts. Exclusive coverage is presented as both a numerical value and a percentage. Non-exclusive coverage does not lend itself to percentile reporting given that several of these abstracts were counted in more than one category.

Table II – Non-exclusive and Exclusive Abstract Coverage of Key Populations

Abstract Type	Exclusive and Non- Exclusive Coverage	MSM	People Who Use Drugs	Sex Workers	Transgender
Oral (n = 354)	Non-Exclusive	44	49	24	15
	Exclusive	**23 (6.5%)**	**30 (8.5%)**	**11 (3.1%)**	**3 (0.8%)**
Poster Discussion (n = 222)	Non-Exclusive	19	13	6	6
	Exclusive	**9 (4.1%)**	**10 (4.5%)**	**4 (1.8%)**	**3 (1.4%)**
Poster Exhibition and Viewing (n = 4,085)	Non-Exclusive	495	380	308	113
	Exclusive	**281 (6.9%)**	**231 (5.6%)**	**150 (3.7%)**	**26 (0.6%)**
All abstracts (n = 4,661)	*Non-Exclusive*	*558*	*442*	*338*	*134*
	Exclusive	***313 (6.6%)***[i]	***271 (5.7%)***	***165 (3.5%)***	***32 (0.6%)***

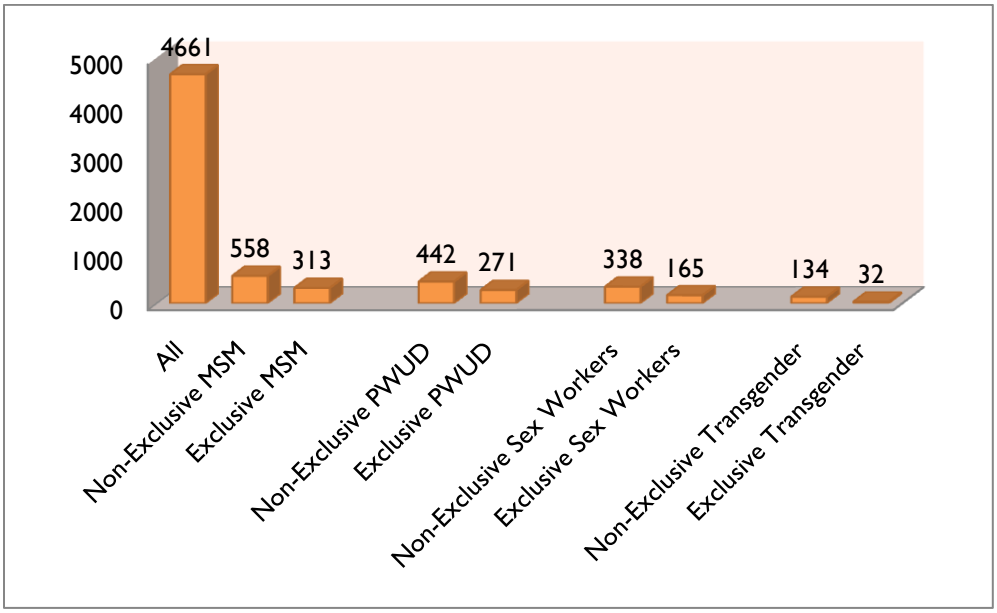
Key
n = number of abstracts in each category, or when taken together
Non-exclusive = number of abstracts that focused on two or more key populations and includes exclusive abstracts
Exclusive = number of (percentage of) abstracts that solely focused on one key population

Two, four, two and zero abstract sessions (oral abstract and poster discussion panels) out of a total of 111 sessions focused exclusively on MSM, people who use drugs, sex workers and transgender people respectively (See Appendix I). Only 558, 442, 338 and 134 of all abstracts made any mention whatsoever of MSM, people who use drugs, sex workers or transgender people respectively.

There have been concerns expressed by the IAC 2010 delegates and advocates that abstracts originally submitted for oral presentation were then relegated to poster exhibition and viewing. The seemingly higher number of posters under some key population categories may further corroborate this concern. Regardless, non-exclusive and exclusive findings across all abstracts continue to reveal the extreme gaps in program coverage of all key populations. Chart II below continues to reveal this glaring underrepresentation of the four key populations across both non-exclusive and exclusive abstracts.

