

The National Response to the HIV/AIDS Epidemic in Peru: Accomplishments and Gaps—A Review

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Abstract: In Peru, after the first case of AIDS was reported in 1983, nearly 20,000 AIDS cases have been notified to date and between 20,000 and 79,000 persons are estimated to be living with HIV. Despite a relatively low HIV prevalence in the general population, the epidemic has importantly mobilized social actors and economic resources and has helped articulate a very active field within the Peruvian health sector. In recent years, the country has become the largest recipient of HIV funding from the Global Fund for AIDS, Tuberculosis, and Malaria in Latin America, for which a substantial national counterpart has been committed. Peru's predictable selection as one of the 12 focal countries for the 5-year impact evaluation of the Global Fund suggested that an analysis of the response to the HIV epidemic in Peru may provide significant lessons on the possibilities of international aid in the AIDS field, particularly in the Latin American context. This article presents an analysis of the impact of the HIV/AIDS epidemic and the nature of the response articulated by the State and civil society in Peru, based on the Universal Access Principles proposed by World Health Organization, UNAIDS, and others. Relying on a number of recent secondary sources, we focus not only on the impact of the epidemic on morbidity and death but also on the changes in society as a whole, particularly in social movements and their dynamic relationship with the State. We start with an epidemiological overview and move to describe the role of social actors in response to the epidemic and then propose a framework for the analysis of the scope and limitations of the national response and elaborate on potential courses of action that may lead to strengthen accomplishments and resolve remaining gaps.

Key Words: civil society, evaluation, HIV/AIDS, national response, Peru, public policy

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INTRODUCTION

The history of the AIDS pandemic is one of the most complex and enlightening of global public health in the last century. After its emergence in 1981 and over the course of the past 25 years, this pandemic has had enormous influence in the lives of people, health systems, and financial flows globally.¹

In Peru, after the first case of AIDS was reported in 1983, more than 20,000 AIDS cases have been notified to date

and between 20,000 and 79,000 persons are estimated to be living with HIV.² Despite a relatively low HIV prevalence in the general population, the epidemic has generated a large mobilization of social actors and economic resources and has, over the course of the years, led to the constitution of a very active field within the Peruvian health sector.^{3,4} In recent years, the country has become the largest recipient of HIV funding from the Global Fund for AIDS, Tuberculosis, and Malaria (GFATM) in Latin America, with about US \$80 million received for projects to be implemented between 2004 and 2012,⁵ which implied the commitment of a substantial national counterpart. Its predictable selection as one of the 12 focal countries for the 5-year impact evaluation of the Global Fund (GF)⁶ suggests that an analysis of the response to the HIV epidemic in Peru may provide significant lessons on the possibilities of international aid in the AIDS field, particularly in the Latin American context.

Here, we undertake an analysis of the impact of the HIV/AIDS epidemic and the nature of the response articulated by the State and civil society in Peru, based on the Universal Access Principles proposed by World Health Organization, UNAIDS, and others.⁷ Relying on a number of recent secondary sources, we focus not only on the impact of the epidemic on morbidity and death but also on the changes in society as a whole, particularly in social movements and their dynamic relationship with the State. We start with an epidemiological overview and move to describe the role of social actors in response to the epidemic and then propose a framework for the analysis of the scope and limitations of the national response and elaborate on potential courses of action that may lead to strengthen accomplishments and resolve remaining gaps.

Epidemiological Overview

The epidemic in Peru has officially entered its third decade. As of August 2007, 19,944 AIDS cases had been reported to the Ministry of Health (MoH).⁸ Probably, the period of highest expansion took place between the mid-1980s and early 1990s. In the late 1990s, the structure of AIDS cases reported yearly had stabilized at roughly 1000 cases per year (Fig. 1). The first cases occurred among men having sex with men (MSM), and it was in this group that the epidemic concentrated early on,^{9,10} with HIV prevalences consistently over 10% in Lima in the past decade, contrasting with figures below 1% among pregnant women and female sex workers (FSWs).¹¹ The male to female ratio, originally 18:1, has been 2.5 to 3:1 over the past decade (Fig. 1), suggesting that HIV expanded promptly in the urban sexual networks of MSM including some women and their children. The epidemic is clearly urban

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**AIDS: Male to Female Ratio
PERU, 1983-2006**

