

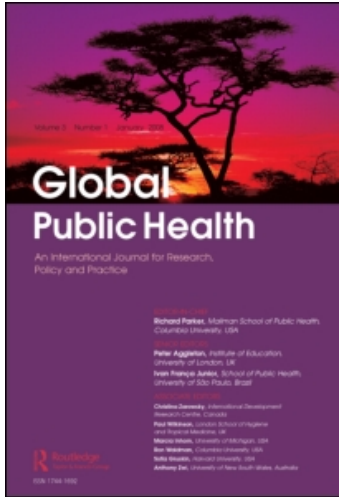
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Implementation effects of GFATM-supported HIV/AIDS projects on the health sector, civil society and affected communities in Peru 2004-2007

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Implementation effects of GFATM-supported HIV/AIDS projects on the health sector, civil society and affected communities in Peru 2004–2007

C.F. Cáceres*, J. Maziel Girón, C. Sandoval, R. López, R. Valverde, J. Pajuelo, P. Vásquez, A.M. Rosasco, A. Chirinos and A. Silva-Santisteban

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The emergence of opportunities for support from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) for HIV-related projects has so far generated funding of over US\$75 million for three proposals in Peru. The size of this investment creates the need for close monitoring to ensure a reasonable impact. This paper describes the effects of collaboration with the GFATM on key actors involved in HIV-related activities and on decision-making processes; on health sector divisions; on policies and sources of financing; on equity of access; and on stigma and discrimination of vulnerable and affected populations. Data analysed included primary data collected through interviews with key informants, in-depth interviews and group discussions with vulnerable and affected populations, as well as several public documents.

Multisectorality, encouraged by the GFATM, is incipient; centralist proposals with limited consultation, a lack of consensus and short preparation times prevail. No accountability mechanisms operate at the Country Coordinating Mechanism (CCM) level regarding CCM members or society as a whole. GFATM-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, and it is unclear whether this has implied reductions in the budget for other priorities. Patterns of social exclusion of people living with HIV/AIDS are diverse: children and women are more valued; while transgender persons and sex workers are often excluded.

Keywords: HIV/AIDS; health systems; access; stigma and discrimination; social capital

Introduction

The memorable Declaration of Commitment on HIV/AIDS which emerged from the United Nations General Assembly Special Session on HIV/AIDS in 2001 (UNGASS 2001) represented a landmark in the recognition of major disparities in resources to fight AIDS worldwide, and defined that any response that did not assign equal importance to prevention and care (including treatment) was insufficient. Likewise, it showed the moral necessity of increasing flows of funding to allow for an

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improvement in the response to HIV/AIDS in the most affected countries. As a consequence, unprecedented measures were put in place to respond to the AIDS pandemic in lower and middle income countries, as defined by the World Bank (World Bank 2007). Among them, the implementation of the so-called Global HIV/AIDS Initiatives (as encompassing the Global Fund to fight AIDS, Tuberculosis and Malaria [GFATM]; the United States President's Emergency Plan to Fund the AIDS Response, and the World Bank Multi-country AIDS programme) represents a very significant commitment of resources to fund the global response to HIV (GHIN 2008).

The GFATM was formed in late 2001 and, to date, it reports to have already committed US\$15.6 billion in 140 countries to scale up prevention, treatment and care concerning the three diseases (GFATM 2009). The GFATM operates on the basis of competitive grants made to proposals submitted by so-called Country Coordination Mechanisms (CCM), platforms of public and private actors, including affected communities, who become the official counterpart of the GFATM grants.

Recently, a call has been made to implement Health Systems Impact Assessments (HSIAs) of investments funded by the Global HIV/AIDS Initiatives (AHPSR and WHO 2008). Fortunately, important analytical work has already been conducted through a number of initiatives in the past 5 years, including the USAID-funded System-wide effects of the Fund (SWEF) series (USAID 2008a), the projects funded by the Alliance for Health Policy and Systems Research (AHPSR) in 2005–2008 (AHPSR 2008), and other studies supported by additional cooperating agencies (such as the Open Society Institute, the Swedish International Development Agency, the European Union and USAID), which in 2006 became part of the Global HIV/AIDS Initiatives Network (GHIN 2008). Here we report on one of these studies, taking place in Peru.

