

**New Perspectives on HIV Prevention – Opportunities and Challenges for Peru**  
**Public Forum and Stakeholder Consultation**  
**November 2-4, Lima, Peru**

**EXECUTIVE SUMMARY**

Policy makers, scientists, civil society leaders and international experts in the area of HIV convened on 2-4 November, 2011 in Lima, Peru within the framework of discussing new findings surrounding HIV prevention strategies and the opportunities and challenges they presented for the response to HIV in Peru. The backdrop for the discussions was the anticipated development of a new Multisectoral Strategic Plan (MSP) for the 2012-2016 period in the country.

These discussions took place in the context of a Public Forum<sup>1</sup> and a Stakeholder Consultation (with participation of 25 representatives from national and local governments, NGOs, academia, affected and vulnerable populations, and technical cooperation agencies). Both activities were convened by an organizing team led by the Unit of Health, Sexuality and Human Development at Cayetano Heredia University School of Public Health, with participation of the Virtual Centre for Coordination of HIV Knowledge (CVCC); other research organizations (INMENSA and ACSA), the Ministry of Health and the National Institute of Health of Peru; the Principal Recipient of three GFATM HIV grants in Peru (CARE-Peru); the Country Coordination Mechanism's representatives of affected and vulnerable communities; and the National Civil Society Health Forum (Forsalud), with support from PAHO and UNAIDS.

The strategies discussed included (a) biomedical approaches, among these ARV-based tools (oral and topical pre-exposure prophylaxis; treatment as prevention) and male circumcision; and (b) structural interventions and strategies, in a Combined Prevention Framework. Besides increasing awareness about recent findings in this field, the forum sought to engage a variety of national actors in a discussion on which strategies and policy initiatives are most relevant for the Peruvian context and are likely to strengthen the national response to AIDS.

Furthermore, at an international level, this experience may also serve other countries and regions as a case study of local discussion surrounding the potential uptake of new prevention technologies and the implications involved with this.

The **Public Forum** was organized into two public sessions on the afternoons of the first and second days, in which formal presentations were made by international experts on the first day and a round table followed on the second day. The **Stakeholder Consultation** took place on the mornings of the second and third days. See Annex 1 for the detailed programme for both meetings. Below you will find a summary of the forum presentations; conclusions of the Stakeholder Consultation can be found on page 10.

**Main Points from Presentations at the Public Forum<sup>2</sup>**

**State of the Global HIV Epidemic (Rafael Mazín, PAHO/WHO, Washington DC)**

Dr. Mazin discussed the variations in the HIV epidemic in the Americas, a region with 3.2 million people living with HIV mainly in North America (48%) and Latin America (45%). While the Caribbean region shows a more generalized epidemic in some specific countries (such as the Bahamas, Belize and Haiti), while in the rest of the continent HIV is concentrated

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<sup>1</sup> Open to the public, with on-line pre-registration at [www.iessdeh.org/foronuevasperspectivas](http://www.iessdeh.org/foronuevasperspectivas)

<sup>2</sup> A live forum webcast was arranged by CVCC. Presentations (Spanish version) are available [here](#).

in specific populations. Men are particularly affected with a 3:1 ratio of infection in relation to women.

Compared with other middle- and low-income regions, the Men who have sex with Men (MSM) population in the Americas has a higher prevalence ranging from 4 to 20%. The male-to-female transgender women (TW) population, moreover, show prevalence estimates of 30-40%. These groups also demonstrate moderate to high incidence rates and MSM report a high prevalence of bisexual behavior, 20-30%, which contributes to HIV transmission from this group to the general population.

Although this group remains at the epicenter of the epidemic, they are not being made a priority, with statistics showing “low to moderate” consistent condom use and only around 50% of them knowing their HIV status. This is further complicated by the heterogeneous nature of the group, with the MSM/TW term incorporating multiple identities and behaviors within different contexts. Additionally, there is a multiplicity of factors involved in the increased risk of MSM/TW, among them environmental (stigma, discrimination and low access to services), sexual networks with high HIV prevalence, behavioral risk, socio/cultural factors, biological factors and other factors (anxiety, alcohol and drug use).

Empirically effective interventions exist (such as those indicated in the [WHO guidelines for the prevention of HIV/STI among MSM/TG](#)) which have just been released and should be implemented. However, the social profile of the epidemic should determine the prevention strategies we use at the country level.

#### **Overview of the broadening HIV prevention landscape (Catherine Hankins, UNAIDS, Geneva)**

Dr. Hankins talked about the critical need for a prevention revolution. Although there has been a 12-fold increase in ART use in just 6 years, for every person who starts taking antiretroviral treatment, two more are infected.

