

# An analysis of abstracts from the Toronto AIDS conference – did we deliver for children?

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## An analysis of abstracts from the Toronto AIDS Conference – did we deliver for children?

The 2006 International AIDS Conference was held in Toronto, Canada and was the largest gathering of HIV researchers to date. Horton (2006) posed a challenge at the conference by highlighting many of the shortcomings in relation to HIV issues and care associated with children. An analysis of the 2004 Bangkok conference showed some of the difficulties associated with abstract acceptance on child-related issues. This study represents a follow-up with a similar analysis for the Toronto conference.

### *International AIDS Conferences — a brief explanation*

The International AIDS Conferences provide a focal point for research, updates and information exchange in the global fight against HIV. Countries from around the world participate in the conferences, which encourage multidisciplinary decision-making and policy formation on the most prominent HIV topics. The meetings are known to influence strategy and policy and to direct the response to the AIDS epidemic over the short term (Gayle and Wainberg 2007). Wells (2006) noted “the biennial AIDS conference is often exhausting and irritating, but it offers a unique view of how science and society interact”.

The Toronto conference was the 16th such meeting, and attracted more than 24,000 delegates. Box 1 lists previous international AIDS gatherings to date.

#### **Box 1. International AIDS Society Conferences to date**

- Atlanta (1985)
- Paris (1986)
- Washington (1987)
- Stockholm (1988)
- Montreal (1989)
- San Francisco (1990)
- Florence (1991)
- Amsterdam (1992)
- Berlin (1993)
- Yokahama (1994)
- Vancouver (1996)
- Geneva (1998)
- Durban (2000)
- Barcelona (2002)
- Bangkok (2004)
- Toronto (2006)
- *Forthcoming Mexico (2008)*

There are many views on the conference, but it is clear that it plays a pivotal role in networking, information exchange and policy-making. For example an editorial in *Nature* (2006) noted “The biennial ritual of activists heckling drug-company officials or tearing down their stands may seem trite, the political speeches tiresome, and the appearances by Hollywood figures and other celebrities frivolous. But that’s the world we live in. Full participation in the AIDS meeting will, as it has in the past, serve to invigorate researchers and ensure the continued relevance of their work.”

### *Background to the study*

The Toronto conference received over 12,000 abstracts, from which an interdisciplinary programme was selected. Abstracts were subjected to a blind review process and awarded one of six levels: oral presentation, key discussion, poster discussion, poster exhibition, CD-only, or reject. The database of abstracts was reproduced on a CD.

The oral presentations formed the major part of the programme. The discussion groups clustered around the posters in the poster area, with gatherings of delegates and a brief (5 minute) discussion. The poster exhibitions allowed for a poster presentation display. Delegates were able to talk informally to authors who were requested to be present at their poster at designated timeslots. CD-only abstracts appeared on the CD, but did not appear in any other way in the programme. The rejected abstracts did not appear on the CD.

The conference comprised five themes, which are listed in Box 2.

### Box 2. The five themes (tracks) at the Toronto AIDS Conference

- **Track A** – Basic science
- **Track B** – Clinical research, treatment and care
- **Track C** – Epidemiology and prevention
- **Track D** – Social and Economic issues
- **Track E** – Policy and Programme implementations

An earlier analysis was carried out of the 2004 Bangkok Conference abstracts (Sherr 2006). This analysis found that child-related abstracts formed 3.6% of accepted abstracts. This was lower than the average acceptance rate for all abstracts. Acceptance of child-related abstracts was more likely in the medical tracks, despite the fact that there were more psychosocial than medical abstracts submitted. Overall, this previous analysis showed an under-representation of child-related abstracts, with an emphasis on medical and empirical/quantitative data in those accepted.

This paper aims to explore the frequency and specifics of child-focused HIV research through a detailed analysis of the abstract database of the Toronto International AIDS Conference. With the understanding and knowledge gained from this analysis it will be possible to inform research and programme agendas, and highlight any changes from the Bangkok conference as planning towards Mexico 2008 proceeds.

## Methodology

The database from the conference was used for this analysis. The database contained 12,780 abstracts and was accessed by courtesy of the International AIDS Society, for which we gratefully acknowledge our thanks. The analysis does not include invited (non-abstract-driven) sessions, such as plenary talks. Two major searches of the database were made.

### *Search 1 – keyword search*

This search provided a list of abstracts where selected keywords had appeared anywhere in the abstract (title or content). Twenty-five keywords were used: 'pregnancy', 'treatment', 'gay men', 'migrant', 'drug use', 'adherence', 'HAART', 'interruption', 'vaccine', 'side-effects', 'women', 'adolescent', 'USA', 'Africa', 'children', 'orphan', 'infant', 'paediatric/pediatric', 'law', 'ethics', 'access', 'prevention', 'microbicide', 'RCT' ('randomised controlled trial') and 'Clinton/Gates'. These comprise the 18 keywords used in the Bangkok analysis which were repeated for an analysis of change over time, plus additional keywords capturing up-to-date themes.

## Search 2 – child-related database creation

A second more detailed selection of abstracts was made, and a child-related abstract database created from this selection. This was carried out as follows.

A computer programme was written to capture all abstracts containing one of the following keywords: 'child', 'children', 'orphan', 'family', 'pediatric', 'paediatric', 'infant', 'youth', 'adolescent', 'pregnancy', 'childbirth', 'baby' and 'child development'. All identified abstracts were then compiled into a specific database for detailed analysis. This search generated a database of 2712 abstracts, drawn from the original 12,780.

This database of 2712 was then further refined by detailed reading, and abstracts shortlisted for direct child-relevance, rather than simply mentioning the word child within the body of the abstract. All abstracts were read through by a researcher for relevance. A random selection were double-coded by a second researcher to ensure agreement with the sort process. A total of 748 abstracts met the inclusion criteria ( $748/2712=27.6\%$ ) and were deemed to be directly related to children.

A separate coding was carried out on the rejected abstracts, which will be written up separately given that this information was not to hand in Bangkok.