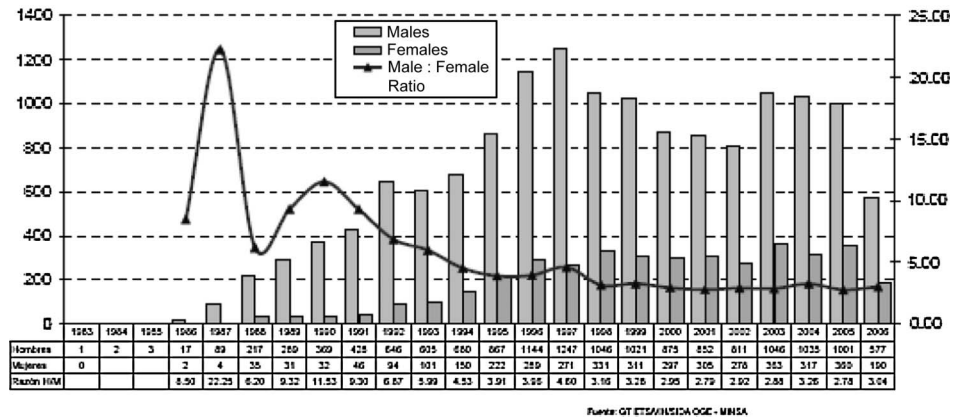


FIGURE 1. AIDS case reporting and male to female ratio, Peru 1983–2006. Source: *Situación Epidemiológica del VIH/SIDA en el Perú. Boletín Epidemiológico Mensual Diciembre 2006*. Available at: http://www.dge.gob.pe/vigilancia/vih/Boletin_2006/diciembre.pdf. Accessed February 8, 2007.

(about 75% of current Peruvian population lives in urban areas) and has concentrated in the coastline and rain forest regions of Peru. Initially affecting mainly the upper-middle classes, it also expanded to all urban sectors with a quick increase among the poor in specific subpopulations.

Although early sexual initiation and a higher number of partners contribute to women’s risk, the epidemic is still driven by sex between men.¹² The MSM label, however, misrepresents the importance of subgroups with contrasting infection rates and HIV prevalence. An analysis of the epidemiological surveillance data found that 51% of transgender MSM were reactive for syphilis and 33% were HIV positive, as opposed to 13% and 18% of nontransgender gay-identified men, respectively, and 11% and 15% among bisexual men, respectively.¹³

Although surveillance data have not been collected regularly in the past decade and comparable data are not available to assess trends in HIV prevalence over time in various subpopulations, ongoing studies suggest that such prevalence figures have stabilized in the past few years, although the impact of increasing access to antiretroviral therapy (ART) in mortality and possibly infectiousness among persons living with HIV remains to be measured. A review of national population-based HIV seroprevalence surveys in developing countries (including Peru) demonstrates that reliable and useful results can be obtained, although they require careful planning and increased financial and human resource investment to maximize responses at the household and individual levels, which are the key elements to validate survey results.¹⁴

Behavioral data available consistently show a high level of awareness and knowledge about HIV transmission mechanisms, despite low condom use rates with nonstable partners and frequent alcohol consumption before intercourse. Among men, the lifetime prevalence of sex with commercial sex workers reaches 44% and ranges from 10% to 15% for having sex with other men. Clients of commercial sex workers and MSM often have steady female partners too and do not consistently use condoms with them, configuring one of the key challenges for continued prevention efforts. A significant variability is found in the levels of sexual risk within the population, as reflected in reported sexual behavior (eg, unprotected sex with non-

spousal partners can be 15–30 times higher in certain groups as compared with other urban adults).¹⁵

Highly active antiretroviral treatment (HAART) was introduced in 1999, and a National ART Program was established in May 2004. By December 31, 2006, 6507 persons were receiving ART free of charge from MoH establishments and 9427 persons from public sources altogether in Peru.¹⁶ A 2003 study estimated that the number of people living with HIV/AIDS (PLHA) needing treatment from public sources would be approximately 10,300 at month 30 of program implementation,¹⁷ so that the treatment coverage can be estimated to be slightly above 90% of the estimated demand for all public sources (ie, 9427 of 10,300) and between 85% and 90% of the MoH demand (ie, 6507 of 7300).¹⁵

A decreasing trend is observed in HIV-related deaths notified in Peru, suggesting, besides notification delays, an actual decrease in HIV-related mortality, potentially resulting from the added effects of higher access to ART and improved treatment of opportunistic infections. Figure 2 shows HIV-related mortality trends in Peru based on recent studies¹⁸ using MoH sources adjusted for subnotification. Similar findings have been reported elsewhere in the region.¹⁹

