Published in final edited form as:

Glob Public Health. 2016 ; 11(7-8): 1076–1092. doi:10.1080/17441692.2016.1161814.

‘Proyecto Orgullo’, an HIV prevention, empowerment and community mobilisation intervention for gay men and transgender women in Callao/Lima, Peru

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Abstract

We used qualitative, quantitative and observational methods to assess the feasibility, acceptability, and potential efficacy of *Proyecto Orgullo* (PO), a pilot community mobilisation intervention to decrease sexual risk, promote health-seeking behaviours, and facilitate personal and community empowerment among gay men (GM) and transgender women (TW) in Peru. PO was adapted from Mpowerment and *Hermanos de Luna y Sol*, two US interventions. PO included six interrelated core elements: 1) Self-reflection Small Group sessions; 2) Supporting peers in HIV prevention; 3) Mobilisation Activities addressing HIV, GM/TW issues, and community empowerment; 4) A Core Group (staff + GM/TW volunteers) designing/implementing those activities; 5) A Project Space; 6) Publicity. PO included specific components for TW, but promoted that GM/TW, who historically have not worked well together, collaborate for a common goal. We found that PO was embraced by GM/TW. PO positively influenced GM/TW's HIV prevention beliefs, self-efficacy, and behaviours; provided social support and created community; facilitated individual and community empowerment; achieved that GM/TW collaborate; and established a functional Community Centre for socializing/conducting mobilisation activities. Community mobilisation strategies, lacking from HIV prevention efforts in Peru but considered key to HIV prevention, can help improve health-seeking behaviours and consolidate social norms supporting preventive behaviours among GM/TW.

Keywords

HIV community mobilisation intervention; gay men; transgender women; Peru

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Disclosure statement: No potential conflict of interest was reported by the authors.

Background

HIV among men who have sex with men and transgender women in Peru

Peru has a concentrated HIV epidemic, in which 12% of men who have sex with men (MSM) and 30% of transgender women (TW) are estimated to be living with HIV; and HIV incidence remains high at 5% (León et al, 2013). Most HIV/AIDS cases in Peru (78%) have been reported in Lima, the capital city (population 8 million). Fifty-five percent of new HIV infections occur among MSM/TW (PanAmerican Health Organization, 2009). Prevalence of other STIs is also high (León et al, 2013; Silva-Santisteban, 2012). Approximately 48% of MSM/TW report unprotected anal intercourse (UAI), with many of those MSM/TW residing in low income areas (Clark et. al., 2014; PanAmerican Health Organization, 2009). Socially marginalized and low income MSM/TW have been identified for being at high risk for HIV (Clark et al, 2007; Snowden et al., 2010). Knowledge of HIV status among MSM/TW is not associated with UAI, and over 52% of sex acts with partners of unknown serostatus are unprotected (Clark et. al., 2014). Fewer than 40% of MSM/TW were tested in the past year (Lee et al., 2013), and only 65% report ever having tested for HIV (Clark et. al., 2014), even though testing and antiretroviral treatment are free through the Ministry of Health. A recent analysis (Cáceres et al., 2014) found low testing rates, with only an estimated 27% of HIV+ MSM/TW aware of their status, and an estimated 18% of HIV+ MSM/TW virally suppressed. The low testing frequency explains late HIV diagnoses and entry into care (Crabtree-Ramirez et al., 2011), which implies increased infectivity.

HIV prevention for Peruvian MSM/TW: The need for a new approach

HIV prevention efforts for MSM/TW in Peru have varied little in 15 years and neglect broadly accepted approaches, such as seeking to change social norms and the combination of biomedical, behavioural, and social/community interventions (Auerbach, Parkhurst & Cáceres, 2011; Schwartlander et al., 2011). Peru's national strategy lacks attention to the conceptualization of HIV prevention and care as a continuum (Berg, 2009; Hardon, 2005). The Global Fund to Fight HIV/AIDS, Tuberculosis, and Malaria (GF) provided funding for nine years for prevention programs targeting MSM/TW, including outreach through a small number of peer promoters for referrals to STI clinics for condom provision, syndromic management of STIs, and HIV testing. Unfortunately, there is little evidence that GF projects in Peru influenced HIV incidence (Cáceres, Borquez, Silva-Santisteban, Guanira, & Hallett, 2014). Messages from promoters have changed little over time and fail to empower MSM/TW to make informed decisions and develop negotiating skills related to real-life issues influencing their HIV vulnerability, *e.g.*, lack of HIV status disclosure because of stigma (Salazar et al., 2013). Neither promoters nor healthcare providers counsel HIV+ MSM/TW on Positive Prevention (Myers et al., 2010; Nagaraj et al., 2013). Prevention efforts for MSM/TW in Peru do not facilitate personal and community empowerment and have lacked a strategy to influence social norms, increase social support, and foster community mobilisation (Cáceres & Mendoza, 2009). Clearly, a new approach to HIV prevention for MSM/TW is needed.

