Aid (In)dependence? Promoting long-term sustainability in the response to HIV/AIDS: the case of the Global Fund in Peru

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I, Ana Beatriz Amaya Amaya, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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Abstract

In the current scenario of decreasing aid, it is critical to develop mechanisms to guarantee the sustainability of programmes once donors exit a country. This study seeks to provide an in-depth understanding of this process in Peru, an upper-middle income country and recipient of multiple HIV/AIDS Global Fund grants that, given recent economic growth, has allocated strategic funding for HIV/AIDS activities within the national budget. The aim of this study is to evaluate the transition of Peru from receiving Global Fund financing for HIV/AIDS to the increasing role of national institutions and capacity for policy development. For this, an original framework was employed, which allowed for the analysis of inputs (resources invested), actor motivations and incentives, HIV policies and plans, and their effects on programmatic sustainability; finally providing recommendations to inform decision-makers on priority areas that must be strengthened to ensure sustainable HIV/AIDS programming.

To achieve these objectives, a case study (2004–2012) was conducted, employing a review of the literature and in-depth interviews among the main actors working in HIV in Peru, carried out between October–December of 2011.

Findings demonstrate that Peru has made important progress towards ensuring a sustainable response for HIV/AIDS, primarily in the allocation of government funding and creation of spaces for actor discussion. Yet, this is not without challenges. The weak leadership and lack of coordination between the central and regional levels has exacerbated the already existing capacity issues in the regions, in this case related to HIV activity planning and implementation. Moreover, in order for HIV to remain a policy priority, mechanisms of accountability must be strengthened, as well as information systems to demonstrate need and key areas for action. Although findings are specific to the Peruvian context, this experience leaves important lessons learned in programmatic sustainability for other countries.

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List of abbreviations

AIDS – acquired immunodeficiency syndrome
ART – antiretroviral therapy
CARE – Cooperative for Assistance and Relief Everywhere
CBOs – community-based organisations
CCM – Country Coordinating Mechanism
CONAMUSA – Coordinadora Nacional Multisectorial en Salud (National Country Coordinating Mechanism)
COREMUSA – Coordinadora Regional Multisectorial en Salud (Regional Coordinating Mechanism)
CSOs – civil-society organisations
DAC – Development Assistance Committee (OECD)
DFID – Department for International Development
DIRESAS – Regional Directorates of Health
DrPH – Doctor in Public Health
EBPHP –Evidence Based Public Health Practice module
EU – European Union
FSW – female sex worker
GAVI – Global Alliance for Vaccines and Immunization
GDP – gross domestic product
GHI – Global Health Initiative
GIZ – German Agency for Technical Cooperation
GNI – gross national income
HIV – human immunodeficiency virus
HIVOS – International Humanist Institute for Cooperation with Developing Countries
IMAI – Integrated Management of Adolescent and Adult Illness
IMF – International Monetary Fund
LMIC – low-middle income country
LMPD – Leadership, Management and Professional Development module
LSHTM – London School of Hygiene and Tropical Medicine
MAP – Multi-Country AIDS Program (World Bank)

MDGs – Millennium Development Goals

MSM – men who have sex with men

NGOs – non-governmental organisations

ODA – official development assistance

OECD – Organisation for Economic Cooperation and Development

OPA – Organisational and Policy Analysis project

PAHO – Pan American Health Organization

PEPFAR – President's Emergency Plan for AIDS Relief

PLHA –people living with HIV/AIDS

SIS – Seguro Integral de Salud

STIs – sexually transmitted infections

UMIC – upper-middle income country

UN – United Nations

UNAIDS – Joint United Nations Programme on HIV/AIDS

UNDP – United Nations Development Programme

UNICEF – United Nations Children's Fund

USAID – United States Agency for International Development

WHO – World Health Organization

Chapter 1 Integrating statement

The Doctor in Public Health (DrPH) degree at the London School of Hygiene and Tropical Medicine (LSHTM) seeks to train leaders and future leaders in public health who want a flexible career which combines management and research. The academic standards are at the level of the traditional PhD degree but the specific intention of the programme is to train students to conduct doctoral-level research as well as organisational management analysis and enable them to apply these skills to policy and practice; and to develop them as accomplished leaders and managers in the field of public health. As such, the programme at LSHTM consists of three components: the taught course component, which consists of two compulsory modules and where we are also free to take other masters-level modules; the Organisational and Policy Analysis (OPA) project component, where we apply what we learned from the taught course component by conducting research at an organisation; and the research project leading to the thesis, which is shorter in length than the traditional PhD thesis but is equal in academic rigour and seeks to make a clear contribution to public health practice.

I first became aware of the DrPH degree when I was studying for a Master in Public Health in Global Communicable Diseases. At that time, I had already worked for several years as a research consultant at the Pan American Health Organization (PAHO) and was keen to continue exploring ways to disseminate and promote evidence-informed policies at the organisational level. Conversely, I knew I wanted to continue to develop my research skills at the doctoral level, as well as further expand my leadership and management capacity. After reading about the different components of the DrPH programme at LSHTM and discussing it with staff, I knew it was the best choice since it combined all of those elements and provided the flexibility in terms of work options I wanted after the degree.

The taught course component consists of the Leadership, Management and Professional Development (LMPD) module and the Evidence Based Public Health Practice (EBPHP) module, conducted over a 10-week period. The LMPD module presented the foundations of leadership and managerial theory through reviewing case studies and applying these organisational theories to real-life examples. The assignment for this module enabled us to apply leadership theories and management frameworks to prior work experiences. I chose to analyse a previous working experience in a research institute where there were some concerns related to leadership which had an apparently negative effect on teamwork. This

assignment was extremely valuable in helping me reflect on ways to address workplace conflict and apply change management theories to form recommendations to foster positive work dynamics and group morale. Furthermore, being aware of these theories was useful when conducting the fieldwork component of my research project since one of my objectives sought to understand actor roles and governance issues within a specific policy environment.

The EBPHP module, on the other hand, helped strengthen my skills in finding, appropriately evaluating and effectively disseminating evidence, this with the objective of applying research-based evidence to public health settings. One of the requirements of this module was to conduct a systematic review at the end of the term, and I focused on the effect of text health warnings on tobacco packages on smoking behaviours and attitudes. This assignment was useful in teaching me how to conduct a comprehensive literature review on a particular topic and to critically evaluate the findings these research articles identified, and arrive at policy recommendations (in this case, recommending steps to follow to curb the sale of tobacco in developed nations). These skills proved extremely useful when conducting the literature review for the OPA and research project component of the DrPH programme. Moreover, I focused the policy brief portion of this assignment on placing an environmental tobacco smoke ban in El Salvador, my country of origin. This exercise was useful in providing a space to consider and summarise the available evidence on tobacco use in El Salvador and conduct a stakeholder analysis in the country in order to identify possible opportunities and barriers for the uptake of a policy.

In addition, I also took three other masters-level modules during my first two terms at LSHTM – Economic Analysis for Health Policy; Analytical Models for Decision Making; and Health Systems – to update my knowledge in these specific areas, and as a preparation for my research project.

The OPA project allowed me to put into practice what I learned in the LMPD and EBPHP modules. I decided to conduct my OPA project at the HIV/AIDS department of the World Health Organization (WHO) over a three-month period in Geneva, Switzerland. More specifically, I analysed the role of the Integrated Management of Adolescent and Adult Illness (IMAI) initiative on policy changes in resource-limited settings. This project received ethical approval from LSHTM and was based on data collected through semi-structured interviews, participant observation and a review of the relevant literature. Through this project I gained a greater insight of how internal political processes at an organisation's

headquarters influence work conducted in the field, and examined the mechanisms through which effective leadership and motivation promote successful work practices. Moreover, the research report provided feedback on what works well, as well as recommendations on how to improve internal communication processes and visibility within the department.

After my initial research project comparing the effect of international aid for HIV/AIDS on the health systems of Honduras and Costa Rica fell through due to the repercussions of a *coup d'état* in Honduras, leaving the country without access to international aid, I began to explore other possibilities always related to aid for HIV/AIDS in low- and middle-income countries (LMICs). While reviewing the literature on Peru, I found the country's success in obtaining multiple Global Fund grants particularly interesting, given the low HIV prevalence. Although I wanted a research topic that followed my area of interest, it was also important for me to ensure that the findings would be useful for the country under study. I therefore contacted the head of the HIV/AIDS strategy office in Peru and was pleased to learn that they needed more research in this area and were particularly concerned about the eventual exit of the Global Fund from the country.

Despite being involved in several research projects in the past, this project presented considerable challenges in organisation, securing access to the country executive offices and data sources. The project enabled me to apply the knowledge I gained during the taught component of the DrPH, particularly in critically appraising research articles and institutional policy-making. It helped me to consolidate the research skills I gained during my OPA. During my fieldwork in Lima I interviewed a much wider range of country stakeholders, requiring individualised approaches and sensitivity. Doing all of the interviews myself, without a support team, was challenging but also allowed me to inquire further on emerging themes and adapt the questionnaire as necessary. Moreover, the research project taught me a great deal, not only about Peru and the policy processes related to the financing of an HIV/AIDS programme but also about overcoming challenges in conducting research on politically charged topics and managing effective collaborations with partners.

The DrPH has been a very rewarding experience. The different components of the programme have exposed me to different areas of pubic heath research and management and were an excellent preparation for the research project. Most importantly, I believe I gained valuable skills both as a researcher and future public health manager, to enable me to work

towards my goal of advising on best polices to improve access to health care and ensure the equitable distribution of resources in health.

Chapter 2 Introduction

2.1 Rationale of the thesis

The issue of sustainability of essential health programmes is a key concern in global health policy. The still looming global economic crisis and decrease in development aid in the past years (OECD, 2013) means setting the foundations for sustainable programming should be a priority for all countries receiving aid. Health programmes which were created based on a need and, in some cases, donor interest, that are prematurely discontinued (Heller, 2005) without carefully planned handover, leave unmet needs, are wasteful of human, monetary and technical investments and can decrease community trust and support for future programmes (Shediac-Rizkallah & Bone, 1998).

Projects that are primarily donor-driven hinder a country's future sustainability due to the lack of trained health workers to continue the projects (Dickinson, 2008; Lele et al., 2004), generating further aid dependence in the long-term (Godfrey et al., 2002).[1]

Sustainability is also reflected in the commitment of the governments to allocate a share of its budget to health according to country needs (Atun et al., 2010; Gruen, et al., 2008; Heller, 2005; LaPelle et al., 2006; Lu, et al., 2006; Mills & Bennett, 2002; Ooms, 2006; Pavignani & Colombo, 2009; Savaya & Spiro, 2012). The relationship of health expenditure to government revenue and per capita GDP varies according to the region. In Latin America we can observe a positive trend where, as the economy grows and revenue increases, so does the government expenditure on health, whereas Africa and Asia show a negative trend (Fan & Rao, 2003). This means that in Latin America, greater economic growth does translate into a larger allocation of the budget to health, whereas this is often not the case in Africa and Asia. Kenya, Rwanda and Zambia are cases where it is believed that the governments decreased their spending for HIV/AIDS as a result of increased donor funding, thus displacing government funding (WHOMPS, 2009). Other studies have found similar displacement of expenditure due to international aid (Lu et al., 2010; Ooms et al., 2008). Lu and colleagues calculate that on average for every $1 of aid for health, the Ministry of Finance in a developing country reduced the amount of government spending for health by about $0.43 to

[1] Zambia provides an example of this, where they effectively graduated from technical assistance of a PEPFAR-funded HIV project by strengthening the capacity of the Ministry of Health to scale-up clinical services (Torpey et al., 2010), though not graduating from financial aid in the process.

$1.14 (Lu et al., 2010). However, overall they did find that development aid for health has a positive and significant effect on domestic government spending for health (Lu et al., 2010).

While the end goal of sustainability is shared by many countries, the ability of a country to fill the gap in resources once a donor stops their investment is directly related its income-level (Lu et al., 2006; Ooms, 2006). However, this is not only dependent on the economic ability of the government but also requires political will to maintain these programmes and interventions (Atun et al., 2005; Pavignani & Colombo, 2009; Schell et al., 2013). A clear example is Russia, now a upper-middle income country (Atun et al., 2005), which after the exit of the Global Fund to fight AIDS, Tuberculosis and Malaria (from now on referred to as 'Global Fund') failed to meet its commitment to continue funding for HIV/AIDS prevention activities among high-risk populations due to the perception of harm reduction programmes to be culturally unacceptable (Tkatchenko-Schmidt, et al., 2008) and the strong opposition from the Church and political lobbying to implement these types of programmes (Twigg, 2007). This resulted in the Global Fund having to extend funding for another two years to avoid leaving a large part of these high-risk populations without access to these programmes (International AIDS Society, 2009; Global Fund, 2009).

Issues around the provision of aid in middle-income countries are particularly challenging. As countries move from being low- to middle-income, the economic progress may not be matched with the governance or technical capacity necessary to sustain existing programmes without external assistance. Therefore, understanding how middle-income countries who have reached a certain level of development should prepare for transition out of aid, even where the proportion of aid is not as significant as the government allocation to a programme, can provide wider lessons on what any country receiving aid can do to plan for self-sufficient programmes in the future and the role of donors in this process.

Peru is a middle-income country that has received financial assistance for its HIV/AIDS programme from the Global Fund since 2004 and whose changing context in terms of economic growth, decentralisation and national budgetary strategy makes it a useful case study for other middle-income countries receiving aid, which will gradually become self-reliant in funding and implementing their disease control programmes. The dedicated funding allocated to disease-specific programmes such as HIV/AIDS programmes in the last decade and their status as priority diseases (Caines et al., 2005b) make them a useful example in examining the transition out of aid. This is even more so given the visibility of these

programmes and their central role within government reform initiatives. Given that the Global Fund is one of the largest donors for HIV/AIDS, pooling funding from governments, the private sector, foundations and individual donors (Lele et al., 2005), examining the HIV/AIDS programmes it funds can elicit greater understanding of donor support and its dynamics in middle-income countries.

2.1.1 Peru's background

Peru is a constitutional republic with a democratic government (Central Intelligence Agency, 2013). The country has a stable government, with President Ollanta Humala assuming office in 2011. His platform was based on implementing far-reaching macroeconomic policies and sustaining growth, with an emphasis on improving equity among the population (World Bank, 2013). Indeed, Peru is the seventh largest economy in Latin America (World Bank, 2005), classified as a UMIC by the World Bank, with a GDP per capita of $6,568 (World Bank, 2013). This change was the result of a 6.4% GDP growth rate between 2002–2012 which resulted in more than a 50% per capita growth in that decade (World Bank, 2013). According to the World Bank (2013), reforms which included fiscal consolidation, trade openness, exchange rate flexibility, financial liberalisation and prudent monetary policy, enabled this growth, coupled with a favourable external environment with high commodity prices.

However, the country is also characterised by high inequality, in 2011 reporting a Gini index in 2010 of 48.1 and poverty rate of 18% in urban areas and 56.1% in rural areas (World Bank, 2013). When comparing access to water and sanitation services to other countries in the Latin American and Caribbean region, Peru is one of the most unequal countries with 78% of the non-poor having access to a water connection at the national level, compared to 45% of the poor covered. In rural areas, on the other hand, 45% of the non-poor have access to a water connection, while 28% of the poor do (World Bank, 2012).

As will be explained in the literature review of this thesis (see section 3.2.1), a recent proposal to classify recipient economies based on their net aid to GNI ratio makes for a more nuanced approach to understand aid dependency (Glennie & Prizzon, 2012). Under this classification, Peru was characterised as a Very Low Aid Country (VLAC) in 2009 with 0.37 aid to GNI ratio. In contrast, it was classified as a LAC in 1990 with 1.56 aid-to-GNI ratio, when it was also classified as a lower-middle-income country (Glennie & Prizzon, 2012),

which illustrates the relevance of rapid economic growth in the country. Nonetheless, aid quantity is an important but inconclusive factor. As shown by the definition of aid dependency, dependency is also associated with the ability of a country to provide services across population groups without technical assistance (Brautigam, 2000), which is complicated by the still high inequalities. Although Peru has not been classified as an overall aid dependent country; according to a recent OECD report, the lack of quality healthcare services and persistent inequalities in access to health 'has been holding back Peru's economic development' (OECD, 2015). Aid has been fundamental in providing a range of essential services for marginalised groups and also provided a basis on which to coordinate actors and provide services, which has been critical to maintain the HIV/AIDS response.

Indeed, Peru's total expenditure on health as a percentage of GDP was 4.5% in 2011 (WHO, 2013), which is significantly below the average for the Americas, which stands at 6.7% (PAHO, 2012). HIV/AIDS prevalence is low, 0.23%, with the highest prevalence (8.93%) found among men who have sex with men (MSM) (Aldridge et al., 2009). There are high rates among certain groups; sentinel surveys indicated that prevalence among transgender individuals reached 20.8% in 2011 (Ministerio de Salud del Peru, 2012).

HIV/AIDS funding comes from the national budget, bilateral donors and multilateral institutions, and the private sector (CONAMUSA, 2006). Reliance on non-governmental sources is significant: from 2005 to 2010, 48.6% of the funding was provided by bilateral donors and multilateral institutions; 36.5% by the government; and 14.9% by the private sector (Navarro de Acosta, 2011). International aid for HIV/AIDS fluctuated considerably from US$29.9 million in 2009 to US$12.4 million in 2010. A disaggregation of donor funding between 2005 and 2010, shows that 43.6% was provided by the Global Fund, while 14.5% was provided by bilateral donors and 4.3% by UN agencies. The remaining 37.6% represents agencies funding clinical trials and European and American NGOs (Navarro de Acosta, 2011). Indeed, since its entry in the country in 2004, the Global Fund has been the most important donor (Cabrera, 2010), providing over US$70 million for the implementation of HIV/AIDS activities in Peru between 2004 and 2013 (Global Fund, 2013a). Most of the money for HIV/AIDS from the Global Fund has been directed towards supporting the majority of the prevention activities in the country, as the government has funded treatment for AIDS since 2006 (Cáceres & Mendoza, 2009). Table 2.1.1 shows the HIV/AIDS country grant proposals to the Global Fund.

Following the start of the first Global Fund grant, the government of Peru undertook important steps to establish a national HIV/AIDS coordinating body: the National Multi-sectoral Coordinating Centre in Health (CONAMUSA), the Global Fund CCM in the country, with representation of different government sectors, civil society and international stakeholders, and with decentralised branches (OECD, 2007). These branches are called the COREMUSAS, which are the Regional Multi-sectoral Coordinating Agencies for Health and they are located in seven regions (Metropolitan Lima, Callao, Chimbote, Ica, Piura, Loreto and Pucallpa). The COREMUSAs are composed primarily by regional government authorities and NGOs working at the regional level (OECD, 2007). However, these regional coordination branches do not have any formal status and lack access to resources (Cáceres, et al., 2009). Moreover, there are differences between COREMUSAs, which are largely explained by the level of transfer of authority to the region as a result of decentralisation. This also has a direct impact on the participation of different actors working in HIV who are more likely to be engaged the activities if there is some level of support and organisation (Iguiñiz-Romero et al., 2011). On the other hand, regional participation at the CONAMUSA is also poor (OECD, 2007) due to the predominance of central-level institutions who are reluctant to include their regional counterparts (Iguiñiz-Romero et al., 2011).

The CONAMUSA was also instrumental in developing the 2007–2011 National Multi-sectoral Strategic Plan for the Prevention and Control of sexually transmitted infections (STIs) and HIV, approved in 2007. This plan was developed under the direction of the Ministry of Health with the participation of actors from government ministries, civil society, international organisations and academia (Ministerio de Salud del Peru, 2006a). This document provided the national strategy to address HIV/AIDS in the country through nine objectives and also served as a reference document for the development of the Global Fund grant proposals for rounds 6 and 8. Despite the success of this plan in guiding the actions of the different actors, attempts at developing a new plan initially for the 2012–2016 period and now the 2013–2017 period have not materialised (El Peruano, 2013), leaving the country to follow guidelines developed in 2007. Moreover, although there has been an important emphasis on HIV care in the regions, with many creating Regional Multi-sectoral Plans for 2007–2011 (Cáceres & Mendoza, 2009), their implementation has varied across the regions (Iguiñiz-Romero et al., 2011).

Table 2.1.1. Global Fund HIV/AIDS grants 2004–2012

Round	Grant period	Title	Amount disbursed
2	2004–2008	'Strengthening prevention and control of AIDS in Peru'	US$ 21,347,134 Successful
5	2006–2010	'Closing gaps to achieve the Millennium Development Goals for HIV/AIDS in Peru'	US$ 12,867,465 Successful
6	2007–2011	'National multi-sectoral plans: integrating resources for the fight against HIV/AIDS in Peru'	US $32,669,809 Successful
8	2009–2013	'Making a difference: consolidating a broad and integral response to HIV and tuberculosis in Peru'	US$72,775,647 (for TB and HIV/AIDS) Unsuccessful
10	2012–2013	'Building social capital to prevent HIV and improve access to comprehensive health care without transphobia or homophobia for the transsexual, gay/MSM population in Peru[2]	US$4,344,113 (for phase I) Successful
		TOTAL	**US$71,228,521**

Source: The Global Fund to Fight AIDS, Tuberculosis and Malaria, Peru Grant Portfolio.

It is important to note that the CONAMUSA is also responsible for the TB programme, whose 1990 programme was considered a model of efficiency at the global level (WHO, 2002). In contrast to the HIV/AIDS programme, initiatives to combat tuberculosis in Peru have taken place since the 1930s and advocacy groups for TB have been active since the 1970s. Due to political pressure from these groups, between 1990 and 1996, 98.6% of the programme was funded by government sources until 1996 when this reached 100%. As a result, cure rates were almost 80% (Rosenberg et al., 2011). According to Bonilla and Bayona (2007), political commitment, coordination, management and cooperation through partnerships among different sectors has been crucial in the National TB programme's

[2] Round 10 began after the fieldwork portion of this thesis was undertaken and thus does not form part of the analysis.

success. The partnerships have been particularly important in maintaining political commitment even when leaders change and services are decentralised. However, TB remains an important concern in the country, particularly Multi-Drug Resistant TB (MDR-TB) and Peru has received funding from the Global Fund for TB through four grants (Global Fund, 2013a). Nonetheless, the formation of the TB programme and the structures created through it can provide valuable lessons for the HIV/AIDS response. Although some of the findings suggest lessons may be transferrable between these programmes, a detailed analysis is beyond the scope of this thesis.

2.1.2 Changing context and sustainability of the HIV response in Peru

Two of the key contextual factors that impact the health sector (Iguiñiz-Romero et al., 2011) and therefore may have an effect on the HIV response, have been the administrative decentralisation process and inclusion of HIV/AIDS as a separate budget line in a recent national budgetary strategy called 'results-based budget'. The results-based budget consists on moving from traditional sector-based funding to allocating resources according to measurable products and results (Ministerio de Economia y Finanzas del Peru, 2013b). This budget is planned by the regions who must choose specific activities according to expected outcomes. Activities are implemented by the institutions who have the best expertise in the area. Examples of measurable products include specific activities or inputs such as number of children who received a full vaccination scheme or vaccinations or areas with working telephone installations (Ministerio de Economia y Finanzas del Peru, 2008).

The national decentralisation process was approved in 2002 with the objective of achieving comprehensive, harmonious and sustainable development in the country through the balanced distribution of competencies and functions at the three levels of government (national, regional and local), with the participation of the population (Dammert, 2003). In addition, it sought to strengthen democracy, governance and equity in the regions (Presidencia del Consejo de Ministros, 2012). Following approval, the actual decentralisation process began in 2004, dividing the country into 25 regions and one province and focusing on the transfer of only administrative and managerial responsibilities to regional and local governments (Dammert, 2003).

In line with administrative decentralisation, decentralisation in the health sector began in 2005 following a plan for the progressive transfer of responsibilities to local and regional governments. (Ministerio de Salud del Peru, 2004). This 2007–2011 National Concerted Plan directed the transfer of 124 functions and incorporated the Regional Directorates of Health (DIRESA) (which were composed of regional public health facilities and previously reported to the Ministry of Health) into the regional and local governments' administrative structures (Iguiñiz-Romero et al., 2011). Therefore, these regional facilities gained managerial and administrative roles but financing continued to be allocated from the central level.

The process of decentralisation and economic growth was accompanied by the introduction of a new budgeting results-based strategy. Due to these socio-economic changes and Peru assuming middle-income status, as well as the country's change in eligibility for HIV/AIDS Global Fund grants (Global Fund, 2012b), the government decided to include funding for HIV/AIDS and tuberculosis activities as a separate budgetary line within the results-based budget in 2011 given the visibility of these diseases in the national policy development agenda, considered strategic diseases to tackle for maximum results (Cabrera, 2010).

This budgeting strategy based on results began in the fiscal year 2007 (Cordova, 2007) and sought to restructure the budgetary processes by including information on performance, direction of the allocation of resources, mandates and commitments, evaluation of results through indicators and sustainability of investments (Marcel, 2006). Among the advantages of this type of budgeting is the logical link between public management and results, as well as the ease of measuring and monitoring outcomes (Ministerio de Economia y Finanzas del Peru, 2006). Furthermore, given the prior history of corruption in the country, this type of budget aims to create more transparency in the use of public resources and promote accountability (Cordova, 2007).

This new budgetary strategy is significant for the HIV/AIDS programme as it influences how resources are allocated, which is based on the programme performance at the regional and local levels. In this sense, the difference of this approach from traditional budgeting is that the negotiations and allocations are based on results; budget allocations are tied to products or services; resources are distributed according to the role of the institutions; and these allocations can be adjusted according to levels of change in results (Ministerio de Economia y Finanzas del Peru, 2008). The impact of these issues are discussed in more detail later in this thesis.

The main instrument of this budgetary strategy is strategic budgetary programming. The objective of this process is to clearly and systematically make decisions on the necessary interventions and resources to address a particular problem of major importance in the country (Ministerio de Economia y Finanzas del Peru, 2008). The inclusion of HIV/AIDS as a strategic budgetary line together with tuberculosis means that specific activities are scrutinized to a larger degree and funds may be discontinued if there is no evidence of need or effective management of resources.

However, common criticisms of these type of budgetary initiatives in the country are that they are increasingly difficult to implement and require skills in costing and interpretation of trends, which is also highly dependent on the quality of available data. Moreover, lack of coordination between institutions with cross-cutting competencies for public administration generates the risk of establishing parallel programmes and implementing inconsistent and uncoordinated actions, to the detriment of the population (Armijo, 2005).

2.1.3 Why is Peru a worthy case study to understand sustainability?

Although much attention has been given to the topic of aid effectiveness until now, few studies go beyond an analysis of the current situation and anticipate the future, as countries become increasingly self-sustaining and require a lower volume of aid; or address the relationship between national, sub-national and international donors as it develops over time. There is very little evidence internationally on the transitional period documenting how countries move, or can potentially move, from receiving aid, managing the process of aid reduction and sustaining achievements in the long-term. This is true also for the case of the Global Fund, currently one of the largest donors for HIV/AIDS programmes. The limited knowledge on the effects of Global Fund grants on countries and how it has enabled countries to become self-sufficient in funding their health programmes is partly due to its relatively recent establishment (2002), and not enough time transpiring until now to appraise results. However, the lack of evidence may also be due to an acceptance that for a vast number of countries achieving sustainability is a very distant possibility, and for which the key concern is to sustain funding levels.

Peru has been selected as a case study in this analysis due to a range of reasons. While Peru is not an aid-dependent country, it has been a significant recipient of Global Fund grants in the

region, receiving over US$70 million by 2012. Its transition outside of Global Fund support due to its economic growth has been coupled with far-reaching changes in the financial and administrative context. This economic growth has transformed Peru into a middle-income country with decreasing eligibility to apply for new Global Fund grants, which at the time of the fieldwork of this study could only be sought to implement programmes for high risk populations. However, this rapid growth has also been combined with growing inequalities, which may result in more HIV/AIDS infections and marginalisation, particularly among high risk populations. This is especially important given that the Global Fund has historically provided the majority of funding for HIV/AIDS prevention programmes. Understanding how (and if) the government will fund these programmes is critical in a context of high inequality.

Furthermore, the change in the budgetary structure of Peru has sought to make allocation more transparent and based on performance. The results-based budgetary strategy is significant for two reasons. First of all, its association with decentralisation means it moves the onus of managing activities from the central level to the regions, with the central level, in this case the Ministry of Health, retaining its steering role. Secondly, its focus on allocation of resources based on results is an exercise that can support planning for sustainability, given that regions are periodically required to report on the performance of their HIV/AIDS activities. This is why an effective transition from Global Fund funding to this type of budgetary strategy is an important contributing factor to the long-term existence of essential HIV/AIDS services.

Moreover, as the literature shows, governance is a critical factor that has an effect on aid effectiveness and sustainability of aid (Scheirer, 2005; Saxenian et al., 2014; Schell et al., 2013). The country has experienced a process of extensive decentralisation that has created new and more accountable regional structures at the expense of potential weakening of the central institutions' operational role. Given that this process has started recently, regional and local actors may not be fully prepared to take on these new roles, which given the new budgetary strategy will now also include managing and coordinating HIV/AIDS activities possibly in collaboration with a wide-range of actors, among these NGOs and civil society.

At the same time, Peru's trajectory to middle-income status creates opportunities and challenges shared by many other countries receiving aid. The economic growth experienced in the Latin American region in the past decade and increasingly in other regions such as Africa, generates a new panorama for donors and recipients, and bringing a renewed

emphasis on the fact that development should be associated with gradual steps to prepare for transition out of aid and embedding viable exit strategies into the policy cycles. In this sense, assessing transition from aid from the Global Fund in Peru and its associated challenges and opportunities, provides a useful case study for other middle-income countries that are in the process of graduating from aid or low-income countries by providing lessons learned for transition to sustainability in a country that was previously in the same situation.

The Global Fund has been the most important donor for HIV/AIDS in Peru since the first grant was approved for the country in 2004, until the present, when they are beginning to gradually end financing. While there are some articles assessing the operation of the Global Fund in Peru (for example CONAMUSA, 2008; Tan et al., 2003; Vasan et al., 2006), a search on evidence about financing and sustainability of HIV/AIDS programmes in Peru in Spanish and English resulted in few studies, mainly on coordination (Buffardi et al., 2011; Spicer et al., 2010); country cost-effectiveness analyses (Aldridge et al., 2009); and decentralisation and results-based budgeting in the country (Armijo, 2005; Cordova, 2007; Iguiñiz-Romero et al., 2011). Most of these sources were not related to health policy and programmes. However, these do not tackle the specific issue of changes due to the handover of financing of the HIV programme. Furthermore, a literature search demonstrated that evidence on this topic from Latin America is generally scarce. The case of the gradual retreat of the Global Fund in Peru and the expanding new role of the government in funding these activities provide a unique opportunity to learn about the institutional change, policy development and managerial processes required to plan and maintain sustainable programmes. The lessons from Peru in this respect are likely to be extremely relevant to other middle-income countries in Latin America or other regions increasingly facing similar challenges.

2.2 Research question, aim and objectives

The **research question** that this study is seeking to address is: what is required for a middle-income country currently receiving donor aid for an essential disease programme to prepare for programmatic sustainability?

The **aim** of this study is to assess the key factors supporting and hindering the progression of a middle-income country (Peru) from receiving Global Fund support for HIV/AIDS towards programmatic sustainability in the 2004- 2012 period.

To achieve this aim, this study sought to meet the following three **objectives**:

1. To examine the inputs (financial resources, human resources and data) that have an important effect on HIV/AIDS policies and activities.
2. To analyse how evidence informs Global Fund proposal development, and how this process supports the development of country capacity to generate and use evidence over time, and promote accountability.
3. To assess the roles and motivations of the main actors involved in the HIV/AIDS programme in Peru as the country progresses towards programmatic sustainability.

Based on the analysis, the thesis will identify recommendations that can be useful to government institutions in Peru and to donors designing exit strategies from aid in a range of low and middle income countries following significant periods of donor support for particular disease programmes.

2.3 Conceptual framework

There are a range of conceptual frameworks that have sought to underpin research of sustainability in the health sector; these vary according to the type of sustainability they address. It was deemed useful to analytically separate those definitions of sustainability relevant to health programmes which continue after aid has been scaled back, from those that take place at the end of a regular funding cycle, whether it is from the government or an external agent. This thesis will focus on the former.

LaPelle and colleagues (2006) provide an example of how to analyse a public service after funding has ended: a tobacco control initiative in Massachusetts. Two strategies were employed: redefining the scope of services and creatively using resources. This model however, does not apply for our purposes since elements of this model such as ensuring funding and creating demand for services are already present in our case.

Torpey and colleagues (2010) provide a service sustainability framework which they apply to the example of HIV/AIDS services in Zambia. This framework considers the following types of service sustainability:

1. Technical sustainability: the continuous provision of quality, facility-based HIV/AIDS clinical services according to national standards.

2. Programmatic sustainability: effective management, coordination and implementation of HIV/AIDS services.

3. Social sustainability: referring to sustained HIV/AIDS activities that depend on the demand for HIV/AIDS services by the community.

4. Financial sustainability: involves adequate and ongoing funding to reach HIV/AIDS service targets and objectives.

Moreover, contextual factors required for sustainable HIV/AIDS services include enabling national health policies, collaboration among non-governmental organisations (NGOs) and a favourable political climate on behalf of the government and other stakeholders (Torpey et al., 2010).

While according to the authors, all of these elements are necessary to reach overall sustainability, the Torpey case study mainly focused on operational sustainability (the

addition of technical and programmatic sustainability) as it continued to receive President's Emergency Plan for AIDS Relief (PEPFAR) support after the intervention, thereby not reaching financial or social sustainability (Torpey et al., 2010). Furthermore, it mainly concentrates on service delivery, rather than understanding the policies that made the outcome possible, which is the objective of the present study. However, elements of this model are helpful such as the concepts of programmatic and financial sustainability which respectively deal with the management of human and financial resources.

Concurrently, this study will mainly focus on programmatic sustainability. This area is most relevant area for the Peruvian case since the study seeks to explain how the HIV/AIDS programme moves from being partially funded by an outside body such as the Global Fund to increased government investment. An integral part of this is observing how the change in the managerial structures and the governance context affects the takeover of activities and the work of the different actors in the country.

Gruen and colleagues (2008) describe how a health programme functions as a complex system that depends on the interactions between the health concerns of the population, the programme components and the drivers of the programme, within a sociocultural, political and geographical context, also depending on the health system characteristics and the availability of resources.

The interaction between health and the programme is bidirectional, describing how the health status informs the programme design and how the programme should also change as a result of the health status of the population. Methods should also be in place to optimise and measure programme quality.

The second interaction is that between the programme and its drivers or motivations of the donors, governments or multilateral agencies funding the programme. Flow of financial resources depends on the priorities of these actors and thus shapes how the programme is designed. At the same time, programme results can have an effect on the drivers through the demonstration of positive or negative results. The last relationship is that between the health concerns and the programme drivers. In an ideal world there would be a direct relationship between how priorities are set and the health needs of the population. However, experience shows us that it is usually a subjective process which may override actual need, especially in the policy sector (Gruen et al., 2008).

This model is useful in that it puts the emphasis on the relationship between the different components of a health programme. However, it fails to consider the external environment and the inputs that make these relationships happen. This study utilises the elements of drivers, referred to as 'actor incentives', and programme to adapt it to Olsen's (1998) framework for sustainability of health care.

Olsen (1998) presents a conceptual framework used to study the sustainability of health services in developing countries. This is based on three cluster of factors which are:

1. Contextual factors: factors in the environment which cannot be manipulated by the health organisation but which have an impact on how health services function. These can be divided into general and specific factors.

    a. General contextual factors include issues such as the general political situation, democratisation processes, the government health policy, budget allocations for health and economic mechanisms.

    b. The specific contextual factors are those related to the health and health services such as the general health conditions, the availability of health services and the roles defined for public and private providers.

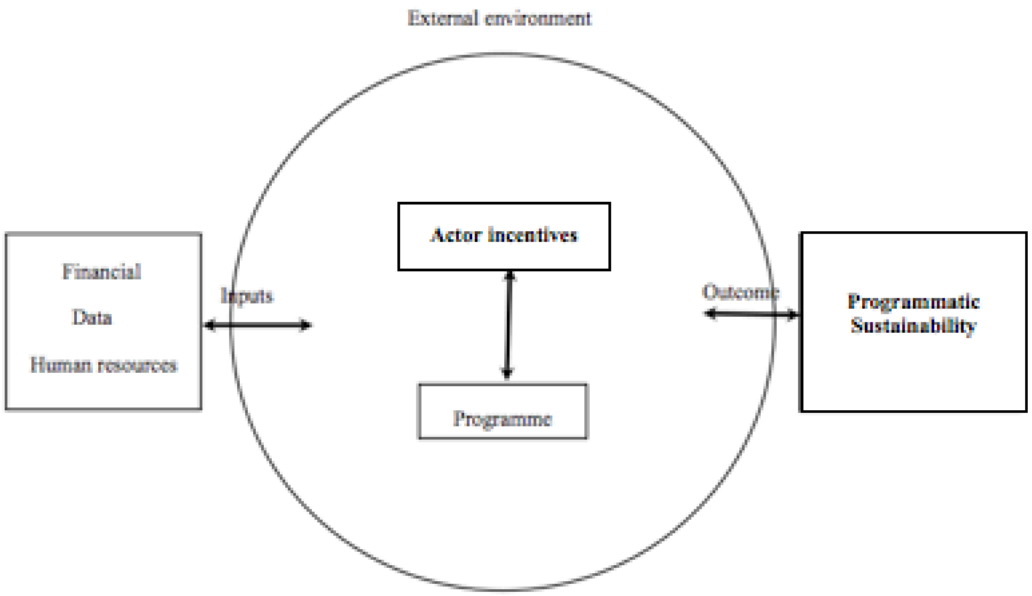
2. Activity profile: this includes the kind of services carried out, the choices made in terms of technology and level of care. These choices are usually based on perceived needs and resources available.