The context of Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM)-funded HIV/AIDS projects in Peru

After the first case of AIDS was reported in 1983, over 20,000 cases have been reported to date, and between 20,000 and 79,000 persons are estimated to be living with HIV in Peru (Ministry of Health 2007, Bastos *et al.* 2008). Despite a relatively low HIV prevalence in the general population, the epidemic has generated a large mobilisation of social actors and economic resources, and has, over the course of the years, led to the constitution of a very active field within the Peruvian health sector (Cueto 2001, Cáceres 2003). In recent years, the country has become one of the largest recipients of HIV funding from the GFATM in Latin America, with over US\$75 million received for projects to be implemented between 2004 and 2012 (GFATM 2009), which implied the commitment of a substantial national counterpart. This means an investment of slightly over US\$3 per capita in Peru and, roughly, US\$1000 per person living with HIV, according to current estimates of people living with HIV/AIDS (PLHA) population size (Caceres and Mendoza 2009). The total governmental expenditure on health for 2008 was estimated at 10,288 million nuevos soles (approximately US\$3430 million; Caceres *et al.* 2009), which represents approximately US\$120 per capita.

This magnitude of investment in a middle-income country with a concentrated epidemic¹ is significant, and likely it will have an impact on the interrelationship between the actors involved, the organisation of the response to the epidemic, the redistribution of public resources and the quality of care offered to PLHA; and the analysis of its effects on the health sector, civil society and affected communities may provide significant lessons at different levels (Caceres and Mendoza 2009). At the country level, it can provide much needed feedback on planned and unplanned consequences of mobilisation around the application process as well as project implementation. At the level of the relationship between the GFATM and individual countries, it may help identify potential gaps and problem nodes to improve GFATM-specific processes. Finally, at the level of mechanisms of international cooperation altogether, it may provide important lessons on the possibilities and shortcomings of international aid in the AIDS field, particularly as regards the operation of the GFATM funding model in Latin America, a region with predominantly concentrated epidemics, democratic but still unstable regimes and emerging civil society movements.

The study we report here, was aimed to assess the impact of the interaction between Peruvian HIV/AIDS stakeholders for the development and submission of HIV/AIDS projects as well as for the implementation of such projects upon approval. Analysis during the first phase of the study was focused on the following objectives:

Component I

Identify the effects that the country's participation in the processes generated by the Global Fund has had on (1) the institutional actors involved in work on HIV/AIDS in Peru, and (2) the interactions between those actors in processes of policy decision-making and project implementation.

Component II

Identify effects of the interaction with the GFATM on the structure and functioning of the Ministry of Health (MoH).

Component III

Understand the impact of access to these funds upon public and private resources and policies to fund the response to the AIDS epidemic.

Component IV

Assess equity in access to project benefits, and impact on stigma and discrimination affecting PLHA and vulnerable groups.

A second phase is being conducted to focus on key areas identified during the first phase, and on emerging issues derived from the progress of current projects. Findings will be reported subsequently.

Methods

The study is being implemented over a period of 30 months (September 2006–February 2009). The first phase of the study was implemented between September 2006 and August 2007. This stage used a variety of techniques – quantitative and qualitative – based on both primary and secondary data sources.

To guide data collection and analysis, a set of 4–5 best case scenario hypotheses was developed for each component. Best case scenario hypotheses were defined as those describing the ideal performance situation for a number of dimensions considered key for each of the components. For example, for Component I, the main focus was the CCM (called CONAMUSA in Peru) and key dimensions were: (a) multisectoral work; (b) horizontal communication; (c) representativeness of delegates; (d) comprehensiveness of multisectoral involvement throughout project phases and management; and (e) capacity to conduct monitoring and evaluation. Table 1 shows a list of all hypotheses under study. All hypotheses represented ideal conditions that were clearly unlikely to describe actual facts from the start. The study aimed to assess to what extent, and how, actual occurrences departed from the hypothetical formulations (see Table 1).

For each hypothesis, a set of indicators, instruments and sources were established, which configured the set of methodological tools used to fulfil the goals of each component:

Component I

The first phase of the study focused on three aspects of the CCM: multisectoral participation; representation; and capacity for monitoring and evaluation. Thirty-two key informant interviews were conducted with key actors from the public sector, cooperation agencies, organisations of PLHA and vulnerable groups (i.e., sex workers and gay/lesbian/transgender organisations), non-governmental organisations (NGOs), faith-based organisations, academic institutions and the *Principal Recipient* (i.e., the organisation selected to administer the GFATM grant). Review and analysis of secondary data (official documents: the projects; the specific action plans; performance reports) were conducted as well.

Component II

The collection of information included 33 in-depth interviews (IDI) with key actors from the public sector, cooperation agencies, organisations of PLHA and members of *Sub-Recipient Consortia* (i.e., organisations responsible for implementing GFATM grant activities). Also, two regions of the country were considered as part of a case study to evaluate the diverse realities of the national response against HIV/AIDS.

