WORKSHOP REPORT

ADVANCES AND CHALLENGES IN THE PRODUCTION OF STRATEGIC INFORMATION ABOUT HIV IN LATIN AMERICA

SOUTH-SOUTH COOPERATION

APRIL 15TH – 17TH, 2008
LIMA, PERU

ONUSIDA
PROGRAMA CONJUNTO DE LAS NACIONES UNIDAS SOBRE EL VIH/SIDA
ACNUR UNICEF PMA PNUD UNFPA
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Organización Panamericana de la Salud
Oficina Regional de la Organización Mundial de la Salud

ORGANISMO ANDINO DE SALUD · CONVENIO HIPÓLITO UNANUE ·

Workshop Report. "Advances and Challenges in the Production of Strategic Information about HIV in Latin America". South-South Cooperation. 1st ed. Lima: UNAIDS/ UNFPA 2009.
84 p.

1. HIV 2. AIDS 3. AIDS-EPIDEMIOLOGY 4. LATIN AMERICA

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Printed in Lima
First edition: July 2009

Hecho el Depósito Legal en la Biblioteca Nacional del Perú
ISBN ...

Financial support for this publication was provided by UNFPA.

ACKNOWLEDGEMENTS

UNAIDS, PAHO and ORAS-CONHU appreciate the contributions of each and every participant in the workshop "ADVANCES AND CHALLENGES IN THE PRODUCTION OF STRATEGIC INFORMATION ABOUT HIV IN LATIN AMERICA," and especially thank the countries that shared their experiences to benefit the collective knowledge and improved future practices of HIV surveillance in Latin America: Argentina, Bolivia, Colombia, Chile, Peru, Uruguay and Venezuela.

We also express our gratitude to the United Nations Population Fund (UNFPA), whose financial support made the publication of this document possible.

Finally, we would like to acknowledge the key role of Dr Pedro Chequer, mentor and promoter of South-South Cooperation activities with regard to HIV strategic information in South America.

PROLOGUE

As a program aimed at coordinating actions of the United Nations specialized agencies to fight the HIV pandemic, UNAIDS supports the articulation of HIV-related activities of UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, WHO and the Word Bank. The mission of UNAIDS and its co-sponsors is to guide, strengthen and support global efforts to contain the course of the epidemic. Such efforts are aimed at preventing the spread of HIV, providing care and support to people affected by the disease, reducing the vulnerability to HIV among people and communities, and mitigate the human and socioeconomic impact of the pandemic.

Over 25 years after the identification of the first AIDS case in Latin America, we know that universal access to prevention requires the planning and implementation of programs based on a good understanding of the HIV epidemic in each country and its evolution over time. This includes the identification of, for example, population groups affected by HIV in each country; risk behaviors determining the spread of the virus, and the size of most-at-risk populations, among other key topics. Nevertheless, based on the experience of international reports such as UNGASS and the needs of technical support expressed by the various National AIDS Control Programs in the region, we know that there is a significant gap with regard to HIV-related strategic information available in Latin America, which may contribute to the invisibility of key populations, misguide resource distribution and, potentially, affect the adequacy and effectiveness of strategies defined to prevent and control the epidemic.

Since 2005, conscious about the importance of adequate, opportune strategic information for decision making, technical assistance provided by UN agencies in Latin America has been intensified, particularly in topics related to the production of HIV-related information and its utilization in planning and decision making processes. Moreover, the South-South Cooperation strategy has opened windows of opportunity for the exchange of successful experiences and for collective learning, both across individual countries and across country blocks such as MERCOSUR and the Andean Subregion, with the expectation of improving HIV-focused information systems and interventions, national responses and universal access to prevention, treatment, care and support in Latin America. In this context, collaborative, well coordinated work involving the various UN agencies, as well as their alliance with the Andean Health Organization Hipólito Unanue Agreement (ORAS-CONHU) has generated added value for the provision of technical assistance to countries, and an excellent opportunity to join efforts and strengthen its quality and coverage in the region.

When, back in April 2008 the Workshop "Advances and Challenges in the Production of Strategic Information about HIV in Latin America" took place, the need emerged, upon request from several

participating countries, to prepare a Workshop Report that would reflect the key emerging ideas and experiences shared during the workshop, and provide guidance to technical teams in Ministries of Health, National AIDS Control Programs and UNAIDS co-sponsors.

One year after the workshop took place, UNAIDS, PAHO and ORAS-CONHU, with complementary support from UNFPA's Office in Peru, are pleased to make broadly available the useful ideas and contributions to the improvement of HIV-focused strategic information in the region that were presented and discussed by representatives of participating countries. We are confident that the future planning of evidence-informed HIV prevention and control activities will be significantly strengthened with this contribution.

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PREFACE

UNAIDS is a program designed to coordinate the work of the United Nations System in the fight against the HIV epidemic. UNAIDS supports the coordination of HIV practice for UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, WHO and the World Bank. The mission of UNAIDS and its cosponsor organizations is to guide, strengthen and support world efforts to mitigate the impact of the epidemic. These efforts aim to prevent the spread of HIV; provide attention and support to people infected with and affected by the disease; reduce the vulnerability of people and communities to HIV; and, mitigate the human and socioeconomic impact of the epidemic.

Universal access to prevention, treatment, care and support for HIV is a commitment assumed by countries as well by the international community. When and how a country achieves these goals depends on the initial epidemiological characteristics, the political environment, existing policies, the structure and provision of health services, and other factors related to the health system and other issues specific to each country. In order to carry out effective program planning, countries are encouraged to set ambitious national goals that can be used to plan and monitor their progress toward universal access. A quantifiable goal for universal access (coverage, for example) and a target population can vary according to different HIV infection-related interventions in different environments, which is why it is very important to make strategic information available at both the national and sub-national levels along with the commitments to universal access to treatment, prevention, care and support that have already been made by countries in the region and the world at large.

As such, one of the core tasks of UNAIDS and its cosponsors is to connect the processes of analyzing the strategic information available in each country to its processes of decision-making, and through this link, improve national responses to HIV.

In continuing this line of work, the UNAIDS Sub-Regional Office of the Southern Cone organized a regional meeting on Strategic Information in November 2007, "MERCOSUR MEETING ON EPIDEMIOLOGICAL MONITORING FOR SOUTH-SOUTH COOPERATION." Professionals responsible for the epidemiological surveillance in Argentina, Brazil, Chile, Paraguay, Peru, and Uruguay participated in that meeting, as well as focal points for PAHO and UNAIDS and other experts in the issue. The objectives focused on:

- Sharing and discussing case definitions for the purpose of epidemiological surveillance in MERCOSUR; analyzing common aspects to work toward a possible harmonization.

- Defining methods and available tools to improve epidemiological surveillance in MERCOSUR.
- Reviewing the situation of epidemiological surveillance to identify the need to conduct first- and second-generation surveillance studies.
- Recognizing the value of epidemiological surveillance as a fundamental component for adequate monitoring and evaluation of programs.
- Identifying gaps in the capacities of human resources and establishing a South-South cooperation agenda.

The advances and weaknesses in the area of epidemiological surveillance were discussed during the workshop. The need to articulate answers based on strategic information that is significant or of common interest to Latin American countries was also identified. In this context, some areas were defined as priorities for strengthening:

1 Developing studies of vulnerable populations: the vulnerable populations to be characterized should be defined, and at least three should be prioritized for the conduct of studies (for example: men who have sex with men (MSM); male and female sex workers (SW), along with their clients; and intravenous drug users (IDUs) and drug users (DUs)).

2 Promoting the design of studies with populations that overlap (for example: IDUs/MSM/SW; DUs/MSM).

3 Promoting comparative studies between countries in the following areas:

- HIV advocacy
- Design of studies of vulnerable populations that can establish a bridge between these populations and the general population
- Epidemiological surveillance of pregnant women
- Follow-up of vertical transmission and active epidemiological surveillance of these cases

4 Transferring, sharing, exchanging and harmonizing valid methodologies for studies of vulnerable populations.

5 Developing epidemiological surveillance of pregnant women in representative municipalities.

6 Developing sentinel surveillance of tuberculosis-related morbidities.

7 Developing surveillance of risk and occurrence of HIV antiretroviral resistance.

8 Harmonizing case definitions.

Given the needs identified in the meeting, participants proposed continuing to strengthen capacity in issues of epidemiological surveillance and sustaining periodic technical meetings.

Since this experience in the Southern Cone, the Pan American Health Organization (PAHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Organismo Andino de Salud – Convenio Hipólito Unánue (ORAS-CONHU) have joined forces to hold a second regional Workshop – Seminar entitled "ADVANCES AND CHALLENGES IN THE PRODUCTION OF STRATEGIC INFORMATION ABOUT HIV IN LATIN AMERICA."

The Workshop – Seminar took place in Lima from April 15th to 17th, 2008. The purpose of the Workshop – Seminar was to support and promote improvement in the production of strategic information on HIV in the region through South-South cooperation mechanisms in order to improve the planning and monitoring of the objectives of universal access to prevention, treatment, care and support. This analysis of experiences and lessons learned in each country regarding the production of strategic information was carried out in order to achieve the following objectives:

- Increase the harmonization of methodologies and indicators to facilitate comparisons of information about HIV produced within the region.

- Identify the gaps and the needs for technical assistance to improve the production of strategic information.

The workshop relied on the participation of representatives from the National AIDS Programs and epidemiologists from the Ministries of Health from Argentina, Bolivia, Brazil, Colombia, Venezuela, Chile, Ecuador, Paraguay, Peru and Uruguay. In addition, different experts in HIV epidemiology from inside and outside the meeting presented papers and participated in discussions.

This report presents a summary of presentations, discussions among participants and conclusions reached during the meeting. The contents were organized taking into account the original meeting agenda: first, an overview of systems of surveillance, production and analysis of strategic information was presented from the UNAIDS standpoint, considering the reports countries submit biennially to the United Nations General Assembly Special Session on HIV. Subsequently, participating countries presented on selected topics of epidemiologic surveillance, from estimation of population sizes to HIV prevalence in specific key populations (i.e. men who have sex with men, female and male sex workers, prison inmates, injection drug users, pregnant women, young people and the general population). Thirdly, a number of presentations discussed progress and challenges in the region as regards the measurement of resistance to antiretroviral drugs and early warning indicators, AIDS case definitions, innovative experiences in HIV surveillance among MSM, and cohort studies to assess the impact of antiretroviral treatment. The final section presents the conclusions of group work and plenary, which focused on the perspectives of HIV strategic information production and utilization in Latin America.

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I.

INTRODUCTION: A LOOK AT SYSTEMS OF SURVEILLANCE, PRODUCTION AND ANALYSIS OF STRATEGIC INFORMATION

CHALLENGES IN ESTIMATING HIV PREVALENCE IN COUNTRIES WITH LOW-LEVEL AND CONCENTRATED EPIDEMICS

Rob Lyerla, UNAIDS, Geneva

The workshop's introductory presentation focused on the review of the challenges in estimating the prevalence of the Human Immunodeficiency Virus (HIV) in countries with low-level and concentrated epidemics. The need to capture the epidemiological dynamic of HIV infection in a better way was stressed, given that solely knowing precise prevalence is not sufficient; more information on the tendencies of the epidemic through time with more specific estimates is necessary. This need is especially accentuated in locations where no data exists. What is required to overcome this challenge? The answer appears to be simple: one needs to know who are actually infected (numerator) and who are actually exposed to it (denominator) – a simple fraction.

A lot of good quality data is currently available. Of course, it is necessary to keep in mind that some of this data will not be useful when referring to low-level and concentrated epidemics, as is the case for data from national surveys where high-prevalence populations are not necessarily represented. Furthermore, when considering data from specific studies, there could be a bias in the denominator and/or in the numerator, given the selection of the study subjects. One must also keep in mind that results obtained from specific studies are difficult to generalize. And of course, there are cases where data does not exist.

Some of the general challenges to estimating prevalence in our countries include: access to high-risk groups who are known to carry the majority of infections; stigma and discrimination; access to health services; and finally, adequate funding that is related to prevention. When working with vulnerable populations like men who have sex with men (MSM), sex workers (SW), and injecting drug users (IDU), there are even more specific challenges. The question that always comes up is what the definition of MSM is. The fact that a clear definition of MSM does not exist can result in the exclusion of some groups that could bias the prevalence estimates.

One must remember that MSM is an epidemiological definition; given that many different groups exist within the HIV epidemic, they are often described with the same terminology. The same thing occurs with SW; when we mention infected SW, we could be including SW who, given their HIV infection, are no longer SW.

Many questions come up when one must count on data from specific populations: Where do we count them? How do we count them? When do we count them? These questions definitely do not have clear answers, given the different dynamics of each population. An additional question is: What methods do we use to gain information about these populations? With respect to this question, we could mention the use of respondent-driven sampling (RDS), a specific method used to learn about high-risk behaviors in certain populations. The disadvantage of this methodology is that one must know if the population sample is really representative of the total population.

New methods proposed by UNAIDS currently exist, including the "Scale Up" methodology, which tries to estimate the effective size of a specific population based on clear definitions of it.

The case of low-risk populations presents particular issues; for example, information obtained from pre-natal care centers might not be useful to achieve population surveillance. Also, one must consider the future of an unlinked anonymous test, as well as how results of this method will help to monitor the epidemic. If we have a country with an IDU-centered epidemic, one must consider what the contribution and/or the usefulness of information from pre-natal clinics would be in helping to understand epidemic trends.

Other questions that come up refer to, for example, the usefulness of obtaining information from rural as well as urban areas. Perhaps their usefulness lies in the ability to establish differences between the geographic areas themselves.

Other populations that are important to keep in mind given their vulnerability are incarcerated populations and migrant populations. We know that both are more vulnerable and thus are higher-risk populations.

The 2001 UNGASS declaration assumed commitments in the reduction of HIV prevalence in the most affected countries by 2005 and globally by 2010; in both cases a 25% reduction was proposed, controlling for the impact of the implementation of antiretroviral treatment therapy (ART) (which has caused an increase in HIV prevalence).

An important thing to know for countries with concentrated epidemics is when risky behaviors began, because then it will be easier to estimate the incidence of HIV infection.

The United Nations General Assembly Special Session on HIV (UNGASS) reports are sources of concrete and trusted information because they originate from individual reports from each country that are based on standardized procedures, which ensure a considerable degree of uniformity and reliability. The steps that guide the development of these reports are the (i) planning, (ii) concrete deadlines, (iii) data evaluation and (iv) data utilization.

