
**Monitoring the Implementation of the UNGASS
Declaration of Commitment
Country Report
Peru**

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This report was prepared by the country researcher(s), as identified in the document. The International Council of AIDS Service Organizations (ICASO) provided financial and technical support but has not edited, commented and/or in any way influenced the final content of the report. The collection of data followed a similar methodology among countries, but the interpretation and analysis is the responsibility of the researcher(s).

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Executive Summary

This report gives details of the compilation of data and evaluation of the Implementation of the 2001 UNGASS Declaration of Commitment, a process that was made possible by the Non-Governmental Organization, Via Libre, as part of the project of the International Council of AIDS Service Organizations (ICASO) that took place in the Peruvian civil society between October and December 2005.

The completion of the current monitoring and evaluation report had the purpose of creating an evaluative treatise of the scope and limitations of the national response to HIV/AIDS from an independent point-of-view and with the support of leaders in the civil society and with the available academic and program data. At the same time, it proposes a reflection on the incorporation and participation of the civil society in such a response.

The methodology used for the report was constructivist and included a wide range of participants. It is further based upon gathering data from secondary governmental sources and ones from other sectors. The assessment of the scope and limitations of the national response was addressed with qualitative data collection techniques. Four discussion workshops were set up for leaders of the civil society, who were arranged into subgroups: leaders of the People Living with HIV, leaders of the organizations of vulnerable populations, directors of non-governmental organizations, and renowned professors of universities and research centers from around the nation. On the basis of this data, the first report, discussed and strengthened through the first plenary session with all the leaders of the civil society, was prepared. A second report was discussed in a meeting with delegates chosen from the first plenary session, and a preliminary written version was approved in the last plenary session that took place on December 15th, 2005. Later, the final report was handed out to all the participants via the Internet in order to collect their suggestions and observations for the final written version.

In section one of the discussion of the results, the general statistics of the country and ones specific to the epidemic that attempt to illustrate its situation in the national socio-economic context are given. In section two of the same, the characteristics of the national response during the period of the study are briefly touched upon, placing emphasis on the significant advances and setbacks that have been shown in both the government as well as the civil society. And in section three, the advances and limitations of the HIV/AIDS policies are discussed from the point-of-view of Peruvian civil society. In the last section, there is a short discussion about the monitoring system as well as the data system.

Among the main conclusions, we can see that the national response has reached a significant level of advancement in relation to access to treatment that to a large extent has transformed the response in the face of the epidemic in the country. It is a significant advance resulting from the mobilization of the civil society, international financial support, and the commitment of the government.

In the area of prevention and volunteer testing, there were structural limitations that caused subsequent setbacks during the 2002 – 2003 period where the conservatism of the Ministry of Health (MINSA) prevailed and the continuation of or improvements to the programs were neglected (after changes began due to Health Care reform), which culminated in the dismantling of the National AIDS Program. Despite the new political will of the current authorities, the balance is still negative.

The response to the epidemic has also been transformed by the development of the Project financed by the World Bank and by the dynamic that the new resources have brought about, as well as the new inter-institutional relationships represented by the formation of CONAMUSA and the consortiums.

Furthermore, new discussion points have appeared on the agenda without causing others to disappear, points like the concerns about access to information on the epidemic and on the different processes of the national response, about the economic, legal, and cultural barriers (such as discrimination and the stigma), about the deficient levels of the quality of health care, about the lack of integration between preventive and recuperative health care, about the sustainability of the treatment in the short and long term, the levels of adherence and resistance to medications, about the weakening of preventive actions, about the absence of a full frontal assault on all types of discrimination associated with HIV/AIDS (by seropositiveness, by the practice of commercial sex, by homosexual behaviors, and by alternative gender identities), about the weakness of the government in acting in favor of the protection of the rights (health, employment, family, education) of PLWA and other vulnerable populations, about the lack of support and care for people in the terminal stage, about children living with HIV, about orphans, and others.

History and Methodology

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The completion of the current monitoring and evaluation report had the purpose of creating an evaluative treatise of the scope and limitations of the national response to HIV/AIDS from an independent point-of-view and with the support of leaders in the civil society and the available academic and program data. At the same time, it proposes a reflection on the incorporation and participation of the civil society in such a response.

The purpose of the report is to become part of the body of documents that contribute to the reflection on the evaluation of the implementation of the commitments made by Peru at an international level in 2006, as well as to be a document that supports the advocacy processes that accompany that reflection. At the same time, it contributes to the reflection on the national environment necessary so that the civil society maintains its vigilance, the 2006 – 2010 Multi-sector National Plan (with a time frame for launching around the first trimester of 2006) will be mapped out, as well as the establishing of more agreed upon views from the civil society on the existing gaps in the country response.

The methodology used for the report was constructivist and included a wide range of participants. It is further based upon gathering data from secondary governmental sources, consolidating data from the different departments of the Ministry of Health, the National Multi-sector Health Care Coordinator (CONAMUSA), the project and program reports elaborated by the civil society, and certain research reports written during the study period from prestigious academic institutions around the country.

The assessment of the scope and limitations of the national response was addressed with qualitative data collection techniques. Four discussion workshops were set up for leaders of the civil society, who were arranged into subgroups: leaders of the People Living with HIV, leaders of the organizations for vulnerable populations, directors of non-governmental organizations, and renowned professors of universities and research

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Throughout the entire process – from the design stage to the final writing of the report – more work was done with a consulting committee that gave advice on the reflections and methodological decisions made. This committee was composed of the following people: Mr. Pablo Anamaria, President of Peruanos Positivos – the National Coalition of People Living with AIDS, Dr. Carlos Caceres, Vice Dean of the School of Public Health and Administration at Cayetano Heredia Peruvian University, Dr. Roberto Lopez, Director of the Non-Governmental Organization Health Action International with headquarters in Lima, Marie Françoise Sprungli, President of the Peru AIDS Network, and Dr. Robinson Cabello, Executive Director of the Non-Governmental Organization Via Libre and Vice President of CONAMUSA.

Because of time and resource constraints, it was not possible to have access to primary source information from other regions of the country. To overcome the centralization, the reflections from national encounters of organizations of PLWA and vulnerable populations were retrieved and added. Also, documents and research reports written in different regions of the country were incorporated so that the perspective of the report was strengthened by nationwide views and experiences.

Lastly, it is important to point out that the General Office of Epidemiology (OGE) of the Ministry of Health has submitted their formal response on the information relating to epidemiological data. However, there still has been the no formal response given from the National Sanitary Strategy for the Prevention and Control of STI's, HIV, and AIDS (ESN) related to the requested information on the program indicators and management budgets.

Results

Section 1: Epidemiological Situation of HIV/AIDS in Peru

• POPULATION STATISTICS

According to the latest population census, there are 26,152,256¹ living in Peru. In the last thirty years, the average annual growth rate has systematically fallen from 2.5% to 1.6% as a consequence of a significant reduction in the birth rate and mortality rate. A further reduction in the growth rate, to 1.3%, is expected by the year 2010².

The population of Peru is exceedingly young; the age groups containing the largest percentage of population are those from 5 to 9 (10.5%), from 10 to 14 (11%), and from 15 to 19 (10.2%). Furthermore, in terms of gender distribution, 50.1% of the population is female and 49.9% of the population is male. Moreover, the capital, Lima, has the greatest concentration of inhabitants with 8'028,000, an increase of 1'593677 from 1993³.

• BASIC ECONOMIC STATISTICS

According to the official figures from the Ministry of Economics and Finance, Peru has experienced sustainable macroeconomic growth during the period from 2001 – 2005. The accumulated growth of the GDP is 20.6%, exportations have grown 44.7%, private investment is up 25.2%, and public spending has risen 19.9%. Nevertheless, this growth is not proportional to the increase in household per capita consumption that in the period of 2001 – 2004 increased slightly – 6.7%. These effects have implied a reduction in the poverty rate and, above all, the extreme poverty cited in the last few years⁴.

¹ National Institute of Statistics and Informatics. 2005 National Population and Housing Census.

² General Office of Epidemiology of the Ministry of Health. Peru: 2004 Basic Health Indicators

³ National Institute of Statistics and Informatics. 2005 National Population and Housing Census.

⁴ Waldo Mendoza Bellido. Development and Poverty in Peru, 2001 – 2005: Economic Growth and Poverty. Discussion Paper. Pontifical Catholic University of Peru, 2005. http://palestra.pucp.edu.pe/portal/especial_01/textos/pon02_02.pdf

Between 2001 and 2004, the poverty rate fell from 54.3% to 51.6% as did the extreme poverty⁵ rate from 24.1% to 19.2% during the same time period. The largest effects of the reduction in poverty are seen in the rural areas and in the provinces. In the rural areas, the poverty rate fell from 77.1% to 72.5%, and the rate of extreme poverty decreased from 49.8% to 40.3%. In the provinces, poverty fell from 63.3% to 57.7% and extreme poverty from 32.9% to 25.6%. In Metropolitan Lima, however, the poverty rate increased from 31.8% to 36.6% and the extreme poverty rate from 2% to 3.4%⁶.

Another, complementary way of evaluating poverty is through the phenomenon of periodic unemployment⁷; from this standpoint, 68% of the households have experienced poverty at least once in the last four years, and only 32% did not experience poverty during the same time period. Just 25% of the sample studied experienced poverty for four straight years (structural poor), while the remaining 43% frequently change their status⁸.

Table #1
Poverty dynamic and type of poverty

	Lima	Urban	Rural	Total
Poor at least 1 year	55	52	86	68
4 years	8	13	41	25
3 years	10	12	17	14
2 years	15	11	16	14
1 year	22	16	12	15
No years poor	45	48	14	32

- **INDICES OF THE INCIDENCE AND PROPAGATION OF HIV/AIDS**

⁵ Related to the inability of households to buy a basic food basket.

⁶ Waldo Mendoza Bellido. Development and Poverty in Peru, 2001 – 2005: Economic Growth and Poverty. Discussion Paper. Pontifical Catholic University of Peru, 2005. http://palestra.pucp.edu.pe/portal/especial_01/textos/pon02_02.pdf

⁷ In the last few years, the social phenomenon called "empleo móvil", or periodic unemployment, meaning a significant portion of the population lost their job during the year and returned to the workforce after a short time off, has manifested itself. The mean time period from employment and unemployment has been reduced. 38% of the population of working age changes their working condition (employed – unemployed – inactivity) in less than one year, and less than half of the stable Active Working Population has a job for twelve straight months.