Component III

Methodology was focused on reviewing the budgets of the projects funded in the second, fifth and sixth *rounds* (i.e., administrative waves for grant consideration) of the GFATM grant making operation, as well as the MOH budget for the prevention and treatment of HIV/AIDS. Some difficulties were experienced in obtaining

Table 1. Best case scenario study hypotheses.

Component	Hypotheses
I. Stakeholders, political processes and the CCM	<ol style="list-style-type: none"> 1. The country coordination mechanism (CONAMUSA) has become a 'multisectoral' actor that organises the national response to the HIV/AIDS epidemic beyond activities related to the Global Fund (GF). 2. CONAMUSA is the expression of an equitable relationship between the State and civil society. 3. CONAMUSA is a representative expression of its constituent sectors. 4. GF projects have become multisectoral strategies throughout the full process of their formulation, implementation and evaluation. 5. CONAMUSA is in the best position to develop monitoring and evaluation activities of GF projects.
II. Health sector	<ol style="list-style-type: none"> 1. Global Fund to fight AIDS Tuberculosis and Malaria (GFATM)-funded projects have been incorporated by the Ministry of Health (MoH) so as to become complementary and synergistic in the national response to STI/HIV/AIDS, including primary and secondary prevention. 2. GFATM-funded projects have strengthened MoH/ National STI/HIV Strategy in their roles, and this has allowed for the adoption of technical regulations and strategies which advice the national response to STI/ HIV/AIDS in the public and private sectors. 3. The implementation of the GFATM-funded projects has used the processes established in the public sector for the purchase of medicines, rather than creating parallel processes outside the system, or processes that conflict with the public drug purchasing mechanisms. 4. The implementation of the GFATM-funded projects has allowed for the accumulation of knowledge and evidence on various areas of STI/HIV/AIDS work, which is used by the MoH to improve evidence-informed programmes.
III. Financial flows	<ol style="list-style-type: none"> 1. The national response channels resources from a variety of sources to guarantee the sustainability of STI/HIV/AIDS prevention and comprehensive health care activities. 2. The National Treasury has assumed the costs of comprehensive care for STI/HIV/AIDS, without affecting assignments to the purchase of medicines and supplies for other diseases or health needs. 3. The comprehensive HIV/AIDS health care programme is covering the majority of HIV care costs, so that PLHA's pocket expenses have decreased. 4. Access to comprehensive HIV/AIDS treatment allows beneficiaries to maintain or recover their productive activity.

Table 1 (Continued)

Component	Hypotheses
IV. Impact on equity, stigma and discrimination	<ol style="list-style-type: none"> 1. GFATM-supported projects have contributed to non-discriminatory, equitable access to STI/HIV/AIDS prevention and care. 2. Implementers of GFATM-supported projects construct discourses that normalise PLHA's experiences and so contribute to fight against the stigmatisation of PLHA and vulnerable populations. 3. As a result of the implementation of GFATM-supported projects, the experience of living with HIV is becoming normalised. 4. The GFATM-funded projects produce valuable knowledge, which is broadly disseminated and empowers affected and vulnerable populations, also supporting their surveillance efforts.

financial information and reports from the MOH, mainly due to slow official procedures. The categories of analysis considered include gaps in financing, coverage and sustainability of the National HIV Treatment Programme. Additionally, data from a survey of 558 PLHA (Girón *et al.* 2007) were analysed to assess the individual impact of programmes on out-of-pocket expenditures and access to jobs among PLHA, one key beneficiary group of these projects.

Component IV

A total of 13 IDI were conducted with leaders, activists and representatives of academia. Information from three databases was processed for analysis of the situation of stigma in the general population, vulnerable groups (i.e., men who have sex with men [MSM] and female sex workers) and PLHA. Analysis was supplemented with information from focus group discussions (FGD) with service users about their experiences and perceptions related to stigma and exclusion. Also, a sample of communication materials, prepared as part of the activities of GFATM-funded projects, was defined and analysed to describe approaches taken with PLHA and vulnerable groups, as well as explicit content on stigma and discrimination. Information from a survey conducted with PLHA was used to analyse the working conditions, expanding on treatment and socio-economic stratification.

Key informants were selected to cover a broad range of public and private actors. IDI and FGD participants were selected on a convenience basis among those who participated in grassroots organisations or who visited health care establishments to request care. IDI and FGD guides addressed the main analytical categories for each study component. All interviews were recorded and transcripts were analysed using atlas.ti.² Analysis was based on a-priori defined categories but allowed for the incorporation of emergent categories. All participants provided informed consent. The study protocol was approved by the Institutional Ethical Committee of Cayetano Heredia University.

