

Peru: Effects of the Implementation of Global Fund-supported HIV/AIDS Projects on Health Systems, Civil Society and Affected Communities, 2004-2007

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Abstract

Because the Global Fund grants for HIV-related projects in Peru are substantial, they must be closely monitored in order to ensure reasonable impact. This paper describes the effects of such monitoring and support on key actors involved, decision-making processes, health sector divisions, policies and funding sources, equity of access, and discrimination of vulnerable and affected populations. Data were collected through interviews with key informants, discussion groups with affected populations, and a review of secondary data.

Multisectorality, encouraged by the Global Fund is in its initial stages with centralist proposals with limited consultation, a lack of consensus and short preparation times, prevailing. No effective accountability mechanisms operate within the Country Coordinating Mechanism (CCM). Global Fund-funded activities have required significant input from the public sector, sometimes beyond the capacity of its human resources. A significant increase in HIV funding, in absolute amounts and in fractions of the total budget, has been observed from several sources including the National Treasury, but it is unclear whether this has reduced the budget for other priorities. Patterns of social exclusion of people living with HIV/AIDS (PLWHA) are diverse: children and women are less excluded, while transgender persons and sex workers are often more excluded.

Background

Peru is bordered by Ecuador and Colombia to the north, Brazil on the east, Bolivia on the southeast, Chile on the south, and by the Pacific Ocean on the west. It is home to 27.9 million people and averaged a 1.2% annual population growth rate between 2001

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and 2007 [1]. Peru ranked 79th out of 179 countries on the UN Human Development Index in 2006 [2].

Official Development Assistance to Peru was US\$ 467.9 million in 2006 [3]. Peru remains heavily indebted but has been excluded from international debt relief agreements. The country's total external debt was US\$ 28.17 billion or 30.2% of GDP [1, 3].

As of 2006, a considerable number of Peruvians (about 25%) faced severe constraints in access to health care, in large part due to the high cost of health care [4]. In 2006, out-of-pocket expenditures accounted for one-third and external resources accounted for 1.6% of total expenditure on health [5]. With funding from the World Bank, the Peruvian government has been attempting to improve the equity of and access to health care services for its poor rural population since 2000 [6].

The majority of reported HIV/AIDS cases are concentrated in Peru's large urban areas, and sexual transmission accounted for 97% of cases in 2007 [7]. That same year, there were 76 000 people living with HIV/AIDS in Peru [8].

Despite a relatively low HIV prevalence in the general population, Peru's HIV epidemic has mobilized social actors, economic resources, and the Peruvian health sector [9,10]. In recent years, the country has become the largest recipient of HIV funding from the Global Fund in Latin America, with over US\$ 77 million received or committed for projects implemented between 2004 and 2012 [11].

This magnitude of investment in a middle-income country with a concentrated epidemic is significant, and it will likely have an impact on the relationships among the actors involved, the organization of the response to the epidemic, the redistribution of public resources, and the quality of care offered to PLWHA. Analysis of its effects on the health sector, civil society and affected communities may provide significant lessons at multiple levels.

Table 1 Basic Socioeconomic, Demographic, and Health Indicators*

(*) Full data sources for all indicators are provided in Annex 1.

Indicator	Value	Year	Source
Population (thousands)	27,898	2007	World Bank
Geographic Size (sq. km)	1,280,000	2007	World Bank
GDP per capita, PPP (constant 2005 international \$)	7,403	2007	World Bank
Gini index	49.55	2006	World Bank
Government expenditure on health (% general government expenditure)	13.8	2007	WHO NHA
Per capita government expenditure (current US\$)	99	2007	WHO NHA
Physician density (per 10,000)	12	1999	WHO SIS
Nursing and midwifery density (per	7	1999	WHO SIS

10,000)			
Maternal mortality ratio (per 100,000 live births)	240	2005	WHO SIS
DTP3 coverage (%)	80	2007	WHO SIS
Estimated adult HIV (15-49) prevalence (%)	0.5 (0.3-0.6)	2007	UNAIDS
Estimated antiretroviral therapy coverage (%)	48 (36-62)	2007	WHO/UNAIDS/UNICEF
Tuberculosis prevalence (per 100,000)	136	2007	WHO GTD
Estimated malaria deaths	128	2006	WHO WMR

Table 2 Global Health Initiative Investments*

Global Fund

Round & Disease Priority	Approved (in US\$)	Disbursed (in US\$)
Round 2, HIV/AIDS	22,166,497	21,619,940
Round 2, TB	25,552,603	25,198,382
Round 5, HIV/AIDS	12,867,465	8,700,781
Round 5, TB	32,306,243	12,814,527
Round 6, HIV/AIDS	24,153,662	15,140,430
Round 8, TB	15,178,076	0
TOTAL:	132,224,546	83,473,060