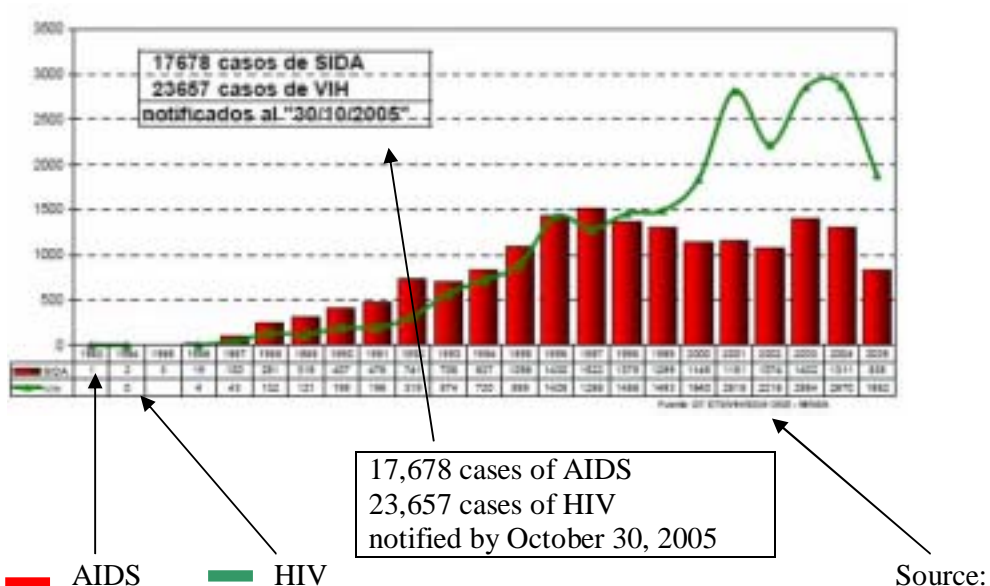
⁸ Francke, Pedro. Institutional change in the programs in the fight against poverty: Peru 1980 – 2005. Work document. Lima, April 2005.

The first case of AIDS in Peru was reported in 1983, and as of October 2005, the official statistics from the General Office of Epidemiology of the Ministry of Health (OGE) state that there are 17,678 notified cases of AIDS and 23,657 people infected with HIV. The most frequent way of contracting it is through sexual intercourse with an incidence of 97%, and only 1% contracts it through transmission of blood and 2% through vertical transmission⁹.

Through twenty-two years of the epidemic, the accumulated incidence is concentrated in the Region of Lima and the Constitutional Province of El Callao (73% of all the reported cases of AIDS), while the other 27% is spread throughout the country with Ica, Loreto, La Libertad, Ancash, Piura, Arequipa, Junin, and Lambayeque being the other regions with the largest incidence of HIV/AIDS cases. Moreover, the profile of the epidemic between men and women has shown significant changes in which the proportion of infected men-to-women has dropped from 14-1 in 1990 to a stable rate of 3-1 over the past eight years¹⁰.

Graph #1

AIDS cases according to year of diagnosis, Peru: 1983 – 2005



The data from the 2002 – 2003 OGE Sentinel Surveillance Study indicates that in the vulnerable groups, the prevalence of HIV in men that have sex with other men (MSM) is 13.9% [Sample Size 3280, Confidence Interval 95% 12.7%- 15.1%]. These figures illustrate a profile of an epidemic concentrated in the MSM populations with these

⁹ General Office of Epidemiology of the Ministry of Health. Peru: Epidemiologic Bulletin. October 2005. <http://www.oge.sld.pe/vih/Boletin%202005/octubre.pdf>

¹⁰ General Office of Epidemiology of the Ministry of Health. Peru: Epidemiologic Bulletin. October 2005. <http://www.oge.sld.pe/vih/Boletin%202005/octubre.pdf>

being the most vulnerable to HIV. Nevertheless, it must be underlined that these figures are not representative of an overall national rate but are only focused on the cities with high prevalence: Lima: 22.9%, Iquitos: 11.6%, Pucallpa: 5.7%, Arequipa: 6.6%, and Sullana: 10.2%. As indicated by the same source, the prevalence of HIV in female Sex Workers (FSW) is 0.49% [Confidence Interval 95% 0.31-0.76%]. For pregnant women, as stated by the 2003 CETSS Monitoring Sheet, the estimate of the prevalence of HIV is 0.50% [Confidence Interval 95% 0.47%-0.53%], while this is just 0.21% [Confidence Interval 95% 0.13-0.32%] according to the 2002 sentinel surveillance study¹¹. There are no new, up to date, and official statistics for the country, which limit the conclusions on the time period of the study. Today, surveillance data for MSM and pregnant women is being gathered, but it is impossible to obtain any additional data.

In relation to the MSM, it must be stressed that important differences in the rates of infection and rates of prevalence of the disease are hidden behind this label since it does not distinguish between the population of MSM whose occupation is the sex trade from those with other jobs, nor does it distinguish among the different sexual identities, lumping them all together into a homogenous group for data gathering purposes, and even worse, making the execution of more effective prevention and treatment strategies more difficult. Although there are no statistics that illustrate the importance of the differentiation inside the MSM at population levels sufficiently broad, a focused population study of a non-representative sample of the MSM population, carried out in Lima in 1996 and published in 2002, found that 33% of the transgendered MSM and transvestites polled had a seropositive diagnosis in contrast to the 18% of homosexual males and the 15% of bisexual males¹².

With respect to vertical transmission and the available data, it is important to point out that, based upon a comparison of regional statistics, the coverage for giving birth at any medical facility within the public and private health system and prenatal care is limited and varies widely throughout the country, which leads to a restriction on placing any weighting factor upon the women included in the services for representing the population of pregnant women in general. Likewise, the proportion of children of HIV-positive mothers who do not serorevert at 18 months of age is 5.5% in mothers who received prenatal care and AZT and 29.2% in mothers who did not receive prenatal care and did not receive AZT. This illustrates a protection effect of the antiretroviral therapy (OR: 0, 14, Confidence Interval, 95%) in relation to those who were not treated due to a late postnatal diagnosis. The risk of infection is reduced by one-third to one-twentieth in children of mothers who are treated with AZT¹³.

Most people contract the infection between the ages of sixteen and twenty-four, and approximately 70% of those affected are between twenty and thirty-nine years old¹⁴, or in other words, the population that is in the prime reproductive period. Until July of

¹¹ Base line study of objectives 1 – 4 of the actions project in HIV/AIDS. Global Fund for the Fight against AIDS, Tuberculosis, and Malaria, April 2005.

¹² Tabet S, Sanchez J, Lama J, Goicoechea P, Campos P, Rouillon M, Cairo JL, Ueda L, Watts D, Celum C, Holmes KK. HIV, syphilis and heterosexual bridging among Peruvian men who have sex with men. *AIDS*. 2002 Jun 14;16(9):1271

¹³ Velásquez-Vásquez C. Vertical Transmission of the Type-1 Human Immunodeficiency Virus (HIV). Perinatal Maternal Institute of Lima. Magazine: *Gynecology and Obstetrics*, Peru 2002 48(4): 235-242.

¹⁴ General Office of Epidemiology of the Ministry of Health

2005, the Epidemiologic Bulletin of the OGE reported 5,231 deaths associated with AIDS; yet, it is important to consider that there is a high probability that this figure suffers from the underreporting associated with the stigmatization processes present in Peruvian culture and, in particular, the health care services.

The data provided by the OGE is based on information from the 2002 – 2003 sentinel surveillance studies without having performed HIV prevalence studies in any of the four populations: pregnant women, MSM, SW, and People Deprived of Liberty. Today, there is a study of pregnant women and People Deprived of Liberty in progress and another study focusing on MSM's is scheduled to begin in 2006. However, there is no study planned for the case of SW's, but the results of the currently ongoing "Preven" Study are expected to be able to update the current data. The condition of the information coming from the government presents serious difficulties for analyzing the situation during the time period of the report.

- **BUDGETS AND COSTS OF THE PUBLIC SECTOR IN THE AREA OF HEALTH CARE**

Each year for the last five years, the budget for the health care sector has increased. In 2000, it was 1.727 million Nuevos Soles; in 2002, it was 2.139 million Nuevos Soles; and in 2005, it was 2.652 million Nuevos Soles. The health care budget is mainly used for current costs (around 90%), particularly associated with personnel, social obligations, and goods and services¹⁵. It is important to realize that these macro increases are not in balance with the diminishing resources for different interventions (non-operating costs).

Table #2

Health Care Budget by Cost Category
(in millions of Nuevos Soles – complete source)

Cost Category	2000	2001	2002	2003	2004	2005 (a)	2006 (b)	VARIATION	
								ABSOLUTE (b-a)	%
CURRENT COSTS	1,549	1,625	2,047	2,000	2,254	2,428	2,301	(127)	(5)
1. Personnel and Social Obligations	364	424	619	765	852	1,004	1,033	(30)	(3)
2. Retirement Obligations	167	171	177	176	175	194	191	(3)	(2)
3. Goods and Services	962	970	1,136	792	764	902	780	(121)	(13)
4. Other Operating Costs	55	60	116	267	462	329	296	(33)	(10)
CAPITAL COSTS	179	314	91	92	132	224	130	(94)	(42)
5. Investments	135	286	63	68	99	157	48	(109)	(69)
6. Other Capital Costs	44	29	28	24	34	67	82	(16)	(24)
TOTAL	1,727	1,939	2,139	2,092	2,386	2,652	2,431	(221)	(28)

- **OTHER RELEVANT STATISTICS ABOUT HEALTH CARE**

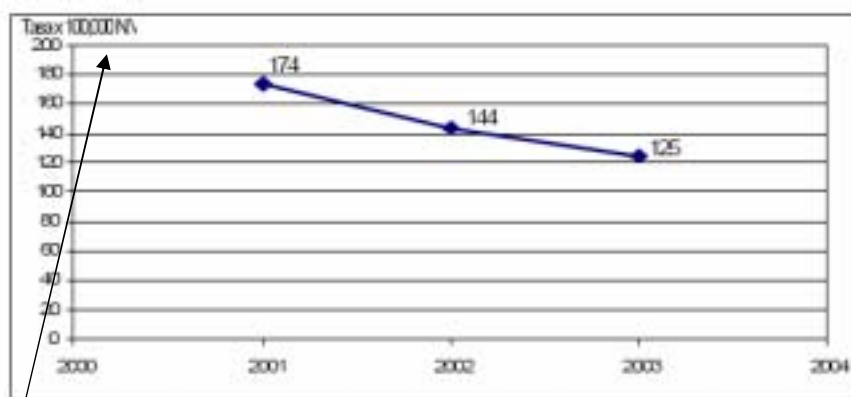
In the past fifty years, there has been a reduction in the gross mortality rate, falling from 21.6 deaths out of 1,000 people in the period of 1950 – 1955 to 6.2 deaths in the period of 2000 – 2005. Furthermore, there have been important changes in their profiles with the mortality rate caused by transmissible diseases declining, and the rate produced by

¹⁵ Ministry of Economics and Finance. Economic Transparency Portal, (Consulta amigable SIAF – SP) User friendly information. <http://ofi.mef.gob.pe/transparencia/default.aspx>

external causes and cancer increasing. At a national level, the primary cause of death is acute respiratory infection (mortality rate: 77.01 out of 100,000 people), followed by diseases of the urinary system, vascular brain diseases, and ischemic heart disease¹⁶.