We developed Proyecto Orgullo (Project Pride), a community mobilisation intervention to decrease sexual risk behaviour and increase HIV testing among Peruvian gay men (GM) and

transgender women. Community mobilisation strategies are designed to engage community members to take action towards a mutual goal, are increasingly seen as core components of combination HIV prevention programs (Auerbach et al., 2011; Borquez et al., 2013), and may create social contexts that help optimize health and well-being, including sexual risk reduction (Campbell & Cornish, 2010; Coetzee et al., 2004). Community mobilisation interventions for HIV prevention have demonstrated promise in increasing safer sex (Berg, 2009; Schwartlander et al., 2011), improving services (Salazar, 2013), and increasing HIV testing (Salazar et al., 2013). To our knowledge, PO was the first intervention conducted in Peru that utilized community mobilisation methods to change social norms, increase social support, and facilitate GM/TW's empowerment around safer sex, HIV testing, and health (Coates, Richter & Cáceres, 2008). The aims of this paper are to assess the feasibility and acceptability of Proyecto Orgullo and to examine the process of implementation and potential efficacy of the intervention on HIV risk among GM/TW.

Development of Proyecto Orgullo (PO)

To develop PO, we conducted extensive formative research, including; reviewing previous research we and others had conducted on Peruvian MSM/TW; working with a Community Advisory Board (CAB) of Peruvian activists with expertise working with GM and TW; and drawing upon the guiding principles and core elements underlying the Mpowerment Project (MP) and methods from Hermanos de Luna y Sol (HLS) to determine how best to address HIV risk for GM and TW in Peru. Through interviews and focus groups with GM/TW and CAB input during our formative research, we found considerable interest in an MP and HLS approach to HIV prevention, particularly regarding opportunities to discuss issues that affect GM/TW's vulnerability to HIV and lack of HIV testing, such as homophobia/transphobia, societal stigma, and poor treatment by healthcare providers. MP is a well-established multi-level intervention for young gay and bisexual men who support each other regarding sexual risk reduction and HIV testing, community mobilisation, and individual and community empowerment. MP's efficacy in decreasing unprotected sex and increasing HIV testing has been tested through two randomized, controlled trials (Hays, Rebchook & Kegeles, 2003; Kegeles, Hays & Coates, 1996; Kegeles, Rebchook, Hays & Pollack, 2002). HLS is a small group HIV prevention intervention for Spanish mono-lingual Latino gay male immigrants to the US (Díaz, 2007) that focuses on individual empowerment and self-critical analysis. HLS' aims are to: provide experiences of social support and enhanced self-esteem; promote critical awareness of the social and cultural forces that impact men's lives; increase sexual self-knowledge and recognition of the sexual contexts and personal vulnerabilities that limit men's ability to practice safer sex; and facilitate community involvement to support a sense of increased personal agency (Díaz, Ayala, Bein, Henne & Marin, 2001; Díaz, Ayala & Bein, 2004). The development of PO remained consistent with the theoretical premises of MP and HLS, many of which are the same.

The research team included Peruvian researchers from Universidad Peruana Cayetano Heredia (UPCH) and US researchers from the University of California, San Francisco (UCSF) and the University of California, Los Angeles (UCLA) with substantial expertise in HIV prevention research with MSM/TW from low socioeconomic strata in Peru. This team has been collaborating effectively for the last twelve years on other studies. The specific

implementation activities part of the intervention were conducted by the team at UPCH and UCLA established in Lima, while UCSF researchers also participated in the design, implementation, monitoring and evaluation of the intervention during regular trips to Peru and communication via phone and email. Dr. Kegeles, who developed MP, was intrinsically involved in the development of PO, while Dr. Díaz, who developed HLS, has retired from research but provided consultations at the beginning of the project. The seven principles guiding PO and MP, based on underlying theories, are described in Table 1, and are reflected in the six PO core elements, which are designed to function synergistically and are described in Table 2.

In this article we refer to the homosexual men in the intervention as gay men (GM), and not MSM, since in order to feel comfortable participating in the project, they needed to self-identify, to a degree, as gay. We use the term TW to refer to the biological men in the intervention who self-identified as women. We believe this was the first intervention in Peru that had specific components for TW separate from the needs of GM, while actively promoting that GM and TW collaborate for a common goal.