Objectives and Methodology

This study aims to assess the impact of interaction among Peruvian HIV/AIDS stakeholders on the development and submission of HIV/AIDS projects, as well as on the implementation of such projects upon approval. Analysis during the first phase of the study, presented here, was focused on the following objectives: **I** – Identify the effects that participation in the Global Fund processes has had on institutional actors involved in work on HIV/AIDS, and on the interactions among those actors in policy decision-making and project implementation; **II** – Assess the effects of the interaction with the Global Fund on the structure and functioning of the Ministry of Health (MOH); **III** – Understand the impact of access to these funds upon public and private resources and policies to fund the response to the AIDS epidemic; and **IV** – Assess equity in access to project benefits, and impact on stigma and discrimination affecting PLWHA and vulnerable groups.

The study was implemented between September 2006 and February 2009. Data collection measures included interviews with key informants²; in-depth interviews and focus groups with vulnerable and affected populations; a review of secondary data from the health sector and nongovernmental organizations (NGOs); analysis of existing databases; analysis of a package of communications materials prepared as part of Global Fund activities; and a review of previous studies (including baseline and follow-up studies measuring indicators established by the Global Fund projects). For each component, analysis was guided by four to five “best-case scenario” hypotheses that formulated ideal conditions to which empirical data could be compared.

Results

Leadership and Governance

Although Peru’s Country Coordinating Mechanism (CCM) is responsible for implementing the country’s National Multisectoral Strategic Plan (MSP), the multisectoral character of the CCM was still evolving in 2006-2009 [12]. Various interpretations of its meaning existed among stakeholders, and achieving consensus on the roles of different actors within the CCM was difficult, given the lack of other truly multisectoral experiences in the past. Important absences were apparent early on. For example, representatives of vulnerable communities were notably lacking. Commitment of sectors other than health was weak, largely because the epidemic was understood mainly as a “health sector problem.” The CCM needed reinforcement through a stronger representation of organizations participating in the national HIV/AIDS response, including public, civil society and regional organizations.

Despite efforts to include varied actors in Peru’s HIV/AIDS response, a centralist view was established within the CCM during the body’s first years; efforts were focused on Lima, where the epidemic was most apparent, and many regions were left out of the national response. In an effort to address this problem, the proposal submitted to the Global Fund sixth round took into account the regions and created Regional Coordination Mechanisms (RCMs) to decentralize decision-making and take action according to regional HIV/AIDS needs. No formula was created to reconcile the regional interests with the interests of the National Response as a whole. RCMs continue to operate in a legal vacuum, and no channels of responsibility have been established between the CCM and the RCMs.

Peru’s CCM exhibits a number of notable shortcomings. There are no mechanisms of accountability for CCM representatives, nor channels for communication between representatives and those represented. The body’s efforts at monitoring and evaluation are weak. And while the majority of institutions that form the CCM are also sub-recipients of Global Fund project activities, there are no policies within the CCM to prevent, define or manage conflicts of interest.

² Key informants include: officials in the public sector and in cooperation agencies, organizations of people living with HIV/AIDS, NGOs, churches, academics, the Principal Recipient (PR) and Sub-Recipients (SR)

Effects on the structure and functioning of the Ministry of Health

The public sector is responsible for the implementation of Peru's treatment programme; as such, recent Global Fund activities have demanded a sizable response from the sector which has not always been able to perform, given its limited human resource capacity. In the first stages of execution, the lack of clarity on the roles, functions or competencies of the various actors involved in Global Fund activities – the MOH, the CCM, the Principal Recipient (PR), and Sub Recipients (SR) – generated project delays. Additionally, the implementation of Global Fund-supported activities has forced the MOH's National HIV/STI Sanitary Strategy (NHSS) to dedicate time to additional administrative tasks, rather than to improve the coordination within the MOH offices and with other public institutions and regional governments. Although Global Fund activities have required some investment by Peru's public sector, they have also offered resources for a significant number of activities, which are expected to be continued by the MOH and other public institutions.

The MOH has adopted a number of objectives from Global Fund projects. In so doing, the MOH has bypassed some of the lines of intervention emphasized in its own 2001-2004 National HIV/AIDS Plan, such as the prevention and treatment of other STIs, and the prevention of parenteral transmission. While the NHSS at the MOH has improved its technical capacities, existing demands tend to prevent Ministry personnel from taking a proactive role and completing the development of missing regulations.