The maternal mortality in Peru has also declined. In 2001, it was 174 women out of 100,000 L.B.; in 2002, this figure dropped to 144 out of 100,000 L.B., and in 2003 to 125 out of 100,000 L.B. The estimates for the following years showed continual decline. Yet, despite the observable decrease, there are still regional differences. Fifteen regions report maternal mortality rates higher than the national average with Puno, Ayacucho, Huanuco, and Cajamarca being the four regions with the highest reported rates. In contrast, the lowest mortality rates are found in Callao, Lima, and Ica. A sobering fact is the large number of the maternal mortalities in the adolescent population; out of the approximate 1,200 pregnant women who die annually, 18% are adolescents.

Graph #2
Maternal Mortality Rate – Peru 2001 – 2003



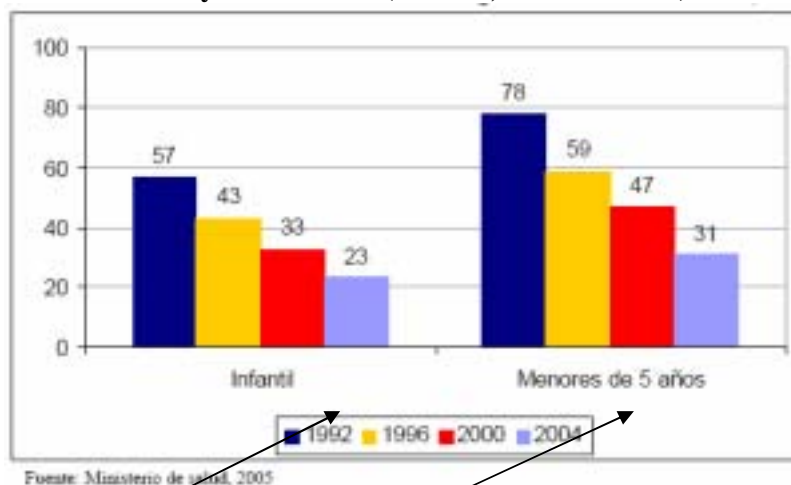
Rate x 100,000 L.B.

Source: Ministry of Health, 2005

Furthermore, the infant mortality rate at a national level has been continually declining as well; the figure of 57 out of 1,000 L.B. in 1992 has dropped to 23 out of 1,000 L.B. in 2004. Yet each year, approximately 7,200 babies who are less than one year old die. From 2000 – 2005, 50% of the poorest of the population accounted for almost 70% of the recorded infant mortalities in the country.

¹⁶ General Office of Epidemiology of the Ministry of Health. Basic Health Indicators, 2004.

Graph #3
Infant Mortality Rate – Peru (out of 1,000 live births)



Infant → Less than 5 years old
 Source: Ministry of Health, 2005

Section 2: General Situation of the response to HIV/AIDS

2.1 Response of the Peruvian Government to the HIV/AIDS Epidemic

In Title I, Persons and Society, Chapter II, Social and Economic Rights, Article 7 of the 1993 Constitution of Peru, it is stated emphatically that all citizens, families, and communities have the right to health care. It is also the duty of the government to contribute to the promotion and defense of that right. In the subsequent articles, 9, 10, and 11, it is recognized that the state must protect the health of the family and of the community, as well as recognizing the universal and progressive right of all people to social security for their protection from the contingencies that the law determines, for the improvement of the quality of life, and for the guarantee to free access to health care services and pensions through state run and private agencies or a combination of the two. What is more, the state must monitor the successful implementation of this¹⁷.

In addition, the right to health care is endorsed by the General Health Care Law (# 26842), Title I, Rights, Duties, and Responsibilities Concerning Individual Health Care, and in the respective articles that cover the right of all people to health care¹⁸.

Furthermore, Peru has also signed international treaties that, according to Article 55 of the Constitution of Peru, are in effect laws for the country. This determination also

¹⁷ 1993 Constitution of Peru. <http://tc.gob.pe/legconperu/constitucioncompleta.html>

¹⁸ General Health Care Law #26842. <http://www.congreso.gob.pe/ntley/Imagenes/Leyes/26842.pdf>

concur with the final Fourth Disposition of the Constitution that specifies “the laws relating to the rights and freedoms that are recognized by the Constitution are furthermore interpreted in accordance with the Universal Declaration of Human Rights and with the international treaties and agreements on the same matters ratified by Peru.” The following are the international agreements signed by Peru:

- a. Universal Declaration of Human Rights, approved by Congressional Resolution # 13282.
- b. International Pact on Economic, Social, and Cultural Rights, approved by Decree-Law # 22129.
- c. International Pact on Civil and Political Rights, approved by Decree-Law # 22128.
- d. American Convention on Human Rights, “Pact of San Jose, Costa Rica”, approved by Decree Law # 22231.
- e. Additional protocol to the American Convention on Human Rights in the area of Economic, Social, and Cultural rights “Protocol of San Salvador”, approved by Congressional Resolution # 26448.

According to the applicable laws, there are no professions and/or behaviors that are illegal, such as homosexuality, intravenous drug use, or sex work, although what is punishable is the sale of narcotics and procuring. However, embedded in the character of local governments and the national police force are reproachful attitudes towards sex workers based upon the arguments of maintaining order and good conduct.

At the same time, though, there are laws existing in Peru that recognize the rights of people living with HIV/AIDS^{19 20}. Yet, according to the comparative report on the situation of HIV/AIDS and Human Rights in the Andean Community of Nations²¹, people living with HIV/AIDS confront serious difficulties in regards to gaining access to health services or to the sustainability of such once they manage to receive them. The report also affirms that in spite of the existence of laws that recognize the principles of autonomy of will, confidentiality, right to work, and worker protection in the case of being terminated for discrimination, the situation of people living with HIV/AIDS is continually plagued by all types of abuse that in most cases constitute a violation of their fundamental rights theoretically protected by national laws.

As stated by the Report on the situation of HIV/AIDS and Human Rights in Peru for monitoring the implementation of the obligations stemming from the declaration of commitments in the fight against HIV/AIDS, it is highlighted that “despite the existence of laws relating to the rights of people living with HIV/AIDS, these are not respected by the authorities or the general population that, in its majority, does not know the existence of these laws; in view of this situation, the rights are violated or outright

¹⁹ CONTRASIDA Law # 26626

²⁰ Amendment to the CONTRASIDA Law, Supreme Decree 004-97-SA.

²¹ Andean Community of Nations. HIV/AIDS situation and human rights in the Andean Community of Nations: Monitoring of the implementation of obligations stemming from of the declaration of commitment in the fight against HIV/AIDS. December 2003. LACCASO and Via Libre.

omitted, and thereby the basic principle of respect that we should have for each other is transgressed.”²²

Moreover, the fundamental role of the Defensoría del Pueblo (Ombudsmen Office) as the agency in charge of defending the constitutional rights of the people and the community, as well as monitoring the implementation of the duties of the government administration and of public services must be stressed. As highlighted in the monitoring reports of the rights of people living with HIV/AIDS, the Ombudsmen Office has taken an active role in promoting an equitable culture, above all in the matter referred to as AIDS, a situation rife with harsh discrimination, which allows these people to be abused; likewise, the reports state that the office considers that one of the principle needs of PLWA is the right to the access to basic medications; similarly, it is active in collaborating with different institutions and other PLWA, requesting information, and monitoring the implementation of the precautionary measures created in favor of the PLWA by the Inter-American Human Rights Commission, since this information is highly restricted by the legally qualified agencies like the Ministry of Health and the Ministry of Foreign Relations²³.

The National Multi-sector Health Care Coordinator (CONAMUSA) is a coordinating agency, formed by representatives of the government, bilateral and multilateral international cooperation, the civil society, and organizations of people directly affected by HIV/AIDS, Tuberculosis, and Malaria in Peru. CONAMUSA was set up as an association that attempts to promote and create consensus, develop messages and concepts shared among all sectors, repair the gaps between the public and private sectors, and complement and strengthen all that the government is working on in the area of the HIV/AIDS prevention. CONAMUSA has developed a strategic plan for the medium and long term, as well as an action plan for the short term²⁴. The following details the strategic objectives of CONAMUSA:

STRATEGIES	STRATEGIC OBJECTIVES AT 3 YEARS
POLITICAL INCIDENCE	That the ministries involved in CONAMUSA have incorporated the objectives and goals in the fight against HIV/AIDS, Tuberculosis and have allocated

²² Gutiérrez J. Report on the situation of HIV/AIDS and Human Rights in Peru for monitoring the implementation of the obligations stemming from the declaration of commitments in the fight against HIV/AIDS, May 2003. Report written by LACCASO and Via Libre.

²³ Ibid.

²⁴ <http://www.conamusa.com/conamusa/index2.php>

	budgets consistent with them. That the objectives must incorporate the rights of the citizens.
COMMUNICATION AND DIFFUSION	That public opinion, institutions, and businesses know the gravity of the HIV/AIDS and TBC problem; that there is support for and surveillance of the initiatives in the fight against these epidemics.
STRENGTHENING OF COLLABORATION AMONG STAKEHOLDERS	That the member institutions of CONAMUSA combine their resources and capacities around the national plans for the fight against HIV/AIDS and Tuberculosis.
STRENGTHENING THE ORGANIZATIONS OF AFFECTED PEOPLE	That the greatest percentage of the affected population is better organized and united and to better achieve effectiveness in the practice of the rights and the implementation of their duties in HIV/AIDS and TBC.
MUTUAL LEARNING	That mutual learning has contributed to institutional harmony and made possible the improvement of the effectiveness of the actions of CONAMUSA in the fight against HIV/AIDS and TBC.
RESOURCE RAISING	That CONAMUSA has a fund raising system at both a national and international level that allows it to implement the steps in its plan for struggling against HIV/AIDS and Tuberculosis.

Source: CONAMUSA web page (search: December 2005)

In the last five year period, the Ministry of Health developed the 2001 – 2004 Strategic Plan for the Prevention and Control of STI's/HIV/AIDS. The Plan included five specific objectives and fourteen expected results and in order to implement these, there were nine strategies suggested. In addition, this Plan featured thirty-one evaluation indicators.

The evaluation study of the 2001 – 2004 Strategic Plan²⁵, which responds to the needs of the MOH, indicates that important elements linked to the culture and to sexual behaviors were left out, that no mechanisms were promoted for achieving multi-sector social responses, and further, that the civil society was not recognized as a relevant stakeholder. It also stresses that there was no evidence that the plans were formally approved by any department and, as a result, the required budgets were not allocated for their implementation.

Moreover, the same study²⁶ points out that the strategies did not define the ways to approach and facilitate the implementation of the planned objectives and in general did

²⁵ MOH – UNAIDS – Policy Project. Evaluation of the 2001 – 2004 MOH Strategic Plan for the Prevention and Control of VIH/AIDS in Peru. Final report. Lima, Peru, September 2005.