Findings

A summary of findings in each of the study components is presented below.

Component I: Effects of the processes generated by the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) on HIV/AIDS stakeholders and their interaction in Peru

According to key informants, the multisectoral character of the Peruvian CCM is still at an early stage (Sprungli 2003, Cunill Grau 2005). Stakeholders have diverse points of view about this concept, often according to their sector. For example, the MOH focuses on consensus building mechanisms across members rather than on membership, while other public sector representatives emphasise the need for presence of diverse sectors. Community-based organisations focus on public–civil society partnerships, while PLHA organisations suggest that the multisectorality concept is simply unclear in the CCM and that, in any event, the inclusion of the financial sector is a priority to guarantee a sustained response after the end of GFATM support.

The Declaration of Commitment on HIV/AIDS (UNGASS 2001) calls for the development of national multisectoral strategies, ‘...that integrate the HIV response into mainstream development planning, with the full and active participation of civil society and the private sector’. The document encourages working with stakeholders and all partners to incorporate the national efforts on HIV/AIDS into the national development plans. The document calls for increased engagement of civil society and increased accountability of all partners (O’Donnell 1997). Indeed, the response to HIV/AIDS should go far beyond the involvement of the health sector and should include all public sectors and key private actors as well. However, in the Peruvian CCM there were significant absences from key sectors, notably tourism, businesses and vulnerable groups, and regional entities had limited involvement. Informants reported that the articulation of different sectors was very difficult given the lack of other truly multisectoral experiences from the past. Moreover, the level of commitment of sectors other than the health sector was weak and hesitant as a result of understanding the epidemic as ‘a problem of the health sector’ (Boeninger 1984, Tanaka 2001).

In relation to participatory management, informants indicated the predominance of mainly centralist proposals with limited consultation, lack of consensus and short preparation time. Reportedly, the process for the formulation of the second round proposal showed strong collaborative work and democratic discussion, but for the preparation of proposals submitted for the fifth and sixth rounds this was lost due to the short time left before the deadline when the decision to apply was adopted. In the latter cases, consultants were hired to do most of the writing, and the opportunity for more participatory work and shared ownership of the product was lost (Junqueira 1998).

Since the Peruvian State has no formal policies in place to frame public–private partnerships, this coordination mechanism with regard to HIV/AIDS seems to be void of referents. For example, there seems to be tension between the expected guiding role of the Health Sector regarding National HIV/AIDS policies and its ability to support a truly horizontal mechanism in the CCM where leadership can be assumed

by any of its members (Collins 2003). At present the MOH seems to remain the only actor with the capacity to convene other sectors and organisations, since most of civil society organisations did not feel capable of assuming the presidency of the CCM.

Communities of PLHA have become new players. Their involvement in GFATM projects may have generated some undesirable effects on the process of organic articulation of PLHA, such as fragmentation. Before the submission of the first successful HIV/AIDS proposal to the GFATM in 2002, PLHA organisations were committed to building a National Coordinating Organisation (*Peruanos Positivos*). Shortly after the start of such projects in late 2003, consortia bidding to become project implementers had to include organisations of PLHA as a requirement of the bidding process in Peru. As a consequence, individuals and organisations of PLHA were invited to join the consortia, creating distrust and competition among PLHA organisations and their leaders. In 2006, 16 organisations abandoned the national coordination to become freestanding and participate in consortia applying to become implementers of GFATM projects.

The CCM has still to become consolidated as a multisectoral body with a strong representation of organisations participating in the National Response to HIV/AIDS (Presidencia de la República 2004). However, criteria for representativeness have not been discussed appropriately and differ across its constituents. In the public sector, appointments have been governed by rules that in sectors other than health often lead to the appointment of representatives with little experience and/or responsibilities on HIV/AIDS issues and without decision-making powers. In the academic sector, representatives have not been selected in an orderly process involving all academic institutions/units with stakes in HIV/AIDS research, and absences have been particularly important in the social science arena. Only community-based organisations and people living with HIV have selected their representatives through election, although rules had to be defined internally, given the absence of a constitution for the CCM.

Evidence collected also showed that there are no mechanisms of accountability of representation, as well as channels for communication between representatives and those represented. This has been observed in many other collectives based on representation in Peru (Panfichi 2005). Informants also described the existence of conflicts of interest within the CCM, given that several organisations represented in it were also implementers of the GFATM projects and were part of the Sub-Recipient Consortia (The Global Fund to Fight AIDS 2003, 2004, 2006). Moreover, CCM members have privileged access to information regarding bids and competitive procedures. In fact, there are no policies within the CCM to prevent, define or manage conflicts of interest. Probably as a result of this, monitoring and evaluation as a function of the CCM has not been fully accomplished so far, in spite of its importance. Furthermore, the CCM should be a space for the discussion of technical products resulting from project implementation that should be used to enrich the response to the epidemic.