The formative research revealed the need to create separate but parallel curricula for the four-session Small Groups (SG) intervention component with GM and TW. The sessions for TW included issues such as internalized transphobia, the risks of using silicones and hormones for body modifications, and risk reduction in the context of sex with heterosexually identified men. The team and the CAB considered that GM and TW would feel more comfortable attending separate groups aimed at self-reflection. TW in Peru have less skills, education, and financial resources, and are more disenfranchised than GM. In addition, historically GM and TW in Peru have not worked well together, reflecting the stigma and judgment toward TW by some GM who consider TW's behaviour "vulgar", and the social exclusion and internalized transphobia among TW that makes them feel intimidated by GM, whom they often consider as to have more education and social privilege. The specific components for TW we developed for the intervention were informed by the Guidelines for multisectorial Work for and with Transgender Populations in Peru (Salazar & Villayzán, 2010), the Theory of Gender and Power (Connell, 1987), and the Gender Affirmation Framework for Conceptualizing Risk Behavior among Transgender Women (Sevelius, 2013). We believe that this is the first intervention in Peru that had specific components for TW separate from the needs of GM, while actively promoting cooperation among GM and TW to attain the common goal of HIV prevention.

Implementation of PO

We conducted a full pilot of PO with GM/TW age 18-45 for nine months. With the CAB's input, we selected Callao, part of metropolitan Lima and the main port of Peru, to conduct the pilot. Callao (900,000 inhabitants) is predominantly a lower income area with its own identity. The CAB included members of gay and transgender small community organisations in Callao (which neither had a physical project space, nor conducted any activities), whose buy-in was key to recruitment and PO implementation.

We hired four part-time Coordinators (a TW, two GM, and a heterosexual man) with previous experience working with the GM/TW communities and HIV/STI issues to facilitate

the SG, staff the Community Centre, and work with the *Grupo Impulsor* (GI), the group that serves as the decision-making body of the project. We trained the Coordinators on all aspects of the intervention, and supervised them through weekly meetings in order to monitor implementation and to ensure that the intervention core elements were implemented with fidelity.

We started conducting the pilot in June 2012, beginning with a SG to attract participants to PO. The GI started functioning in July 2012 with participants who had finished the first wave of SG (the four sessions of the SG curricula). Participants who attended consecutive waves of the SG were invited to participate in the community mobilisation activities and, if interested, in the GI. All core elements were implemented concomitantly between July 2012 and March 2013. Most activities were implemented at the Community Centre. Due to the distances within Callao, we provided a small transportation reimbursement to attend the SG and the GI. Participants were not provided a financial incentive other than transportation and refreshments.

Methods

We used a combination of qualitative, observational and quantitative methods to evaluate the intervention. The study was approved by the IRBs at UPCH, UCSF and UCLA.

Data collection and analysis

We collected qualitative data using a semi-structured interview guide to examine the experiences of the Coordinators implementing, and of GM/TW participating in the intervention. During the last two months of the pilot, we conducted 25 semi-structured interviews with a purposive sample of GM/TW participants in the SG, the GI, and mobilisation activities, and a debriefing group with eight GI members. Interview and debriefing group participants provided informed consent and received the equivalent of \$3.50 for their participation. We asked about their perceptions and experiences with intervention components they had participated in, and if participation influenced them to be more reflective about their sexual risk and to support their peers in reducing sexual risk. We also interviewed the four Coordinators at the end of the intervention to assess their perceptions of the intervention and implementation challenges. All interviews were audio-recorded and transcribed verbatim into Spanish. We also made phone calls to 22 participants to find out why they had stopped attending the SG. We collected demographic data and neighbourhood of residence within Callao of participants in the intervention. We observed 50% of the SG, 80% of the GI meetings and 50% of the mobilisation activities using an observation checklist to assess the completion of objectives of the intervention activities. Observations were unobtrusive to the participants in the intervention. Notes from the observations and 30 supervisory meetings with the Coordinators helped to inform the development of the interview guides above and complemented data from the interviews.

Our analysis of the qualitative data was iterative and was informed by the Framework Method (data immersion, identifying a thematic framework to classify data, assigning text segments to established codes, and defining concepts to interpret excerpted data) applied in health research (Ritchie & Spencer, 1993). Interview transcripts were entered into Atlas ti

™, a qualitative analysis software to organise and code the data. First, three analysts, including AM, this paper's first author, individually read a subset of interviews and assigned preliminary codes to those interviews. Analysts then compared their initial codes and together finalized a codebook that they applied to all the interviews. Coding discrepancies were resolved through discussion. Then analysts summarized the coded data and met periodically to discuss the findings. For data verification, AM read all the interview transcripts and reviewed all data summaries. Data from all sources were triangulated to identify domains for interpretation. Those domains were based on a priori issues (such as those included in the interview guides) and salient themes emerging from the data. Demographic data were entered into Excel spreadsheets and used to assess recruitment, intervention reach, and retention. Demographic data helped to inform the rest of our data.