²⁶ Ibid. 26

not coordinate the participation of other sectors and stakeholders for the social response to HIV/AIDS. In regards to the evaluation of the plan, it is stated that just six indicators could be directly attained from primary sources; the rest of them featured a high cost because they imply preparing sentinel surveillance studies or special studies and/or their inclusion in population surveys.

In regards to government financing for HIV/AIDS programs, there is no available information due to the structure of the planned budgets. Nevertheless, as stated by the Evaluation Report of the 2001 – 2004 Strategic Plan, in 2003 the amount allocated for HIV/AIDS prevention and control measures by the different ministries was 7.29 million Nuevos Soles (approximately 2.1 million American Dollars). With the exception of the MOH and the activities of the Peruvian Armed Forces and Police Committee for the Prevention of HIV/AIDS (COPRECOS), the greatest proportion of funding from the other ministries (Ministries of Education and Justice) in 2004 was compensated by the Global Fund. Apart from this, other information available from the year 2000 states that the MOH gave out an amount of 18.5 million Nuevos Soles (approximately 6.2 million American Dollars) to PROCETSS (essentially aimed at communication activities for prevention, the social merchandising of condoms, screening and diagnosis, management of STI's, interventions in the vulnerable groups, and surveillance). At the moment, it is extremely difficult to gain access to this information²⁷ due to the establishing of the Comprehensive Health Care Model and the eliminating of the organization by Programs. There was a formal request made to the ESN for the budgets of the last five year period, and, except for the confirmation of its reception, there has been no response as yet.

The development processes of the last two national strategic plans have been elaborated with only the direct input from the MOH; no other sub-sectors of the Health Sector (Social Security – ESSALUD, Peruvian Armed Forces and Police Committee for the Prevention of HIV/AIDS – COPRECOS, and the private sector) and even less other sectors like the Ministry of Education, the Ministry of Women and Human Development, or the Ministry of Labor have been included. The participation of the civil society has been very limited with a highly reduced list of people summoned to meetings and with short term processes. A solution to this may be creating a process that lasts longer to guarantee that the representatives of the civil society have the possibility of consulting with their organizations and giving opinions and positions that are more representative of their group.

In the middle of 2002, a participative process began with the support of UNAIDS in order to develop the Multi-sector Plan for the Prevention and Control of HIV/AIDS. Coordination and initial meetings began with the participation of international facilitators. Unfortunately, the process was abruptly terminated because of two circumstances that happened during that period. On one hand, there was a lack of political will by the Ministry of Health, which did not assume the leadership of the process, and on the other hand, the civil society did nothing to pressure for its continuation, placing its attention on the design and subsequent execution of the Project

²⁷ Ibid. 26

for Strengthening the Prevention and Control of Tuberculosis and HIV/AIDS in Peru. The agenda of the abovementioned project exceeded the possibilities of action and reflection of the civil society organizations.

In regards to a doctor's obligation for reporting any positive result on an HIV test performed in the country, there is indeed a list of diseases that are subject to active epidemiological surveillance, and any positive results of HIV testing are found on this list. This law affects everyone involved in public services, but not the private sector.

Lastly, when discussing types of ARV treatment therapy, there are two that have been developed: first line, or NAÏVE, and second line, or RESCUE.

Number of treatments acquired from IDA (International Dispensary Association) until November 2004²⁸

THERAPY	Total
First Line A: zidovudine * + lamivudine* + nevirapine*	2825
First Line B: estavudine* + lamivudine + nevirapine	363
First Line C: dinanosina + lamivudine + nevirapine	363
Special 1: zidovudine + lamivudine + efavirenz	72
Special 2: zidovudine + lamivudine + indinavir	57
Special 3: zidovudine + lamivudine + nelfinavir	17
Special 4: zidovudine + lamivudine + abacavir	24
Special 5: estavudine + lamivudine + ritonavir* + saquinavir*	14
Special 6: didanosine* + lamivudine +ritonavir + saquinavir	15
Second Line 1: ritonavir +lopinavir +lamivudine +estavudine	139
Second Line 2: ritonavir +lopinavir + lamivudiane + didanosine	142
Total	4030

(*) zidovudine (AZT); lamivudine (3TC); nevirapine (NVP); estavudine (d4T); didanosine (DDI); lopinavir (LPV) ritonavir (RTV); Saquinavir (SQV).

Section 2: General Situation of the response to HIV/AIDS

2.2 Participation and Mobilization of the Society at a National Response Level to the HIV/AIDS

²⁸ CARE: Fourth Trimester HIV/AIDS Report (August 16, 2004 – November 30, 2004). From the HAI-LA paper: Benefits and Risks of the Public and Private Initiatives aimed at increasing access to HIV and AIDS medication in Peru www.care.org.pe/websites/fondomundial/segavan1.htm

The civil society active in HIV/AIDS in this country is widespread and dynamic. It has managed to bring to the forefront processes of advocacy, prevention, care, treatment, support, and research that enrich the experiences of the country. Indeed, some of the institutions composing it started their activities in the first five year period of the last decade.

The organizations of the civil society have produced important changes and have remained alert to the advances and setbacks in the national response. In the year 2001, they publicly denounced the setbacks and gaps made by the reform of the Ministry of Health and for the lack of political will of the management of that time. And from that same year, access to treatment as an object of political incidence was established and different activities were developed towards that end, for instance, the International Symposium on Access to Treatment, legal actions, and denouncements made to the IACHR. In the year 2002, these organizations were the driving force behind the proposal to the Global Fund, pressuring the government to take responsibility for the process with a multi-sector perspective in times when the MOH suffered from a lack of clear and necessary political will to respond to the epidemic, achieving a stronger, collaborative effort, and presenting the country proposal that would be approved and financed.

Starting from this experience and based upon the demands set forth in the Global Fund regulations of the application for grants, the National Multi-sector Health Care Coordinator (CONAMUSA) was formed, a coordinating agency, composed of representatives of the government, bilateral and multilateral international cooperation, the civil society, and organizations of people directly affected by HIV/AIDS, Tuberculosis, and Malaria in Peru. CONAMUSA was set up as an association that attempts to promote and create consensus, develop messages and concepts shared among all sectors, repair the gaps between the public and private sectors, and complement and strengthen all that the government is working on in regards to the prevention of HIV/AIDS. CONAMUSA has developed a strategic plan for the medium and long term as well as an action plan for the short term²⁹.

Those who participate in CONAMUSA are representatives of Non-Governmental Organizations, delegates from two universities (one public and the other private), delegates from the organizations of the affected people – in the case of AIDS, these are representatives of Peruanos Positivos – National Coalition of People Living with HIV – and the Network of Women living with AIDS. The election processes of the participants, if at one time were wide and autonomous, are now facing difficulties for participation since the mechanisms for periodic reelection and for the inclusion of new members have not been adequately established. The current president of CONAMUSA is the Minister of Health, the vice-president is a representative of the civil society (chosen by the Assembly of CONAMUSA), and the executive secretary is a delegate from a non-governmental, interfaith organization; this structure shows leadership by the MOH and the active presence of organizations of the Civil Society.

²⁹ <http://www.conamusa.com/conamusa/index2.php>

This Country Coordinating Mechanism, formed in the year 2002, as recently as 2005 established itself as an organization within the legal framework of the MOH by a supreme decree signed by the President of the Republic. The expectations for this multi-sector organization are wide-ranging from the perspective of the members of civil society. There are many critical viewpoints that suggest that the agenda of CONAMUSA is far too limited in relation to the Project financed by the Global Fund, that the summoning and participation of other government sectors has been partial or at least unsuccessful, and that there are problems with the representativity of the delegates that make it up. In all, the experience is a first attempt at a multi-sector accord and as long as it creates wide scale participative processes that actively summon other sectors (the most important being the Ministry of Economics, the Ministry of Labor, the private sector, and the vulnerable populations) and manages to incorporate in its agenda the national needs – further than the current projects – it will achieve institutionalization and legitimacy throughout the entire political and social society.

About the data, there is a legal framework in place concerning the transparency of the public management and public property of such generated by the state institutions. However, in relation to the available data, it must be stated that little exists. The government information systems contain serious limitations in efficiency because there is such a huge amount of it, many times unorganized or unprocessed, that does not correspond to systemized organization thus doubling efforts on processing and analysis; likewise, there are limitations in opportunity because the data entry process takes inordinate amounts of time (as an example, to write this current report, the official available data comes from the 2002 – 2003 sentinel surveillance studies); furthermore, it is limited in access because there are no institutional channels for disseminating the data and therefore steps are carried out that, most of the time, are discretionary; and finally, there are the difficulties surrounding its cultural appropriateness, which leads to a limitation in access. The main concern is that the different audiences composing the civil society are not taken into account when considering the way the information is presented; many times it is aimed at a highly specialized, academic audience, but the dissemination is not designed with other affected populations in mind and even less if we think about populations in every region of the country.

Concerning the inclusion of and listening to the civil society in the processes that the government is developing, there are two distinct periods within the years of 2001 – 2005: 2001 – 2003 and 2004 – 2005. During the former, the circumstances were very negative, especially regarding the actions of the MOH, the lack of willingness to dialogue, and the intolerance to lifestyle diversity and to different ways of thinking. In the latter period, there seemed to be more openness to dialogue and more willingness to listen. However, what is considered urgent to institutionalize are the processes of including the civil society and dialoguing with it so these allow the dispositions and personal beliefs of the current authorities to be overcome.

In the years 2003 and 2005, there were evaluation processes performed for the implementation of the UNGASS declarations of commitment, both having been carried out with limited participation by the civil society: during the first year by the conservative perspective of the MOH and its pulling away from the civil society and the

second by the short implementation period for the evaluation that hindered a process of deep reflection and contribution to the country report.

The final version of the 2003 evaluation was never disseminated. A preliminary version was known about, but it was not widely spread, and on top of that, the forms of presentation were not changed for reaching different populations. The actual paper can be found, but in realistic terms, the reflections are not readily accessible to different audiences.

The stakeholders at the different levels in the civil society are aware of the commitments assumed by the state in UNGASS. There are those who handle them at a conceptual level and have managed to transform them into a tool for their own advocacy. An example of this was when the civil society brought about the signing of the Global Fund Proposal in 2002 by the MOH when the authorities offered resistance to a full frontal assault against the epidemic and when the proposal considered programmatic responsibilities and rather large budgetary ones. This project based its goals to a large extent on the commitments assumed by UNGASS at the request and proposal of the civil society.

Other stakeholders report simply knowing about them, and a third group of stakeholders, recently included in the field of HIV/AIDS, reports that they learned of the commitments during the process of this current report.

The problems in the workplace for PLWA have not been a field of concern for the government, but neither has it been part of the agendas of the civil society. Even more, the information about this is very limited.

The civil society in the country provides:

- The point-of-view of living with HIV and of the situations of vulnerability that contribute to the reflection of the strategies in order to generate an appropriate national response to the needs, image registries, and the social, economic, and cultural conditions of the target populations and with it to influence favorably its effectiveness.
- Epidemiological and social knowledge through research that helps to overcome the gaps in data that exist in the national information system.
- Abstract and operative knowledge on innovative intervention strategies in the promotion and prevention for different populations through the work developed by NGO's and PLWA in similar interventions for targeted populations.
- Knowledge and expertise on health care and treatment of PLWA since there are institutions from the civil society that have been providing health care and treatment for several years.