The new UNAIDS strategy ‘Getting to Zero’ focuses on zero new infections by revolutionizing HIV prevention; zero AIDS-related deaths by catalyzing the next phase of treatment, care and support; and zero discrimination by advancing human rights and gender equality. To reach these goals, new strategies must be based on knowledge of local epidemics and analysis of whether responses address these epidemic dynamics. Efficient use of resources will get returns on investments, resulting in fewer infections, more people treated, and less stigma and discrimination. Combination prevention is key to lowering new infections and should be tailored to national and local needs and contexts; use a combination of behavioral, biomedical, and structural elements; create synergies; fully engage affected communities, be decentralized, and adapt to changing epidemic patterns.

In Latin America, only 10 countries report having universal access targets and, of these, 65% report antiretroviral treatment targets and only 50% report prevention targets for key populations, such as MSM, TW, sex workers or people who inject drugs. .

Effective biomedical HIV prevention modalities for sexual transmission that are the subjects of normative guidance for their implementation from WHO and UNAIDS are correct and consistent condom use (80-90% effectiveness) and voluntary medical male circumcision for heterosexual men in high HIV prevalence settings (about 60% effective).

Promising strategies that have yet to be the subject of WHO/UNAIDS normative guidance are treatment for prevention (HPTN 052 trial: 96% reduction in sexual transmission) and topical and oral antiretroviral pre-exposure prophylaxis (PrEP). This approach can involve vaginal and rectal gels, suppositories, films, and rings for topical application or antiretroviral tablets (currently, tenofovir or tenofovir/emtricitabine). CAPRISA 004 found 1% tenofovir vaginal gel to reduce risk by 39%, rising to 54% when used in more than 80% of sex acts. Oral PrEP trials have promising results in men who have sex with men and transgender women (iPrEx study: 44%), heterosexual couples (Partners PrEP study: 73%), and heterosexual men and women (TDF2 study: 63%). A modest but promising result from the vaccine trial in Thailand (31% risk reduction) using a Thai clade-specific B/E vaccine, is spurring on a trial of

booster doses, a trial among MSM in Thailand, and a clade-specific A vaccine trial in South Africa.

Effective communication about partial prevention is key as no biomedical strategy is 100% effective. Several countries in southern Africa have used an effective football analogy to convey this: male circumcision is the goalkeeper in football who needs the defenders for a good defense. These are knowing your status, correct and consistent condom use, staying with one sexual partner, avoiding penetrative sex, and postponing sex.

Finally, addressing socioeconomic factors and changing the context to make individuals' default decisions healthy will have even greater impact in reducing HIV transmission. The Political Declaration that Peru signed at the High-Level meeting in June 2011 has bold new targets for 2015: 50% reduction in sexual transmission, 50% reduction in HIV transmission among people who inject drugs, 50% reduction in TB deaths among people living with HIV, no new infections in children, and 15 million people on treatment (15-by-15).

### **The status of HIV treatment and its role in prevention (Pedro Cahn, Fundación Huésped, Buenos Aires)**

Dr. Cahn began his talk discussing how ART has improved substantially since its inception. According to Walensky et al. the survival benefits of ART in the US are clear with 3 million life years saved. There is also ecological evidence from Argentina that after HAART implementation, HIV incidence rate fell. Argentina now demonstrates a 26-fold reduction in AIDS-related mortality.

Moreover, trial data from Haiti shows the benefits of initiating ART earlier, at CD4 counts of 200 to 350 versus standard treatment at less than 200. This data led to the WHO's decision to initiate ART earlier. Dr. Cahn recommends treatment to start when a person has less than 500 CD4 count, which is now the standard in Argentina. In the case of having a CD4 count above 500 but also having another co-infection or being pregnant, treatment should also start.

ART also reduces blood-borne viruses and viruses in the genital tract, aiding in reducing transmission of other diseases. A study by Quinn et al showed that transmission of HIV is facilitated if the HIV-positive person has another virus and Garcia and Coovadia found increased rates of vertical transmission among women infected with a virus. Moreover, evidence from San Francisco, Switzerland and British Columbia shows that the community viral load decreases with increased treatment of HIV-positive individuals, thereby decreasing incidence.

Further evidence supporting early treatment comes from Donnel who found that HIV transmission was reduced among sero-discordant couples who started treatment early. However, there was evidence of transmission not virologically linked to the seropositive partner, making the case for the need of other simultaneous prevention strategies.