Findings

We have organised our findings into two sections. The first section examines the feasibility and acceptability of PO with respect to the six core elements. The second section examines evidence of how the intervention may have influenced health-seeking behaviours and HIV risk among GM/TW in Callao. Both sections also highlight how the pilot propelled the processes of self-reflection and personal and community empowerment important for change and inherent to a community mobilisation intervention. We use fictitious names for the participants quoted in this section.

Feasibility and acceptability of PO

A variety of evidence indicates that the intervention was feasible, acceptable and embraced by GM/TW, including: the number of participants and their engagement in the SG; the number of GI members and the issues they discussed in the meetings; and the number, content, and diversity of mobilisation activities. The intended processes of individual and community empowerment and mobilisation appear to have occurred. While it takes time to start up a multicomponent intervention, in nine months PO established its presence and attracted GM/TW to participate. The pilot was successful in achieving the goal of having GM and TW collaborate together.

a) Self-reflection and individual empowerment through the SG—In total, 68 GM and 47 TW (N=115), average age 33, from five out of the six Callao neighbourhoods (except the farthest and wealthiest), attended the different waves of the SG. Eighty seven percent reported having completed high school (95% GM, 73% TW). Self-reports on occupation were more vague. Only a few reported being students. Most reported some form of employment (full, part-time, or sporadic.) Some TW supported themselves through sex work. Based on our observations, most participants were low income. Participants who identified as TW encompassed a diversity and fluidity of self-presentations, including using makeup, different gender enhancements and bodily modifications, and dressing and identifying as women either part or full time.

We observed that the sessions were very effective in facilitating introspection to explore issues many of the participants reported having never considered or talked about before, such as identity, stigma, relationships, and HIV. Maricarmen, a TW we interviewed, related

that the sharing of experiences and the way the Coordinators motivated and encouraged participants created a trusting atmosphere conducive to learning and self-growth. Mixing participants of different ages worked because they socialize together and consider themselves part of the same community. Younger participants learned from older participants' resilience and how they coped with negative experiences, while older participants learned from younger ones who may be more open about their sexuality and/or gender identification.

For GM, watching segments of the television program 'Queer as Folk' (<http://www.sho.com/sho/queer-as-folk/home>) enabled them to discuss the impact of HIV on their lives. For TW, watching the video 'Industrial Silicone' (<https://www.youtube.com/watch?v=scvSX9CanqA>) provided the framework to discuss using silicones and/or hormones. Afterwards, some of them reported that they had decided to wait injecting silicones for bodily modifications. Alfredo, a GM, recalled how the SG helped him act upon stigma. He told a co-worker who always made homophobic remarks that the stereotypes of weakness and irresponsibility he attributed to gay men rather applied to him because of how he mistreated his wife and did not take responsibility for his children. Also because of participating in the SG, Pepe, another GM, recounted how he came out to his future brother in-law by telling him that the 'friend' his mother was introducing to the brother in-law was in fact the participant's partner.

In general, participants were very engaged in the SG's discussions and exercises. Most GM (80.9%) attended all four sessions. However, only 57 % of TW attended the four sessions, even if we scheduled them at different times and days. When we called those TW to ask why they had stopped attending most of them referred to work obligations, either as hairdressers or doing sex work. However, the Coordinators' impression was that some TW stopped attending because they felt intimidated by what they perceived as long sessions or abstract concepts. . Because of the high attrition, after five waves we stopped conducting SG with TW and instead implemented '*Martes Femeninos*' (MF), (Feminine Tuesdays) which consisted of weekly workshops led by the TW Coordinator. MF provided an opportunity to cover much of the same content of the SG but in the context of learning specific information about human rights and body feminization or a new skill (knitting, manicure, pedicure, and makeup) TW potentially could use to produce an income. Attendance at MF was consistent and averaged 10 TW.

b) Talking to friends through Informal Outreach—Diffusion of the intervention and its messages in the community occurred. Consistent with the core element of Informal Outreach, participants spoke to friends about prevention and the project, setting in motion a diffusion process of communicating with and encouraging each other about risk-reduction. The following quotes illustrate participants' responses when asked about their conversations related to HIV prevention with friends:

I was talking to someone [and she said] 'I didn't use a condom.' I tell her: Look, you already did it, you enjoyed it, now you have to go to be tested three months from now. I told her that the world will not end, that there are people who survive with the illness for a long time, follow their treatment and do well. Because if we

lost our head in that moment now it is time to be aware, because if you do not take care, value, love yourself, no one will do it for you. So, I am saying this because I appreciate you and you are my friend (Mariana, TW).