- Help and support strategies for the people in terminal stages and support for affected children and orphans, overcoming, to some extent, the gap in the governmental actions that do not respond to these needs.
- Advocacy for the protection of human rights and the rights of PLWA.

In a process of self-evaluation, the following weakness and future challenges are considered:

- A large number of these potentialities have been carried out in the processes of the Project financed by the Global Fund; however, the links on the inside of the civil society itself that can provide feedback to those processes and energize the joint actions still remain to be strengthened.
- An important weakness is the absence of organized surveillance systems. A series of reports do exist for the institutions that are nothing more than anecdotes and do not constitute precedents or case histories and therefore do not give support for the processes of advocacy and the defense of the rights of PLWA and other vulnerable populations.
- The unwritten agenda of the civil society concerning HIV/AIDS is still centered on prevention, attention, and treatment linked to the health sector. Only very cautiously has there been any struggle included in it against the stigma and against the discrimination towards the conditions of vulnerability that influence the transmission of HIV/AIDS: sex work, homosexuality, adolescent sexual activity, needs concerning labor space, reflections about family and school, and many others that carry with them actions of coordination and advocacy to other state institutions.

- There is also a debilitating weakness in summoning other stakeholders from the civil society that are not working directly in the field of HIV/AIDS in order to strengthen joint actions. There are also no stakeholders from the private sector. What is more, the processes of the civil society regarding HIV/AIDS have not been unified with larger processes relating to health and development that involve coordination and joint action among other organizations of the civil society that are engaged with other problems or situations of health care and rights.

Section 3: National Policies on HIV/AIDS and their Implementation

3.1 Access to treatment, care, and support

In the period from 2001 – 2005, the greatest advance in the national response against HIV/AIDS has been seen in the area of access to universal antiretroviral treatment and to free medications. Before 2004, to give a history of the delivery of antiretroviral treatments from the MOH, there are only thirty-five documented cases of treatments given to infants born from mothers who are living with HIV, and these were primarily distributed to control vertical transmission.

According to the 2002 estimates, there were 9,000 people who needed ARV treatment, and only 25% of these had access to it, taking into account the beneficiaries of Social Security, the Armed Forces and National Police, and the NGO – Aid for AIDS – that were providing treatment³⁰. However, it was in May of 2004 that the National Sanitary Strategy launched the HAART Program (Highly Active Antiretroviral Treatment Program) with financial support from the Global Fund. Up until November 28, 2005, the number of people who received treatment in the country was 6,298.

Table #3

Number of People who received Antiretroviral Treatments in the Health Sector

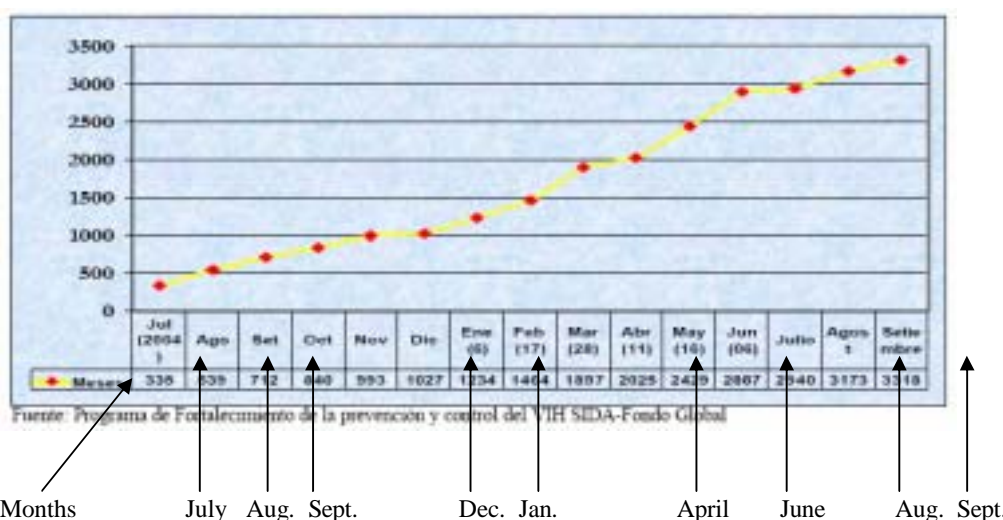
Health sub-sector	# of people who received antiretroviral treatments
MOH (MINSa)	3,752
Peruvian Armed Forces and Police Committee for the Prevention of HIV/AIDS (COPRECOS)	213
Social Security (ESSALUD)	2,333
Total	6,298

Source: National Sanitary Strategy. December 16, 2005

It is important to point out that there is no information about the people receiving treatment in private health care facilities. We conclude, based upon the cost of these medications in the country and their access being centralized to urban areas of major development, that these people belong to middle/high or high socio-economic groups and therefore correspond to a lower figure.

³⁰ Public-Private Initiatives Aimed at Increasing Access to AIDS Medicines. Phase I. Country Situation Analysis – Peru. HAI-LA. Lima, August, 2004.

People receiving Highly Active Antiretroviral Treatment (HAART) at a National Level July 2004 – September 2005



Source: Global Fund Program for Strengthening the Prevention and Control of HIV/AIDS

The MOH treatments were launched in five hospitals in the cities of Lima and Callao since these two contain the highest prevalence of HIV/AIDS in the country. The offer was then extended throughout the nation, and from the start of December 2005, treatments have been given out in fifty-four public health care facilities as well as three NGO's (Via Libre, Impacta, and Hogar San Camilo)³¹. However, according to figures from the month of August, the percentage of treatments in regions other than Lima and Callao, which when summed up constitute 25% of the cases at a national level, represented just 10% of the total. This situation is just an illustration of some of the difficulties in implementing the HAART Program on a national scale.

Since 1997, the use of prophylactic treatment for controlling opportunistic diseases has been provided in the country, yet based upon interviews of health care professionals who worked in the Program and comparison with the International Guides, prophylactic

³¹ HAI-LA paper, Benefits and Risks of the Public and Private Initiatives aimed at increasing access to HIV and AIDS medication in Peru

treatment is incomplete, and there are difficulties in its regular supply. The treatment of opportunistic diseases is not free and has to be paid for by the PLWA themselves, which places stress upon their already limited monetary resources.

There are different ways of accessing antiretroviral medications. They can be found in the private market with name brand drugs for first line therapy costing up to 15,000 Nuevos Soles (approximately \$4,500³² American Dollars) per person per year and between 3,500 and 4,000 Nuevos Soles (approximately \$1,050 and \$1,200 American Dollars) for generic drugs³³. At this moment, there are no records for the number of people receiving antiretroviral medications in the private health care system with the only exceptions being the NGO's cooperating with the HAART Program.

People can also gain access to the medications through the Social Security system and the Peruvian Armed Forces and Police Committee for the Prevention of HIV/AIDS. There are also three NGO's (Via Libre, Impacta, and Hogar San Camilo) that are supplied with these medications through the financing of the Global Fund yet that must supply their logistics network and human resources through their own organizations. In addition, two other NGO's (Doctors Without Borders and Aid For AIDS) provide treatments out of their own resources for a reduced number of PLWA.

There are fifty-four health care facilities of the MOH that provide free access (just to ARV therapy medications) as stated by the data of the National Sanitary Strategy posted on December 15, 2005. The overall goal of the MOH was to incorporate another 114 facilities into the HAART Program.

The national level treatment goals of the HAART Program of the MOH are proposed in the commitments from the Global Fund both for their implementation as well as their financing. According to the proposal presented by CONAMUSA (lead by the MOH and financed by the GF), there were to be 7,000 PLWA incorporated into the project for the first year of its existence (2004), and the goal is to reach 9,000 included and maintained PLWA by the year 2007, as stated by the suggested planning of the second phase³⁴. The financing provided by the MOH will increase each year so that at the end of five years, the program will be financed solely by the Peruvian government. However, the proposed goals for the first phase quickly showed their good intentions but also their lack of feasibility since the established goal was not met in the first year. Because of this lack of fulfillment, the GF questioned giving more financial support since they had placed a mark of 30% of the established goal for the first year as the requirement for continued financial support. With great effort, this goal was surpassed.

This setback in the fulfillment of goals is explained by the implementation conditions since the health care system was not ready for the installation of HAART; moreover, the ESN experienced less freedom to make decisions because of the health care reform

³² Exchange rate of 3.41 N.S. for every 1 U.S.D.: Dec. 15, 2005.

³³ Ibid.

³⁴ The estimated number of people living with HIV-AIDS and needing treatments has varied in the last three years for difficulties in the estimation process. In 2002, the ESN estimated that for the year 2004, 9,000 people would need treatments. In 2005, the ESN gave the figure of 7,000 people based upon the consulting process by a team of researchers from the Cayetano Heredia Peruvian University that responded to a request made by Via Libre on December 15th.

launched in 2001. Also, it took time to strengthen capabilities and to manage the processes, yet the results have been positive with the last period of incorporating PLWA into the treatment program demonstrating greater progress. At the moment, the coverage is somewhere above 70% of the established goals.

In order to enter the HAART Program, a person diagnosed seropositive must gain access to CD4 and VL tests. The entrance parameters according to law are: a CD4 less than 200 and a VL greater than 50,000. The person is then evaluated by a medical team (doctor, psychologist, social worker, nurse). One of the HAART selection criteria is the need for family support, or in other words, to be accepted in the program, the PLWA must be accompanied by a family member and have a permanent residence. Yet, this restriction for people who do not have their family's support is flexible, and close relatives or friends may be considered adequate, depending on the personal feelings of the health care provider.

About the number of people trained in the health care system for implementing the HAART Program, it must be pointed out that there was an initial training process for health care workers on a national level for ARV medication management, and at the moment, there is a continuous training program that includes sixty-four doctors from around the country. What can be said about the training, however, is that the number of doctors is reduced and the selection of staff to be trained does not necessarily correspond to the current working staff because they are constantly rotating positions within the health care facilities. Furthermore, the training content did not include any part of the interpersonal dimension for treating PLWA and respecting their human rights.

Moreover, there are limitations to the system of monitoring and evaluating the staff that makes up the ESN at different levels.

What is more, Informative Programs about treatments do not exist in the country, which translates into a lack of very basic, much less fully detailed, information about ARV treatments for people in the general population and especially in the vulnerable ones. There is no program of this type for PLWA, meaning that some organizations in the civil society and in the PLWA population itself have created activities specifically concerning this need. Yet, the efforts are very weak and can not be considered as true Informative Programs.

In terms of the formal and informal restrictions to access to treatment, it can be stated that the formal restrictions target the PLWA who do not have a family network and the PLWA whose work or duties keep them from having a permanent home. Taking into account the harsh stigma associate with HIV/AIDS in society and the nature of families to discriminate against their own members, these criteria form a barrier to access to treatment. Further still, in populations like MSM and male and female SW's, who by their own behaviors do not conform to the dominant standard, they are less likely to find support in their own families.