ART remains extremely important. There should not be a debate between treatment and prevention, but they should be complementary. However, barriers remain to ART use, including reaching universal testing, reducing stigma and discrimination, lack of adequate laboratory facilities, among others. Additionally, many patients start care at a late stage (76%), which results in high costs across the board and could be tackled with improved testing for case detection.

### **Reducing Community viral load through HIV testing linked to care and treatment (Albert Liu, San Francisco Department of Health, San Francisco)**

Dr. Liu began his talk explaining how the epidemiology of HIV in San Francisco shows a similar picture to the rest of the US in that most new infections are taking place among MSM. The HIV prevalence among MSM in San Francisco is similar or higher than the prevalence among the general population in various countries in Africa.

The first comprehensive US HIV/AIDS strategy and goals have been rolled out for 2015 to respond to these concerns. These include lowering the annual number of new infections by 25% and reducing health disparities. In San Francisco, the goal is to reduce by 50% the number of new HIV infections by 2017 with resources concentrated among MARPS. Another goal is to maximize the cascade of prevention, care and treatment. This entails expanding access to routine testing and increasing testing of high-risk people.

The health department has also employed multiple strategies to improve linkages to care and partner services. One of these is moving towards a team approach for diagnoses to place a person into care within 3 months; provision of universal ART, regardless of CD4 count; and also offering a host of other services related with care such as mental health services, substance abuse treatment and housing support, provided by a multidisciplinary team.

A new PrEP Demonstration Project is being planned in San Francisco and Miami in which 500 MSM will be enrolled and will receive PrEP for up to 12 months. Participants will have quarterly follow-up visits, and the goals of the project will be to determine feasibility, acceptability and uptake of PrEP in the STD clinic setting, as well as safety, adherence, and changes in sexual behavior.

San Francisco has pioneered the use of community viral load (CVL) as a metric of HIV prevention and treatment effectiveness in the community, which is now recommended as part the National HIV/AIDS Strategy. CVL can be calculated using the sum of most recent viral loads for all HIV positives (total CVL) or dividing this total by the number of people included (mean CVL). The latter is useful to identify districts or sub-populations that may experience disparities in access to treatment and prevention. In San Francisco, decreases in CVL from 2004-2008, during a period with increased HIV testing, ART coverage and rates of virologic suppression, was associated with decreased new HIV infections. CVL measures are based on surveillance data, so the quality and completeness of this laboratory data are important. CVL does not capture those who are not yet diagnosed, those who are diagnosed but not yet reported, and some who are acutely infected. Ecological fallacy may also be a concern, given that this summary measure may not reflect factors at the individual level.

### **Pre-exposure prophylaxis to prevent sexual transmission: “Can a pill a day prevent HIV: PrEP” (Robert Grant, Gladstone Institute of Virology, San Francisco)**

Dr. Grant explained how ART to prevent HIV acquisition (either as PEP or PrEP) can be a useful tool to prevent new infections among key populations. Multiple prevention trials had been found to be ineffective in the past, such as intensive counseling, vaccine trials, microbicides, diaphragms, mass STI treatment and herpes suppression; mostly because they have not been implemented on most at risk populations (MSM, sex workers and IDUs).

The PrEP/Iprex study, jointly funded by the US NIH and the Gates Foundation, looked at pre-exposure prophylaxis testing the efficacy of using Tenofovir and Emtricitabine once a day to prevent HIV acquisition among HIV negatives. The study included 11 sites with 2499 participations, 55% of which were from Peru.

The trial resulted in significant differences between the groups provided treatment vs those given a placebo; showing a  $p=0.002$  and an efficacy of 42%, yielding 35 averted HIV infections. Among participants who reported no unprotected receptive anal intercourse (URAI) at screening, PrEP did not offer any additional protection. However, among those who reported URAI (80% of the participants), PrEP showed a 52% efficacy rate.

Adherence was a problem, with only 50% of the participants in the treatment group showing detectable drug levels in their blood, meaning they were taking fewer than two pills a week. Those with detectable drug levels did show a 92% reduction in risk of HIV acquisition. Adherence was higher in the US, with drug detection rates reaching 90%, whereas outside of the US it was only 50%.

PrEP concerns include behavioral compensation, which means a reduction in condom-use among people taking the drug or problems with resistance. In the Iprex trial there was no

evidence of behavioral compensation, although this may be due to the use of a placebo; however, there were two cases of emtricitabine resistance among people already infected with HIV, with resistance declining within six months.

Due to these results, the US CDC has given interim guidance for its use, and researchers are now conducting an open label study among participants of the original trial. This study will help elucidate ethical, sexual behavior implications, as well as the monitoring frequency required and how to improve adherence.