The 748 shortlisted abstracts were then coded for the variables shown in Table 1.

**Table 1. Coding used for shortlisted abstracts**

Code	Full abstract database mentioning children (n = 2712)	Hand-screened database of child-relevant abstracts (n = 748)
Abstract number	✓	✓
Author title	✓	✓
Abstract in full	✓	✓
Track number (A, B, C, D, E)	✓	✓
Abstract presenter gender	✓	✓
Decision on paper (1 = oral, 2 = key challenge/poster discussion, 3 = poster exhibition, 4 = CD-only, 5 = reject)	✗	✓
Presenting country/continent (1 = Africa, 2 = Europe, 3 = Asia, 4 = North America, 5 = South America, 6 = Australia, 7 = Antarctica)	✗	✓
Type of paper (1 = medical, 2 = psychosocial, 3 = both, 4 = other)	✗	✓
Empirical (1 = yes, 2 = no)	✗	✓
Methodology of study (0 = N/A, 1 = quantitative, 2 = qualitative, 3 = both)	✗	✓
Children focused upon (1 = infected, 2 = affected, 3 = both, 4 = not specified)	✗	✓
Age of children (1 = infants, 2 = children, 3 = adolescents, 4 = mixed, 5 = not specified)	✗	✓
Random control trial (1 = yes, 2 = unsure, 3 = no)	✗	✓
Sample number quoted in abstract (n)	✗	✓

Data were entered into an Excel worksheet and then coded and entered into SPSS (Statistical Package for the Social Sciences, a statistical software package used for data analysis and data management) for analysis.

## Results

### Abstract acceptance

Of the 12,780 abstracts submitted to the conference, the decisions were as shown in Table 2.

**Table 2. Decisions on abstracts for the Toronto AIDS Conference**

Decision	Number of abstracts
Oral presentation	301
Key discussion	86
Poster discussion	126
Poster exhibition	3984
CD-only	5629
Rejected	2654

The chance of acceptance under the different categories (Table 3) was calculated for all the abstracts submitted ( $n=12,780$ ), and for all those that appear on the CD (i.e. all abstracts except those that were rejected;  $n=10,126$ ). The latter calculation was made to facilitate comparison with the Bangkok conference (where the rejected abstracts were not available for analysis and 'CD-only' was taken as rejection).

**Table 3. Chances of acceptance under the different categories**

Category of acceptance	% chance for all submitted abstracts ( $n=12,780$ )	% chance for selected abstracts ( $n=10,126$ )
Oral presentation	2.36	2.97
Poster discussion	0.99	1.24
Key discussion	0.67	0.85
<i>(Poster and key discussions combined)</i>	<i>1.66</i>	<i>2.09</i>
Poster exhibition	31.17	39.34
CD-only	44.05	55.59
Rejected	20.77	NA

Therefore, on submitting an abstract, authors had a 2.36% chance of being accepted for an oral presentation, a 0.99% chance of being accepted for a poster discussion, a 0.67% chance of being accepted for a key discussion, a 31.17% chance of being accepted for a poster exhibition, a 44.05% chance of being accepted for the CD-only and a 20.77% chance of having their abstract rejected.

Of the selected abstracts, i.e. excluding the 'rejected' list ( $n=10,126$ ), the chances were: oral presentation 2.97%, poster discussion 1.24%, key discussion 0.85%, poster exhibition 39.34% and CD-only 55.59%.



## Keyword analysis

The keyword analysis was carried out using the full database, i.e. the one containing all submitted abstracts ( $n=12,780$ ). Table 4 gives the selection decisions for the abstracts containing the keywords. The percentages are calculated as a percent of all abstracts containing the keyword in question.

**Table 4. Selection decisions for keyword-containing abstracts**

Keyword	Total abstracts	Oral presentation		Poster (KD,PD,PE)		CD-only/Reject	
		<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Pregnancy	447	9	2.0	145	32.4	293	65.6
Treatment	4137	96	2.3	1467	35.5	2574	62.2
Gay men	342	9	2.6	141	41.2	192	56.1
Migrant	393	11	2.8	120	30.5	262	66.7
Drug Use	963	23	2.4	347	36	593	61.6
Adherence	995	9	0.9	371	37.3	615	61.8
HAART	971	27	2.8	392	40.3	552	56.9
Interruption	84	3	3.6	30	35.9	51	60.7
Vaccine	300	20	6.7	123	41	157	52.3
Side-effects	271	1	0.4	77	28.4	193	71.2
Women	2933	78	2.7	991	33.7	1864	63.6
Adolescent	636	11	1.7	198	31.2	427	67.1
USA	890	21	2.4	314	35.2	555	62.4
Africa	2217	71	3.2	833	37.6	1313	59.2
Children	1844	43	2.3	530	28.7	1271	69.0
Orphan	513	7	1.4	132	25.7	374	72.9
Infant	365	12	3.3	144	39.4	209	57.3
Paediatric	348	17	4.9	118	33.9	213	61.2
Law	681	27	4.0	216	31.7	438	64.3
Ethics	94	4	4.3	29	30.9	61	64.9
Access	3028	64	2.1	1017	33.6	1947	64.3
Prevention	4537	88	1.9	1464	32.3	2985	65.8
Microbicide	101	6	5.9	42	41.6	53	52.5
RCT	26	1	3.9	15	57.7	10	38.5
Clinton/Gates	94	4	4.3	41	43.6	49	52.1

The highest chances of rejection were found for abstracts with the keywords 'orphan', 'side-effects', 'children', 'adolescent' and 'migrant', in that order. The lowest chances of rejection were found for abstracts containing the keywords 'randomised controlled trial', 'microbicide', 'vaccine' and 'Clinton/Gates', in that order. Conversely the keywords 'vaccine' and 'microbicide' appeared in abstracts with the highest likelihood of acceptance for oral presentation (6.7% and 5.9%, respectively). The next highest chances of acceptance for oral presentation related to abstracts that had the word 'paediatric' (4.9%), 'Clinton' or 'Gates' (4.3%), 'ethics' (4.3%), 'law' (4.0%) and 'randomised controlled trials' (3.9%). The highest acceptance as posters (PD, KD, PE) was found for those abstracts with the

keywords 'randomised controlled trial', 'Clinton/Gates', 'microbicide', 'vaccines', 'HAART' and 'gay men'. The lowest acceptance for posters (PD, KD PE) was found for those with the keywords 'orphans', 'children' and 'side-effects'.