Access also remains limited for other reasons such as the little amount of information given to the population on these treatments, the cost of the health care, and the cost of the tests – even though by law, those can not cost more than twenty Nuevos Soles (six American Dollars). Furthermore, there is the prolonged waiting period for receiving test results since the analysis of all the tests is done solely by the National Institute of Health, which implies an overload and more waiting, more still when we consider all the tests coming from other regions around the country. Last of all, there is the stigma and the discrimination found in the health care facilities themselves³⁵.

When considering the difficulties that adolescents and minors have in gaining access to treatments, there are gaps in the law that may produce inaction in the face of the specific needs of these populations. It is essential to point out that male and female adolescent sex workers share the same limitations since it is necessary for a parent or guardian to accompany them in order to gain access to the HAART Program.

Likewise, another important barrier to access and adherence to HAART comes in the form of the documented difficulties in buying, storing, and distributing the medications. In a recent study carried out by HAI-LA³⁶ where program coordinators of the health care facilities were interviewed, the responses showed general concern for delays in distribution, for receiving soon to be expired medications and lots of medications with concentrations not considered in the treatment protocols, and for stock-outs of certain medications (for example, efavirenz was not in any of the facilities from March to July of 2005). This lack of supply has lead to difficult situations in some cases³⁷ like patients having to buy their own drugs, a change of therapy that includes the individual and public health problems, or the violation of the program users' right to health care.

³⁵ Stigma and Discrimination: The look at people living with HIV-AIDS in Peru.

³⁶ HAI-LA Idem.

³⁷ These cases are documented by PLWA in the Diagnostic Workshop and by studies such as the one carried out by HAI-LA.

In terms of gaps other than those previously mentioned, in the HAART Program there are difficulties in the diagnostic capabilities of the laboratories for opportunistic diseases, weaknesses in the data system and in monitoring the therapy, and difficulties in receiving comprehensive medical attention.

Additionally, there are structural limitations in providing timely and quality medical care at the hospitals for program users. The budget limits, lack of physical buildings and equipment, and the low wages paid to hospital staff, professional as well as non-professional, contribute to an unstable situation, one in which medical attention that is given to terminally ill people with HIV/AIDS happens to get worse because of the lack of a strategy designed for their care and of staff not sensitized to the circumstances of PLWA and, even worse, prone to discriminate against them.

Here, it is worth establishing that the ESN has put forth efforts to train teams of professionals in order to improve the quality of health care and the attitude towards PLWA, thus achieving some advancement in health care within the Program. However, there is still a high prevalence of discrimination against PLWA in terms of care in Emergencies wards and others within hospitals³⁸.

In the 2001 – 2004 National HIV/AIDS Plan and the recently published 2005 – 2009 Plan³⁹, there is no direct reference given to home care. To include home care in joint effort with the health care services would entail concrete resources and actions for developing the connection between both social institutions represented by the Family (understood as the society you live with, not necessarily of blood or formal bonds) and the Ministry of Health. Nevertheless, despite the absence of and weak improvements in this category, it is important to highlight two processes that were carried out in the country as potential elements for the development of the plan. The first was the Comprehensive Health Care Model (MAIS) that the Ministry of Health included as a political line since 2001, where family and community institutions are seen as key stakeholders in the production of health care and the national response to the health care problems⁴⁰. Unfortunately, the implementation process of this is slow, but it at least exists as a policy framework. The second was that in the activities planned for the second phase of the project financed by the Global Fund, there were some activities

³⁸ Diez Canseco, Francisco. Stigma and Discrimination: The eyes of people living with HIV-AIDS in Peru. Policy Project. Lima, 2005. In the qualitative study, it shows that the environment of health care services reproduces the stigma and discrimination existing throughout the entire society. It also confirms the perception that attitudes of the staff of the HAART Program have improved in the last few years (p.42).

³⁹ Both plans are published on the National Sanitary Strategy for the Control of Sexually Transmitted Diseases, HIV, and AIDS web site: www.minsa.gob.pe. (Search: Nov. 12, 2005 and Dec. 15, 2005)

⁴⁰ Comprehensive Health Care Model, Ministry of Health, 2001.

designed to strengthen the strategy of combining health care services with the community institutions⁴¹.

Access to antiretroviral treatment is a significant development in the national response, a result of the mobilization of the civil society, international financial support, and the commitment from the government. Yet, it must be stated that there are still three major concerns within the civil society in regards to the response of the government. First, there is the concern for the universality of access as long as there still is no full frontal assault against the economic, legal, and cultural barriers (such as the stigma placed on and discrimination against people because they are seropositive or for their nonconforming sexual behavior). Next, there is concern for quality comprehensive health care as long as there are no strategies being developed with holistic and joint approaches between treatment and the quality of life for PLWA, as well as improving the quality levels of health care and treatment. Lastly, there is the question of sustainability because no one can guarantee political will further than the government and authorities in power now, and even worse, when it is well known that the emergence of resistance will greatly increase the cost of treatment.

⁴¹ Project for Strengthening the Prevention and Control of TB and HIV-AIDS. Second Phase Proposal, 2005.

3.2 Prevention

The National Response for the prevention of HIV/AIDS includes many different tools. One of these is the male condom, available in the market and distributed through public health care services as well. Nevertheless, starting in the year 2001, a reduction in the distribution coverage of male condoms on the part of the State has been proven, and currently, despite public statements made by the government itself that it is no longer conservative and moralistic, there has been no substantial change observed in the access to concrete resources like the distribution of male condoms through the health care services.

Another tool is the female condom, one not easily found and at a cost of around S/.30.00 Nuevos Soles (\$8.50 American Dollars). Since more than half of the Peruvian population lives on less than S/.6.80 Nuevos Soles per day (\$2.00 American Dollars)⁴², this tool is out of reach for the majority of the population mainly because of its price⁴³.

⁴² INEI. Poverty Situation in Peru, 2004.

⁴³ It must be pointed out that in an action research project done with female sex workers and their clients in a non-representative population and with an intentional sample, there was significant receptivity to this tool. Garcia, Patricia, UPCH, Lima, 2004.

Lubricants are another one, readily found in the markets of the densely populated cities but a resource that is very scarce in rural areas or cities far from the capital. In the last four years, these have not been distributed through the public health care services, an activity viewed as a setback in the fight against the epidemic since in the decade before, these were distributed in the preventive strategy for MSM.

Next, sterile, disposable syringes are widely used in the public health care services and are found in the open market as well. Yet at the moment, there are no reported cases of HIV positive people who use intravenous drugs.

Another resource to prevention is information management and prevention messages. Within this context, the content of widespread prevention messages transmitted through the media and school programs and aimed at a general audience is based upon two, strongly emphasized ideas: abstinence and the use of condoms. The latter is understood since it is not explicitly said that it is about male condoms. The messages, however, are generally abstract and do not provide anything concrete about differentiated behaviors: multiple partners, commercial sex, or homosexual behavior.

When citing the knowledge levels of adolescents and young people, these are heterogeneous throughout the country and probably different between the rural areas and the urban areas, where access to information is greater. In a population study of adolescents between the age of 12 and 19 in three regions of the country⁴⁴, it was observed that a high proportion of adolescents knew the condom was a form of protection against contracting HIV/AIDS: 63% of adolescents between 12 and 14 and 93% of those between 15 and 19. Furthermore, the study found that certain, incorrect perceptions persisted such as good hygiene as a form of prevention (30%), the existence of a vaccine for HIV (10%), or that the authorized sources of information are the teachers (between 39% and 49% in the distinct populations of the study) or the parents (between 8% and 36%); likewise, 40% of the adolescents believe that the information coming from teachers is insufficient. In addition, according to a base line study of the Project financed by the Global Fund, the level of understanding in adolescent and young people about HIV/AIDS is close to 85%.

There is a significant effort being put forth by the schools to include determined content about HIV in the curriculum, but, considering the educational crisis the Peruvian education system is experiencing, the implementation is still insufficient because the limitations of both the human and physical resources is too great to broach the proposed topics. In addition, contents of sexual diversity, cultural diversity, and sexual rights are still not incorporated.

The MOH does have health care facilities that offer prevention and counseling services for STI's and HIV/AIDS: twenty-five STI Reference Centers (CERITS), thirty-five Periodic Health Care Units (UAMP), 138 hospitals, and 1,203 health centers.

⁴⁴ Presentation of the Results of the Diagnostic Study on Adolescents in Peru: Sexual Behavior and Access to Condoms. Garcia, Patricia, MPH. CONAMUSA – Global Fund.

The differentiated service law for adolescents and young people does exist, yet its implementation is limited. These differentiated services are found only in urban areas, but trained staff is limited for these since there are very few specialists on the subject, and furthermore the approach is from the point-of-the-view, needs, and wishes of adult sexuality. There have also been experiences provided with health care services of local coverage in the civil society.

What is more, the vulnerable populations lack strategies of focused education, including the strategies for Peer Health Educators (PHE's) that made important strides in the past decade but were weakened during the years 2001 through 2003. The organization and activities of the PHE's in MSM and SW, which were dismantled as educational strategies, are today focused on mobilizing vulnerable populations for gaining access to the services provided by the Periodic Health Care Units (UAMP). Furthermore, the perception of the civil society is that the interventions that demonstrated their efficiency and efficacy before 2000 have started to break down, and as a result, the number of PHE's, materials, and supplies to execute their activities has also diminished.

In the services of the UAMP directed at controlling STI's, the health care provided there is still not comprehensive; for example, they do not focus on the reproductive health and mental health needs of the vulnerable populations. Moreover, the resources have become limited and attention for sexually transmitted infections, something seen as a strategy of prevention of high importance in vulnerable populations, has become neglected. Even though in 2004 a large number of cases (vaginal flow)⁴⁵ were diagnosed syndromatically, only 77% of these could be treated in contrast to the 91% of the cases treated in 2000. This also happened in the case of other diagnoses: urethral discharge, genital ulcer, and inguinal swelling. In 2004, 88%, 91%, and 69% respectively of the cases reported were treated, and in 2000, 93.4%, 96%, and 90% respectively of the cases reported were treated. Such statistics graphically illustrate that

⁴⁵ MOH – UNAIDS – Policy Project. Exposition of the results of the evaluation of the 2001 – 2004 MOH Strategic Plan for the Prevention and Control of VIH/AIDS in Peru. Final report. Lima, Peru, September 2005.

the populations with greater prevalence in the described and concentrated epidemic were neglected.

The weakening of strategies of prevention could be the result of a loss of priority for these activities once the Treatment Program became part of the MOH. This fact plus limited human resources created the context of treatment related activities far exceeding the installed capabilities in the MOH and could have caused this weakening in the area of prevention during the years of 2004 and 2005. It must not be forgotten that this process had its beginnings in the dismantling of programs brought on by the organizational restructuring of the MOH and the lack of political will in the fight against HIV/AIDS in 2001 – 2003.