Component II: Effects of the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) on the structure and functioning of the Ministry of Health (MOH)

The GFATM projects and activities have involved considerable effort from the MOH and Regional Directorates of Health, which are responsible for the implementation

of the National Response to fight HIV/AIDS and the National HIV Treatment Programme. The MOH has, at times, exceeded the capacity of its human resources and mechanisms, which were put in place to implement various aspects of GFATM project activities.

In the initial stages of implementation, the insufficient clarity of roles, functions or competencies, of the MOH, the CCM (Ministerio de Salud 2002, 2005), the Principal Recipient and Sub-Recipient Consortia, generated some delays and difficulties. For example, during implementation of the first of the three GFATM-funded projects, the role of the Ministries of Health and Education in relation to prevention activities was not clear, and Sub-Recipient Consortia did almost the entire work without liaising with them. Currently, however, communication is reported to have improved among stakeholders.

The implementation of GFATM-supported activities has forced the National STI/HIV Strategy of the MOH to dedicate time to additional administrative tasks rather than to improving coordination within the MOH offices and with other public institutions and regional governments. GFATM activities have offered resources for a significant number of activities which are expected to be continued by the MOH and other public institutions, although the latter cannot ensure that public or other resources will be available on a sustainable basis. The limited capacity and resources of the MOH, in a context of time constraints and innumerable demands, prevents it from addressing gaps on the regulation and allocation of resources for the organisation of activities required for an integrated and sustainable response to the epidemic. For example, the interpretation of both coverage of and adherence to treatment remained largely undefined, which created problems in the measurement of performance indicators of GFATM-supported projects. As the Coordinator of the National HIV/STI Strategy put it, 'since the start it became clear that within the MOH there were no staff members who were prepared to carry out or supervise the implementation of the GFATM Projects'. However, it was assumed that the National HIV/AIDS Strategy had to do everything³ (CARE Perú and Universidad Peruana Cayetano Heredia 2007a, 2007b). In fact, the objectives of GFATM-funded projects became the guiding principles of MOH HIV work and bypassed some of the lines of intervention of the 2001–2004 National HIV/AIDS Strategic Plan, such as the prevention and treatment of others STI (different from HIV) and actions related to preventing blood transmission (ONUSIDA, MINSA, Proyecto Policy 2005, Fondo Mundial 2006b).

Knowledge management poses an additional challenge. There is limited capacity at the MOH to process all the information generated by the implementation of GFATM projects. At the time of data collection the MOH had failed to establish an integrated, state-of-the-art monitoring and evaluation system that could provide feedback to GFATM activities. Apparently the failure to create such a system, planned as an output of the first GFATM project, stemmed from a disconnect between consultants and their counterparts at the MOH; information was still being collected through temporary homemade databases. In fact, large volumes of information are channelled to the National HIV/AIDS Strategy, where existing infrastructure is insufficient for organising and decision-making. Moreover, the public sector, on one hand, and the Principal Recipient and Sub-Recipients, on the other hand, are using different indicators to evaluate their activities concerning the GFATM projects. The MOH uses public health indicators to evaluate all public

Table 2. Total investment for HIV/AIDS in Peru, by funding source, 2005 and 2006 (US\$).

Funding source	2005	2006
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

Source: CARE-PERU, MINSA, Zúñiga y Portocarrero (2007).

programmes, while GFATM-project implementers use project-defined output, effect and impact indicators to demonstrate performance.

Component III: Effects of the economic and financial contribution of the Global Fund

According to public sector budgetary data, significant changes have occurred in the national response to the epidemic, through a considerable increase in funding for HIV/AIDS, both in absolute amounts and in figures relative to the total budget. Increases in HIV/AIDS public budgetary levels reflect new activities in HIV/AIDS, mainly around the National HIV Treatment Programme. A tendency to a further increase of economic resources to the epidemic in the public and private sectors is also apparent (see Table 2). The United States Agency for International Development has maintained HIV/AIDS cooperation (USAID 2008b), and the United Nations System has recently increased its cooperation to respond to the heightened need for technical support and evaluation. Nevertheless, since 2006 the MOH has become the main funder of the HIV/AIDS response in Peru, due to the assumption of all antiretroviral treatment costs: interestingly, only 11% of the total GFATM support in the three projects was allocated to cover costs of antiretroviral treatment, and this amount was to be expended in the first 2 years of the first project, (i.e., 2004–2005). All other expenses in those projects are focused on prevention, plus some training, equipment purchases, other treatments (opportunistic infections, STI) and overhead expenses (see Figure 1).