Overall, of the 1844 abstracts with the keyword 'children', 2.3% were accepted for oral presentation. The acceptance rate for oral papers for the conference was 2.4%. The keyword search shows that abstracts containing the keywords 'pregnancy', 'adherence', 'side-effects', 'adolescents', 'children', 'orphans', 'access' and 'prevention' had less than this rate of acceptance. The conference average for poster acceptance (combining all forms of exhibition and discussion) was 32.8%. The conference rate of rejection was 64.8%. Keywords associated with higher-than-average rejection included 'pregnancy', 'migrants', 'side-effects', 'adolescents', 'children', 'orphans' and 'prevention'.

## Child-related abstracts

### *Abstract acceptance*

The detailed search produced 748 abstracts relevant to children. This represents 7.4% of all abstracts that appeared in the database (excluding those that were rejected outright;  $n=10,126$ ). These were subjected to full coding and detailed analysis. Child-related abstract outcomes are shown in Table 5.

**Table 5. Decisions on child-related abstracts**

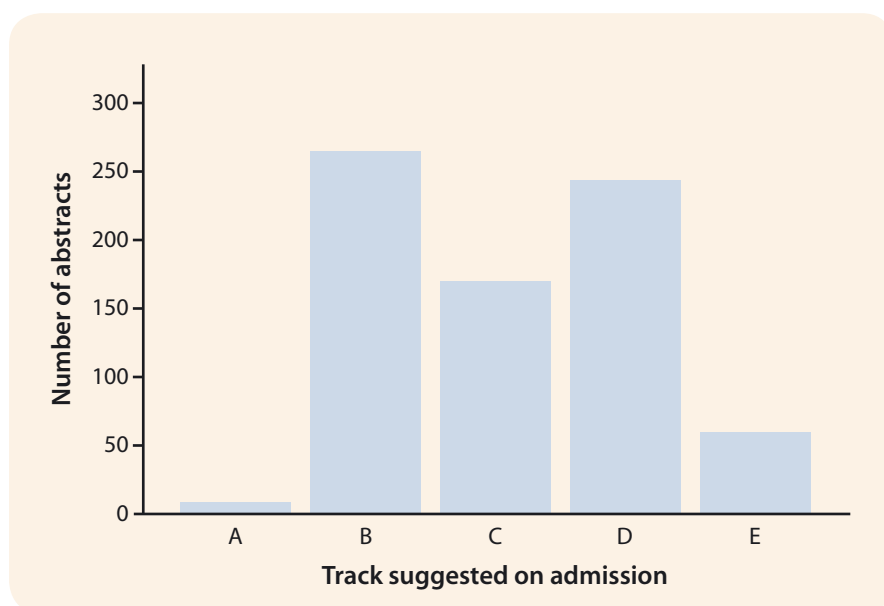
Decision	Number of abstracts	%
Oral	30	4.0
Key/poster discussion	9	1.2
Poster exhibition	291	38.9
CD-only	418	55.9
<b>Total</b>	<b>748</b>	<b>100.0</b>

An abstract on children had a slightly higher than average chance of receiving an oral presentation, a lower chance of a key or poster discussion and a similar rate for poster exhibition or CD-only acceptance. This is in contrast to the Bangkok conference.

## Track submission

Only the oral presentations were allocated tracks. Of the child-related abstracts, none were in track A, 14 (48.3%) were in track B, 3 (10.3%) in track C, 7 (24.1%) in track D and 5 (17.2%) in track E. By far the majority of oral abstracts on children were in the medical track (B), which accounted for nearly half of all child-related oral presentations.

When submitting an abstract, authors suggest a relevant track (Figure 1). Table 6 sets out acceptance according to suggested track by the authors – this gives an indication of area of study. For the purpose of this analysis, three groups are used: oral, poster (exhibition or discussion) and CD (which is designated as rejected).



**Figure 1. Track suggested by authors on submission**

**Table 6. Acceptance of child-related abstracts according to track suggested by authors on submission**

Track suggested on submission		Reduced decision on abstract			Total
		Oral	Poster	CD	
A	<i>n</i>	0	5	3	8
	% within track suggested on admission	0	62.5	37.5	100
	% within reduced decision on abstract	0	1.7	0.7	1.1
	% of total	0	0.7	0.4	1.1
B	<i>n</i>	12	115	139	266
	% within track suggested on admission	4.5	43.2	52.3	100
	% within reduced decision on abstract	41.4	38.2	33.3	35.6
	% of total	1.6	15.4	18.6	35.6
C	<i>n</i>	4	57	109	170
	% within track suggested on admission	2.4	33.5	64.1	100
	% within reduced decision on abstract	13.8	18.9	26.1	22.8
	% of total	0.5	7.6	14.6	22.8
D	<i>n</i>	7	100	136	243
	% within track suggested on admission	2.9	41.2	56.0	100
	% within reduced decision on abstract	24.1	33.2	32.6	32.5
	% of total	0.9	13.4	18.2	32.5
E	<i>n</i>	6	24	30	60
	% within track suggested on admission	10.0	40.0	50.0	100
	% within reduced decision on abstract	20.7	8.0	7.2	8.0
	% of total	0.8	3.2	4.0	8.0

Of the eight abstracts submitted to track A, none were accepted as an oral presentation, five (62.5%) were accepted as some form of poster, and three (37.5%) were rejected. Of the 266 abstracts submitted to track B, 12 (4.5%) were accepted as an oral presentation, 115 (43.2%) as some form of poster and 139 (52.3%) were rejected. Of the 170 abstracts submitted to track C, four (2.4%) were accepted as oral presentations, 57 (33.5%) as some form of poster and 109 (64.1%) were rejected. Of the 243 abstracts submitted to track D, seven (2.9%) were accepted as oral presentations, 100 (41.2%) as some form of poster and 136 (56%) were rejected. Of the 60 abstracts submitted to track E, six (10%) were accepted as oral presentations, 24 (40.0%) as some form of poster and 30 (50%) were rejected. This variation was significant (chi squared=15.09,  $p=0.05$ ).

