KEY MESSAGES:


- The national HIV program received significant external support from bilateral and international organizations until 2010. The program’s share of domestic public funding has since increased substantially.

- Since 2011, the Ministry of Finance has worked to improve allocative efficiency of HIV/AIDS public funding for high-risk groups, using budgeting for results and transferring resources directly to the Regions.

- The HIV/AIDS prevalence in 2010 was estimated at 0.4 percent, below the Latin American and the Caribbean regional prevalence of 0.5 percent.

Box 1. HIV/AIDS Program Implementation Milestones in Peru

1995: Creation of the National Strategy for Control of STIs for preventing HIV/AIDS
2003: The Global Fund (GFATM) provided US$6.5 million in initial support to fight HIV/AIDS in Peru
2004: The government and the GFATM financially support free coverage of ART prophylaxis for infected pregnant women and rapid on-site testing
2011: Government and MEF designate TB and HIV/AIDS as priority programs for budgeting for results, substantially increasing financing to these programs

Where does Peru stand on HIV/AIDS?

Peru is an upper-middle income country, with a US$5,880 per capita Gross National Income (GNI) (The World Bank data, 2012). Over the past ten years, Peru has achieved high growth rates, low inflation, macroeconomic stability, and significant advances in social and development indicators (The World Bank, 2013).

From the first reported HIV case in 1983 to 2008, there was rapid increase in the number of HIV/AIDS cases in Peru. Since 2008, the Ministry of Health (MOH) reports a decline of new cases (Figure 1). The MOH also reports a decrease in the total number of infected children over the last 10 years, from 5,600 cases in 2000 to 4,000 in 2010 and 3,200 in 2012 (MINSA-Spectrum, 2013). The decline of cases among children was reported and verified by
diagnostic and laboratory services.

The prevalence of HIV in Peru is estimated at 0.4 percent, which is below the LAC regional average (UNAIDS, 2012). Recent estimates from the Global Burden of Diseases study show that HIV accounts for 1.8 percent of the total burden of disease in Peru and 1.9 percent of the total number of deaths (Ortblad, et al., 2013). Recent figures (as of December 31, 2012) from the Department of Epidemiology of the Peruvian Ministry of Health (MOH) show that 48,809 cases of HIV and 29,454 cases of AIDS have been reported since 1983, though these numbers may be an underestimation since many people living with HIV (PLWHA) do not know their status. UNAIDS (2013) estimates that there are around 76,000 PLWHA in Peru. A study financed by the World Bank (Vargas, 2014) estimates around 67,000 people living with HIV/AIDS in 2013. From 2001 to 2013, 56 percent of reported HIV cases were in the Lima-Callao area, with 10 percent in the mountain region, 15 percent in the Amazon region, and the remaining 16 percent in other coastal states. An estimated 3 percent of reported cases had no known location (MINSA, 2013).

Peru is responsible for 4.2 percent of the total HIV/AIDS DALYs in LAC, although the country has seen the fourth largest reduction in the number of HIV/AIDS related DALYs in the Region (43 percent%) between 2000 and 2010 (Figure 2). This fast reduction is influenced by successful implementation of policies such as: (a) Reducing vertical transmission, through the use of HIV testing in pregnant women, ART prophylaxis, and clinical management of HIV-exposed neonates and positive mothers; (b) Promoting safe behaviors to avoid new infections through increased HIV testing, counseling and condom distribution, targeting male and female sex workers (MSW and FSW), and men who have sex with men (MSM). From 2006 to 2008, 54 percent of educational activities were directed to FSWs and 21 percent to MSM, and; (c) Diagnosis and early treatment of HIV by raising national policy awareness of the need to increase access to ART. In 2006, the government started ART support for adults. The program provided PLWHA with CD4 viral cell count/viral load testing. Initially, the program was implemented solely in hospitals but has been expanded to selected health centers. Since 2004, ART is provided free of charge.

### Public Expenditures in HIV/AIDS in Peru

From 2000 to 2010, three subsectors financed and provided health interventions for the prevention and treatment of HIV/AIDS: (i) the public sector, including the MOH and social security; (ii) the private non-profit sector with NGOs such as Socios en Salud, and Via Libre; and (iii) bilateral and international organizations such as the Global Fund and USAID. Since 2011, international financing from USAID and other international organizations has decreased substantially. During the same time, the Ministry of Finance started to complement public funding for HIV/AIDS to high-risk groups using the budget for results methodology to transfer resources to the Regions (Figure 3). The average budget allocated to high-risk groups by the public system during the period 2011-2013 represents 79 percent of the estimated total costs.

Furthermore, the amount allocated by the MEF to high-risk groups during this period represents 44 percent of total program expenditures. Most of the remaining program expenditures are directed at the general population.
The Cost of HIV/AIDS in Peru

Estimations for 2013 found that the unit cost of providing HIV treatment for adults was US$409, of which US$294 go towards annual ART costs and US$115 for medical consultation costs. ART costs were based on 13 ARV combinations used by patients of the public program. Consultation unit costs were based on estimates from the NGO IMPACTA. The cost of treatment per child was estimated at US$555, with US$115 for medical consultation and US$440 for ART, which is 50 percent more expensive than adult ART. The cost of testing a pregnant woman for HIV was estimated at US$9. The unit cost of screening, condom distribution and peer Community Health Workers (CHW) was estimated at US$103 based on World Bank data (2011).