3. Organisational capacity: this represents the capacity to carry out tasks in the organisation. The aims of the organisation, the technology and their demand determine the nature of the load. Included in this area are also the structure (decision-making processes, division of labour, roles, coordination of work); institutional values and behaviour; manpower incentives; leadership; and resource mobilisation and financial management.

This framework is useful for understanding factors that are important for sustainability and describing structures and processes. Limitations of this model are that it may not be as useful to study complex processes but it does allow for grouping cross-sectional data which can then be compared with other time periods.

As this thesis seeks to address a policy scenario, structures and relationships that have an effect on sustainability, a framework using elements of the Gruen and Olsen frameworks was developed. See Figure 2.1 for a visual representation of the framework.

Figure 2.3.1 Framework of programmatic sustainability



Source: Developed by the author based on Olsen (1998) and Gruen et al (2008).

This framework is composed by the external environment, the inputs (financial, data and human resources), the actor incentives and programme, and the outcome, which in this case is understood as the ability of the country to achieve programmatic sustainability. The 'external environment' is those factors which affect health but are not part of the health sector, such as the changing political environment in Peru, the social environment in the country and the economic situation. Conversely, the actor incentives and programme components are found within the internal environment, referring to factors which are specific to the health sector and includes the HIV/AIDS situation in the country (which addresses Gruen's health element).

'Inputs' (or resources) include the finances allocated to HIV/AIDS activities through the government results-based budget; the health workforce that exists in the country; and the information available on the HIV/AIDS burden in the country and regions and the 'policy inputs' – policies already in place for HIV/AIDS.

The actor incentives replaces and further develops Gruen's 'stakeholder drivers' because besides drivers it also encompasses motivations from other actors involved in the policy process but who may not necessarily be the funders. This is defined as the ability of the government to manage the HIV/AIDS programme. The programme includes the strategies in place to align Global Fund activities within the existing HIV/AIDS programme and the perceived quality of the interventions. The ultimate goal may be effective HIV/AIDS programmes, but given the focus of this work on sustainability, the study assesses the programmatic continuity of services that were partly funded with Global Fund money. This was done by comparing the activities implemented during the study period with current government plans, as well as obtaining the point of view of Global Fund recipients and sub-recipients on the success of these activities and the changes that resulted from the takeover of responsibilities.

Finally, as figure 2.3.1 demonstrates how these elements continuously interact with each other in a bidirectional manner. The inputs have an important impact on both the actor incentives within a country and the programmes that are being implemented, since decisions on what to include in the response are based on the available resources. These actor incentives and programmes have an effect on the inputs, not only because these are the 'users' and 'managers' of the inputs but because based on the programme results and decisions the inputs can either be increased, reduced or can end. On the other hand, the actor incentives have a bidirectional relationship with the programme. The decision-makers (actors) shape the response of the programme but at the same time must respond to programme challenges and needs. Moreover, all of these elements have an effect on the programmatic sustainability of the HIV/AIDS programme, whose results also have an effect on the inputs, actor incentives and the programme. Programmatic sustainability is not a static concept and can even be conceptualised as a process that takes place over time, therefore the inputs, actor incentives and the programme must manage the challenges and opportunities that emerge from and relate to the progression towards sustainability.

This model, created for the purposes of this study, draws on the strengths and weaknesses of both frameworks since it places Gruen's dynamic relationship between the programme and the stakeholder drivers in an otherwise quite static Olsen framework, which only lists the factors affecting sustainability. While the factors within the model may be interrelated and it can be difficult to distinguish between cause and effect, the framework will facilitate in-depth analysis of the phenomena in their rich context. Table 2.3.1 explains how each of these framework components relate to the research objectives and results.

Table 2.3.1 Research objectives and framework components

Research objectives	Relevance to individual framework components	Results
Objective 1: To examine the inputs that have an important effect on HIV/AIDS policies and activities.	Inputs and programme	Paper 1 (Chapter 4)
Objective 2: To analyse how evidence informs Global Fund proposal development, and how this process supports the development of country capacity to generate and use evidence, and promote accountability.	Actor incentives and programme	Paper 2 (Chapter 5)
Objective 3: To assess the roles and motivations of the main actors involved in HIV/AIDS work in Peru as the country progresses towards programmatic sustainability.	Actor incentives and programme	Paper 3 (Chapter 6)

2.4 Methods

2.4.1 Data collection and data description

A case study approach was used looking at the example of Peru in the 2004–2012 period, employing qualitative methods to understand the changes associated with the process of the government taking responsibility for formerly Global Fund planned and financed HIV/AIDS activities. The case study can be described as instrumental, as it seeks to facilitate understanding on a specific issue, which can then frequently help generate transferable lessons for another situation (Stake, 1995). This case study is instrumental since by examining the case of Peru it also seeks to identify useful lessons for other middle-income country preparing for programmatic sustainability. While this case study will elicit factors unique to the context of Peru, the rise to middle-income status and gradual decrease of donor aid associated to it, is common to other developing countries.

To achieve this aim the study employed in-depth interviews and a documentary review of the literature, including policy, budgetary and administrative literature related to the operation of the Global Fund and results-based budget in Peru. Given that the study findings are presented in three research paper-style chapters, each paper discusses the specific literature reviewed. Below, a general overview of the methods used by this thesis is included.

1. In-depth interviews: 35 in-depth interviews were conducted with national and international stakeholders following a guide shaped by the conceptual framework between October–December, 2011.

An initial detailed mapping of the relevant actors working in the area of HIV/AIDS was conducted based on a review of the literature, development of criteria based on the research question and consultations with researchers working on HIV/AIDS and health system governance in Peru. This process sought to ensure that the sampling was comprehensive and the potential for bias minimised. The literature available in Peru showed that the main stakeholders working in HIV/AIDS in Peru can be organised into four sectors. These are the government; international organisations; NGOs and civil-society organisations; and academia (Cáceres & Mendoza, 2009). The pharmaceutical industry was excluded due to its limited involvement in HIV policy and programming.

The interviews sought to gather information on the experience of the different stakeholders throughout time on the transition from Global Fund to government funding activities. Much of the information gathered was not previously available in written form since some of these issues had not been systematically recorded for analytical or accountability purposes. This approach made it possible to compare perceptions between what was found in the policy and administrative documentation, as well as gather first-hand reflections on findings described in the literature.

All the interviews were conducted in Spanish with the exception of one, which was conducted in English. My fluency in Spanish meant that the interviews could be done independently without the use of a translator and subtle meaning adequately captured. The recommendation provided by van Nes and colleagues (2010), to collect, order and conduct preliminary analysis in the original language as long and as much as possible in order to avoid limitations in the analysis and interpretation, was followed. As explained in the analysis section, illustrative quotations were later translated into English for publication of results.

The advantage of conducting in-depth interviews with the use of a guide was that it allowed certain themes to be followed but at the same time provided the flexibility to follow new leads and use different wording in order to capture valid information about the topic (Yin, 2003). Indeed, one of the advantages of having one researcher conducting all of the interviews was that emerging themes from prior interviews could be explored further and the guide could be adapted as necessary. This also helped identify a saturation point after which no new data was gleaned from the interviews (see section 2.4.2).

In addition to belonging to one of these groupings, interviewees were carefully selected based on several other criteria. These were 1) Direct participation and expertise on HIV/AIDS work in Peru: this included involvement in the Country Coordinating Mechanism (CCM), implementing activities, or as an external party that evaluated Global Fund activities or had an advisory role in the process; 2) Longevity in the HIV/AIDS policy environment: given that the thesis seeks to evaluate the 2004–2012 period, it was important that interviewees had a certain degree of longevity working in HIV/AIDS and could comment on changes over time; and 3) Familiarity with unfolding or future events in the area of HIV/AIDS: besides commenting on the past, it was critical that interviewees be aware of ongoing issues and the

remodelling of planning, roles and funding around HIV/AIDS. This process led to setting the initial interviews.

Additionally, 'chain sampling', with interviewees nominating other interviewees with potentially relevant expertise (Mays & Pope, 2000) was used to supplement the information provided by the interviewees and ensure a wide representation of actors within the study. Table 2.4.1 provides a description of the four groups of interviewees.

Government interviewees included officials at the Ministry of Health who worked directly with Global Fund projects, as well as members of the CCM called CONAMUSA (Coordinadora Nacional Multisectorial en Salud) and regional CCMs, COREMUSAs (Coordinadora Regional Multisectorial en Salud) that are involved in the decision-making and implementation of HIV/AIDS policies and activities. Other government officials were selected since they also belong to the CCM and are knowledgeable about the processes involved in requesting funding from the Global Fund. These officials were frequently also part of the transition into government uptake of activities and could therefore comment on these changes.

Interviewees from international organisations were frequently also sitting on the CCM providing more of an advisory role but could also give their perspective on the country environment around HIV/AIDS, as external parties. In some cases, they had also been part of Global Fund activities in the past.

Members of NGOs and civil-society organisations (CSOs), depending on how long they had been working in the health sector and HIV/AIDS particularly, proved to be good sources of information concerning HIV/AIDS advocacy and activities before the Global Fund and the changes that have taken place along the way. They were also important actors in the decision-making process of developing proposals for the Global Fund as members of the CCM and at times implementers of Global Fund activities.

Table 2.4.1 Respondent characteristics

Sector	Number of interviews	Institution	Position	Examples of type of information gathered
Government	10	Ministries of Health; Education; Women & Social Development; Finance & Economics; Foreign Affairs; Justice. CONAMUSA and COREMUSA leaders. Regional health leaders.	• High-level & middle-level management at the central level. • Regional and local-level leaders. • Coordinating mechanisms leaders.	• Information on interaction with Global Fund officials and other donors. • Experiences during the transitional period of takeover of responsibilities; effect of decentralisation and results-based budget. • Effect of policy change on prioritisation of the HIV response. • Use of technical assistance and bearing on decision-making. • Coordination of regional HIV planning. • Relationship with other ministries – multi-sectoral response.
International organisations	7	Bilateral (3) Multilateral (4)	• High-level & middle-level management. • Programme officers.	• Information on discussions around sustainability with government officials. • Role in providing technical assistance and supporting capacity-building in the country. • How their roles changed following the start of Global Fund funding.
NGOs and CSOs	14	National-level NGOs and CSOs (9) Regional-level NGOs and CSOs (5)	• Leaders from organisations implementing Global Fund prevention activities. • Leaders from organisations providing direct HIV/AIDS care. • Advocacy leaders. • Project implementers. • Coordinating mechanism members.	• Information on the role of these actors on decision-making within the CCM. • Participation in the implementation of Global Fund activities. • Changes in the HIV policy environment over time. • Advocacy role around HIV. • Relationship between the regions and the central level. • Funding sources for their activities.
Academia	4	Universities (3)	• Heads of research units. • University professors.	• Information on strategies to promote research in HIV and perception of government uptake of evidence for decision-making. • Role in increasing local capacity both in policy and planning and the health professions. • Quality of HIV data.
TOTAL	35			

Finally, academics and experts working on the HIV policy environment were consulted. Usually they did not sit on the CCM but many were involved in studies in this areas.

2. Documentary review of information. Grey literature and peer-reviewed articles were reviewed on issues surrounding the HIV/AIDS programme in the country, the results-based budgeting strategy and Global Fund proposals published in the 2000–2016 period. A review of secondary data, national policy and regulatory guidelines was also conducted.

The documentary review was carried out using Spanish and English key words and searching in Spanish and English databases to gather as much relevant information as possible, which may not be available in the other language.

A list of key terms was drafted, together with synonyms. The main themes explored in the documentary collection included the terms 'HIV', 'AIDS', 'financing', 'decentralisation', 'sustainability', 'aid', 'coordination', 'Global Fund' and 'donors' together with 'Peru'. The databases searched included MEDLINE/Pubmed, Web of Science, LILACS, Global Heath, EMBASE and Google Scholar. The bibliographies of relevant articles were also reviewed to identify other important sources.

The documentary review provided the contextual basis for the study and informed the main themes explored during the in-depth interviews, as well as serving as a comparison point to the information obtained during these interviews.

Reviewing a variety of documents was important in order to provide the full context in which HIV/AIDS activities are implemented in the country and to ensure that all relevant material was evaluated. When documents were not published through the regular mechanisms, such as peer-reviewed journals or via institutions as grey literature, great care was taken to critically appraise their quality and usefulness for this thesis.

The peer-reviewed articles assisted in framing the global health environment in which aid is provided and how this has affected Global Fund priorities and allocation of grants. Moreover, they provided a background on debates related to sustainability of aid and the Peruvian HIV policy context, as well as the effect of Global Fund financing.

The grey literature contributed mainly to the understanding of international policies published by institutions such as the United Nations (UN) and the Joint United Nations Programme on HIV/AIDS (UNAIDS). National reports from the ministries and other Peruvian institutions were also examined, providing information on areas such as institutional missions and goals; expenditure; evaluation of Global Fund activities; and relevant policies regarding HIV. This literature also allowed for an understanding of the economic situation in Peru, decentralisation and local capacity.

The review of Global Fund specific documents, among these the proposals, score cards, technical and financial reports and evaluation reports was useful in understanding how Global Fund processes took place, obtaining results from their grants and understanding the criteria used to provide funding and categorise countries according to income level. The analysis of the Global Fund proposals, which is presented in results chapter 5, was useful in understanding the evidence base, evaluation mechanisms and consistency in activities between funding proposals. However, it should be noted that these reports, while at times developed by external consultants or auditors, may reflect the official view of the Global Fund, limiting a critical reflection on the internal discussions within the Global Fund and how it addresses or fails to address sustainability. For this reason, a thorough review of both peer-reviewed and 'grey' literature was crucial in addition to eliciting views from the interviewees, in order to put these 'official scripts' in perspective.

Databases from institutions such as the World Bank, UN, WHO and Ministry of Finance, on topics such as GDP growth, health expenditure, HIV/AIDS budgeting and disease burden were also examined to contribute to the analysis of spending and disease trends.

Moreover, a review of laws and agreements, as well as local newspapers and articles helped provide the context of the political and social situation related to HIV/AIDS and in the country in general.

2.4.2 Data analysis

Following data collection, the documentary data and the interviews were analysed thematically. The analysis identified latent themes that go beyond explicit expressions but involved further interpretation of underlying ideas. Thematic analysis is characterised by being a flexible research tool to identify, analyse and report patterns within data that can provide rich, detailed and complex results (Bruan & Clarke, 2006). The thematic analysis of

data derived from interviews was employed primarily in results chapter 4 and 6. Chapter 5 involved thematic analysis of the proposals submitted to the Global Fund and the main policy documents on HIV/AIDS in Peru. Conventional content analysis, a method used to interpret meaning from the content of text data (Hseih, 2005), is the term used for chapter 5 to distinguish it from thematic analysis, which was used for the analysis based on interviews. However, content and thematic analysis are terms that are frequently used interchangeably since they use the same approach of developing codes or themes (Bruan & Clarke, 2006).

While the conceptual framework sought to ensure that major dimensions identified in the literature, are covered when collecting data, the thematic analysis followed an inductive approach (Bruan & Clarke, 2006; Green & Thorogood, 2004). The analysis was data-driven and sought to reflect the complexities and interrelationships in the data while reflecting back on the components of the framework. This led to a constantly evolving coding frame, which informed the construction of the narrative.

The following steps were followed for the data analysis (Green & Thorogood, 2004).

a) Familiarization with data from each of the conceptual framework components.

During this step the literature associated with the subject area was examined to become familiar with the theories behind this area of study and form a contextual background of the country and internationally around the topic. Once the interviews were conducted, the transcripts in Spanish were read, and wherever necessary the recordings were listened to, in addition to the field notes from each of the meetings. This allowed a full understanding of the interviewees' responses to the questions, relating this to the literature. Whenever necessary, additional literature was searched to fill in gaps from interview findings.

b) Defining themes in each framework component and identifying possible new themes.

Once the background information and interview results had been familiarised, themes within the data were identified as they related to the different elements of the framework. During this stage new themes or sub-themes were also identified which were also taken into account for the next step.

c) Indexing and assigning codes to each theme.

After the themes were identified, each interview was coded utilising the qualitative software NVivo (version 10), which provided a space to organise and index these themes. When sub-themes were present they also received a sub-code, which further disaggregated the components of a code, these were also included within the software for easy identification.

d) Identifying relationships between the recurring themes and charting these relationships.

Relationships between different themes were noted and charted using NVivo. This was useful in inferring meanings and explanations in the next step.

e) Interpreting the meanings of relationships and forming explanations on why these take place and the impact of these relationships.

Once these steps had taken place, interpretation of the meaning of the different themes and their relationships (similarity, overlap, contrast) with other themes could begin. At this point, as mentioned earlier, interview quotes were translated from Spanish into English, in order to avoid losing any of their original meaning during the analysis phase (van Nes et al., 2010).

Green and Browne (2005) identify comprehensiveness, thoroughness and transparency as key criteria to improve the quality of qualitative analysis. Interview data was assessed as typical, following the response of the majority of the interviewees or atypical and this was registered as well as noting specific quotes. The analysis was critical, testing emerging hypotheses and looking for evidence to disconfirm the cases and driven by comparison between data. In this sense, the data analysis was contemporaneous related to a saturation point where no further insights were gleaned from the data, demonstrating content validity (Francis et al., 2010). This saturation point was identified during the fieldwork when no new themes or ideas were emerging from the interviews and the interviewees confirmed the insights that others had provided.

Furthermore, reflexivity was ensured by keeping a fieldwork journal to record key impressions while conducting the interviews, as well as understanding the contextual factors within the country (Mays & Pope, 2000). Moreover, the data was validated using triangulation, a tool that helps to offset the limits to generalizability caused by a single study

by allowing the researcher to draw conclusions from "asymmetrical but independent observations of the study population" that when pointing to the same conclusion tend to confirm each other (Wolff et al., 1993: 133) and helps reduce measurement and sampling bias (Patton, 1999). The study employed methodological triangulation, which checks for the consistency of findings by using different data collection methods (Denzin, 1978; Patton, 1999). This took place by triangulating the interview results with the literature review, field notes and journal entries to produce informed recommendations and conclusions for the study. This consisted in reviewing and forming relationships between the types of data in order to confirm or negate explanations formed by the interviews. When inconsistencies were observed, these were noted and further explored leading to the final conclusions. Validation of findings was also sought through structured discussions with other researchers familiar with the topic, who contributed to the interpretation of findings given the complex country transition, resulting in two published articles in peer-reviewed journals and another that will be submitted to a peer-review journal.

2.5 Structure of the thesis

This thesis is organised in a 'research paper style' format, hence it is divided into a general literature review, a description of the study setting, and three research paper-style chapters which include their chapter-specific literature review, methods, results, discussion and conclusion. Two of these research papers include an addendum located immediately after the respective papers, for an extended interpretation of the implications of the findings. Finally, a general discussion is presented which seeks to bring together the key findings, interpret their implications and identify recommendations for policy.

The chapters are described below.

Chapter 3 presents the theoretical background which supports the study. This chapter is divided into three major sections. It begins with a general overview of international aid and discusses issues related to aid effectiveness and aid in middle-income countries. The second section provides an analysis of aid dependence by discussing some of the key concepts as well as enabling factors for effective sustainability and country examples of transition to self-sufficiency. Section three discusses the main characteristics of global health initiatives and their approach to funding, ending with specific information on how the Global Fund operates.

Chapter 4 is a paper assessing the period of Global Fund financing of HIV/AIDS activities by examining changes in indicators, as well as inputs such as economic resources, human resources and monitoring and evaluation systems in the country in order to understand how these elements have an impact on HIV/AIDS policies and activities. This chapter focuses on objective 1 of this thesis.

Chapter 5 and its addendum (section 5.7) is a paper focused on lessons learned from the process of HIV/AIDS Global Fund proposal development in Peru between 2002 and 2009 by examining their evidence-base; relevance and consistency with other proposals and HIV/AIDS policies; as well as the appropriateness of the monitoring and evaluation systems. The relevance of these results to sustainability is also explained. This chapter addresses objective 2 of this thesis.

Chapter 6 and its addendum (section 6.8) is a paper analysing the roles and incentives of actors working in HIV in Peru and the implications for programmatic sustainability. This chapter addresses objective 3 of this thesis.

Chapter 7 presents a summary of the main findings and a general discussion on the implications of these findings. It concludes with some recommendations for action in the country and for aid funders and recipients in general, as well as suggestions for future research.

The appendices provides further contextual information about Peru, the information sheets and consent forms used for the in-depth interviews, the interview guides in Spanish and English and the ethical approval forms.

2.6 Ethical approval

Ethical approval was granted by Universidad Peruana Cayetano Heredia on 11 October 2011 (reference number 058954) and by the Ethics Committee at LSHTM on 7 September 2011 (reference number 6022).

Participants were provided with an information sheet detailing the study objectives, process and procedures ensuring the confidentiality of their responses and these were also explained to them by the interviewer. Those who gave their consent to participate in the interview were asked to sign two copies of a consent form, one to keep, and one for the researcher. Written consent forms, textual data and recordings were kept with the researcher at all times.

Chapter 3 Literature review

The literature was included based on its ability to provide the health policy context, which had an impact on the process of Global Fund HIV/AIDS financing in Peru, and its subsequent exit. A review of the literature was conducted, selecting and appraising publications that are most relevant conceptually and methodologically to the main focus of this thesis: sustainability and its related themes. Based on this, the chapter is divided into three major sections:1) panorama of international aid (brief overview of the international aid scenarios and aid in middle-income countries); 2) the process of change from aid dependence to transition and sustainability; and 3) the emergence of global health initiatives and their role. It is beyond the scope of this DrPH thesis to conduct a comprehensive examination of the extensive literature around aid, its effects and their sustainability.

3.1 Panorama of international aid

Aid, also referred to as development assistance, consists of the financial and in-kind contributions that seek to improve the health of developing countries. This development assistance is usually provided by high-income governments, public-private partnerships such as the Global Fund, non-governmental organizations and private foundations (IHME, 2014).

Aid for health grew globally by more than US$15 billion in a 17-year period, increasing from US$5.6 billion in 1990 to US$21.8 billion in 2007 (Ravishankar et al., 2009). Aid from UN agencies and development banks decreased in this period, with the Global Fund, as well as the Global Alliance for Vaccines and Immunisation (GAVI) Alliance and international NGOs being the mechanisms accounting for the greater amount of development aid for health (Ravishankar et al., 2009).

Several studies have reported how aid has contributed to decreased mortality and morbidity in the diseases it targets (for example Akachi & Atun, 2011; Floyd et al., 2010; de Jongh et al., 2013). The Global Fund, for instance, has reported 8.7 million lives have been saved through their support in providing funding for HIV, tuberculosis and malaria in the 2002–2012 period (Global Fund, 2012a); although this figure has been contested by McCoy and colleagues (2013) who believe the methods used to calculate this may have overestimated the number of ‘lives saved’.

In the area of HIV/AIDS, specifically, the last 15 years were characterised by an unparalleled international response to fight the disease and the consequent distribution of funds that had never been mobilised for any other single disease (Spicer et al., 2010). This influx of money created management problems from the beginning due to the lack of coordination among the multiplicity of actors involved in providing the funding and managing the programmes. Measures began to be put in place to ensure that all actors were working towards the national HIV/AIDS goals. UNAIDS proposed the 'three ones' fundamental principles for the coordination of national HIV/AIDS activities (UNAIDS, 2005). This model is based on a framework of action for HIV/AIDS; a national coordinating authority for AIDS; and a surveillance and evaluation system at the country level.

However, the current economic climate due to the financial crisis and Eurozone turmoil has resulted in a decrease in all development aid by 4% for 2012, following a fall in 2011 of 2% (OECD, 2013). At the same time there has also been a shift in aid allocations from the poorest countries to middle-income countries (OECD, 2013). Research by Riddell (2007) confirms that this trend has been going on for some time now, reporting that the 63 poorest countries of the world receive less than half of the total official development assistance (ODA). The reasons for this will be discussed later on. However, it is clear that poor targeting of aid not only does diverts resources from areas of most need but it also increases funding volatility generating uncertainty among countries on when they will receive aid and under what terms (Riddell, 2009; Hay & Williams, 2005). This generates challenges among developing countries, whom may have weak governance already, in planning for the long-term to ensure effective investments (Celasun & Walliser, 2006; Dodd & Lane, 2010; Schwartlander et al., 2011; Stover, et al., 2011). Moreover, this uncertainty in funding strengthens the case for generating country mechanisms that can sustain effective implementation after funding has ended.

According to Slob and Jerve (2008), there are several reasons why aid can end. This can be due to graduation from aid, when the recipient can manage without the help of external aid; aid disqualification, if the recipient does not follow good governance standards; similar to this, if there is a mismanagement of aid; or if donor priorities change and they decide to revise their criteria for country investment.

This thesis focuses on the first criteria related to graduation from aid and the transition towards programmatic sustainability. In this process, it is crucial that donors and country actors ensure that these resources are actually reaching its objectives and through that, generating mechanisms for eventual end of aid. Understanding the usefulness of aid has led to a rich literature dedicated to measuring aid effectiveness, with some of the main themes in this area discussed below.

3.1.1 Does aid work?

Several diverging points of view on whether aid tend to achieve its goals have been widely debated and contested from different perspectives. Indeed, few studies have examined in detail the process by which external investment result in health impact (de Jongh et al., 2013). An early study by Cassen and Associates (1994) found that projects funded by aid did achieve their aims and contributed to economic growth but that the contribution of aid to poverty reduction was low. Sachs (2005), however, argues that growth requires investment and investment requires savings. These savings can only happen once a country has an income beyond what it requires for survival. Following this logic, aid is effective because it helps a country accumulate savings and this leads to growth. Hailu and Shiferaw (2012), contest these findings in their study by finding no statistically significant long-term relationship between aid and economic growth in developing countries and that the likelihood of a country exiting from high levels of aid only increases according to the rate of government investment. Thus, strengthening policies and institutions that promote public and private investment will have a positive effect on future aid independence.

Moreover, common criticisms of aid are that aid planning is not accountable nor does it respond to the people or country needs (Easterly, 2006). Furthermore, Moyo (2009) has argued that aid causes corruption, generates bottlenecks and decreases competitiveness. On the other hand, Burnside and Dollar (2000) found that while overall aid has a low impact on growth, in settings with good policy environments aid does lead to growth. These results were later confirmed in other studies (McGillivray, 2005). The association of aid with growth is particularly important for sustainability, since aid frameworks and procedures should in theory help countries set the foundations to becoming self-sufficient. However, this cannot happen if appropriate policies are not in place to manage aid and encourage economic growth.

A related concept is fungibility of foreign aid, which occurs when external aid substitutes domestic country expenditure on health (Lu et al., 2010). Besides going against international agreements, countries that utilise aid to substitute for their own health spending have the potential to weaken their health systems and the cost would inevitably be translated to the population in the form of out-of-pocket payments (Lu et al., 2010).

A critical factor for effective aid is good governance expressed as sound public institutions that are able to manage this aid in a transparent and accountable manner (Burnside & Dollar, 2000). The idea that aid should prioritise countries with good public institutions to ensure results is in contrast with the view that aid should build institutions through 'capacity building', which is the approach favoured by UN agencies and other donors (Easterly, 2006). The former view assumes that aid should target countries with good institutional capacity, and this creates a risk that aid is provided to countries that can benefit very little from investments. In a situation of acute health issues, such as high HIV/AIDS incidence and prevalence, where there is lack of institutional capacity or political will to address these problems, ensuring an effective response to the disease should predominate over expectations for countries to begin to develop their health systems and governance capacity.

In response to these concerns, the Paris Declaration was established in 2005 to improve the effectiveness of aid (OECD, 2008), with the subsequent Accra Agenda for Action (OECD, 2008) and Busan Partnership agreement (OECD, 2011) seeking to build on these principles for effective development cooperation. The initial Paris Declaration was signed by more than 100 development agencies and countries (Lawson, 2010), and is based on the principles of ownership, harmonisation, alignment and results and mutual responsibility. Although important progress has been made in aid efficacy, especially with regards to the alignment of programmes, the results eight years after the Paris Declaration show that there is still much left to do in terms of donor coordination (Biesma et al. 2009; Lawson, 2010). This lack of coordination has frequently led to higher transaction costs, diluted the efficacy of aid, weakened the steering role of the government and made monitoring difficult (Archarya, de Lima & Moore, 2004; Atun et al., 2010; Brugha et al., 2004; Grundy, 2010; Marchal et al., 2009).

Coordination is broadly seen to be a crucial element to ensure aid effectiveness. The term 'coordination' has been associated with many different dimensions: 'effectiveness' (Buse &

Walt, 1996; Conway et al., 2008; European Commission, 2007; Wollmann, 2006), 'efficiency' (Conway et al., 2008; European Commission, 2007), 'harmony' (Conway, et al. 2008), 'distribution of tasks' (United Nations, 2010), coherence (Wollmann, 2006), 'consistency' (Wollmann, 2006), 'common goals' (Peters, 1998; Wollmann, 2006) and 'delegation' (European Commission, 2007). In general, the international community follows the definition espoused by the Paris Declaration Principles (OECD, 2008), where coordination is associated with harmonisation. This is defined as the process through which donor countries delegate activities, simplify procedures and share information to avoid any duplication (OECD, 2008). The creation of effective working relationships between partners (Johnson, Hays, Center & Daley, 2004; Scheirer, 2005) and the establishment of mechanisms for mutual accountability (Walsh, Mulambia, Brugha & Hanefeld, 2012) have been identified as important in achieving effective coordination of programmes.

3.1.2 Aid in middle-income countries

Issues around aid in middle-income countries are complex since they may be experiencing economic prosperity but could also still require aid due to difficulties such as socio-economic inequalities disadvantaging particular population groups or political reasons which limit investments in a certain area. Economic growth has led some countries, especially in Latin America (Astorga, 2010), to graduate from being low-income countries to middle-income countries (Lee & Kim, 2009)[3]. This growth has been associated with factors such as increased political stability and administrative capacity (Cornia, 2011; Reynolds, 1985), yet some analyses suggest that economic growth may be initially associated with increased inequality (Kuznets, 1955; Morrison, 2000). This is particularly a problem in Latin America, which together with sub-Saharan Africa remain the most unequal regions in the world (Lopez & Perry, 2008). In health, this inequality could potentially leave a segment of the population with reduced access to care.

Middle income countries play a key role in achieving development targets, including in health. By 2008 approximately 1.3 billion people, representing three quarters of the world's poor, lived in middle-income countries. This has resulted in an exponential increase since 1990, when 93% of the poor people worldwide lived in low-income countries. This means

[3] The World Bank classifies countries according to income level according to 2012 GNI per capita. These economies are subdivided into low income if they are $1,035 or less; lower middle income, $1,036 to $4,085; upper middle income as $4,086,946 to $12,615; and high income $12,616 or more (World Bank, 2013).

that the majority of the poor do not live in fragile countries but in stable middle-income countries (Sumner, 2010). This is important in the health system strengthening debate given that there is robust evidence showing that poverty is associated with poor health and lower life expectancy (OECD, 2003).

Despite this data, there is still a discussion about whether it is effective to provide aid for middle income countries (Eyben & Lister, 2004; Fenton, 2008). The logic promoted by those who oppose an increase in aid is that as the HIV/AIDS burden decreases and the countries become wealthier and are able to invest more of their own health budgets for health, in some cases beginning to take up activities funded in the past by donors (Eyben & Lister, 2004).

However, this pattern was not seen in the Latin American region. Despite high economic growth in the region during the 2004–2008 period, national health expenditure grew at a slower rate in comparison with the regional growth rate. This is demonstrated by a decrease in national health expenditure as a percentage of GDP from 6.8% in 2004–2005 to 6.4% in 2008. During the global economic crisis from 2008–2010 this percentage increased from 6.4% in 2008 to 7.0% in 2010 to lessen the impact of the recession and respond to the H1N1 pandemic, yet these increases could not be sustained and decreased again in 2011 to 6.7% of GDP (PAHO, 2012).

Moreover, the reasons for providing aid to middle income countries can include political and commercial objectives. Thus according to the Department for International Development (DFID), OECD countries continue to provide aid to middle-income countries seeking to: a) reduce poverty and social exclusion; b) generate international public goods; and c) promote other aspects of bilateral and multilateral relationships with commercial and political interests (Eyben & Lister, 2004).

Middle-income countries receive US$17 billion of net global concessional development assistance, as well as 43% of bilateral official development assistance (DFID, 2004). This aid is provided principally through three mechanisms: multilateral development banks, multilateral organisations (such as UN organisations and the European Union) and bilateral donors (Eyben & Lister, 2004).

This section has highlighted a few of the main debates around aid with a focus on middle-income countries, as well as the main factors that hinder and promote aid effectiveness. The view of aid as an ‘addendum’ or ‘subsidy’ to national efforts supposes that aid at some point

will become redundant leading to a situation where countries can sustain gains that have been achieved and build on these. However, in some cases, countries become dependent on aid, and fail to commit institutional and financial resources, which leads to a scenario where aid sustainability is difficult to attain. The following sections discuss issues around aid dependence means and how this is associated with sustainability.

3.2 The progression from aid dependence towards sustainability

3.2.1 Aid dependence

Aid dependence has been defined as a situation where a country cannot perform the core functions of government such as operations and maintenance, or the delivery of public services without foreign aid or expertise (Brautigam, 2000).

Countries with high aid flows that suffer successive economic crises over a long period of time risk a situation of high aid dependency. This can be further complicated in situations of poor governance and mismanagement where aid becomes a mechanism for government consumption, rather than public investment (Moss, Petterson & van de Walle, 2006). Indeed, a key element identified in the literature for a country to move from aid dependency to self-sufficiency is the ability of the government to collect revenue through taxation, thus decreasing the need for aid (Azam et al, 1999).

Aid dependency also has a negative effect on strengthening government accountability since the state may have a higher incentive to respond to donor demands rather than those of their constituents. Reliance on aid means that governments may not be motivated to invest in developing their own capacities since resource flows are not associated with government efficiency (Moss, Petterson & van de Walle, 2006). This generates a moral hazard where aid dependence may thus be associated with decreased incentive to adopt good policies and reform institutions (Heller & Gupta, 2002).

Furthermore, the significance of aid given other resources has an effect on the aid provider's influence on policies and resource allocations (Eyben & Lister, 2004; WHO, 2002) and the effects of the aid burden in the country (due to transaction costs or government capacity) (Eyben & Lister, 2004; McKinsey & Company, 2005; Ooms, 2009).

Historically, aid dependence has generally been measured as the ratio of aid to gross domestic product (GDP), reflecting how reliant the country is, or of aid to public expenditure (Eyben & Lister, 2004). The OECD (2003) defined high aid dependency as net development assistance greater than 9% of gross national income (GNI) and low aid dependency as below 3%. However, a more recent attempt at classification has been proposed by Glennie and Prizzon (2012) that classify recipient economies in a more nuanced manner, based on their net aid to GNI ratio as: 1) High Aid Countries (HACs), above 10% ; 2) Middle Aid Countries (MACs), between 2% and 10%; 3) Low Aid Countries (LACs), between 1% and 2%; and 4) Very Low Aid Countries (VLACS), below 1%. These classifications are used by donors to determine which countries are at risk of being highly dependent on aid in order to address these risks or to identify countries that will soon be ineligible for aid. Countries in the process of becoming ineligible for aid for essential disease programmes may be inclined to examine possibilities to sustain these programme in the long-term.

3.2.2 Transition towards sustainability

The definitions of sustainability are diverse, reflecting different underlying disciplinary approaches. As a result of these multiple angles, some authors have described it as a concept that 'lacks consensus and direction' (Phillis & Andriantiatsaholiniaina, 2001). However, most of these definitions have been a focus of research in environmental, energy and economic sciences (Sheate, 2010). The major approaches to defining sustainability within the health sector are presented below.

In a recent report, the Global Fund defined sustainability as the endurance of a system or process (Global Fund, 2014). PEPFAR, a US public-private partnership that provides funding for HIV/AIDS, defines sustainability as the capacity of a country to achieve long-term success and stability and provide services without interruption and without affecting the quality following the end of the financing (USAID, 2013).

LaPelle and colleagues (2006), on the other hand, define sustainability of programmes as 'the capacity to maintain programme services at a level that will provide ongoing prevention and treatment for a health problem after termination of major financial, managerial and technological assistance from an external donor'.

Other definitions of sustainability are related to 'continuity' (Scheirer, 2005; UNICEF, 1992), 'routine' (Greenhalgh et al., 2004), 'maintenance' (Gruen et al., 2008; LaPelle, Zapka & Ockene, 2006; Shediac-Rizkallah & Bone, 1998), 'permanence' (O'Loughlin et al., 1998), 'incorporation/implementation' (Bracht, et al., 1994; Pluye, Potvin & Denis, 2004; Stefanini & Ruck, 1992) and 'institutionalisation' (Shediac-Rizkallah & Bone, 1998). The definitions also vary according to the type of sustainability we are referring to.

For the purposes of this research, sustainability in health is defined as the capability of the government to manage health programmes long-term without depending on the intervention of external bodies for technical or financial support within a given social, political and economic environment.

A necessary process, and the main focus of this thesis, is transition towards sustainability. Thus, transition is defined as the period when actors plan for and takes the necessary steps and actions towards sustainability within a given social, political and economic environment.