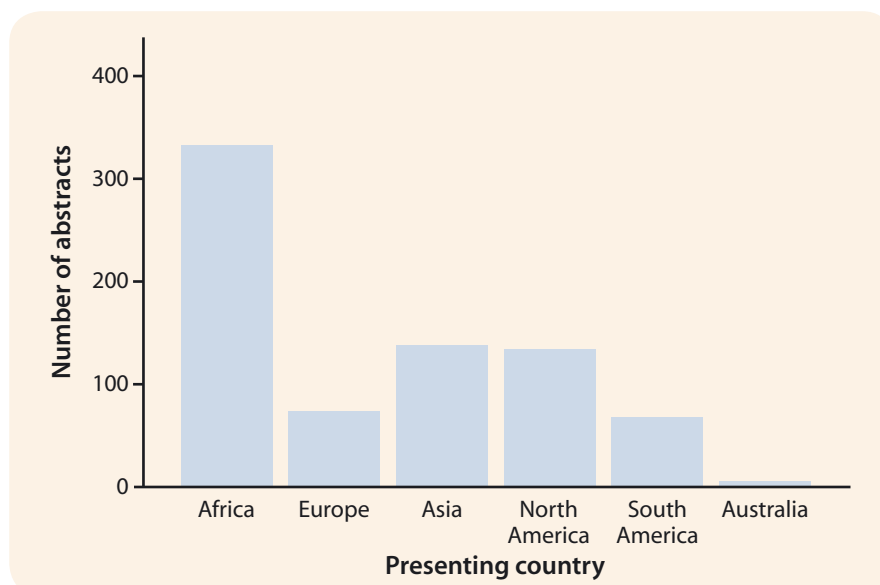
## Gender of presenter

There were no significant effects on acceptance of child-related abstracts according to the gender of the presenting author. Where gender was coded, 39.7% were male presenters and 57.1% were female presenters (chi square=1.073,  $p=0.983$ ).

## Geographical location of presenting authors

Given that the majority of children infected with and affected by HIV are located in Africa, it was not surprising that the majority of child-related abstracts came from Africa. The international distribution by continent is shown in Figure 2. Table 7 gives the geographical location of the presenting authors according to outcome decision.

The majority of papers on children came from Africa (331; 44.3%). Of these 3% were given an oral presentation. Seventy-four (9.9%) papers came from Europe, with three (4.1%) receiving an oral presentation. A total of 139 (18.6%) came from Asia and two (1.4%) were allocated an oral presentation. A total of 135 papers (18%) came from North America, 13 of which (9.6%) were given an oral presentation. Of the six South American papers, one (1.5%) was given an oral presentation. Only three papers came from Australia. None was given an oral



**Figure 2. Geographical location of presenting authors**

**Table 7. Geographical location of presenting authors and abstract decision**

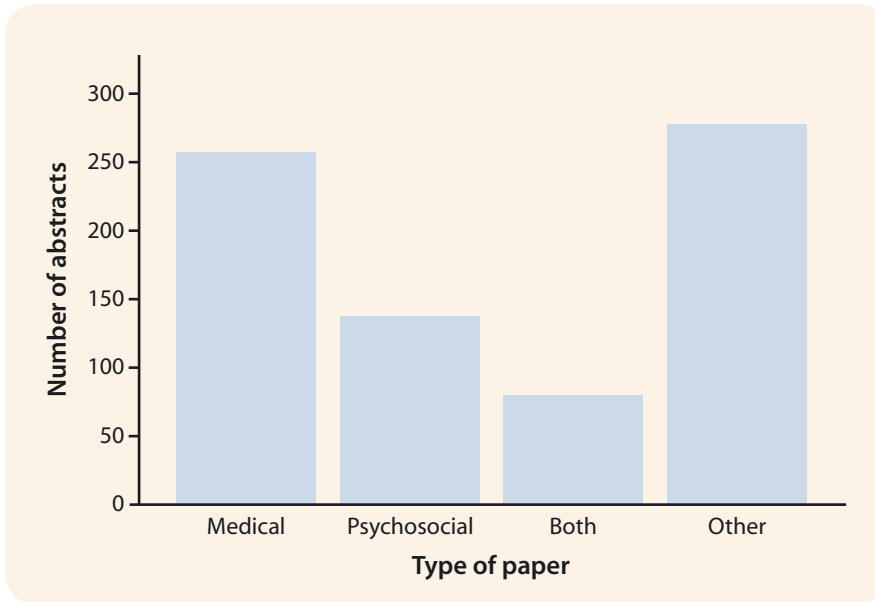
Presenting continent		Decision on abstract			Total
		Oral	KC/PE/PD	CD/reject	
Africa	<i>n</i>	10	140	181	331
	% within presenting country	3.0	42.3	54.7	100
	% within reduced decision on abstract	34.5	46.5	43.3	44.3
	% of total	1.3	18.7	24.2	44.3
Europe	<i>n</i>	3	40	31	74
	% within presenting country	4.1	54.1	41.9	100
	% within reduced decision on abstract	10.3	13.3	7.4	9.9
	% of total	0.4	5.3	4.1	9.9
Asia	<i>n</i>	2	54	83	139
	% within presenting country	1.4	38.8	59.7	100
	% within reduced decision on abstract	6.9	17.9	19.9	18.6
	% of total	0.3	7.2	11.1	18.6
North America	<i>n</i>	13	55	67	135
	% within presenting country	9.6	40.7	49.6	100
	% within reduced decision on abstract	44.8	18.3	16.0	18.0
	% of total	1.7	7.4	9.0	18.0
South America	<i>n</i>	1	12	53	66
	% within presenting country	1.5	18.2	80.3	100
	% within reduced decision on abstract	3.4	4.0	12.7	8.8
	% of total	0.1	1.6	7.1	8.8
Australia	<i>n</i>	0	0	3	3
	% within presenting country	0	0	100	100
	% within reduced decision on abstract	0	0	0.7	0.4
	% of total	0	0	0.4	0.4

presentation. The geographical variation was significant (chi squared=40.54,  $p=0.0001$ ). Although North America accounted for only 18% of submissions, it accounted for 44.8% of oral acceptances. Papers from Africa accounted for 44.3% of submissions and 34.5% of oral presentations.