‘They were surprised about what I was telling them, and how diseases are transmitted, they didn't know that there were health care places where they can go.’ (Juan, GM)/ ‘In the last conversation I had with six trans, I explained... about the project, for our rights, and the benefits we could have for our own future.’ (Shakira, TW)/ ‘I have told them what we talked about in the sessions, about self-care and the correct way of using a condom.’ (José, GM)/ ‘I give them condoms because they don't have any. And I tell the truth, that if I don't have a condom I don't feel safe having sex. I tell them that one can get any type of disease [referring to STIs], and not just HIV.’ (Miguel, GM)

Based on referrals and attendance we know that participants talked to their friends about PO, invited them to the SG, mobilisation activities, and the Community Centre. In one case, for example, we observed that the male partner of a TW first used to just drop her off, while later he participated himself and helped with small tasks at the centre, reflecting more openness and comfort. In addition, a couple of TW reported that they brought their dates to Movie Night in order to, ‘be sure they also get a prevention message....’

c) Community mobilisation: GM and TW working together through the Grupo Impulsor

The GI met weekly, for a total of 32 meetings. Attendance was scarce at first, but gradually increased, including among TW, whose participation at the beginning was tentative. A few elements helped coalesce and facilitated the functioning of the GI, and the Coordinators' role was key. The Coordinators, themselves part of the GI, facilitated or co-facilitated the GI meetings. While the presence and previous experience of a few members of the existing gay and transgender organisations in Callao in the GI was welcome, the Coordinators, especially at the beginning, worked to remind all members about the goals of PO and that at the GI meetings everyone was equal, regardless of their external affiliation. The Coordinators regularly emphasized the project's ground rules, that included mutual respect and listening to each other. Referring to the growth and participation in the GI, Daniel, a GM we interviewed stated: ‘In the GI everyone gives their opinion, and every day there are more and more participants in the meetings. They start loosening up and start giving their opinions and exchanging ideas.’ The Coordinators trained GI members to plan and organise mobilisation events, and helped them discover they could do things for themselves, such as developing a script for a speech and speaking in public in front of a group of peers or community authorities, something most of them had never done before, and being able to say, ‘Hello we are here from Proyecto Orgullo.’ Progressively, members took more responsibility and became more committed as they saw the results of their efforts reflected in activities they organised, and as they transformed the rented space into a Community Centre they claimed their own. Referring to her work with the GI and the innovation of the project, Camila, a TW, said, “I like this group because it makes us meet and participate in many things that have never been done in Callao before.”

The Coordinators applied and built on a few concepts, implicit in PO's guiding principles: 1) the need for GM and TW to work together and support each other to build a stronger community; 2) the GI members as the decision-makers of the project (instead of the Coordinators telling them what to do); and 3) that since the project's resources were limited they had to rely on themselves. Referring to GM/TW collaborating, a Coordinator stated that PO achieved what previously had not been accomplished in Lima. He recalled that at the beginning of the project there was little interest in working together since TW and GM did not see much commonality among themselves, other than living in the same district. This was reflected in aggressive comments and captious jokes exchanged between GM and TW during the first few GI meetings. While jokes continued being part of the meetings, their tone changed, and the barbs previously exchanged stopped or greatly diminished. The process of working together was slow and one of building trust and interacting. It made a difference that they shared a space to socialize and realize that the issues affecting the two communities were similar, and that perhaps it did not matter that GM may be a little more educated or that TW may have less skills. Consistent with their role, the Coordinators modelled behaviours demonstrating how to work together, and that GM and TW were of equal importance within the project. Arturo stated that at first he was a little annoyed because TW can be '*escandalosas*' (scandalous or outrageous), but that later he got used to working with them. Tito said: 'Now they [TW] are my friends. Without even realizing it I have become friends with the ones who participate [in the GI].' Some TW also emphasized the respect and unity. Dina stated: 'At least in the context of the GI meetings, I have seen a lot of communication. I have never seen funny faces, but I have seen praise instead. We have treated each other affectionately.'

The Coordinators worked for the GI not to depend on the project's resources. A Coordinator recalled that at first, GI participants asked, '*Y la Cayetano que va a dar?*' [And Cayetano, the university, what is it going to give?]. While the concept and practice of cooperativism is widespread in Peru, she explained that GM/TW are used to receiving large incentives from the GF and non-governmental organisations to participate in HIV prevention studies or activities. The Coordinators, instead, tried to instil the concept that the GI needed to self-manage, in order for them to continue working by themselves when the project ended. In addition, the Coordinators made it explicit and transparent what financial resources the project could provide, besides renting and furnishing the community centre. The GI members adapted to that and functioned with the available resources. As a reflection of self-management and community empowerment, they found resources themselves for the mobilisation activities and the Community Centre. For example, GI members brought desserts to sell at 'Karaoke Night' in order to buy Christmas ornaments for the Centre. For the '*Chocolatada*' before Christmas, they obtained donations of milk, chocolate, sugar, and pannetones. At '*Martes Femeninos*', they paid for some of the materials for the beauty workshops and, through community contacts, asked for assistance from the 'First Lady' (the sister of the mayor) of Callao, who provided an instructor for those workshops through the municipality. There were some challenges with the GI, such as that some members who also worked with organisations were used to a more vertical and hierarchical way of functioning. Punctuality to attend the GI meetings, perhaps reflecting cultural norms, remained an issue throughout.