The term sustainability can be further disaggregated according to the area it addresses. There are six major types of sustainability that are identified from the literature:

1) *Political sustainability* is associated with the political will to continue a programme. Political commitment to a particular initiative is important since a government may choose to forego an unpopular policy due to political pressures (Pavignani & Colombo, 2009); this is also relevant to donors who may experience drastic shifts in levels and commitment to provide aid.
2) *Fiscal sustainability,* also related to financial sustainability, is defined by the International Monetary Fund (IMF) as 'the capacity of a government, at least in the future, to finance its desired expenditures to service any debt obligations (including those that may arise if the created fiscal space arises from government borrowing), and to ensure its solvency' (Heller, 2005). Financial sustainability results from resource availability, fiscal capacity and the relative priority of health care provision (Pavignani & Colombo, 2009). Having the necessary financial resources to invest in health and social programming is a fundamental element of sustainability. As the definition above suggests, the concept of fiscal space implies that a country that has reached this level can invest in local needs according to government priorities with greater freedom than if this money originated from external sources.

3) *Social sustainability* refers to activities whose long-term viability depends on the demand for these services (LaPelle et al., 2006; Torpey et al., 2010), highlighting the importance of planning activities that respond to need and context and which can be further adapted over time (Sheirer, 2005).
4) *Organisational sustainability* is defined as putting systems in place to reach goals and increase stakeholder value in the long-term, usually within an organisation, by considering economic, environmental and social factors in the strategies (Sheidiac-Rizkallah & Bone, 1998).
5) *Programmatic sustainability* is the development of long-term capacity to sustain a programme through effective management, coordination and implementation of services (Gruen, et al., 2008; LaPelle et al, 2006; Olsen, 1998; Sarriot et al., 2004; Torpey et al., 2010; Walsh, et al., 2012). This type of sustainability requires that once financial investment is made, mechanisms to maintain and scale-up services need to be developed. This involves having a strategic vision and the generation of capable institutions and individuals to conduct these activities.
6) *Technical sustainability* relates to the capacity to continue carrying out certain technical functions specific to the programme (Pavignani & Colombo, 2009). This differs from programmatic sustainability in that it refers to the technical expertise of the workforce. Indeed, technical assistance or 'technical cooperation' are important contributions from donors since a country may depend on the counsel of external entities without developing local evidence to support its work. Technical assistance is defined by the Organisation for Economic Cooperation and Development (OECD) as the 'provision of know-how in the form of personnel, training, research and associated costs. It comprises donor-funded: a) activities that augment the level of knowledge, skills, technical know-how or productive aptitudes of people in developing countries; and b) services such as consultancies, technical support or the provision of know-how that contribute to the execution of a capital project' (OECD, 2011a).

These different types of sustainability are closely related and are all important to maintain a programme. However, the particular context in the country determines their relevance as an object of study. This means that if a country has an expressed need for services for a particular disease, for example in the case of HIV/AIDS where affected populations require

long-term access to treatment, social sustainability may be present but the ability to continue these programmes through appropriate management and coordination of services (programmatic sustainability) may not be available, which would require research in this area.

Indeed, programmatic sustainability is frequently observed as a weakness in countries that are seeking to transition out of aid since the ability to graduate from aid may mean that they have the financial resources available to continue services but this does not necessarily translate into the capacity to implement these services, which may have been facilitated by prior donor grants. In this sense, it can be inferred that programmatic sustainability remains a key type of sustainability in middle-income countries that are transitioning out of aid. Moreover, while the markedly vertical design of many donor-funded programmes, including the HIV/AIDS programmes, gives them a degree of autonomy, the vertical design can make the transition into full government financing difficult by generating tensions with other government institutions, for example in terms of allocation of financing (see section 3.3.1).

Related to this is the importance to ensure that grants develop problem-solving skills and foster community involvement rather than institutionalise programmes that are merely the vehicles to solve problems (Green, 1989). Indeed, the literature shows that improving technical capacity requires long-term planning and a transitional approach (Akerlund, 2000; Hay & Williams, 2005; Torpey et al., 2010) to facilitate the hand-over of new responsibilities by the governments or national agents. Additionally, it is also understood that many countries may require technical assistance even if they can fund their own programmes (Vermund et al., 2012). Yet, the ultimate goal of technical assistance should be to develop capacity so it is no longer needed (Godfrey et al., 2002; Lele et al., 2004).

The ability to continue to provide services at the same or better level reaching sustainability is closely related to the presence of several enabling factors. The literature shows a number of factors are associated with successful transition to government ownership and sustainability. The eight most commonly cited enabling factors for sustainability identified in the literature include: 1) *Adequate, stable and predictable financing to cover the costs of services, medicines, technologies, personnel and management*. Despite large inflows of aid for health, it is widely understood that domestic investments are an essential factor for long-term sustainability of programmes (Atun, et al, 2010; Bossert, 1990; Gruen et al., 2008; Hailu & Shiferaw, 2012; Heller, 2005; LaPelle et al., 2006; Lu, Michaud, Khan & Murray, 2006;

Mills & Bennett, 2002; Ooms, 2006; Pavignani & Colombo, 2009; Savaya & Spiro, 2012; Schell et al., 2013); 2) *Alignment of donor activities with government policies*, facilitating long-term planning (Bossert, 1990; Hay & Williams, 2005; Johnson, Hays, Center & Daley, 2004; OECD, 2011; Scheirer, 2005; Scheidiac-Rizkallah & Bone, 1998; Slob & Jerve, 2008; Tibbits et al., 2010); 3) *Political support*, frequently described as political will, to continue to provide the programmes (Pavignani and Colombo, 2009; PEPFAR, 2012; Schell et al., 2013); 4) *Good governance*, expressed as sound policies and institutions. This also entails the existence of mechanisms to hold actors accountable and strategic planning including the ability to develop programmes that can adapt over time (Scheirer, 2005; Saxenian et al., 2014; Schell et al., 2013; Walsh, Mulambia, Brugha & Hanefeld, 2012); 5) The presence of *effective leaders* who promote the continuity of actions and foster actor involvement, including actors that are less powerful politically (Akerlund, 2000; Archarya et al., 2004; Brugha et al., 2004; Marchal et al., 2009; Savaya & Spiro, 2012; Scheirer, 2005; Sridharan et al., 2010). 6) Fostering *ownership* among the diverse national actors to ensure that they are committed to continuing to develop the programmes (PEPFAR, 2012; Schell et al., 2014; Sheidiac-Rizkallah & Bone, 1998); 7) The development of *effective partnerships* through the support of other organisations to continue or improve existing services (Johnson, Hays, Center & Daley, 2004; Scheirer, 2005; Schell et al., 2013)*;* and 8) *Building local technical capacity* to respond to these changes in responsibilities (Godfrey et al., 2002; Johnson, Hays, Center & Daley, 2004; LaPelle et al., 2006; Lele et al., 2004; Mills & Bennett, 2002; Ostrom, Gibson, Shivakumar & Andersson, 2001; Pavignani & Colombo, 2009).

Although these enabling factors are seen as important to support transition to sustainability, in practice, all of them may not be in place. Furthermore, there are certain implicit assumptions, for example that the economic or political situation in the country or foreign policy priorities that influence funders' decisions will be aligned to support the transition appropriately. Moreover, as political priorities change and given the surmounting criticism of aid, political support for donor funding itself may not be present (Dodd & Lane, 2010). However, the value of planning for transition is understanding the weaknesses at the national level and addressing these to ensure successful long-term programmes. Within programmatic sustainability, certain factors such as the development of partnerships, good governance and alignment of donor programmes with national policies are essential. However, as previously

mentioned, the interrelatedness of the different types of sustainability necessarily means considering a package of supportive policies.

To complement these findings, Box 3.2.1 presents relevant lessons on enabling factors for sustainability identified from the experiences of tuberculosis programmes in several countries. As these tuberculosis experiences show, there is no one-size-fits all approach to planning for sustainability, particularly in LMICs countries. Rather this requires flexible forms of working that are adapted to the local realities. This does not mean that proven enablers for sustainability should be disregarded. Instead we should consider that even if these are not found, developing efforts to reach these as a step towards transition to sustainability should be the goal. Moreover, as these studies show, there are many similarities in how HIV/AIDS and TB programmes can move towards sustainability. This is why in the case of the Global Fund, their initial efforts in investing in local health capacity and the health system response is likely to be cost-saving in planning for the sustainability of HIV, TB and malaria in the long-term.

Box 3.2.1 Learning from the experience with Tuberculosis programming

While this thesis focuses on the specific area of HIV/AIDS, as another 'big three disease', the response to tuberculosis presents an example of programme area that has made important strides towards sustainability facilitated in part by being rooted on community-level work and similar to HIV/AIDS, propelled by the need to establish systems to manage long treatment periods.

Similar to HIV/AIDS, countries with high tuberculosis burdens have also received a significant amount of aid, at times with negative effects. A study by Mauch and colleagues (2012), researching the 11 high-burden tuberculosis and LIC countries, found a crowding-out effect of government funding by large donors such as USAID, Gates Foundation and Global Fund. Indeed domestic funding spent on TB control diminished or stayed the same in 7 of the 11 countries (notable exceptions were Ethiopia, Kenya, Mozambique and Tanzania). This confirms Lu et al's (2010) findings of the crowding-out effects of funding for health for HIV in sub-Saharan. However, as discussed earlier, this is not unique to these diseases but can be a negative effect of aid generally.

A study by Amo-Adjei (2013) on the sustainability of the Ghana TB programme found that while the integration of the TB programme in the national response was seen positively for sustainability; a TB programme with an autonomous financial administration, a feature characteristic of a vertical programme, was also beneficial. Furthermore, this study also found that as HIV was more likely to receive greater attention from funders and the government than TB, synergies and collaboration between both services could be a good impetus for sustainability. This has also been highlighted by other studies, in addition to coordinating government efforts with those of donors and NGOs, as well as ensuring adequate financing that consider the costs of mobilizing community health workers (Lienhardt & Ogden, 2004; Maher, 2003).

Financing has a clear effect on the motivation for sustainability. An Atun et al. (2005) study in the Samara oblast in the Russian Federation found that despite the introduction of DOT (directly observed treatment, the TB strategy proposed by WHO characterised by monitoring patients' treatment, which reduces complications due to TB and drug-resistance), at that time only 26% of the population was covered by this strategy with high rates of hospitalizations. The manner TB hospitals were reimbursed, according to each service provided and acting as social care institutions, led to perverse incentives to keep patients hospitalized for long-periods and for community-based providers to keep referring them to the hospitals since it did not affect their revenue. This was an obvious deterrent for sustainability both at the programmatic and financial level demonstrating the importance of analysing the provision of services as a whole and pre-empting issues in developing a long-term strategy beyond focusing on enabling factors.

In addition to these findings from the literature on what leads to successful transition and sustainability, there are few empirical studies of countries who have undergone transition from donor funding, particularly from Global Health Initiatives (GHIs). Given the newness of some of these examples, several of these have not yet been reported in peer-reviewed articles. Below a synthesis of some recent examples and the identified success factors for sustainability are presented.

3.2.3 Country examples of transition to self-sufficiency

Most recently, several studies have explored programmes that have transitioned out of aid and their experiences. This section briefly discusses examples of studies conducted on transition to sustainability from four different donors: The Bill and Melinda Gates Foundation; the Gavi Vaccine Alliance; USAID; and the Global Fund.

The Avahan programme was established in 2003 to address HIV/AIDS in India by working closely with several NGOs to implement programmes in different states. This programme was funded by the Bill and Melinda Gates Foundation and in 2007 they begun to discuss a transition strategy to transfer ownership to country actors and incorporate it as a government strategy (Bennett et al., 2011). The process of planning for transition entailed enhancing government capacity by supporting government technical and managerial skills; developing capacity within the NGOs through specific training programmes; and strengthening management and governance structures within the community. Among key findings is the importance of a partnerships and coordinated approach for effective take-over of roles, as well as aligning the programme with government policies (Sgaier et al., 2013). Moreover, findings showed that transition mechanisms should be built-in from the start of the grants and funding should be alocated for these purposes. The time involved in developing such a strategy should also be considered (Bennett et al., 2011).

The Gavi Vaccine Alliance was established in 2000 with the purpose of providing funding for recipient countries in the area of vaccines, supplies and programme support. As we will see later, their approach to sustainability is to ensure government commitment to slowly increase domestic co-financing of vaccines in parallel to a decrease in Gavi funding. A recently published article outlines the results of a 2012 pilot where Gavi supported transition planning for sustainability in Bhutan, Republic of Congo, Georgia, Moldova and Mongolia. This was

done by conducting country assessments of readiness to graduate from aid and interactions with country officials to support the transition process. Main challenges faced were related to the nature of vaccine procurement and pricing. However, more general findings demonstrated the importance of national champions to reach the decision-makers and the importance of reliable informtion systems (Saxenian et al., 2015).

Another study sought to assess the lessons learned from phase-out of USAID funding of a family planning program in Mexico. USAID supported Mexico's family planning program between 1974 and 1999 and it is now considered to be one of the strongest public sector programmes in existence. However, there were a number of challenges related to this phase-out, particularly related to weak coordination and collaboration of actors throughout the process as well as the lack of institutionalisation of some targeted programmes for key populations, namely adolescent, rural and indigenous populations, which were not included as part of the Ministry of Health portfolio in time for the end of USAID funding hindering the possibility for continuing these programmes. This phase-out also took place during the financial crisis and the decentralisation of the health system, demonstrating the need to prepare for changes in the external environment. Moreover, coordination of national actors and donors is essential to develop clear timelines for transition and institutionalise generate technical capacity (Alkenbrack & Shepherd, 2005).

Box 3.2.2 Global Fund Technical Evaluation Reference Group Report

A particularly relevant example for this thesis is a sustainability review conducted by the Global Fund Technical Evaluation Reference Group.

This group reviewed 12 Upper Middle Income or High Income Countries[1] that have received funding from the Global Fund for any of the three diseases. Of these 12 countries, four had fully transitioned from Global Fund support (Algeria, Croatia, Equatorial Guinea and Estonia). Their findings show that income classification is insufficient to classify aid graduating countries, this should be coupled by 'trigger factors', such as population growth, per-capita burden and proportion of external financing as a percentage of total financing for the three diseases.

Furthermore, effective coordination of sustainability plans, that are followed and implemented, generates greater possibility for successful transition and a country's ability to assume financial responsibility. Supporting the generation of enabling factors for sustainability and facilitating the implementation of the sustainability plans through donor support from the beginning were also found to be key (Mogeni et al., 2013).

These examples of transition countries demonstrate that irrespective of funding model, planning for sustainability of any programme entails considering the health sector as well as external factors. The factors that enhance successful take-over identified in these studies coincide with the literature findings on enabling factors for sustainability. What is more, they add on important nuances such as the importance of clear planning for sustainability from the beginning (Alkenbrack & Shepherd, 2005; Bennett et al., 2011; Mogeni et al., 2013); importance of data and efficient information systems (Saxenian et al., 2015); considering factors beyond income level in classifying countries readiness for transition (Mogeni et al., 2013); and promoting donor participation in the process of planning for sustainability (Mogeni et al., 2013).

In recent years, global health initiatives have emerged as one of the main mechanisms for channelling investment in the health sector. For this study, we are interested in aid-provided global health initiatives such as the Global Fund, and exploring programme sustainability in middle-income settings. The following section discusses Global Health Initiatives in general and the Global Fund in particular.

3.3 The emergence of global health initiatives and their role

The emergence of global health initiatives (GHIs) changed the aid landscape, encouraging donors to pool their funding towards specific aims. Brugha (2008) defines a global health initiative as 'a blueprint for financing, resourcing, coordinating and/or implementing disease control across at least several countries in more than one region of the world'.

These institutions emerged with the goal to rapidly scale-up the pace of work in immunisation and distribution of medication to avoid further catastrophic results from the propagation of diseases that were already seen as global threats (Lele et al., 2005). Additionally, they were founded under the premise that the inclusion of stakeholders which in the past had been neglected by governments and international organisations, such as CSOs and NGOs can be beneficial in targeting assistance to those in most need, and in improving accountability (UNAIDS, 2010).

The majority of funding for these initiatives comes from traditional donors. The Global Fund raises funding by convening country governments every three years for its replenishment mechanism. Until now, 95% of the funds for the Global Fund have come from donor governments and the remaining 5% from private foundations, the private sector and individuals (Global Fund, 2013b). Furthermore, these initiatives avoid large overhead costs by relying on direction and support from partners at country level (Caines et al., 2005b).

The WHO Maximizing Positive Synergies Collaborative Group (2009) identified around 100 GHIs, with a number of them accounting for two thirds of all external funding for HIV/AIDS, 57% for tuberculosis and 60% for malaria. Four GHIs dominate the aid scene by providing the most funding for these three diseases: the Global Fund; the GAVI Alliance; the President's Emergency Plan for AIDS Relief (PEPFAR); and the World Bank Multi-Country AIDS Program (MAP).

3.3.1 Approach to funding

While these GHIs have made an important contribution to improving the status of these diseases since their creation (Lele et al., 2005; WHOMPS, 2009), the manner in which they have done so has had varying effects. Although the discussion around vertical versus

horizontal approaches[4] to health programmes has been continuing for more than 50 years, in the context of significant efforts to address access to health care, the creation of GHIs brought the debate between project funding or health systems strengthening back to the international agenda (Gonzalez, 1965; Foster, 2000; Maciocco & Stefanini, 2007; Oliveira-Cruz et al., 2003; WHO, 1978).

GHIs have been widely criticised for favouring a vertical approach (Biesma et al., 2009; Das Gupta & Gostin, 2009), which may have a negative effect on sustainability (Stefanini & Ruck, 1992) due to the focus on funding discrete and often fragmented programmes instead of strengthening the overall health system. This is demonstrated by the fact that around 60% of them target three diseases, namely HIV/AIDS, tuberculosis and malaria (Caines et al., 2005b). The focus on a few communicable diseases has been found to divert attention from the prevention of these diseases in the first place (Caines, 2005; Lele et al., 2005; WHO, 2002), while also creating parallel programmes (Bennett et al. 2006; Biesma et al., 2009; Pfeiffer et al., 2010; Walt et al., 1999; WHO, 2002) and generating higher transaction costs (Balabanova et al., 2010; Biesma, et al. 2009; Easterly & Pfutze, 2008).

An example of this is that while aid for HIV/AIDS more than doubled between 2000 and 2004, aid intended for primary care dropped by almost half between 2000 and 2004 (WHO, World Bank & OECD-DAC, 2007). Moreover, in the 2006–2007 period the WHO budget allocation for infectious diseases reached 87% of the total budget, which is even greater for the WHO extra-budget that is allocated by external donors. This distribution was similar even for regions such as the Western Pacific, where three-quarters of mortality is due to non-communicable diseases (Stuckler et al., 2008). Furthermore, by focusing on infectious diseases, funders and governments neglect the underlying issues which may be associated with high disease burden, many times related to the economic and social circumstances or the state of the health care system.

However, donors have generally prioritised investment in vertical programmes because monitoring results and maintaining accountability as well as tracking investments may be perceived as easier. Although general budget support and integrated approaches to delivering

[4] Vertical programmes are the 'selective targeting of specific interventions not fully integrated in health systems' (Msuya, 2004); while a horizontal approach 'seeks to tackle the overall health problems on a wide front and on a long-term basis through the creation of a system of permanent institutions commonly known as general health services' (Gonzalez, 1965) or health systems.

services are efficient uses of funding, given that they avoid spending on developing separate projects and are easy to align to country priorities (Atun, Bennett & Duran, 2008; Killick & Lawson, 2007), inefficient public sector management and governance may lead to project failure (Atun, Bennett & Duran, 2008; Buse & Harmer, 2007; Spicer & Walsh, 2012) and generate concerns among donors that funds will be diverted to other areas (Travis, et al., 2004; WHO, World Bank & OECD-DAC, 2007). Moreover, vertical programmes may also be desirable when a rapid response is needed; and in cases where there is a need to deliver complex services requiring a highly skilled workforce; or addressing the needs of target groups of the population, which are difficult to reach (Atun, Bennett & Duran, 2008).

On the other hand, the premise that GHIs have increased the visibility of previously neglected sectors of society, through the participation of NGOs and CSOs (Harmer et al., 2013; UNAIDS, 2010) has been debated, given that frequently organisations that successfully secure grants are able to do so because they may have access to social, political and economic capital (Kapilashrami & McPake, 2013). Other negative effects of GHIs are that they may skew national priorities by imposing their own agendas (Buse & Harmer, 2007; Kapilashrami & O'Brien, 2012; Kapilashrami & McPake, 2013); create incentives to divert health human resources from other areas to work on these diseases (Bennett & Fairbank, 2003; Hanefeld & Musheke, 2009; Kapilashrami & O'Brien, 2012); deprive certain stakeholders from being involved in decision-making; follow inadequate governance practices; make erroneous assumptions on the efficiency of the public and private sectors; include insufficient resources for partnership-building and alliance costs; misuse resources through the inadequate use of country systems and poor harmonisation; and finally, generate poor incentives for staff to engage in partnerships (Buse & Harmer, 2007). The extensive reporting mechanisms that these GHIs frequently require may have a detrimental effect on partnership-building, where the focus on generating results can lead to competition among actors (Harmer et al., 2013; Kapilashrami & McPake, 2013; Spicer et al., 2010). Moreover, these ruptures in relationships between partners may jeopardise the sustainability of programmes by halting the coordination of activities.

According to Dodd & Lane (2010), GHIs can help countries build sustainable programmes by fostering useful policies such as: setting objectives to increase long-term financing for health; defining strategies for funding long-term innovative financing instruments; providing staff with incentives to make more use of existing, long-term investments; aligning funding behind

country multi-year plans and provide incentives for countries to develop such plans; and making systematic use of financial sustainability plans, cost-sharing rules and exit strategies. The diversity of funding approaches and support areas of these GHIs means their approaches to sustainability are different as well. In the following section, the main mechanisms that GHIs use to encourage sustainability are discussed.

3.3.2 Global health initiative mechanisms to encourage sustainability

The alarms raised by the economic crisis of 2008 and the push to make the most of resources by fostering aid effectiveness and exit strategies, has led the GHIs to consider the importance of planning for sustainability, making this a rapidly evolving field.

The approaches to sustainability have taken different modalities, partly in response to the different areas that are funded by these initiatives. While the Global Fund is currently taking important steps to develop plans for sustainability, other GHIs such as the Gavi Vaccine Alliance and PEPFAR have developed frameworks that are currently being implemented by recipient countries. Understanding these organizations' steps to ensure sustainability can generate important learnings for the Global Fund. This section briefly discusses how the Gavi Vaccine Alliance and PEPFAR address sustainability, ending with an assessment of the Global Fund approach.

Following from the findings of their pilot study of 2012 (see section 3.2.3), the Gavi Vaccine Alliance has collaborated with recipient countries before, during and after graduation by helping them identify and address risks to sustainability; support them in developing transition plans; and establishing targets to ensure the timely implementation of activities towards graduation (Saxenian et al., 2015).

The assessment of country graduation readiness focuses on promoting: a) accessible service delivery platforms (implemented by the government, NGOs and the private sector); sound policies and institutions that involve all actors; and adequate and predictable funding to cover the costs of technologies and personnel (Saxenian et al., 2015).

While this approach is specific to Gavi and the nature of vaccine supply and distribution, with explicit indicators that address vaccine procurement, pricing forecasting and so on, their

focus on developing capacity, fostering political will and most importantly, their direct participation in supporting recipient countries plan for sustainability can be directly translated to a Global Fund financing scenario. While this approach theoretically seems feasible, outside of the findings from the pilot study, there is a lack of robust data on the effectiveness of this framework. This may require several years to understand the long-term potential of such an approach but nonetheless, it is an important step forward.

On the other hand, PEPFAR has developed several iterations of frameworks and tools to assess transition of the HIV/AIDS programmes they have supported (PEPFAR, 2012; PEPFAR, 2013; PEPFAR, 2015). Recipient countries are required to fill-in these tools and dashboards to identify challenges to sustainability early on. For this, PEPFAR considers ownership as the key determinant for sustainability and thus seek to foster political ownership and stewardship, where the country actors fully implement and monitor activities; institutional and community ownership, that entails funds management and implementing transparent policies; forming capabilities throughout the health system; and promoting mutual accountability by developing mechanisms for civil society, private sector and donor input (PEPFAR, 2012).

Most recently, the PEPFAR Country Operational Plan (2015) also assesses five areas of sustainability: data availability; local leadership; domestic financing; accountability; and an enabling environment, which includes policies, laws and regulations that support programme implementation.

In this sense, PEPFAR has undergone a process of 'learning by doing' and have refined their assessment tools to address the challenges they have encountered in implementing these tools. Their targeted approach through the five sustainability areas, while keeping the issue of ownership as a guiding principle, is attractive for the context of the Global Fund. However, PEPFAR's targeted approach, as opposed to assessing the entire programme cycle, is possible given the focus on one disease, as opposed to three diseases that are funded in some Global Fund recipient countries. Thus in practice, this framework may not be applicable for the Global Fund.

The Global Fund acknowledges the importance of moving from responding to emergency needs to considering sustainability (Global Fund, 2015). Moreover, the Global Fund has understood the need to support countries transitioning out of aid by developing specific

policies such as the Continuity of Services policy (COS) and Transitional Funding Mechanism that ensure continuity of life saving and essential support after the grant has expired in the case that the country cannot fill the gap immediately (Mogeni et al., 2013). However, in relation to planning for sustainability, while the Global Fund currently asks countries to describe how the funding will be aligned with national policies and how it can be managed later on in their concept notes, there are no requirements to develop sustainability plans or conduct country readiness assessments.

Phasing out of funding from any of these GHIs necessarily requires understanding other donor processes and coordinating with them to plan for sustainability, especially if they are funding the same programme. The Gavi and PEPFAR experiences show the importance of planning for sustainability and possible lessons that they Global Fund can apply in their own processes. However, as previously explained, these would need to be adapted and tested in specific Global Fund recipient countries.

3.3.3 The Global Fund

The Global Fund has become since its inception one of the biggest actors in financing for health, disbursing since its creation in 2002 more than US$30 billion for 129 countries, of which around US$16 billion has been invested on HIV/AIDS (Global Fund, 2016).

The current Global Fund 2012–2016 strategy, was developed in consultation with a diverse group of stakeholders and seeks to sustain and scale-up the gains achieved in the fight against the three diseases. This strategy is based on: investing in countries with strong value for money and funding according to national strategies; evolving the funding model to provide funding in a more proactive, flexible and predictable manner; actively supporting grant implementation; promoting human rights; and sustaining gains and mobilising resources (Global Fund, 2011a). Most recently, the 2014–2016 Global Fund New Funding Model was presented which builds on the objectives from the 2012–2016 strategy but also allows for flexible funding that eligible countries can apply for when they need to; simplifies the application process; ensures early discussion of indicative funding, hence increasing aid predictability; gives greater focus on high disease burden and low resource countries; and has greater engagement with country-level processes (Global Fund, 2013c). An important difference in this model is that there is an added level of approval, the Technical Review Panel, an independent body that evaluates the proposal and recommends prioritised

interventions to fund. Once this concept note is approved, it is presented to the Grant Approval Committee, whom recommend the level of funding for grant-making. Once the grant is developed it will be presented to the Board for approval and the three year cycle of the grant can begin (Global Fund, 2014).

The Global Fund specifically requires the formation of a CCM for its operation in a country, which determines priorities for the three diseases and submits proposals to the Fund. Membership in these committees includes country ministries, partner agencies (such as WHO, UNICEF, UNAIDS and bilateral agencies), NGOs, CSOs academia and the private sector (Global Fund, 2011b).

In response to criticisms of the vertical approach from the Global Fund, there is now greater willingness to include health systems components into proposals. However, an analysis of country proposals found a greater demand for direct provision of services rather than technical capacity-building, where $118 million was requested for direct provision of health services and in contrast, funding requested for country capacity was only $50 million (WHOMPS, 2009). Most proposals include training activities but fail to take into account support for pre-service training and training institutions, as well as long-term strategies to address the lack of adequately trained personnel (Drager et al., 2006). This may be due to a number of reasons, one of them being the requirement that sustainability of salaries financed by the Global Fund be proven after the proposed period is over (Drager et al., 2006). Moreover, although it is recognised that there is a need for strengthened capacity and support in governance, only 1% of the total funds requested in the eighth round of the Global Fund were for strengthening governance (WHOMPS, 2009).

Country eligibility for Global Fund funding is based on income per person and disease burden, meaning that in principle grants should be provided on the merit of the proposal submitted (Lu et al., 2006). Income level is determined according to the OECD-DAC list of countries eligible for ODA, with LMICs and upper-middle-income countries (UMICs) only being able to apply to a maximum of 65% and 35% of the total amount needed for their disease programmes; this is the case for Peru. Starting in 2012 low-income countries also had to contribute 5% of total disease programme costs and the proportion of domestic contributions for all countries should increase over the years of each grant, with the view of making these programmes self-sustaining over time (Global Fund, 2011c). There should also be a greater focus on poor and/or vulnerable populations in UMICs and LMICs (The Global

Fund, 2010). Furthermore, the policy for 2011 also states that at least 55% of the funding approved for grant renewals should be for low-income countries, and UMICs that are part of the G-20 and have a less than an extreme disease burden are no longer eligible for grant renewals (Global Fund, 2011c).

Country income graduation is another consideration for these countries that are leaving the middle-income category. This occurs when a country moves from an eligible income level to a higher no-longer eligible level, while transitions are movements from one income category to another level which does not include high-income level. Graduation may be automatic or voluntary. Automatic graduation takes place when the country is classified as high income and voluntary graduation occurs when the country chooses to self-finance its disease programme. The Global Fund Secretariat works with the World Bank to develop an early warning system to alert the countries in advance of their transition to another income level, as well as generating incentives for graduation (The Global Fund, 2010).

However, it is important to note that the focus on disease burden and income level has been widely criticised for failing to consider other important factors related to equity and programme management and success. Most recently, the Equitable Access Initiative was proposed, which brings together several UN agencies and GHIs together to discuss new manners to classify country funding needs (Global Fund, 2015).

3.4 Summary

This chapter has presented a synthesis of some key concepts related to aid effectiveness and factors associated with aid dependence, as well as enabling factors for effective sustainability; through the presentation of findings from peer-reviewed literature and empirical studies. Furthermore, the main characteristics of GHIs was also discussed with a focus on how these address sustainability and how the Global Fund conducts their work. However, there is a lack of research on what needs to be done to prepare middle-income countries–the group of countries that are most likely to graduate from aid—to transition out of aid and reach programmatic sustainability.

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SECTION A – Student Details

Student	Ana Beatriz Amaya Amaya
Principal Supervisor	Dina Balabanova
Thesis Title	"Aid (in)dependence? Promoting long-term sustainability in the response to HIV/AIDS: the case of the Global Fund in Peru"

If the Research Paper has previously been published please complete Section B, if not please move to Section C

SECTION B – Paper already published

Where was the work published?			
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Where is the work intended to be published?	Health Policy and Plannning or Globalization and Health
Please list the paper's authors in the intended authorship order:	Ana B. Amaya, Dina Balabanova, Carlos F. Caceres, Neil Spicer
Stage of publication	Not yet published

SECTION D – Multi-authored work

For multi-authored work, give full details of your role in the research included in the paper and in the preparation of the paper. (Attach a further sheet if necessary)	**Ana Amaya conducted the study and drafted the manuscript. DB, CFC and NS provided guidance and support**

Student Signature: **Date:** 08/09/2015

Supervisor Signature: **Date:** 08/09/2015

Chapter 4 Inputs for sustainability - Key resources needed for a sustained HIV response post-donor involvement: the case of the Global Fund in Peru

Abstract

Under the current economic crisis and global decrease in aid, it has become important for countries receiving aid to plan for the future when aid is no longer available or required. Peru, which was granted over US$70 million for HIV/AIDS from the Global Fund to fight against AIDS, Tuberculosis and Malaria (Global Fund) through several grants since 2004, is in the process of increasing their investments on HIV/AIDS following recent economic growth and exemplified by the inclusion of HIV/AIDS activities in their new 'results-based' budgetary strategy. This study assessed the period of transition from Global Fund support of HIV/AIDS activities in Peru towards a scenario of programmatic sustainability (2004–2012), examining inputs which have an important effect on HIV/AIDS policies and activities. Finally, recommendations on priority areas that must be strengthened for sustainable HIV/AIDS programming are formulated.

The analysis draws on 35 in-depth interviews to key stakeholders working in the area of HIV/AIDS in Lima, Peru from October–December, 2011 and a review of peer-reviewed and "grey" literature; secondary data; and national policies. Findings suggest that Peru is demonstrating significant progress towards a sustainable HIV/AIDS response. Main inputs identified as important for sustainability were: economic resources, health workforce and availability of reliable data. Despite improved HIV/AIDS indicators and an important increase in investment for HIV/AIDS; local health authorities are having difficulties managing the results-based budget. Moreover, although there have been greater investments on human resources, these are still insufficient. This poor planning has been compounded by unreliable and outdated data on the epidemic and little direction from the Ministry of Health. The inclusion of HIV/AIDS within the results-based budget is a first step towards promoting continuity of the activities but this must be supported by improved governance, data and planning. These lessons are significant not only for Peru but provide important knowledge for other countries facing similar challenges.

4.1 Introduction

In the 1990 and 2007 period, aid for health grew at the global level in more than US$15 billion (Ravishankar et al., 2009). In the area of HIV/AIDS, the unparalleled international response to fight the disease meant that it experienced the greatest disbursement of funds ever mobilised for a single disease (Spicer et al., 2010). Yet, under the current environment of fiscal constraints causing a decrease in global aid in the past two years (OECD, 2013) and despite calls for longer-term aid and predictability of funding (Celasun & Walliser, 2006; Dodd & Lane, 2010), donors may not be able to continue funding health programmes in lower and middle income countries at the same level, particularly if economic growth may enable many such countries to start funding their own programmes (Global Fund, 2010; Lu et al., 2010).

Sustaining successful programmes is important in order to continue the benefits of investment in financial and human resources over a long period of time (Dickinson, 2008; Lele et al., 2004; Shediac-Rizkallah & Bone, 1998), whose effects transcend HIV and have positive spill-over effects on the health system in general. The definition of sustainability varies according to the approach, whether it is fiscal (Gruen et al., 2008; Heller, 2005; Lu et al., 2006; Pavignani & Colombo, 2006; Torpey et al., 2010), programmatic (Gruen, et al., 2008; LaPelle et al, 2006; Olsen, 1998; Sarriot et al., 2004; Torpey et al., 2010; Walsh, et al., 2012), political or technical (LaPelle et al., 2006; Pavignani & Colombo, 2006; Ooms, 2006; Torpey et al., 2010). For the purposes of this study sustainability in health is defined as the capacity of the government to manage health programmes without relying on the intervention of external bodies for technical or financial support within a given social, political and economic environment. Within this wide definition of sustainability, this study will focus on programmatic sustainability, namely the capacity to sustain a programme through effective management, coordination and service implementation (Torpey et al., 2010).

In the case of Peru, the HIV/AIDS epidemic is concentrated among most-at-risk groups, with prevalence among the general population found to be 0.23%; yet among men who have sex with men (MSM), this reaches 8.93%, (Aldridge et al., 2009). It is a concern that sentinel surveillance surveys reported prevalence among transgender individuals to be 20.8% (Ministerio de Salud del Peru, 2012). To support the response to the HIV epidemic, the country has received four grants (rounds two, five, six and ten) from the Global Fund to fight AIDS, Tuberculosis and Malaria (hereafter referred to as the Global Fund) in the 2004-2013

period (Global Fund, 2013). The programmatic focus on these Global Fund grants has mainly centred on increasing access to treatment and diagnosis (round two); implementing prevention and sensitisation activities (all rounds); and strengthening capacity among civil society (all rounds), key populations and community agents (round 10). The country's classification as an upper-middle income country by the World Bank (2013), effectively reduced the funding it is eligible to apply for (Global Fund, 2010). In this context, given its current economic growth, the Peruvian government was able to include HIV/AIDS activities as a strategic budget-line in a recent national budgetary strategy called 'results-based budget', which allocates funding to programmes according to measurable outcomes in 2011 (Cabrera, 2010).

A number of contextual changes are likely to have a significant impact on sustainability; the broad administrative and financial decentralisation occurring in the country is one such process. Decentralisation is closely associated with how decisions are made, budgets are managed and services are delivered. Changes that come about with decentralised decision-making can have an impact on the continuity of past policies and activities. In Peru there have been several attempts to decentralise the government into more manageable administrative regions (Dammert, 2003). Many of these attempts were frustrated due to political changes, each new government implementing different policies and one president devolving power to the state after a decentralisation process had already begun, to maintain political control. The end of 11 years of dictatorship in the year 2000 and the economic reforms of the 90s, which focused on local development, led to social demands for greater political participation of the regions in the democratic process (Herrera, 2003; Paulet, 2004). Thus the current form of decentralisation was implemented until 2004, dividing the country into 25 regions and one province (Lima) (Dammert, 2003). This decentralization plan sought to generate sustainable development in the country through the appropriate allocation of competencies and functions among the three levels of government (national, regional and local) and to avoid any duplication of efforts and waste of resources (Dammert, 2003). It also aimed to promote democracy, governance and equity in the regions (Presidencia del Consejo de Ministros, 2012). While this allocation of resources has been a gradual process, by 2011 92.4% of the administrative functions had been transferred to the regions (Valdes, 2012). On the other hand, the decentralisation of the health sector began in 2005 (Ministerio de Salud del Peru, 2004), incorporating the Regional Health Directorates (DIRESAS), which are

composed of regional health facilities and were previously managed by the Ministry of Health, into the local and regional administrative structures (Iguiñiz-Romero et al., 2011).