STRATEGIC INFORMATION ABOUT HIV: A PERSPECTIVE BASED ON UNGASS REPORTS

Gabriela de la Iglesia and Patricia Bracamonte, UNAIDS

The planning includes the assigning of roles and activities for data processing. It is important that they are constructed in a shared and consensual manner so that every available perspective is represented. Data collection should be completed by previously established deadlines upon analyzing all possible sources. Merely considering the entire spectrum of information sources will result in better data.

Data evaluation includes not only the analysis of data characteristics, but also the identification of its weaknesses and strengths; this should be a multisectoral process that incorporates all perspectives of all the different actors involved in the issue.

The data utilization phase should contain an exhaustive analysis and validation of the data along with the assumption and appropriation of it on the part of each interested actor. If all of the steps are completed, one can be sure that the report represents the reality of the epidemic and the response to it in each country.

What is the need for an analysis of the strategic information contained in the UNGASS reports? The information contained in these reports constitutes, at least in theory, a reflection of what is happening in each country through systematized information that facilitates the development of an epidemiological profile of each country, which allows for the construction of a global report. At the level of the United Nations General Assembly, this report allows for the strengthening of elements that could be improved, a task promoted by UNAIDS.

The analysis of information contained in UNGASS reports includes three processes, namely: qualitative analysis, quantitative analysis, and comparative analysis of the information. Qualitative analysis in this case is focused on the evaluation of the quality of the information, which should consider whether the data is representative, as well as its applicability and level of disaggregation. Once these characteristics are analyzed, we can determine whether the data is valid. Quantitative analysis is focused on verifying that each country reported all of its indicators, and whether these indicators are complete, not only expressed as percentages but also as fractions (i.e. with a numerator and a denominator) and in a disaggregated form by age, sex and other pertinent variables. Comparative analysis allows for the assessment of which information from each country is comparable, not just from year to year, but also between countries and regions in order to establish the epidemic's trends.

UNGASS reports often present incomplete information for various reasons. In the case of Latin America, the most frequent problems include the non-disaggregation of data by sex and age, or the incompleteness of the numerator and/or the denominator upon which calculations are based. It is often common that the data has not been reported or that the indicators' definitions are not reconciled with the international standards.

COMMENTS AND DISCUSSION

- An adequate methodology is needed to find the number of new infections, especially in the case of pregnant women who represent the general population, and to identify the groups where new infections are occurring.
- One cannot lose sight of the fact that strategic information has an important political component.
- Given the lack of information, the option to resort to *proxy*[1] information exists. This option is not perfect, but it can help to reveal trends.
- Peru has an epidemic stabilized at a prevalence of 0.3% in the general population, which is known thanks to ongoing surveillance studies.
- One must not only consider at-risk populations but also and especially risky practices, and that risk can be associated with types of behavior.

[1] Information that is considered similar to other information that is unobtainable, or that leads to an estimate of the missing data.

II.
THE STATUS OF THE EPIDEMIC IN SPECIFIC POPULATIONS

SIZE ESTIMATES OF THE MOST-AT-RISK POPULATIONS

The Colombian Experience

Luis Ángel Moreno, Ministry of Social Protection,
(Ministerio de Protección Social), Colombia

An important step in the estimation of population sizes is revealing and discussing the data from research performed in Latin America. In this sense and for practical effects, five concrete examples of priority studies that are being developed in Colombia in 2008 were presented.

First, the Study of Sexual Behavior and HIV Prevalence in Men who have Sex with Men (Estudio de Comportamientos Sexuales y de Prevalencia de VIH en Hombres que tienen Sexo con Hombres), which, through the use of combined strategies, will look for qualitative and quantitative information with the intention of providing information to all actors in the general health system, the national government, and the general population about the magnitude, the characteristics and trends of the HIV epidemic among MSM and the sexual behaviors associated with it. In this case, the methodology will be an anonymous serological survey linked to a probability sample. The clusters will be selected through the utilization of respondent-driven sampling (RDS) and health service providing institutions, clinics and hospitals from six cities will be included.

Second, the HIV Prevalence in Pregnant Women Study (Estudio de Prevalencia de VIH en Gestantes) will be conducted again. There have been 6 surveillance studies in Colombia with worrying results in the last two measurements. This requires a complete follow-up with pregnant women in relation to HIV. One factor that does not favor the study of pregnant women is the limitation of the national budget, which currently cannot ensure the necessary technical conditions for its execution. The idea of this surveillance study is to include 13 cities, three of which will use their own resources for funding, in concordance with the public health norm that health departments finance their own studies.

Third, the Prevalence of HIV in Sex Workers (Estudio de Prevalencia de VIH en Trabajadoras Sexuales) study will be carried out. This study will include five sites that include health-providing institutions and will employ a non-probability design.

Fourth, the Study of Behavior and Vulnerability Factors in HIV Infection in Women (estudio de comportamiento y factores de Vulnerabilidad en infección por VIH en Mujeres), in which only behaviors are measured, will study a population that is being affected by conditions in its daily life and that has not been evaluated until now.

Finally, the Study of HIV Prevalence in Tuberculosis Patients (Estudio de Prevalencia de VIH en Pacientes con Tuberculosis) will allow for the measurement of the prevalence of this coinfection. This study will consider five cities and a group of 449 patients.

With respect to the implementation and procedures necessary for the success of all the proposed studies, the use of similar instruments has been considered pertinent. These instruments have been reviewed by a committee of experts, who have established the crux or thematic area that corresponds to each question, in order to avoid an excessive number of questions.

The biological component of the studies, which will contribute to concrete data on prevalence, will be based on two laboratory methodologies: the dry blood analysis technique and the conventional tube technique.

It is important to emphasize the participation of different actors, the intellectual authors of the studies, academia, the National Institute of Health (Instituto Nacional de Salud), and the Liga Colombiana de Lucha contra el Sida, among others.

There are other important limitations in the design of these studies that should be kept in mind. These are mostly due to the use of probability methods, the training of personnel who participate in the studies, the lack of standardized operational definitions used, and stigma and discrimination. It is necessary that cooperation agencies support these initiatives in all countries.

It is fundamental for the implementation of these studies that they are agreed upon and adequately represent reality; only in this way can the results be used to sensitize decision-makers, mobilize civil society, design communication campaigns and focus on prevention activities.

The Uruguayan Experience

Rubén Berriolo, Ministry of Health (Ministerio de Salud), Uruguay

An important objective in Uruguay is discovering the changes in HIV prevalence in the population, as well as determining the molecular characteristics of the circulating HIV strains. The epidemic was initially marked by the F and B subtypes, but recently some cases of the C subtype and the combined B/F forms have been seen.

Another important objective is to evaluate the implementation of new technologies for the identification of recent seroconversions, applying the desensitized ELISA method.

In Uruguay only with the arrival of the Spectrum program it became possible to visualize the importance of knowing the size of each of most-at-risk populations.

Regarding sex work, Uruguay has regulated it since 2003. This regulation has allowed female sex workers to be monitored every month and the Ministry of Public Health (Ministerio de Salud Pública) has provided them with visitor's cards. Furthermore, there are institutions that watch over the protection of and respect for sex work, such as the National Commission for the Protection of Sex Work (la Comisión Nacional de Protección del Trabajo Sexual), which is made up of different government institutions and female sex worker representatives.

In Uruguay, female sex workers have been monitored since before the 1970s; since then there have been estimations of their number. That is how in 1981 2,300 SW were monitored and by the end of the 1990s it was estimated that there were 5,000 female sex workers. In 2006-2007, there

was a SW population census in Montevideo, jointly organized by the Ministry of Public Health and the Asociación de Trabajadoras Sexuales (Female Sexual Workers Association), which counted 1,345 SW. The census included prevention activities for HIV and condom distribution. The monitoring of sex work also includes male sex workers, and the Ministry of Public Health (el Ministerio de Salud Pública) has 52 centers that provide services to this population. It is estimated that there could be approximately 3,000 male sex workers; a census carried out in 2006-2007 managed to evaluate 1,721 of these. At the beginning of 2008 a study of behaviors and HIV prevalence among this group was initiated, but there have been difficulties in its implementation.

In the case of incarcerated populations living with HIV, more exact data exists. In Uruguay this group totals 132 with a seropositive diagnosis and 28 with an AIDS diagnosis, and the co-morbidity with TB in this group is high. Another problem with this population is the high rate of drug use (71%). Furthermore, 14% refer to having or having had an HIV-positive partner.

Regarding the MSM population, it is estimated that this population represents 2-5% of males between 15 and 49 years of age in the country. During 2008 a serological behavioral study of MSM was implemented with the participation of NGOs that work with and/or are composed of MSM.

With respect to intravenous drug users, it is known that it is difficult to access this population; it is even more difficult to know how many people compose it. It is estimated that 0.7% of people between 15 and 49 years of age are IDUs.

Finally, it must be recognized it is difficult to estimate the size of the majority of these groups, and one must resort to combined methods and periodic measurements. Furthermore, it is necessary to work in an interdisciplinary manner, in consensus with the different actors that are involved in the issue.

COMMENTS AND DISCUSSION

- It is important to consider not only the sanitary monitoring of the female sex workers, but also the need to define mechanisms to better reach their clients.
- There should be more work on issues of stigma and discrimination, especially that which comes from Government institutions
- There should be work on improving the empowerment of the female sex workers, as well as with trans and male sex workers.
- The quality of data collection should be improved so that the data is more reliable.
- It is necessary to reconcile the methodologies used to study different populations, as well as to reconcile the data obtained from different studies and surveillances to avoid overestimating the epidemic.
- Some methodologies, like the capture-recapture method and the home surveys, have been utilized by some countries to reveal the size of some key populations. However, it is still a challenge to count on information about the number of people that are MSM or SW, to cite a few examples. The intensification of efforts is required at the regional level to count on cost-effective tools that can be used in a sustained way to discover population sizes.

THE HIV SITUATION AMONG MEN WHO HAVE SEX WITH MEN AND TRANSGENDER POPULATIONS

The Bolivian Experience

Juan Pablo Protto, representing Ronny Rossel, Ministry of Health and Sports (Ministerio de Salud y Deportes), Bolivia

The following is a review of the Study of Male Sexuality and HIV in Bolivia (MSHB) (Estudio sobre Sexualidad Masculina y VIH en Bolivia (SEMVBO)), paying special attention to some of its methodological and operational aspects. We must keep in mind that Bolivia, like many other countries in Latin America, has an epidemic concentrated in MSM, and that Bolivia has limited HIV and STI prevalence studies.

The estimated MSM population in Bolivia is around 5% of the male population between 15 and 49 years of age, which means that their numbers are around 115,708 (within a range of 46,283 to 161,991). There is no clear number for HIV prevalence in MSM in Bolivia; data is scattered and sample sizes to determine this figure have not been very adequate. As such, prevalence estimates have ranged from 14% in La Paz to 21% in Santa Cruz.

Given this reality, this second-generation epidemiological surveillance of MSM to determine the incidence and seroprevalence of HIV, along with the seroprevalence of syphilis and herpes simplex virus 2 (HSV-2) among MSM, was considered for the cities of Santa Cruz de la Sierra, Cochabamba, and La Paz/El Alto. Another objective of the study is to determine the knowledge, attitudes, practices and behaviors that are associated with the propagation of HIV. In addition, information that will be important in assisting other funding agencies, the National Program for STI/HIV (Programa Nacional de ITS/VIH), and other local organizations involved in the strategic planning and definition of policies to combat HIV will also be collected.

Despite the fact that the study is in its data collection phase, so far the MSHB study has allowed for the identification of the main behavior indicators for MSM in the selected geographic areas; as such, the study supports the development of local abilities for the establishment of surveillance of HIV and behavior among vulnerable populations. In addition, the experience has allowed for the systemization of design and implementation procedures for prevalence and behavioral studies, which now relies on standardized guides.

This surveillance has relied on the participation of both external and internal partners, including the United States Agency for International Development (USAID), Socios para el Desarrollo, the CDC Global AIDS Program for Central America and Panama, the Pan American Health Organization (PAHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS), IBIS/HIVOS, the U.S. Military Infectious Disease Research Program – Naval Medical Research Center Detachment (NMRCD), the Ministry of Health and Sports – National STI/AIDS Program (el Ministerio de Salud y Deportes-

Programa Nacional ITS/SIDA), the Departmental Centers of Surveillance and Reference (DCSR) (los Centros Departamentales de Vigilancia y Referencia (CDVIR)) of the selected cities, the Departmental Laboratories and the National HIV Reference Laboratory (Cenetrop / Labimed / Inlasa) (los Laboratorios Departamentales y Nacional de Referencia de VIH/SIDA (Cenetrop / Labimed / Inlasa)), Adesproc Libertad, CIES (El Alto), the Institute of Human Development (IHD) (Instituto de Desarrollo Humano (IDH)) and the Fundación Redvihda.

The methodological part included the taking of a sample of 1,200 MSM (400 per department). To be included in the sample, subjects had to be at least 18 years of age, be men that reported having sexual relations with another man in the last year, be willing to give their written informed consent, and be living in the department of study. A verbal agreement was made with participants who could not read or write, along with a digital fingerprint. People who were under the effects of alcohol, drugs, or other substances, did not clearly understand the process of informed consent, or did not reside in the department of study were excluded. The sample was created through the RDS technique, which, as we know, is a modified form of the snowball sampling technique, which is useful for studying difficult-to-reach populations and also allows for the identification of networks within the populations of study. The provided incentives for completed participation and for each successful recruitment (a dual system of incentives) consisted of condoms, lubricant and condom cases.

For the interview process, the space, which included a waiting room, private and separate rooms, and bathrooms, ensured the confidentiality of the interview process. Furthermore, a meeting with neighbors to inform them of the activity that would take place was also considered. The interview occurred with an instrument validated by the community both in terms of language as well as the type of questions. The instrument was applied by pairs and included questions to be skipped and additional sections, depending on the interviewees' answers. The interviews lasted approximately 45 minutes.

Coordinating meetings at the departmental level were held each week and national meetings via teleconference were held every two weeks, along with monthly teleconferences with partners, to organize the fieldwork. The follow-up visits at the departmental level occur monthly.

In conclusion, it is important that the country have MSM studies in order to maintain updated data and improve knowledge of the HIV and STI epidemics, which in turn can generate a larger consensus and debate with respect to the strengthening of local abilities, specific policies, and needs estimates. It is also important to know the administrative and technical needs for these types of studies, given the general and local level of commitment, and to consider the level of involvement of different actors.