d) Community mobilisation activities—A process of community mobilisation took place through different activities designed and run by the participants. The total number of activities conducted during the pilot intervention was 53. The fewest number of participants in the activities was four, and the largest number was 35. The GI organised weekly small size activities such as GM/TW-themed ‘Movie Night’, regular medium-size activities such as ‘Bingo and Karaoke Night’, and large size events to coincide with particular dates such as Christmas. Medium and large size activities were always jointly held for TW and GM in order to build community and concentrate on issues that both communities face. A typical weekly calendar included activities Saturday afternoons and every evening but Sundays. All activities included some aspect of HIV prevention. For example, films at Movie Night were followed by a discussion about the film facilitated first by a Coordinator and later in the project by GI members. The idea for Friday discussion groups came from the GI as a need to talk about topics that could not be elaborated upon during the SG or large mobilisation activities. Bingo and Karaoke Nights functioned as social opportunities to share food, sing, and dance, integrating HIV prevention messages and encouraging participants to do informal outreach. ‘*Sábados Gigantes*’ included organising PO activities. One of the Coordinators recalled that *Sábados* slowly became like an open house where the two communities could interact, use the computer, learn to use Facebook, design flyers for activities, and during lunch talk about different topics, including HIV. While more complicated to organise, outings had the highest attendance. HIV prevention messages and community building exercises were incorporated into outings. For these events, the project rented a bus and provided a small breakfast, but attendees brought their own lunch. For some GM/TW, these outings provided the rare opportunity to visit non-urban areas, to which they otherwise would not have access because of lack of financial resources to get there, or because the fear of stigma or violence may cause some TW not to travel relatively long distances by themselves using public transportation.

e) Community Centre—For participants the space was their home. Consistent with one of the principles of PO of creating health-promoting settings, the Centre became a point of reference, was essential to support a sense of ownership in PO and the process of community empowerment, and contributed to community building and the visibility of the project. The PO Centre provided GM/TW with a sense of belonging to a community with its own space. Participants became invested in improving and decorating the space, thus transforming it into their own social space. Willy referred to feeling freer at the community centre,

‘Sure, you become friends and open up, you know this is your space and you feel freer, more comfortable, and you can talk about your things.... This is my space and I can talk more freely. I know that the person next to me is my peer and he won't criticize me, won't disclose what I saying, because it is understood that what we talk about here is confidential and stays with us.’

Elisa commented on the centre providing a healthy space, an alternative to getting drunk, ‘I like it. It is not large but at least you have a place where to enjoy yourself in a good way. You are not with those bad ideas, you are not thinking only in the fun, in drinking, getting drunk, the bad company. You don't see that here, the space is comfortable.’

Contrary to previous experiences in Peru to establish similar centres for gay men, the consensus among the Coordinators was that the PO Community Centre was feasible and functional because of that sense of belonging and investment in it developed by the participants. We observed one instance, for example, when Tatiana arrived at the space while two other TW walked by and asked her what she was doing there. She responded, 'here is my home', referring to PO, and added, "how come you don't know *Proyecto Orgullo*?" That conversation resulted in that one of those two TW passers-by started going to PO activities.

Participants took home condoms and lubricants, but we found that the project's supply of condoms at the PO Centre was unable to meet the demand. We also found that there was no need to open the centre on Sundays since GM and TW go out on Saturday night and use Sunday to rest. Through PO, members of existing organisations learned the importance of a community space and how to organise it, opening the way for them to seek funding and consider having their own space and activities.

f) Publicity—On-going publicity was essential to promote the project. Word of mouth, another indication of diffusion of the intervention within the community, worked very well to attract participants to PO. The GI members and the Coordinators designed flyers and cards to promote the project and specific activities. Those were distributed at venues attracting GM/TW such as hair salons and volleyball fields. One of the Coordinators managed the project page on Facebook, which is very popular in Peru. While GM/TW may not own a computer, they access the web at Internet booths. Because most GM/TW own a cell phone, calling or texting them to remind them of activities worked well. A challenge, however, is that because they use pre-paid cell phones, their numbers may change, or they may lose or have their phones stolen. There are no GM/TW bars or discos in Callao for venue-based outreach.