Financing

Peru has received three Global Fund grants for HIV/AIDS, in Global Fund Rounds Two, Five, and Six. The PR for all three grants is CARE, an international NGO. According to public sector budgetary data, significant changes have occurred in the national response to the epidemic due to a considerable increase in funding for HIV/AIDS, both in absolute amounts and in amounts relative to the total budget. Increases in HIV/AIDS public budgetary levels reflect new activities in HIV/AIDS, mainly around the Comprehensive Care Programme (see Table 4). Interestingly, only 11% of HIV funding in the three projects was allocated to HIV treatment, and this amount was to be expended in the first phase, the first two years of the project, in 2004-2005. All other expenses were focused on prevention, plus some training, equipment purchases, and overhead expenses. ART expenses have been entirely covered by the National Treasury since 2006.

Budgetary information in the public sector is not regularly organized by specific diseases. According to another study [13], HIV/AIDS budgetary increases have not implied cuts in other health programmes.

Table 3: Total investment for HIV/AIDS in Peru, by funding source, 2005 and 2006 (US\$)

Funding source	2005 (US \$)	2006 (US \$)
GFATM	4 644 784	1 768 372

Ministry of Health	2 191 648	7 040 128
Other – Public Sector	801 969	881 912
Other – Private Sector	606 500	852 100

Information

Large volumes of information are channelled to the NHSS where existing infrastructure is insufficient to organize and use it for decision-making. The MOH lacks a comprehensive monitoring and evaluation system able to provide feedback to Global Fund activities. Serious difficulties were apparent regarding access among affected communities to information generated by Peru's HIV/AIDS projects. Informants thought that information was unclear and focused on processes important to the relationship between the PR, SR and the Global Fund. Internal discussions about dissemination of information on HIV/AIDS do not include other key actors that could play a role in the social oversight of the national response.

Communities/Civil Society

Communities of PLWHA have become active in Global Fund projects, but this involvement has sometimes undermined their original affiliations and patterns of collaboration. Before the Global Fund entered the country, organizations of PLWHA were committed to building a National Coordinating Organization (*Peruanos Positivos*). However, in late 2003, Global Fund guidelines required consortia bidding to become Global Fund project implementers to include PLWHA organizations in their activities. This created competition among different organizations, and in 2006 16 organizations left *Peruanos Positivos* to become independent groups that could participate in consortia applying to become implementers of Global Fund Projects.

Effects on Access, Outcomes and Equity

The main change in the response to the epidemic is increased access to care. The government-led National HIV Treatment Programme, which started in May 2004 with Global Fund funding and became fully funded by the National Treasury in 2006, appears to have succeeded in reducing out-of-pocket care expenses dramatically. In 2000, it was estimated that out-of-pocket payments by PLWHA accounted for more than 90% of spending on treatment. In 2007, the relevant rates, including total household spending on treatment, were much lower. This indicates that the Global Fund-supported roll-out of ART has permitted reductions in out-of-pocket spending (see Table 4).

Table 4: Household expenses and expenses in HIV care by city, 2007 (average monthly expenses in nuevos soles)

City	Total (cases)	Household expenses	Expenses in HIV care and tests
Lima	273	753,8	6,1
Callao	55	733,6	9,4

This country case summary has been prepared as part of the academic consortium of the WHO Maximizing Positive Synergies between health systems and GHIs initiative, June 2009

Chimbote	59	648,7	0,2
Huancayo	28	751,8	0,7
Iquitos	58	284,5	0,9
Total	473	680,7	4,8

Source: Survey among PLWHA in 4 Peruvian Cities, 2007 (CARE Peru & Universidad Peruana Cayetano Heredia, 2007)

The most important effect of implementation of Global Fund projects seems to be reduction of morbidity and mortality among PLWHA. While no specific study of morbidity and mortality has been conducted, both the survey and monitoring statistics from the National Treatment Programme reveal low incidence of complications and of treatment failure.

The socioeconomic distribution of PLWHA in the National Treatment Programme is not different from that of the population in general, and the rates of poverty among PLWHA are similar to the national distribution (i.e., 58.2% among PLWHA, 54.4% in the general population). However, it is not possible to rule out a problem of inequity in access to ART, since there is no information on income distribution amongst the total population of PLWHA.

The economic productivity of PLWHA does not generally appear to have been affected by the infection. Faced with a loss of employment because of HIV, PLWHA have been able to reinsert themselves in the labour market, in part since most of them are independent workers (see Table 5).