The Uruguayan Experience

Rubén Berriolo, Ministry of Health (Ministerio de Salud), Uruguay

The next section is a description of studies, including the serological study and the behaviors, attitudes and practices (BAPs) studies that have focused on the Male Sex Worker population in Montevideo.

The first study took place during the months of August 2006 to February 2007 and was put in motion by the Ministry of Public Health's Priority Program for STI/AIDS (Programa Prioritario de ITS/SIDA del Ministerio de Salud Pública) along with the Asociación de Travestís del Uruguay

–Transvestites Association of Uruguay- (ATRU), with the support of PAHO/WHO. This study included a mapping of the geographic distribution and census of the Male Sex Workers that work on the streets in the department of Montevideo (reaching some 1,721 Male Sex Workers).

The objectives of implementing an HIV Prevalence Study and a simultaneous BAP (behaviors-attitudes-practices) Survey on Male Sex Workers (transvestites, taxi boys, and other MSM) in Montevideo included: to determine the frequency of HIV infection in the population,; to describe some characteristics of the population such as: age, education level, occupation, and civil status, among others; to study the opinions and information held by this population regarding HIV; to learn their habitual sexual practices, and to analyze the frequency of predominant risky behaviors within this population.

A descriptive cross-sectional study took place in the city of Montevideo between the months of January and April 2008; Male Sex Workers (transvestites, taxi boys, other MSM) between 18 and 65 years of age constituted the study population.

During 2006-2007 there was also a census of male sex workers and transvestites in the city of Montevideo performed by ATRU, which evaluated a total of 1,721 participants. This year there will be a new census in zones marked by TAU, and the participants will be recruited through the snowball technique.

This type of surveillance includes a process of informed consent, counseling, blood collection and a brief structured and pre-coded questionnaire about information, perceptions, risky practices, and prevention methods associated with HIV infections and other STIs. Participants will be compensated with condoms and flyers about prevention supplied by the Ministry of Public Health (MPH) (Ministerio de Salud Pública (MSP)) and ATRU.

At this point there is good acceptance by the male and trans sex workers, and the initial reports show an estimated HIV prevalence of 27.3% (41/150).

Another important study in this area is the HIV Infection Prevalence Study (Estudio de Prevalencia de la Infección por VIH), which included information, opinion and practices related to this pathology among the MSM, homosexual, and/or gay populations of Montevideo. This study took place between March and June of 2008; it was a cross-sectional descriptive study whose study population consisted of all men who have sex with men, homosexual and gay men between the ages of 18 and 65 who frequent specific gay venues in Montevideo and who were recruited through the snowball technique.

The evaluation of this study's participants included informed consent, counseling, interviews and blood collection. Condoms and pamphlets were also distributed as a form of compensation for participating.

COMMENTS AND DISCUSSION

- In Uruguay, epidemiological studies have been made possible thanks to funding opportunities directed toward such studies.
- A "taxi boy" is male sex worker who can have female as well as male clients. He is not transgender or a transvestite, and often is not gay. These and other examples presented once again demonstrate the need to standardize operational definitions, including terms that are commonly used within each country.

- There need to be multiple ways to utilize the methodologies used in the different countries, and more importantly, reconcile them within the region. Multi-centric studies with various institutions involved could help this process and also give sustainability to the methodologies that are adopted.
- In Bolivia, seeds have been planted that consider the sexual orientation of possible participants in surveillance studies in order to gain better representation of each population during the duration of the study.
- Case definitions should be as clear as possible; not only will the harmonization of definitions allow for comparisons between countries, but it will also make it possible for each country to analyze the information in the method deemed most convenient for it.
- The necessary processes for protocol approval on the part of multiple ethics committees for collaborative studies often delay the start of surveillance studies, especially when different committees offer contradictory opinions. It would be ideal to establish procedures to simplify the flow of information and discussion of criteria among ethics committees.
- The cost of a study like those presented can reach US$ 180,000, which brings additional challenges to the continuity of periodic production. In this sense it would be useful to unify criteria for the minimum indicators required for each population, among other parameters.
- Studies that involve sexual behavior in a broad and deep sense can take up to two years from their initial organization, including at least three months for data collection.
- At the time of proposing and designing new studies, it is important to have a clear objective as well as an understanding of the utility of each type of data.
- Technical assistance is always important, and its availability should be guaranteed in these types of studies, especially in countries with less established technical capacity.

THE HIV SITUATION AMONG SEX WORKERS

The Argentinean Experience

Elena Reynaga, Red Latinoamericana de Trabajadoras Sexuales, Argentina

An important approach to studying the HIV situation for sex workers is working in pairs. This is how a study about HIV prevalence and Treponema Pallidum, along with knowledge about HIV and AIDS, was conducted with Sex Workers in Argentina. This was a joint investigation carried out by the National Reference Center for AIDS (el Centro Nacional de Referencia para el SIDA), the Faculty of Medicine at the University of Buenos Aires (la Facultad de Medicina de la UBA), AMMAR, and the Nexo Asociación Civil.

The objective of the study was to estimate HIV and Treponema pallidum prevalence among male and female sex workers (SW) in Argentina. A population of 332 men and women who were over 18 years of age, self-identified as SW, and invited by AMMAR was studied in Buenos Aires and La Plata. All of the participants were given an epidemiological survey; blood samples were also taken for laboratory tests. The invitation to pairs was done through fieldwork. In the blood extraction and test site, there was also a workshop about HIV, emphasizing the importance of obtaining serology results for themselves and for others participating in the study.

This study is a tool for political lobbying, now that the collected information has been distributed to program supervisors from each province.

The results obtained demonstrated that the prevalence of HIV infection was 2.8%, 17.6% and 52.9% in women, men and transgender people respectively; the prevalence of syphilis was 29.8%, 35.3% and 64.7% for women, men and transgender people respectively.

In terms of co-infection of HIV and syphilis, the prevalence was 2.1%, 8.8% and 28.6% in women, men and transgender people respectively.

In conclusion, HIV prevalence is similar to that reported in previous studies, but the high prevalence of syphilis must be highlighted. This is the first study that considered men and transgender people, and it demonstrates that there is a high prevalence of HIV infection and syphilis in these populations. The idea now is to be able to do a study with a larger sample size.

In terms of the evaluation of knowledge about HIV among Sex Workers, 184 women above the age of 18 and self-identified as sex workers were interviewed in Buenos Aires and La Plata. The results revealed that the majority had received information about HIV through mass communication efforts and through the Asociación de Mujeres Meretrices de Argentina –Female Sex Workers Association of Argentina- (AMMAR). Furthermore, it was found that 51% of the participants did not know the

difference between HIV and AIDS. In terms of the routes of transmission of HIV, wrong beliefs were common: 45% thought that HIV was transmitted through mosquito bites, 43% through shared objects, 34% through saliva, and 15% through sharing swimming pools, among other answers. One important note was the self-perception of risk of contracting HIV: 37% declared that they did not have "any possibility of acquiring HIV," even though 4 of them were diagnosed with HIV in this study.

In conclusion, the majority of sex workers have misinformation about basic issues regarding HIV and its methods of transmission. These results will serve to improve the workshops and face-to-face approaches that are being carried out throughout Argentina.

The Colombian Experience

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The Study of HIV and STI Prevalence among Sex Workers (el estudio de Prevalencia de Infección por VIH y otras ITS en Trabajadoras sexuales) was conducted in Bogotá in 2007 and 2008. The general objective of this study was to contribute to the knowledge of the behavior of the HIV and AIDS epidemics in female sex workers in the locations with the highest concentration of commercial sex in Bogotá, and to implement a preventive intervention strategy oriented towards the adoption of safer sex behaviors on the part of this population. Furthermore, this study helped estimate the prevalence of HIV infection, Hepatitis B virus and syphilis; describe the socio-demographic characteristics, practices, attitudes, beliefs, and knowledge related to the exercise of sexuality, HIV and AIDS, Hepatitis B and syphilis, predominantly among female sex workers in Bogota; identify determining factors that impede or favor adequate support from health services; identify the contexts of socialization that impede or favor the exercise of safer sex behaviors, and provide adequate information about STIs and HIV to the women participating in the study.

The population studied included women above 18 years of age who are sex workers in the city of Bogotá. To be selected for the study, the women had to be sex workers in the city of Bogotá, should not have a previous HIV diagnosis, and had to agree to participate in the KAP survey after signing an informed consent form to undergo the offered diagnostic tests. A total of 501 female sex workers were recruited through the "snowball" technique through a publicity approach using printed material (posters and pamphlets) in sites where sex work is carried out in selected locations in Bogotá. The hospitals belonging to the Secretarial District of Health (la Secretaría Distrital de Salud) network were used as locations where the Liga Colombiana de la Lucha Contra el Sida -Colombian League against AIDS- was in charge of the taking of samples and offering pre- and post-test counseling.

At this point in the study, there have been 30 visits to work sex work sites in all of the locations, which have resulted in 535 KAP questionnaires completed, 535 pre-test counseling sessions and samples taken, 216 post-test counseling sessions and communication of results, 33 first dose treatments and 22 second and third dose treatments for syphilis; 107 first dose treatments and 38 second dose treatments of the Hepatitis B Vaccine, 34 references to the STI Project for participants who reported symptoms of other genital infections, 6 referrals to another institution in the network because of the condition of homelessness, 207 telephone calls to sex workers inviting them to pick up their results, and 75 telephone calls reminding participants of their second and third dose treatments for syphilis and/or Hepatitis B Vaccines.

The prevalence of HIV found at this point is 0.7%, with 21.8% for syphilis and 1.3% for the

Hepatitis B antigen (chronic infection), while the prevalence of the Hepatitis B antibody (resolved infection) was 9.2%. The most common identified risk factors were the lack of condom use with a stable partner, the lack of information about HIV, and the lack of access to the general social security health system.

COMMENTS AND DISCUSSION

- One must keep in mind that studies are conducted with people, and one must keep them in mind in order to acquire quality data.
- When designing a study, one must consider its technical viability, its political viability, and finally, that its conclusion and recommendations contribute to decision-making. The study should generate innovation.
- One of the things that should be eliminated from public opinion is that all people who perform sex work are rape victims, or that rape victims necessarily become sex workers.
- Peer work with and among sex workers should also include the transgender population in a close relationship with the female sex workers. The formation of pairs should include a selection process based on an adequate profile in order to achieve participation by women as well as transgender people in screening and evaluation programs.
- Reliance on committed authorities at the ministerial and program levels has been important in the Argentinean experience with the HIV issue, even though the limited availability of resources continues to be a difficulty. However, when HIV prevalence begins to decline, resources begin to be restricted, when the opposite should occur; in other words, the response to good results and good work should be a sustained investment in order to keep improving.
- In the Argentina-Brazil-Uruguay-Chile area, female sex worker organizations did not originate in response to HIV, but rather to the issue of human rights and political repression, fighting for the repeal of repressive laws, as opposed to Central America and the Caribbean, where FSW movements were initiated in response to HIV, and were also created by other people who saw FSW as a risk group. This has created a situation in which once the agencies leave, the FSW organizations disappear; thus the importance of the birth and growth of FSW organizations being stimulated by SW themselves.
- The support for the formation of sex worker organizations that collaborate to stimulate prevention against HIV is needed; these organizations must be sustainable and able to channel the available technical assistance and necessary investment.
- A surveillance system should have very clear surveillance priorities and objectives, and should choose the most important variables to serve as the focus for intervention.
- It is important that each surveillance system and each study incorporate a distribution and communication component with updates reflecting the information produced, and that these results can be used not only to generate knowledge, but also to promote change.

THE HIV SITUATION AMONG INCARCERATED POPULATIONS

The Peruvian Experience

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The HIV situation in penitentiary establishments in Peru was the subject of a Doctors without Borders study in the 1998 and 1999. This investigation of tuberculosis and STIs/HIV found that in the prisons there was overcrowding, violence, unhealthiness, a lack of access to condoms, and inadequate medical attention. During visiting days prisoners received visits from female sex workers, who saw approximately 40 men each; furthermore, there were frequent sexual relations between men in conjunction with drug and alcohol consumption, as well as the informal practice of tattooing and intravenous drug use.

To evaluate the risk of infection for incarcerated populations, we must consider a collection of phenomena that often coexist here: depression and low self esteem in an environment with a high prevalence of STIs/HIV and tuberculosis, in addition to overcrowding, malnutrition, psychological and sexual problems, added to individual factors like drug use, alcoholism, tattoos, homosexual relationships, homosexual and heterosexual prostitution, and a poor response on the part of the health services that exist at the moment.

This study made evident the fact that prison policies are profoundly deficient. From a sanitary point of view, there was no culture of hygiene among the prisoners, the assistance services were insufficient and there was abuse, and above all, the absence of prevention and promotional programs. As a result, in 1999 22 of the 86 existing penitentiary establishments were selected, mostly for their larger capacities that represented 73% of the Peruvian prison population, or 19,823 of 27,200 convicts. These centers were located in 15 of Peru's 24 departments: Lima, Huanuco, Piura, La Libertad, Callao, Lambayeque, Ayacucho, Ucayali, Cuzco, Arequipa, Junín, Ica, Loreto, Ancash and Puno. 6963 prisoners participated, and among them HIV prevalence was 1.1% and syphilis prevalence was 4.1%.

The risk factors associated with HIV infection included drug consumption, sexual relations between men, cocaine use, the presence of genital ulcers, and previous incarceration. The risk factors associated with syphilis included sexual relations between men, the presence of other sexually transmitted infections, the presence of genital ulcers, sexual relations with female sex workers, and having more than two sexual partners. It is important to emphasize the active participation of Doctors without Borders in the execution of this work.

There was a second study in 2004 and 2005, when the incarcerated population was approximately 22,000 people. This study was executed in the framework of the Global Fund programs and the national technical committee was made up of diverse institutions like the Universidad Mayor de San Marcos, the National Institute of Health (el Instituto Nacional de Salud), the General

Directorate of Epidemiology (la Dirección General de Epidemiología) and CARE-Peru. This study took place during the implementation of a free antiretroviral treatment program in Peru. This surveillance study helped to determine the evolution of trends. The sample of incarcerated people was 8,600 in the penal establishments. The preliminary results included an HIV prevalence of 0.15%, significantly lower than the previous study in 1999, which is why the data and methodology are being reviewed in order to achieve a higher level of accuracy. The latest data shows a reduction in estimated prevalence from 1.1% in 1999 to 0.65 or 0.8% in 2007, but the editing process is not yet complete.