## Subject matter

The coding allowed for several possibilities. Medical papers included all those related to medical practice, specific drug related or medical outcome information and medical care. Psychosocial papers included those examining well-being, mental health, psychosocial programmes and provisions. Some papers had a mixed focus and these were included as both medical and psychosocial if the abstract made this clear. Other papers included those on policy, general educative descriptions and those dedicated to raising the awareness of child-related issues in general.

A total of 257 papers (34.4%) were coded as clearly medical, 137 (18.3%) as psychosocial, 77 (10.3%) as both medical and psychosocial, and 277 (37%) as other subject matter (Figure 3).



**Figure 3. Distribution of abstracts according to subject matter**

Table 8 shows acceptance according to subject matter. Of the 257 medical papers (34.4% of all child-related abstracts), 15 (5.8%) received an oral presentation. Of the 137 psychosocial papers (18.3%), four (2.9%) received an oral presentation. Of the 77 mixed papers (10.3%), one (1.3%) received an oral presentation. Of the 277 on other topics (37%), nine (3.2%) received an oral presentation. The variation was significant (chi squared=24.94,  $p=0.0001$ ). These data show that child related abstracts in the medical category have nearly a four-fold higher chance of acceptance for oral presentation.

## Type of methodology employed by the study

### *Empirical vs non-empirical*

Of the abstracts, 358 (47.49%) were coded as empirical, and 390 (52.2%) as non-empirical studies. Twenty-two (6.1%) of the empirical studies were accepted for oral presentation, compared to six (1.5%) of the non-empirical studies. A total of 245 (63.1%) of the non-empirical studies were rejected, compared to 172 (48%) of the empirical studies. This variation was significant (chi squared=34.679,  $p=0.0001$ ).

Table 9 shows that 64.8% of the medical papers were empirical studies, compared to 35.2% of the non-medical studies. This was a highly significant effect (chi squared=112.8,  $p=0.0001$ ).

### *Randomised controlled trials*

Of the child-related abstracts, 40 (5.4%) were coded as randomised controlled trials (RCTs), and 28 (3.8%) as possible RCTs (difficult to fully clarify on the abstract). The vast majority of abstracts (676; 90.9%) were not RCTs. If a study was an RCT it was significantly more likely to be accepted for oral presentation. RCTs had a 10% chance of an oral presentation, compared to a 3.3% chance for non-RCTs (chi squared=9.65,  $p=0.05$ ).

**Table 8. Comparisons between medical and psychosocial papers according to abstract outcome**

Type of paper		Decision on abstract			Total
		Oral	Poster	CD/reject	
Medical	<i>n</i>	15	109	133	257
	% within type of paper	5.8	42.4	51.8	100
	% within reduced decision on abstract	51.7	36.2	31.8	34.4
	% of total	2.0	14.6	17.8	34.4
Psychosocial	<i>n</i>	4	70	63	137
	% within type of paper	2.9	51.1	46.0	100
	% within reduced decision on abstract	13.8	23.3	15.1	18.3
	% of total	0.5	9.4	8.4	18.3
Both	<i>n</i>	1	37	39	77
	% within type of paper	1.3	48.1	50.6	100
	% within reduced decision on abstract	3.4	12.3	9.3	10.3
	% of total	0.1	4.9	5.2	10.3
Other	<i>n</i>	9	85	183	277
	% within type of paper	3.2	30.7	66.1	100
	% within reduced decision on abstract	31.0	28.2	43.8	37.0
	% of total	1.2	11.4	24.5	37.0

**Table 9. Empirical vs non-empirical, and type of paper**

Empirical or not		Type of paper		Total
		Medical	Non-medical	
Yes	<i>n</i>	232	126	358
	% within empirical or not	64.8	35.2	100
	% within type of paper	69.5	30.4	47.9
	% of total	31.0	16.8	47.9
No	<i>n</i>	102	288	390
	% within empirical or not	26.2	73.8	100
	% within type of paper	30.5	69.6	52.1
	% of total	13.6	38.5	52.1

### Quantitative versus qualitative

A total of 336 abstracts (44.9%) used a quantitative methodology; 59 (7.9%) used a qualitative methodology; 36 (4.8%) used mixed quantitative and qualitative methodologies; and 317 (42.4%) had no discernable methodology from the abstract and were mostly descriptive. Acceptance for oral presentation with qualitative, quantitative, or mixed methodology was very similar (5.4%, 6.8% and 5.6%, respectively). Having no clear methodology or a descriptive abstract resulted in low acceptance for oral presentation (1.6%). This variation was significant (chi squared=20.33,  $p=0.002$ ).

Comparisons between the medical and non-medical abstracts revealed that 22.1% of the medical abstracts had no formal methodology, whereas 77.9% of the non-medical abstracts had no formal methodology (chi squared=113.4,  $p=0.0001$ ). Of the medical abstracts, 64.8% used empirical methodology, compared to 35.2% of the non-medical abstracts (chi squared=112.8,  $p=0.0001$ ). Seventy-nine percent of medical abstracts were related to infected children compared to 20.1% of the non-medical papers (chi squared=310,  $p=0.0001$ ).