Questions still remain about the use of PrEP, such as its effectiveness among women. It appears that PrEP could be useful for heterosexual women and men, but two studies showed no benefit among women. Finally, PrEP may also be a useful tool to engage in conversations about prevention, decreasing stigma, or motivating people to get tested.

### **Structural interventions in a combined prevention framework (Carlos Cáceres, Universidad Peruana Cayetano Heredia, Lima)**

Dr. Cáceres began his presentation discussing the limitations of current prevention efforts that focus mainly on the individual. It is time for a prevention revolution which focuses on combination prevention, a multisectoral response, involvement of affected communities, political will and the use of evidence-based approaches.

Prevention strategies can be implemented at multiple levels to respond to contexts of risk. This combination prevention framework can be applied at the local and national context and entails the involvement of affected communities, a human rights and gender equity approach, an exploitation of synergies between strategies at different levels, and finally, it should be decentralized and flexible to differing contexts.

A structural level approach includes action upon various social factors such as policies and environments that have an effect on individual and community risk for HIV (e.g. inequity and gender-based violence); restricted access to appropriate services (e.g. homophobia which limits the discussion around sexual risks); limited access to HIV testing, treatment and sexual communication; and factors creating increased vulnerability to HIV (e.g. laws against homosexuality). These interventions can include different action levels (proximal and distal); different levels of effect (proximal, distal or mixed); and various actions, actors and intervention targets. However, structural-level interventions are not enough on their own, they must support and improve the response of other interventions, but they are not intended to replace individual-level interventions.

Structural interventions may be directly focused on HIV, such as needle exchange programs, or reforming laws concerning sexual orientation or HIV transmission, or may involve a wider focus on issues such as human development, gender equity, education, poverty reduction, redistribution of wealth, and democracy. Both kinds of approaches are defined in the Investment Framework (recently published by Schwartlander et al) as either “Critical Enablers” or “Key Synergies”. A prevention revolution will only be successful if it includes both HIV-related as well as non-HIV-related structural-level interventions. A limitation to this type of interventions is that results are not immediate, but may take some time to be observed, requiring subsequent studies.

### **Ethics, Social Science and HIV Prevention: “Ensuring HIV Prevention is effective because it is ethical” (Marsha Rosengarten, Goldsmiths, U. of London, London)**

Dr. Rosengarten discussed how prevention does not work by imposing obligatory testing or forced disclosure but by designing programmes that enlist people to adopt practices that they perceive are in their interests. With new prevention technologies it will be important to shift from thinking prevention according to what is ‘technically’ proficient—as seen with randomized clinical trials testing for ‘efficacy’—to intervention that incorporates, within it, strategies that enhance the lives of those affected by HIV.

Most commonly, the use or non-use of a prevention technology is attributed to lack of knowledge, asymmetries of power where the user cannot act safely, or a lack of responsibility. These ideas for lack of use regard HIV risk as a stand-alone entity, when we are aware that the prevention tool and the person who is the target of the prevention efforts only have meaning in relation to one another.

In terms of PrEP, current studies have aimed to test a finite biological product and determine its effect; even though we know the effects of PrEP are context specific. These differing contexts may affect the effect of PrEP, including issues with access, cost, regular antibody testing, seroconversion while on PrEP, assumption of negative status, high viral load due to seroconversion, drug resistance and route of transmission. This is a further indication of the importance of understanding that we are dealing with open and fluid objects, where there is a dynamic relationship between the user and the prevention mechanism within the evolving epidemic context in which PrEP is to be used.

The evolution of the contraceptive pill (“the pill”) provides a useful for understanding how a biomedical intervention may lead to outcomes beyond its intended purposes. With the contraceptive pill came changes in reproduction, gender roles in the home and labor force, relations and attitudes to medicine, pharmaceutical interventions. Conversely the pill also changed in terms of different pharmaceutical formulae, non-oral forms and in terms of popularity (now not so popular). We can anticipate that PrEP and other uses of antiretrovirals as prevention anticipate will have implications for decision-making among serodiscordant couples; sexual behavior; and contributing to a new conceptualization of HIV status on viral load rather than positive/negative status.

The main issue then is how to work within contexts that are being generated through the emergence of new prevention technologies instead of assuming prevention, users and their contexts are separate and stagnant entities. Although the HIV epidemic is increasingly complex, just considering this is helpful; as well as understanding what is enabling or obstructing ART use. Biomedical interventions cannot be separated from who they are intended for, nor can they be reduced to a behavioral-change model. A return to a pragmatic context of ethics is necessary, which will enhance prevention because it is ethical.