Another contextual factor was the approval by the government of a new budgetary strategy based on results in 2007. This new budgeting strategy, which would now be managed by the regions, sought to restructure budgetary processes by including requirements on performance, allocation of resources, commitments, evaluation of results through indicators and sustainability of investments (Marcel, 2006). HIV/AIDS and tuberculosis activities were included as separate strategic budgetary lines in 2011. Therefore, the regions had to transition into planning and implementing this new HIV/AIDS budget, which relies heavily on the technical capacity of the regional officials and quality of available data (Armijo, 2005). The gradual retreat of the Global Fund in Peru and the new role of the government in funding these activities are an opportunity to learn about planning and maintaining sustainable programmes, which may be applicable to other middle-income countries or countries that are aid-dependent but will consider ways to protect themselves from inconsistent funding (Hay & Williams, 2005; Riddell, 2009) or plan programmes with a view of future sustainability.

This study contributes to the current scarce empirical research (Sgaier, 2013) on key resources necessary to ensure the sustainability of HIV/AIDS activities after aid ends, particularly in a middle-income country. Moreover, this research is innovative in that it involves a case study on the transition receiving aid from the Global Fund for HIV/AIDS towards programmatic sustainability, employing an original framework to analyse these changes in the 2004–2012 period. This study therefore aims to understand the role country capacity – both in terms of resources and processes – has had on planning for sustainability. The analyses covered both responses to immediate challenges and the ability to learn over time. Second, this was set in the broader context in Peru, which enables or obstructs the transfer of responsibilities to the government, and have had an impact on HIV/AIDS policies and activities. Finally, it aims to provide recommendations based on evidence to inform decision-makers on priority areas that must be strengthened for sustainable HIV/AIDS programming in middle-income countries more generally.

4.2 Conceptual framework

This study utilises a framework developed drawing on the literature on sustainability of health programmes. Frameworks developed for sustainability of programmes vary according to the type of sustainability they refer to and the elements they encompass.

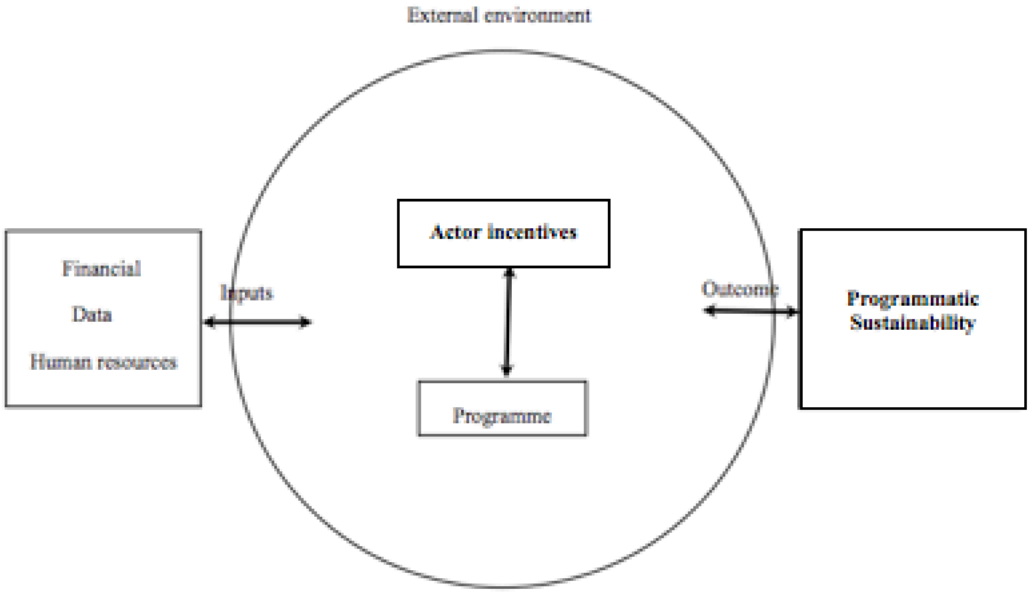
LaPelle and colleagues (2009), developed a framework which they used to analyse a public service after grants have ended, allowing to analyse the redefinition of scope of services and creative use of resources. Torpey and colleagues (2010), on the other hand, suggest the need to consider *technical, programmatic, social* and *financial* sustainability yet mainly focus on *operational* sustainability via service delivery, which is not the objective of the present study. Gruen and colleagues (2008) go further by describing a health programme as a complex system where health concerns, programme components and programme drivers constantly interact. The approach is useful because it identifies the critical importance of the *drivers*, which here in this framework is referred to as actor incentives, and the *programme components*. This model however, does not consider the external environment and inputs that underlines these relationships. Olsen (1998), on the other hand, discusses three clusters of factors useful in analysing sustainability of health services in low and middle income countries. These are the *contextual factors* (general contextual factors such as the government health policy and specific indicators on the disease burden); *activity profile* (the type of services that are delivered); and the *organisational capacity* which is the ability to carry out tasks in an organisation. This framework is helpful in describing structures and processes, yet less useful in following the development of these elements over time, which is one of the main goals of this study.

Therefore, after reviewing the literature around sustainability in health and building on the strengths of the existing frameworks, a framework was developed combining elements of Gruen and Olsen's frameworks (see figure 7.1). This framework analyses inputs (such as programme financing, information systems and health workforce); the relationship between actor incentives (roles and motivations of actors in ensuring sustainability) and the programme policies and plans. Finally, the outcome in this framework is programmatic sustainability. Inputs have an effect on actor motivations and the programme since these will plan according to the resources available. On the other hand, the decision-makers (actors) determine the priorities within the programme, and programme plans can also have an effect on actor incentives. Moreover, all of these aspects have an effect on programmatic

sustainability. Additionally, this framework allows us to study these elements over time, from the entry of the Global Fund in Peru via the first approved grant, through an increased involvement and eventual exit from the country.

Although the elements of the framework are briefly addressed, this paper mainly focuses on the inputs, which are the critical elements in supporting programme goals and ultimately reaching programmatic sustainability (the outcome) by providing the resources to support these programmes. Actor incentives and the programme are explored elsewhere.

Figure 4.2.1 Programmatic sustainability framework[5,]



[5] Based on: Olsen, I. (1998). Sustainability of health care: a framework for analysis. *Health Policy and Planning, 13*, 287-295; and Gruen, R. L., Elliot, J. H., Nolan, M. L., Lawton, P. D., Parkhill, A., McLaren, C. J., Lavis, J. N. (2008). Sustainability science: an integrated approach for health-programme planning. *The Lancet, 372*, 1579-89.

4.3 Methods

A case study approach was applied, comprising of in-depth interviews and a documentary review of the literature, in order to understand how inputs (resources invested in HIV/AIDS) have contributed or not to the sustainability of the HIV/AIDS response in Peru. This was examined for the period 2004–2012, which comprised the transition from higher to lower level of dependence on external assistance for HIV/AIDS. For the documentary review, peer-reviewed and grey (which included policy, regulations and administrative documents) literature were reviewed on issues surrounding the HIV/AIDS programme in the country, the existing policies and Global Fund proposals. This documentary review of the literature helped provide the contextual basis for the study, inform themes explored in the in-depth interviews and serve as a comparison point to the information obtained through the interviews.

The review was undertaken by searching documents published in Spanish and English in the 2000-2012 period in the health databases MEDLINE/Pubmed, LILACS, Global Health, EMBASE, Web of Science and Google Scholar. Key words used for the searches included "Peru", "sustainability", "continuity", "aid", "coordination" "decentralisation", "financing" and "Global Fund".

The 35 in-depth interviews were conducted in Spanish from October to December of 2011 among four groups of stakeholders in Lima, Peru. Stakeholder groups included non-governmental organisation and civil society members; government officials, including representatives of the Ministry of Health, HIV/AIDS strategy and officials from other ministries involved in HIV issues, such as the ministries of finance, gender issues, defence and foreign affairs; multilateral and international organisation members; and members of academia.

Besides belonging to these groups, respondents were selected on the basis of their direct participation and expertise on HIV/AIDS in Peru; the length of their involvement in the HIV policy environment that enables them to comment on development during the study period; and their awareness of ongoing issues or future plans in HIV/AIDS in the country. Moreover, interviewees were also asked to nominate other potential respondents ("chain sampling"

(Mays & Pope, 2000)) who met this selection criteria, in order to ensure a diverse representation and points of view from actors with relevant involvement in HIV/AIDS.

Ethical approval was obtained from Universidad Peruana Cayetano Heredia (approved Oct. 11, 2011 reference number 058954) and the London School of Hygiene and Tropical Medicine (approved Sept. 7, 2011 reference number 6022). Participants were provided with an information sheet which explained the aims of the study and if they agreed to participate, were asked to sign a consent form. All of the individuals contacted accepted to participate in the study.

Following data collection, data were analysed following the conceptual framework discussed in the previous section. The NVivo software (Version 10) was used to facilitate coding and the organisation and preliminary analysis of themes. The data analysis steps included examining the literature and interviews in Spanish to form the contextual background on the topic; the identification of themes within the data as they related to the different elements of the framework; indexing and assigning codes using NVivo; identifying recurring themes and charting these relationships; and interpreting meanings of relationships and forming explanations on why these might take place (Green & Thorogood, 2004). Finally, data was validated through triangulation by comparing the literature and secondary data and interview findings.

4.4 Findings

The main themes that emerged demonstrated a range of crucial inputs (as defined by the framework) for facilitating a sustainable HIV response. The key inputs were around financing issues, health workforce and information systems. Table 4.4.1 presents the main changes in epidemiological indicators mapped against policy and programmatic developments in the 2004-2012 period.

Table 4.4.1 Main policy developments and changes in indicators 2004-2012

	2004	2005	2006	2007	2008	2009	2010	2011	2012
HIV/AIDS prevalence (adults aged 15 to 49)	0.5 (0.4-0.7)	0.5 (0.3-0.7)	0.5 (0.3-0.8)	0.4 (0.3-0.8)	0.4 (0.2-0.9)	0.4 (0.2-0.9)	0.4 (0.2-1.1)	0.4 (0.2-1.2)	0.4 (0.2-1.3)
Deaths due to AIDS	7,922	7,834	6,905	6,014	5,021	4,657	3,609	3,777	4,068
ART coverage	12% (9-16%)	Data not available	Data not available	Data not available	Data not available	44% (37-71%)	57% (39-95%)	59% (39-95%)	59% (38-95%)
Global Fund grants	Round II grant starts: "Strengthening prevention and control of AIDS in Peru" (2004-2008)		Round V grant starts: "Closing gaps to achieve the Millennium Development Goals for HIV/AIDS in Peru" (2006-2010)	Round VI grant starts: "National multisectoral plans: integrating resources for the fight against HIV/AIDS in Peru" (2007-2012)					Round X grant starts: "Building social capital to prevent HIV and improve access to comprehensive healthcare without transphobia or homophobia for the transsexual, gay/MSM population in Peru" (2012-2013)
Relevant policy developments at the national level	• Decentralisation at the state-level begins • Government provides free access to ART with Global Fund support • Country CCM established (CONAMUSA)	Decentralisation of the health-level begins	ART treatment fully funded by the government	• Results-based budgetary strategy is implemented in the country The 2007-2011 National Multisectoral Strategic Plan for the prevention and control of STIs and HIV/AIDS is approved				HIV/AIDS and tuberculosis are included as strategic budgetary lines in the results-based budget	

Source: Indicator data retrieved from UNAIDS.org (2013). AIDSInfo: Peru Epidemiological status. Retrieved from: http://apps.who.int/gho/data/node.main.75.

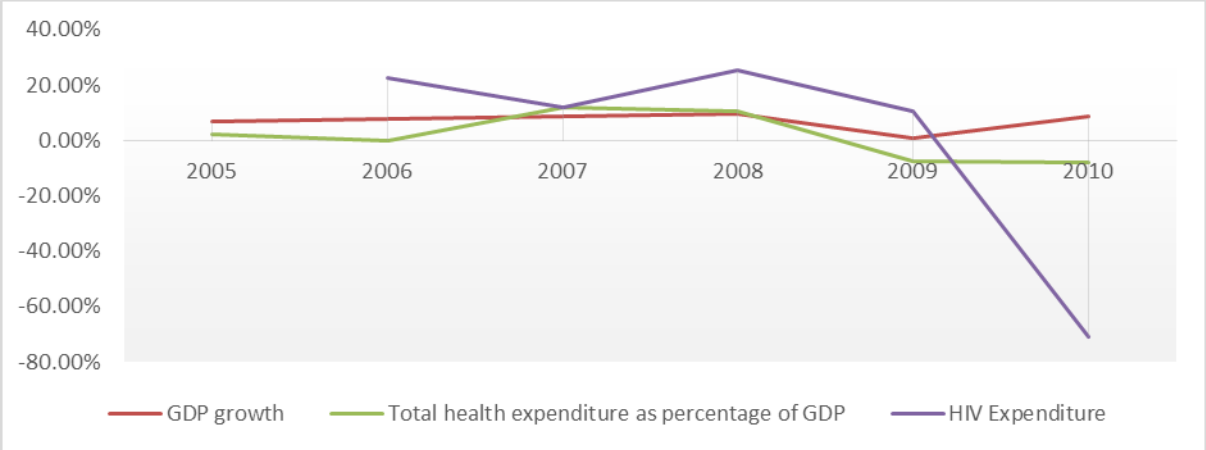
4.4.1 Trends in HIV/AIDS programme financing

Available economic resources and government commitment to investing in HIV/AIDS were identified in the interviews as crucial factors to ensuring the continuity of activities previously funded by the Global Fund. Important reflection of this is the budget allocated for health and HIV/AIDS more specifically.

Despite reporting the second highest growth in the Latin American region, at 6.8% GDP, surpassed only by Panama which grew by 10.6% in 2011 (World Bank, 2011), the country's total expenditure on health as percentage of GDP has fluctuated between 4.3% and 5.7% between 2004-2010, reaching 4.5% of GDP in 2011 (WHO, 2013).

Moreover, when this economic growth is compared with total health and HIV expenditure in the 2005–2010 period (see figure 4.4.1), the result is that GDP growth has frequently been associated with growth in total investment in health and HIV/AIDS activities (including government and international sources of funding). At the same time, the drop in growth at all levels experienced in 2009 was met with a recovery in 2010 in total GDP and total health expenditure growth. However, this was not the case for HIV expenditure. This can be explained in part by the decrease in international aid for HIV/AIDS by more than half in this year, as well as the purchase in 2009 of ART for two years (2009 and 2010), due to a decrease in ART prices. (Navarro de Acosta, 2011).

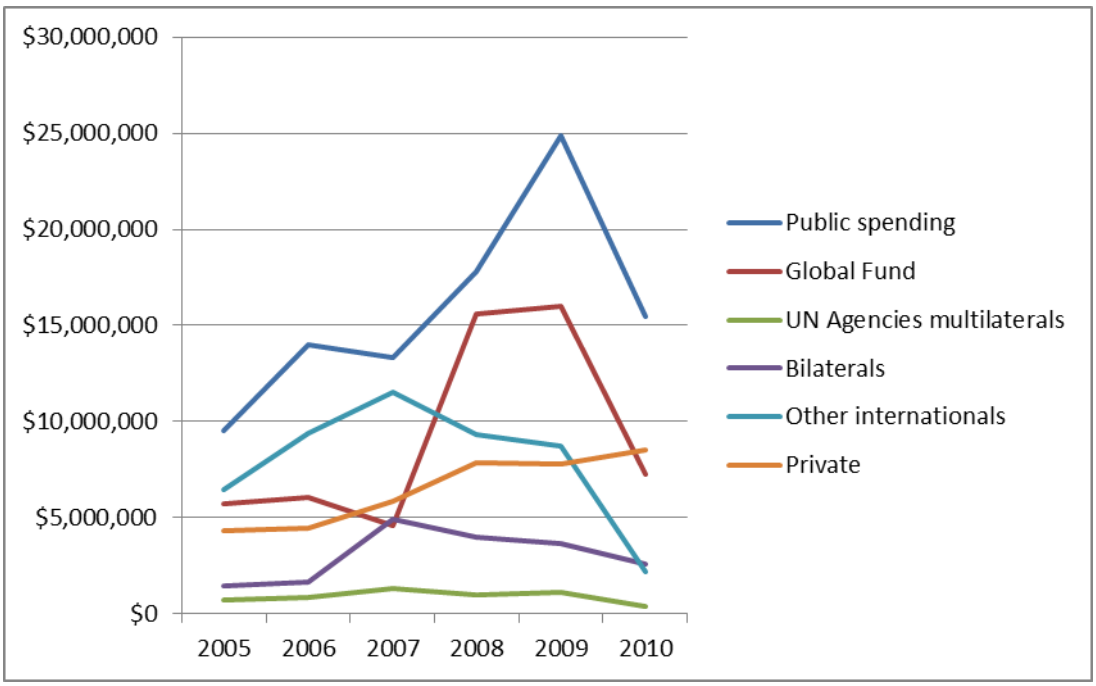
Figure 4.4.1Total health and HIV/AIDS expenditure growth 2005-2010[6]



[6] Data on Total health expenditure as percentage of GDP taken from: World Health Organization. (2011). *Global Health Observatory data repository: Health expenditure ratios by country (all years)* [Data set]. Retrieved from: http://apps.who.int/gho/data/view.main.1900ALL; Data on GDP growth taken from: World Bank. (2011). *GDP growth (annual %)*. Retrieved from: http://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG; Data on HIV expenditure taken from: Navarro de Acosta, M. (2011). Medicion del gasto en SIDA – MEGAS. Lima: Ministerio de Salud del Peru.

In terms of expenditure on HIV/AIDS, it has been dominated by public sector expenditure, followed by the Global Fund funding, which has disbursed 71,228,521 USD for HIV/AIDS projects through four grants from 2004 to 2013 (Global Fund, 2013). Importantly, from 2005 to 2010 private expenditure on HIV/AIDS has steadily increased; 8.1% accounted for private company investments, primarily through the provision of condoms through social marketing campaigns, while the remaining 91.9% of this expenditure comprising home expenses and out-of-pocket costs, (Navarro de Acosta, 2011). Increases in home expenses and out-of-pocket costs can be explained by the increase in the number of patients seeking private care. Figure 4.4.2 illustrates the total spending on HIV/AIDS from 2005-2010.

Figure 4.4.2 Total national spending on HIV/AIDS 2005-2010[78]



As discussed earlier, an important contextual factor during the transitional period of higher government involvement in financing the HIV response has been the introduction of the results-based budget in 2007 and the inclusion of HIV/AIDS and TB activities as a strategic budgetary line in 2011. In 2011 these activities represented 0.2% of the national budget (Ministerio de Economia y Finanzas del Peru, 2011), whereas in 2012 they grew to almost

[77] Data drawn from Navarro de Acosta, M. (2011). *Medicion del gasto en SIDA – MEGAS.* Lima: Ministerio de Salud; World Bank (2013) World DataBank: World Development Indicators. Retrieved from: from http://databank.worldbank.org/data/views/reports/tableview.aspx?isshared=true&ispopular=series&pid=1 ; and World Health Organization (2013) Global Health Observatory Data Repository: Health financing – health expenditure ratios by country. Retrieved from:from http://apps.who.int/gho/data/node.main.75

[8] Data taken from Navarro de Acosta, M. (2011). *Medicion del gasto en SIDA – MEGAS.* Lima: Ministerio de Salud.

0.4% of the national budget (Ministerio de Economia y Finanzas del Peru, 2012) as the government increased its financial responsibility. Moreover, in 2011 8.2% of this government total came from external funding and the private sector (Ministerio de Economia y Finanzas del Peru, 2011); in 2012 this decreased to 3.3% (Ministerio de Economia y Finanzas del Peru, 2012). This can be explained by a trend towards increased government investment in HIV/AIDS and the end of Global Fund round six in 2012, where the majority of these activities were included into the results-based budget.

Some respondents suggested that the increased allocation from the government to HIV/AIDS was not only a response to the economic growth and a growing political commitment, but also to effective pressure from CCM members to increase investment.

> *"There has to be some sort of commitment. The country has to say, I will do this and this is what is happening now with the results-based budget. Many of the things that have been implemented have been included into the budget and that generates sustainable activities; and this is the result of having worked all this time and shown results (Government representative)"*

Furthermore, besides having a budget allocated for HIV/AIDS, determining whether this money was actually spent helps to assess the effectiveness of this budgetary strategy. It also helps us to understand the organisational capacity that is in place to manage this new budget and ultimately, to ensure a sustainable response. Table 4.4.2 shows the percentages of HIV/AIDS and tuberculosis-allocated budget that were actually spent in 2011–2012 by level of government.

It is evident that while the absorption of the budget at the national and regional levels is at fairly high levels, the ability to absorb funds at the local level is clearly lagging behind. In this case, the 0% at the local level in 2011 resulted from funding for a project in Arequipa, a region with a high number of HIV cases, to reduce HIV/AIDS and tuberculosis infection risk among the population that was not implemented (Ministerio de Economia y Finanzas del Peru, 2011).

Table 4.4.2 HIV/AIDS and tuberculosis percentage of spent budget according to level of government 2011–2012[9]

	Absorption of funding	
	2011	**2012**
National	79.1%	86.3%
Regional	96.9%	90.4%
Local	0%	39.9%

The lack of training to plan and execute the new results-based budget was a strong theme that emerged from the interviews. This was due to a rapid transfer of responsibilities due to the decentralisation process, without first verifying the ability to conduct these tasks:

> *"There are still difficulties in the management capacity at the different levels and this means that even when there are resources available from the normal public treasury funds or through extraordinary contributions, all of the resources available are not planned for or executed (Academia respondent)".*

Additionally, a more detailed assessment of the absorptive capacity of two local governments with highest numbers of HIV/AIDS cases, the results varies widely (18.3% absorption of funding for Lima and 0% for Loreto in 2012 (Ministerio de Economia y Finanzas, 2012)). It was reported that Lima's local government was not only unprepared in managing this budget but individuals working there were not fully committed to developing an appropriate HIV/AIDS response, instead prioritising other activities. Loreto, on the other hand, belongs to the largest region in Peru but is also very remote and sparsely populated, which may explain the difficulties in collecting appropriate data and managing resources according to need. Cajamarca was the only local government reporting 100% absorption of funding in 2012 (Ministerio de Economia y Finanzas, 2012). This is an area that has experienced a recent increase in HIV cases that have been widely publicised through the media, which could explain the commitment of the local authorities to use allocated funds to stop the spread of HIV/AIDS.

[9] Data taken from Ministerio de Economia y Finanzas del Peru. (2012). *Consulta Amigable: consulta de ejecucion del gasto* [Data set]. Retrieved from: http://ofi.mef.gob.pe/transparencia/Navegador/default.aspx?y=2011&ap=ActProy and Ministerio de Economia y Finanzas del Peru (2011). *Consulta programas estrategicos – presupuesto por resultados: seguimiento a los programas estrategicos* [Data set]. Retrieved from: http://ofi.mef.gob.pe/bingos/pestrategicos/Navegador/Default.aspx

It is also important to examine the allocation of resources for different types of HIV/AIDS activities. Figure 4.4.3 below shows the percentage of funding per HIV/AIDS programme function from 2005-2010.

Figure 4.4.3 Relative distribution of HIV/AIDS funding allocation per function, 2005-2010[10]

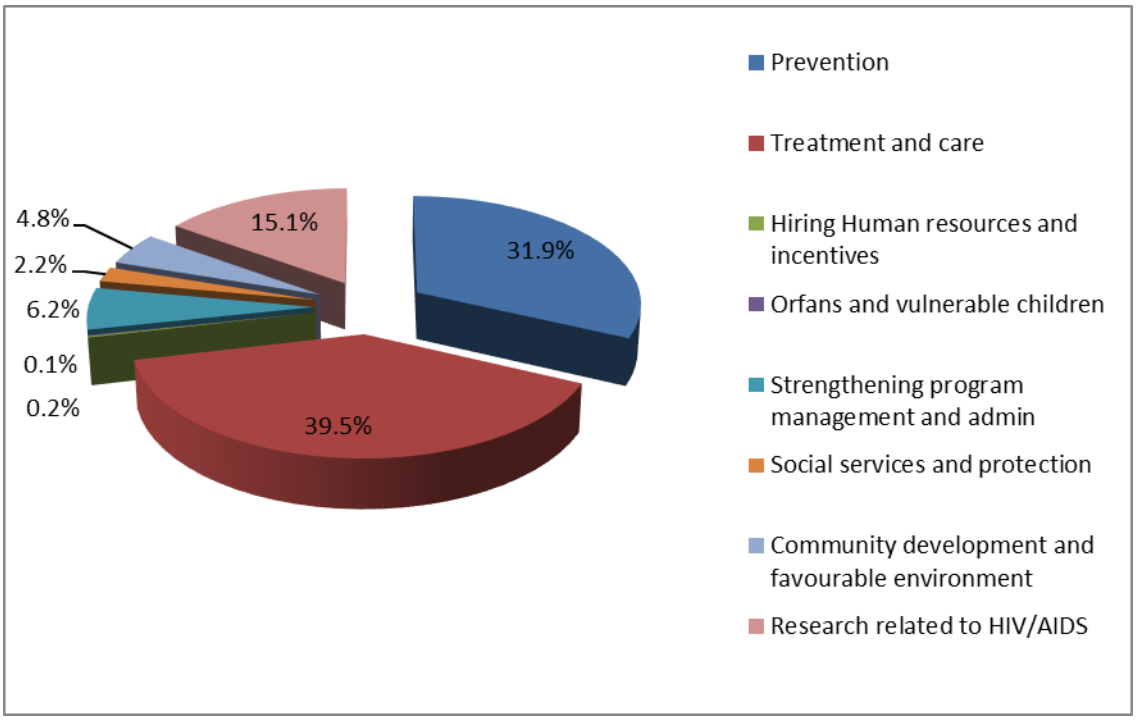


Figure 4.4.3 demonstrates that the largest fraction of HIV/AIDS expenditure has been directed towards treatment and care, a major share of which is purchasing antiretroviral therapy (ART) that is almost entirely funded by the central government, with some responsibilities already transferred to the regions. This is followed by prevention, with a significant 31.9% of investment (of which, 49.2% was covered with international funding). The third most important category of investment was HIV research the majority of which is in concept of clinical trials in Peru, almost entirely (i.e. 99.4%) covered by research agencies funding these trials. Strengthening management and administrative processes trails behind at 6.2% of investment, followed by community development and promotion of a favourable environment (i.e. promoting multi-sectoral initiatives such as financing the work of the Country Coordinating Mechanism (Navarro de Acosta, 2011).

[10] Data drawn from Navarro de Acosta, M. (2011). *Medicion del gasto en SIDA – MEGAS.* Lima: Ministerio de Salud.

4.4.2 Persisting data issues

The expectation is that the design and implementation of the most effective investment to combat HIV/AIDS requires reliable data on the scale and spread of epidemic. Indeed, the lack of available, reliable and up-to-date data emerged in the interviews as a key concern for a sustainable HIV response. This is seen to hamper the ability to plan and respond to needs as well as invest effectively to sustain programmes and activities. However, identifying unavailable data and weak monitoring systems emerged as a recurring barrier to appropriate planning in work around HIV/AIDS both within regions and at national level:

> *"These problems take place at all levels, not only in the case of HIV. Suboptimal reporting or non-standardized reporting is what happens since each region has their own type of reporting. They use one tool in one region; another region uses another mechanism; in some places it is automated and in others it's inputted manually, so there is no uniformity in terms of surveillance, and that disorder is reflected in the data (NGO representative)".*

The Global Fund invested in improving the HIV information systems through round 2, with the goal of improving data on ART provision, prevention of STI and HIV/AIDS among vulnerable populations and prevention of vertical transmission. This was conducted through the participation of main stakeholders to formulate a comprehensive indicator monitoring and evaluation system (SMEII in Spanish), as well purchasing computers and training of health workers on its use. During round 6, the Global Fund also supported a plan to strengthen the use of this information system at the regional level. As of 2010, the SMEII is being used by around 50% of the regional and local health authorities, one of its main weaknesses being the poor data quality due to the lack of disaggregated data (Navarro de Acosta & Llanos, 2009).

Likewise, an evaluation of health information systems conducted by USAID in 2009 among 63 hospitals and 151 health centres at the regional and local level in Peru found that less than 5% of the assessed establishments had medical records and databases in an adequate condition. Moreover, the average number of staff devoted to statistics was one person per facility. Information and data use in meetings for analysis or decision-making was found in less than 15% of health facilities (USAID, 2009).

Similar types of problems are found within the structure of the central-level monitoring and evaluation system at the Ministry of Health, which is managed by several entities, including

the General Office of Statistics and Informatics, the General Office of Epidemiology, the national strategy on HIV/AIDS, and the National Institute of Health. The national hospitals use their own information system to input financial and health care data, while laboratory information on HIV is collected at the National Institute of Health.

While the majority of the respondents in this study agreed that there was important research being developed outside of the Ministry of Health, in universities and consultancy companies, these studies were frequently not shared among the main stakeholders, making it difficult to act on these findings and ensure that new policies and programmes are based on evidence.

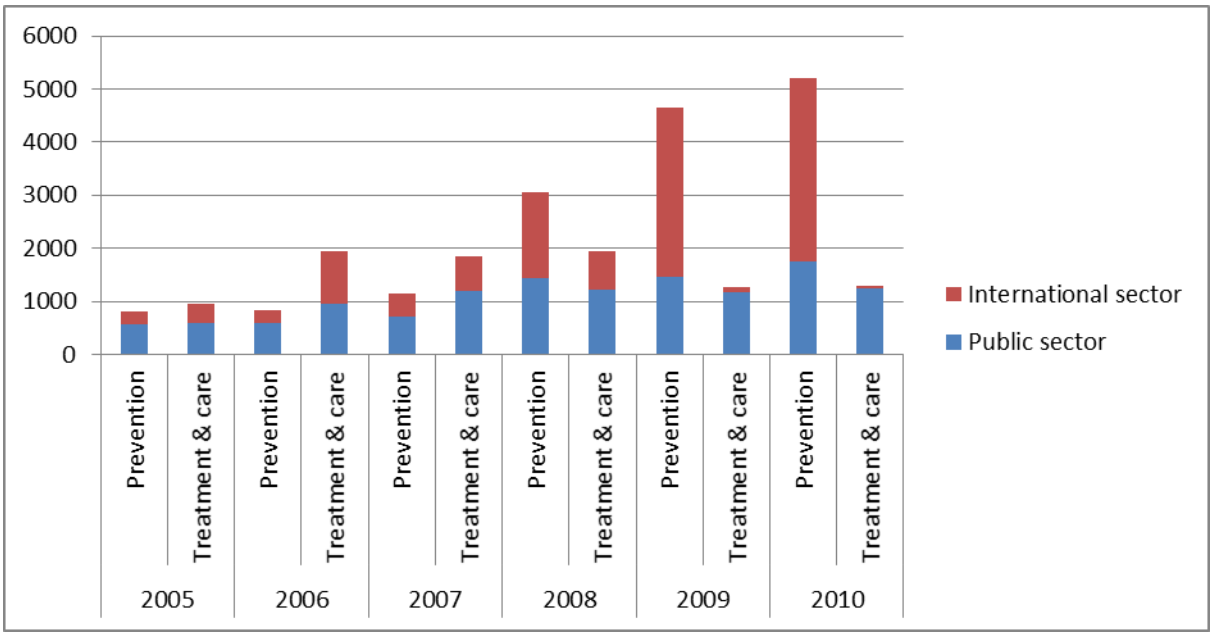
4.4.3 Availability of human resources for HIV/AIDS and technical capacity

Available and appropriately trained human workforce is a major cornerstone for any disease programme, enabling a response to the demand for services (identified through the data) and appropriate planning for the long-term. The importance of human resources for HIV/AIDS for sustainability in Peru was a theme widely shared among different categories of respondents.

As discussed in the financing section, the majority of the HIV/AIDS budget is spent in the areas of prevention, treatment and care. With the expansion of ART provision and the higher number of STI clinics at the national level, the expenditure for human resources in these two areas has increased. While the public sector has absorbed the majority of these expenses, the international sector made a significant contribution to funding most of the prevention activities for HIV/AIDS in the 2005-2010 period (Navarro de Acosta, 2011). Figure 4.4.4 demonstrates this trend of increasing funding for human resources over this five year period.

However, respondents at all levels coincided in stating that there were not enough human resources for HIV/AIDS, especially in the case of infectologists. The cadres that were available were frequently concentrated in the main urban regions and often frequently transferred from one service area to another, this damaging continuity in patient care and generating a need to retrain staff.

Figure 4.4.4 Human resources for HIV/AIDS expenditure for prevention and treatment and care 2005-2010 (amounts in thousands of USD)[11]



With regards to the HIV/AIDS strategy office within the Ministry of Health, the majority of the respondents expressed their concerns about their limited leadership in the HIV response, in part due to the small size of the team (13 people in early 2012), technical capacity and their weak coordinating capacity within this decentralised health system scenario.

> *"The Ministry of health has a coordinating role. Supposedly under the process of decentralisation, the authorities conducting the activities are the regional authorities. This is where there is an important weakness on behalf of the national strategy [office]. They do not have a technical team that can technically support the regional authorities, which is their role within a decentralised process. (International organisation representative)".*

Moreover, data about budget execution in the last two years (2011–2012), demonstrates that despite initial efforts from the Ministry of Health and Ministry of Economy and Finance to train workers at the regional level, the local authorities still lack knowledge and capacity on how to manage this new results-based budget (Ministerio de Economia y Finanzas del Peru,

[11] [11] Data drawn from Navarro de Acosta, M. (2011). *Medicion del gasto en SIDA – MEGAS.* Lima: Ministerio de Salud.

2012). A reflection perhaps of the investment of only 6.2% of funding towards management and strengthening administration on HIV/AIDS between 2005 and 2011 (Navarro de Acosta, 2011). This is compounded by overburdened health care administrators in the regions, often responsible for several programmes at the same time, insufficient health workers to provide care, and inadequate training and infrastructure; highlighting the need to invest more in human resources training and governance.

4.5 Discussion

This study sought to understand the inputs (resources available to address the HIV/AIDS epidemic in Peru) and how they had an effect on programmes and policies in the 2004–2012 period as the country moved towards HIV/AIDS programmatic sustainability. This was set in a setting of broader change within the Peruvian context, which has an effect on this transfer of responsibilities, and on the continuity and type of HIV/AIDS policies and activities that are available.

Peru demonstrates encouraging progress towards programmatic sustainability of the HIV/AIDS response. HIV indicators have improved significantly in the study period. Strengths identified regarding resources were related to an increased allocation of government funding for the HIV/AIDS response over time, as well as greater investment in human resources providing services as well as in managerial and administrative roles. These gains are threatened however, by a weak technical capacity at the regional level in managing the new results-based budget (although some efforts have been developed to address this) and at the central-level in coordinating the HIV/AIDS response. Other key weaknesses include poor information systems and the widely reported insufficient health workers for HIV/AIDS due to structural health systems issues such as urban/rural distribution issues.

As demonstrated in the findings, HIV indicators have improved greatly in the time the Global Fund provided funding in Peru, however the prevalence among MSM (Aldridge et al., 2009) and particularly transgender individuals (Ministerio de Salud del Peru, 2012) remains problematic. Moreover, with a budget for health of 4.5% of GDP in 2011, Peru is well below the average spending in the Americas, calculated at 6.7% in 2011 for the region (PAHO, 2012); pointing towards the need to further increase investment to compensate for the decline in external assistance, and primarily target resources to key affected populations.

As discussed previously available economic resources are widely identified in the literature as being one of the main determinants of a country's ability to sustain funding following donor exit (Atun et al., 2010; Heller, 2005; LaPelle et al., 2006; Pavignani & Colombo, 2009; Savaya & Spiro, 2012). While other countries have implemented varying strategies to increase domestic resources for HIV, such as levies in Malawi and Namibia, or earmarking government revenues for an HIV fund, in the case of Kenya (UNAIDS, 2013); Peru has the advantage of already including HIV/AIDS activities within the budget by results strategy, which directs resources towards specific population groups or goals (Valdes, 2012). This suggests an existence of political will (Pavignani & Colombo, 2009; Schell, et al., 2013) in investing to halt the HIV/AIDS epidemic in the country. However, the transfer of these planning and implementation roles to the regions has been less successful so far due to a lack of training and lack of prioritisation of HIV/AIDS programmes in some regions. However, it must be acknowledged that these problems were identified early on by the ministries of health and finance. Officials from these ministries then began to conduct workshops in the regions to help health managers understand how to plan for this budget. Indeed the literature suggests that continuously training managers on new roles is essential, particularly during this transitional period (Akerlund, 2000; Bossert, 1990; Sridharan, 2007).

Research suggests that designing programmes that are able to adapt over time, in response to new evidence and challenges is crucial for sustainability (Scheirer, 2005). Provided the problems in organisational capacity in the regions are effectively addressed, the results-based budget can prove to be an excellent tool for critically evaluating the effectiveness of past activities, responding to specific regional needs, as well as adapt to new changes in technology and evidence in the HIV/AIDS field.