In conclusion, the incarcerated population in Peru is one of the populations vulnerable to the HIV epidemic, and it requires permanent attention by the state and by society. The high number of incarcerated people turns jails into possible accelerators in the dynamic of HIV transmission for those incarcerated. Furthermore, the condition of incarceration should not impinge upon the human condition, or the right to health, of the people affected.

Future studies should consider sub-populations with a different level of risk and create specific samples or studies for each sub-population. The following is a lesson learned: studies with closed populations subject to periodic exams should reconsider their methodologies in order to eliminate possible bias in participation or selection. Along with biological indicators such as HIV and other STI prevalence, the studies should also consider risk determinants that are dependent on human behavior, the environment, the conditions of life and the response of the state for prevention and control, among other factors, focusing on the real health surveillance, generating knowledge and creating more efficiency.

The Venezuelan Experience

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It is important to study the epidemiological profile of HIV in Venezuelan prisons because incarcerated populations have the right and the responsibility to protect themselves from HIV and other STI infections, co-infections, and opportunistic diseases. Furthermore, the state has the responsibility to ensure that the existing prevention measures for the general population are also available in prisons. In that sense it is necessary to implement and develop strategies for health promotion, prevention and control of STIs/HIV for incarcerated populations.

A study was performed in El Rodeo Prison (la Prisión el Rodeo) to discover the epidemiological profile of HIV and its social determinants. The methodology included an informative session on HIV, individual counseling, an epidemiological survey and a voluntary HIV test. A fourth-generation ELISA test was used. The samples were processed in the Metropolitan Public Health Laboratory (el Laboratorio de Salud Pública del Área Metropolitana) and were confirmed by Western Blot in the Rafael Rangel National Hygiene Institute (el Instituto Nacional de Higiene "Rafael Rangel"). In order to guarantee participant confidentiality, codes based on ID numbers were used, which were only managed by the investigators.

The incarcerated men included in the study were those that manifested their own decision to participate, without considering their juridical condition. Those that expressed a decision not to participate were excluded. Participant recruitment was performed in Rodeo I and Rodeo II penitentiary centers, with 1,000 completed surveys and 1,085 blood samples collected. This study demonstrated an HIV prevalence of 0.33%. 87% of the participants had not previously submitted to an HIV antibody

screening. Drug use was reported in 64.5% of the incarcerated. 66% reported not having used a condom with stable partners, and only 17% reported using a condom with casual sexual partners.

COMMENTS AND DISCUSSION

- Economic resources and technical assistance need to be mobilized to be able to improve surveillance of incarcerated populations. This means that prevalence and sexual behavior studies that occur in jails require intensive advocacy with authorities and decision makers at the political level to make them understand that it is important to raise this information and incorporate it into decision making.
- Prevalence studies in jails require an important level of coordination between the Ministries of Health (or associated institutions) and the Ministries of Justice (or associated institutions) to ensure that the detected cases receive the necessary treatment, whether it is for HIV or for STIs in general. Furthermore, the authorities should ensure the continuity of the studies apart from individual management.
- Measuring HIV prevalence is not sufficient; it is also necessary to discover the factors that explain why people are getting infected. In this sense, behavioral studies are very useful (for incarcerated populations as well as for those who have contact with them) in addition to "hard" data obtained through biological samples. In the same sense, it is important to involve the jail personnel, not only those that work in health, and define protocols to discover the tendency of the infection within the jails (in other words, how many people come in negative and how many come out positive).
- HIV prevalence in Peruvian jails is a reflection of HIV prevalence in the cities where each penitentiary is located. In general, the prevalence in Peruvian prisons is lower than what was thought, which could be explained by the scant usage of intravenous drugs; however, one still must differentiate the presence of the two groups in jail: those that are more similar to the general population, and those at greater risk. Each group must receive differential attention.
- HIV testing is not obligatory in Peru, but it is performed in a systematic manner among volunteers, upon the receipt of information. This allows for its acceptability to be high. HIV testing includes pre- and post-test counseling. Some people seroconvert in prison, but the majority arrives carrying HIV and they do not announce their status out of ignorance or fear of discrimination.
- Violence inside prisons limits the work. In Venezuela there is currently a joint project to construct smaller prisons where there will be more control and where comprehensive projects working on HIV infection can be developed.
- In Argentina HIV testing is not performed routinely before entering prison; instead HIV tests are performed on visitors, which should be modified. In addition access to and usage of condoms by visitors should be improved, a task that should be the responsibility of the Ministry of Justice.
- Prison employees should also receive attention, given that they often have sexual relations with the incarcerated.

THE HIV SITUATION AMONG DRUG USING POPULATIONS

The Argentinean Experience

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In Latin America it is estimated that the majority of intravenous drug users are found in Argentina, Brazil and Mexico. Injectable cocaine use is especially worrying in Brazil and in the main cities of Argentina and Uruguay. The use of injectable heroin is more common on the US-Mexican border. In the mid-1990s, Latin American countries began to develop strategies like needle exchange programs to reduce the damage associated with drug use. Many of these programs were not very systematic, they reached a small portion of the population and they were not replicated in necessary ways. In many cases, the intravenous drug users themselves were the first to adopt prevention initiatives; however, since the end of the 1990s there have been successful preventive efforts directed at intravenous and non-intravenous drug users in the region.

Needle exchange programs and other community initiatives have been implemented by government agencies, non-governmental organizations, and grassroots organizations, with Brazil and Argentina leading this process in Latin America. South-South cooperation in studies has also been developed in the region.

The regional HIV Prevention Project for intravenous drug users in the Southern Cone (el Proyecto Regional de Prevención del VIH en usuarios de drogas inyectables del Cono Sur) completed its first phase in 2000 with the support of UNAIDS. This project was developed in Argentina, Chile, Paraguay and Uruguay in cooperation with the national AIDS programs and a non-governmental organization from each country (Intercambios, Caleta Sur, Prever, IDES). The second phase was developed in 2003, with support from the United Nations Office on Drugs and Crime (UNODC), and the involvement of the Drug Secretariats of each country, as well as that of Brazil. The third phase was developed in 2006-2007.

Another example of cooperation is the Profiles and Trends of Risky Practices project for HIV, Hepatitis B and C among drug users in the context of public health policy in Brazil, Argentina and Uruguay. This project was financed by the Ministry of Science and Technology (Ministerio de Ciencia y Tecnología) in Brazil, and it is working with databases from the three countries with studies completed from 1998 to the present; this project has also relied on the support of the WHO. In Argentina the role of non-governmental organizations in the study and intervention of drug using populations has been recognized by governmental as well as international agencies.

Cocaine for the most part is smoked or inhaled in the South American region; crack is popular in various Brazilian cities, while the use of cocaine paste – called basuco in Colombia, paco in Argentina, and also used in Bolivia, Chile, and Peru – has grown in Argentina and Uruguay in the last decade,

becoming more typical in the principal urban centers in these countries. In addition, the role of non-injectable cocaine use in the transmission of infections has been described in different American cities.

Currently there are various studies taking place concerning seroprevalence and behavior that include the IDU population. Among them we have: "The Determination of HIV Seroincidence and Resistance in Men who have Sex with Men, Female Sex Workers and Drug Users" ("Determinación de seroincidencia y resistencia de VIH en poblaciones de Hombres que tienen Sexo con Hombres, Trabajadoras Sexuales y Usuarios de Drogas"), coordinated by the National Reference Center on AIDS (el Centro Nacional de Referencia para el Sida) and financed by the Global Fund to Fight AIDS, Tuberculosis and Malaria; the "Support Activities for the Prevention and Control of HIV in Argentina" ("Actividades de apoyo a la prevención y el control del VIH en la Argentina") project; the "Profiles and Trends of risky practices for HIV, Hepatitis B and C infection among drug users in the context of public policy: Epidemiological data exchange in Latin America – Brazil, Argentina and Uruguay (PROSUL)" ("Perfiles y tendencias de las prácticas de riesgo para las infecciones de HIV, Hepatitis B y C entre usuarios de drogas en el contexto de las políticas públicas: intercambio de datos epidemiológicos en América Latina – Brasil, Argentina y Uruguay (PROSUL)") project; the "Drug use policies and practices in poor urban populations in the Metropolitan Area of Buenos Aires" ("Políticas y prácticas de uso de drogas en poblaciones urbanas pobres del Área Metropolitana de Buenos Aires") project; and finally the "Drug use in Argentina: policies, services and practices" ("Uso de drogas en Argentina: políticas, servicios y prácticas") project, within the international framework of "University and the use/abuse of drugs: local studies" (2005-2008).

An important approach is the methodological approach for hidden and stigmatized populations through other drug users that form part of a social network in a neighborhood or through a drug consumption network. Participants were also contacted through references from community organizations that have contact with drug users and in treatment centers for drug users. Key informants for this study were current or previous drug users, non-drug using intermediaries, professionals and community leaders that work with this population and members of drug user networks. Drug users were also evaluated as recruiters in community environments, and contact with other drug users privileged ties of trust. The training of recruiters was focused on the study objectives and confidentiality. In some of these studies, the number of participants per consumption network was limited, working with subject quotas of social class, gender, and place of residence.

There was also an HIV and Hepatitis prevalence in IDU study performed in collaboration with the National Reference Center for AIDS (Centro Nacional de Referencia para el SIDA). This study was carried out in drug abuse treatment centers, and the participants were drug users in both in- and out-patient treatment programs. The participating centers included those that accepted the confidential delivery of study results to the drug users, and in this sense the study contributed to the institutional work.

The behavioral questionnaire for High Risk Drug Users (HRDU) was designed for face-to-face interviews with diverse types of HRDU (injectors or consumers of drugs through other methods), in diverse contexts (the street or other "natural environments," dependency treatment programs, harm reduction programs, prisons, etc.). The HRDU questionnaire was accompanied by two other materials; (1) Study design, adaption of questionnaire and indicators; and (2) Interview manual and application of questionnaire, which aided the local adaptation of the questionnaire, as well as the planning and execution of the study. This study was implemented for drug users in Paraguay, Colombia and Argentina.

The study of infections through blood and sexual transmission and risk practices in cocaine paste users in the Metropolitan Area of Buenos Aires was financed by the WHO and executed by Intercambios Asociación Civil for the Study and Care of Problems Related to Drugs. This study was implemented in 2006 and 2007 in drug users over 18 years of age who had consumed cocaine paste

in a non-injectable form for more than 25 days (approximately once a week) during the six months prior to the interview; and whom had never used injectable drugs before. There were 170 participants, of which 83.5% were male; 15.3% were female; and 1.2% transvestite. The average age was 26 (18 – 64). 72% had completed their elementary education, and only 14% had completed their secondary education. 3% of the participants were foreigners, and the HIV prevalence was 2.9% (n=170).

Given the different studies we have reviewed, we could say that the use of scientific evidence and best practices has not always been implemented by governments. We also know that infection transmission is related to cultural, religious, and often juridical factors. Therefore, some public drug and sexual and reproductive health policies could also be contributing to the transmission of HIV or to the failure of treatment for it. In the majority of Latin America and the Caribbean there are diverse obstacles to the expansion and replication of best practices, including chronic shortage of resources, insufficient information about tendencies of the HIV epidemic and its impact on the drug using population; as well as changes in consumption patterns that can contribute to increased HIV transmission, the difficulty of developing data collection instruments to carry out comparable studies, and the difficulty of translating investigations into rapid responses for an intervention.

Scientific collaboration networks are a key instrument for the development of a study, the transmission of results and the use of evidence to define interventions and policies. In this context, in December 2001, WHO and the U.S. National Institute of Drug Abuse (NIDA) organized a meeting in Buenos Aires for experts from the United States, Spain, Latin America and the Caribbean to exchange experiences and lessons learned about the transmission of infections between IDU and their partners. In 2003, the journal Clinical Infectious Diseases published a supplement with the meeting report, which contributed to the dissemination of results and encouraged more collaboration.

With respect to the barriers and the needs for studies in the region, there is an injectable and non-injectable cocaine using population, with very limited heroin use, in Argentina as well as in Brazil and Uruguay. One of the principal questions is related to the integration and interaction of injectable and non-injectable networks, keeping in mind their sexual partners. Some questions still need to be explored in a periodic manner, for example: what is the relationship between changes in usage patterns in the region and new risks for infection transmission? How can the knowledge learned about the HIV epidemics between IDU in the urban centers of Argentina, Brazil and Uruguay be useful to prevent similar epidemics in other Latin American and Caribbean countries among both local as well as immigrant populations that move between countries due to economic and political crises?

Finally, a possible research agenda in the region would need to contemplate the need for multi-centric studies to understand the cultural influence on the risk and care practices, incorporating a vision reflecting different disciplines and methodologies. In addition, existing information should be analyzed to make comparisons and identify trends in the region; identify and discover the influence of economic and social change on behavior for infection transmission, and, even more importantly, analyze what would be the most appropriate interventions. Another task to complete is the design of comparative tools for data collection, study design, and program evaluation among government, academic, community and non-governmental organizations in order to expand and establish collaboration among teams from different countries and organizations. Finally, training needs to be offered on how to write scientific articles and to encourage studies about these issues among young professionals, which would permit a greater diffusion of generated knowledge on this issue.

The Peruvian Experience

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"WHATEVER HAPPENS… Alcohol, Drugs and Sexual Vulnerability" ("A LO QUE VENGA… Alcohol, Drogas y Vulnerabilidad Sexual") is a study completed in 2007 in Peru by the Unit of Health, Sexuality and Human Development (la Unidad de Salud, Sexualidad y Desarrollo Humano), of the Universidad Peruana Cayetano Heredia, in collaboration with UNAIDS and the United Nations Office on Drugs and Crime (UNODC). The objectives of the study were: to explain the magnitude of the link between the consumption of psychoactive drugs, including alcohol, and illegal practices at risk for HIV transmission in the general population as well as in vulnerable populations, including gay men, transgender people, female sex workers and street children; to describe the ways in which drug consumption influences risky sexual behaviors according to gender, sexual orientation and life conditions of the populations involved; to describe the relationship between drug use and sexual exchange as a vulnerability factor for HIV infection; and to identify the barriers to HIV prevention given certain drug and alcohol consumption patterns.