In the health care services, there is still a general lack of respect for the different ways of being male and being female in the population, something that influences the quality of health care. Therefore, it is necessary to foster an attitude of respect towards people of alternative behaviors and identities. Likewise, the health workers need to become actively involved in the fight against the stigma and discrimination, the two main barriers for MSM and SW's for gaining access to prevention services.

When referring to the general population, only the public schools offer any type of Educational Programs, but these are limited in coverage Their impact is still unknown. Yet, for the sake of relevance, there have been no official prevention campaigns carried out in the past five years. Some NGO's did develop prevention campaigns, limited in scope and based mainly upon the ABC prevention strategy, which emphasizes the merchandising of condoms in the population of adolescents and young people yet limited to topics of heterosexual prevention and risk behaviors.

In regards to preventive messages, the few that the government produces hide the situation of and the hazards facing the vulnerable populations, MSM, transvestites, male and female sex workers, and sexually abused men and women.

There does exist a legal and strategic framework for screening pregnant women that requires these women to have an HIV test performed. Nevertheless, since there is no coordination and integration with the reproductive health strategy, the results have been limited. From the civil society, certain NGO's like INPPARES and Via Libre offer services to pregnant women but with limited coverage. The health care professionals are not trained to perform preventive health care that is differentiated i.e. women, pregnant women, and girls.

Access to HIV/AIDS prevention services is limited by costs and by the situation of people without legal documentation. Other barriers are illiteracy, inequality related to gender issues, and the stigma surrounding STI's. These are all issues that are not dealt with because of government strategies. Furthermore, the 2001–2004 national plan did not and the national plan for 2004–2009 does not include the objective of fighting against the stigma and discrimination.

3.3 Counseling and volunteer testing

Since 1997⁴⁶, voluntary access to the ELISA test in the MOH health care services has been part of the law, setting forth that this must be accompanied by pre-test and post-test counseling. However, the voluntary nature of the test is continually questioned when it is requested as a condition for getting a job or even to continue working.

⁴⁶ Law 26626, called the CONTRASIDA Law, which was amended in 2005 by Law 28243, incorporating antiretroviral treatment access. Furthermore, not only the law exists, but also the regulations that enforce them.

Beginning in 1997, PROCETSS, which today is the National Sanitary Strategy (ESN), set up a system of Periodic Health Care Units (UAMP) for male and female sex workers in order for early detection, timely care, and appropriate treatment for sexually transmitted infections – STI's and HIV/AIDS. During 2005, the AMP regulations were in the process of being approved, seeking to institutionalize a previously developed practice. The regulations include the following for the population of male and female sex workers: an ELISA test every six months with counseling and a signed consent.

The services provided by the Periodic Health Care Units (UAMP) must be carried out in the in the STI Reference Centers (CERETS) or in the Periodic Health Care Units (UAMP) themselves. There are a combined thirty-four of these spread throughout the country and located in twenty-two Health Directorates (DISAS): twenty-four CERETS and ten UAMP's. This strategy is supported in the Strategy of the Peer Health Educators and does include in its coverage MSM and male and female sex workers found in formal sex trade districts, yet having more limitations to include the informal male and female sex workers.

According to the data from the ESN for 2001-2002, there was a dip in its coverage. Yet, starting in 2003 is when the progressive increase in the number of attended sex workers was registered for the first time in the UAMP system with a total increase of 29% from the year 2000 to 2004. Nevertheless, in regards to the number of services provided for them, there was no observable increase since only 2.79 were registered in 2000, while in 2004 this figure was 2.29. (Worth mentioning is that once-a-month visits are suggested, and to consider that a SW is being monitored, it is necessary to confirm his/her attendance at least six times a year to the services provided by the UAMP's.)⁴⁷

As stated in the Evaluation of the 2001-2004 Strategic Plan for the Prevention and Control of HIV/AIDS in Peru⁴⁸ developed by the Policy Project at the request of the MOH and UNAIDS, there was an increase in new cases, mainly in the populations of SW's and MSM, observed from the period of 2000-2004, and during the same period, only 48% of the SW's managed to go to six or more checkups, which means by inference that 52% of the male and female SW's made it to health care services that did not have adequate follow up procedures.

Concerning the test for pregnant women, Law 2243 establishes them into a system of exception, so now the HIV test is no longer voluntary but mandatory; however, the overriding concern of the law of vertical transmission is when it refers to counseling services since, in the case of pregnant women, it is possible to do this in a group setting, which departs from the true nature of counseling and violates the confidentiality of the

⁴⁷ National Sanitary Strategy for the Control of ITS and HIV-AIDS, 2005.

⁴⁸ Exposition of the Final Report of 2001 – 2004 MOH Strategic Plan for the Prevention and Control of VIH/AIDS in Peru. Lima, Peru, September 2005. MOH – UNAIDS – Policy Project.

individual. In spite of the existence of the Laws 26626 and 28243, which possess a higher status in the hierarchy of Peruvian law, this minor law is still applied.

Approximately 500,000 pregnant women receive at least one prenatal checkup in the health services of the MOH, and these represent 65% of the expected numbers nationwide. During the period of 2000-2004, on average, 31% of the pregnant women were screened for HIV. From these, 0.32% were diagnosed seropositive, and just 59% of these received antiretroviral therapy to avoid vertical transmission. Out of 71% of the pregnant women who were screened for syphilis in 2004, only 43.23% of them were screened for HIV as well, which is an observable percentage greater than 50% of lost chances for screening for HIV; most were located in the Health Directorates in areas of the highest level of poverty⁴⁹.

Moreover, when considering that the Public Health Care System in Peru consists of more than 6,000 facilities spread throughout the country and that only 25% have laboratory services, and furthermore that, based on estimates, there are only around 200 ELISA readers⁵⁰ nationwide, it is easy to conclude that limitations exist throughout the entire infrastructure of the Public Health Care System for access to diagnoses for a large part of the general population as well as the vulnerable ones.

Furthermore, it is important to point out that in the last two years, through the activities exhibited by the Project financed by the Global Fund, there have been substantial improvements made in relation to the capability and organization of laboratories throughout the nation by decentralizing part of the process and by access to rapid tests. Nevertheless, serious limitations still exist when talking about access to diagnostic tests at a national level and about the timely delivery of results.

Protection of the Human Rights of PLWA and Other Vulnerable Groups

⁴⁹ Ibid.

⁵⁰ Quality of Care Study for patients living with HIV-AIDS (PLWA) in health care facilities. F. Lanos, developed at the request of the "4th Objective" of the Project financed by the Global Fund. Research Report. Lima, 2005.

This country does indeed have a far reaching legal framework for the protection of the human rights of PLWA found in Law 26626 and in its amendment, Law 28243 – the specific legal framework. Once access to treatment was included, the national response took significant steps in the protection of the human rights of PLWA, yet there are still areas of difficulties we can point out:

First, limitations still exist to the access to scientific, timely, and appropriate information about rights, prevention, and treatments when considering access to information that is neither partial nor judgmental and covers the entire spectrum of risk behaviors for reinfection, safe reproduction, and safe sex. Accompanying this, there are also limitations in the ability of support networks to access the information and as a consequence integrate it into the support strategy for the treatment of PLWA.

Second, even though access to treatment is the main advancement made in the last five years, the economic, social, and cultural barriers surrounding it are current concerns. In addition, the cost of the tests, the stock-out processes, and the persistence of the stigma towards and discrimination of the vulnerable populations and PLWA are the main obstacles.

Third, the fight against discrimination in health care services, on the job, and in schools is not part of the government agenda or in any of the plans of the National Sanitary Strategy or in the agenda of other involved sectors like the Ministry of Labor, the Ministry of Justice, and the Ministry of Education.

Fourth, the greatest difficulties lie in the implementation processes of the law and furthermore in the indemnification processes.

Fifth, in relation to the vulnerable populations, the national response deals with the concept of MSM that, in itself, attempts to homogenize a variety of populations and identities. This name has many times made the specific needs of those groups invisible as it tries to group together transvestites, MSM who are not sex workers, and adolescent MSM without considering their particularities, and hence limiting the access of these groups to activities of prevention, health care at public health services, and treatment, which consequently increases their vulnerabilities and questions the execution of their rights.

Sixth, a significant setback that took place in the beginning of December 2005 was the exclusion of the topic of different sexual orientations the National Human Rights Plan because of the influence from the Ministry of the Interior and the Catholic Church. This was a goal that some people fervently worked on for a year.

Seventh, there are some mechanisms in place for denouncing wrongdoing. These can be handled through Transparency (MOH), patient advocacy (ESSALUD), and the Ombudsmen Office. This last organization has intervened in some cases and has made recommendations in others as part of the fulfillment of its office, but it has no real jurisdiction. Steps can also be taken through an appeal to Habeas corpus, which protects the fundamental rights of people (Article 200 of the Constitution of Peru). However, in spite of the existence of all these protocols and procedures, there are extreme deficiencies in the system, and many of the resources are unknown by the different populations and moreover little used. As an example, there have only been five appeals to Habeas corpus lodged by PLWA, two lawsuits for sexual discrimination against a supermarket chain, and two processes in which the Constitutional Tribunal ruled in favor of the PLWA, recognizing their right to health care and to access to treatment, which has now produced national legal precedents.

Eighth, from the civil society, there have been a number of important processes created, mainly by organizations of people living with HIV and NGO's, aimed at securing health care and benefits for PLWA. These efforts have contributed to the protection of human rights since the access to treatment has resulted, to a large extent, from efforts made in that direction.

Ninth, the struggle of the civil society is still focused on the experience of living with HIV and restricted in large part to access to treatment and quality health care in the public health care services. There have been limited efforts in turning economic, work, and social inclusion into issues for the exercising of the human rights of PLWA. Furthermore, it must be stated that the organizations of the civil society that work in the field of AIDS have tenuously responded to the concern for the exercising of the human rights of vulnerable populations without linking these situations to the deepening of the conditions of vulnerability facing the epidemic. It must be noted that these limitations are present in the agendas of both the non-governmental organizations and the organizations of PLWA.

Tenth, even though there is a legal framework, its implementation is just beginning, and there are no protocols for monitoring it. Likewise, the efforts of the civil society for keeping watch that there are no violations of the human rights of the PLWA and vulnerable populations are still rather weak. There is the pending strategy of establishing watch boards from the grassroots formed by organizations of male and female sex workers, PLWA, and different groups of MSM in order to produce joint complaint filing and advocacy.

3.4 Women's Empowerment

There have been very limited actions carried out for empowering women. Yet, one important thing to recall is that during the period of 2001-2003, the term 'gender' was replaced in the documents of the Ministry of Health.

Furthermore, the situation of women, as such, in the midst of the epidemic is hardly made known. Although people know and often cite the fact that the proportion of affected women to affected men has increased from 1 woman to every 14 men in 1990 to 1 to every 3.6, it has not influenced the design of preventive intervention strategies and has not overcome the limited perception of the risk they have. The Ministry of Women and Human Development has not developed any activity, or coordinated with the MOH with regard to the epidemic, or actively participated in CONAMUSA.