Epidemiology of sexually transmitted infections (STIs) in Peru shows a complex pattern which varies for each subpopulation. Prevalences are not uniformly higher among MSM as with HIV infection. Bacterial STIs are higher among FSWs, although results from testing of rectal biospecimens from MSM practicing receptive anal sex are not broadly available. Conversely, syphilis (as reflected in rapid plasma reagin reactivity) is consistently very high among MSM. Herpes simplex virus-2 prevalence is also very high among MSM, FSWs, and, generally, among women, potentially justifying specific interventions.^{15,20}

The Programmatic Response and the Role of Social Actors

The programmatic response to HIV in Peru can be described in 4 phases. Between 1985 and 1995, a slow organizational phase took place, with scarce resources, weak directives, and a legal counterpart that reflected the

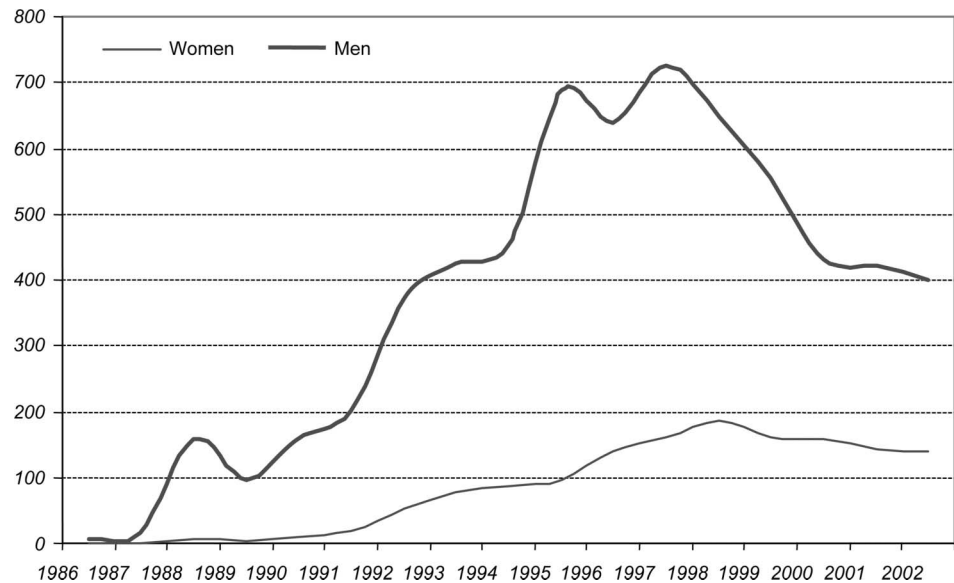


FIGURE 2. Trends in HIV-related mortality in Peru, 1986–2002. Source: Cáceres CF, Mendoza W, Konda K, et al. *Nuevas Evidencias para las Políticas y Programas de Salud en VIH/SIDA e Infecciones de Transmisión Sexual en el Perú: Información disponible hasta febrero 2007*. UPCH and PAHO/WHO; 2007.

stigmatization of AIDS and sexual diversity. Conversely, civil society organizations (CSOs) played a key role since the late 1980s and, especially, early 1990s, with the formation of the first HIV/AIDS community-based organizations, including those of PLHA. Between 1996 and 2000, during Fujimori regime, a modern biomedical program was developed that linked HIV prevention to STI control and that developed a nationwide strategy based on improved surveillance, outreach and periodical medical checkups of members of “core groups” (ie, FSWs and MSM), and free syndromic STI management based on STI clinics. For this task, significant resources were raised; no steps were taken, however, to develop a human rights framework for HIV work, with a focus on stigma and discrimination, an inclusive view of sexuality, and to develop strategies for access to ART (in contrast with other countries in the region). After 2001, government-controlled resources were more limited, and the program was downsized and played a less active role in the definition of policies that CSOs were promoting, such as access to treatment, a new AIDS law, and the formation of a country coordination mechanism for submission of applications to the GFATM that eventually got funded. At present, access to ART is nearly universal and fully funded by the Peruvian government, and GFATM projects essentially support prevention activities. In 2006, with UNAIDS support, a 2007–2011 Multisectoral Strategic Plan for HIV/AIDS²¹ was designed in a national consulting process, which in early 2007 was approved by the Council of Ministers, the highest level of the Executive Branch.