Health-seeking behaviours, HIV risk and HIV testing

While the period of implementation was too short to quantify change, our findings suggest that PO positively influenced participants' beliefs, self-efficacy, intentions, and behaviours related to health and HIV. A couple of GM we interviewed summarized how the project achieved its aims by emphasising personal empowerment and community mobilisation, and compared it to HIV prevention efforts by promoters, which they perceived as more directive or even authoritative. Federico noted: 'The project helps sensitize and provides information, not directly like they come and give you condoms, but through information, discussions, games, which is a basic way of helping.' Enrique explained, "The job of the promoters is to help persons get an HIV test, go for medical check-ups, and have condoms. But PO is different, it is more sociable, for communication, assertiveness, participation. For example, 'Who knows how to make a brochure?' 'Me, me.' 'Then, when can you come?' They arrive and do the work. It is participation, not an obligation, [instead of], 'Tomorrow you have to go to take an HIV test.'"

An important goal of the SG was to clarify information about HIV, examine reasons for getting tested for HIV, create skills for correct condom use, and think more creatively about safer sex and testing. We observed that many participants still had misconceptions about

HIV transmission and prevention. Participants welcomed the chance to practice the proper way of using a condom by putting a condom on a dildo. Surprisingly, we observed that many of them did not know how to do so. Role plays allowed participants to practice how to talk to their partners about safer sex and condom negotiation. During those role plays, participants actively discussed different sexual risk scenarios we presented. In one case, they responded to a TW who always used condoms for sex work but was reluctant to ask her partner to use condoms because she trusted him, telling her she needed to always use condoms to take care of herself. Reflecting trust and a newly gained confidence, we observed that several participants, while at first reluctant, disclosed their HIV+ status during group activities.

We also found indications that PO positively affected HIV testing and sexual risk. For example, a GI member reported that she started using condoms because of being part of PO, and a GM showed a Coordinator that he carried condoms with him, stated that he was grateful for the SG for talking about condoms, and that he now was trying to use them. Four GM approached different GI members to inquire about HIV testing. The GI members provided them with referrals and messages about the importance of seeking medical care if HIV+. One GI member accompanied one of those men to get tested. Another GI member accompanied a second man to get tested and, upon learning he was HIV+, to his first appointment for medical care. Thus, PO promoted HIV testing and GI members also served, informally, to link newly tested HIV+ individuals to care.

Discussion and conclusion

Corresponding to one of the goals of this special issue of Global Public Health, this paper presents empirical research aimed at re-conceptualizing HIV prevention and health promotion for disenfranchised sexual and gender minorities. With PO, we tested a multi-level HIV community mobilisation intervention relevant to the needs, values and social reality of low income GM/TW in Peru that focused on the multiple dynamics and societal factors that make TW and GM vulnerable to HIV, including gender, sexuality, stigma, homophobia and transphobia. The pilot of PO was significant because we found the intervention to be feasible, accepted, and well received by GM/TW, and because it stimulated the processes important for change and inherent to community mobilisation strategies. We found that the PO core elements are well suited for delivering HIV prevention and health-promoting content and that those core elements worked synergistically to produce the intended processes of individual and community empowerment and mobilisation. Because of the short duration of the pilot and the time it takes for community-level interventions to have an effect, a pre and post quantitative outcome evaluation was not appropriate. Consistent with qualitative methods, our findings cannot be generalized, but we believe that the findings related to the implementation and feasibility of PO and the lessons learned below can inform similar interventions not just in Peru but internationally.

Lessons learned

We learned a number of things from this pilot: a) PO demonstrated that a successful community intervention must not be implemented top-down, but bottom-up by the

community, and that disenfranchised, low income GM/TW at high risk for HIV can be engaged and motivated to participating without financial incentives in an intervention that responded to their needs; b) In some cases, TW's social and economic marginalization proved challenging to their participation, but tailoring the format and content of the activities specific for TW to their needs helped to increase their engagement. Future interventions with TW who engage in sex work may consider the framework for factors increasing HIV vulnerability proposed by Poteat et al (2015). While our resources and timeline to do so were limited, future interventions need not only to contribute to the development of TW's skills to find employment, but also attempt to create employment opportunities at large where TW will not be further discriminated against or marginalized; c) PO focused on transgender and gay-related issues separately, as well as together as sexual minorities who face similar societal stigma and internalized oppression. At the start of the pilot, GM and TW held some cross-group ambivalence about each other. The intervention ultimately altered that dynamic and helped to engage GM/TW to work together for a common goal; d) The role of the Coordinators was crucial not only in facilitating the process of GM and TW working together, but for maintaining fidelity to the guiding principles, implementing the core elements synergistically, and the overall success of the intervention; e) Community mobilisation interventions such as PO may be particularly relevant in areas or countries where transgender or gay communities are not well-developed and other opportunities to discuss and reflect about health issues, their social vulnerability, and the diversity of their non-normative sexual and gender expressions may not exist.