### **The multisectoral response to HIV in Peru (José Luis Sebastián, Ministry of Health, Peru)**

Dr. Sebastián began his talk explaining how there have been few variations in the distribution of cases by region since the beginning of the epidemic in 1983. Lima and Callao represent the first place in number of cases in the country, followed by Loreto, Arequipa, Ica and Ancash. Although 600,000 people are believed to be living with HIV, official records show a lower number which means that many people are still not aware of their HIV positive status.

The epidemic has stabilized with most cases being concentrated among individuals between the ages of 20-24 and 30-34, primarily within the male population. Although MSM are an important population, most of the cases are among TW. This should inform the type of interventions to be included in the new Strategic Multisectoral HIV/AIDS Plan (2012-2016).

With regards to a multisectoral response, the State has been involved in formulating a response to the epidemic since 1986, following pressure from organizations of people affected with HIV and their family members. The formation of the CONAMUSA, as the country coordinating mechanism for Global Fund projects, represents an important moment for multisectoral work not only because it has the active presence of several Ministries, but also because it counts with the feedback of civil society, groups of affected communities and other sectors; making it a useful model for other areas. Furthermore, the formulation of the 2007-2011 Strategic Multisectoral HIV/AIDS Plan by the CONAMUSA and the HIV/AIDS Strategy Office to guide the actions in this area marked one of the first in the region. The CONAMUSA and the Strategic Plan also ensure the sustainability of the Global Fund actions by providing guidelines for their continuation.

The process of decentralization, however, means that the Ministry of Health must find new ways of working with the regions, supporting the execution of the new performance-based budgetary strategy which is currently at 70% at the national level; and working to reduce stigma and discrimination through Global Fund projects.

Examples of effective strategies has been the use of peer health promoters; work in prisons; work with the youth in six cities; INFOSALUD, a free telephone line; and primarily the scale-up of ART which since 2004 has placed 16,000 people in treatment. Although ART treatment has decreased the mortality and stabilized the incidence rates, prevention interventions are necessary to stop the epidemic from rebounding to prior levels.

### **Present options for HIV prevention among MSM/trans people (Kane Race, University of Sydney, Sydney)**

Dr. Race emphasized that although MSM and TW do not represent homogenous groups they experience similar social conditions of stigma and discrimination which influence their relationship with society and access to services.

Current options for prevention are treatment as prevention and pre-exposure prophylaxis (PrEP), both requiring greater access to health services among affected populations. Vulnerable groups experience important obstacles to access these health services due to a generalized lack of knowledge about gender variations and homophobia within the health system and within society. MSM and TW may delay or avoid seeking services due to stigma, the potential for encountering insensitive or ignorant health providers; with negative consequences for testing, adherence and health services in general.

Race proposed we consider the 'affective climate' in which access to health services takes place. This refers to what is made possible (or impossible) in the presence (or absence) of stigma: qualities such as trust, hope, care or on the contrary, fear, shame, rejection secret and suspicion. The HIV epidemic creates an opportunity for public health to consider how affective climates influence the use of health services. Race emphasized that proposals about biomedical prevention need to address these conditions if they hope to be effective.

Epidemiologic modeling is important as a tool to predict what will happen when strategies are implemented. However, this is only effective in the measure that the affected members can provide important knowledge about the context they live in. Moreover, responsive social research seeks to understand not only how to make interventions operational but also respond to situations that the predictive sciences cannot account for. Careful monitoring of what is happening in the community is essential given that strategies will not be able to identify the understandings and meaning of the interventions among the group the intervention targets. Therefore, a need exists to research and reflect on how the interventions have an effect on social relationships and the meanings given to the interventions by the target populations.

Each discipline will inevitably have blind spots; so the question is; what is the effect of the different scientific frames that are used to identify and predict the relevant risks? How do they engage the paradigms and understandings of affected groups? How should these different frames be brought together to respond to the epidemic more effectively?

### **Modeling impact of certain combined prevention strategies for MSM in Peru (Annick Bórquez, Imperial College London, London)**

Mathematical modeling was applied to the MSM/Trangender women (TW) case in Peru because the HIV epidemic is concentrated, with MSM/TW representing more than 55% of the new infections in Peru and 70% of total new infections occurring in Lima. The objective of this study was to develop a mathematical model to reproduce the epidemic among MSM, capturing the diversity of the population. Each person is unique, with different behaviors, but for the purposes of the model they defined subgroups with similar risks, which share an identity, prevalence and sexual behavior.