Furthermore, a study conducted in Zambia looking at the sustainability of Community-Based Organisations (CBOs) previously funded by the World Bank Multi-Country AIDS Program (MAP) found similar issues with institutional capacity at the regional level. In this case while there was a view for sustainability within the initial MAP plans, a greater focus on funding project-based activities meant that building the institutional capacity trained in managing the income-generating practices, which would lead to sustainability, was neglected (Walsh et al., 2012). This approach to vertical funding from Global Health Partnerships such as MAP and the Global Fund has been widely criticised in various other studies (Balabanova, et al., 2010; Biesma et al., 2009; Buse & Harmer, 2007; Das, Gupta & Gostin, 2009) and may also be

associated with the perceived low number of trained health workers for HIV/AIDS in Peru. In order to address this, the 2012-2016 Global Fund funding model focuses on investing on areas for high impact and increasing sustainability of programmes (Global Fund, 2011); yet these recent examples suggest that the problems persist.

At the same time, reliable information on the specific inputs that need to be sustained has been reported as crucial for planning and the continuity of activities (Bossert, 1990; Walsham & Sahay, 2006), and this was also confirmed by most of the respondents in this study. However, our findings suggest that while the Global Fund made significant investments in the HIV/AIDS information systems, it still has clear deficiencies, resulting in poor data on national health indicators (Cabrera, 2010). This is in part due to the multiplicity of reporting mechanisms and a lack of timely collection of data. The unreliable, unavailable and outdated data can result in poor targeting of activities and distribution of health human resources, which were found to be important explanatory factor for the weak programming at places indicated in this study. Moreover, this poor targeting also threatens the continuity of actions and does not make the best use of economic resources towards successful outcomes, particularly among most-at-risk populations.

Similar to Peru, Myanmar also has an epidemic concentrated in specific populations, with most infections focused on female sex workers, men who have sex with men, and people who inject drugs (this is not the case in Peru). Yet different from Peru, following the first National Strategic Plan for 2006-2011, the actors in Myanmar reviewed the data on the epidemic and agreed on new National Strategic Plan 2011-2015, which now allocated 80% of funding for these priority communities, compared to less than 70% in 2010 (UNAIDS, 2013). However, in the case of Peru this readjustment has not taken place, due to what are perceived as still prevailing religious reasons, as well as the lack of direction from the HIV/AIDS strategy team, which has not yet developed the regional and national strategic planning processes for the 2012-2016 period (Global Fund, 2012), and continues to work under the guidelines set at the National Strategic Plan for HIV/AIDS 2007-2011.

Furthermore, there is an important literature on the role of leaders and influential individuals who support the sustainability of actions by promoting these changes and coordinating the response of the diverse actors (Archarya et al., 2004; Marchal et al., 2009; OECD, 2011; Savaya & Spiro, 2012; Sridharan et al., 2007). In Peru, this role of overseeing and advising the regions on their responsibilities has been undertaken by the HIV/AIDS strategy office, yet

the HIV/AIDS strategy's ability to do this is still insufficient in view of the tasks. This has mainly been attributed to the small size of the office, the weak technical capacity of the team and the reliance on NGOs to delivery key services, such as prevention activities, frequently making unilateral decisions without consultation and thus undermining the office's work. These actor roles are further discussed elsewhere.

This study has certain limitations. Respondents were asked about events that happened in the past, thus introducing possible recall bias. This was overcome by signposting important events and using triangulation to cross-examine findings. Furthermore, the data on 2011-2012 HIV/AIDS funding period was incomplete when this study was conducted (as well as some ART coverage data). However, a concerted effort was made to collect secondary data from government databases to fill in the gaps in this period. Finally, the interviews were conducted before round ten had begun (January 2012), which meant this round could not be fully included in the analysis and thus making it difficult to report on the complete picture of Global Fund involvement in Peru. Nonetheless, the unique characteristics of this round, which has a significantly lower budget and only targeted towards vulnerable populations means it was not fully comparable with other grants. Yet, the literature on this grant was reviewed and this grant is briefly mentioned in some sections of this paper. Finally, although the case study methodology followed in this study was tailored to the country characteristics, a degree of conceptual generalizability may be possible (Gilson, 2012), identifying lessons that can be useful for other countries.

4.6 Conclusion

The inclusion of HIV/AIDS within the results-based budget in Peru is a first step towards the programmatic sustainability of the activities but this must be supported by improved governance, data and planning. This is especially important for the continuity of successful activities and in ensuring effective investments for HIV/AIDS. While Peru is currently enjoying a period of prosperity, this transitional period is crucial in setting the foundations for a sustainable effective response to HIV/AIDS, which can respond to changes in priorities over time.

Although the process of decentralization is now well under way in Peru, the regions and local health authorities are facing difficulties managing their roles, lacking training to plan for and

execute the results-based budget for HIV/AIDS policy and programmes. This poor planning has been compounded by insufficiently reliable and updated data on the epidemic and little direction from the HIV/AIDS strategy at the Ministry of Health. This points towards a need to strengthen training during the transitional period of hand-over of responsibilities and to streamline data collection. Moreover, the decentralised nature of this budget is an opportunity to be more agile in planning human resources according to local need, type of users and utilisation patterns, in order to increase quality and access to HIV/AIDS care. In Peru, the participation of the academia is also seen as key to ensuring that the human resources are appropriately trained.

These lessons are significant not only for Peru but provide important insights on the key resources necessary to sustain programmes after aid has ended, which may be applicable for countries that are heavily aid-dependent as well as for those in the process of graduating from aid worldwide.

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Thesis Title	"Aid (In)dependence? Promoting long-term sustainability in the response to HIV/AIDS: the case of the Global Fund in Peru"

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12 October 2015

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Chapter 5 A critical analysis of Peru's HIV grant proposals to the Global Fund

Abstract

Peru has applied to six of the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) rounds for funding, achieving success on four occasions. The process of proposal development has, however, been criticised, especially concerning the use of evidence, relevance/consistency, and performance indicators.

We aimed to analyse the Peruvian Global Fund proposals according to those dimensions, providing feedback to improve future local efforts and inform global discussions around Global Fund procedures. We analysed the content of four HIV-focused proposals (rounds two, five, six and eight) regarding epidemic context, needs identification and prioritisation, and monitoring and evaluation systems.

Peruvian proposals submitted after round one were described as resulting from collaborative inputs involving formerly unrepresented sectors, principally 'vulnerable populations'. However, difficulties arose regarding the amount and quality of evidence about the epidemiological context; limited consideration of social determinants of the epidemic; lack of theory-driven interventions and little synergy across projects; and the inclusion of weak monitoring and evaluation systems, with poor indicators and measurement procedures.

Prioritising the development of analytical and technical skills to generate Global Fund proposals would enhance the country's capacity to produce and utilise evidence, improve the technical-political interface, strengthen information systems, and lead to more informed decision-making and accountability.

5.1 Introduction

Despite having a relatively stable, concentrated HIV epidemic and a prevalence of 0.4% among adults (UNAIDS & WHO, 2009), Peru is one of the Latin American countries that has most actively sought and received funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) for those three diseases (Cáceres & Mendoza, 2009).

Since the first time Peru applied for a grant, in 2002, there have been significant changes in terms of Global Fund proposal requirements. Initially, proposals were submitted using a flexible format, evolving over time into fixed formats with very detailed contextual, administrative, and political information (Buse & Harmer, 2007).

HIV/AIDS proposal elaboration processes have undergone different phases in Peru. The unsuccessful proposal for round 1 (which was not available and does not form part of this analysis) was formulated independently by the Ministry of Health. This proposal was followed by three consecutive, successful proposals (rounds two, five, and six) and another unsuccessful proposal submitted for round eight. A new proposal submitted for round 10 under the special provision for key populations has recently been approved but was also not part of this analysis. The proposal approved for the 10th round (for US$12.5 million) in 2011 brought the total amount for HIV/AIDS activities by the Global Fund to approximately US$90 million (Global Fund, 2010). Table 5.1.1 presents a brief description of the four proposals that served as a basis for this study.

Table 5.1.1 Description of Global Fund proposals[12]

Round	Proposal name	Reference framework	Period	Funding level
2	Strengthening prevention and control of AIDS in Peru	National consensus-building process	2004–2008	US$21,347,134 Successful
5	Closing gaps to achieve the Millennium Development Goals for HIV/AIDS in Peru	National consensus-building process	2006–2010	US$12,867,465 Successful
6	National multi-sectoral plans: Integrating resources for the fight against HIV/AIDS in Peru	Multi-sectoral strategic plan	2007–2011	US$32,669,809 Successful
8	Making a difference: consolidating a broad and integral response to HIV and Tuberculosis in Peru	Multi-sectoral strategic plan	2009–2013	US$72,775,647 (for both diseases) Unsuccessful

Source: Peru–Grant Portfolio–The Global Fund to Fight AIDS, Tuberculosis and Malaria. Online. Retrieved from http://portfolio.theglobalfund.org/en/Country/Index/PER

In line with Global Fund regulations, these proposals were developed by the Country Coordinating Mechanism (named Coordinadora Nacional Multisectorial en Salud - CONAMUSA), which included participants from several sectors of the government, civil society, and international aid agencies. The second-round proposal (second RP) was seen as a collaborative effort that all sectors involved in the CONAMUSA participated in and that responded to the national priorities at the time (Sprungli, 2003). The fifth and sixth RPs, on the other hand, were linked to previous discussion processes; the fifth RP was related to the second RP, and the sixth RP was linked to the 2006–2011 National Multi-sectoral Plan for HIV/AIDS (CONAMUSA, 2005; CONAMUSA, 2006). CARE, an international NGO, was designated as the principal recipient of all of these grants.

Proposal development is important because it provides the framework the country will follow to manage funding and achieve results. A 2006 independent assessment of Global Fund

[12] A proposal submitted for the tenth round was approved but did not form part of this analysis

proposal development and review processes for the three diseases in seven countries (Wilkinson et al., 2006), including Peru, found that in the countries under study there was a need to improve communication and clarify Global Fund principles; improve country ownership, donor harmonisation, and alignment with national systems; strengthen and support the technical review process; and use technical assistance and partnerships to improve country proposal development processes. Moreover, while other studies have examined the content of proposals submitted to the Global Fund in other countries (Gurkin, 2011; Libatique, 2004; MACRO International, 2009; Mueller & Hanson, 2005), this study is unique in that it specifically focuses on HIV proposal development in Peru within the 2002–2009 period in order to understand how country processes to develop Global Fund HIV proposals respond to local reality and needs. This analysis will allow for a discussion about both the national response to HIV/AIDS and the opportunities and limitations implied in the emergence of the Global Fund, which from a supranational level influences the scope and content of the country-level response to the epidemic. Furthermore, reviewing these documents and studying their formulation processes are also key steps to better understanding the strengths and weaknesses of broader ongoing activities (WHO & UNAIDS, 2007).

5.2 Methods

This study had the following three objectives in examining proposals in a sequential manner: a) to assess how and to what extent the national proposals submitted to the Global Fund arose from a careful analysis of the national context of the HIV epidemic; b) to assess the consistency of activities and strategies included in the proposals with the expected effects, impacts, and outcomes, as well as determining if there is a logical link from one proposal to the other; c) to assess whether the proposals include the appropriate mechanisms for monitoring and evaluating impacts and outcomes. These three dimensions encompass the key technical aspects of a programmatic proposal, all of which should be evidence-based: background, goals and activities, and performance assessment. For each of these objectives, we formulated indicators intended to operationalize the key dimensions identified for analysis (see Table 5.2.1).

Table 5.2.1 Study objectives and indicators

Objectives	Indicators
1. Do the national proposals submitted to the Global Fund arise from an assessment of the national HIV/AIDS situation, identifying and prioritising intervention needs?	a) Published references b) Contextualised citations c) Updated, time-specific figures d) Statements supported by data e) Consistency of data interpretation across proposals
2. Are the activities and strategies included in the proposals consistent with the expected effects, impacts, and outcomes? Is there a logical link from one proposal to the other?	a) Appropriate intervention models, supported by evidence b) Appropriate adaptation, if possible, validated c) Interventions aligned with a problem d) Continuity and synergy with other plans and projects, particularly previous Global Fund grants and official national strategies
3. Do the proposals include appropriate mechanisms for verifying impacts and outcomes? Are the impacts and outcomes of the projects monitored and evaluated based on a system that provides timely estimates of such indicators?	a) Indicators already existing in the system, rather than 'ad hoc' b) Clearly formulated indicators c) To the extent possible, internationally recognised indicators d) Clear, parsimonious processes to identify targets

To do this, we conducted content analysis of the official texts of four HIV/AIDS proposals submitted to the Global Fund for rounds two, five, six, and eight. We also reviewed the 2007–2011 Multi-sectoral Strategic Plan since it served as a reference framework for the last two proposals. A team of four researchers reviewed the documents, identifying emerging themes and assigning codes according to the objectives. Recurring themes were then charted and agreed upon in order to later interpret them and identify relationships between them. These interpretations were also contrasted with a document review.

This documentary review was conducted by searching grey literature and peer-reviewed articles addressing Global Fund proposals and results in Peru and other countries between 2002 and 2013, using the keywords 'proposal', 'evaluation', 'grants', 'HIV', and 'Global Fund' in the databases Embase, PubMed, LILACS, and Google Scholar. Finally, conclusions and recommendations were developed to improve future Global Fund specific procedures, with potential implications for other similar mechanisms of international aid in the future.

5.2.1 Study limitations

This study has limitations such as the difficulty in defining a single, detailed evaluation framework across different proposals in an evolving context; restrictions in assessing the context where each of these proposals were developed and discussed; and variations in project design and implementation. Nevertheless, researchers' proximity to the projects and the realities they try to address was an advantage given the prior knowledge of how these are conducted. Finally, this analysis is intended to generate lessons for the future, and not serve as an evaluation of processes or actors involved in the past.

5.4 Findings and discussion

We have subdivided our results in three major sections evidence-base of the proposals; consistency and appropriateness of the proposed interventions; and inclusion of appropriate monitoring and evaluation systems.

5.4.1 Evidence-base of the proposals

We examined the extent to which these proposals used substantive, high-quality evidence, and whether the evidence led to a coherent, well-supported assessment that allowed for the identification and prioritisation of key interventions. The emerging themes centred around two basic issues: how the epidemic was characterised and how population sizes were estimated.

5.4.1.1 Characterisation of the epidemic

Content analysis revealed that the scope and depth of information about the epidemic used in the proposals had improved over time, partly due to more rigorous requirements and more standardised submission formats in recent years. For example, in the eighth RP, the HIV epidemic in Peru is described in greater detail as an epidemic concentrated on men who have sex with men (MSM), relying on the most recent prevalence estimates from sentinel surveillance for pregnant women and at-risk populations, following UNAIDS criteria. This description is much more systematic and complete than formulations in the initial proposals (CONAMUSA, 2002) and illustrates improvements facilitated by the Global Fund through improved guidelines. At the same time, however, an arbitrary, inconsistent interpretation of the same evidence becomes apparent according to the intended project focus. The statement below, which suggests imminent feminisation, provides an example of this since the male-female ratio had become stable in 1997 at 3:1, with similar characteristics to today's epidemic (i.e., low prevalence in the general population, high prevalence among MSM):

> *'The epidemic in Peru, as in the rest of the world, has shifted towards younger populations and women. Because of this, the male: female ratio of cases has shifted from 27/1 in 1987 to 2.6/1 in March of 2005, confirming the biological and social vulnerability of the female population (p. 35, fifth RP)'.*

Interestingly, the same variation in the male/female ratio is more accurately summarised in the sixth RP (Section 4.4.2, sixth RP), which states that this ratio had remained around 3:1 for over 8 years, thus suggesting stabilisation (Cáceres & Mendoza, 2009).

Regarding MSM, while high figures are described, no effort is made to explain the low stability of HIV prevalence estimates over time that is presented in the fifth RP using data from sentinel surveillance studies (i.e., 18% in 1998, 11% in 2000, and 13.9% in 2002). It can be argued that such considerable variation had to be explained based on the characteristics of the cross-sectional surveillance operations using recruiter-based convenience sampling. The proposal only states that this average figure hides substantial heterogeneities across different regions of the country. However, other heterogeneities such as the several sub-populations included under the MSM label, including transgender and gay populations, as well as those involved in sex work, are not mentioned.

In fact, while the term MSM was considered representative for an especially complex vulnerable group (where differences across sub-groups were ignored), by the time the sixth and eighth RPs were developed, several studies had shown evidence of other sub-populations with social characteristics that were misrepresented within a generic MSM category. This was the case not only with the transgender population but also of sex worker sub-populations (Cáceres, Konda, Pecheny, Chatterjee, & Lyeria 2006; Hwahng & Nuttbrock, 2007). Nevertheless, the term MSM was maintained in the last two proposals, and such generalisation delayed consideration of specific interventions targeting sub-populations, which would have improved the strategies in place.

Finally, a consistent finding is that the term 'vulnerability', while widely used to identify pre-defined groups such as MSM, prison inmates, sex workers and young people, rarely results in an analysis of the conditions leading to greater social vulnerability which have been identified in prior studies to increase risk of exposure to infection (Auerbach, Parkhurst, & Cáceres, 2011; Gupta, Parkhurst, Ogden, Aggleton, & Mahal, 2008).

5.4.1.2 Population size estimates

A problem encountered during the elaboration of the proposals has been the apparent lack of updated data from the Ministry of Health. Interestingly, the proposals do not show recent data from official sources such as the Epidemiology Bureau, choosing instead to use data from

other sources such as UNAIDS or expert estimates. This results in inconsistencies, especially when dealing with population sizes across proposals.

Regarding people living with HIV/AIDS (PLHA), the number of PLHA is calculated using two different approaches: a) a count based on cumulative case reports and b) estimates of the total number of PLHA. These approaches are inconsistently alternated throughout the submissions. For example, the second RP describes 12,000 reported AIDS cases and an estimated 5000 unreported or unnotified cases, without providing a source for these numbers. Moreover, within this same proposal it is reported that around 7000 HIV cases were eligible to start antiretroviral (ARV) treatment but only 10% of them were actually receiving it. These were unofficial estimates, since no formal study of ARV coverage and needs had been conducted at the time (p. 32, second RP). While in part these inconsistencies reflect an evolving field of population-size estimation, they also suggest the need for additional standardisation so internationally available statistics, for example, are used by default.

Moreover, the same data was frequently interpreted in a different manner in consecutive proposals. For example, the sixth RP used the same estimate of people in need of treatment that was reported in the second RP, although this time a 90% coverage rate was reported (section 4.4.2, sixth RP), disregarding the appropriateness of pointing out any growth or decrease in cases during that period. This suggests that analysis of new proposals requires the consideration of the overall previous or ongoing Global Fund support to the country. This need was in part resolved by the Global Fund with a policy of integration of interrelated grants (Global Fund, 2011). Finally, these proposals lack any reference to PLHA morbidity and survival, either, which would be important in assessing the need for specific services for PLHA, particularly regarding access to services.

Concerning ‘vulnerable groups’, population-size estimates for these groups do not appear until the eighth RP, which used data from the 2008 Universal Access Report, reached through expert consensus. Here MSM and female sex worker (FSW) population-size assumptions, together with their HIV prevalence estimates, were used to approximate the number of HIV-infected MSM and FSW as 20,214 and 644, respectively (section 4.2.1 and 4.2.2, eighth RP). Moreover, figures for pregnant women were taken from aggregate data from the Ministry of Health in order to calculate HIV-screening coverage among pregnant women, the proportion of positive results, and prophylaxis coverage of HIV-positive pregnant women and their

offspring, without discussing how appropriate this combination of sources might or might not be.

In summary, proposals had generally characterised the epidemic by using epidemiological data in an inconsistent, poorly documented manner, without further interpretation. Poor intervention justification often derives from a lack of available, recent data. Clearly, this is a serious problem not only for Peru but in most lower- and middle-income countries (Fraser et al., 2005; Waltham & Sahay, 2006) and represents a serious limitation to the potential effectiveness of the Global Fund mechanism. While the Global Fund submission process requires proposals to be supported by evidence in order to justify actions (Kerkhoff & Szlezak, 2006), it is critical to ensure the functioning of a sentinel surveillance system that regularly collects data from pregnant women, MSM (divided into subcategories such as gay/lesbian and transgender), sex workers, and prisoners (Cáceres, Mendoza, Konda, & Lescano, 2007). Moreover, although social, economic, and cultural data were included, this information was presented separately and did not fully contextualise or explain the quantitative data.

5.4.2 Consistency and appropriateness of proposed interventions

The main emerging themes regarding the consistency between interventions were related to internal (i.e., across proposal components) and external consistency (i.e., across proposals and with other policies and plans). We analysed these two areas in relation to their implications for the various populations affected by the epidemic and for the general population.

5.4.2.1 General Population

Goals and activities aimed at prevention in the general population, including youth, focused on promoting safe sexual practices, managing STIs, increasing risk awareness, and preventing vertical transmission. The two major strategies framed for young people are the sex-education initiative (in the second RP) and syndromic management for STIs (in the fifth and sixth RPs), with the eighth RP including both approaches. In general, no effort was made to present subsequent proposals as a continued, complementary effort. Rather they were presented as external to each other.

The sexuality-education components targeting youths and adolescents, included in the second and eighth RPs, mention the inclusion of a formal sex-education component in the current curriculum for adolescents attending public schools. In fact, a sex-education component was previously included in the curriculum in the 1990s, but its scope, as well as the pedagogic framework, has changed over time according to overall government policy. Education-sector strategies in the Global Fund proposals focused more specifically on promoting HIV education and condom use, through training of school teachers and the use of innovative strategies such as training peer promoters. However, these strategies did not seem to depart from an analysis of the status of sex education in the school system, and they were operationally, rather than conceptually, linked to sex education. It must be said, though, that clear guidance on how to best integrate HIV education in schools was not provided by international technical cooperation agencies, in part due to contrasting political views about sex education during the 2000s. Furthermore, the UNESCO sexuality-education guide was published only until 2009 (UNESCO, 2009).

Training health professionals is a priority in all of the proposals and centres on STI syndromic management and care. The weight assigned to STI prevention and care suggests that these are key strategies to preventing HIV within the general population and in specific groups; however, such presumption is not clearly stated and the strategy is proposed without supporting references for its importance or even STI rates in the general population. For example, we know that women's risk for infection is highly dependent on their male partner's sexual behaviours, and even monogamous women in Peru have been found to be part of large sexual networks (Johnson, Alarcon, & Watts, 2003).

Strategies to combat stigma and discrimination, included in the second and fifth RP, were not delineated within a clear conceptual framework, nor did these activities consider how this issue had been addressed within other contexts. For instance, studies have found little evidence to suggest that the predominant HIV stigma-reduction strategies (among these, the provision of information at the individual level and through mass-media campaigns) have led to significant improvements in the impact of preventive interventions (Mahajan et al., 2008). It is also the case that interventions designed to reduce stigma have limited impact if not coupled with comprehensive programmes to scale up treatment and care services (Maman et al., 2009), making the case for targeting the structural determinants of stigma.

Furthermore, based on a study conducted in five African countries, Holzemer, Uys, and Makoae (2007) developed a conceptual framework modelling the dynamics of HIV stigma. This model describes the context in which stigma occurs as one that can be divided into the environment, the health care system, and the agent, suggesting activities to manage each of these. Along those lines, the final evaluation of the fifth RP explains that while there was an improvement in the attitude of the general population toward PLHA, the same improvements have not fully reached health care institutions and schools, primarily concerning vulnerable populations (Cáceres et al., 2012).

Prevention of mother-to-child transmission (PMTCT) was also present in all proposals, and they focused on (a) increasing coverage for HIV screening during pre-natal care (or delivery in the case of pregnant women who did not receive pre-natal care) and (b) offering access to PMTCT. Formulation of the coverage activity reflected legal changes during the decade (i.e., HIV screening became mandatory in 2004), while the latter activity reflected evolving models of PMTCT over time. However, projects generally failed to ensure appropriate follow-up of children perinatally exposed to HIV, primarily due to problems estimating perinatal transmission rates due to information-system weaknesses (CARE Peru, 2009).

5.4.2.2 "Vulnerable" populations

Interventions focused on 'vulnerable populations' (i.e. MSM and female sex workers) across all proposals have continuously relied on a combination of peer outreach and regular medical check-ups, focusing on STI screening and treatment as well as voluntary HIV counselling and testing (VCT). Although this combination has been in place since the 1990s, and community involvement is a proven practice to ensure participation (UNAIDS, 2005), the proposals lacked any analysis of the effectiveness of this approach or its impact on MSM. Furthermore, a study conducted by CARE found that peer promoters were frequently perceived just as recruiters who brought their peers to medical check-ups, neglecting their educational role (CARE Peru, 2009). The medical component of the model was positive in its concern for offering a safe, non-discriminatory environment to traditionally marginalised populations, although the predominant concept of care seemed to reflect the traditional paradigm of controlling HIV spread through sex workers, where the main focus is placed on preventing outcasts from spreading diseases (Evans & Lambert, 2008).

5.4.2.3 People Living with HIV/AIDS (PLHA)

All four proposals included actions targeting PLHAs, which have generally diversified over time. The second RP included funding to start up a national HIV treatment programme (with a commitment from the government to assume treatment costs after year 2) and establish laboratory-based monitoring, as well as improve provider training and develop comprehensive care for PLHA, although what comprehensive care entails was not defined. After the second RP, proposed activities diversified to replace the importance-of-treatment provision, which was state-funded then. New actions included some clearly relevant additions such as improving care for TB/HIV co-infection (added in the eighth RP), as well as activities that were not supported by evidence and lacked basic implementation criteria. An example of this was promoting care and services for orphans and children whose mothers were living with HIV, despite their being few in number and despite the fact that they were never clearly identified and mapped. Treatment for opportunistic infections was included in the fifth RP, but with limited duration and coverage.

Given the participation of PLHA in the CONAMUSA, they had the opportunity to be vocal during proposal development, and their request for the inclusion of peer counsellors and family support was appropriately expressed in the second RP, as well as in workshops included in the fifth RP. The latter proposal also included micro-finance loans, although this activity was not rooted in a careful assessment given the literature available on the strengths and weaknesses of such initiatives (Caldas et al., 2010; Dworkin & Blankenship, 2009), and may explain the numerous implementation issues experienced early on (Cáceres et al., 2012). In the eighth RP, special attention was paid to PLHA sub-groups with increased vulnerability (such as sex workers, transgender persons, adolescents, and prison inmates) by means of joint work and efforts involving PLHA grassroots organisations and health facilities. In synthesis, while many of the proposed activities were relevant over time, starting with the creation of the national treatment programme, these activities rarely emerged from a comprehensive monitoring of PLHA needs and did not necessarily reflect a well-thought-out, comprehensive strategy, but instead a juxtaposition of numerous activities of varying relevance and feasibility.

5.4.2.4 Development of a favourable environment

The development of a favourable socio-political environment for overall HIV/AIDS activities was addressed in the National Multi-sectoral Strategic Plan through several of its objectives. Objective 7 aimed to promote a favourable political, social, and legal environment with a human rights perspective and with the participation of the most vulnerable communities (MSM, FSW, and prisoners) and PLHA (Ministerio de Salud del Peru, 2007). Objective 8, on the other hand, proposed ensuring a comprehensive and coordinated multi-sectoral response regarding the development of joint activities for the prevention and control of STIs and HIV/AIDS. The latter strategic objective aimed to strengthen information systems and ensure monitoring and evaluation to enable timely decision-making processes and measurement of goals (Ministerio de Salud del Peru, 2007).

The second RP proposed advocacy campaigns to strengthen CONAMUSA; whereas the fifth RP proposed a communication campaign to prevent discrimination against PLHA, workshops to improve health workers' and schoolteachers' attitudes, and activities to strengthen PLHA organisations. The sixth RP addressed the relationship between the government and civil society, promoting the formation of inter-sectoral committees to ensure budgetary allocations to implement the STI and HIV/AIDS plans, the integration of an information system, and timely decision-making about HIV/AIDS policies.

In summary, most of the HIV response strategies in the proposals were risk-centred. Very few specific actions were aimed at reversing the vulnerability of affected populations or addressing major determinants of such conditions, other than some media-based campaigns aiming to sensitise the general population to HIV-related stigma. The approach that has prevailed for managing risk and vulnerability has mainly focused on the individual, regardless of whether it was directed toward key populations or the general population. Moreover, the approach primarily focused on medical care, behavioural change, and STI syndromic care, replicating the traditional public heath approaches with a biomedical and clinical view of health (Castro, 2003).

It is important to highlight that these proposals' aims were not the result of comprehensive, systematic discussions about the epidemic and its evolution in Peru, given prior interventions (including preceding Global Fund grants). As explained above, nearly all of the evidence presented in the second, fifth, and sixth RPs derives from studies conducted in 2002, making it difficult to argue across proposals or clearly account for the success of ongoing activities to

justify the need for continued, complementary actions. Moreover, given that most of the activities proposed corresponded to the 2007–2011 Multi-sectoral Strategic Plan objectives, it could be argued that both the plan and the proposals responded to the same few unchecked strategies developed over a decade before. This has been found in prior studies (Brugha et al., 2004; Kapilashrami & McPake, 2013; Libatique, 2004) where proposals seemingly state facts to support the country's view rather than the other way around. Additionally, while there were opportunities for synergies or complementarity in actions that involved scaling up, unfortunately, most of the proposed activities were external to each other.

5.4.3 Inclusion of an appropriate monitoring and evaluation System

This section addresses the existence of a monitoring and evaluation (M&E) system built into the proposal, which relies on sensible impact and outcome indicators and is based on an up-to-date information system. We focused on the second RP M&E procedures, given that subsequent proposals followed the same model, and we provide additional comments for the other proposals.

The five higher-level indicators presented in the second RP represent indicators to measure both impacts and effects. These five indicators were: (1) proportion of HIV-positive MSM; (2) proportion of HIV-positive female sex workers; (3) proportion of HIV-positive pregnant women; (4) proportion of infants of HIV-positive mothers who do not serorevert by 18 months of age; and (5) proportion of PLHA accessing comprehensive care.

Four of the five indicators mentioned required the use of biological markers of infection as impact indicators, while the indicator on comprehensive care coverage can be considered an effect indicator. In addition to impact/effect indicators, a number of outcome indicators for specific activities were included. These included, for example, providing information on infection prevention and condom use to youth and most-at-risk populations; coverage of prophylaxis to prevent vertical transmission; and coverage of and adherence to ARV treatment.

At the same time, the first three indicators measure HIV prevalence, and their use as impact indicators has become inappropriate over time given that this figure represents both new and existing cases within a context of increasing access to antiretroviral treatment, where prevalence is expected to increase due to longer survival rates among those infected. This

limitation was unknown in 2002 since treatment scale-up was just in its infancy; therefore, use of these indicators was appropriate for the second RP. However, subsequent proposals continued to use the same indicators or modifications of unknown feasibility such as use of HIV incidence among MSM (fifth RP), thus failing to address increasingly clear evaluation problems in previous proposals.

This evaluation framework presented a number of limitations that restricted the observation of impacts and effects. Not only were indicators frequently inappropriate to estimate positive change (as described above), but targets were not based on a thorough analysis of realistic change according to trends, as was the case for prevalence targets among FSW and pregnant women (for whom targets of maximum prevalence did not represent a challenge as they had already been reached at baseline). Targets for condom use for populations such as adolescents and prison inmates were also unrealistic in the proposed time frame (e.g., increases of up to 100%). The representativeness of other indicators was also problematic, where the use of pre-natal care data to measure HIV testing coverage among pregnant women was of limited utility given the still moderate coverage of pre-natal care during 2002 to 2003 (Ministerio de Salud del Peru, 2006). This problem could have been avoided by reviewing the literature on achievable targets of change for specific interventions according to their baseline levels.

Finally, the proposals had two major, persistent shortcomings: a) an overall evaluation design built into the project was lacking, affecting the likelihood that data collection would follow the same procedures in each phase and would facilitate the comparability and validity of results; and b) indicators proposed in most cases did not rely on an existing, reliable information system, and no provision was made to develop such a system, even in subsequent proposals submitted when such problems were already apparent (CARE Peru, 2009). Across proposals, major difficulties included the following: a) a lack of standardised methods of measuring indicators and b) a lack of provisions to improve the capacity and commitment of the Ministry of Health regarding the timely collection of reliable indicators. Eventually, when projects were implemented, this implied the need to employ ad hoc surveys and other secondary sources to fill this gap in information. These issues were also found in the principal recipients' summative evaluation of the second RP (CARE Peru, 2009).

5.5 Conclusion

This study sought to analyse the content of the four HIV-focused proposals submitted by Peru to the Global Fund from 2002 to 2009 in order to assess if the evidence presented in the proposals was accurate and reliable and allowed for adequate assessment, identification, and prioritisation of interventions; whether the four proposals showed relevance and internal and external consistency; and finally, if appropriate monitoring and evaluation mechanisms were proposed.

Key findings show that the evolution of Global Fund proposal requirements has translated into greater rigour in presenting evidence, yet this has been limited by a weak information system that does not provide the tools to respond to changes in the epidemic. While prior Global Fund grants have sought to improve these information systems, the multiplicity of reporting mechanisms and lack of training among health workers need to be addressed to effectively plan and implement activities. Moreover, the concentrated nature of the Peruvian epidemic requires targeted interventions that go beyond the traditional MSM grouping, including transgender populations, for example. Besides targeted interventions, the Ministry of Health should also focus on proposing comprehensive policies that include other sectors in order to address the root causes of vulnerability, to tackle the drivers that perpetuate the increased exposure of these populations to HIV. The lack of consistency across proposals has hindered efforts that at times seemed disjointed from existing policies, such as in the case of sexuality education. This may in part be explained by the turnover and lack of long-term, stable policy-makers, which has been found to be an important factor affecting continuity and scale-up of actions (Balabanova et al., 2013). Promoting continuity among civil servants despite political shifts would be one way to respond to this problem, as well as ensuring that the main stakeholders are trained in relevant HIV policies.

This study has also shown a number of limitations in Peru that go beyond the proposals of the Global Fund, such as clear deficiencies in the surveillance system of the HIV/AIDS epidemic or in the selection of interventions to respond to it. The country should use this and other studies, including internal project evaluations, to improve their capacity in terms of proposal design, implementation, and evaluation. This analysis does not imply, however, that the Peruvian HIV projects funded by the Global Fund have been ineffective. On the contrary, a recent summative evaluation has shown that the second, fifth, and sixth RP have played a positive, useful role in such response, and they represent an important example of

collaboration between the state and civil society to confront a major social problem (Universidad Peruana Cayetano Heredia, 2013). This leads us to suggest that while good projects can be implemented in problematic ways, projects with limitations can also find solutions for such shortcomings as they are being implemented.

Two questions may be posed for the ongoing discussion about the opportunities presented by the Global Fund, considering that funding will significantly decrease: 1) Should the Global Fund make additional efforts to ensure the quality of proposals through the direct provision of technical assistance although it has consistently sustained that it is only a funding mechanism and such assistance should be primarily provided by partners active in the country (Wilkinson et al., 2006)? 2) Given that other studies have found that current decision-making processes may favour political negotiations over technical consistency (Libatique, 2004), should the pre-eminence of local political agreement be maintained, or should other mechanisms be found to strengthen the relative weight of technical consistency and efficiency?

Finally, to ensure that positive results are obtained and targets are reached in Global Fund projects, particularly in a time of fiscal constraints, it seems clear that greater effort should be placed on setting activities based on improved epidemiological data and available evidence of intervention effectiveness. Moreover, heightening technical quality, allowing for flexibility to correct inappropriate indicators or targets as identified during implementation, and setting precise monitoring and evaluation frameworks and procedures within the proposals submitted for funding, would greatly strengthen future proposals. These limitations we identified here are likely to be present in many other proposals from countries receiving aid from the Global Fund, reminding us of the need to improve information systems and to accurately set targets in lower- and middle-income countries, and, at the level of the Global Fund, to substantially improve proposal evaluation. The extraordinary opportunity still offered by the Global Fund to curb the pandemic must not be missed.

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5.7 A critical analysis of Peru's HIV grant proposals to the Global Fund – ADDENDUM

By analysing the use of evidence in the Peruvian proposals for HIV/AIDS to the Global Fund, this chapter aimed to understand how evidence informs proposal development and how this process supports the development of country capacity to generate and use evidence, and promote accountability. This addendum provides additional analysis for the implications of HIV/AIDS proposal development to the Global Fund in Peru for sustainability following the publication of this chapter in a peer-reviewed journal.

What are the implications of these findings for sustainability of the HIV/AIDS response in Peru?

To operationalise this aim, this chapter was led by three specific sub-objectives: 1) to assess how and to what extent the national proposals submitted to the Global Fund arose from a careful analysis of the national context of the HIV epidemic; 2) to assess the consistency of activities and strategies included in the proposals with the expected effects, impacts and outcomes, as well as determining if there is a logical link from one proposal to the other; and 3) to assess whether the proposals include the appropriate mechanisms for monitoring and evaluating impacts and outcomes.

The findings from this chapter provide important reflections on three supporting factors for programmatic sustainability: alignment of donor-funded activities with national policies, existence of political will and related to this, appropriate decision-making based on need.

As this chapter shows, Peru sought to align their proposed Global Fund-funded activities from the beginning. This process improved over time with proposals for rounds two and five being agreed through consensus, whereas from rounds six and on these were based on the national HIV multi-sectoral strategic plan. Alignment of donor funded-projects with government policies is important since it has been proven to result in a more long-term sustainable and coherent national response (Hay & Williams, 2005; OECD, 2008; Scheirer, 2005; Tibbits et al., 2010). In Peru, this alignment may have been the result of the greater level of organization within the CONAMUSA generated over time, as well as the

requirement given by the Global Fund for countries to consider issues related to sustainability within their proposals. According to Slob and Jerve (2008), alignment proves that there is a demand for activities, which generates greater success for phasing-out of funding. However, while there may have been demand for these activities expressed by the interest in aligning the proposals with the national HIV/AIDS plan, this demand frequently seems to have had little relation with actual need expressed by the data.