Various stakeholders have played distinct roles in response to the epidemic, in relation to their reading of the epidemic and their specific interests and responsibilities, as described in Table 1.

Scope, Accomplishments, and Limitations of the Social Response

Here, we articulate some directions to evaluate the national response to HIV in Peru, which adapt elements from

the UNAIDS universal access framework. Not only the governmental response but also the response of Peruvian society in general is discussed:

Understanding of the Epidemic and Its Determinants and Definition of the Response

Contrasting understandings of the epidemic, with both technical and political perspectives, may lead to distinct responses.

Has Consensus Been Built About an Evidence-Based Understanding of the Epidemic?

Although HIV/AIDS has been the focus of innumerable discussions, the profusion of understandings and readings informing academic and programmatic action have led to substantially diverging views of the distribution and determinants of the epidemic in Peru. Although early on it became concentrated on MSM, with female cases resulting from transmission from bisexual men, key officers in the government and international agencies have claimed now and then that true “heterosexualization” and “feminization” are occurring,²⁶ contributing to inconsistent, inaccurate, even contradictory messages in the media and also to bad HIV/AIDS programming. As already explained, comparably appalling disagreement has occurred regarding estimations of numbers of PLHA.²

Have the Explanatory Models Been Sufficient?

Throughout most of the history of HIV in Peru, individual risk has been the privileged explanatory model. According to this model, behavioral exposure resulted from ignorance, irresponsibility, or sexual pathology. In the mid-1990s, this view underwent substantial criticisms internationally because of its stigmatizing and victim-blaming logic, and a new focus emerged on vulnerability and structural interventions.²⁷ In Peru, with little concern for this, the restructured AIDS program based HIV control on “communication for behavioral change” (ie, condom use) and periodic medical checkups for expedited STI treatment in “core

TABLE 1. Roles of Stakeholders in the Response to the HIV/AIDS Epidemic in Peru

Stakeholders	Key Contributions
The national AIDS program	In one of the most revealing examples of the evolving relationship between the epidemic and specific actors, the health system faced the challenge of ideologically incorporating constituencies secularly excluded such as MSM (particularly transgender persons) and FSWs not only as a population to serve but also as key partners, together with persons living with HIV. In the past, only registered sex workers had access to sanitary control to prevent their presumed role of vectors of disease to others. This evolving response, which used the international language of commitment and human rights, is not free of contradictions and conflict but suggests some progress, where the discussion of treatment and access to care are politically more straightforward than the discussion of sexuality and sexual diversity, resulting in an increasingly medicalized response at the expense of less meaningful reiterative prevention activities.
The sexual diversity movement	Active since the early 1980s, the Peruvian LGBT movement got involved in HIV work early in the epidemic and received international funds. During the 90s, it limited its participation to HIV work due to the death of historical leaders and the decision of focusing on sexual and human rights. ²² Finally, after the year 2000, a new generation of LGBT organizations throughout Peru reacted to the nonexistence of preventive work aimed to LGBT networks, in a context of increasing visibility of other HIV-related activities involving MSM, such as government programs funded by GF projects and clinical trials. At this point, the transgender community claimed for an independent status, refusing to be conflated within the “MSM” category.
AIDS service organizations	Formed in the early 1990s, they reflected the social concern for the lack of governmental action on HIV at that time. After establishing the Red SIDA-Peru as an AIDS NGO network, in the mid- and late 1990s, they implemented specific government-funded activities. After 2000, older and newer ASOs formed the “Collective for Life” to achieve access to treatment and comprehensive care and later pushed for the constitution of CONAMUSA, a country coordination mechanism (as established by the GFATM), to design and submit applications. Since 2004, various NGOs, organized in consortia, are the main implementers of GFATM-funded projects.
PLHA organizations	Initially focused on self-support and self-training in the absence of treatment, various PLHA groups emerged in the 1990s but failed to coalesce in a larger movement. After 2000, they succeeded forming Peruanos Positivos (Positive Peruvians), the first national PLHA network, and were the basis of the treatment action coalition “Collective for Life” that led to broader consensus for legal changes for treatment provision. With representation in the CCM, they participate in implementation of GF-funded projects and remain a key player in HIV-related processes.
Academic and research centers	The involvement of academia in AIDS work has been partial and limited, mostly dealing with descriptive clinical studies. Epidemiological studies have been conducted by a small number of researchers from San Marcos and Cayetano Heredia Universities, which have to a lesser extent participated in social research on HIV, together with the Catholic University and economic research centers. After 2000, a number of clinical trials are being conducted in Peru by NGOs participating in international networks. The minor role of policy-oriented research in academia has probably led to its failure in articulating a more sophisticated critique to promote improvements in HIV-related policies.
The pharmaceutical industry	Besides lobbying and co-option strategies with health institutions and physicians, pharmaceutical companies have also participated in the public debate on access to ART and eventually have tried to persuade PLHA of the superiority of original drugs (as opposed to copies and generics). ²³
Faith-based organizations	The Catholic Church has had a sustained participation in the AIDS debate. Initially, only criticizing prevention based on sex education and condom use, it later became involved in care of PLHA, particularly women and children ²⁴ and more recently has been advocated for access to comprehensive care. Other churches did not participate in the debate, except for the Anglican Church, which after 2000 became very active in work with PLHA.
International agencies	With sustained participation in various areas of HIV work, historically, the largest contribution came from bilateral donors such as USAID, seconded by DFID and GTZ. In 2002–2003, USAID funded a study requested by the MoH to assess the conditions for implementation of a National ART Program in Peru. ¹⁷ At present, the UNAIDS Coordinator works closely with the government and the CCM. Private donors and organizations such as Doctors Without Borders-Belgium have played a distinct role, more prone to work with social organizations and prevention activities, including prisons. ²⁵ HIVOS made a key contribution by strategically funding key community-based organizations at specific times, generating new work in care in the early 1990s or stronger organizations of affected and vulnerable communities subsequently. More recently, the emergence of the GFATM, with much larger grants and a focus on achievement-based resource facilitation rather than on technical cooperation, has transformed the logic of AIDS funding.