### Focus of the study

From the abstracts it was noted whether the focus of the study was on infected children ( $n=308$ , 41.2%), affected children  $n=130$ , 17.4%), both ( $n=151$ , 20.2%) or not specified ( $n=159$ , 21.3%). There was no significant variation according to this issue. Of the 308 (41.2%) papers on infected children, 3.9% were given an oral presentation. Of the 130 papers (17.4%) on affected children, five (3.8%) were given an oral presentation. Of the mixed focus (151, 20.2%), eight (5.3%) were given an oral presentation. Where the group was not specified (159, 21.3%), four (2.5%) were given an oral presentation. This variation did not differ significantly (chi squared=9.56,  $p=0.13$ ). However it seems from the data that generalised abstracts are less successful than specific (focused on infected, affected or both).

### Age of children

The age range of the children is of particular interest. The coding revealed that 66 abstracts (8.8% of the total) focused on infants, four of which (6.1%) were given an oral presentation; 37 (4.9%) focused on young children, three (8.1%) of which were presented orally; 114 (15.2%) focused on adolescents, five (4.4%) of which were given an oral presentation; 162 (21.7%) had mixed ages, of which seven (4.3%) were given an oral presentation; and 369 (49.3%) did not specify an age range and 10 of these (2.7%) were given an oral presentation. This variation did not reach statistical significance (chi squared=6.6,  $p=0.58$ ).

An analysis was carried out to explore the type of study (medical, psychosocial, both or other) according to the age bands of the children. Of the studies on infants, 90% were medical, 1.5% psychosocial, 6.1% both and 1.5% other. Of the studies on young children, again the majority were medical (62.2%), with 13.5% psychosocial and 10.8% both. Of the abstracts concerning young children, 13.5% fell into the 'other' category, covering such items as education or awareness. In contrast, the abstracts focusing on adolescents included very few medical studies (5.3%). The majority of these abstracts related to education and awareness-raising (72.8%). The psychosocial papers on adolescents were similar in proportion to those on children (16.7%). This variation was statistically significant (chi squared=237,  $p=0.0001$ ). Thus it seems that the medical issues around infants provides the predominant focus.

Table 10 sets out the age band of the children according to whether the studies were empirical or not. It shows that 84.8% of the studies on infants were empirical, compared to 83.8% on young children. However, only 46.5% of studies on adolescents were empirical. The differences were significant (chi squared =129,  $p=0.0001$ ).



**Table 10. Empirical vs non-empirical studies according to age band of the children**

Age of children		Empirical or not		Total
		Yes	No	
Infants	<i>n</i>	56	10	66
	% within age range	84.8	15.2	100
	% within empirical or not	15.6	2.6	8.8
	% of total	7.5	1.3	8.8
Young children	<i>n</i>	31	6	37
	% within age range	83.8	16.2	100
	% within empirical or not	8.7	1.5	4.9
	% of total	4.1	0.8	4.9
Adolescents	<i>n</i>	53	61	114
	% within age range	46.5	53.5	100
	% within empirical or not	14.8	15.6	15.2
	% of total	7.1	8.2	15.2
Mix	<i>n</i>	109	53	162
	% within age range	67.3	32.7	100
	% within empirical or not	30.4	13.6	21.7
	% of total	14.6	7.1	21.7
Not specified	<i>n</i>	109	260	369
	% within age range	29.5	70.5	100
	% within empirical or not	30.4	66.7	49.3
	% of total	14.6	34.8	49.3

## Bangkok–Toronto comparisons

This section of the report provides a brief comparison between the Bangkok abstracts and the Toronto abstracts. There were some slight variations in coding between the two, and this was accommodated by a recoding of some of the Bangkok data. For example, for Bangkok submission by country was provided, and this was recoded to continent to allow comparison. For Bangkok, abstracts that were totally rejected were not available for analysis. For Toronto, those that were rejected from the programme but still appeared on the CD were coded as CD/Reject. Although there was access to the additional abstracts that were rejected from the programme, the comparison data exclude these to allow comparison. A separate analysis of rejected papers from Toronto will be required, and no comparison is possible.

For the keyword search, the same keywords were employed for both conferences. A further 7 keywords were entered for Toronto. Table 11 compares keyword presence in abstracts for both meetings.

In order for the data to be comparable between the two conferences, the denominator was set as the number of papers appearing as oral presentations, posters (any type), and on the CD. This totalled 8057 abstracts for Bangkok and 10,126 for Toronto. This number does not include the additional papers that were rejected from Toronto as there is no comparable number for Bangkok. For all keywords (except 'interruption' and 'HAART') there were more submissions for Toronto than for Bangkok. There were notable increases in 'children' (13.8% to 18.4%), 'adolescents' (2.4% to 6.4%), 'orphans' (0.8% to 5.1%) and 'Africa' (14.4% to 22.1%).

**Table 11. Keywords in abstracts from Bangkok and Toronto**

Keyword	Total Toronto (n=10,126)	% of all abstracts (oral, poster, CD)	Total Bangkok (n=8057)	% of all abstracts (oral, poster, CD)
Pregnancy	447	4.4	294	3.7
Treatment	4137	40.9	2823	35.03
Gay men	342	3.4	177	2.2
Migrants	393	3.9	89	1.1
Drug use	963	9.5	684	8.5
Adherence	995	9.9	550	6.8
HAART	971	9.7	822	10.2
Interruption	84	8.4	70	0.9
Vaccine	300	3.0	100	1.2
Side-effects	271	2.7	199	2.4
Women	2933	29.3	1959	24.3
Adolescents	636	6.4	191	2.4
USA	890	8.9	122	1.5
Africa	2217	22.1	1156	14.4
Children	1844	18.4	1112	13.8
Orphans	513	5.1	65	0.8
Infant	365	3.7	180	2.2
Paediatric	348	3.4	117	1.5
Law	681	6.8	–	–
Ethics	94	0.9	–	–
Access	3028	30.2	–	–
Prevention	4537	45.4	–	–
Microbicide	101	1.0	–	–
RCT	26	0.3	–	–
Clinton/Gates	94	0.9	–	–

### Abstract outcome

From the handsorted articles (i.e. those found to be directly child relevant; 337 for Bangkok and 748 for Toronto), abstracts were less likely to be given an oral presentation at Toronto (3.9%) compared to Bangkok (6.0%). However, they were more likely to be accepted as a poster (40.2% in Toronto vs 34.6% in Bangkok) and less likely to be on the CD-only (reject) (55.9% in Toronto vs 59.4% in Bangkok) (Table 12). This distribution did not show significant variation, but showed a trend (chi squared=4.6,  $p=0.098$ ).