These findings point to positive political will to continue the activities, which is an important component for sustainability (Atun et al., 2005; Mogeni et al., 2013; Pavignani & Colombo, 2009; Schell et al., 2013); yet at the same time political will should be informed by a critical analysis of the data and the needs brought by the HIV/AIDS epidemic. In practice the findings show that rather than basing activities on actual need and directed towards most affected populations, activity priorities were frequently based on negotiations at the national level based on CONAMUSA member interests rather than negotiations informed by data. The importance of negotiations in setting priorities and decision-making has been widely studied (Bossert, 1990; Brugha et al., 2004; Gruen et al., 2008; Kapilashrami & McPake, 2013; Libatique, 2014) and is considered an habitual part of the policy process. However, it is also understood that in order for these decisions to respond to need they should be informed by data (Bossert, 1990; Fraser et al., 2005). Despite multiple attempts to improve the national information systems, the country still suffered from unreliable and insufficient data in order to develop efficient policies to address most affected populations. Even when data was available, there was lack of technical capacity to coherently and consistently analyse this data. The findings show that this technical capacity did not seem to improve over time despite efforts to strengthen the information systems. In this sense, actors did not improve their use of evidence for more appropriate priority-setting over time. This reiterates the view that while a country may be have the financial resource to take-over full funding of a disease programme, this does not directly imply that the country will not require technical assistance (Vermund et al., 2012).

While political will seems to currently favour investments in HIV/AIDS, a lack of focus on the actual need, based on the data, means that this political will is shaky at most. Any political changes or the entry of a conservative government, as discussed earlier on in the Russian example of failure to fulfill commitments to invest in HIV/AIDS preventative activities due to political reasons (Tkatchenko-Schmidt, et al., 2008), could mean that

activities that are needed are discontinued. Importantly, this also implies that if the data points in the future to a lack of need for a continued high investment in HIV/AIDS services, this will mean policy makers may decide to decrease investments. In this sense, sustainability should not be considered a static notion but rather should be seen as a flexible concept that responds to current realities.

Conclusion

This chapter provides evidence for three key supporting factors related to the use of evidence and country learning from the process of developing Global Fund grants that are relevant to sustainability. In the case of the HIV/AIDS response in Peru, the findings demonstrate good alignment of Global Fund activities to the national policies, which provides an optimistic view for long-term planning and an eventual take-over of funding responsibility by the government. This alignment of activities is a reflection of positive political will in the country to continue to invest in the HIV/AIDS programme. However, this political will was frequently based on internal political negotiations with little consideration of the available evidence. It should be noted though that inadequate monitoring and evaluation systems in the country mean that data is frequently not reliable or readily available.

In this sense, Peru has a positive scenario for sustainability in relation to alignment of Global Fund activities to national policies and political will. However, it must work to strengthen the monitoring and evaluation systems within the country as well as the importance given to making evidence-informed decisions for a more effective use of resources and targeting of key populations for the HIV/AIDS response in the long-term. These enabling factors should be considered within the wider context of programmatic sustainability, which also requires a positive economic environment, appropriate coordination, among other factors.

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Thesis Title	"Aid (In)dependence? Promoting long-term sustainability in the response to HIV/AIDS: the case of the Global Fund in Peru"

If the Research Paper has previously been published please complete Section B, if not please move to Section C

SECTION B – Paper already published

Where was the work published?	Global Public Health		
When was the work published?	05 February 2014		
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Student Signature: **Date:** 08/09/2015

Supervisor Signature: **Date:** 08/09/2015

Our Ref: LA/RGPH/P5229

12 October 2015

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Material requested: Ana B. Amaya, Carlos F. Caceres, Neil Spicer & Dina Balabanova (2014) After the Global Fund: Who can sustain the HIV/AIDS response in Peru and how?, Global Public Health, 9:1-2, 176-197

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Chapter 6 After the Global Fund: who can sustain the HIV/AIDS response in Peru and how?

Abstract

Peru has received around $70 million for HIV/AIDS from Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund). Recent economic growth resulted in grant ineligibility, enabling greater government funding; yet doubts remain concerning programme continuity. This study evaluates the transition from Global Fund support to increasing national HIV/AIDS funding in Peru (2004–2012) by analysing actor roles, motivations, and effects on policies, identifying recommendations to inform decision-makers on priority areas.

A conceptual framework, which informed data collection was developed. 35 in-depth interviews were conducted from October-December, 2011 in Lima, Peru among key stakeholders involved in HIV/AIDS work.

Findings show that Global Fund involvement led to important breakthroughs in the HIV/AIDS response, primarily concerning treatment access, focus on vulnerable populations and development of a coordination body. Nevertheless, reliance on Global Fund financing for prevention activities via nongovernmental organisations, compounded by lack of government direction and weak regional governance, diluted power and caused role uncertainty. Strengthening government and regional capacity and fostering accountability mechanisms will facilitate an effective transition to government-led financing. Only then can achievements gained from the Global Fund presence be maintained, providing lessons for countries seeking to sustain programmes following donor exit.

6.1 Introduction

A large number of low and middle-income countries currently receive considerable amounts of aid to support their HIV/AIDS programmes, thus making the question of how to sustain these programmes central to the international development agenda (UNAIDS, 2013). There are many definitions for sustainability, usually associated with words such as 'continuity' (Scheirer, 2005; UNICEF, 1992), 'maintenance' (LaPelle, Zapka & Ockene, 2006; Gruen et al, 2008; Shediac-Rizkallah & Bone, 1998) or 'incorporation/implementation (Bracht et al., 1994; Pluye, Potvin & Denis, 2004; Stefanini & Ruck, 1992). In this paper, sustainability is defined as the capability of a government to manage health programmes long-term without depending on the intervention of external bodies for technical or financial support within a given social, political and economic environment.

Until 2000, Peru financed a large portion of HIV/AIDS programmes though external assistance. From 2005 to 2010, 48.6% of the funding for HIV/AIDS was provided by international organisations; 36.5% was finance by the government; and 14.9% by the private sector (Navarro de Acosta, 2011). Bilateral donors such as USAID, DFID, GiZ and international organisations such as Doctors without Borders and UNAIDS played a key role in providing aid the past (Ministerio de Salud del Peru, 2006). However, since its entry in 2004 (Cabrera, 2010), the Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund) has been the most important financial donor for HIV/AIDS, providing over $70 million USD in the 2004–2012 period via four approved rounds (Table 6.1.1) for the implementation of HIV/AIDS projects, primarily supporting prevention activities (Global Fund, 2012). The percentage of Global Fund funding as a share of total HIV expenditure fluctuated in the 2005-2010 period, the lowest point reached in 2005 with an 11% contribution and the highest in 2008 with 28% of total HIV funding (Ministerio de Salud del Peru, 2012).

Table 6.1.1 HIV/AIDS Global Fund-approved grants

Round	Grant title	Total approved	Principal recipient	Main activities
2	"Strengthening prevention and control of AIDS in Peru". (2004-2008)	$21,347,134	CARE Peru	• Increasing access to diagnosis, treatment and prevention of vertical transmission • Prevention actions such as prevention of mother to child transmission (PMTCT), sex workers and men who have sex with men (MSM) • Care among people living with HIV/AIDS (PLHA) • Prevention activities such as behavioural interventions and condom distribution programmes • Strengthening civil society and reducing stigma
5	"Closing gaps to achieve Millennium Development Goals for HIV/AIDS in Peru". (2006-2010)	$11,702,911	CARE Peru	• Strengthen objectives set in round two with exception of ART treatment which by 2007 was funded by the government
6	"National Multi-sectoral plans: Integrating resources for the Fight against HIV/AIDS in Peru". (2007-2011).	$31,827,512	CARE Peru	• Strengthen objectives set in round five • Proposal was centred around developing decentralised activities at the national-level, identifying three macro-regions: North, South-Central and Eastern
10	"Building social capital to prevent HIV and improve access to comprehensive healthcare without transphobia or homophobia for the transsexual, gay/MSM population in Peru". (2012-2013).	$4,344,113 (phase I) Phase II to be submitted in August 2013	Instituto Peruano de Paternidad	• Strengthening capacity among key populations of MSM and transgendered • Training community agents for prevention and care • Sensitising law enforcement officials
	Total	$69,221,670		

Source: Global Fund to Fight AIDS, Tuberculosis and Malaria (2012). Peru Portfolio

Country recipients of Global Fund assistance are expected to create national structures called Country Coordination Mechanisms (CCM) to identify priorities, develop and submit proposals according to the specific priorities and harmonise programmes with national policies and programmes. They also act as overseers of grant implementation and liaise on emerging issues with the Global Fund (Global Fund, 2011b). Peru established such a body of country actors in 2004, namely the National Multi-sectoral Coordinating Centre in Health (CONAMUSA: Coordinadora Nacional Multisectorial de Salud), with representation of different government sectors, civil society and international stakeholders. The Committee has sought to decentralise some of its functions in line with the country administrative decentralisation process, and created Regional Multi-sectoral Coordinating Agencies for Health (COREMUSAs) (Buffardi, Cabello & Garcia, 2011). However, these regional coordination branches have yet to be formally registered and lack access to resources (Cáceres et al., 2009).

The context of external assistance in Peru has changed. In 2010 the HIV/AIDS programmes were included into a national results-based budget, a strategy which seeks to focus government resources on key populations and achieve impact (Cabrera, 2010). Furthermore, Peru became an upper-middle-income country (World Bank, 2013) and due to this status can now only apply for smaller Global Fund grants focused on key populations, as is the case for round 10 (Global Fund, 2012a). This is due to Global Fund eligibility criteria that rates countries according to their disease burden, political commitment, effectiveness of their CCM and the poverty situation in the country (Global Fund, 2011a). However there is a lack of clarity about the continuity of specific dimensions of the national HIV response (particularly if they have been successful and are still deemed necessary) and the roles and responsibilities of different country actors. There have been justifiable concerns about the sustainability of HIV/AIDS programmes and achievements, as well as other health programmes that were created to address genuine need. In some cases, donor interest may be prematurely discontinued (Gruen et al., 2008). Discontinuation of programmes not only leaves unmet needs, it can be wasteful of human, monetary and technical investments and can decrease community trust and support for future programmes (Shediac-Tizkallah & Bone, 1998). Moreover, actor incentives and asymmetries in access to knowledge about the context in which projects are being implemented have been found to hinder sustainable development

outcomes, following development assistance (Ostrom, Gibson, Shivakumar & Andersson, 2001).

While the end goal of sustainability is relevant to many countries, the economic development of a particular country frequently determines its ability to continue to fund activities once a donor leaves (Lu, Michaud, Khan & Murray, 2006; Ooms, 2006). Moreover, sustainability also requires the political commitment to continue to prioritise these programmes (Atun et al, 2005; Schell, et al, 2013). A clear example is Russia, now an upper-middle-income country (World Bank, 2013), and no longer eligible for Global Fund grants, where after the end of Global Fund grants, the government reneged their commitment to continue funding for HIV prevention activities among drug users due to pressure from the church and political lobbing (Twigg, 2007). Due to this, the Global Fund convened a special meeting to discuss the case and decided to provide funding for a further two years (Global Fund, 2009; International AIDS Society, 2009). In that case disruption is not due to scarce resources but resistance to internationally accepted best practices and state policies excluding groups which are not seen as socially deserving.

Existing evidence shows that programmes that are primarily donor-driven jeopardise the sustainability of country health programmes since they often ignore the original priorities of a country and disrupt investment in training health workers to continue the projects (Dickinson, 2008; Lele, Saran, Govindaraj & Konstantopoulos, 2004); creating aid dependence in the long term.

This paper seeks to enrich current knowledge on these important issues by means of a case study designed to capture the transition from Global Fund entry in 2004 through increased financing of HIV/AIDS programmes by the government, until 2012. This type of study is particularly relevant in the current context of fiscal constraints, where donors are targeting funding to countries that need it the most, as well as the increasing number of countries graduating from aid as their income increases (Glassman, Duran & Sumner, 2012). Thus, the 2012–2016 Global Fund funding model focuses on investing in areas with high potential for impact and increasing the sustainability of funded programs (Global Fund, 2011c). The paper examines the enabling and limiting factors during this process, with a focus on actor motivation and influence on programme implementation. Furthermore, this study is based on the proposition that the Global Fund investment in the HIV response in Peru has developed the necessary structures and processes for a coordinated and sustained response from all

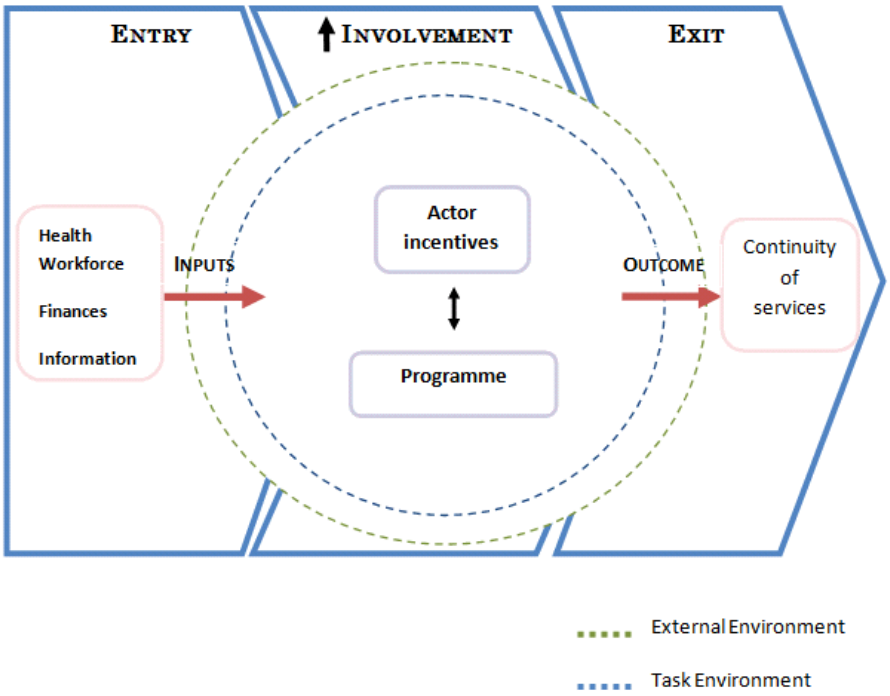
actors towards the continuity of successful policies and interventions led by the government. The recommendations derived from this study seek to inform countries becoming less dependent on external assistance but facing similar constraints, and contributing to the global policy debate on the effect of donor assistance on national health policies.

6.2 Conceptual framework

This study utilised a case study approach, employing policy analysis and guided by a conceptual framework. A number of frameworks have sought to conceptualise sustainability of policy and programmes in the health sector (Gruen et al., 2008; Lapelle, Zapka & Ockene, 2006; Olsen, 2010; Torpey, Mwenda, Thompson, Wamuwi & van Damme, 2010). These vary in terms of the aspects of sustainability they refer to, and the explanatory factors considered regarding how countries cope after funding ends. Lapelle et al. (2006) provide a framework based on two strategies which are based on redefining the scope of services and creatively using limited resources; yet their focus on finding funding and creating demand for services are already defined in our case. Torpey and colleagues' (2010) framework is useful in differentiating between technical, programmatic, social and financial sustainability; though they concentrate on service delivery, rather than explaining the policies that made the outcome possible, which is the objective of the present study. Gruen and colleagues' (2008) framework represents health programme functions as a complex system that depends on the interactions between health concerns, programme components and the programme drivers, within a sociocultural, political and geographical context; which are also shaped by health system characteristics and resources available. Still, this framework does not capture comparisons over time periods or inputs that make the relationships happen. Olsen's (2010) framework focuses on health services in low income countries, based on: contextual factors, activity profile and organisational capacity. Again, the model does not support the study of complex processes and the interactions between different components.

For this study, a hybrid model (Figure 6.2.1) was developed drawing on the strengths of Olsen's (1998) and Gruen and colleagues' framework (2008).

Figure 6.2.1 Framework based on Gruen's and Olsen's sustainability frameworks



Source: Adapted from Gruen, R. L., Elliot, J. H., Nolan, M. L., Lawton, P. D., Parkhill, A., McLaren, C. J., Lavis, J. N. (2008). Sustainability science: an integrated approach for health-programme planning. The Lancet, 372, 1579-89 and Olsen, I. (1998). Sustainability of health care: a framework for analysis. Health Policy and Planning, 13, 287-295.

This framework represents an open system (a system that functions by constantly interacting with its surroundings) where organisations are exposed to the social, political and economic context in the country and must adapt to it in order to function ('external environment'). Inputs such as the country capacity, finances and data available on the disease burden are essential for an appropriate response. These inputs shape what programmes will be available and which actors will plan and implement them (referred to as the 'task environment'). This programme component includes the HIV/AIDS policies (including financing arrangements) and activities in place and the perceived effectiveness of the response. If actions are to take place and be sustained, it is critical to consider the incentives and roles of the key actors including their leadership, mutual relationships and coordination of tasks, which have a direct impact on the programme. The outcome of interest is the effect of the programmes and

actors on the continuity of activities. The framework allows these elements to be captured over time, with key phases being: a)Global Fund entry in Peru in 2004, b)full-blown involvement, and c)preparation for exit in 2012. Interpreting the outcomes, programmes and actor roles as they are now, requires an understanding of the history of current policies and relationships.

This framework was used to identify themes and relationships emerging from the data. Given the central role of actors in implementation of the programme, this paper specifically focused on the actor incentives and programme response components, as key explanatory factors for ensuring policy and programme sustainability.

6.3 Methods

A case study approach was adopted to analysing the period of 2004 to 2012, focussing on how the behaviour of different actors enabled or hampered the move towards sustainability of national financing for HIV/AIDS programmes. The case study involved conducting 35 in-depth interviews in Lima, Peru (October-December 2011), guided by the framework among four types of national and international stakeholders currently or formerly responsible for HIV work (Table 6.3.1). The in-depth interviews allowed us to explore predefined themes while giving the respondent freedom to bring in new perspectives and make linkages between events and outcomes (Yin, 2003). Respondents were selected on the basis of their involvement in HIV work or expertise during the period of study; as well as direct or indirect participation in Global Fund projects. "Chain sampling", a method which involved asking stakeholders to nominate other potential respondents (Mays & Pope, 2000), was also used to ensure diverse representation of relevant actors within the study.

This was complemented by a documentary review, which entailed a review of grey literature, policy documents, peer-reviewed articles, and national laws and local news articles in Spanish and English on issues surrounding the HIV/AIDS programme in the country, the results-based budgeting strategy and the Global Fund proposals, published in the 2000–2012 period. Key terms included "HIV", "AIDS", "financing", "sustainability", "coordination", "aid", "decentralisation", "Global Fund" and "Peru". Databases searched included MEDLINE/Pubmed, LILACS, Web of Science, Global Health, EMBASE and Google Scholar. This data provided the contextual basis for the study and informed the interpretation of main emerging themes, enabling triangulation.

Ethical approval was obtained from the Universidad Peruana Cayetano Heredia (approved the 11th of October 2011, reference number 058954) and the London School of Hygiene and Tropical Medicine (approved the 7th of September 2011, reference number 6022). Participants were provided with information, guaranteed confidentiality and asked to sign a consent form.

Table 6.3.1 Respondent characteristics

Sector	Number of interviews	Institutions	Positions
Government	10	Ministries of health; education; women & social development; finance & economics; foreign affairs; justice. CONAMUSA and CORAMUSA leaders. Regional health leaders.	• High-level & middle-level management at the central level. • Regional and local-level leaders. • Coordinating mechanisms leaders.
International organisations	7	Bilateral (3) Multilateral (4)	• High-level & middle-level management. • Program officers.
NGOs and CSOs	14	National-level NGOs & CSOs (9) Regional-level NGOs & CSOs (5)	• CSO & NGO leaders. • Project implementers. • Coordinating mechanism members
Academia	4	3 universities	• Heads of research units • University professors
TOTAL	35		

Following data collection, the documentary data and the interviews were analysed using the original framework mentioned in the previous section. Thematic analysis (Green & Thorogood, 2004) was used to examine the interviews and the qualitative software NVivo (version 10), provided a space to organise and index emerging themes. Specific attention was paid to interpreting the actors' roles, the meaning of the relationships and their impact on programmes and their sustainability. These interpretations were triangulated with the documentary review and analytical field notes, to arrive at policy recommendations.

6.4 Findings

A number of themes emerged from our interviews as central to explaining the process of an expanded role of national actors and moving towards sustainable HIV response. These relate first, to actor incentives (mechanisms for joint work and the power and position of civil society); second, to the nature of programme implementation (government prioritisation of the HIV response, the effect of Global Fund on policy and practice; and the impact of country decentralisation as a key contextual factor affecting sustainability); and finally, the perception of the future positioning of these actors in programmes sustained at the national-level. Table 6.4.1 provides an overview of the main actor roles.

Table 6.4.1 Main actor roles

	Main responsibilities in HIV/AIDS policies and programmes	Involvement with other actors	Level of participation in CONAMUSA	Received money from the Global Fund	Role change after Global Fund entry	Relationship with Global Fund
Government						
STI & HIV strategy office	• Leading and coordinating the HIV/AIDS response • Development of policies and plans.	All sectors	High	Yes (indirectly)	None	Country Counterparts; Implement certain activities
Other Ministry of Health offices (such as National Institute of Health; General Epidemiology bureau and the National Health Insurance)	• Diagnosis • Surveillance of the epidemic • Monitoring and evaluation of activities (in part) • Funding of treatment and care (National Health Ins.)	Primarily STI & HIV strategy	Mainly delegated to the HIV strategy though the Minister of Health alternates as the head of CONAMUSA.	No (except in special cases, e.g. studies)	None	Country counterparts
Other Ministries (such as the Ministries of Education; Foreign Affairs; Labour; Tourism, Women; and Social Affairs and Justice).	• The ministry of education: participates in activities related to the promotion of healthy lifestyles in adolescents and young people • The Armed and Police forces: contribute to the prevention and control of HIV/AIDS among their populations. • Others have very limited participation.	Primarily the government, NGOs & CSOs, as well as some UN agencies.	Low/medium	Yes (indirectly, primarily: education and justice)	Increased involvement in HIV activities	Country Counterparts; Implement certain activities

	Main responsibilities in HIV/AIDS policies and programmes	Involvement with other actors	Level of participation in CONAMUSA	Received money from the Global Fund	Role change after Global Fund entry	Relationship with Global Fund
Non-Governmental Organisations (NGOs)						
HIV/AIDS service organisations	• Social advocacy to increase prevention and access to treatment and care • Main implementers for Global Fund projects	All sectors	High	Yes	Switched their role from advocacy to project implementation	Principal and sub-recipients of projects (some)
PLHA organisations	• Support and training of their constituents • Advocate for access to treatment and improvement in care • Implementation of activities	All sectors	High	Yes	Switched their role from advocacy to project implementation	Sub-recipients of projects (some)
LGBT. MSM, TS and sex worker organisations	• Social advocacy • Representing their peers at the policy-level • Educating their peers • Implementation of activities	All sectors	High	Yes	Switched their role from advocacy to project implementation	Sub-recipients of projects (some)
Faith-based organisations	• Primarily involved in the care of children and women living with HIV/AIDS.	State, other NGOs and PLHA	Low	Indirectly	Increased involvement in HIV activities	None

	Main responsibilities in HIV/AIDS policies and programmes	Involvement with other actors	Level of participation in CONAMUSA	Received money from the Global Fund	Role change after Global Fund entry	Relationship with Global Fund
International NGOs (e.g. CARE, Pathfinder, local IPPF Affiliate)	• Managing Global Fund projects • Involved in implementation of activities	All sectors.	Low	Yes	Increased involvement in HIV activities	Principal and sub-recipients of projects
International Organisations						
UN agencies	• Providing technical assistance • Funding training and projects	All sectors	Low	No	Decreased funding	Supports Global Fund projects
Other bilateral organisations	• Technical assistance • Provision of funding to support government projects and research.	State, NGOs and CSOs.	Low	No	Decreased funding	Supports Global Fund projects
Academia	• Conducting research • Capacity building • Contributing to the development of policy • Serving as external reviewers for Global Fund projects.	All other sectors directly or indirectly.	Low	Occasionally (activity-based)	None	External reviewer of projects; occasionally as consultants

6.4.1 Actor incentives

6.4.1.1 The NGO dilemma

> *"...People Living with HIV/AIDS' organisations should return to what they should have never left, their role of social oversight... from the moment they became involved as project executers, I think they lost this role (Academia respondent)."*

NGOs emerged as important actors due to their strong CONAMUSA representation and important role as programme implementer, especially in HIV prevention. The Global Fund funding led to the emergence of many new NGOs together with older ones, which was seen (both by donor and NGOs representatives) as a positive development since it ensures a more effective way of reaching vulnerable groups, strengthened the political position of these groups, and increased their training and overall capacity. However, respondents from other sectors argued that the role of NGOs primarily as project executers hindered their position of advocacy and making the government accountable to agreements made due to their commitment to producing results. The pattern of direct funding has also diminished the steering and coordinating role of the Ministry of Health, with a government official stating that Global Fund NGO sub-recipients frequently made unilateral decisions without consulting government bodies.

NGO leaders reported that they are organised into networks to coordinate their work towards common goals, such as demanding greater access to medications. However, a concern voiced by members of academia was that NGO involvement in these networks is on an adjunct basis, meaning they are not held accountable. A more important side effect has been that the NGO-led isolated and uncoordinated programmes meant that there has been insufficient political activism to ensure access to HIV services for all, which is an important requirement to ensure that government commitments towards sustainability are maintained.

6.4.1.2 Effective coordination yet dwindling commitments

> *"When people meet each other and develop trust, they work better together; I think this is what the Global Fund has been able to do (NGO respondent)."*

Central to the continuity of activities is the ability and commitment of the different actors to work together in a coordinated and coherent manner towards common goals. It is a widely supported view that the CONAMUSA since its constitution in 2004 has been instrumental in bringing together the main actors working with HIV and developing proposals. However, a frequent criticism both from national and regional actors is that decision-making has been concentrated at the national level, with little input from regional leaders; as well as the lack of active involvement of other ministries besides the Ministry of Health. Thus, many respondents from the NGO sector stated that there is no real 'multi-sectoral' response. Moreover, some respondents with health systems expertise viewed the preparation of proposals to the Global Fund as insufficiently reflective of population need but corresponding to the interests of the Principal Recipient or the organisations that participated in the CONAMUSA assembly.

As stated by the majority of the respondents, the work of the COREMUSAs (regional coordinating bodies) has varied in terms of performance mostly due to overburdened staff and lack of resources. However, Callao, one of the regions most strongly affected by HIV, was frequently noted by sub-national respondents, as an example of success mainly due to their multi-sectoral efforts convened through their regional committee. This was explained as resulting from committed individuals who met regularly and understood the needs in the region. In addition, round VI of the Global Fund was seen among NGO leaders as bringing a different way of working, from implementing projects in the regions directed from the central-level, to developing macro-region (groupings of regions) led projects so local capacities could be strengthened; this was seen as a positive legacy of inter-regional work.

In comparison, a common perception of respondents about the relationship between the stakeholders in the long-term was that a lack of commitment for collaborative work:

"There is a divorce between the State and the organisations to intervene. When it does happen it is because the funders force them to or it is part of the requirements for funding but it is not because the State wants to work closely with NGOs (NGO respondent)".

Indeed, respondents at all levels saw the rules for receiving a Global Fund grant to be fostering better accountability and collaborative work across sectors and requiring political will at the government level by promoting HIV as a priority. In this sense, NGO respondents saw the Global Fund proposal process as laying the ground for stronger political commitment. This point of view was shared by several government respondents, which reported that their actions are driven not only by the need to continue the response to HIV, but also to take a formal responsibility to sustain the commitments expressed in their grant proposals.

6.4.2 Programme implementation

The changes in actor incentives and behaviour have had a direct impact on programme implementation, both in terms of strategies and policies for HIV/AIDS and the effects of the socio-political decentralisation. This has been a gradual process, with complete transfer of health functions to the regions concluding in 2008.

6.4.2.1 HIV/AIDS: a national priority but with a weak strategy

> *"The Multi-sectoral Strategic Plan has undoubtedly been an important tool for planning, but in this new government we need to build on this knowledge and motivation of the government to develop a new Multi-sectoral Plan (NGO respondent)."*

Themes around planning and strategy emerged as key in the analysis of the potential for sustainability. Central to effective programming is the ability to develop and enact a strategy reflecting national priorities including the priority of HIV/AIDS in the country. All respondents agreed that a single national HIV strategy is the best approach to integrate the health, education, development and law enforcement sectors working in this area thereby building the foundations for lasting and effective actions. However, the development of this strategy has not been easy. Respondents recalled that following a first frustrated attempt for the 2001-2003 period, the 2007-2011 Multi-sectoral Strategic

Plan for the Prevention and Control of STIs and HIV/AIDS was approved. This strategic planned signalled a concerted effort from different sectors would be needed to increase HIV/AIDS treatment and prevention under the leadership of the Ministry of Health (Ministerio de Salud del Peru, 2006). The shared opinion with regards to this plan was that the participation of the various actors in its development meant they were invested in working within this framework. Yet a view from the NGO sector was that the plan objectives were too ambitious both in terms of results and funding required within this time period; as well as having weak prevention strategies, especially among the most vulnerable populations including MSM and transgender women.

Though at the time of the interviews in 2011 the appointment of the President was fairly recent, the predominant view among the respondents as compared to prior more conservative administrations, was that HIV was perceived as being of a higher priority for the central government than before and was expected to continue as such. This was supported with the fact that the government referred to the inclusion of HIV/AIDS, together with TB, as a national health strategic line in 2004 and the results-based budgetary strategy starting in 2010. This meant that HIV/AIDS programmes were given a separate budget instead of being aggregated within the general health budget, as was previously the case.

As stated by NGO leaders, although a limited number of regions have developed Regional Multi-sectoral Strategic Plans for HIV/AIDS, where they do exist, they are seen as more successful than the National Multi-sectoral Strategic Plan for STI and HIV/AIDS due to the smaller number of actors involved.

An issue negatively affecting the sustainability of actions and progress in the response was the lack of a national strategic plan for 2012-2016, which is yet to be approved. This was frequently seen as a major concern since it essentially implied that the different sectors involved continue to work under guidelines and indicators set over six years ago.

6.4.2.2 Global Fund as a facilitator for new models of working

> *"There are things that operationally the international cooperation can do faster, in a more effective and efficient manner than the State itself (NGO respondent)."*

The process of applying for and implementing Global Fund grants emerged as important preparation for setting long-term sustainable policies. The Global Fund proposals both affected and were affected by national planning processes. The development of the round six Global Fund grant in line with the objectives of the multi-sectoral plan was considered as key by the majority of the respondents, and this was seen as a measure of significant progress in aligning donor activities with national policy. Furthermore, although one of the objectives within the plan was to strengthen the monitoring and evaluation mechanisms to follow-up on the results of the plan itself, the lack of updated and quality data remains a major concern among all of the sectors interviewed, especially within academia.

Additionally, two of the most common views among respondents of the influence of the Global Fund in long-term planning are: (1) in requiring the creation of the CONAMUSA, which has become the main multi-sectoral policy space to discuss HIV issues; and (2) in serving as a catalyst to implement new strategies. In this sense, it was seen as a useful mechanism to begin to pilot or expand strategies proposed by the Ministry of Health and also an opportunity to study the cost-effectiveness of certain activities; with one respondent stating that international cooperation has the tools to operationalize plans faster and in a more effective manner than the government itself. The most commonly cited example by respondents of the piloting of strategies was the first phase of the Global Fund's round two grant in 2004 which was identified at that moment as an important driver for implementing health promotion activities and most importantly, increasing access to ART. By 2006, the provision of free ART was fully funded by the government; which had a positive effect on coverage and was seen to mark a first step towards sustaining the results of the Global Fund programmes. Yet this is somewhat contested by respondents from NGOs who expressed concerns that the distribution of ART often does not reach the most vulnerable populations, and the issues are

compounded by the lengthy tender of the medications frequently resulting in disrupted supply.

Round 10 (approved in 2011) was seen as an important success for the NGOs since it was specifically formulated to increase access to services and decrease stigma and discrimination among MSM and transwomen; again placing greater attention on addressing this issue at the national level.

6.4.2.3 Rapid decentralisation hampering leadership and governance

> *"There are still difficulties in the management capacity, which means that even though the resources are available, they may not all be planned for or implemented at the regional level (Academia respondent)."*

The governance capacity in Peru is an essential component of ensuring continuity of successful HIV programmes. The process of decentralisation emerged as having a large effect on the central-level leadership in HIV. It was a predominant view that decentralisation took place rapidly, with insufficient preparation and without verifying capacities of different actors to act, given the transfer of responsibilities from central to regional level. At the central level, the STI and HIV programme in the Ministry of Health was transformed in 2004 into an STI and HIV strategy office. According to government officials, this resulted to major change in responsibilities. The head of the HIV programme who was previously director of the programme became a facilitator of HIV activities within what is now deemed a 'strategy' department.

According to some respondents, though this strategy office should coordinate the work around HIV in the country, in practice its position has at times been limited. A key source of this, identified in interviews with those working outside the government, was the technical capacity of the strategy team which was seen as smaller compared to the one found in other larger organisations. According to academia and NGO actors, this weakness has been compounded by the significant number of personnel within the strategy team hired with Global Fund money. According to several government officials,

in 2005 there were officially three people hired by the Ministry of Health and 10 more people hired with Global Fund support. Up until the moment the interviews were being conducted, several of those 10 people were still being funded by the Global Fund, though they were seeking to be incorporated into the regular Ministry of Health budget. Nonetheless, while certain procedures such as the purchase of ART still take place at the central level; within the present context of decentralisation, it is the regions who develop the plans and budgets.

The prior experience with the Global Fund, which is also based on indicators and results, was expressed by members of the CONAMUSA as an important strength in transitioning to results-based budget. However, the tension between planning and managing, and how the funding was implemented in the regions were evident from the beginning. It was suggested this was primarily in terms of poorly developed plans given the budgets available; not allocating all of the funding available or deviating funds for other purposes; and also what some deemed 'cultural and political' motivations.

> *"We have had to travel to the regions to explain that the results-based budget is to reach targets; that they can diversify a little, taking advantage of this push to fix other things that aren't working, but first they have to reach the goals... this has been an important challenge, explaining to these people who are used to the immediate political moment, the world of political campaigning, who [think that] if everything is ok right now, tomorrow is not as important (Government respondent)".*

Four areas emerged among the respondents in government, academia and NGOs as the most important causes for this poor execution of budget plans for HIV activities. These were that the plan was prematurely rolled-out without proper planning, monitoring mechanisms and lack of training, which led to inappropriate identification of needs and funding requirements; with short timelines. In one instance, a region had to develop the budget in four days, with very little dialogue between the central, regional-level and local levels, and with no access to up to date data on health indicators and human resources distribution, to inform planning. This lack of quality data also had an important effect on

accountability, with respondents from academia and NGOs noting that this hampers tracking and corroborating results.

6.4.3 Looking towards the future: perceived contribution to sustainable programming

The perception of the actors on what sustainability entailed and their contribution to it demonstrates both their vision for the future and what they consider priority areas that need to be addressed for a sustained HIV response. It is a widely shared view that although the basic prevention activities and universal treatment would continue, there is also a need to maintain other successful prevention activities such as NGO-managed peer-promoters for health promotion and micro-finance projects, an activity the other sectors disagreed with, seeing it as a failed project; as well as ensuring the political will to continue to see HIV/AIDS as a priority issue in the long-term, also linked to the financial resources from the government. The need to enhance country governance and capacity was also a concern among respondents in various sectors, given the issues in the initial years of the results-based budget. Furthermore, a common thread throughout all of the interviews was that for sustainable planning, there was a need for greater advocacy and accountability of government activities on behalf of NGOs; a role which until that moment was perceived as weakened. One respondent went as far as suggesting that NGOs had to transition from a focus on their constituents to support a shared goal of increasing access to the population in general.

Yet when asked about their future role post-Global Fund environment, most stakeholders believed their roles would not change. The NGO respondents were divided in their opinion, with some stating they would continue their advocacy work, albeit with less resources; while the majority were concerned about the uncertainty of how to continue their activities and supporting the need for a continued research and peer-promoter projects among their constituents. At that time they had not been approached by the Ministry of Health in participating in the results-based budget, though they expressed the interest in continuing their role as project implementers.

The role of CONAMUSA as a space to convene different actors would end with the exit of the Global Fund, according to actors belonging to sectors outside of the government; unless efforts are made to reconfigure its mandate or a separate mechanism is created. Yet, although some government respondents saw the CONAMUSA as a valuable mechanism, they suggested that in the long-term it will no longer be necessary, given that the regions would be responsible for the majority of planning and NGOs would cease implementing projects. Even so, many other believed the COREMUSAs which in some regions have gained political support and have a more operational role, would likely continue to exist.

6.5 Discussion

This paper sought to examine the process of promoting sustainability of HIV programmes following the exit of a major donor, the Global Fund. This issue has received surprisingly little attention in the literature despite its relevance to multiple settings. The roles and behaviours of the main country stakeholders were analysed during the transition of Global Fund entry in 2004, with subsequent implementation of four grants, and then the increased role of national institutions in 2012, associated with the scaling down of the Global Fund involvement and how they impact and promote the sustainability of the HIV response.