Data were collated on number of new partners in a year, number of sexual acts, condom use and sexual positioning during anal sex divided into fixed insertive, fixed receptive and versatile (who practice both insertive and receptive anal sex). Individuals were divided into four subgroups: men who mostly have sex with women, men who mostly have sex with men, sex workers, and transgender women at higher risk. PrEP was introduced in the model specified by efficacy, adherence, coverage, period of implementation and prioritization according to risk. PrEP was introduced in the model as a hypothetical 10 year intervention, starting in 2012.

According to the WHO threshold all of the scenarios are cost-effective, although debate exists concerning the use of this threshold. Using the World Bank threshold, it would be considered cost-effective among certain prioritized groups with low coverage. Compared with the results of a study by Aldridge showing the cost of different interventions, PrEP is comparable or more expensive than the rest of interventions, and therefore should not be prioritized as the only response but it may be a cost effective additional intervention to make available.

In a separate analysis to estimate the cost of a PrEP intervention to avert one third of the new infections that will occur in the next ten years, the estimate ranges from 186 to more than 400 million USD. Given that the 2007 Global Fund's investment in Peru was 30 million USD, it shows us that PrEP in isolation is not an affordable strategy to arrest the epidemic. To conclude, the epidemiological impact of PrEP is mainly determined by program characteristics such as coverage and prioritization strategy and individual level adherence. If PrEP is prioritized to vulnerable groups and implemented in a rapid pace, it can be a cost-effective intervention among MSM and can significantly contribute to combined prevention efforts.

### **Round table**

#### **Are there options to improve the response to HIV among MSM/trans in Peru?**

- **Percy Minaya (National Health Institute, Peru)**

The response to HIV should be cross-cutting and comprehensive; focused on vulnerable groups and applied to different scenarios; but above all they should be based on the available evidence. Although significant advances have taken place in the past years, with the involvement of civil society and funding from the Global Fund, we must look retrospectively at the efficiency of these interventions. Moreover, although important steps have been reached with regards to treatment, this is not of the required quality.

The participation of different sectors must be strengthened as well as work with the regions in order to achieve an effective national response. Although it was mentioned that treatment-based-prevention requires an investment of 400 million USD, past experience with negotiating investment in treatment shows that in order to reach our goals we require the combination of research, activism and determination. Furthermore, all of these decisions must be promoted within an ethics, human rights and right to health framework.

- **Ernesto Gozzer (COREMUSA Lima representative, Peru)**

Lima contains 70% of people affected by HIV but the unifying entity has been weakened and the municipality, the LGBT group and Via Libre have had an important role in the reactivation of the COREMUSA Lima. It is a multisectoral problem and there is a need to strengthen the individual and institutional capacities to ensure a sustainable response. The substantive issues of the epidemic are related with the social determinants of health which transcend the health sector, making the issue of a multisectoral response even more critical.

Another important issue is prevention to address the epidemic in an effective manner, focusing on what works and using the available resources. Finally, we need to monitor what is happening in our communities to expand coverage basing our actions on evidence.

- **Pablo Anamaria (People Living with HIV)**

One of the weaknesses in the response is focusing on collecting needs instead of reaching real consensus concerning what type of response we want, what it means to respond to HIV and what the objectives of the group are. Moreover, the last years have been characterized by importing interventions and inventing formulas, which are not validated by the communities, and which include responses that do not answer to the structural, economic and emotional needs of the people affected by the epidemic.

The multisectoral strategic HIV/AIDS plan needs to be planned according to the evidence and humanity, designed to meet goals, since frequently we forget we are talking about people's lives. Further efforts should be placed on strengthening the health services and finding ways to fill the gaps on what we have achieved; while addressing the structural elements of the affected populations, including quality of life, nutrition, quality treatment, respect and timely access to testing.

- **Patricia Bracamonte (UNAIDS, Peru)**

Important contextual elements at the national level are the strategic plans; a democratic government that makes a difference in terms of a human rights' focus; a stable, concentrated epidemic; new evidence around vulnerable populations and indigenous populations; as well as emerging challenges in the public HIV agenda, particularly around human rights and access to health services among adolescents.

The national response has changed with a multisectoral approach consolidated by the CONAMUSA, an Ombudsman office, as well as an interesting human right's surveillance role played by the affected populations. Moreover, the participation of the Global Fund in the country, the provision of HAART and the new performance-based budgetary strategy speaks of the changing process taking place in the country.