LGBT, lesbian–gay–bisexual–transgender; NGO, non-governmental organization; ASO, AIDS service organization; DFID, United Kingdom Department for International Development; GTZ, German Bureau for Development Cooperation; CONAMUSA: Comisión Nacional Multisectorial de Salud (National Health Multisectoral Committee).

groups.” Although this formulation led to coherent programmatic action and represented a step forward as compared with ambiguous preexisting policies, it completely disregarded explanatory frameworks in use at that time.²⁸ Criticisms to this model are 4-fold: First, It insisted on understanding sexual behavior as individually controlled and resulting from rational choice. Second, it assumed that STI control was a key element in HIV prevention, an assumption recently recognized as overly optimistic,²⁹ and did so with almost no local evidence. Third, it treated vulnerable groups just as core groups with more sex partners and riskier sexual practices, with no

understanding of the structural conditions leading to increased vulnerability, and no provisions for vulnerability reduction, such as the strengthening of community organizing.^{30,31} Fourth, it failed to use the formulations about confronting stigma and discrimination and protecting the human rights of affected communities, particularly PLHA and their families, through the incorporation of a clear human rights perspective.

Has the Response Been Comprehensive?

Throughout most of its history, the national response has been partial. Until 2000, when only prevention-related

activities had been established in public health services under an individualistic rational choice paradigm, the strategies in place were insufficient. “Behavioral change communication” in place was not designed based on a strategy of messages changing over time according to an evolving HIV/AIDS context, with both general elements and elements oriented to specific subgroups.

The second major limitation of the national response, until 2000, was the absence of efforts to facilitate access to treatment and comprehensive care. Until then, treatment was not seen as an option on grounds of (1) lack of national resources and (2) a potential for an increase in transmission. This changed only with the emergence of “Collective for Life,” the United Nations Global Assembly Special Session on AIDS (UNGASS) Declaration,³² and finally the successful application for funding to the GFATM, with a project to cover antiretroviral costs in the first 2 years, provided that the national funds would bear those costs thereafter.

Finally, a public policy to address vulnerability and counter stigma and discrimination has not been fully developed, despite its explicit inclusion in ongoing GF-funded projects. Vulnerability has not yet been understood as the result of a dynamic social process where various groups can, even temporarily, become less able to protect themselves from HIV, including minors in reformatories or participating in atypical forms of sex work, migrants, or members of ethnic groups in the Amazon. Rather, it has just become a more acceptable term to refer to traditional high-risk groups: MSM, FSWs, and, to a lesser extent, prison inmates. Newly called “vulnerable populations” tend to be considered as fixed homogeneous constituencies disregarding substantial diversity within, for instance, “MSM.” More importantly, no new strategies to alter conditions conforming their vulnerability have been set up, and public programs have remained, for over a decade, focused on basic outreach for referral to periodic medical checkups for free syndromic STI treatment. The increasing participation of organizations representing these groups will possibly lead to a broader stronger strategy.