[i] In 2008 at the IAC in Mexico City, only 6.7% of abstracts focused exclusively on MSM.

Chart II – Number of Non-Exclusive and Exclusive Abstracts Focused on Key Populations



Key:
Non-Exclusive: Abstracts that focused on more than one key population
Exclusive: Abstracts that focused only on one key population
All: Total number of abstracts (oral, poster discussion and posters)
PWUD: People who use drugs

NON-ABSTRACT DRIVEN SESSIONS

Non-abstract driven sessions[j] are designed by the Community Program Committee, the Leadership and Accountability Program Committee, and the Scientific Program Committee, with stakeholder input. These stakeholders are not defined on the IAC 2010 website. These sessions vary in format and focus and include three types of sessions namely symposia sessions, bridging sessions and special sessions.

MSM, people who use drugs, sex workers and transgender people were grossly underrepresented in all non-abstract driven sessions

Chart III below reports on non-exclusive and exclusive coverage of MSM, people who use drugs, sex workers and transgender people in all non-abstract driven sessions taken together.

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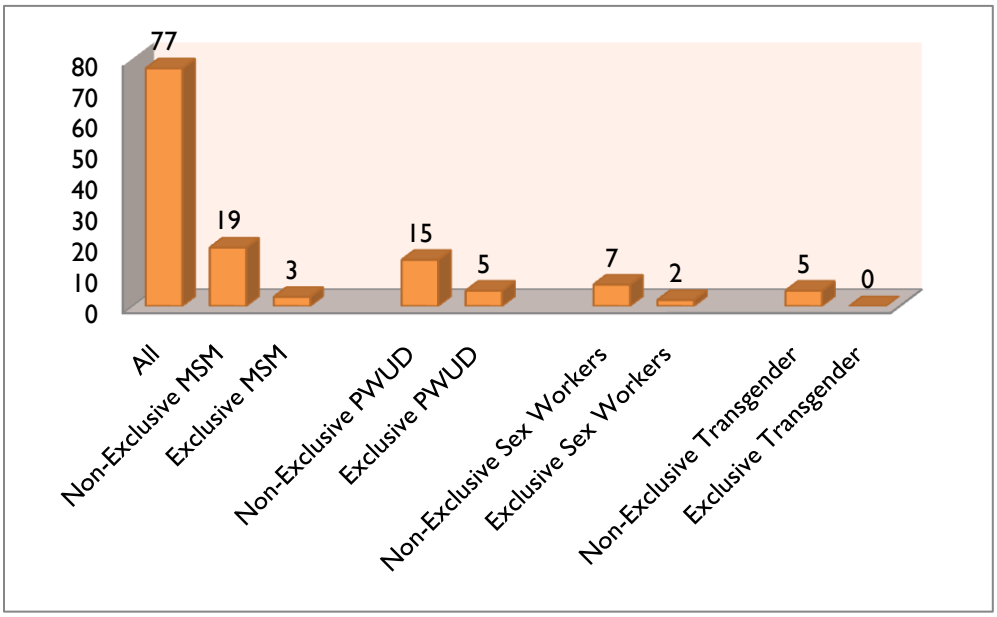
[j] According to www.aids2010.org, "***Symposia sessions*** *will deal with critical issues that defy simple solutions. Focusing on a single, clearly defined topic or issue, speakers and delegates will share experiences, contribute relevant research findings and brainstorm ideas to identify possible ways forward. Sessions will also report new findings and announce forthcoming research and new initiatives.* ***Bridging Sessions*** *connect the three program components (Science, Community, and Leadership & Accountability) to provide an opportunity for multi-disciplinary, multi-perspective dialogues on topics of common interest. Through moderated panel discussions, speakers will share knowledge and perspectives on the particular issue selected. Together with contributions from delegates, members of the panel will be encouraged to illuminate linkages and synergies between their different areas of expertise.* ***Special Sessions*** *feature presentations by some of the world's key research leaders, AIDS Ambassadors and policy specialists. These sessions, 60-minutes long and held mid-day, are highly engaging for all delegates.*