### Submission by geographical location

The comparison between the two conferences shows that submissions from Africa, Asia and South America to Toronto were fewer than submissions to Bangkok (Africa, 44.3% vs 54.1%; Asia, 25.6% vs 19.0%; and South America, 11.3% vs 8.8%). However, there were more submissions from Europe and North America (5.6% vs 9.9% and 3.4% vs 18.0%, respectively; chi squared=43.2,  $p=0.0001$ ) (Table 13).

**Table 12. Abstract outcome, Bangkok and Toronto**

Reduced decision on abstract		Conference abstract submitted to		
		Bangkok	Toronto	Total
Oral presentation	<i>n</i>	20	29	49
	% within reduced decision on abstract	40.8	59.2	100
	% within conference abstract submitted to	6.0	3.9	4.5
	% of total	1.8	2.7	4.5
KC/PE/PD	<i>n</i>	116	301	417
	% within reduced decision on abstract	27.8	72.2	100
	% within conference abstract submitted to	34.6	40.2	38.5
	% of total	10.7	27.8	38.5
CD/reject	<i>n</i>	199	418	617
	% within reduced decision on abstract	32.3	67.7	100
	% within conference abstract submitted to	59.4	55.9	57.0
	% of total	18.4	38.6	57.0

**Table 13. Abstract geographic origin, Bangkok and Toronto**

Presenting country		Conference abstract submitted to		
		Bangkok	Toronto	Total
Africa	<i>n</i>	144	331	475
	% within presenting country	30.3	69.7	100
	% within conference abstract submitted to	54.1	44.3	46.8
	% of total	14.2	32.6	46.8
Europe	<i>n</i>	15	74	89
	% within presenting country	16.9	83.1	100
	% within conference abstract submitted to	5.6	9.9	8.8
	% of total	1.5	7.3	8.8
Asia	<i>n</i>	68	142	210
	% within presenting country	32.4	67.6	100
	% within conference abstract submitted to	25.6	19.0	20.7
	% of total	6.7	14.0	20.7
North America	<i>n</i>	9	135	144
	% within presenting country	6.3	93.8	100
	% within conference abstract submitted to	3.4	18.0	14.2
	% of total	0.9	13.3	14.2
South America	<i>n</i>	30	66	96
	% within presenting country	31.3	68.8	100
	% within conference abstract submitted to	11.3	8.8	9.5
	% of total	3.0	6.5	9.5

### Comparison of study focus

It was possible to code whether the focus was on HIV-positive children (infected), HIV-affected children, a combination of these, or studies where the focus was not specified (Table 14).

**Table 14. Comparison between Bangkok and Toronto according to study focus**

Children focused upon		Conference abstract submitted to		
		Bangkok	Toronto	Total
Infected	<i>n</i>	68	308	376
	% within children focused upon	18.1	81.9	100
	% within conference abstract submitted to	20.5	41.2	34.8
	% of total	6.3	28.5	34.8
Affected	<i>n</i>	190	130	320
	% within children focused upon	59.4	40.6	100
	% within conference abstract submitted to	57.4	17.4	29.7
	% of total	17.6	12.0	29.7
Both	<i>n</i>	62	151	213
	% within children focused upon	29.1	70.9	100
	% within conference abstract submitted to	18.7	20.2	19.7
	% of total	5.7	14.0	19.7
Not specified	<i>n</i>	11	159	170
	% within children focused upon	6.5	93.5	100
	% within conference abstract submitted to	3.3	21.3	15.8
	% of total	1.0	14.7	15.8
Total	<i>n</i>	331	748	1079

For both conferences together, HIV-positive children accounted for 34.8% of the abstracts. The figure for this group was higher for Toronto (41.2%) than Bangkok (20.5%). Affected children accounted for 29.7% of abstracts in total. This figure was notably lower in Toronto (17.4%) compared to Bangkok (57.4%). Studies covering both groups accounted for 19.7% of abstracts, and these were similar for both conferences (Toronto 20.2%, Bangkok 18.7%). Those abstracts where the focus was not specified accounted for 15.8% of submissions, with a higher number for Toronto (21.3%) than Bangkok (3.3%). Qualitative analysis and reading of this latter group points to an emerging focus on education for all groups, particularly among adolescents. This distribution varied significantly (chi squared=199,  $p=0.0001$ ).

### Comparison according to empirical or non-empirical studies

Table 15 shows a significant effect according to type of study (empirical vs non-empirical) comparing Toronto to Bangkok. Overall there were 452 empirical studies across the two conferences, compared to 629 that were not empirical. A total of 47.9% of Toronto abstracts were empirical compared to 28.2% of Bangkok abstracts (chi squared=36.5,  $p=0.0001$ ).

**Table 15. Comparison between Bangkok and Toronto for empirical vs non-empirical studies**

Empirical or not		Conference abstract submitted to		
		Bangkok	Toronto	Total
Yes	<i>n</i>	94	358	452
	% within empirical or not	20.8	79.2	100
	% within conference abstract submitted to	28.2	47.9	41.8
	% of total	8.7	33.1	41.8
No	<i>n</i>	239	390	629
	% within empirical or not	38.0	62.0	100
	% within conference abstract submitted to	71.8	52.1	58.2
	% of total	22.1	36.1	58.2
Total	<i>n</i>	333	748	1081

## Discussion

The data collected from the Toronto conference differ from the Bangkok data in that they provide more detail, and also that they include outright rejections as well as those which were 'CD-only'. The factors associated with acceptance or rejection of an abstract are complex. The absolute numbers of papers within a category may affect chances of acceptance. Topical issues clearly surface, and the decision-making strategies, competencies and biases of the committee members, reviewers and planners may also contribute. With these caveats, it is still important to analyse the trends.