Certain limitations have to be acknowledged. Some recall bias of the respondents may have occurred, given that they were asked about the history of current initiatives and policies; however there was an effort to signpost and remind the respondents about the basic timeline of events. Inevitably, the personal interests and position of the respondents may have influenced their responses, however, this was offset by interviewing a wide-range of respondents and using triangulation to cross-examine findings. The study employed a case study methodology tailored to the unique characteristics of the country, nonetheless there is a level of conceptual generalizability and identifying lessons that are relevant to other countries.

Peru is advancing towards sustainability of the HIV/AIDS response. The use of the CONAMUSA and the decentralised COREMUSAs as spaces for inter-sectoral discussion, suggests that these working relationships can carry on in the long-term. Moreover, the inclusion of HIV/AIDS in the results-based budget and the transfer of the responsibilities to the regions, demonstrates that the country is focused on improving the performance of their HIV programme and increasing access to care by maintaining some of the previous activities. However, if these gains are to be sustained, the coordinating mechanisms may have to continue to be active, and it is essential that the capacities at the Ministry of Health and regional-level are strengthened. Major threats to this sustainability, nonetheless, are posed by the lack of integration of prevention activities

focused on most-at-risk populations and the still weak accountability role of NGOs as overseer of government commitments.

In 2004-2012, the nature of the Global Fund funding in Peru has changed dramatically, with increasing participation of the government in financing the HIV programme (Ministerio de Salud del Peru, 2012). This has occurred amidst a decentralisation process and a problematic process of planning and implementing the results-based budget in the regions; pointing to the need to train the health professionals in the regions on these changes. This need for strengthening local health capacity following decentralisation is not unique to Peru. Brazil and Russia, large federal states, have faced similar challenges during their process of decentralisation primarily in ensuring role clarity (Collins, Araujo & Barbosa, 2000) and effective decision-making (Danishevski, Balabanova, McKee & Atkinson, 2006), though in the Russian case decision-making power is associated with historical political ties and a complex hierarchical system.

Unlike other countries such as Ghana (Atun & Kwansah, 2011) and Mozambique (Ooms, Van Damme & Tammermann, 2007), Peru does not require Global Fund financing to expand their ART program or increase the number of health workers. In Peru the Global Fund has financed most HIV prevention efforts, similar to Kazakhstan (UNAIDS, 2013) and Kenya, where the majority of health promotion activities are donor funded and implemented by NGOs (Wamani, 2004). Moreover, though the basic prevention activities are included in the results-based budgets there is still uncertainty about the targeted prevention work focused on vulnerable populations, particularly since there is no national precedent of contracting NGO to deliver services paid by public budgets. Some of the problems that emerge have parallels in India, experiencing rapid economic growth and involving NGOs in project implementation (Chakma, 2013) but facing challenges in ensuring efficient monitoring mechanisms and accountability structures to ensure that public grants are reaching the most vulnerable populations.

These issues are relevant for other countries that are experiencing economic growth given that this growth has frequently been associated with increased social and economic inequality (Kuznets, 1955; Morrison, 2000). This is particularly concerning for

stakeholders working in the HIV/AIDS field given the rise in prevalence in many countries among traditionally socially-excluded groups; making it crucial to consider the effects of both economic and social inequality on the HIV/AIDS response and generate strategies to address these effects.

On the other hand, the predominant role of NGOs in Peru in prevention programmes at times making unilateral decisions, threatened a coherent programme response and undermined the coordinating role of the Ministry of Health-based HIV strategy office. Similar governance issues as a result of new partnership models has been found in multiple settings (Caines et al., 2004; Kapilashrami & McPake, 2013; Ooman, Bernstein & Rosenzweig, 2008; Spicer et al., 2010; WHOMPS, 2009). An example of this is found in Zambia where PEPFAR's support of civil society was observed to be at the cost of building government capacity (Ooman, Bernstein & Rosenzweig, 2008). Moreover, the literature shows that this focus of NGOs on project implementation may have negative effects on the vulnerable populations these organisations are meant to serve; which in their work with international bodies, refocus their agendas on short-term interventions (Kapilashrami & O'Brien, 2012; Seckinelgin, 2005), also resulting in a loss of legitimacy of their original role (Doyle & Patel, 2008; Kapilsashrami & O'Brien, 2012; Spicer et al., 2011).

However, the transitional period where Global Fund support was phased out also presents an opportunity for NGOs to retake this social accountability role. Similar to the agreements signed at CONAMUSA to remain independent of decision-making when applying for funding (Ministerio de Salud del Peru, 2006), NGOs should also commit to being accountable themselves in the long-term, via self-regulation with a supporting enforcement structure either at the sectoral or national level, or through independent assessments (Lloyd, 2005). However, this study clearly demonstrates that the role of the government - through its central coordinating bodies, oversight and advisory role in relation to the regions - is key in ensuring sustainable HIV policy and programmes.

6.6 Conclusion

The study findings demonstrate some of the enabling and limiting factors for sustainability, emphasising the need to strengthen the role of the Ministry of Health central strategy office and sub-national level; and building mechanisms accountability among all actors. It is clear that the Global Fund's involvement in the country would not solve all of the difficulties in providing an integrated and sustainable HIV response but it has left some important foundations to build on such as the importance of inter-sectoral work, focus on most-at-risk populations and (in theory) universal access to treatment. The inclusion of HIV into the new budgetary strategy based on results also raises hope that the needs stemming from the HIV epidemic will be associated with its budgetary allocation. However, for an appropriate response, besides prevention activities, there is still a need for greater focus on the structural determinants of the disease and on most-at-risk populations (particularly MSM and transgender populations) to effectively reduce incidence. This can only be achieved, by developing a coherent strategy with participation of all sectors and strengthening the technical capacity in the Ministry of Health and governance in the regions; the nine-year presence of the Global Fund has catalysed some of these processes, but it is now the responsibility of the country actors to sustain and build on these gains.

6.7 References

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6.8 After the Global Fund: who can sustain the HIV/AIDS response in Peru and how? - ADDENDUM

By focusing on actor roles and motivations, this chapter sought to examine the factors supporting or hindering the transition from Global Fund entry in 2004 to increased financing of the HIV/AIDS programme by the Peruvian government in 2012. Following the publication of this chapter in a peer-reviewed journal, this addendum provides additional analysis on how the relationships of the actors working with HIV/AIDS in Peru are affected by incentives generated during this transitional process as well as the implications of these findings for programmatic sustainability of the HIV/AIDS response in the country.

How are actor relationships affected by incentives generated by the transition towards the end of Global Fund-funding?

The sustainability of a health programme is affected by the interactions between actors, as well as with the programme, with the flow of financial resources depending on the priorities of the actors, who shape the programme, as well as these programme results affecting the actors through positive or negative results (Gruen et al., 2008). These incentives frequently have an effect on actor relationships, leading to changes in actor roles. This not only affects the interactions between actors but will have an impact in the ability of a country to plan for sustainability (Ostrom, Gibson, Shivakumar & Andersson, 2001). As discussed in the findings and shown in table 6.4.3, three groups of actors experienced major changes in their roles as a result of the entry of Global Fund funding in the country: other ministries (outside of the Ministry of Health), national NGOs and international NGOs.

The national NGOs changed from a role of advocacy to implementers of programmes. The direct funding that they received meant that at times they overrun the coordination of the central level, which was described as weak at best. While greater agency for NGOs to

implement much needed prevention programmes is a positive step as a result of the Global Fund projects, the lack of coordination from the ministry meant that the activities were sometimes not reported to the central level. Furthermore, this change in behaviour NGOs also narrowed their advocacy and watchdog role, a gap that will need to be retaken by them or other actors in order to ensure that the political will and as a consequence, promised funding for HIV/AIDS is allocated by the government following end of Global Fund support, especially in the case of most affected populations. Moreover, beyond economic funding, the policy spaces and opportunities for these actors to work together in partnership through mechanisms similar to the CONAMUSA is also an important point that needs to be advocated. As shown in the experience of the transition from an HIV/AIDS programme in India and a study reviewing sustainability of Global Fund programmes across 12 countries, reassuring country stakeholders that the programme will continue with the same vision and commitment for collaborative work as well as working with them prior and during transition is essential to ensure buy-in for a transitional process and to make sure that these efforts lead to a scenario that enables sustainability in the long-term (Sgaier et al., 2012; Mogeni et al., 2013).

Other important issues emerged from the data. Interestingly, as shown in table 6.1.1, the international NGOs were designated as the principal recipients for the four grants under study. While this is not unusual, the findings infer that in the case of Peru, placing the Ministry of Health in a leadership role, rather than having a steering but non-executive role, would have helped develop their coordination with the other partners, leadership and management capacities early on. This would have also made it easier to integrate these activities within the other ministry initiatives. As shown in the findings, these international NGOs were seen to have greater manpower and technical capacity than the HIV/AIDS strategy office within the Ministry. Moreover, the role of these international NGOs, who are frequently involved in developing technical reports that present national statistics, as principal recipients may generate adverse incentives to report data that supports the need for continued funding for their services. The problems in the interpretation of data during Global Fund proposal development has been discussed in chapter 5 of this thesis.

At the same time, similar to the national NGOs, while there was no agreement to continue to fund NGO-led activities under the results-based-budget, the international NGOs were confident that there would be no change in their role as implementers, or that this would only decrease slightly, since they could not identify capacity within the Ministry of Health to continue to do these. As such, they saw their continued involvement in the implementation of activities as essential. While this is a pragmatic approach to ensuring individuals affected by this disease receive needed services, this has detrimental effects for sustainability given that for long-term programmatic sustainability, activities should be integrated within the Ministry of Health who is meant to provide the national direction on health issues. Indeed, enhancing government capacity and political will through the development of capacity and technical skills was seen as a key element in successful transition from a Bill and Melinda Gates Foundation programme in India. Similar to the case of Peru, this project began by providing grants to NGOs to run programmes but the eventual transition took place in order to institutionalize it within the government support (Bennett et al., 2011; Sgaier et al., 2012). This could be seen as an example for Peru where NGOs' relevance initially in providing services does not necessarily negate the guidance role of the Ministry of Health.

At the same time, while the central level may remain weakened, the decentralisation process and the introduction of the results-based budget favours this leadership role to be overtaken by actors at the regional level. Within this new budgetary strategy, the regions is the ultimate point where funding will be distributed and projects will be implemented. The positive results of the few regions that have already been able to develop their own Regional Multi-Sectoral Plans and organized COREMUSAS, albeit with some initial problems in terms of implementation, provides hope that partnerships between different actors and sectors can be sustained and the activities can be continued. Nonetheless, problems remain in the participation of these regional actors within the CONAMUSA, the national space for discussion of HIV/AIDS activities. Bridging the gap between the regional and national actors will not only improve the implementation of activities but can also help support the development of relevant national HIV/AIDS policies that respond to the needs of the local level.

Moreover, multisectorality was expressed as a key achievement reached through Global Fund projects. The increased participation of other ministries, outside of the ministry of Health was seen as a positive development, particularly in involving the ministries of education, to promote sexual education, and justice, to improve prevention and treatment among the police-force and within prisons. While these ministries received funding indirectly from the Global Fund, their relationship with the Ministry of Health did not change and they still had little participation within CONAMUSA. In this sense, the incentives generated by the indirect funding from the Global Fund and the possibility of ending this funding, caused limited behavior change in these ministries, which still saw the ministry of health as their direct counterpart. Nonetheless, there was an understanding that given the value shown to these intersectoral partnerships, these projects would continue to be funded by the government in a case of decreased Global Fund support.

On the other hand, multisectorality seems to be working well in some regions, with important participation of regional government sectors outside of health in the COREMUSAs at times developing regional Multi-Sectoral plans. However, as shown earlier in this thesis, the degree of participation of actors varies from one region to another and is largely dependent on the position of HIV/AIDS as a priority in the region and the availability of resources to fund meetings and transportation of participants.

What are the implications of these findings for sustainability of the HIV/AIDS response in Peru?

The findings presented in this chapter uncovered several factors that support or hinder sustainability of the HIV/AIDS response in Peru in relation to actor motivations and influence. These can be organized in three closely related categories: ensuring a coherent response to HIV/AIDS in Peru; effective programme coordination; and the development of partnerships.

A coherent response to a disease-programme is crucial not only in a context when part of these activities are funded by a donor. A coherent national response ensures more

effective use of resources, avoids the duplication of activities through parallel programming and allows for easier integration of activities (Bossert, 1990; Hay & Williams, 2005; Slob & Jerve, 2008). In the case of Peru, coherence of the HIV/AIDS response is closely related to the efforts made early on to align the Global Fund proposals with the national HIV/AIDS plan and viewing HIV/AIDS as a national priority, discussed in chapter 5. However, while the country has made important efforts to align Global Fund activities with the national plan, the unilateral actions that were frequently taken by some NGOs in the country, without consulting with the Ministry of Health, had the potential to negatively affect this coherence. While the increased agency and development of technical skills in the NGOs is an important success generated by Global Fund grants, this should not come at the expense of the government's coordinating role (Oomman et al., 2008). Hence, this difficulty is directly related with the ability of the Ministry of Health and more specifically the HIV strategy office, the main directing body for the disease, to appropriately coordinate the activities at the national level.

As demonstrated in the findings, the Strategy Office's internal capacity has proven to be weak with the majority of the officers still being funded through Global Fund grants. While there was an overall perception that HIV/AIDS is considered a political priority and there is political will to continue to fund it, in part demonstrated by its inclusion in the results-based budget, this was not translated into the allocation of more funding for the Strategy Office. Although officials at the Ministry expressed that there were plans underway to generate permanent positions for the officials, it brings into question whether this political will is only at the level of discourse or if it has potential to be translated into tangible actions. Nonetheless, the Strategy Office's coordinating role was overtaken by the CONAMUSA, which is seen as a effective space for coordination of the HIV response.

The CONAMUSA has been perceived positively as an institution formed through the Global Fund funding process. However, the permanence of this body, which was created specifically to help develop proposals for the Global Fund, is unclear. This means that while at the moment the positive coordination of actors through CONAMUSA is seen as

contributing to sustainability, the ability for this to remain so, considering the weak leadership of the ministry, is questionable. Nonetheless, the CONAMUSA should be seen as an important ally for the Ministry of Health and not as a replacement for their leadership and coordinating role. Moreover, in order for this body, or its regional branches, to contribute to the response, clear legislation allowing for this role post-Global Fund should be developed and the accountability role of the NGO sector, which at the time when the interviews were conducted was seen as weakened, should be prioritized.

The importance of effective partnerships between actors for sustainability has been widely documented (Johnson, Hays, Center & Daley, 2004; Scheirer, 2005). In the case of Peru, these partnerships have been facilitated by the CONAMUSA and multisectoral work on HIV/AIDS activities funded by the Global Fund at the national and regional level. These partnerships have been seen as constructive, involving actors from different sectors within the government working on joint HIV/AIDS activities at the national and regional level; as well partnerships generated through the CONAMUSA, which brought together a variety of actors. However, as noted in this chapter, these partnerships were mostly seen to have developed from interpersonal relationships and there is still some tension regarding the role of the NGOs as implementers of these programmes. Nonetheless, the partnerships developed at the national level do not overlap with those developed at the regional level since they involve different actors. In order for these partnerships to be continued in the long-term, the importance of existing partnerships and between governance levels should be highlighted in the national HIV/AIDS plans.

Conclusion

This chapter uncovered important supportive and hindering factors for sustainability of the HIV/AIDS response in Peru in relation to actor roles and motivations. The country's alignment of policies towards a coherent response to HIV/AIDS was observed to be a positive enabler for sustainability. However, this is endangered by individual bilateral actions of some NGOs. Nonetheless, this is a direct effect of the still weakened coordinating role at the central level. The partnerships between actors from different

sectors generated through the Global Fund grants is seen as a positive enabler for sustainability, yet these have mostly relied on interpersonal relationships between the actors. Generating mechanisms to institutionalize these partnerships will be critical in order for the basis for joint collaboration be maintained in the long-term. Finally, the findings demonstrate a still weak coordinating role from the Ministry of Health but one that has been replaced by the national coordinating body developed to manage Global Fund grants, the CONAMUSA.

This shows that Peru has developed a positive scenario for sustainability in relation to alignment of HIV/AIDS activites with national priorities and the development of successful partnerships between actors. A constraint for sustainability is the still weak coordinating role of the Ministry of Health, specifically the HIV/AIDS Strategy Office. It will be critical to support the Strategy Office's coordinating capacity by strengthening their leadership roles and allocating funding to maintain a team that can oversee activities in the regions. These supportive and hindering factors regarding the relationship between the actors and the programme should be considered in the wider context of other supportive and hindering factors related to the HIV/AIDS programme. Otherwise, the important building blocks that have been generated through the Global Fund grants will be overtaken by these constraints, leaving little possibility for long-term programmatic sustainability.

Chapter 7 Progression towards programmatic sustainability in a middle-income country (Peru): supportive and hindering factors.

Discussion and conclusions

While there is an understanding that every aid programme is finite and funders tentatively plan that their investments will be sustainable in the long-term (Lu, 2006; Ooms, 2006); it is surprising how little preparation for donor exit is in-built into these interventions from the beginning (Caines, 2005a; Heller, 2005). This is a particular concern since the literature suggests that as many as 40% of all new programs do not last beyond the first few years after the end of initial funding (Savaya, Spiro & Elran-Barak, 2008). The concern about sustaining the activities is relevant to middle-income countries that may soon graduate from aid (Global Fund, 2010; Lu et al., 2010) due to economic growth, as well as to countries that are highly aid-dependent and seek to protect themselves from funding volatility (Hay & Williams, 2005; Riddell, 2009). Despite this interest, there are few documented examples exploring the process by which large-scale health programme may become sustainable once funding has ended (Sgaier et al., 2013), especially exploring the policy process. In the case of HIV/AIDS programmes, the increased lifespan of people living with HIV/AIDS due to effective drug treatments is a prime illustration of the need to plan for increased, long-term investment in services (Stover et al., 2011).

Peru provides an instructive example of a country that has received Global Fund support for HIV/AIDS over a period of time, yet due to recent economic growth, is in a position to increase government investment in this area. The distinct periods of Global Fund financing for HIV/AIDS in the country and the expanding role of the government in funding HIV activities provides an exceptional opportunity to study the country's progression towards programmatic sustainability of the HIV/AIDS response.

This thesis aimed to assess the key factors supporting and hindering the progression of a middle-income country (Peru) from receiving Global Fund support for HIV/AIDS

towards programmatic sustainability in the 2004 and 2012 period. Apart from informing research, this thesis also sought to provide recommendations to inform decision-makers on priority areas that must be strengthened to improve the potential for a sustainable HIV/AIDS response both in Peru and in other countries facing a similar scenario.

Specific thesis objectives were addressed in chapters four, five and six. These were primarily addressed as follows: chapter four examined the inputs (financial resources, human resources and data) that have an important effect on HIV/AIDS policies and activities (objective one); chapter five analysed how evidence informs Global Fund proposal development, and how this process supports the development of country capacity to generate and use evidence, and promote accountability (objective two); finally, chapter six assessed the roles and motivations of the main actors involved in the HIV/AIDS work in Peru as the country progresses towards programmatic sustainability (objective three). The following section provides a summary of the key findings.

This chapter presents the overall learning from this thesis by summarising the key elements necessary for sustainable programming, stemming from the Peruvian case, and identifies the contribution of the findings to the field of research. The limitations of the study are also recognised and the implications of this research to the literature more generally are discussed. Finally, it concludes with a section reflecting on possible areas for future research.

7.1 Key elements for promoting sustainability: the case of Peru

Peru demonstrates an encouraging progress towards sustainability of the HIV/AIDS response. This thesis identified the range of factors supporting and hindering the sustainability of the HIV/AIDS response in the country that have evolved in the 2004–2012 period. Besides a favourable economic environment most of these relate to macro-level governance conditions. These include the existence of strong political will; coherent policies and strategies related to effective alignment of activities; good organisational and technical capacity, as well as available human resources; and effective leadership. Recognising the limits of the government institutions in middle-income settings, creating

effective partnership structures, supported by sound accountability mechanisms also emerged as essential. However, the country context mitigates the role of these factors and the way they influence sustainability. In the case of Peru, the transition is taking place within the context of a stable government; favourable economic environment; a process of decentralisation at the state and health level; the implementation of a new results-based budget; and weak health information systems. Other contextual factors include high social inequality and low overall HIV prevalence.

The findings below are divided into three major sections: technical capacity and priority setting within the HIV/AIDS programme in Peru; policy alignment and coordination of the HIV/AIDS response; finally, the influence of important contextual factors including the economic environment and decentralisation, on sustainability.

7.1.1 Technical capacity and priority setting within the HIV/AIDS programme in Peru

Having adequate and timely information on the nature of the HIV epidemic is of prime importance for planning and sustaining activities (Bossert, 1990; Fraser et al., 2005; Waltham & Sahay, 2006); as well as having the local technical capacity to plan appropriately according to need (Johnson, Hays, Center & Daley, 2004; LaPelle et al., 2006; Mills & Bennett, 2002; Pavignani & Colombo, 2009). Indeed, the purpose of aid should ultimately be to develop capacity so it eventually becomes obsolete (Godfrey et al., 2002; Lele et al., 2004). Likewise, it is has been shown that strengthening capacity in the initial stages of hand-over of roles translates into greater success in sustaining the process of change over time (Akerlund, 2000). Testing the use of evidence for planning a sustained response, country grant proposals submitted to the Global Fund and related policy documents were analysed in order to capture the context in which evidence informs the development of HIV/AIDS activities and how this explains the generation of country capacity to use this evidence and promote accountability. This also included an assessment of the use of evidence and consistency between proposals, both crucial elements for the continuity of successful activities. The literature suggests that Global Fund proposal requirements, which are based on demonstrating that clearly specified

results that have been achieved, may generate competition among actors (Harmer et al., 2013; Kapilashrami & McPake, 2013; Spicer et al., 2010), with a detrimental effect on partnership-building. This was not found in the case of Peru, where these requirements instead strengthened country actors' abilities to generate and present data in a more systematic and rigorous manner, which are similar to the reporting requirements embedded in the later introduced results-based budget, thus requiring only minor adjustments. However, despite multiple attempts to improve the monitoring and evaluation systems, in part through projects funded by the Global Fund itself, these still do not fully respond to the demand for data. The information system for HIV/AIDS has been found to generate unreliable indicators for planning and management, in part due to the multiplicity of reporting mechanisms and the lack of timely data collection, which poses a significant obstacle to understanding and tracking the epidemic among most affected populations. However, the findings of this thesis were in line with an external evaluation of Global Fund activities (Universidad Peruana Cayetano Heredia, 2013), demonstrating that funded activities have had a positive effect on the HIV/AIDS response and the limitations of the Global Fund proposals have been overcome in the implementation phase, through the collaboration of the state and civil society. Nonetheless, the implications of a continued poor targeting of resources in the long-term due to unreliable data are that investments will not be appropriately allocated towards the most effective interventions.

Besides the use of evidence, there is an extensive literature on how priorities for action are negotiated at the national level (Bossert, 1990; Brugha et al., 2004; Gruen et al., 2008; Kapilashrami & McPake, 2013; Kapilashrami & O'Brien, 2012; Libatique, 2004). A focus on understanding how decisions are made is important to elucidate policy makers' motivations for sustainability and their ability to interpret the data. Our findings suggest that decisions on what to prioritise in the Global Fund proposals were based on previously developed strategies and historical approaches, instead of a critical appraisal of current and future epidemic trends. This is in part due to the lack of reliable data to support policy but also due to the need to reflect political negotiations and take account of the interests of the members of the CONAMUSA. The risk of this is that priorities may

be set according to the usual paradigms, which instead of addressing the underlying social determinants of health such as inequity can potentially exacerbate them.

Indeed, the perception that decisions were based on CONAMUSA member interests was illustrated with cases where NGO members successfully negotiated increases in much needed prevention activities aimed at vulnerable populations, predominantly implemented by NGOs. The preponderance of prevention activities funded by the Global Fund, responded to the insufficient attention to disease prevention by the government but at the same time, some respondents perceived it as an overinflated demand for these activities in order to justify continued funding of NGOs. As shown in addendum 6.8, the designation of international NGOs, whom are also frequently involved in separate research studies to generate HIV/AIDS data, as principal recipients would risk producing adverse incentives for them to use data supporting the continuation of funding for their own activities. Furthermore, prior studies have found that reliance on NGOs for project implementation may both decrease their legitimacy as advocates for their constituencies (Doyle & Patel, 2008; Kapilashrami & O'Brien, 2012; Spicer et al., 2011) and redirect their efforts to short-term interventions (Kapilashrami & O'Brien, 2012; Seckinelgin, 2005). At the moment, round ten of the Global Fund is focused on decreasing discrimination and improving access to care among these key populations but once this funding has concluded, it will be important to evaluate which interventions are most effective and necessary to implement into the regions.

Apart from that, the importance of a stable cohort of policy-makers who have the relevant technical expertise, have been involved in initial planning of strategies and programmes (including of Global Fund funding), and hence understand the issues and how they have evolved over time, has been documented (Balabanova et al., 2013; Scheirer, 2005; Sridharan et al., 2007). In the case of Peru, the inconsistencies in interpreting the data and the lack of synergy and complementarity between Global Fund-financed activities over time can also be explained by the lack of consistency among the key policy-makers involved in decision-making in the CONAMUSA over time. This had a detrimental effect on continuity and scaling-up of interventions from one proposal to the next.

Furthermore, a consideration for programmatic sustainability is that activities can only be continued if there is existing demand for services (LaPelle et al., 2006; Torpey et al., 2010). Despite a low overall HIV prevalence in Peru, the number of PLHA is increasing and the prevalence among vulnerable populations is still high, signalling an increasing demand for services. In order to respond to this demand, technical expertise and the availability of trained health human resources is crucial, with appropriate, sustained staffing directly affecting the quality of care. (Buse & Harmer, 2007; Dickinson, 2008; Drager et al., 2006; Godfrey et al., 2002; Johnson, Hays, Center & Daley, 2004; LaPelle, et al., 2006; Lele et al., 2004;; Ostrom, Gibson, Shivakumar & Andersson, 2001; Pavignani & Colombo, 2009; Sridharan, et al., 2007). Unfortunately, this is an area that still remains a problem in Peru. Although the expansion of the provision of ART and the process of decentralisation should in theory result in higher numbers of human resources in the regions, public expenditure data shows that investment in this area has fluctuated throughout the years (Navarro de Acosta, 2011). Moreover, as the experience in other settings has shown (WHOMPS, 2009; Drager et al., 2006), the majority of aid received from the Global Fund in Peru was directed to areas other than training. This trend continues as Global Fund funding has diminished, resulting in a low number of trained infectologists, physicians, nurses and nutritionists. Moreover, the policy of rotation of personnel (periodically moving personnel from one health area to another) is an important concern since those cadres working in HIV and experienced in region-specific issues are then moved to other areas, which has a negative effect on the continuity and quality of care.

The literature shows developing technical capacity of managerial and clinical staff requires long-term planning (Hay & Williams, 2005) and that a country's ability to fund their own programme does not mean they no longer require technical assistance (Vermund et al., 2012). Indeed, as the findings in this thesis demonstrate, the technical capacity to plan and manage their new roles in Peru is still weak at all levels of government. At the same time, representatives of the international community, UN agencies and bilateral donors, reported that their presence in the country would continue to primarily consist of providing technical assistance and this need is also made explicit

by the government. This will assist the continuity of activities in the short-term, but planning for the long-term, the country must develop greater organisational and technical capacity, especially in the regions.

These findings point to the need to not only streamline the information systems but also to strengthen the technical and organisational capacity in the country to make evidence-informed decisions on planning and implementing activities; as well to increase training of human resources in HIV/AIDS services.

7.1.2 Policy alignment and coordination of the HIV/AIDS response

A sustainable HIV/AIDS response in Peru is highly dependent on policies ensuring the continuity of successful activities. Alignment of donor activities with government policies is widely recognised to promote a sustainable and coherent national response (Bossert, 1990; Hay & Williams, 2005; Johnson, Hays, Center & Daley, 2004; OECD, 2008; OECD, 2011; Scheirer, 2005; Tibbitts et al., 2010). Furthermore, the existence of an alignment plan among different actors demonstrates that there is a demand for these activities and facilitates the institution building and strategies required by phasing-out of funding (Slob & Jerve, 2008). Peru started the process of aligning Global Fund activities with local priorities early on. Global Fund proposals for rounds two and five were agreed by national consensus-building processes and from round six onwards followed the national HIV multi-sectoral strategic plan. This ensured that activities were integrated within the national response, yet there was still a priority given to prevention activities implemented by NGOs. Moreover, following the end of Global Fund grants, these activities were also incorporated into the operation of government institutions through the development of plans to align and transfer interventions (Cabrera, 2010), which proved to be an important tool in planning budgets.

Having programmes that can adapt over time is also key for sustainability (Scheirer, 2005). Certainly, the implementation of the results-based budget in the regions is an opportunity to examine which specific activities should be maintained to respond to population needs in the area. It is expected that the emergence of new technologies or changes in treatment guidelines will warrant programmatic and budgetary adjustments, so

the regional and local authorities must be prepared to respond to these changes. With regards to prevention activities previously funded almost in their entirety by Global Fund funding and implemented by NGOs, these should be integrated into the regional budgets yet their appropriateness and efficiency must first be evaluated for the particular region.

Moreover, leaders and motivated individuals who promote these changes and coordinate the response of actors involved in HIV work are important not only to increase aid effectiveness but also to sustain gains over time through inter-sectoral work (Akerlund, 2000; Archarya et al., 2004; Brugha et al., 2004; Balabanova et al., 2013; Marchal et al., 2009; OECD, 2011; Savaya & Spiro, 2012; Sridharan et al., 2007). A high level of coordination frequently requires communicating a commitment to sustainability, engaging others, overcoming barriers, creating capacity and organising the distribution of tasks (Green & Plsek, 2002). The role the Peruvian HIV strategy office in overseeing and advising the work in the regions has been key to ensuring sustainable HIV policies and interventions, however its ability to fulfil these responsibilities remains weak. This is mainly attributed to the limited capacity of the small team coordinating the HIV response at the Ministry of Health, as well as the predominant role of the NGOs in implementing the prevention activities funded by the Global Fund. The problem that emerged with NGO implementation of these activities was that they frequently made unilateral decisions without the input of the Ministry of Health, which threatened a coherent response to the epidemic and undermined the coordinating role of the ministry.

Strengthening the leadership and coordinating role at the central level is a priority in order to ensure successful activities are sustained and there is an integrated multi-faceted response to HIV/AIDS at the national level. Increasing the Ministry of Health staff skills in coordinating, planning, critically appraising the evidence and fostering partnerships is essential for this.

Consequently, the literature also shows that support from other organisations through effective partnerships among country stakeholders is an important element of this coordinated response (Johnson, Hays, Center & Daley, 2004; Scheirer, 2005), as well as their ability to hold members accountable (Walsh, Mulambia, Brugha & Hanefeld, 2012).

Peru has made important advances in this area. The wide representation of actors in the CONAMUSA and their use as the main policy spaces for actor dialogue on HIV issues are an important legacy of the Global Fund in the country. Partnerships between government institutions have also flourished due to the promotion of multisectoral initiatives through Global Fund grants. However, the participation of these ministries within the CONAMUSA has remained low. Despite relatively weak coordination by the HIV strategy office, these partnerships have thrived due to positive personal working relationships between actors. The use of the CONAMUSA to discuss the 2007-2011 Multi-sectoral Strategic Plan for the Prevention and Control of STIs and HIV/AIDS demonstrates that the CONAMUSA's contribution to policy goes beyond developing proposals for the Global Fund. These are seen by some respondents as useful structures that must be sustained, while simultaneously seeking to increase participation of other ministries and regional actors in policy and strategy development at the central level.

Moreover, this study shows that while the COREMUSAs are particularly valuable regional spaces for inter-sectoral discussion on HIV issues, their participation in the policy process varies according to the region in part because the prevalence rate in some regions is very low and HIV is not seen as a priority. Other reasons include the prioritisation of other issues due to political campaign promises or the resistance by some officials to invest in HIV/AIDS activities, which they still see as an immoral disease. These mechanisms must be strengthened so they can contribute to the debate at the regional level. One of the difficulties noted in the interviews was their lack of access to a budget to plan activities. Allocating a small budget to the COREMUSAs could facilitate greater participation of various stakeholders in decision-making at this level, and in general increase the pace of transition to self-sufficiency.

7.1.3 Contextual factors impacting a sustainable HIV response

The factors promoting or hampering sustainability must be understood within the Peruvian context. The economic environment emerged as a key contextual factor in the analysis. Economic ability to invest resources for a desired purpose without undermining the government's financial position (frequently defined as fiscal space) (Hay & Williams, 2005), is crucial to determining if a country can fill the gap left by the end of donor funding (Atun, et al, 2010; Bossert, 1990; Gruen et al., 2008; Hailu & Shiferaw, 2012; Heller, 2005; LaPelle et al., 2006; Lu, Michaud, Khan & Murray, 2006; Mills & Bennett, 2002; Ooms, 2006; Pavignani & Colombo, 2009; Savaya & Spiro, 2012; Schell et al., 2013). As discussed in this thesis, sound fiscal policies and an international increase in commodity prices, has on the one hand increased Peru's ability to independently fund activities, while also making it ineligible for full HIV/AIDS programme funding from donors such as the Global Fund; which made planning for the end of this funding important.

Although this positive economic environment has not been proportionally coupled with an increase in expenditure in health, as seems to be the case in the majority of countries in Latin America (PAHO, 2012), the introduction of a separate budgetary line for HIV/AIDS (together with tuberculosis) in the results-based budget signals the importance the government assigns to combating the disease. Indeed, this is an example of positive political will, which the literature suggests is an important factor for sustainability (Atun et al., 2005; Pavignani & Colombo, 2009; Schell et al., 2013) in order to ensure policies are favourable for the response. Furthermore, the diversification of Peru's exports and its strong fiscal policies provide a positive growth outlook for the country but in order to maintain the fight against HIV/AIDS as a policy priority, strong advocacy from NGOs needs to be maintained. This includes presenting the evidence demonstrating the need to address the disease. This finding is relevant for other low- and middle-income countries where economic growth may be associated with increased political stability and administrative capacity (Cornia, 2011; Reynolds, 1985), but with it also the potential to increase inequality (Kuznets, 1955; Morrison, 2000). In the case of HIV/AIDS, the increased prevalence among traditionally socially-excluded groups in many countries

demonstrates the point that both economic and social inequality can have a negative effect on the response.

Decentralisation in Peru has also provided the backdrop to the transfer of responsibility. Decentralisation in general, is expected to have an impact on sustainability because it has a direct effect on how services are delivered (Casas, 2004; Dammert, 2003; Iguiñiz-Romero et al., 2011). It is also closely associated with how budgets are managed; changes in these mechanisms can have an effect on the continuity of policies and investment decisions. This may increase the requirements for effective organisational capacity to manage activities, particularly where most of the capacity is located at the central level (Olsen, 1998; Sarriot, et al., 2004; Schell et al., 2013; Walsh, Mulambia, Brugha & Hanefeld, 2012). The recent decentralisation of health functions in Peru, in combination with the transfer of the responsibilities associated with planning the results-based budget for HIV/AIDS, intensified the existing organisational and technical capacity problems in the regions. Cadres in the regional administrations have often poor training on how to manage these new tasks. Furthermore, some regions are less inclined to consider HIV/AIDS a planning priority, other issues being prioritised in part due to political campaign promises. Both of these issues led to low absorption of funding allocated for HIV/AIDS for 2011, the first year. This had a detrimental effect on future budgetary planning, given the need to demonstrate demand and results under the new budget. As the literature suggests, continuously training managers on the new roles and requirements is fundamental, especially during this transitional period (Bossert, 1990; Sridharan, 2007). It should be noted that these difficulties were identified early on and the ministries of health and finance started training the health officials in these roles. Moreover, these difficulties also point to the need to diagnose in advance the capacity of the regions to manage the new responsibilities, to ensure an easier shift in roles.

7.2 Limitations

A number of limitations to the research presented in this thesis should be recognised. The nature of research was qualitative, with in-depth interviews being the main source of primary data. Given that respondents were frequently asked about events that took place in the past, even though these questions did not entail a distant past, some recall bias may have occurred. This was addressed by signposting of key events and reminding respondents of the general timeline of events.

Accepting the implicit bias in any social research introduced by the personal values, beliefs and perceptions of the respondents and the researchers, a number of steps were taken to minimise this. A careful purposive selection of respondents was undertaken, in order to ensure that the range of respondents represented a wide variety of interests and views, as well as to ensure that all the elements of the framework are covered. Furthermore, triangulation was also employed to cross-reference findings and improve validity.

As shown earlier, sustainability is a broad term with many dimensions related to political, fiscal, social, organizational and technical issues. Programmatic sustainability, which was identified in the literature review as a particular weakness for middle-income countries, is most relevant for this case study since it can help explain how beyond financial resources, the HIV/AIDS programme can be sustained following the end of Global Fund support through effective management and coordination of services. This focus may have led to missing important dimensions of sustainability including some that interact closely with programmatic sustainability.

The framework facilitated the interpretation of the dynamic interactions between the various factors influencing programmatic sustainability and the broader context. Yet, the interrelationship between these factors frequently made it difficult to distinguish between cause and effect. These difficulties are generic to health systems and policy research (Gilson, 2012) and were addressed by triangulation of results and validating analyses through the consultation with researchers familiar with the topic and stakeholders not involved in the study.