The study included four Peruvian cities: Lima, Callao, Iquitos and Chiclayo, and participants between the ages of 18 to 25 were recruited from the general population as well as from vulnerable populations (gay men, transgender people, female sex workers, people living with HIV, street children, incarcerated people, and people in rehabilitation for drug consumption).

The study had both quantitative and qualitative components. The quantitative study included a behavioral study of a representative sample of the target population, men and women between 18 and 30 years of age from the cities mentioned above. The sampling was probability-based, and included a sequencial selection of clusters, households and people. A total of 1,739 people were interviewed (Lima/Callao: 586, Iquitos: 546 and Chiclayo: 577).

The qualitative study included in-depth interviews with vulnerable populations to discover their perceptions, habits and customs with respect to sexuality and its relationship with alcohol and drug consumption; focus groups with men and women were also held to discover the normative aspects and social discourse about sexuality and drug/alcohol consumption.

Among the most important findings of the quantitative study, the majority of young people do not consider alcohol to be dangerous when it is consumed in large quantities, while drugs like cocaine and marijuana, among others, are considered risky. Condom use under the effects of alcohol is very low despite the fact that the number of sexual relations under the effects of alcohol is high. In Chiclayo, the prevalence of non-condom usage was 9.7% among the total sample, but 25.5% among people who consume alcohol, which suggests a strong link between alcohol consumption and risky behaviors.

Among the qualitative findings, the perception of alcohol diminishing inhibition is highlighted. Some people explained that they have to drink alcohol to feel free, different; furthermore, alcohol is seen as a facilitator for casual sexual relations. Men use condoms less frequently with casual partners when they are under the effects of alcohol or drugs, and these same men later continue to have unprotected sex with their stable partners.

In the transgender sex worker community there is an established difference between work and fun. "Fun" occurs with principal or regular partners, and the possibility of having unprotected

penetrative sex with these partners is frequent. The condition of being a sex worker in this population increases the frequency and quantity of illicit psychoactive drug and alcohol consumption.

Meanwhile, in the gay and bisexual populations, the consumption of marijuana, cocaine and alcohol occurs within clubs and other locations of entertainment, or within merely sexual contexts.

In the case of female sex workers, the use of psychoactive drugs, including alcohol, is found to be influenced by poverty and maternity; more alcohol is consumed during work in comparison to situations of daily life.

In the street children population, the results concur with those of various clinical and experimental studies that demonstrate the relationship between physical abuse, victimization, and the use of drugs and alcohol among children and adolescents. The children's' stories show three different types of sexual activity: sexual aggression, sexual exchange, and consenting sexual relationships with other children.

The incarcerated population has a practice of alcohol use that is related to sexual practices as "entertainment." Chicha (liquor prepared by the prisoners through a fermentation process of fruit brought by their families) is consumed, and there is an exchange of sex for drugs on the part of prisoners who are drug users (lacras); rapes are also frequent. According to the participants interviewed, the lack of incentives makes the prisoners focus their interests on the sale of illegal drugs (the production and sale of homemade alcohol, the sale of illicit drugs). This is added to the overcrowding, sexual trafficking of men as well as women, the presence of alcohol and/or drugs and the reduced condom usage in different circumstances.

For male participants living with HIV (PLHA), risky behaviors, multiple partners, and alcohol consumption characterize life before diagnosis. The consumption of alcohol in concrete social situations, looking for fun or a loss of inhibitions, was correlated with unprotected sexual relations. The partners of women living with HIV frequently consumed alcohol, which brought consequences of sexual pressure and/or violence in some cases.

The group of people in drug rehabilitation reported frequent occurrence of sexual contact under the effects of drugs, especially during initial consumption periods, and as drug use increased, sex became a second priority after drugs. The presence of (unprotected) sexual exchange for drugs in order to maintain consumption exists, as well as the occurrence of STIs in various stages of life driven by drug consumption.

To conclude, the use of alcohol and drugs is a part of a culture of leisure, and these substances are used as de-inhibiting agents *par excellence*, with performance elements ("representing" fun), based on a subjective need to consume alcohol to "have fun." Alcohol also leads to unprotected sexual relations. For trans and female sex workers, drug and alcohol consumption constitutes another transaction component. Heavy drug users, the male incarcerated population, and street children often exchange (unprotected) sex for drugs. Drug and alcohol consumption is also a way to legitimize stigmatized practices that can be "denied" or "forgotten," such as non-heterosexual sexual practices among men and casual sexual relations for women. There is also a male discourse that legitimizes non-consensual sexual practices with women if they are found to be under the effects of alcohol or drugs, in the sense that by consuming alcohol and drugs, these women knew what they were exposing themselves to.

The relationship between non-injectable drug and alcohol consumption and the risk of HIV is a reality that preventive programs should keep in mind. There is also the need to continue studying (in both qualitative and quantitative, epidemiological and descriptive studies) this relationship in each of the populations considered in this work.

COMMENTS AND DISCUSSION

- There are standardized instruments that can be used to find information about drug and alcohol use. These instruments also contain different methods to ensure the quality of data collected from drug using populations.
- The homogenization of operational definitions is very important for the validity of these studies and the usefulness of their findings.

THE HIV SITUATION AMONG THE GENERAL POPULATION AND THE PREVENTION OF THE VERTICAL TRANSMISSION OF HIV THROUGH PREGNANCY MONITORING

The Peruvian Experience

Mónica Pun, Ministry of Health (Ministerio de Salud), Peru

Epidemiological information about HIV and AIDS is received and processed by the General Directorate of Epidemiology (GDE) (la Dirección General de Epidemiología (DGE)). This information comes from 7,370 notifying units, both public and private, through the use of the NOTIVIH program. The final product is a quarterly- or monthly bulletin of HIV and AIDS cases, distributed by age and sex, way of transmission and department and province. We have achieved 50% implementation of notification by district. All of this information is automatically available in a disaggregated fashion from in each health department in the country.

Between 1996 and 2000, the Program of Control of Sexually Transmitted Diseases and AIDS (Programa de Control de la Enfermedades de Transmisión Sexual y SIDA (PROCETSS)) managed HIV surveillance of pregnant women under the age of 25. This program started as part of a second-generation surveillance system. These studies included a quality batch sampling methodology and established the level of the Peruvian epidemic as a concentrated epidemic. 78% of all notified cases are concentrated in Lima. One crucial study that helped to standardize the information took place in 1996 and 1997, when 12,000 pregnant women were screened at the Maternal and Neonatal Institute (Instituto Materno Perinatal) and information was collected from sexual networks. The most interesting part of this study was that it showed a more elevated HIV prevalence in pregnant women, 1.5%, as compared to the figure of the time, which was 0.3%. 86% of pregnant women reported to be monogamous. Beginning in 2002, thanks to this study, pre-natal care was enshrined in law. In 2001 surveillance became the responsibility of the GDE.

HIV screening among pregnant women in Peru was above 85-90% from 2002 to 2006. The obtained results have contributed to more rational decisions, and have strengthened the capacities of the country. Health care workers have participated in multi-centric studies and have become more committed to the fight against the epidemic. The national epidemiological surveillance system has been strengthened through the completion of studies with methodological designs that abide by ethical considerations and respect for human rights. These studies also uncovered the fact that the epidemic is still concentrated; this allows us to elaborate plans and estimate needs for pregnant women and children affected by vertical transmission, as well as to evaluate the notification sensitivity for children in the system. Strengthened capacities include good organization and the formation of a national epidemiological network, which includes official regional study teams appointed through directorial resolutions. The weakest part is still the acquisition of reactive agents and materials.

We also must point out what we have called third-generation surveillance, which includes estimates of STI/HIV incidence, as well as measurements of coverage, compliance, resistance to treatment, and mortality.

The Argentinean Experience

Liliana Orellana y Adriana Basombrío, Ministry of Health (Ministerio de Salud), Argentina

The experience of epidemiological surveillance of vertical HIV transmission in the city of Buenos Aires should be shown within the framework of the epidemic. Buenos Aires has a population of 3,049,941 inhabitants (8% of the country), and within that between 20,000 and 24,000 people are infected with HIV, out of which 50% do not know their serology. The rate of vertical transmission (VT) for the period of 2003-2006 was 4.4% The prevention of VT was established as one of the relevant strategies between 2000 and 2008 and was justified by the increased feminization of the epidemic, which revealed the vulnerability of women and children in the sectors with the least resources, as well as the high VT rate.

The objectives of this study were to provide health centers with the necessary materials for a comprehensive and effective approach to promote spaces of exchange and update for those who work in the field, in addition to creating an information system enabling the epidemiological surveillance of births and newborns of mothers with HIV.

Among the efforts and successes of this program, the VT rate has significantly declined in Buenos Aires in the last 7 years (20% in 2000; 2.2% in 2006); nevertheless, the data is still not what should be expected of countries where there are available resources to reduce the rate to around 1%.

There are basic actions that should be carried out to help bring down the VT rate, such as the promotion of a voluntary HIV test and offering an HIV test to pregnant women and their partners by health care providers.

Other actions that have been carried out include the elaboration of recommendations for the prevention of vertical transmission of HIV (2002, updated in 2004), the distribution of specific graphic materials, training sessions, and systematic notification of infections in Buenos Aires; these actions have strengthened the surveillance of vertical transmission.

The methodology used included the active search for birth notifications beginning in January 2003; the performance of HIV Polymerase Chain Reaction (PCR) tests in children born from 2003 – 2006 in reference laboratories; and the study of exposed and infected children (41 children).

The project to strengthen the prevention of vertical HIV transmission in 2007 looked for factors associated with VT in seropositive women who carried their pregnancies to term in 2003 – 2006. The methodology included a stratified probability sample with a uniform design fixed in one period. Clinical histories of 247 women with HIV and exposed (but not infected) children were analyzed. The qualitative study included surveys of pregnant women who had been seen by the Buenos Aires public health system.

In conclusion, the importance of early pre-natal care is evident; this care must include an HIV test. The results confirm the effectiveness of familiar strategies. The joint work with the teams allows for collaborative knowledge and collective adjustments in order to continue to bring down the vertical HIV transmission rate.

COMMENTS AND DISCUSSION

- In Peru one of the problems to be solved in terms of HIV and pregnancy is follow-up care. Many pregnant women are lost in the post-test process because the confirmation test takes up to two months; the inclusion of rapid-response testing in the Global Fund project has improved this process.
- In Peru, male-female HIV infection has varied during the course of the epidemic; previously there were 23 men for every woman infected, now this ratio is about 2.5 to 3 men for every woman infected.
- Epidemiological surveillance of pregnant women should include information about infected women before and during pregnancy in order to improve the control of vertical transmission.
- Quality of care for women living with HIV should be improved in terms of the sexual and reproductive health component; focus should not only be on increasing coverage, but should also consider access to counseling and contraceptives.

THE HIV SITUATION AMONG YOUTH

The Peruvian Experience

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The PREVEN study was an epidemiological study that took place at the national level in Peru to better understand the epidemiology of HIV and STIs, with sampling at different levels and house-by-house of people between the ages of 18 and 29. This study had 15,259 consenting participants, out of which 16,867 were invited to participate. 7,485 men and 7,774 women constituted the sample, of which more than 70% provided biological samples to be analyzed for HIV and STIs.

The information was collected house by house and employed the technology of portable hand-held computers, which allowed not only the registration and storing of epidemiological information, but also the transmission of information in a more efficient and uniform manner.

The HIV prevalence found was 0.14%, while syphilis, gonorrhea, chlamydia and trichomoniasis had prevalences of 0.26%, 0.15%, 6.5% and 2.12% respectively. The PREVEN study represents 72% of Peruvian youth between the ages of 18 and 29, using the 2005 census as a reference, which estimated that there are 26,152,265 Peruvians.

Analysis of the epidemiological data showed that men have many more sexual partners than women; 8,841 men reported 11,243 sexual partners, while 8,716 women reported 5,212 sexual partners.

A study was also conducted with 3,720 female sex workers at the national level, which found prevalences of 17.6%, 1.3%, 5.5%, 1.3%, 3.7% and 0.4% for chlamydia, gonorrhea, syphilis, primary syphilis (RPR ≥ 1:8), trichomoniasis and HIV, respectively.

The Colombian Experience

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The Colombia Project (el Proyecto Colombia) was developed within the framework of the Global Fund to Fight AIDS, Tuberculosis and Malaria. It was based on the creation of the Country Coordinating Mechanism (CCM) (Mecanismo Coordinador de País (MCP)), created in January of 2002, with members of the State, international cooperation, and civil society. The "Construction of an

inter-sectoral response to reproductive and sexual health, with an emphasis on the prevention and treatment of STIs and HIV, with youth and adolescents residing in communities receiving displaced populations in Colombia" (Proyecto "Construcción de una respuesta intersectorial en salud sexual y reproductiva, con énfasis en prevención y atención a las ITS, VIH /SIDA, con jóvenes y adolescentes residentes en comunidades receptoras de población desplazada en Colombia") project was implemented in April of 2004.

The study of sexual and reproductive health for displaced populations includes adolescent pregnancy (country average: 20.5%, displaced women: 33.6%), physical violence committed by partner (general: 39%, displaced, 44.3%), and sexual violence committed by partner (general: 6%, displaced: 8.2%), in a country with a total fertility rate of 2.4% in the general population and 4.2% among displaced women.

HIV is also caused by displacement. From 2004 to 2007 214 cases of infection among displaced populations were reported: 71 women (34%) and 143 men (66%). Displacement is a de facto cause of HIV on the part of those who live at the margin of the law.

There are conditions that increase the youth population's vulnerability to STIs/HIV in the context of displacement, including: the change of cultural surroundings, school abandonment, a lack of social roots, family pressure to provide economic resources, frequent exposure to sexual abuse and often to forced sex work. These conditions favor solitude, isolation, a lack of emotional support, insufficient access to health services, or access to services that do not consider cultural differences, marginality and poverty, and the absence of lifestyle alternatives.

The goal of this project was to reduce vulnerability to STIs, HIV and AIDS in a population of 600,000 adolescents and youth in 48 municipalities immersed in the context of forced displacement, from a comprehensive perspective of human rights, HIV, and gender equality.

The objectives were to strengthen the social response and inter-sector coordination in the Project's municipalities; to strengthen the access and quality of municipal sex education services and sexual and reproductive health services, with an emphasis on HIV; and the formation and empowerment of adolescents and youth immersed in contexts of displacement.