Effectiveness in Relation to Goals

Rather than a well-established monitoring and evaluation (M&E) system, as needed for a full goal-based evaluation, a number of partially integrated instruments for surveillance, monitoring, and evaluation exist, with no regular output. In 2005, however, a special goal-based evaluation of the 2001–2004 Multisectoral Strategic HIV/AIDS Plan was undertaken.³³ Similarly, the ongoing implementation in Peru of several GFATM-funded projects has involved periodic goal-based evaluations; more recently, the GFATM commissioned an impact assessment within its global 5-year evaluation.⁶

Is There Evidence of Effectiveness of Prevention Efforts?

The lack of a well-established M&E system has made it unfeasible to evaluate the impact of HIV prevention programs on HIV dissemination during the past decade. Prevalences of HIV estimated either in sentinel surveillance or in numerous academic studies in the general population and in specific groups cannot be rigorously used to assess such trends. Although HIV prevalences in all groups seem to have

remained stable in the past 10 years,^{10,15,34} such stability could be interpreted both as a plateau stage of the epidemic, with little impact of ongoing programs, and as an actual effect of such programs in an otherwise more severe epidemic. The improvement of a national M&E system should become a key priority, particularly, because the scale-up of treatment will affect the parameters that define prevalence. The evaluation of the 2001–2004 Multisectoral Strategic Plan³³ concluded that some deterioration was evident in performance indicators for MoH HIV/AIDS activities, particularly in STI diagnosis, treatment of diagnosed STIs, and coverage of periodic medical checkups of MSM and FSWs.

Is There Evidence of Impact on HIV Morbidity and Mortality?

As opposed to prevention, impact of comprehensive care programs in morbidity and mortality can be directly monitored, given that people under treatment are permanently followed up. In May 2006, the MoH published an assessment of the first 2 years of the HAART program in Peru,³⁵ where it claimed that 4000 untreated PLHA had entered the program and that mortality, after an initial increase, had showed a clear decay. As described, by December 2006, the number of people under treatment had surpassed 10,000, with an estimated 90% coverage of the total demand.¹⁶ Not only trends in mortality but also those in morbidity, adherence, therapeutic response, and factors affecting those parameters should remain under assessment.

Is a Human Rights–Based Program to Counter Stigma and Discrimination and Advance Equity Already in Place?

Although the decision to provide treatment was a key policy change in this direction, broader efforts to develop a human rights policy in the national AIDS response have only been articulated in the second project funded by the GFATM (ie, period 2006–2010)⁵ and more recently in the 2007–2011 Multisectoral Strategic Plan.²¹

Political Mobilization and Community Strengthening

Has Leadership Been Apparent Across Social Actors in Response to HIV?

Leadership has clearly been a key factor for the most important transformations of the national response to HIV. The leadership of a group of professionals and PLHA in the early 1990s constituted a civil society response to HIV, which established a crucial dialogue with the State from a humanist eclectic perspective.⁴ The MoH leadership in the mid- to late 1990s to professionalize the public HIV response led to a stronger resourceful program. Although its comprehensiveness has been questioned, it clearly transformed HIV/AIDS into a public priority and set up a standard for national guidance of HIV work that was not evident in the 2001–2004 period.³³ Finally, shortly after 2000, community leadership successfully pushed for the implementation of a national treatment program and the preparation of a successful application to the GF.

Has Civil Society Participation Become Stronger Over Time?

Collaborative HIV/AIDS work by CSOs, including those of vulnerable and affected communities, has faced

periods of higher and lower intensity over the past 15 years. Although participation of CSOs in public programs increased with their active involvement in implementation of GFATM-funded projects, this has occurred at the expense of a significant loss in social capital among CSOs, due to the logic of competition among consortia and, especially, the emergence of conflicts of interest.³⁶ In her 2003 study of the Peru Country Coordination Mechanism (CCM), Sprungli³⁷ explained the successful preparation of a proposal for the GFATM as based on trust, shared values, and clear goals and proposed that social capital (ie, the capacity to obtain benefits based on utilization of social organization resources, such as networks, norms, and trust, which facilitate cooperation for mutual interest) was created in the process. The recent problems may suggest, conversely, that a fraction of the social capital of AIDS CSO has been lost in the past decade.