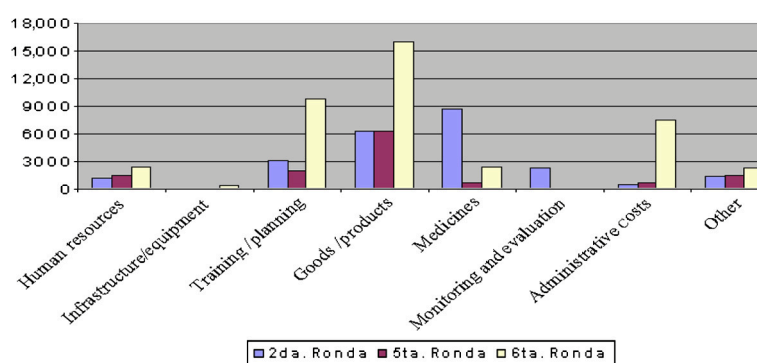


Figure 1. Amounts approved by the GFATM for second, fifth and sixth rounds, by category. Source: Official documents from the GFATM-supported HIV/AIDS Projects in Peru (second, fifth and sixth rounds; Fondo Mundial 2003, 2006a, 2006b.

Note: Only for the second round project, 'other' included overhead.

With regard to sustainability, while no formal state commitment has been made to continue public funding of the National HIV Treatment Programme, its continuity is very likely, considering the consolidation of the view of access to HIV treatment as a right, together with positive trends in the Peruvian economy. Conversely, the sustainability of HIV/AIDS prevention activities, based mostly on the contributions of GFATM, has not yet been discussed.

Budgetary information in the public sector is not regularly organised by specific diseases. Only estimates could be obtained, and, whether or not such increased expending on HIV/AIDS has adversely affected the levels of funding to respond to other disease burdens, is unclear.

The main change in the response to the epidemic is increased access to care. The HIV treatment programme appears to have succeeded in reducing HIV care out-of-pocket expenses dramatically. In 2000, it was estimated that more than 90% of expenditures on treatment was spent out-of-pocket by PLHA (Ministerio de Salud y Universidad Peruana Cayetano Heredia 2004). In 2007, according to a survey conducted among PLHA from four cities (CARE Perú and Universidad Peruana Cayetano Heredia 2007a, 2007b), the rates were much lower, as was the proportion of HIV care expended among PLHA with respect to their total household expending. This indicates that the effects of HIV treatment have allowed for reductions in out-of-pocket expending. The expenses that PLHA are still assuming are, apparently, costs of consumables used in the tests (needles, gloves, etc.) and, in some cases, user fees as well as certain diagnostic tests (see Table 3).

According to results of the same survey, the employment situation of PLHA seems not to have been affected by the infection. While some lost their jobs because of HIV, they have been able to reinsert themselves in the labour market. An aspect that likely facilitated their reinsertion seems to be employment category; the majority of PLHA report that they are independent workers, who carry out business and service-related activities (see Table 4).

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

Table 3. 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
Total	473	680.7	4.8
Lima	273	753.8	6.1
Callao	55	733.6	9.4
Chimbote	59	648.7	0.2
Huancayo	28	751.8	0.7
Iquitos	58	284.5	0.9

Source: Survey among PLHA in four Peruvian Cities, 2007; CARE Perú and Universidad Peruana Cayetano Heredia 2007a and CARE Perú and Universidad Peruana Cayetano Heredia 2007b.

Table 4. 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 PLHA in four Peruvian Cities, 2007; CARE Perú and Universidad Peruana Cayetano Heredia 2007a and CARE Perú and Universidad Peruana Cayetano Heredia 2007b.

The most important effect of implementation of the GFATM projects seems to be reduction of morbidity and mortality of PLHA. While no specific study of morbidity and mortality has been conducted, both the survey and monitoring statistics from the National HIV Treatment Programme reveal low incidence of complications and failure of treatment (CARE Perú and Universidad Peruana Cayetano Heredia 2007a, 2007b).

Component IV: Equity of access to benefits of Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM)-funded projects, and impact on stigma and discrimination affecting people living with HIV/AIDS (PLHA) and vulnerable groups

According to critical views among key informants, actions targeting either MSM or female sex workers, are of a fairly limited scope, and pay little attention to the social roots of vulnerability. While in earlier stages actions included a large peer-education component, as well as a medical care programme, the peer-based programme lost its educational aim and focused on recruiting subjects to attend a programme of periodic medical check-ups.⁴ This programme, which maintained similarities with the mid-twentieth century strategy of prostitution sanitary control (Guereña 2008), reflected a primarily biomedical strategy, based on the diagnosis and treatment of STI, without sufficient focus on preventive information and interpersonal resources to support risk reduction.