Thirty-four ally organizations participated in 47 municipalities and 9 localities in Bogotá, as well as 83 ally organizations working on the Global Fund Project in Colombia (GFPC). In terms of education, educational services were improved through the strengthening of educational processes for sexuality in both formal and informal educational communities. This improvement was achieved through teacher and health professional training, using the peer-based strategy and involving the community through schools for parents.

Two thousand fifty-five education workers were trained, 233 educational institutions participated in the project's development, and 209 educational institutions were included in the Sex Education Project (Proyecto de Educación para la Sexualidad) as part of the Educational Institutions Projects (EIP) (Proyectos Educativos Institucionales (PEI)).

Over five hundred eighty-nine thousand youth were trained through the peer-based strategy, of which 19,968 were youth leaders. Lessons learned included experiential and participatory learning processes promoted by the GFPC, which allowed for changes in teacher attitudes with regard to sexual and reproductive health from the perspective of individuals, partners, mothers and fathers, and finally as social agents or as citizens. Furthermore the way in which mothers and fathers live their own sexuality is transmitted to their sons and daughters. As such the GFPC includes actions about sexuality and STI and HIV prevention for families in order to facilitate the necessary family support for youth.

Another important milestone has been the development of youth-friendly services through the implementation of the sexual and reproductive health model for adolescents, with an emphasis on counseling and the offering of emergency contraception (EC) and modern contraception methods, which includes a prevention program through the distribution of information, education and counseling on issues like pregnancy, contraception, STIs/HIV, violence, abuse, addiction and family planning methods, including EC and condoms. This strategy established a relationship between peer education and friendly services, emphasizing the rights, services, times, institutions, and even people involved. Considering that some health centers did not guarantee for youth conditions of confidentiality, due to the possibility of running into a neighbor or someone else either as a worker or as a client, friendly service points were opened in sites that were not geographically related to the base action unit, in universities or in other health units.

COMMENTS AND DISCUSSION

- There are many youth interventions, but very few studies, especially concerning those under 18 years of age. This is of course related to ethical regulations in each country. Access to this information should be improved because it is vital to understanding what is going on with youth and adolescents and designing more adequate interventions.

III.

METHODOLOGICAL ADVANCES AND CHALLENGES

MONITORING ANTIRETROVIRAL RESISTANCE AND EARLY WARNING INDICATORS

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The intention of this presentation is to describe the PAHO/WHO strategy regarding measuring the risk and occurrence of HIV antiretroviral drug resistance to (HIVDR), considering that the emergence of resistance to these treatments is inevitable given the high HIV mutation rate and need for lifelong treatment. WHO recommends that countries develop a public health strategy to minimize the emergence and transmission of HIVDR.

The goals of the PAHO/WHO HIVDR strategy are to support the ART program practices and national planning, minimize the preventable emergence of resistance to antiretrovirals for HIV infection, restrict the degree to which resistance reduces the effectiveness of a few limited standardized regimens, and complete this work in the context of the national HIV prevention and treatment plans.

There are some fundamental questions, such as if the national program is creating HIV drug resistance beyond an acceptable level. We should measure the early warning indicators in treatment centers and watch the occurrence of resistance and develop monitoring surveys in surveillance sites. Another parameter to be measured is the transmission of HIV resistant strains by measuring the occurrence of HIVDR in recently affected people using HIVDR threshold surveys).

The elements of the national strategy for the prevention and evaluation of HIVDR recommended by WHO for countries that are expanding their antiretroviral therapy (ART) program, include the formation of a national Work Group in charge of the strategy for HIVDR, based on a 3-5 year plan with an allocated budget. Another important element is the periodic evaluation of the "early warning indicators" (EWI) for all of the ART sites (or representative sites). One should also keep in mind the implementation of studies to monitor the prevention of HIVDR and associated factors in ART sentinel sites, along with threshold HIVDR transmission studies in geographic areas where ART has been used in an extensive way for 3 or more years. Furthermore, a HIVDR database should be created; a WHO-accredited HIVDR genotyping laboratory should be opened in the country or the region, along with the assessment and support of HIVDR prevention activities and the elaboration of an annual report on HIVDR and recommendations that include the usage of data for ART and prevention planning.

HIVDR Early Warning Indicators (EWI) are indicators that already exist and are related to the management of the program itself. The WHO recommends the collection of available EWI at all ART sites or a collection from representative sites implementing the national treatment program.

The EWI for HIVDR recommended by the WHO cover the following areas: (i) Prescription practices, or knowing what percentage of patients that are beginning ART and who have been

prescribed a first-line regimen with data collection done for a predetermined amount of time; the suggested target is 100%, (ii) Percentage of patients lost to follow-up during the first 12 months of ART; the suggested target is < 20%, (iii) Retention of first-line ART patients, reporting the percentage of patients who are initiating ART during a determined period of time and who are in an appropriate first-line ART regimen 12 months later; the suggested target is > 70%, (iv) ARV drugs picked up on time, or what is the percentage of ART patients that pick up their prescribed drugs on time (before the previous dosage is finished); the suggested target is > 90%, (v) Fulfillment of appointments to receive ART, measured in terms of the percentage of ART patients that keep all of their clinical appointments on time (during the 7 days of scheduled appointments); the suggested target is > 80%, and (vi) Continued supply of drugs, reporting the percentage of months during a year in which the antiretroviral drugs have not run out; the suggested target is 100%. When these targets are not reached at a site, it is considered to be an early warning indicator for emergence of HIVDR at that site or if it occurs at many sites it is an EWI in general for the National ART Program.

In order to select ART sites to monitor HIVDR EWI, countries should evaluate which EWI can be obtained from the existing sources, both medical and pharmacy records. Available record systems should be evaluated to identify which data could be extracted and which information fields should be used from each system. If electronic record systems are being used in these sites, electronic systems should be programmed in the appropriate way, and if paper systems are being used, or it is not possible to download the data from an electronic system, the data collectors should be trained to extract the necessary information from paper systems in a standard way.

The maintenance of recommended levels for the indicators helps to strengthen health services. As part of the WHO strategy regarding HIVDR, the EWI for HIVDR are monitored in all the ART sites throughout the country, or in representative ART sites. The studies to monitor HIVDR prevention in the surveillance centers complement the monitoring of the EWI with laboratory results and with information about patients and sites in an individual format to support a more detailed analysis later on.

In addition to EWI's that are collected at all or many ART sites, WHO/PAHO recommends that countries perform HIVDR Monitoring using cohort studies. These are recommended to be done at a few representative ART sites. These studies follow a cohort commencing with about 130 persons initiating ART with a 1 year cohort follow up minimum of 96 in order to assess viral suppression rates and direct measures of HIVDR mutation occurrence in patients not suppressed. Other variables measured include baseline genotyping, and individual and ART site factors that could affect treatment failure and emergence of resistance. Studies regarding the monitoring of HIVDR prevention must include within their criteria confirmed diagnosis of HIV-1 infection, eligibility for ART according to national or site regulations, initiation of an adult ART regimen on-site on or after the initiation of the study regardless of age or antiretroviral history, and informed consent according to national protocol. Individuals that are participating in a clinical trial, individuals that are part of an observation cohort, individuals that are re-initiating ART, individuals that are being moved from another ART site and starting a first line regimen with 3 or 4 drugs, and individuals infected with HIV-2 or co-infected with HIV-1 and HIV-2 should be excluded.

Studies monitoring HIVDR prevention and associated factors in pediatric ART surveillance sites should have the same focus as studies for adults, but with additional considerations, such as the history with respect to antiretrovirals that includes the mother's experience during pregnancy and breast-feeding; and prescription practices that include appropriate dosages according to weight; and the evaluation of sites, including the availability of appropriate pediatric formulas. Specific WHO protocols for pediatric populations are available.

Some key results of these studies include the evaluation of the percentage of the cohort that achieved "HIVDR prevention" after 12 months of ART (> 70%). Additionally, among those isolates with

detectable virus, the HIVDR mutations and their patterns should be described, and the association between the occurrence of HIVDR and the mutation patterns, as well as the characteristics of the patient and factors relative to the site, should be evaluated.

The third measure tool for HIVDR risk and occurrence is meant to answer the question – is HIVDR being transmitted in our country. Surveillance of transmitted resistance to anti-HIV drugs should help to evaluate if the standard ART regimens in the country continue to be effective. The pre- and post-exposure prophylactic strategies should also be evaluated, including the regimens for the prevention of mother-to-child transmission (PMTCT); information should be given to investigators that are developing prevention strategies based on vaccines and microbicides; clinical trials based on anti-HIV drug resistance should be evaluated for their utility before commencing treatment.

Studies to evaluate the transmission of HIVDR should be conducted in geographic areas of the country where the emergence of resistance is most likely and expanded to other areas when it becomes necessary.

The Method for the Threshold Study of Resistance to anti-HIV Drugs (TS-RPHIV) uses the prevalence classification of resistance to anti-HIV drugs transmitted in a specific geographic area in 1 of 3 categories: low prevalence (≤ 5%), high prevalence (≥ 15%), and moderate prevalence (5% - 15%).

The WHO databases for HIVDR at the national level should include surveillance of HIVDR transmission and monitoring in antiretroviral programs. The genotyping laboratories should be selected by the Ministry of Health and should be accredited by the WHO Global Laboratory Network so that results correspond to the surveillance and monitoring of HIVDR. The WHO network can provide technical assistance and training to support the development of laboratories within the country in order to receive accreditation.

In conclusion, Latin America should put serious effort into the collection, analysis and monitoring of the early warning indicators of HIVDR. The countries can also contribute specific elements from their national databases to the sub-regional and global WHO HIVResNet database.

As part of the Latin American laboratory network strategy, reference laboratories for HIVDR can solicit a self-evaluation checklist, and people designated by the national authorities may solicit WHO accreditation. One or more laboratories can be designated as regional laboratories if adequate criteria are fulfilled. In terms of technical assistance, PAHO/WHO will support countries in the implementation of a HIVDR strategy through the distribution of technical guidelines, protocols and checklists to evaluate national laboratory capacity, as well as the provision of technical guidelines for the monitoring and publication of early warning indicators for HIVDR. Additional technical assistance can take the form of country missions to assist with specific protocol development, lab capacity building, survey site assessments and annual report development.

TOWARD THE HARMONIZATION OF A CASE DEFINITION IN SURVEILLANCE AND MONITORING

Jesús María García-Calleja, World Health Organization

Among the existing HIV case definitions, we have the following: AIDS clinical case definition of 1985 made in Bangui, later modified to include information on HIV testing (WHO and CDC definition, 1986, which was modified again in 1988). In 1994, there was an additional modification that included information about antibodies against HIV and opportunistic infections like TB, recurring pneumonia and invasive cervical carcinoma.

Other definitions include: the European definition of 1993, modified for children in 1995; the PAHO case definition published in Caracas in 1989; the Brazilian definition of 1987, revised in 2004; and finally, the Australian case definition.

As we have been able to observe, there is no common HIV case definition used by countries but there has been a consensus around the definition of AIDS. Historically, AIDS surveillance has been considered important because it grossly measures the effects of the HIV epidemic, and also includes nationally representative data tied to basic information about sex and age.

The need to periodically revise the advanced HIV case definition is based on the massive increase in antiretroviral therapy coverage, as well as the existence of limited reports of these two conditions in some countries, especially in Africa and Asia. Another important reason is to reach consensus, given the existence of multiple case definitions and the fact that countries need a simplified definition of both cases and infection stages. Additionally, as it is currently defined, the AIDS definition does not give complete information about the burden of the disease. Currently there is a need to change the advanced HIV case definition; this would basically help to monitor the morbidity and mortality associated with HIV more effectively, and it would simplify the estimates of the burden associated with HIV. Furthermore, an improved case definition would imply a greater consistency in current diagnostic practices (including recommendations for treatment).

The processes for a new clinical definition and a new definition for surveillance have included a meeting in Geneva in 2004 and regional meetings in 2005, with the goal of a global meeting to incorporate recommendations in 2006. The recommendations for the surveillance of the course of HIV infection include: first HIV diagnosis, symptomatic needs for ART/prophylaxis, AIDS diagnosis, and death.

The advantage of having surveillance definitions is that these can be used in patient follow-up care; implementation cost is reasonable, and they can help in the estimation of numbers of people needing ART in health care centers. They also allow for better follow-up for HIV patients and increased prevention for partners of people living with HIV.A pilot definition for advanced HIV cases should be created in some countries in different regions, then a comparative analysis of records should be conducted, and the new definition should be adapted to the management of infected patients.

With a view to facilitating the scaling up of access to antiretroviral therapy, and in line with a public health approach, WHO in consultation with partners, countries and regional offices has made some changes to the HIV case definition for surveillance, and to the clinical and immunological classifications of HIV-related disease. HIV case definitions are harmonized with the clinical staging and immunological classifications to facilitate improved HIV-related surveillance, to better track the incidence, prevalence and treatment burden of HIV infection, and to plan appropriate public health responses. The revised clinical staging and immunological classification of HIV, available at http://www.who.int/hiv/pub/vct/hivstaging/en/index.html, are designed to assist in clinically managing HIV, especially where there is limited laboratory capacity.

COMMENTS AND DISCUSSION

- Patients should be notified not only of HIV infection, but also of other associated infections.
- An opportune and adequate triangulation of information should be conducted in order to determine the exact level of the epidemic.

EVALUATION OF THE IMPACT OF ANTIRETROVIRAL TREATMENT: A CHILEAN COHORT STUDY

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The experience of the Chilean AIDS Cohort (Cohorte Chilena de SIDA) in the monitoring of the impact of ART serves as an important example in Latin America. The organization of access to ART in Chile included 33 tertiary-level centers with continuous professional training, national ART guides based on national and foreign evidence, centralized acquisition and administration of antiretrovirals, the evaluation of requests for ART initiation and review by a Scientific Advisory Committee, the production of CD4 studies, the viral load and genotyping in reference laboratories, the guarantee of access provided by Law 19.666 of Explicit Guarantees (public and private sectors) (Ley 19.966 de Garantías Explícitas (sectores público y privado)) starting in 2005, and the incorporation of generic drugs starting in 2006.

The Chilean Cohort is multi-centric in character and includes 33 centers, out of which 29 have participated in more than 95% of the follow-up of active therapy. The data generated in these centers is sent electronically to a central executive unit, where the verifying unit analyzes the data, asks for clarifications and randomly monitors the data. The centers also have periodic meetings to revise criteria and plan studies. The Chilean Cohort represents the largest number of patients in a cohort in a non-developed country. The Global Fund has financed all organization and follow-up work.