Considering that this epidemic is centered on vulnerable groups, particularly MSM, the interventions for women are usually directed towards female sex workers as a vulnerable group. However, this strategy only focuses on the topics of STI's and HIV and has not considered empowerment itself.

Currently, peer counseling that uses the principle of Meaningful Involvement of People Living with or Affected by HIV/AIDS (MIPA) and the UNGASS commitments includes counseling for women living with HIV, which has been asked for by the civil society in the face of the attention needed for this population group.

Lastly, PLWA organizations, vulnerable populations, and NGO's have attempted some actions but with limited coverage and without political incidence on the topic. And, the feminist organizations have not broached the topic of HIV/AIDS in their action agendas.

Section 4: Monitoring and Evaluation

The 2001-2004 Strategic Plan for the Prevention and Control of STI's/HIV/AIDS includes thirty-one evaluation indicators. According to the analysis performed as part of the evaluation report of this plan, only six indicators could be obtained directly through primary sources; for the rest, two of them depended on the Sentinel Surveillance Study of HIV/AIDS, two others depended on the notification and registration system for HIV/AIDS, ten others required special studies and/or their inclusion in population surveys that were never carried out or incorporated, three more could be obtained from the ENDES surveys, another eleven could be obtained directly through or with substitute indicators (proxy) of the monitoring and statistical system of the Sanitary Strategy, and the last three come from the data system of the blood bank⁵¹.

Even though the 2005-2009 Plan of the National Sanitary Strategy for the Prevention and Control of STI's-HIV/AIDS⁵² accounts for these indicators, it never mentions how the data from the indicators will be managed. In other words, neither the key elements, such as sources of information, method of registering the information, frequency, those in charge, and the rest, nor the processes, which include both the construction of the indicator as well as its diffusion, are identified.

Moreover, it must be stressed that the protocols for accountability or feedback to the civil society (including the affected population) as part of the management of the information with respect to the advance and evaluation of the plan have not be established.

⁵¹ Ibid. 26

⁵² 2005-2009 Plan of the National Sanitary Strategy for the Prevention and Control of STI's-HIV/AIDS.
<http://www.minsa.gob.pe/portal/03Estrategias-Nacionales/03ESN-ITSSIDA/Archivos/PLAN%20ESTRATÉGICO%20DE%20LA%20ESN%20VIH%20SIDA.doc>
(accessed December 2005)

Conclusions, Recommendations, and Lessons Learned

From the government

About the national response:

The dismantling of the Program for Controlling Sexually Transmitted Diseases and AIDS during 2001-2003 illustrates to us the dangers that the response to this epidemic faces if it fluctuates depending on the interests and personal beliefs of the authorities in charge of the ministries. It is necessary to continue the process of institutionalizing the national response, an activity that has been developing over the past two years that in the future might legally, strategically, and budgetarily include the commitments taken on by the government before the stakeholders and the general population.

Furthermore, the MOH leadership in the national response, visualized more clearly in the last two years, will have to incorporate by necessity the capabilities of effectively summoning the other health sub-sectors and other ministries for a coherent and joint effort. During the period, there are gaps still in existence that show a national response far removed from a multi-sector focus and practice coming from the institutions that make up the government yet with the current management by the Ministry of Health starting the first concrete steps for including and working together with the civil society.

Something motivated by a highly purposeful civil society and the formation of CONAMUSA in the financial framework of the Global Fund has been the development of including the civil society in the work over the past two years, and it is necessary to continue and reinforce this joint work by institutionalizing participatory processes, expanding the participative processes for electing representatives, and widening the agenda to include concerns from a true inter-sector perspective that responds to both national and regional needs.

About access to health care and treatment:

Access to treatment from the National Sanitary Strategy is a significant step forward in the national response and a result of the actions of the civil society, international financial support, and the government commitment. The civil society demonstrates its concern to the State's response on three dimensions: First, there is the concern for the universality of access as long as there still is no full frontal assault against the economic, legal, and cultural barriers (such as the stigma towards and discrimination against people because they are seropositive or for their non-conforming sexual behavior); second, there is the concern for quality comprehensive health care given that there are no strategies being worked on with holistic and coordinated approaches between treatment and the quality of life for PLWA, as well as improving the quality levels of health care and treatment; and third, there is the concern for sustainability as long as no

one can guarantee political will to sustain the program in the national budget further than the government and authorities in power now, and even worse when it is well known that the emergence of resistance will greatly increase the cost of treatment.

About prevention:

Many current factors favor the perspective of alarm in the prevention of HIV/AIDS in a country with an epidemic of a concentrated type where MSM have the greatest prevalence at 13%. Some of these factors are the government taking steps to weaken the strategies of prevention for vulnerable populations observed during the period, especially when considering the limitations for gaining access to prevention tools, the decrease of the treatment percentages for sexually transmitted infections diagnosed in the services provided by the Periodic Health Care Units (UAMP), the weakness of educational strategies, and the failure to act in the fight against the stigma in the health care services.

Prevention in adolescents, young people, and the population in general also shows serious shortcomings. It must be highlighted that certain steps for incorporating explicit content on prevention in school curricula have been taken, yet the process is still in the start up stage with a number of trained teachers well below what the nation needs. Still, the contents of the preventive messages do not incorporate the differentiation of risk behaviors and are aimed toward an ideal heterosexual relationship from an adult perspective.

About counseling and volunteer testing:

The gains here are strongly influenced by the actions for prevention, which indicate a worrisome situation; however, the actions developed around the project financed by the Global Fund have provided substantial improvements regarding laboratory capabilities in the priority regions of the country, but the current laboratory capability locally and regionally is still lacking. Likewise, the capabilities to develop adequate counseling for the different behaviors and gender identities of people are still in the initial stages of the process.

About the protection of the human rights of the PLWA and other vulnerable groups:

Even if there is a legal framework in the country for protecting the human rights of PLWA and other vulnerable groups together with the international treaties the country has signed, it must be stated that there are nearly no surveillance and compensation processes in cases where rights were violated. The government has not done enough to create a culture based on rights, to build protocols of surveillance, and to repair the damages that could make the full exercising of the human rights of PLWA, MSM, SW's, and adolescents possible.

About women's empowerment:

This is a topic that deserves much greater attention than what the government has committed to it. The differentiated conditions of life, sexuality, and health of women in a society with unequal gender relations have not been included in the diagnostic analysis or in the strategies of the government's response. The vulnerability of women is not an object of reflection or of preventive communication towards the different populations. Moreover, the conditions of vulnerability for the health of women living with AIDS, for their quality of life, and for the care of their dependents (children, parents, and partners living with AIDS) in an environment of social stigmatization and discrimination are not concerns assumed by the government's response.

About monitoring and evaluation:

The government has entities directed towards gathering, analyzing, and disseminating information, yet the information that the civil society can obtain from these suffers from fragmentation since these entities are not unified into one system. Many times the information is passed on well after it has been collected and hence loses its power of timeliness, or there is no system of widespread dissemination for the different stakeholders and populations due to the tools used as well as the content design. The possibilities of energizing surveillance and participation come out of the operativity of an information system and the transparency of the steps the institutions show. Finally, it is important to mention that the budgets for the fight against HIV/AIDS and their breakdown into categories are not in the public domain.

From the civil society

About the national response:

The civil society active in HIV/AIDS in this country is widespread and dynamic. It has managed to bring to the forefront processes of advocacy, prevention, care, treatment, support, and research that enrich the experiences of the country. Likewise, it has produced significant changes. On the basis of its mobilizations, there have been important processes produced and commitments made from the government in regards to the epidemic.

A large number of these potentialities have been carried out in the processes of the Project financed by the Global Fund; however, the links on the inside of the civil society

itself that can give feedback to those processes and energize the joint actions still remain to be strengthened.

About the inclusion of ARV treatment:

Research, the implementation of programs, and advocacy are the most important activities that are developed by the different institutions of the civil society as they strive to offer to the program the perspective of PLWA and the populations of greatest vulnerability as well as the technical, academic, and political reflections that contribute to the building of an effective, efficient, sustainable program that has with it a perspective of human rights.

About prevention:

The civil society has shown significant effort in designing alternative strategies for prevention and promotion to the different population groups that are in part recouped in the national strategies. Furthermore, it is necessary to start a larger dialogue among the organizations of vulnerable populations concerning the strategy that will allow better adaptations to the strategies from the perspective of the communities.

However, an important weakness is the absence of organized surveillance systems especially in terms of treatment, prevention, and rights. A series of reports do exist for the institutions that are nothing more than anecdotes and do not constitute precedents or case histories and therefore do not give support for the processes of advocacy and the defense of the rights of PLWA and other vulnerable populations.

Appendix 1:

Working Committee chosen to consolidate the results of the First Plenary Session

Ines Mendoza

The “Miluska Vida y Dignidad” Association of Female Sex Workers
Vulnerable Populations

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Rosa Blanca Ecumenical Parish Center
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Sonia Parodi

Peruvian Coordinator of PLWA
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Richard Muñoz

IMPACVIH – PLWA Mutual Support Group
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Jorge Bracamonte

Aldo Araujo
MHOL – Homosexual Movement of Lima
NGO’s (Vulnerable Populations)

Percy Minaya

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Appendix 2:

List of the participating leaders from Peruvian society in the elaboration process of the Report

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Luis Alberto Yupanqui

Alianza en Accion - PLWA Mutual Support Group
Liliana Briceño Hilaes

“Angel Azul” Association – First Association for the rights of transvestite, transgendered, and transsexual people in Lima, Peru
Gaby Mariño Llamuja
Jana Villayzan
Mariana Bermúdez Castillo

Health Action International, NGO
Roberto Lopez Linares
German Rojas

The “Miluska Vida y Dignidad” Association of Female Sex Workers
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Ines Mendoza
Karina Cerna
Angela Villon

Doris Guevara

CARE

Dr. Virginia Baffigo

Dr. Lourdes Kusunoki

Patricia Bracamonte

Rosa Blanca Ecumenical Parish Center, NGO

Rev. David Limo

Luisa Parra

Gabriel Ochoa

CEPESJU – Study Center for the Economic and Social Problems of Young People –
NGO

Julia Campos Guevara

Código Blanco– PLWA Mutual Support Group

Martin Ismael Davila Arroyo

Ana Maria Cumpa Trujillo

Collective for Life (A community based organization gathering people and NGO's of
PLWA)

Lidice Lopez

Mercedes Atocza Lopez

Peruvian Coalition of PLWA

Pablo Anamaría

Irene Aquino

Sonia Parodi

Foro Salud (organization of the civil society in the health care field)

Maria Luisa Vasquez

San Camillo Home

Dr. Luis Hercilla

IES – Education and Health Institute (NGO)

Carmen Murguia Pardo

IMPACVIH – PLWA Mutual Support Group

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