In relation to stigma and discrimination, we reviewed information from a survey conducted in 2007 in three cities in Peru where GFATM-funded activities to reduce stigma and discrimination have been implemented (CARE Perú and Universidad Peruana Cayetano Heredia 2007a, 2007b). Responses to questions exploring attitudes to PLHA speak of the existence of discriminatory attitudes towards that group 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, in the Peruvian Amazonia, culturally more open to diverse sexual expressions.

The processes of social exclusion towards PLHA are complex and diverse, and stem from a number of conditions that generally define the socially excluded (Goffman 1970). According to qualitative findings, health workers' perceptions about PLHA are diverse on the basis of their characteristics, with a clear role of discourses around guilt and innocence (Parker and Aggleton 2002, Ogden and Nyblade 2005). In those discourses, children and women (i.e., 'innocent victims') are

more valued and deserve compassion, while transgender people and sex workers (i.e., guilty, depraved, the embodiment of risk) are more questioned and, generally, socially excluded.

To assess the role of GFATM project implementers in the construction of discourses that could support the normalisation of living with HIV and hence combat stigma and discrimination against HIV/AIDS, we performed content analysis of a series of communication materials produced by those projects. Analysis showed a diversity of messages and perspectives in materials prepared for specific target populations. Some materials targeting adolescents and young adults still conveyed frightening messages about HIV, which possibly produced misinformation and perpetuated the social discredit of PLHA. One cartoon targeting adolescents used 'the Exterminator' as a central character from whom young people had to protect themselves; this character was portrayed as a rapist living with HIV. Likewise, subliminal epigraphs may unwillingly change the central messages of otherwise adequate materials: An otherwise useful guide targeting PLHA included the following message: 'All good comes from God. Evil comes from yourself'. Other materials, however, showed a positive perspective.

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 conditions of social exclusion (Llanos *et al.* 2006, Girón *et al.* 2007; see Table 5).

Table 5. Rating of PLHA on treatment received and capacity of resolution in the health centre.

Item of rating		Total	Male	Female	Transgender
Rating of PLHA on treatment received	<i>N</i> =	503	334	135	34
		Percentage (%)	Percentage (%)	Percentage (%)	Percentage (%)
	Excellent	23.4	23.9	22.2	23.5
	Good	57.9	56.0	62.2	58.8
	Regular	18.1	19.2	15.6	17.7
	Bad	0.4	0.6	0.0	0.0
	Very bad	0.2	0.3	0.0	0.0
Rating of PLHA on capacity of resolution	<i>N</i> =	501	333	135	33
		Percentage (%)	Percentage (%)	Percentage (%)	Percentage (%)
	Always	66.1	62.8	73.3	69.7
	Sometimes	33.1	36.6	25.9	27.3
	Never	0.8	0.6	0.8	3.0

p = n.s.

Source: Survey among PLHA in four Peruvian cities, 2007; CARE Perú and Universidad Peruana Cayetano Heredia 2007a and CARE Perú and Universidad Peruana Cayetano Heredia 2007b.

Serious difficulties were apparent regarding the degree to which information generated by the projects was accessible to affected communities and their leaders, and options to provide feedback existed. Informants thought that the availability of information was limited, and that it focused on processes important to the relationship between the Principal Recipient, the Sub-Recipients and the GFATM. While issues about dissemination of information were discussed among those actors, such discussions did not include other key actors that could play a role in the social oversight of the national response.

Discussion

Here we have described key findings of a study examining the expected and unexpected system-wide effects of collaboration with the GFATM for HIV-related interventions in Peru. Study goals focused on: (a) stakeholders and decision-making processes; (b) the health sector; (c) financial flows; and (d) access, stigma and discrimination.

Generally, the study has described a multifaceted process that changed the ways in which HIV/AIDS work was traditionally conducted. The GFATM's top-down call for a *country coordination mechanism*, as the interlocutor at the country level, has established the need for multisectoral and public-private articulation as the foundation of the national response to the epidemic, and has introduced the opportunity for broader commitment and, to some extent, a more democratic process. Clearly, the GFATM-funded projects in Peru have configured a new relationship between the public sector and civil society. But real multisectoral involvement implies fairness in decision-making by all actors (Cunill Grau 2005). This new framework, not tested before in Peru, has brought new challenges overall for the MOH, other public sectors, NGOs, PLHA organisations and vulnerable groups (Caceres and Mendoza 2009).