Some challenges remain around data about the distribution of the epidemic; high dependence on international cooperation which still provides 47% of the funding for HIV/AIDS; and the need to improve education related to STIs, as well as the public distribution of condoms, which is now primarily taking place at private pharmacies.

General recommendations to revitalize the response to the epidemic include: a response focused on a combined prevention approach; dividing the strategy according to the prevailing modes of transmission; designing a strategy towards sustainability of the response, increasing the performance-based budget and resources in the regions; strengthening the health system for universal treatment and counseling; greater participation of the private sector; integrating the response within a MDG, human rights, social inclusion and gender framework; improving the monitoring system; and exploring south-south cooperation opportunities.

- **Giovanny Romero (Homosexual Movement of Lima, Peru)**

Vulnerable communities find themselves in a socio-cultural context which promotes vulnerability, and HIV reactivates the violence, stigma and discrimination that these populations have to endure.

In Peru, one person loses their life every week due to their sexual orientation. The state has a role in this since until now they have yet to ratify the rights of the homosexual community. Furthermore, if it is a concentrated epidemic, the state must answer how many people are part of this epidemic, and define how to effectively respond to it.

## **Report from the Stakeholder Consultation**

### **Day 1**

#### **Has the response to the HIV epidemic been effective in Peru (for example, with regard to the MSPs and the GF projects)? Concerning treatment? Concerning prevention? Concerning solidarity and human rights?**

- In the 90s there were a variety of prevention interventions for MSM, sex workers, adolescents and vertical transmission, but these were centralized and did not reach the regions. The participation of the Global Fund has been helpful but it has only focused on some regions.
- The health care professionals that are trained are rotated to other areas, losing an important human resource.
- Health care professionals should be trained in this area starting at the academic level.
- Treatment supply remains a challenge on behalf of the State.
- An important percentage of the population is not aware of their serological status.
- Innovative interventions concerning health lifestyles among adolescents and youth have taken place in Callao, promoted by the COREMUSA (regional coordinating mechanism).
- The implementation of operational research for prevention interventions should be mandatory, since successful interventions should be recorded and shared.

#### **Is the local response adequate to our epidemic profile?**

- Each region has its particular characteristics but the Regional Strategic Multisectoral Plan does not ensure that this will be taken into consideration.
- There is a concern that the regions will not follow the Regional Strategic Multisectoral Plan once the Global Fund leaves the country.

#### **Are there mechanisms for the local community to incorporate emerging perspectives? What are the barriers? Are there any facilitators?**

- Lima COREMUSAS have prioritized the reduction of vertical transmission to zero without working with the community. It is important to work with vertical transmission but also in prevention with vulnerable populations; they do not have to be mutually exclusive.
- Another obstacle is lack of capacity at the primary care level.

#### **Have we incorporated any structural interventions? What key structural changes have we not considered/should we include?**

- Hate crimes and attacks against TW are not being addressed. This is a vital structural response to promote understanding around sexual diversity.
- Another challenge is the organization of the health care services.

#### **Is it feasible/relevant in Peru to incorporate any biomedical prevention programme (besides PMTCT)? Is there political will? What are the issues?**

- If it is not currently possible to ensure coverage of all people needing ART, how can the model of treatment as prevention be applied?
- PMTCT is also a form of prophylaxis but it is more acceptable because it does not involve sexual activity and therefore does not generate moral judgments.
- There is an inadequate perception of risk, and the consistent and correct use of condoms must be addressed in prevention and educational messages.
- The Multisectoral Strategic Plan should be proposed as a balance of interventions to be addressed not only by the Ministry of Health but by other actors as well. This should entail a real commitment on behalf of the State, with a strong technical and advocacy strategy.

### **Day 2**

#### **Core issues concerning the epidemic in Peru**

- There is a lack of updated knowledge of the epidemic. The health services are not adequate, which translates into information problems. The primary care services are in a worse position.
- There is a clear lack of population-level studies with regards to HIV. What we have at the moment are specific studies for specific purposes and when population-based assumptions are based on specific studies, this creates problems at the intervention level. Likewise, epidemiologic modeling exercises are only suppositions about the future.
- The current Multisectoral Strategic Plan has not been evaluated yet and without this it is difficult to begin a new plan that is based on proper guidance and that can be effectively implemented.
- The biomedical interventions need adequate services. HAART and vertical transmission interventions have experienced serious problems and the lack of expected success is due to poor quality health services.

### **Structural Strategies**

- There is agreement on the need of structural strategies, but lack of clarity regarding which ones to implement and how they can be implemented.
- International laws against hate crimes and the discrimination according to sexual orientation and gender identity have not been signed by the State.
- The media has contributed to the problem by generating stigma and discrimination among the population.
- Manuals and norms that do exist are not being applied.