Chart III – Number of Non-Exclusive and Exclusive Non-Abstract Driven Sessions Focused on Key Populations



Key:
Non-Exclusive: Non-Abstract Driven Sessions (NADS) that focused on more than one key population (includes exclusive NADS)
Exclusive: NADS that focused only on one key population
All: Total number of NADS (symposia, bridging and special sessions)
PWUD: People who use drugs

Of all non-abstract driven sessions, only 3.8%, 5.1%, 2.5%, and 0% exclusively focused on MSM, people who use drugs, sex workers and transgender people respectively.

WORKSHOPS

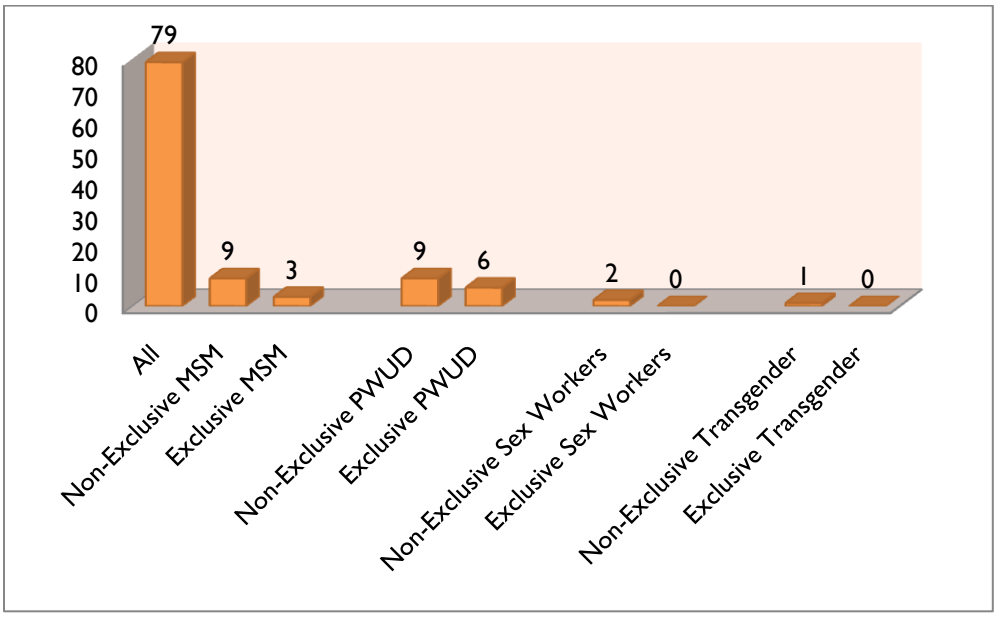
As previously presented in Table I, half of the workshops were designed by the CCC, while the rest were selected from proposals submitted through the IAC website. The IAS describes its workshops as *"high-quality, targeted workshops to promote and enhance opportunities for knowledge transfer, skills development and collaborative learning, to increase the capacity of delegates to introduce, implement, and advocate for effective, evidence-based HIV and AIDS interventions in their communities, countries and regions."*[33]

Workshops last for 90 or 180 minutes and are an important mechanism for the dissemination of specialized skills for HIV professionals to respond to the needs of the continually escalating epidemic among MSM, people who use drugs, sex workers and transgender people all over the world. There are three categories of workshops: (a) community skills, (b) leadership and accountability and (c) professional development.

MSM, people who use drugs, sex workers and transgender people were grossly underrepresented in all categories of workshops.

The following chart shows non-exclusive and exclusive coverage of MSM, people who use drugs, sex workers and transgender people in all the IAC 2010 workshops.

Chart IV – Number of Non-Exclusive and Exclusive Workshops



Key
Exclusive = Workshops that were exclusively focused on one key population
Non-Exclusive = Workshops that focused on more than one key population
PWUD = People who use drugs
All = total number of workshops

Of all workshops, only 3.7%, 6.4%, 0% and 0% exclusively focused on MSM, people who use drugs, sex workers and transgender people respectively.