It is clear, as well, that public sectors other than the health sector still find it difficult to understand their roles in 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 (UNDP and UNAIDS 2005).

There is also a need to create mechanisms of accountability within the CCM for the organisations it represents, with regard to the CCM itself and to Peruvian society as a whole (ONUSIDA 2006). Moreover, the CCM must fulfil its commitment to define a code to prevent and manage conflicts of interest, as well as effective mechanisms for monitoring and evaluation (The Global Fund to Fight AIDS 2003, 2004, 2006).

Since initially organisations of MSM and sex workers were not participating in the CCM, their needs were likely not being appropriately considered in the design and implementation of the projects, although subsequently this changed. In fact, in recent years international stakeholders, including the GFATM (The Global Fund 2008), have made a call for increased participation of such communities, and thus their involvement may increase. As multiple actors have recognised (Sweat and Denison 1995, ONUSIDA 1998), the HIV epidemic draws upon the fault levels of society and quickly affects groups that have been socially excluded from the full exercise of their rights, including access to services. In this context, legal barriers,

human rights abuses, and stigma and discrimination towards PLHA, but also to groups most at risk, should be recognised and addressed (Caceres *et al.* 2008a).

Within the health sector, the main overall conclusion is that the implementation of GFATM projects has emphasised the role of private organisations, with limited mechanisms for transfer of funds to the MOH. However, the new processes have demanded a substantial increase in activities performed by the National HIV/STI strategy technical team at the MOH, and seem to have led to a loss in their capacity to guide and oversee the health sector aspects of the national response in more proactive ways. Logistic systems have also experienced problems in meeting project demands, and the capacity to process the substantial amount of information generated has also been limited. In fact, one of the key present debates regarding GHIs is concerned with the tension between vertical programme funding and support to health systems (GHIN 2008). While justification for this discussion is less clear in middle-income countries with more institutionalised health systems, the size of HIV/AIDS investments introduces instabilities that must be understood through operations research and addressed through appropriate funding mechanisms (Buse and Walt 1996). Fortunately, the GFATM is already addressing this with its call for health systems strengthening components, and also with the establishment of dual management mechanisms, through which part of the funds is to be administered directly by the public health sector (The Global Fund 2008).

The evolution of HIV/AIDS funding in Peru also reveals the key political step that collaboration with the GFATM implied: the Peruvian State assumed a formal commitment to fund HIV/AIDS treatment; which included a government-initiated legal reform (to make access to treatment an entitlement of all PLHA; Caceres *et al.* 2008b). However, this seems to have occurred without a clear definition of implications on funding of other health programmes (or, better, without a clear commitment to avoid that meeting the often more visible AIDS service needs affected other health responses). Again in the line of looking at health systems more comprehensively, the valuable HIV response should strengthen the health sector and become a basis for good, participatory programming, rather than reduce access to care for other diseases (Hanson *et al.* 2003).

Fortunately, increased access to treatment seems to have benefited PLHA in terms of reduced morbidity and mortality and reinsertion in the labour market. With regard to care, there was no indication of differential access based on gender or sexual orientation. However, there is less evidence with regard to prevention services. Prevention messages seem to need more careful crafting in response to a better defined rights-based perspective. Finally, it was clear that communities must be allowed to become more engaged in these processes, including access to, and discussion of, knowledge generated by project implementation.

This study confronted important limitations: First, key informants may have overemphasised the importance of the gaps. We tried to balance this by seeking to identify positive accounts on a regular basis. Second, the quality and regularity of available secondary data were limited, which often made it difficult to draw solid conclusions, particularly in the analysis of financial flows. Finally, this is a dynamic process, and some of the situations here described are changing quickly.

The second phase of this study will present an analysis on: the processes of generation of proposals to the GFATM; an assessment of the relationship between the GFATM-related processes and the National Decentralisation Policy; and a

strengthened analysis of the programme impact on PLHA, through a new survey with a recruitment strategy based on PLHA organisations. We hope that this and other studies will help maximise the positive impact of the significant investment that the world is making to substantially strengthen the response to the HIV/AIDS epidemic at this point in history.

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Notes

1. WHO and UNAIDS define concentrated HIV epidemics as those where HIV has spread rapidly in a defined sub-population, but is not well established in the general population (see UNAIDS and WHO 2008).
2. Qualitative analysis software. Information available at <http://www.atlasti.com/>
3. Interview with the Coordinator of the National HIV/AIDS Sanitary Strategy in Peru.
4. Regular medical care implies a monthly visit to the STI reference centre, which includes laboratory tests and delivery of condoms (50 condoms per month).

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