Table 5: Loss of employment due to HIV/AIDS by employment status, Peru, 2006 (% PLHA and % cases)

Ever lost employment due to HIV?	Total	Employment Status		
		Employed	Unemployed	Not EAP
Total	473	68.3	5.5	26.2
Yes	186	74.7	3.8	21.5
No	287	64.1	6.6	29.3

Source: Survey among PLWHA in 4 Peruvian Cities, 2007 (CARE Peru & Universidad Peruana Cayetano Heredia, 2007).

Discrimination and Vulnerable Populations

According to key informants, actions targeting “vulnerable populations”, i.e. men who have sex with men (MSM) or female sex workers, are fairly limited, and HIV/AIDS programmes in Peru devote little attention to the social roots of vulnerability. While earlier programmes included a large peer-education component, as well as a medical care programme, peer education has since been abandoned, and resources have been reallocated to recruit subjects for a programme of periodic medical check-ups. As a

consequence, Peru's HIV/AIDS strategy is primarily biomedical, without substantial emphasis on preventive information and interpersonal resources for risk reduction.

Responses to questions exploring attitudes towards PLWHA reveal discriminatory attitudes in the general population. Importantly, differences in the prevalence of such attitudes were identified across geographic regions, but not across educational levels. Attitudes were most positive in Iquitos, a city in the Peruvian Amazonia, with a culture generally more open to sexual diversity. According to qualitative findings, health workers' perceptions about PLWHA vary on the basis of the characteristics of individuals infected. Perceptions of "guilt" or innocence in contracting the disease play a clear role in how PLWHA are treated [14,15]; children and women (i.e., "innocent victims") tend to be more valued, while transgender people and sex workers are, generally, socially excluded.

A review of communication materials prepared for specific target populations of the Global Fund projects showed diverse messages and perspectives. Some materials still present frightening messages about HIV directed to adolescents and young adults, which may produce misinformation and contribute to stigma and social marginalization of PLWHA.

Among PLHA responding to the survey, no differences were reported on the quality of care at public clinics based on gender and sexual orientation. Interpretation of this finding, however, is limited by potential differences in expected quality of care based on pre-existing social exclusion (see Table 3) [16,17].

Discussion

The Global Fund-funded projects in Peru have defined a new relationship between the public sector and civil society with many positive aspects, although several issues remain to be resolved. Multisectorality implies fairness in decision-making by all actors. The process of instituting multisectorality within Peru's Global Fund activities is still new, and has meant new challenges overall for the MOH, NGOs, organizations of PLWHA, and vulnerable groups.

Generally, the study has revealed a multifaceted process that has changed the ways in which HIV/AIDS work is conducted since the introduction of funds from Global Fund. The Global Fund's top-down call for a CCM has required multiple sectors as well as both public and private actors to articulate a consistent, national response to the epidemic. This has introduced the opportunity for broader commitment and, to some extent, a more democratic process. The Global Fund-funded projects in Peru have configured a new relationship between the public sector and civil society. However, more work is needed to ensure fairness and genuine inclusivity in decision-making processes [18,19].

Organizations of vulnerable populations, while not involved in the CCM originally, have recently been invited to participate. However, their needs are still not considered adequately in the design and implementation of the projects. To achieve equity in input to Peru's HIV/AIDS strategy, the health sector and other sectors must recognize that the HIV epidemic is a broad social problem, rather than only a health problem. Activities funded by the Global Fund should improve the level of equity in access to project

benefits and counter stigma and discrimination directed towards PLWHA and vulnerable groups. It is also clear that other public sectors still find it difficult to understand their role in the response to a problem that is perceived merely as a health problem. A well-defined strategy is needed to mainstream the public response to HIV/AIDS in ways that really strengthen its scope and impact [20].

Within the health sector, the main overall conclusion is that the implementation of Global Fund projects has emphasized the role of non-state organizations, with limited mechanisms for transfer of funds to the MOH. However, the new processes related to implementation of Global Fund-funded projects have demanded a substantially increased time commitment from the NHSS Technical Team, and seem to have led to a loss in their capacity to guide and oversee the health sector components of the national response in more proactive ways. Logistic systems have also experienced problems in meeting project demands, and the NHSS's capacity to process the substantial amount of information generated has also been limited.

Instabilities introduced by the size of HIV/AIDS investments in relation to other health investments must be addressed through appropriate funding mechanisms and through operations research [21]. There is also a need to create mechanisms of accountability within the CCM for the organizations it represents, with regard to the CCM itself and to Peruvian society as a whole [22,23]. Moreover, the CCM must fulfil Global Fund requirements with regard to the adoption of a code to prevent and manage conflicts of interest, as well as the creation of effective mechanisms for monitoring and evaluation [24-26].

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