The incorporation of patients into the cohort has been progressive and has increased in the last few years. The cohort currently has more than 7,000 people receiving therapy. This has changed the mortality tendencies, which have been decreasing, but they should be decreasing even more, given that infected people keep arriving at centers for treatment at advanced stages of the disease, and despite the therapy the mortality of this group is still high.

In general, the impact of ART can be viewed historically in the increase in CD4 counts and in the decrease of viral load, but the central issue is not necessarily laboratory data, but rather how are we affecting or improving the survival of people infected with HIV. More than 50% of the patients in the cohort continue to receive initial therapy, and 21% have changed due to its toxicity, without constituting a therapeutic failure. 21% of the patients have therapeutic failure, out of which almost half have passed away and the rest give up, fail, and later enter rescue therapy.

The Chilean initiative is a good experience to replicate. It is not difficult to implement, the costs are not very high, but it does require a lot of work at the interdisciplinary level with constant monitoring. The centralization of analysis has allowed for more rigorous capture of information, which provides a high administrative value.

- Adherence surveillance should be improved. At this point, this surveillance has been based on self-reports generated by users, but there is a need for innovative mechanisms that would evaluate whether the patients are receiving medication.
- Within adherence surveillance, not only adherence to medication should be considered, but also compliance with check-ups and periodic tests.
- Surveillance of resistance should also be included, using modern laboratory techniques like genotyping, especially with patients whose therapy has failed.

INNOVATIVE EXPERIENCES IN THE SURVEILLANCE OF MEN WHO HAVE SEX WITH MEN IN PERU AND ECUADOR

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UNAIDS estimates that there are over 1.7 million people living with HIV/AIDS (PLHA) in Latin America, of which 240,000 have new infections and around 95,000 deaths have been caused by AIDS. The infection is concentrated in high-risk groups, predominantly MSM (8-24%), which represent 42% of all accumulated AIDS cases. Peru also has a concentrated epidemic: HIV prevalence in the general population is about 0.4% in men and 0.1% in women, while in high-risk groups prevalence reaches 14.5%, 1% and 1% in MSM, female sex workers, and incarcerated populations, respectively. HIV incidence is also variable and depends on the study and the population under study. Studies conducted in cities like Lima report incidences from 3.5% (1988-2000) to 6.2% (2002-2004).

At this point, around 8,000 MSM have been screened in sentinel surveillance sites, and a multivariate analysis shows that HIV prevalence is growing 6% each year, despite the fact that there is an increase in condom use with the last steady or casual sexual partner.

Since 1996, Peru had applied "second-generation HIV surveillance," which, in addition to obtaining traditional indicators (e.g, AIDS cases, HIV prevalence, AIDS mortality, etc.) added behavioral factors in the study of populations most exposed to HIV, since these elements are the engine that fuels the epidemic. This methodology was useful until 2004, when the Ministry of Health launched the program of highly active antiretroviral therapy (HAART) with the support of the Global Fund, which in August 2007 was covering more than 11,000 people. Today, because the life expectancy of HIV positive people is increasing in several years due to antiretroviral treatment, the prevalence is no longer useful to assess the spread of HIV. In this context, the incidence, or number of new cases that occur in a susceptible population, is the only thing that can really tell us how the epidemic is moving. In order to assess incidence, follow-up studies of groups of people not infected but at risk of becoming infected with HIV need to be done, to see how many of these become infected in a given period of time. The disadvantage of these studies is that they are very expensive and results are available only after the follow-up.

The need for more precise data on the epidemiology of HIV in MSM stimulated the implementation of a third-generation surveillance study. The primary objective was to identify recently infected HIV cases and estimate HIV incidence through a desensitized ELISA test in 5 cities in the Andean region. Another objective was to estimate the prevalence and patterns of resistance to antiretroviral drugs among recently infected MSM, as well as to describe the genetic variability of the HIV-1 virus that circulates in Lima, Arequipa, Sullana and Ica in Peru, and in Guayaquil in Ecuador.

The study was conducted between March and July of 2006 and used a convenience sample. A total of 2,608 MSM at high risk for HIV acquisition were recruited. The inclusion criteria were: to be born male, to be 18 years of age or older, to have had anal sex in the last 6 months, and to have

at least one of the following risk factors: Exchange of sex for money, food, drugs or shelter; to be a partner of an HIV-positive person and report inconsistent condom use with that partner; to have had an STI diagnosis at the time of the screening or within the previous 6 months, and/or to have had unprotected anal sex in the last 6 months. The only exclusion criterion was to have an HIV-positive test. In the same year, the General Epidemiology Division of the Ministry of Health used the same methodology and inclusion criteria to widen the surveillance to another 5 Peruvian cities (Iquitos, Tarapoto, Huancayo, Chiclayo and Trujillo).

The collection of information included a physical exam, an STI diagnosis, a blood sample, a behavioral questionnaire (self-administered through a computer connected to the internet), HIV counseling, HIV rapid test, RPR for syphilis and an evaluation of acceptability to participate in HIV prevention studies (vaccines, pre-exposure prophylaxis and circumcision).

Here are some of the preliminary results of this study:

- The age of initiation of sexual activity is generally 15 years old, with a small variation across cities. The median age of onset of sexual intercourse was 15 years old. Iquitos and Tarapoto were the cities with the lowest median age for sex debut, and Huancayo was the city where that median age was highest.

- The sexual identity of the participants was mostly gay and bisexual, with 5% of them self-defining as heterosexual. Likewise, 12% self-defined as transvestites in Ica, Trujillo and Chiclayo, while this proportion was much lower (4%) in Huancayo and Tarapoto.

- When asked about their role in anal sex over the past 5 years, approximately one third said that their role was exclusively insertive and another third had been entirely receptive; the rest of the interviewees mentioned not having been exclusively active or passive during the last 5 years. Huancayo and Tarapoto are the cities with the lowest proportion of exclusively insertive men. Generally, towns in the mountains have a higher proportion of insertives, while in towns in the forest the proportion of insertives is much lower.

- Consistent condom use was defined as having used condoms in all sexual acts that the person had with their last sexual partner. Thus, the consistent use of a condom with the last sexual partner was only 47.2%, much lower than previously reported in other surveillance studies. Condom use was lower in those cities where insertive sex was predominant (Arequipa, Huancayo) and highest where sex was more frequently receptive (Iquitos, Tarapoto)

- Regarding their history of STIs, genital and/or anal ulcers in the last 3 months, 21.9% of respondents reported having had an STD in the past 3 months and 7.1% claimed to have had an ulcer in the genital or anal area in the same time period. Cities with high proportions of STI or ulcers were Trujillo (35.9% and 7.0%), Lima (37.8% and 12.3%) on the coast, and Tarapoto (31.8% and 10.9%) and Iquitos (29.5% and 15.3%) in the jungle.

- Regarding the rate of HIV-1, Lima (10.7%) remains the city most affected by this infection, followed by the cities of Iquitos (9.8%), Sullana (9.4%), and Tarapoto (6.7%). The cities with lower rates were Huancayo (2.2%) and Trujillo (2.3%). It should be mentioned that these rates described can not be used as prevalence data, due to the methodology of the study, i.e. all individuals who know their HIV positive status were excluded from the study.

The preliminary studies of the molecular HIV epidemiology were conducted in Lima, Sullana, Ica, Arequipa and Guayaquil. The GAG region was amplified from a total of 257 samples for HIV genotyping; 11 samples could not be amplified. 252 were sub-type B, 2 were sub-type A and one

was sub-type F; the analysis of 18 samples is still pending. All Peruvian specimens were sub-type B, while the three that were not sub-type B were found in Guayaquil, Ecuador.

All these results are preliminary and there are still some tasks pending, including the analysis of information from the cities of Chiclayo, Trujillo, Huancayo, Tarapoto and Iquitos, as well as the conclusion of the analysis of antiretroviral drug resistance, the calculation of HIV-1 incidence in the other 5 cities, and analysis of sexual networks in seroconversion, among others.

The study limitations included the type of study, the convenience sampling, the exclusion of HIV-positive people and the limitations of the test in detecting the recently infected.

COMMENTS AND DISCUSSION

• Due to the changing dynamics of the HIV epidemic, the methodology to be used for measuring the state of the epidemic must adapt to change. As access to treatment in Peru is almost universal, the prevalence of HIV is not an accurate measure of what is happening in relation to the HIV epidemic. The incidence of new infections among those at risk is a better way to track the epidemic. This approach can be taken using indirect methods of estimating impact, since cohort studies to determine the incidence are difficult to implement and can be expensive.

"KNOW YOUR EPIDEMIC" - THE SITUATION AND PERSPECTIVES OF STRATEGIC INFORMATION ABOUT HIV IN THE REGION

Final Reflections From PAHO

Mónica Alonso, Regional Advisor for Strategic Information about HIV, PAHO

In the year 2007 there were almost 500 new cases of HIV infection per day, and almost 250 deaths per day, according to a UNAIDS surveillance summary of HIV and STIs in the region. It is important to make use of the surveillance data of HIV/STIs to conduct an adequate situational analysis and to discover the trends of the infection. Surveillance also helps improve advocacy and the mobilization of resources, focus interventions, and plan and evaluate programs.

Thus it is important to know our epidemic, or to know and utilize the available information to direct actions and interventions toward where the epidemic is found. In addition, knowing the epidemic means also understanding phenomena that occur in relation to HIV transmission in each country.

As we know, a lot of data about HIV is generated, but it is important to know how to use it, to know which data we need and not end up drowning in information. Too much information that bears little use is often collected, from which nothing important can be inferred. To know the epidemic, it is necessary to use data and prioritize and select information. In order to obtain this information on time, it must be of adequate quality and part of a sustainable process (forming part of a real information system). Here lies an important challenge, to utilize strategic information to make decisions and associate it with a strategic plan. From a political point of view, it is important to have evidence that supports decisions at this level, because this has to do with accountability and the mobilization of resources. Thus data analysis should be strengthened and combined with ethnographic information, mapping, and qualitative studies. Surveillance is a fundamental component of policy impact evaluation and it also represents a window of opportunity to study the political, economic and social context.

As such, we should work to cover the information gaps and prioritize quality, paying attention to vulnerable groups and understanding that the data can serve multiple purposes at the national level. An increased and improved use of information should also be ensured. The role of civil society is important; alliances and information sharing with civil society should occur not only to produce information, but also to ensure its use.

Final Reflections From Most At Risk Populations

Ronald Álvarez, Movimiento Homosexual de Lima (MHOL), Peru

It is understood that the challenges in building a social response to the impact of HIV and AIDS are very large, and that within civil society, vulnerable communities assume these challenges as their responsibility. However, this responsibility does not only belong to the organizations and communities within the vulnerable populations, but also engages the strong will and participation of the State, regional and municipal governments, civil society institutions that specialize in the issue, and the transgender, gay, bisexual, sex worker communities, as well as those living with HIV, so that everyone can improve and multiply the best experiences that really work.

The first actions in response to the epidemic occurred in the second half of the 1980s. MHOL promoted prevention campaigns in social spaces in the community of Lima and other close regions, which were accompanied by informative workshops and safe sex. Later on the first sustained prevention strategies were implemented: peer promotion and the informative hotline Sidayuda. In addition, MHOL supported the Program of Support for the Self-help of People Living with HIV and AIDS (Programa de Soporte a la Autoayuda de Personas Viviendo con VIH y SIDA (PROSA)) during its first period of existence.

Along the same lines, another pioneer experience was the Asociación Germinal (1989), which consisted of a collection of actions directed toward the prevention of HIV in adolescents who frequented social spaces and/or sex work for the transgender, gay and bisexual (TGB) population of Lima.

Furthermore, the Asociación Vía Libre (1990) emerged as a professional health initiative oriented toward the development of preventive interventions in TGB populations through the accompaniment and care for people living with HIV.

Later on toward the end of the 1990s, the responses from vulnerable communities were intermittent and isolated. The role of the Ministry of Health is highlighted here, through the implementation of the PROCETTS Peer Educational Promoters System (Sistema de Promotores Educadores de Pares del PROCETTS) (1997), which generated spaces for identification and recognition, which resulted in the formation of TGB organizations, especially in the country's interior.

Towards the end of the 1990s, there was an important process of re-activation and strengthening of civil society. In the context of struggle for a return to democracy, different community and political expressions emerged among TGB, SW and PLWH. TGB organizations were articulated at the national level, and since 2002 sex worker organizations have been formed. Objectives rapidly grew and became more complex, while new forms of relationship with other social actors emerged. In addition, PLWH networks integrated, initiating strong processes of political lobbying, and finally achieving universal free antiretroviral treatment.

The execution of Global Fund programs in Peru initiated a new era in the response to HIV: a multisectoral approach. In Peru, the National Institute of Health (Instituto Nacional de Salud) presented a proposal in the first round of GF Bidding, but the project was not financed. In the second round the Peruvian proposal was formulated by the National Multisectoral Health Commission (CONAMUSA), which grouped the State, civil society, PLWH, etc. From this moment, multisectoral compromises and dialogue became a constant component of the efficient execution of programs responding to the epidemic.

Since 2004, UNAIDS has encouraged countries to adhere to the "Three Ones" in order to effectively respond to the epidemic: an agreed HIV Action Framework that provides the basis for coordinating the work of all partners (the Multisectoral Strategic Plan (MSP) for STIs, HIV and AIDS, Peru 2007-20011); a National AIDS Coordinating Authority, with a broad-based multisectoral mandate (CONAMUSA); and an agreed country-level Monitoring and Evaluation System (the epidemiological surveillance system of the General Division of Epidemiology, Ministry of Health). Our MSP has been designed along the proposed lines. Peru is the first country to successfully implement the Three Ones in the region.

Throughout this long process, transgendered people, gays, bisexuals, female sex workers, people living with HIV and other sectors of civil society have always had a present force. At first this force was very concentrated in Lima and in the TGB communities, or only in aspects of support and mutual help, or very much determined by the Ministry of Health's epidemiological demands. Nevertheless, these experiences have allowed for the creation of important spaces for articulation and regional and national convergence, with the common goal of confronting the challenges of the epidemic.

Estimates of health coverage that the Ministry of Health provides for the populations most exposed to the epidemic are probably inaccurate; upon accepting that coverage reaches no more than 10% of the most exposed populations, a commitment should be made to reach 50%. Nonetheless, the Ministry of Health and all of the actors committed to the fight against HIV clearly understand that coverage urgently needs to be increased (MSP).