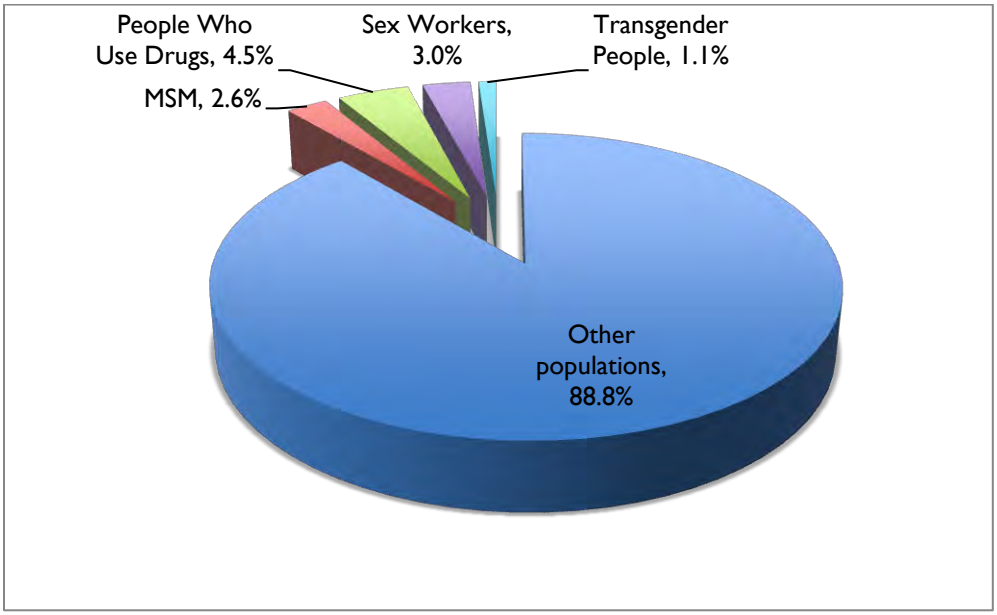
COLLECTIVE ESTIMATE OF COVERAGE IN ALL SESSIONS

MSM, people who use drugs, sex workers and transgender people were grossly underrepresented in all sessions across the IAC conference program.

Taken together across the IAC conference program, only 2.6%, 4.5%, 3.0% and 1.1% of all sessions[k] exclusively focused on MSM, people who use drugs, sex workers and transgender people respectively (see chart below).

[k] For the purpose of this analysis by **all sessions** we mean all affiliated events, bridging sessions, commercial satellite sessions, cultural activities, global village sessions, non-commercial satellites, plenary sessions, special session, symposium, community skills development workshops, leadership and accountability development workshops, and professional development workshops. Sessions also include abstract sessions where multiple oral and poster discussion abstracts are presented together (described later). Thus, the total number of sessions excluding poster exhibition and viewing abstracts is 528 (abstract sessions n=111, non-abstract driven sessions n=77 and activities n=340).

Chart V – Exclusive Coverage of MSM, People Who Use Drugs, Sex Workers and Transgender People in All Sessions



IMPLICATIONS FOR LEADERSHIP AND ACCOUNTABILITY IN THE GLOBAL AIDS RESPONSE

There is mounting and compelling evidence that MSM, people who use drugs, sex workers and transgender people are particularly vulnerable to HIV. All HIV professionals and health workers must possess the skills to effectively respond to the HIV prevention, treatment, care and support needs of these populations. The lack of opportunity to do so for a large cohort of AIDS professionals at the IAC undermines collaborative responses to global public health.

The poor program coverage of MSM, people who use drugs, sex workers and transgender people at the IAC raises questions about how programming decisions are made through IAS and IAC governance structures and procedures. It further reveals the sobering lack of opportunity for knowledge production and discourses that could be crucial to stemming the epidemic among these populations.

Our analysis therefore provides an opportunity for advocates to ensure leadership, transparency and accountability within the CCC and subservient governance structures in a manner that aligns future programming at the IAC with epidemiological burden and health needs of key populations on the ground.