Implications for future research

Our findings do not provide conclusive evidence, but they do point to the potential feasibility and acceptability of the intervention. They indicate the need for further research using a combination of biomedical, behavioural, social/community and structural strategies, and engaging the health system to address some of the barriers that exist at that level. Structural obstacles to health-seeking behaviours and HIV prevention and care remain in Peru, including: a lack of sensitive health services for GM/TW, the separation and lack of linkage between HIV testing services and HIV care, and facilities' lack of capacity to retain or reengage patients in HIV care (Scherr-Williams et al., 2013).

While we were implementing PO, international consensus was growing about the need to address the Continuum of Care and Prevention (Berg, 2009; Hardon, 2005) and the role of treatment and viral suppression in prevention (Hall et al., 2013). In Peru, where the majority of people living with HIV are not virally suppressed, focusing on sexual risk reduction among both HIV+ and HIV- individuals, increased HIV testing, and engagement in care will contribute to a decrease in HIV incidence, besides reducing morbidity and mortality. Considering that in most of Latin America HIV prevalence is generally over 10% (Bastos, Cáceres, Galvao, Veras & Castilho, 2008; Miller et al., 2013), that the HIV epidemic is concentrated among GM/TW, and that those GM/TW are affected by the same vulnerabilities, health disparities, and social and structural issues as in Peru, this future research will provide evidence of broader international relevance and may influence the development of meaningful policies and programs. PO could be applied to such research

because it targets multilevel issues and its design is inherently flexible, allowing adaptations and fluidity while still adhering to its core elements.

Interventions that facilitate personal and community empowerment by helping GM/TW critically analyse their needs and challenges can create opportunities for them to define issues and develop action plans to carry out solutions. Such interventions could operate synergistically with individual-level or clinically oriented programs to help maximize prevention and healthcare engagement outcomes. Our findings suggest that community mobilisation strategies that respond to the lived realities of GM/TW in Peru are feasible and may help GM/TW build community, contribute to enhance sexual health and health in general, decrease vulnerability and risk of HIV transmission, affirm sexual and gender identities, and develop a sense of agency in their lives.

Acknowledgments

We are extremely grateful to the participants in this study, the members of the Community Advisory Board, Clara Sandoval and Elizabeth Lugo at Universidad Peruana Cayetano Heredia and the four Coordinators for their efforts implementing the study.

Funding: This work was supported by the National Institutes of Mental Health under Grant [R34 MH086330].

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Table 1
PO guiding principles

1. Multilevel approach to HIV prevention: addressing issues at the individual/social/community/structural levels.
2. Social focus: relating HIV risk reduction to the development of self-esteem, life skills, and supportive social interactions.
3. Community-building: creating healthy social support networks and health-promoting settings (Kretzmann & McKnight, 1993; Minkler, 1990).
4. Peer-Based: peers as change agents (Cialdini, 1993; Rosen & Solomon, 1985).
5. Empowerment philosophy: building a sense of agency and the community's ability to address their own issues (Freire, 1974; Freire & Faundez, 1989; Rappaport, 1981).
6. Diffusion of messages: informal communication and modeling by peers promote community change and social norms encouraging HIV prevention (Rogers, 2003).
7. Positive focus on sexuality and self-acceptance: building pride in sexual and gender expression.

Table 2**PO core elements**

1. Small Groups (SG): four group sessions of peer-led, 2-3 hour meetings with 8-10 GM or TW focused on empowerment, self-reflection, sexual/gender identity, societal/internalized homophobia/transphobia, social support, HIV risk, HIV testing and treatment, sexual communication skills. Participants first recruited through community-based organisations in Callao, and later by participants inviting friends.
2. Informal Outreach: in the SG, participants learned skills to talk to peers about HIV prevention. Training included role-plays, asking participants to talk to peers and problem-solving those conversations at the following session; reinforced in the mobilisation activities and via posters in the PO Centre, texting, and Facebook.
3. Formal Outreach: mobilisation activities helped build a community in which GM/TW support each other and analyze issues that render them vulnerable to HIV. All activities addressed HIV prevention.
4. Grupo Impulsor (GI) (Leadership Group): comprised of GM/TW participants and Coordinators (paid staff) and empowered to make decisions, analyzed issues facing GM/TW, designed and implemented project activities, and helped diffuse HIV prevention messages in the community.
5. Community Centre: a locale to conduct project activities, promote healthy sexual behaviors and build community; had drop-in hours, TV, DVD, and computers. Information, referrals, safer sex materials and condoms were available.
(6) Publicity: conducted through word of mouth, distribution of materials and social media.