Acceptance for the conference was difficult given the high number of submissions. Authors had only a 2.4% chance of their abstract being accepted for oral presentation, compared to a 6.1% chance in Bangkok in 2004. Conversely, the chance of rejection was much higher – 64.8%, compared to a 31% rejection rate in Bangkok. The Toronto conference included a number of non-abstract-driven sessions, and the data need to be interpreted in this light.

Medicine and North American politics seemed to play a key role in whether an abstract was included – evidenced by the high occurrence of the words 'vaccine', 'microbicide' and 'Gates' or 'Clinton'. Also of note was the emerging interest in ethics and law, and the continued endorsement of randomised controlled trials.

'Children', 'adolescents' and 'orphans' featured as keywords in the abstracts most likely to be rejected and least likely to be accepted as an oral presentation. The analysis also showed that acceptance of abstracts that focused on children or adolescents was below the conference average. The only exception was abstracts with the keyword 'paediatric'. Clearly the medical focus on children is the one that is getting through. This is backed up by evidence from the track placement – child-related abstracts were more likely to appear in track B. This result reinforces the perception of conference delegates that children were largely missing from the programme (Rollins 2006).

It was pleasing to note that the gender of the presenter played no significant role in the abstract decision.

Although North America accounted for only 18% of submissions, it accounted for 44.8% of oral acceptances. Papers from Africa accounted for 44.3% of submissions, and 34.5% of oral presentations. It was of note that there were no child-related submissions from Australia.

Within the child-related abstracts, medical papers had a four-fold greater chance of oral acceptance over psychosocial or other categories of study. There were slightly fewer empirical studies than non-empirical studies (358 vs 390). Empirical studies had a four-fold greater chance of oral acceptance over non-empirical studies. The majority of studies were not randomised controlled trials (675 vs 68). However RCTs were three times more likely to be accepted for oral presentation.

It was pleasing to note that quantitative and qualitative methodologies were equally likely to be accepted. The coding ensured that only clear qualitative methodology was coded as such, and that descriptions or position papers were coded as having no clear methodology. It was evident that having no clear methodology or a descriptive abstract resulted in low oral acceptance (1.6%).

Only half the abstracts specified an age grouping for the children in the study. Where age was reported, young children were least likely to be the focus, while adolescents or studies with mixed ages predominated.

Compared with the Bangkok conference, there have been a number of changes. For all keywords except 'interruption' and 'HAART', there were more submissions to the Toronto conference. There were notable increases in abstracts containing the keywords 'children' (13.8% in Bangkok to 18.4% in Toronto), 'adolescents' (2.4% to 6.4%), 'orphans' (0.8% to 5.1%) and 'Africa' (14.4% to 22.1%). Child-related abstracts were less likely to be given an oral presentation at Toronto (3.9%) compared to Bangkok (6.0%). However, they were more likely to be given a poster (40.2% in Toronto vs 34.6% in Bangkok) and less likely to be on the CD-only (reject) (55.9% for Toronto vs 59.4% for Bangkok). The focus in Toronto was more notably on HIV-positive children, and the type of study being reported was more likely to be empirical.

Two trends are of note in the comparisons. First, it is of concern that fewer child-related abstracts were accepted as oral presentations in Toronto than in Bangkok, despite the growing need and the high profiling of this issue. This may have been counterbalanced by the non-abstract driven presentations, but it is a pattern that should be reversed for Mexico. Second, from the field side, it is notable that there was an increase in submission of empirical and methodologically sound abstracts. Hopefully this reflects a concerted movement in the field towards evaluation and dissemination among child related programmes – a trend to be endorsed in policy, funding and hopefully reflected in Mexico.

Thus, in conclusion, the analysis from Toronto and comparisons with Bangkok show some changes, but there is still an urgent need for a more child-focused strategy. In Toronto, medical abstracts generally predominated in terms of child-related studies (Julg and Goebel 2006). However, it would be unfair to claim total neglect as there were medical abstracts on children and these sessions were well attended. Studies that were accepted tended, in the main, to be empirical investigations, use quantitative methodology and be focused on HIV-infected children, particularly infants. These trends are clear, yet it is unclear what the underlying reasons are. The trends may reflect the quality of submissions, the investment of research resources into specific areas, or the current views of the selection committee. Strategic responses to this data should aim to increase awareness of children and children's needs to the international community, broaden the arena of study to children affected by HIV as well as those infected, increase willingness to fund child-related research, and enhance the capacity for rigorous methodology in applied settings.

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## About the Bernard van Leer Foundation

The Bernard van Leer Foundation funds and shares knowledge about work in early childhood development. The foundation was established in 1949 and is based in the Netherlands. Our income is derived from the bequest of Bernard van Leer, a Dutch industrialist and philanthropist, who lived from 1883 to 1958.

Our mission is to improve opportunities for children up to age 8 who are growing up in socially and economically difficult circumstances. We see this both as a valuable end in itself and as a long-term means to promoting more cohesive, considerate and creative societies with equality of opportunity and rights for all.

We work primarily by supporting programmes implemented by partners in the field. These include public, private and community-based organisations. Our strategy of working through partnerships is intended to build local capacity, promote innovation and flexibility, and help to ensure that the work we fund is culturally and contextually appropriate.

We currently support about 140 major projects. We focus our grantmaking on 21 countries in which we have built up experience over the years. These include both developing and industrialised countries and represent a geographical range that encompasses Africa, Asia, Europe and the Americas.

We work in three issue areas:

- Through “Strengthening the Care Environment” we aim to build the capacity of vulnerable parents, families and communities to care for their children.
- Through “Successful Transitions” we aim to help young children make the transition from their home environment to daycare, preschool and school.
- Through “Social Inclusion and Respect for Diversity” we aim to promote equal opportunities and skills that will help children to live in diverse societies.

Also central to our work is the ongoing effort to document and analyse the projects we support, with the twin aims of learning lessons for our future grantmaking activities and generating knowledge we can share. Through our evidence-based advocacy and publications, we aim to inform and influence policy and practice both in the countries where we operate and beyond.

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