RECOMMENDATIONS

The need for leadership, transparency and accountability is more significant now than ever before, given persistent economic crises and dwindling resources for global health and the AIDS epidemic. As a premier venue for researchers, scientists, funders, government officials and people at the front lines of HIV service

delivery to engage in constructive dialogue, the IAC can serve as a vehicle for change. It has the potential to influence knowledge production, policy and advocacy strategies, donor responses, research foci, industry behavior and political scenarios. Therefore, the IAC has a responsibility to all of its stakeholders to ensure that it allows the voices of all people affected by HIV to be heard at levels that are truly reflective of their needs. The following broad recommendations provide a framework for the IAS and the IAC to review program-related governance and operations to help bolster public health efforts targeting MSM, people who use drugs, sex workers and transgender people.

Program coverage of key populations at each IAC must seriously and respectfully reflect epidemiological burden and on-the-ground needs

The disconnection between epidemiology and conference programming is egregious. The IAC must make certain that the populations who are most impacted by HIV can meaningfully participate at all levels of the conference. Further, mainstream HIV professionals must walk away from the IAC having had adequate access to skills in order to respond to the needs of key populations in their respective communities and countries. The level of program coverage seen at IAC 2010 is woefully insufficient for transfer of knowledge or skills to a wide spectrum of professionals.

The IAC must make its abstract review mechanisms and program decision-making processes transparent and easily available to stakeholders

While the IAC pursues a blinded peer-review process for evaluating submitted abstracts, it should also create mechanisms for conducting and communicating effectively with global HIV constituencies about how these decisions are made. Relegating abstracts submitted in one category of presentation to another is a practice that signals executive decisions and processes that undermine the idea of a fair and open review process. This practice also side-steps opportunities to elevate issues of importance to the four key populations. We believe that making available comprehensive information regarding the number of abstracts submitted and their acceptance or rejection is an effective way to demonstrate transparency and accountability.

The IAC must ensure that scientific reviewers bring appropriate skills and expertise that allow for diverse and meaningful programming of key populations

The CCC must be able to review and ensure the expertise and appropriateness of abstract reviewers to score abstracts related to key populations. Abstracts that end up being downgraded or rejected as a result of high inter-rater variability during the abstract review process should trigger a secondary review process by reviewers qualified on issues of concern to MSM, sex workers, transgender people, and people who use drugs. The final assessment should be based on an abstract's contribution to advancing the field.

Clinical, epidemiologic, and intervention studies employing traditional experimental designs are important but should not be privileged over social science, policy, evaluation, operations, or other research approaches for which research and methodological designs may be different. This is particularly important in relation to research focused on MSM, sex workers, transgender people and people who use drugs given the constellation of social, cultural, political, legal, and economic factors that drive the HIV epidemic for these groups. The IAC

should encourage an interdisciplinary pool of research in its call for abstracts. Reviewers should be well matched by expertise to evaluate abstracts. For example, operations research should be evaluated by reviewers with expertise in operations research. In addition, abstracts should be evaluated within disciplinary categories. For example, abstracts focused on community mobilization strategies should be judged against best practice standards established within the sector focused on community mobilization strategies. The IAC must conduct its review processes with this understanding and in a way that allows for a more even playing field across sectors.

Abstract preparation tools and support should be developed and made available to key populations in close consultation with networks representing these groups

Key populations must be encouraged and resourced appropriately to submit focused abstracts that highlight on-the-ground realities. Non-governmental organizations and civil society, as well as research and academic institutions that focus on issues of concern to key populations, must be leveraged for their expertise in overall conference programming. Strategic partnerships that are fostered between the IAS and these key stakeholders must be modeled in a manner that encourages greater participation and abstract submission rates from potential presenters who focus on MSM, transgender, people who use drugs or sex workers. We need innovative methods to help support abstract authors, given that marginalized populations are often isolated from these resources, especially in low- and middle-income countries. The newly formed partnership between the IAS and Health [e] Foundation for the delivery of online abstract preparation courses must ensure sensitive capacity building and technical support mechanisms.