What can we learn from Peru’s HIV/AIDS programmatic innovations in budgeting for results?

I. DECENTRALIZED PUBLIC HIV/AIDS FINANCING IS KEY TO INCREASING EQUITY IN COVERAGE

The budget increase for Peru’s HIV/AIDS Program was accompanied by financial decentralization, meaning that the MEF allocates the HIV/AIDS program budget directly to the MOH, the 25 regional governments, the DIRESAs, and the hospitals. Financial resources are allocated based on the budgeting-for-results (BFR) approach of linking the public budget with the delivery of services to different high risk groups.

Equity has improved among women of childbearing age in quintiles 1-2, which includes 40 percent of the poorest women. Household surveys from 2004-2012 show an increase in the number of women who are knowledgeable about the transmission of HIV from mother to fetus, from 30 percent in 2004 to 46 percent in 2012. However, it is estimated that only 18 percent of infected children are being treated. The situation becomes even more critical among native Amazon communities, which constitute a new emerging at-risk group currently missing from the program discussion.

II. ART COVERAGE AND INCREASED LAB CAPACITY ARE KEY TO REDUCING HIV TRANSMISSION AMONG HIGH-RISK POPULATIONS

ART service coverage and rapid response are important elements for success in combating HIV/AIDS. Recent assessment of UNAIDS data shows that the faster decreases in the incidence of HIV took place in countries that rapidly increased HIV treatment coverage. Closing the coverage gap means active HIV testing, promotion of condom use, and full access to ART.

 Increased laboratory capacity and expansion of rapid diagnostic testing would have the greatest impact on program coverage and can dramatically decrease the epidemic, as ART treatment for more infected people could reduce the infection rate.

The MOH has secured access to reduced price ART through an agreement with the Pan American Health Organization’s (PAHO) Strategic Drug Fund. However, the public laboratory network faces gaps in the technical capacity needed to support increased diagnostic services, which has the very real risk of undercutting the potential for accelerated progress in HIV/AIDS treatment.

III. BUDGETING FOR RESULTS (BFR) FACILITATES ACCOUNTABILITY IN THE HEALTH DELIVERY MODEL FOR HIV/AIDS

The new method for allocating financial resources, budgeting-for-results (BFR), involves linking the public budget with the delivery of services to different risk groups. BFR involves the participation of all decentralized institutions in different roles.

The MOH and the MEF suggest priority groups and the types of interventions, but each of the decentralized units drafts budget formulations. The budgeting process includes quantification of intermediate outcomes and
interventions, as well as activities, goals and associated financial resources, using specialized software.

The MEF consolidates budget implementation progress every six months and publishes information on the MEF website. Adjustments to the HIV/AIDS program budget are made continuously throughout the year in every institution, but they need approval from the regional government and the MEF.

Every national and regional institution has access to real time monitoring of HIV/AIDS program budget execution, achievement of operational targets, number of services provided, and analysis of intermediate and final results.

This new budgeting method facilitates higher levels of accountability in the delivery of HIV/AIDS services and links spending with results. Also, this approach may help determine any necessary expenditure increases or decreases in a particular line/intervention.

IV. HUMAN RESOURCES ARE STILL A LIMITATION IN PERU

The limited number of community health workers (CWHs) could also potentially undermine accelerated progress in reducing the dimension of disease. Additional questions related to CHWs include whether they should become part of the formal health system and how best to compensate them—cash, voucher, or goods. Programmatic expansion of CHW models that have proven cost-effective for vulnerable populations in Peru, such as Partners in Health/Socios en Salud and their work with CHW in the TB control program, and international examples, such as Brazil’s community health workers program, should be considered.

Resolving issues surrounding the CHWs would be an appropriate first step in developing a strategic human resources plan. Some of the incremental resources needed for extending coverage to key populations may well be funded with a re-appropriation of existing financial resources. This initiative could accompany a discussion on human resources in which there is ample room for a more cost-effective allocation of resources.

Challenges

Despite these achievements, Peru still faces a number of challenges in halting the spread of HIV, which include the following:

- In 2011-2013, just 44 percent of total program expenditures were allocated to high risk groups (pregnant women and children, MSM, adolescents and PLWA)
- Only 43-48 percent of eligible infected people (under the WHO 2013 guidelines) are being treated with ART by the public system.
- The total cost of scaling up the program and closing the coverage gap among high-risk groups is estimated at around US$32 million over the three years 2014-2016.
- High-risk groups include infected pregnant women and their children, MSM, sex workers and native populations from the Amazon. Native populations need culturally appropriate interventions and comprehensive messages in local languages.
- Limited numbers of CHWs can undermine the accelerated progress in HIV/AIDS in Peru. CHW involvement in the formal health system must be addressed in order to create a strategic human resources plan.

References

IHME. 2010. Global Burden of Disease (database)
MINSA. 2012. Boletín Epidemiológico sobre el VIH /SIDA. Lima: MINSA.

This HNP Knowledge Brief highlights the key findings from a study by the World Bank on the “The Role of Prioritizing and Budgeting for Results” by Veronica Vargas.