Have Other Fundamental Aspects of Sound Social Policing Around HIV/AIDS (ie, Accountability of Program Implementation, Decentralization, Multisectoral Participation, and Sustainability of the Response) Been Taken Into Consideration?

A number of sources^{33,36} show progress and gaps. Regarding “accountability,” the constitution of a CCM in 2002 generated a collegiate mechanism for decision making on HIV programming; issues remain, however, about the prevention and resolution of conflicts of interest; the relationship between the CCM, the government, and other actors; and transparent procedures to assess the quality and appropriateness of task performance. Concerning “decentralization,” in the context of a slow but effective process of a Statewide administrative decentralization in Peru, the MoH has recently agreed to coordinate a process for the implementation of Regional Multisectoral Plans that become the actual implementing instruments for the 2007–2011 Multisectoral Strategic Plan, although the process will be difficult given the considerable centralization of decision making in Lima. “Multisectoral participation” also remains a challenge, because besides the health sector, other sectors of the State administration have remained reluctant to understand AIDS as a broad problem of overarching strategic importance, which poses perhaps more important challenges in areas other than health. Finally, regarding “sustainability,” the present distribution of AIDS funding, with treatment fully covered with national funds, and most of prevention activities presently incorporated in GFATM-funded projects, concerns emerge with regard to the future funding of prevention. The existence of a Multisectoral Strategic Plan with full formal support is an opportunity for reasonable planning of the funding structure that prevention and care should adopt in the future, recognizing that such funding will probably have to come from national sources.

CONCLUSIONS

The increasing access to combination ART is changing the face of the epidemic in Peru and transforming HIV disease into a chronic treatable condition. The provision of HAART not only represents a key step forward in the quality of the national response with direct impact on the healthy life

expectations of persons affected but also brings new challenges for surveillance and prevention.

Based mainly on individual behavioral change models and STI treatment nearly since its inception, HIV prevention strategies should be substantially reinforced with a clear incorporation of measures to address social vulnerability, which recognize its structural determination and also its dynamic quality. One key element in this perspective should be the inclusion, once and for all, of a sexual health perspective that considers present views of human sexuality and sexual diversity and that recognizes the links between HIV/AIDS and sexual health and rights. Moreover, the social consequences of HIV, particularly stigma and discrimination, should be addressed with clarity, using comprehensive conceptual frameworks rather than simplistic approaches, and understanding the connections between HIV-related stigma and the one concerning nonconforming sexual expressions.

Because the lack of an appropriate M&E system limits our ability to evaluate the impact of programmatic action over the past decade, the development of a strong information system is crucial. Such development may take advantage of studies carried out in the context of ongoing GFATM-funded projects. Routine data collection should integrate population-based (biological, behavioral) and administrative data. Glaring needs pointed out in recent studies are found with regard to systematic information on perinatal transmission and anti-retroviral coverage, adherence, and viral resistance. Improved mechanisms are also needed concerning dissemination and sharing of process data and research findings to maximize the utilization of information generated with public funds.

The future of HIV prevention and mitigation of its social impact are, in the short term, shaped by commitments with the GFATM through already funded interventions and, potentially, new grants. The magnitude of ongoing projects represents an unprecedented investment in the fight against HIV in Peru, and its implementation has engaged a substantial sector of civil society. This context offers important opportunities and challenges. Opportunities refer to the possibility of making distinct steps in the fight against AIDS in Peru, departing from a comprehensive understanding of the epidemic and its determinants. Challenges refer to the need to ensure effectiveness of this large investment, by planning the most adequate interventions and implementing them with appropriate quality and coverage; construct a comprehensive sustainable response from a human rights perspective; and strengthen CSOs, particularly those of affected and vulnerable communities.

It is then crucial that Peruvian civil society implements mechanisms that take these opportunities and confront these challenges, based on the lessons learned throughout the history of the national response to HIV in Peru. This will not be possible without clear efforts to renovate leadership, to strengthen a democratic practice of consensus building based on evidence of the degree of pertinence and effectiveness of ongoing prevention and care activities, so that some may be scaled up and others improved; to substantially develop programmatic M&E; and to create social capital by ensuring accountability and strengthening the participation of civil society and a decentralized multisectoral commitment.

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