The IAC should program non-abstract driven and plenary sessions with greater rigor and transparency to help advance the human rights issues for which the IAS continues to strive

There were no plenary sessions that exclusively focused on MSM, sex workers or transgender people at IAC 2010. Exclusive program coverage of MSM, people who use drugs, sex workers and transgender people in non-abstract driven sessions were 3.8%, 6.5%, 2.6% and 0% respectively. Both plenary sessions and non-abstract driven sessions are exclusively programmed by the CCC and subservient working groups and governance structures. There is a lack of transparency to the method by which programming decisions were made for these sessions, which failed to involve a formal submission process from potential participants.

Plenary sessions and non-abstract driven sessions benefit from the attendance of large cohorts of IAC conference delegates. Select sessions are webcast and therefore have the unique capacity to shape opinions and inform global, national and regional efforts to fill major gaps in the AIDS response. The IAC must therefore ensure a rigorous process for programming non-abstract driven sessions and plenary sessions in a manner that reflects the epidemic and focus of the conference.

The IAC should develop and disseminate a comprehensive resource tool for HIV workers that synthesizes information presented at each biennial conference pertinent to key populations

Knowledge concerning strategies for tackling the epidemic among MSM, people who use drugs, sex workers and transgender people has been made disparate and diluted by structural barriers, the violation of human

rights and the general invisibility of these populations. Weak programming at the IAC only adds to this challenge and further diminishes any possibility of mapping out available information related to these four vulnerable groups. The collation of new scientific developments, knowledge, information and civil society responses is integral to building capacity to respond in concert with vulnerable groups. These strategies must find their dissemination point at the IAC. A report that synthesizes all input and knowledge gathered at the IAC pertinent to MSM, people who use drugs, sex workers, and transgender people would be a useful advocacy and learning tool for those working in the field of HIV.

Civil society must be engaged through open representation on the Conference Coordinating Committee and the three program committees for 2014 and beyond.

The MSMGF urges the IAS to review its processes in order to create substantive room for thought leaders and representatives who are members of key populations, incorporating their leadership at the structural and committee levels within IAC governance structures. This can be done by more deliberately seeking expanded participation of MSM, transgender people, people who use drugs, and sex workers at the level of the CCC, Co-Chair positions, and the various committees that serve the IAC. Civil society must be fully engaged not only in the planning, monitoring, and evaluation of the IAC but also in decision-making related to representation. Such engagement necessarily entails more than simple, tokenistic representation; it must ensure that the participation of MSM, people who use drugs, sex workers and transgender people is geographically relevant, transparent, and reflective of priorities on the ground.

CONCLUSION

Major findings from this analysis underscore the need for rigorous and transparent programming and decision-making within planning bodies for the IAC in 2012 and future conferences. For organizations working with and on behalf of key affected populations, the chance to connect and strategize with international funders, researchers and local implementers working on similar issues in other parts of the world is especially important. Grassroots activists and HIV workers do not have access to a conglomerate wealth of resources in their home countries comparable to what could potentially be accessed through the IAC platform. With a mandate to address the global AIDS pandemic and a powerful tool to do so, the IAS has an obligation to remedy inadequate program coverage of issues important to MSM, people who use drugs, sex workers and transgender people in meaningful and inclusive ways. The MSMGF therefore urges an immediate review of IAS and IAC decision-making processes that determine program coverage, including a review of the operations of IAC governance structures.

APPENDIX 1 – COMPLETE DATA SETS

Table 1 - Men who have sex with men

PROGRAM CATEGORY	Non-exclusive[l] MSM	n[m]	Exclusive[n] MSM
ABSTRACTS	**558**	**4,661**	**313**
1. Oral	44	354	23
2. Poster Discussion	19	222	9
3. Poster Exhibition	495	4,085	281
ABSTRACT SESSIONS[o]	**36**	**111**	**2**
1. Oral	25	71	2
2. Poster Discussion	11	40	0
NON-ABSTRACT DRIVEN SESSIONS	**19**	**77**	**3**
1. Bridging	2	12	1
2. Special Session	2	18	1
3. Symposium	15	47	1
ACTIVITIES[p]	**34**	**340**	**9**
1. Affiliated Events	0	5	1
2. Commercial Satellite	0	9	0
3. Cultural Activity	6	59	1
4. Global Village	5	49	3
5. Non-commercial satellite	14	131	1
6. Plenary[q]	-	8	0
7. Workshops	**9**	**79**	**3**
a. Community Skills Development	*3*	*30*	*2*
b. Leadership & Accountability Development	*1*	*23*	*0*
c. Professional Development	*5*	*26*	*1*