Final Reflections From People Living With HIV

Pablo Anamaría, Observatorio Latino, Aid for AIDS, Peru

In order to incrementally increase the effectiveness of the national response to the epidemic in the context of global financing, there are two acceptable points of departure: the effective strengthening of strategic information systems, and the knowing whether information is being used appropriately to form policies and programs.

In the context of Global Fund financing, Latin America has maintained a stable profile in the latest rounds (5% of global financing) with a slight increment in the number of approved proposals between Rounds 6 and 7 (6 in Round 6 and 10 in Round 7), but this has not been sufficient and thus requires all emerging opportunities to be taken advantage of. As such, there should be a way to solve the lack or inconsistency of strategic information that influences access to funding.

The problem in preparing proposals is that strategic information is not being used, while the information that is used has not undergone quality control, which allows for the inclusion of less pertinent data, while the information presented responds to political interests, and not necessarily to reality.

On the other hand, some indicators are still not consistent with the data and the evidence, and there is an overestimation of coverage or of the size of the population to be reached, which means that there are no data collection systems that overcome bottlenecks in an opportune manner.

Thus, in order to improve the possibility of obtaining GF financing, we must focus on four points: (i) construct alliances with the community sector, (ii) create, construct or develop community capacity, (iii) know the epidemic, not make it invisible, and (iv) Construct management systems of knowledge or innovation that allow the information to be used to form policy.

IV.
CONCLUSIONS, NEXT STEPS AND FINAL AGREEMENTS

GROUP WORK CONCLUSIONS

Group I, National Programs and Civil Society: definitions of SW, MSM and IDU for future studies

- Sex worker (SW): male, female, transgender SW. People older than 18 who exchange sexual services for money. Minors under 18 years of age are excluded because they are victims of sexual exploitation.
- MSM: MSM is an epidemiological category and it does not always respond to reality. Different groups appear in different studies: (i) gay and homosexual: men who only have sexual relations with other men, (ii) men with bisexual behavior: men who are gay or heterosexual and who have sexual relationships with men and women, (iii) transgender and transvestite people: people who are biologically male and adopt a female gender identity with diverse sexual practices.
- IDU: we have intravenous and non-intravenous drug users. The term CHRD (consumer of high-risk drugs) should be used for studies.
- Risky behaviors: the lack of condom use in sexual relations, the use of medical instruments and contaminated needles.

Group II, Epidemiology: the definition of basic methodologies to estimate seroprevalence in MARPs

- Methodology to find the seroprevalence in MARPs: work in a collective manner covering all populations and have a general vision. The most frequently used methodologies are respondent-driven sampling (RDS), snowball sampling and time-location sampling (TLS) with the utilization of services. The application of one or another methodology will depend on the country and the available financial resources. The comparisons between RDS and TLS should be analyzed, and work should begin based on the comparison of results and methods; the level of experience of each country should be analyzed for each methodology to see which is the most recommended, and biological surveys should be complemented by questionnaires and behavioral tests. People above the age of 15 should be incorporated.
- Methodology to define population sizes for MARPs: to calculate the numerator and denominator, one should use a combination of: national census data, capture and recapture studies, the multiplier method, the friend method, etc.. Population size calculation guides are currently being elaborated. More advanced countries can support countries that are still in periods of development or implementation of these strategies.
- Spectrum use for population estimates: it results in much help in concentrated epidemics to define the response model to be used. The final idea should result in a multi-centric study that depends on the data bases to adjust the curve.

Group III: Guidelines for a Regional Work Plan to Improve Strategic Information

GROUP A (Venezuela, Colombia, Ecuador, Peru, Chile, Bolivia) & GROUP B (Argentina, Uruguay, Paraguay, Brazil)

Activity to be implemented according to workshop agreements	How	When	Who	Resources and technical support necessary for the implementation's success
I. Formation of a MERCOSUR entity responsible for strategic information	• Form a MERCOSUR entity with government actors, civil society, and academia that articulates policies, defines strategies, proposes studies, identifies needs and fundamentally, defines proposals for HIV/AIDS and STI issues • Utilize existing MERCOSUR mechanisms for this • Define the actors involved	Next meeting in mid-May in Buenos Aires		Technical cooperation and financial support from international cooperation agencies
II. Case Definition	• Conduct an analysis in each country and assume the pertinence and facility of use for each case definition proposed by PAHO	One year	Each country	PAHO
III. Multi-centric Studies	• Definitions of vulnerable populations • Large-scale proposals for multi-centric studies • Conduct multi-centric studies in most exposed populations • Political decision for the 8th round of proposals for the Global Fund for the Andean area • Proposal to conduct studies of vulnerable populations should also include antiretroviral resistance studies	By June 2008	Regional Technical Committee	
IV. Early Warning Indicators	• Incorporate early warning indicators into the Sub-regional Plan. • Monitoring Plan – estimates and projections should be included in the proposal for the Global Fund	One Year	Regional Technical Committee	
V. National Consensus Meetings	• Agree on the "official" definition of "most exposed sub-populations"	6 Months (2008)	Each country	

FINAL AGREEMENTS

1 ESTIMATES

- Countries need to receive more technical assistance to make estimates. This includes how to make estimates, statistical orientation, study implementation (so that each country conducts two or three studies in two or three years), methodological soundness, improved study of epidemic patterns, especially those that are similar for various countries or for the whole region, so that the information is methodologically comparable with that of other countries, and to have harmonized indicators that can compare the status of the epidemic with the rest of the regions.
- Technical support is required for the elaboration of comparative evaluation instruments for the populations in the study in order to carry out studies like censuses that provide quality data and information about behavioral characteristics of these populations.
- These studies should include HIV and STI prevalence and behavior.
- It is important to incorporate a younger population (younger than 18 years, starting from 15 years or younger, according to the average age of sexual initiation). To do this it is necessary to have advocacy in each country to modify the juridical frameworks that limit access to adolescents for HIV screening, condoms, and other reproductive health services.
- RDS, TLS, snowball sampling and data from health centers themselves constitute the possible forms and methods to reveal information about the prevalence in the most exposed populations. There are countries like Brazil that have had the possibility to implement studies using TLS and RDS. Consequently it was proposed that both methods be compared so that these results can be useful for the region.
- Each country should identify its research needs and available resources.
- Technical cooperation must contribute to the facilitation of contact between countries to exchange/gain experience and promote multi-centric studies for the year 2010.
- There are methodologies to define the sizes of the most exposed populations, such as censuses, capture-recapture, the multiplier method, the friend method, among others; RDS and TLS could also be included. TLS has generated satisfactory results in studies with MSM.
- The values that Spectrum utilizes must be changed so that the estimates better reflect the reality and the projection of the epidemic in Latin America. The examples of the discrepancies in HIV mortality estimates found between in-country data in the region and figures generated through Spectrum, as well as the data referring to children living with HIV, or the differences between national behaviors and subnational behaviors of the epidemic were mentioned. WHO has offered to transmit the region's concern to the team that works on the Spectrum estimation method.

2 CASE DEFINITION

- The standardization of a single advanced HIV case definition for the region requires prior agreements and consensus at the country level. This consensus requires:

- For the short term:
- An agreement among epidemiological and clinical perspectives
- Strengthening diagnostic capacity in the country
- Reinforcing the capacity of health professionals
- Conducting diagnosis of the situation with respect to notification, surveillance of the epidemic, and the status of health services in the countries
- Improving the countries' information systems
- Developing pharmacological resistance studies

- For the long term:
- Standardizing the definition used by countries at the regional level

3 OTHER

- The involvement of organizations of vulnerable groups in studies of the most exposed populations should incorporate the perspective of human rights and help generate usage of health services on the part of the target population, which could impact the rejection rate in recruitment as well as increase screening coverage.

- Sex workers' clients should be included in studies about sex workers.

- Male sex workers are different from female SW and from transgender SW. Studies should include and differentiate these sub-populations.

- PAHO and WHO have offered to assist countries who are integrating their updated guides on estimates of the most exposed populations, generating virtual spaces for the distribution and exchange of knowledge.

- Multi-centric studies should be conducted in countries with the support of cooperation agencies.

- Technical assistance is required for:

    - The elaboration of instruments in order to make studies comparable.

    - The dissemination of completed studies.

    - Strengthening South-South cooperation in order to improve clinical management, epidemic surveillance and information systems.

APPENDIX

APPENDIX 1

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APPENDIX 2

Meeting Program

DAY 1: 15 APRIL 2008

Time	*Theme and Presenters/Panelists*
8:30 • 09:00 am	Participant Registration UNAIDS Andean Sub-Region
9:00 • 09:30	Opening: Words of Welcome and Meeting Objectives Dr. Hernán Garrido Lecca Minister of Health, Peru (Ministro de Salud del Perú) Sr. Jorge Chediek Resident Coordinator of United Nations System in Peru Dr. Oscar Feo Executive Secretary ORAS-CONHU
9:30 • 10:00	Program Presentation and Explanation of Methodology Dr. Lourdes Kusunoki Facilitator
10:00 • 10:30	Introduction and Expectations of Participants Dr. Lourdes Kusunoki Facilitator
10:30 • 11:00	Coffee Break
11:00 • 11:45	A Look at Systems of Surveillance, Production and Analysis of Strategic Information Dr. Robert Lyerla Director of Epidemiology and Impact Analysis, UNAIDS Dr. Gabriela De la Iglesia / Patricia Bracamonte UNAIDS

11:45 • 1:00 pm Panel 1: Size Estimates of the Most Exposed Populations

The Colombian Experience
Dr. Luis Angel Moreno
Ministry of Social Protection (Ministerio de Protección Social)

The Uruguayan Experience
Dr. Rubén Berriolo
Ministry of Health (Ministerio de Salud)

Moderator: PAHO

1:00 • 2:30 Lunch

2:30 • 4:00 Panel 2: The HIV Situation among Men who have Sex with Men and Vulnerable Sub-Populations (Transgender Populations): Advances, trends, and necessities for strengthening the production of strategic information

Bolivia
Dr. Ronny Rossel
Ministry of Health and Sports (Ministerio de Salud y Deportes)

Uruguay
Dr. Rubén Berriolo
Ministry of Health (Ministerio de Salud)

Moderator: ORAS-CONHU

4:00 • 4:15 Coffee Break

4:15 • 5:45 Panel 3: The HIV Situation among Sex Worker Populations: Advances, trends and necessities for strengthening the production of strategic information

The Argentinean Experience
Elena Reynaga
Red Latinoamericana de Trabajadoras Sexuales

The Colombian Experience
Dr. Luis Angel Moreno
Ministry of Social Protection (Ministerio de Protección Social)

Moderator: UNAIDS

DAY 2: 16 APRIL 2008

8:30 • 9:00 am Summary of Day 1
Voluntary Country

9:00 • 10:10	Panel 4: The HIV Situation among Incarcerated Populations: Advances, trends and necessities for strengthening the production of strategic information The Peruvian Experience Dr. Mónica Pun Ministry of Health (Ministerio de Salud) The Venezuelan Experience Dr. Daysi Matos Ministry of Health (Ministerio de Salud) **Moderator:** PAHO
10:10 • 10:30	Coffee Break
10:30 • 11:40	Panel 5: The HIV Situation among Drug Using Populations: Advances, trends and necessities for strengthening the production of strategic information The Argentinean Experience Diana Rossi Intercambios Asociación Civil The Peruvian Experience Dr. Carlos Cáceres / Ximena Salazar Universidad Peruana Cayetano Heredia **Moderator:** ONUSIDA
11:40 • 1:00 pm	Group Work
1:00 • 2:00	Lunch
2:00 • 3:00	Group Work Plenary Session
3:00 • 4:00	Keynote Address: Monitoring Antiretroviral Resistance and Early Warning Indicators Dr. Donald Sutherland OPS International Public Health Division/ Division des affairs International Public Health. Agency of Canada/ Agence de Santé Publique du Canada
4:00 • 4:15	Coffee Break
4:15 • 5:45	Panel 7: The HIV Situation among Youth: Advances, trends and necessities for strengthening the production of strategic information The Peruvian Experience Dr. César Cárcamo PREVEN, Universidad Peruana Cayetano Heredia

The Colombian Experience
Dr. Luis Angel Moreno
Ministry of Social Protection (Ministerio de Protección Social)

Moderator: UNAIDS

DAY 3: 17 APRIL 2008

8:00 • 9:30 am Toward the Harmonization of a "Case definition" in Surveillance and Monitoring
Dr. Jesús María Calleja
WHO

Moderator: UNAIDS

9:30 • 10:00 Evaluation of the Impact of Antiretroviral Treatment: A Chilean Cohort Study
Dr. Carlos Beltrán
Advisor for CONASIDA, Ministry of Health (Ministerio de Salud), Chile

10:00 • 10:15 Coffee Break

10:15 • 11:15 Panel 6: The HIV situation in the general population through transmission during pregnancy: Advances, trends and necessities for strengthening the production of strategic information

The Peruvian Experience
Dr. Mónica Pun
Ministry of Health (Ministerio de Salud)

The Argentinean Experience
Dr. Liliana Orellana / Dr. Adriana Basombrío
Ministry of Health (Ministerio de Salud)

Moderator: PAHO

11:15 • 12:00 Innovative Experiences in the Surveillance of Men who have Sex with Men in Peru and Ecuador
Dr. Jorge Sánchez
Medical Health Studies, Peru (Investigaciones Médicas en Salud (INMENSA – Perú))

12:00 • 1:00 pm Know your Epidemic: Final reflections on the status and perspectives of Strategic Information about HIV in the Region
Dr. Mónica Alonso
Regional Advisor for HIV, Strategic information, OPS

Ronald Alvarez
Movimiento Homosexual de Lima (MOHL)

Pablo Anamaría
Observatorio Latino

Moderator: Facilitator

1:00 • 2:30 Lunch

2:30 • 4:00 Group Work: Conclusions, next steps and final agreements
Facilitated by the Commission of representatives from countries selected to work on the final agreements

4:00 • 4:30 Closure of Event

Mr. Jorge Chediek,
Resident Coordinator of the United Nations System in Peru

Dr. Jesús María Calleja
Epidemiology, WHO

Dr. Robert Lyerla
Director of Epidemiology and Impact Analysis, UNAIDS

Dr. Ruben Mayorga
UNAIDS Coordinator for Peru, Ecuador and Bolivia