### **Biomedical Strategies: Treatment as Prevention and Pre-Exposure Prophylaxis**

- An unfortunate lack of leadership has led to a delay in the updating of the national technical guidelines to reflect the 2010 WHO treatment guidelines.
- There are variations in treatment coverage data, with the Ministry of Health stating it reaches 96%, while the UNGASS reports 70% coverage levels (although this discrepancy reflects that we are dealing with two different indicators rather than only one – the MoH refers to registered people waiting for treatment; the UNGASS indicator refers to the estimated total number of HIV cases). Treatment coverage levels should be substantially increased before considering treatment as prevention.
- We are aware of the efficacy but not the effectiveness of the measure and whether people will understand what taking treatment as prevention entails.
- Concerning PrEP, the most useful strategy would be to focus it on a population and generate interest for its use within that population. Work is needed to develop a sense of ownership of this strategy as part of a combination prevention package.
- Further research will be beneficial to understand who can benefit from PrEP and how prepared the health care services are to assume this responsibility.

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## Appendix: Final Programme

### Public Forum (2 and 3 November, 2.30-7pm)

#### 2 November

- 2.30-2.45 Welcome: C. Caceres (USSDH/UPCH), M. Rivera (Director of Research, UPCH), P. Minaya (Director, INS), R. Ehmer (UNAIDS-Peru), R. Mazín (PAHO/Washington)
- 2.45-3.10 Status of the Global HIV Epidemic (Rafael Mazín, OPS)
- 3.10-3.35 Overview of the broadening HIV prevention landscape (K. Hankins, UNAIDS)
- 4.05-4.25 The status of HIV treatment and its role in prevention (P. Cahn, F. Huésped)
- 4.25-4.45 HIV testing linked to care & treatment – Community Viral Load (A. Liu, SFDPH)
- 4.45-5.15 *Coffee Break*
- 5.15-5.40 Pre-exposure prophylaxis to prevent sexual transmission (R. Grant, Gladstone I of V)
- 5.40-6.05 Structural Interventions in a Combination Prevention framework (C. Caceres, UPCH)
- 6.05-6.30 An ethical and social science perspective on new HIV Prevention options (M. Rosengarten, Goldsmiths, U of London)
- 6.30-7.00 Discussion

#### 3 November

- 2:30-3:00 Feedback from Day 1 of Stakeholder Consultation (TBN)
- 3:00-3.40 The multisectoral response to HIV in Peru (J. Sebastián, MoH-HIV Programme)
- 3.40-4.00 Open Discussion
- 4:00-4.25 Present Options for HIV Prevention among MSM/trans people (K. Race, U. of Sydney)
- 4:25-4:50 Modeling impact of certain combined prevention strategies for MSM in Peru (A. Borquez, ICL)
- 4.50-5.20 *Coffee break*
- 5:20-6.30 Round table: Are there options to improve the response to HIV in Peru (P. Minaya, INS of Peru; E. Gozzer, Municipality of Lima; P. Bracamonte, UNAIDS-Perù; P. Anamaria, community of PLH; G. Romero, Gay Community)
- 6:30-7:00 Discussion and closure

### Stakeholder Consultation (3-4 November, 9-1pm)

#### 3 November

- 9:00 Welcome, introductions and orientation for group work
- 9:30 Group work
- 11:00 Coffee break
- 11:30 Group work (continued)
- 12:00 Plenary

#### *Discussion Guide for group work session:*

- Has the response to HIV been effective in Peru (for example, with regard to the MSPs and the GF projects)? Concerning treatment? Concerning prevention? Concerning solidarity and human rights?
- Is the local response adequate to our epidemic profile?
- Are there mechanisms for the local community to incorporate emerging perspectives? What are the barriers? Are there any facilitators?
- Have we incorporated any structural intervention? What key structural change have we not considered/should we include?
- Is it feasible/relevant in Peru to incorporate any biomedical prevention programme (besides PMTCT)? Is there political will? What are the issues?

#### 4 November

- 9:00 Recapitulation and orientation for second day
- 9:30 Consensus on central issues in the HIV epidemic in Peru and strategies we have/have not adopted
- 10:00 Structural Interventions: What do we need to do? How do we do it?
- 11:00 Coffee break
- 11:30 Treatment and Prevention – Feasibility, opportunities and challenges for Peru
- 12:15 Pre-exposure prophylaxis – Feasibility, opportunities and challenges for Peru
- 13:00 Plenary and closure