[l] Total number of abstracts or sessions that focused on two or more key populations
[m] n=total number of abstracts or sessions
[n] Abstracts or sessions that focused solely on one key population
[o] Abstract Sessions = Panel presentations of multiple abstracts presented together for an audience in one room
[p] These estimates include workshops
[q] We do not report on non-exclusive coverage of key populations on plenary sessions given the challenge in quantifying coverage of any key population

Table II - People who use drugs

PROGRAM CATEGORY	Non-exclusive PWUD	n	Exclusive PWUD[r]
ABSTRACTS	**442**	**4,661**	**271**
1. Oral	49	354	30
2. Poster Discussion	13	222	10
3. Poster Exhibition	380	4,085	231
ABSTRACT SESSIONS	**33**	**111**	**4**
1. Oral	25	71	3
2. Poster Discussion	8	40	1
NON-ABSTRACT DRIVEN SESSIONS	**15**	**77**	**4**
1. Bridging	2	12	0
2. Special Session	2	18	1
3. Symposium	10	47	3
ACTIVITIES	**34**	**340**	**16**
1. Affiliated Events	0	5	0
2. Commercial Satellite	0	9	0
3. Cultural Activity	4	59	1
4. Global Village	5	49	3
5. Non-commercial satellite	15	131	5
6. Plenary	1	8	1
7. Workshops	***9***	***79***	***6***
a. Community Skills Development	*2*	*30*	*1*
b. Leadership & Accountability Development	*5*	*23*	*4*
c. Professional Development	*2*	*26*	*1*

[r] PWUD = People who use drugs

Table III - Sex Workers

PROGRAM CATEGORY	Non-exclusive Sex Workers	n	Exclusive Sex Workers
ABSTRACTS	**338**	**4,661**	**165**
1. Oral	24	354	11
2. Poster Discussion	6	222	4
3. Poster Exhibition	308	4,085	150
ABSTRACT SESSIONS	**19**	**111**	**2**
1. Oral	13	71	2
2. Poster Discussion	6	40	0
NON-ABSTRACT DRIVEN SESSIONS	**7**	**77**	**2**
1. Bridging	0	12	0
2. Special Session	0	18	0
3. Symposium	7	47	2
ACTIVITIES	**26**	**340**	**12**
1. Affiliated Events	0	5	0
2. Commercial Satellite	0	9	0
3. Cultural Activity	6	59	5
4. Global Village	7	49	4
5. Non-commercial satellite	11	131	3
6. Plenary	-	8	0
7. Workshops	***2***	***79***	***0***
a. Community Skills Development	*1*	*30*	*0*
b. Leadership & Accountability Development	*1*	*23*	*0*
c. Professional Development	*0*	*26*	*0*

Table IV- Transgender People

PROGRAM CATEGORY	Non-exclusive transgender	n	Exclusive transgender
ABSTRACTS	**134**	**4,661**	**32**
1. Oral	15	354	3
2. Poster Discussion	6	222	3
3. Poster Exhibition	113	4,085	26
ABSTRACT SESSIONS	**17**	**111**	**0**
1. Oral	12	71	0
2. Poster Discussion	5	40	0
NON-ABSTRACT DRIVEN SESSIONS	**5**	**77**	**0**
1. Bridging	0	12	0
2. Special Session	1	18	0
3. Symposium	4	47	0
ACTIVITIES	**15**	**340**	**6**
1. Affiliated Events	0	5	0
2. Commercial Satellite	0	9	0
3. Cultural Activity	9	59	5
4. Global Village	2	49	1
5. Non-commercial satellite	3	131	0
6. Plenary	-	8	0
7. Workshops	***1***	***79***	***0***
a. Community Skills Development	*0*	*30*	*0*
b. Leadership & Accountability Development	*1*	*23*	*0*
c. Professional Development	*0*	*26*	*0*

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