At the same time, following the publication of the second paper that composes this thesis (chapter 5) it was perceived that the components that helped visualise the analysis over time included in the early framework were not easily understood. This led to further development to streamline the framework and updating it for the purposes of this thesis and presented in the framework section (section 2.3) and paper 1 (chapter 4). While this meant a change in the visualisation of the framework and its clarity, the main elements of the framework were unchanged. Therefore, it did not constrain the analysis.

The start of round 10 of the Global Fund in Peru after the fieldwork for this thesis had concluded (January, 2012) meant that the stakeholders could not be interviewed about the activities stemming from this funding round. Due to this, round 10 could not be fully included in the analysis, although it is briefly referenced to in several sections of the thesis based on Global Fund data. This is a limitation since the exclusion of round 10 meant this thesis could not provide the complete picture of Global Fund involvement in the country. Nonetheless, the singular nature of this round, which is still ongoing, has a significantly lower budget given the country's eligibility for these grants and is only targeting specific vulnerable populations; means it is not fully comparable with the other grants but stands as an example of the final stages of Global Fund involvement in the country.

This was also the case for the inclusion of the HIV/AIDS activities in the results-based budget, which at the time of the fieldwork was a recent event and where there is still a lack of information given that it is an ongoing process. Thus it was not possible to observe the final effect of this budgetary strategy on programmatic sustainability. However, the interviews sought to elicit views on this topic and understand the possible consequences of this new budgetary strategy for sustainability.

Moreover, the analysis of the proposals was hampered by the variations in each proposal's project design and implementation modalities, evaluation frameworks, as well as in assessing the context in which these proposals were developed and discussed. This was addressed through in-depth attention to understanding of the practices involved in proposal development in Peru and consultation with key stakeholders.

One of the goals of this thesis was to conduct research which may be applicable to other countries within the region or in other areas of the world. Given that this is a case study whose methods were tailored for the specific country setting, findings have to be generalized with caution. However a degree of conceptual generalizability may be possible (Gilson, 2012); specifically identifying lessons learned that can be adapted to other countries.

7.3 Conclusions

Peru has demonstrated important progress towards a sustainable HIV/AIDS response. Essential factors for sustainability identified in this thesis were: a) increased government investment in the programme; b) political will by the government; c) effective leadership and coordination; d) alignment of activities; e) useful partnership structures; f) good organisational and technical capacity; and g) available human resources (see table 7.3.1).

As thesis findings show, Peru is faring well in four of these factors. These include increased government funding for the HIV/AIDS programme; efforts to align Global Fund proposals with national priorities; political will, demonstrated through the inclusion of HIV/AIDS activities into a strategic budgetary line as well as the development of national policies to deal with the HIV/AIDS epidemic; and the creation of effective partnerships through the CCM and between different government sectors.

However, much remains to be done with regards to the national health information systems, which generate unreliable data, affecting the development of evidence-informed policies to respond adequately to needs; tackling the weak technical and organisational capacity at all levels, especially related to managing the new results-based budget, which is now the main source of funding for HIV/AIDS activities; still insufficient human resources for HIV/AIDS; and the poor leadership and coordinating role of the national HIV strategy office, which also has a negative impact on the development of a coherent government-led response.

Table 7.3.1 Main factors supporting and hindering programmatic sustainability of the HIV/AIDS response in Peru

	Supportive factors	Hindering factors
Inputs	• Conducive economic environment and inclusion of HIV/AIDS as a strategic budgetary line	• Weak information systems (related to technical capacity), which do not report reliable data • Insufficient human resources in particular infectologists, physicians, nurses and nutritionists.
Actor incentives-Programme	• Political will at national level exemplified by the inclusion of HIV/AIDS activities into results-based budget • Alignment of Global Fund proposals with national priorities initially agreed by consensus and later on the national HIV multi-sectoral strategic plan • Creation of effective partnerships among country stakeholders both between sectors of the government and between groups of actors within CCM	• Weak leadership and coordinating role of the Ministry of Health • Poor technical and organisational capacity at all government levels exacerbated by decentralisation

In order to overcome these threats to sustainability, it is crucial that the government invests in streamlining the health information system, so there is greater access to reliable and up-to-date data on the HIV/AIDS epidemic; as well as support an improvement in technical capacity at all levels. These two steps are crucial in order to develop evidence-informed policies and strategies for HIV/AIDS, which are based on proven interventions and allow for the best use of available resources to deal with HIV/AIDS, especially among most-at-risk and marginalised populations. Moreover, this course of action will also allow policy-makers to critically assess which activities to include within the results-based budgets, according to the specific population needs.

On the other hand, increasing the training and distribution of human resources for HIV/AIDS is important, particularly in areas with high disease burden in order to increase access to quality services in these regions. This is likely to lead to a better control of drug resistance and prevention of new HIV infections.

Addressing the weaknesses in the Ministry of Health, and more specifically the HIV strategy office, will not only support the overall response to HIV/AIDS by improving the coordination of activities and the provision of guidance for the regions but will also result in generating more productive and effective partnerships. This requires both investing in training policy-makers on managerial and technical skills, as well as increasing their budget so they have the resources necessary to respond to the demanding task of liaising with 25 regions. Encouraging the advocacy and social accountability role of the NGOs and CSOs is critical to ensure government commitments are maintained and HIV/AIDS continues to be a political priority, according to needs.

Moreover, findings demonstrate that we must move away from traditional approaches aiming to sustain past activities, and instead generate processes that allow actors and programmes to adapt to changes in available resources, evidence and need. This approach will help to promote a sustainable response to HIV/AIDS in countries facing similar scenarios.

Finally, this thesis sought to identify recommendations that can be useful for the Peruvian government on the sustainability of their HIV/AIDS programme as well as to donors designing exit strategies from aid in a range of low and middle-income countries. Findings show that Global Fund activities that were aligned with national policies and made use of cost-sharing strategies, for example through the funding of ART, were later taken up successfully by the government; which contributed to planning for sustainability. The lessons learned from this practice could have been applied to other areas such as funding certain prevention activities similar to the approach taken by Gavi and other donors who supported successful integration of previously funded programmes into national level programmes.

Furthermore, the Peruvian case shows that designating the Ministry of Health as principal recipient of the Global Fund grants could have helped them strengthen their coordination and leadership role early on, facilitating the transition towards programmatic sustainability. Recommending the active participation of the Ministry of Health, either as principal recipient of Global Fund grants or through another capacity, to help position them in this managerial and leadership role should be considered in other countries applying for Global Fund grants

Likewise, the requirement of the formation of a country coordinating mechanism by the Global Fund was found to enable national partnership-building, as well greater participation of previously excluded groups in decision-making, which ultimately had positive effects on setting the foundation for sustainable programmes where NGOs could continue to support the work of the government. However, these successes were also associated with scarce funding for generating local capacity and increasing human resources, which were some of the threats to sustainability identified in this thesis.

Nonetheless, the Global Fund is aware of these issues and has sought to address them through the 2014–2016 Global Fund New Funding Model. This funding model seeks to simplify the grant application process; promote early discussion on possible funding levels, with a view to increase aid predictability; prioritise countries with low resources and high disease burden; allow for flexible funding for eligible countries; and generate greater engagement with country-level processes. This is a promising development since the focus on improving country processes via streamlined application procedures, flexible funding and aid predictability can facilitate long-term planning for sustainable activities and support local capacity building. Moreover, if implemented appropriately, the Global Fund can be more effective in promoting positive results for countries seeking to become less dependent on aid.

7.4 Contribution to knowledge

Despite the importance of sustainability of programmes after aid has ended, the global debate has centred mainly on discussing strategies and alternative pathways for exiting aid, especially in the African region (Slob & Jerve, 2008), often remaining at conceptual level. Empirical research on what happens when funders leave a country and the possible steps to ensure sustainability in the aftermath of exit is scarce. The majority of the studies found on sustainability mainly focus on the scale-up of activities (Sgaier et al., 2013) and do not research the process of handing-over of activities after aid has finished in developing countries. This issue is particularly underexplored in the Latin American region where other countries are also growing economically (Barcena, 2011) and hence may be decreasing their demand for aid. The research presented in this thesis seek to fill this gap. It employs an innovative approach, undertaking a case study on the transition towards programmatic sustainability in the context of a middle-income Latin American country. Thus, the focus on understanding the process over time is relevant to many other lower and middle income countries that may undergo similar policy and institutional transitions. It also provides a basis for comparison with subsequent studies, in the region or globally.

The study also contributes to development of analytical approaches to study the issues of sustainability after donor exit. Prior frameworks to study sustainability of health programmes focused on ensuring funding and creating demand for services (LaPelle et al., 2006); operational sustainability and service delivery (Torpey et al., 2010); the interaction between health concerns, programme components and actor motivations (Gruen et al., 2008); or the relationship between contextual factors, activity profile and organisational capacity (Olsen, 1998). None of these models allows for policy analysis of sustainability taking into account both the external environment and resources invested and understanding the complex processes that have occurred over time. The framework developed in this thesis allows for a comprehensive understanding of the effect of inputs; actor motivations and incentives; programme policies and strategies; on programmatic sustainability in the 2004–2012 study period. It identifies plausible associations between these elements and thus provides a detailed explanatory narrative for the observed events.

This framework therefore seeks to contribute to the sustainability literature, providing researchers and country officials with a tool to understand the dynamic processes that have an effect on programmatic sustainability. This is done by analysing distinct moments of policy development, in this case related to the contribution of the Global Fund financing to the HIV/AIDS response.

The case study approach, which used a variety of qualitative methods to understand this process was well suited to the topic and is adding to the emerging literature using similar approaches (Balabanova et al., 2013). The in-depth interviews with key stakeholders, guided by the conceptual framework, were useful in elucidating the diverse perspectives of the changes that have taken place in the study period, as well as comparing these interpretations with what is found in the literature.

This thesis also provides important learning on the role and behaviour of donors in middle-income countries; particularly by exposing which elements are useful for building country capacity and which hinder future programmatic sustainability. The factors that were beneficial included the alignment of grants with national policies; use of cost-sharing strategies; and the requirement for creating a country coordinating mechanism. However, the relatively smaller share of funding for sector-wide strengthening and specifically directed at increasing the technical capacity of main actors in the country has made the hand-over of roles difficult due to lack of preparation and training for this transitional period. This supports the literature demonstrating the negative effect of vertical programming on sustainability (Stefanini & Ruck, 1992); yet it must also be acknowledged that the Global Fund has taken steps to address these problems through their new funding model (Global Fund, 2013).

7.5 Future research agenda

This thesis provides important lessons on the transition from donor involvement towards sustainable national HIV/AIDS response by the government. Thesis findings on the processes involved in this transition open up new areas of research to explore in low- and middle-income countries that are planning for sustainability.

The study elicits the importance of further empirical work to conduct more case studies on other types of sustainability in countries that are middle-income but not experiencing economic growth or undergoing a rapid administrative and health system decentralisation process. Building a critical mass of research in this area will allow to assess how the process of planning for sustainability relates to different contexts.

Given the changes that are under way in applying for Global Fund grants and how these are implemented, analysing if the new Global Fund policies might have an effect on how programmes incorporate plans for sustainability at the country-level will also be a key area to research.

Finally, there is also scope for further research which addressed more broadly the perceptions of global health governance players, particularly donors, in this process. Such an analysis would be useful to compare the incentive to promote sustainability among the global health architecture, among those at the national and local level; and trace how this translates into planning for sustainability even before aid is provided.

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APPENDICES

Appendix 1: Peru Country Context

This case study is based on Peru. Peru is located in South America and has a population of 30.5 million inhabitants and a territory of 1,285,215.6 km^2 (Instituto Nacional de Estadistica e Informatica del Peru, 2013). The population density of 22 inhabitants per km^2 makes it the fourth most populated country in South America after Brazil, Colombia and Argentina (Prosalus, 2009). The capital is Lima and geographically, the country is divided by the Andean Mountains into three areas: the coast, where the main cities are located; the mountains, where half of the population lives; and the Amazon, which has a small population (Prosalus, 2009). Politically, the country is decentralised into 25 administrative regions and one province (Lima), with each region having its own regional government (Casas, 2004).

The official language in Peru is Spanish with two co-official languages Aymara and Quechua due to a large indigenous population (Central Intelligence Agency, 2013). Thus the population is composed of three main ethnic groups, 45% Amerindian, 37% Mestizo (mixed Amerindian and white), 15% white and 3% others (Central Intelligence Agency, 2013). Public expenditure on education as a percentage of GDP is 2.7% with an adult literature rate of 8.6% among individuals aged 15 and above (UNDP, 2013). The percentage of female representation in parliament, a measure used by the UN to estimate gender equality, was 21.5% for 2013 (UNdata, 2013). As is common in the Latin American region the majority of the population is religious, 81.3% of the population identifying as Roman Catholic, 12.5% as Evangelical and the rest as other or none (Central Intelligence Agency, 2013).

The country's main exports are mineral products at 56.3%, petroleum and natural gas at 13.0%, fishing products at 2.8% and agricultural products at 1.2% (Banco Central de Reserva del Peru, 2013). Around 17.5% of fiscal revenues come from these commodities and about 40% of Peru's exports are destined for China and the EU meaning the economy is sensitive to commodity price changes and economic problems in these countries. However, Peru is ranked as the first largest producer of silver, second largest of copper and zinc and third largest of tin, and the diversity of its exports makes it less

exposed to possible commodity price changes than other nearby countries such as Chile, Ecuador or Bolivia (World Bank, 2012).

Figure 8.1.1 Map of Peru

Source: Ministry of Health, Peru.

Life expectancy in Peru is calculated at 74.2 years (Instituto Nacional de Estadistica e Informatica, 2013), with a total median age of 26.7 years (Central Intelligence Agency, 2013). The main causes of death at the national level are upper respiratory infections, ischemic heart diseases and cerebrovascular diseases. Main causes of morbidity are non-communicable diseases (58.5%); communicable, perinatal and maternal diseases (27.6%), and accidents and injuries (14.7%) of the total (Alcalde-Rabanal et al., 2011).

Total mortality was reported at 6.0 per 1,000 inhabitants while infant mortality was reported at 19.5 per 1,000 births in 2010 (Ministerio de Salud del Peru, 2013). Maternal mortality on the other hand was reported at 67.0 per 100,000 births (UNDP, 2013).

The health system in Peru is divided between the public and the private sector. The public sector is divided into services for the uninsured and insured individuals. The uninsured population can either pay a small fee to receive care through the network of health establishments managed by the Ministry of Health or in the case that they live in poverty or extreme poverty, this care is subsidised by the Seguro Integral de Salud (SIS). Similar to other Latin American countries, all working individuals are insured through their contributions to the social security system. In Peru this social security system has two subsystems: the traditional social security (EsSalud) and the private provision of care (EPS). The EsSalud provides care for the working population and their dependants, but since 1997 the private sector has sold private services to the EsSalud through the EPS. Moreover, policemen, military personnel and their families are covered under their own health subsystems, the Policia Nacional del Peru (PNP) and Sanidades de las Fuerzas Armadas (FFAA). There is also a mandatory accident insurance (SOAT) which covers care for automobile accidents and injuries (Alcalde-Rabanal et al., 2011).

The private sector is divided into for-profit and not-for-profit sectors. The for-profit sector includes the EPS, private insurers, private clinics, laboratories and hospitals, as well as informal health providers such as shamans. The not-for-profit sector includes institutions such as NGOs, the Peruvian Red Cross and Church health services (Alcalde-Rabanal et al., 2011).

Within these subsectors 60% of the population use Ministry of Health services; 30% of the population are covered by the EsSalud; and the FFAA, PNP and private sector provide services for the remaining 10% (WHO, 2013). At the same time, 90% of Ministry of Health establishments are located in urban areas, 7% in semi-urban areas and 3% in rural areas (Ministerio de Salud del Peru, 2006b). In 2005, there were 31,431 available beds with a ratio of 1:12 beds per 1,000 inhabitants. Of these, 50% were located

in Ministry of Health hospitals, 20.7% in FFAA hospitals and 21.6% in the private sector (Alcalde-Rabanal et al., 2011).

Moreover, the average density of health professionals per 10,000 inhabitants for 2010 was 11.7 for physicians and 6.7 for nurses and midwives (Ministerio de Salud del Peru 2011). However, these health professionals are primarily concentrated in Lima, with 53.19% of physicians, 40.23% of nurses, 44.25% of dentists and 41.47% of midwives living in the capital (Ministerio de Salud del Peru, 2007). Of concern is also the increasing number of health practitioners migrating from the country. From 2004 to 2008, there was a 308.8% increase in the migration of physicians, nurses and midwives representing 15,088 health professionals. This seems to respond to an oversupply of trained professionals graduating from universities, which do not respond to the internal demand and hence do not find employment (Ministerio de Salud del Peru, 2011).

HIV/AIDS in Peru

According to the Ministry of Health, HIV/AIDS prevalence among the general population is 0.23% and by 2009 there were 73,000 people living with HIV/AIDS, mainly concentrated in large urban areas (Ministerio de Salud del Peru, 2012). The highest prevalence is found among men who have sex with men (MSM) with a prevalence level of 8.93%. This is followed by female sex workers (FSW) and pregnant women who have prevalence levels of 2.1% and 0.15% respectively (Aldridge, et al., 2009). Yet sentinel surveillance surveys in the two cities where 71% of the cases are concentrated found prevalence among transgender individuals to be 20.8% (Ministerio de Salud del Peru, 2012).

An analysis by Alarcon et al. (2010) found that 56% of new cases take place among MSM; 12% among people with casual sex partners and their stable partners; 2% among sex workers and their clients; and 13% among partners of sex worker clients and injection drug users. Among the MSM group, the most affected subgroup is the transgender population with 20.8% prevalence and 9.07 incidence (Ministerio de Salud del Peru, 2012). The Global Fund round 10 for Peru, which was approved in 2011, is specifically

directed towards increasing access to services and decreasing stigma and discrimination among the MSM, gay and transsexual population (Global Fund, 2012b).

Within the 25 regions in the country, 71% of HIV/AIDS cases take place in Lima and Callao, which are the urban regions where one third of the population resides; added to the cases in Loreto and Arequipa, two other regions in the country with a high number of cases, these four regions contained 80% of all registered cases between 1983–2011 (Ministerio de Salud del Peru, 2012). Deaths due to AIDS have decreased from 7,922 yearly deaths in 2004 to 4,068 deaths in 2012, primarily due to the increased access to ART coverage which has increased from 12% in 2004 to 59% in 2012 (UNAIDS, 2013).

Appendix 2: Interview guide (English)

INTERVIEW GUIDE

Name _____

Institution _____

Position _____

Date of Interview _____ Place_____

Personal Information

1. Could you tell me a little about your background? (Education/training/past work)
2. What is your current position?
3. What does your organisation do?

C	**Broader context (within donor presence, national institutions and wider governance)** *1.* What is the current political/social/economic environment in Peru and its relationship to health? *2.* What was the political/social/economic environment in 2004 when the first Global Fund grant was approved? *3.* In your opinion, what is the position of health and HIV/AIDS within country/international priorities? ***4.*** Who are the main actors in HIV/AIDS in Peru, considering civil society as well as the public sector and international cooperation? ***5.*** What is CONAMUSA's role in the area of HIV/AIDS?	
B	**Country Capacity (structures and processes)** *1.* What is the situation in the regions in terms of HIV/AIDS? Are they all at the same level or do you believe there are important differences between them? *2.* What is the current relationship of the CONAMUSA with the regions?	

	3. What is the role of the COREMUSAS? *4.* How do the health programmes in the regions interact with the central HIV/AIDS programme? *5.* In your perception, what is the human resources situation in the country? *6.* Is there a difference with the human resources available in the regions? *7.* Can you tell me your main source of data on HIV/AIDS in the country?	
B	**Higher to lower dependence on external technical assistance** *1.* How often to you solicit advice from another organisation on obtaining grants or for consulting work? *2.* How do you decide which organisation to contact and what are usual mechanisms for funding this? *3.* What kind of projects is this for? *4.* How do you think the technical capacity in the country can be strengthened? *5.* What is your training for management? *6.* Do you have any examples of training programmes that exist or should exist to improve the management capacity in the country? *7.* What percentage of your time do you devote to trainings?	
A	**Activities and interventions (characteristics and changes over time)** *1.* How has the HIV/AIDS programme been effective/ineffective in reducing the prevalence of HIV/AIDS? *2.* What was your involvement during the application process for Global Fund grants? Specifically for Round 6? *3.* How were priorities chosen for grants within this committee (CONAMUSA)? *4.* How were the proposals prepared according to the chosen priorities? *5.* What was your involvement during round 6 activities? *6.* What is your perception of the success/lack thereof of the round 6 activities? *7.* Which changes have taken place since the introduction of these activities into the government budget? *8.* What could have been improved? *9.* What was done correctly? *10.* When did you find out about the alignment of round 6 activities into the National Budget? *11.* What was your contribution to the process of ensuring the alignment of these activities? *12.* Do you think this process will hinder/benefit the result of the activities? *13.* Has your interaction with the funder changed? Why? *14.* Who do you consider lead this process?	
A D	**Mechanisms/policies to promote sustainability** *1.* What is sustainability for you?	

	2. How does the government contribute to sustainable programme planning? *3.* What is the role of the regional governments with regards to sustainable planning? *4.* How do other organisations contribute to sustainable programme planning?	
D	**How do stakeholders promote sustainability** *1.* How does your organisation contribute to sustainable programme planning? *2.* What do you think is the responsibility of national and international stakeholders in ensuring sustainability of programmes?	
D	**Behaviour of different stakeholders** *1.* What do you do that you didn't do before after government involvement in the projects? *2.* What do you do to report data? *3.* Is the country prepared for an eventual Global Fund exit? *4.* What do you think will be the role of the Global Fund after this process?	
E	**Recommendations for sustainability** *1.* Are you aware of any mechanisms in place to ensure the continuity of these activities? *2.* What is the effect of these changes on the HIV/AIDS panorama in the country?	
E	**Recommendations for coordination of actors** *1.* Do you belong to any coordination committees for HIV/AIDS? *2.* What is your role within this committee? *3.* What is the future of the CONAMUSA?	

Appendix 3: Interview guide (Spanish)

GUÍA DE ENTREVISTA

Nombre _____

Institución _____

Puesto _____

Fecha _____ Lugar _____

Información Personal

1. ¿Me podría decir un poco sobre su formación? (Educación/formación/trabajo previo)
2. ¿Cuál es su puesto actual?
3. ¿Cuál es el objetivo de su organización?

C	**Contexto general (relacionado con la presencia de donantes, instituciones nacionales y gestión internacional)**

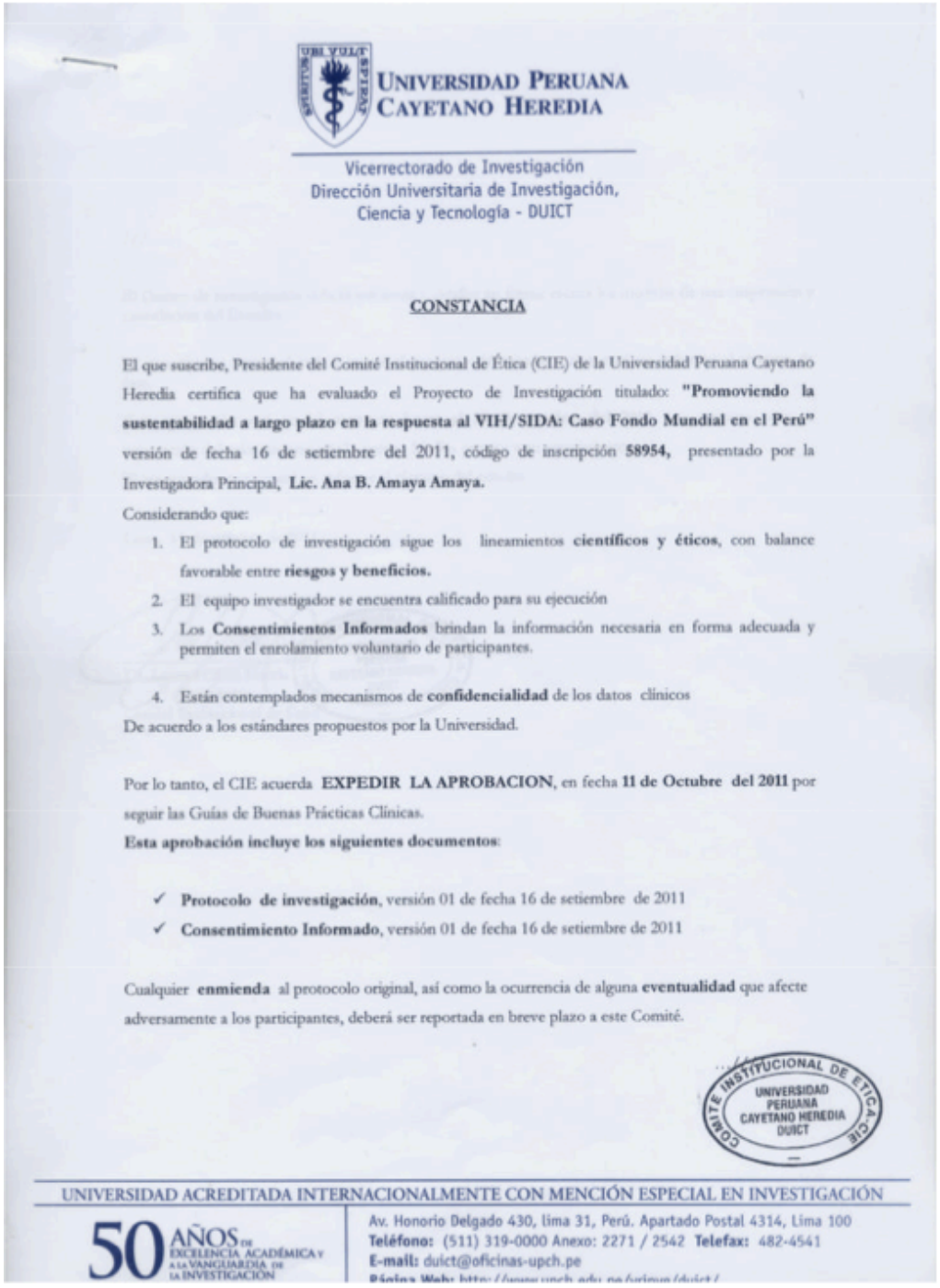
	1. ¿Cuál es el ambiente actual político/social/económico en el Perú y su relación con la salud?	
	2. ¿Cuál fue el ambiente político/social/económico en el Perú en el 2004 cuando la primera ronda del Fondo Mundial fue aprobada?	
	3. En su opinión, ¿cuál es la posición de la salud y VIH/SIDA dentro de las prioridades nacionales/internacionales?	
	4. ¿Quiénes son los principales actores para VIH/SIDA en el Perú, tomando en cuenta la sociedad civil, así como el sector público y de cooperación internacional?	
	5. ¿Cuál es el papel de la CONAMUSA en el área de VIH/SIDA?	
B	**Capacidad nacional (estructuras y procesos)**	
	1. ¿Cuál es la situación de la región en términos de VIH/SIDA? ¿Están todos al mismo nivel o piensa que existen importantes diferencias entre ellos?	
	2. ¿Cuál es la relación actual de la CONAMUSA con las regiones?	
	3. ¿Cuál es el papel de las COREMUSAS?	
	4. ¿Cómo interactúan los programas de salud de las regiones con el programa central de VIH/SIDA?	
	5. En su percepción, ¿cuál es la situación de recursos humanos en el país?	
	6. ¿Existen diferencias en los recursos humanos disponibles en las regiones?	
	7. ¿Me podría decir cuál es su fuente principal de datos de VIH/SIDA en el país?	
B	**Nivel de mayor a menor de dependencia en asistencia técnica**	

	1. ¿Cuán a menudo solicitan ayuda de otra organización sobre la obtención de fondos o para trabajos de consultoría?	
	2. ¿Cómo deciden cuál organización contactar y cuáles son los mecanismos usuales para financiar esto?	
	3. ¿Para qué tipo de proyectos son utilizados?	
	4. ¿Cómo considera que puede fortalecerse la capacidad técnica del país?	
	5. ¿Cuál es su formación en gerencia?	
	6. ¿Conoce algún ejemplo de programas de formación que existan o deberían existir para mejorar la capacidad de gestión en el país?	
	7. ¿Qué porcentaje de tiempo utilizan para entrenamientos?	
A	**Actividades e intervenciones (características y cambios en el tiempo)**	
	1. ¿Cómo ha sido el programa de VIH/SIDA efectivo/no efectivo en reducir la incidencia de VIH/SIDA?	
	2. ¿Cuál ha sido su papel durante el proceso de aplicar a fondos del Fondo Mundial? ¿Específicamente para la Ronda 6?	
	3. ¿Cómo se decidieron las prioridades para las propuestas dentro de este comité (CONAMUSA)?	
	4. ¿Cómo se prepararon las propuestas de acuerdo a las prioridades decididas?	
	5. ¿Está involucrada su organización en la ronda 6? ¿En qué actividades?	
	6. ¿Cuál es su percepción del éxito/fracaso de las actividades de la ronda 6?	
	7. ¿Cuáles cambios se han llevado a cabo desde la introducción de estas actividades al presupuesto del gobierno?	
	8. ¿Qué podría ser mejorado?	
	9. ¿Qué ha dado resultado?	
	10. ¿Cuándo le informaron del alineamiento de las actividades de la ronda 6 en el presupuesto nacional?	

	11. ¿Cuál fue su contribución al proceso de asegurar el alineamiento de estas actividades?	
	12. ¿Considera que este proceso apoyará/no apoyará el resultado de estas actividades?	
	13. ¿Han habido cambios en su interacción con la parte que provee el financiamiento? ¿Por qué?	
	14. ¿Quién considera que dirigió este proceso?	
A D	**Mecanismos/políticas para promover la sostenibilidad**	
	1. ¿Qué significa sostenibilidad para ti?	
	2. ¿Cómo contribuye el gobierno a la planificación de programas sostenibles?	
	3. ¿Cuál es el papel de los gobiernos regionales con respecto a la planificación sostenible?	
	4. ¿Cómo contribuyen otras organizaciones a la planificación de programas sostenibles?	
D	**Como promueven los interesados directos la sostenibilidad**	
	1. ¿Cómo contribuye tu organización a la planificación de programas sostenibles?	
	2. ¿Cuál consideras que es la responsabilidad de los actores internacionales en asegurar la sostenibilidad de los programas?	
D	**Comportamiento de los diferentes interesados directos**	

	1. ¿Qué haces ahora que no hacías antes/después de la participación del gobierno en los proyectos?	
	2. ¿Qué hacen para reportar datos?	
	3. ¿Está preparado el país para la salida del Fondo Mundial?	
	4. ¿Cuál consideras que será el papel del Fondo Mundial después de este proceso?	
E	**Recomendaciones hacia la sostenibilidad**	
	1. ¿Conoces de algún mecanismo para asegurar la continuidad de estas actividades?	
	2. ¿Cuál es el efecto de estos cambios en el panorama de VIH/SIDA en el país?	
E	**Recomendaciones hacia la coordinación de las diferentes partes**	
	1. ¿Perteneces a algún comité de coordinación para VIH/SIDA?	
	2. ¿Cómo cambiará la interacción entre las diferentes instancias después de la intervención del Fondo Mundial?	
	3. ¿Cuál es el futuro de la CONAMUSA?	

Appendix 4: Universidad Peruana Cayetano Heredia ethical approval



UNIVERSIDAD PERUANA CAYETANO HEREDIA

Vicerrectorado de Investigación
Dirección Universitaria de Investigación,
Ciencia y Tecnología - DUICT

CONSTANCIA

El que suscribe, Presidente del Comité Institucional de Ética (CIE) de la Universidad Peruana Cayetano Heredia certifica que ha evaluado el Proyecto de Investigación titulado: **"Promoviendo la sustentabilidad a largo plazo en la respuesta al VIH/SIDA: Caso Fondo Mundial en el Perú"** versión de fecha 16 de setiembre del 2011, código de inscripción **58954,** presentado por la Investigadora Principal, **Lic. Ana B. Amaya Amaya.**

Considerando que:

1. El protocolo de investigación sigue los lineamientos **científicos y éticos**, con balance favorable entre **riesgos y beneficios.**
2. El equipo investigador se encuentra calificado para su ejecución
3. Los **Consentimientos Informados** brindan la información necesaria en forma adecuada y permiten el enrolamiento voluntario de participantes.
4. Están contemplados mecanismos de **confidencialidad** de los datos clínicos

De acuerdo a los estándares propuestos por la Universidad.

Por lo tanto, el CIE acuerda **EXPEDIR LA APROBACION**, en fecha **11 de Octubre del 2011** por seguir las Guías de Buenas Prácticas Clínicas.

Esta aprobación incluye los siguientes documentos:

- ✓ **Protocolo de investigación**, versión 01 de fecha 16 de setiembre de 2011
- ✓ **Consentimiento Informado**, versión 01 de fecha 16 de setiembre de 2011

Cualquier **enmienda** al protocolo original, así como la ocurrencia de alguna **eventualidad** que afecte adversamente a los participantes, deberá ser reportada en breve plazo a este Comité.

COMITÉ INSTITUCIONAL DE ÉTICA CIE
UNIVERSIDAD PERUANA CAYETANO HEREDIA DUICT

UNIVERSIDAD ACREDITADA INTERNACIONALMENTE CON MENCIÓN ESPECIAL EN INVESTIGACIÓN

50 AÑOS DE EXCELENCIA ACADÉMICA Y A LA VANGUARDIA DE LA INVESTIGACIÓN

Av. Honorio Delgado 430, lima 31, Perú. Apartado Postal 4314, Lima 100
Teléfono: (511) 319-0000 Anexo: 2271 / 2542 **Telefax:** 482-4541
E-mail: duict@oficinas-upch.pe
Página Web: http://www.upch.edu.pe/vprinve/duict/

UNIVERSIDAD PERUANA CAYETANO HEREDIA

Vicerrectorado de Investigación
Dirección Universitaria de Investigación,
Ciencia y Tecnología - DUICT

///.....

El Centro de Investigación deberá informar y detallar en forma escrita los motivos de una suspensión y cancelación del Estudio.

El investigador reportará cada 6 meses el progreso del estudio y alcanzará un **informe** al término de éste.

Esta aprobación será tendrá **vigencia hasta el 10 de octubre del 2012**. Los trámites para su renovación deberán iniciarse por lo menos 30 días previos a su vencimiento.

El investigador presentará un informe al término del estudio

Lima, 11 de octubre de 2011

COMITÉ INSTITUCIONAL DE ÉTICA
UNIVERSIDAD PERUANA CAYETANO HEREDIA
DUICT

Dr. Leonid Lecca García
Presidente
Comité Institucional de Ética
/emg

Av. Honorio Delgado 430, lima 31, Perú. Apartado Postal 4314, Lima 100
Teléfono: (511) 319-0000 Anexo: 2271 / 2542 **Telefax:** 482-4541
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UNIVERSIDAD PERUANA
CAYETANO HEREDIA

Vicerrectorado de Investigación
Dirección Universitaria de Investigación,
Ciencia y Tecnología - DUICT

CONSTANCIA

El que suscribe, Presidente del Comité Institucional de Ética (CIE) de la Universidad Peruana Cayetano Heredia certifica que ha evaluado los siguientes documentos:

- ✓ **Consentimiento Informado,** Entrevista a profundidad mujeres, versión 01 de fecha 16 de setiembre del 2011

Del Proyecto de Investigación titulado: **"Promoviendo la sustentabilidad a largo plazo en la respuesta al VIH/SIDA: Caso Fondo Mundial en el Perú"** versión de fecha 27 de setiembre del 2011, código de inscripción **58954,** presentado por el Investigador Principal, **Lic. Ana B. Amaya Amaya.**

Los cuales han sido **APROBADOS**, en fecha 11 de octubre del 2011. Por ajustarse a los estándares propuestos por la Universidad

Lima, 11 de octubre de 2011

COMITÉ INSTITUCIONAL DE ÉTICA
UNIVERSIDAD PERUANA CAYETANO HEREDIA
DUICT

Dr. Leonid Lecca García
Presidente
Comité Institucional de Ética

/ermg

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Página Web: http://www.upch.edu.pe/vrinve/duict/

Appendix 5: LSHTM ethical approval

LONDON SCHOOL OF HYGIENE & TROPICAL MEDICINE

ETHICS COMMITTEE

APPROVAL FORM
Application number: **6022**

Name of Principal Investigator	**Ana B Amaya**
Faculty	**Public Health and Policy**
Head of Faculty	**Professor Richard Smith**

Title: **Aid (In)Dependence? Promoting long term sustainability in the response to HIV/AIDS – The case of the Global Fund in Peru"**

This application is approved by the Committee.

Chair of the Ethics Committee .....

Date ..7 September 2011

Approval is dependent on local ethical approval having been received.

Any subsequent changes to the application must be submitted to the Committee via an E2 amendment form.

Appendix 6: Consent form (Spanish)

CONSENTIMIENTO INFORMADO

Título del Estudio: "Promoviendo la sustentabilidad a largo plazo en la respuesta al VIH/SIDA: El caso del Fondo Mundial en el Perú"

Nombre del Investigador Principal: Ana B. Amaya Amaya

Correo electrónico: ana.amaya@lshtm.ac.uk

Teléfono: 2033300

El objetivo de este estudio de investigación es evaluar la transición de un país (Perú) de una situación de alta dependencia en financiamiento del Fondo Mundial para VIH/SIDA al rol creciente de las instituciones nacionales. Busca proporcionar recomendaciones basadas en la evidencia para informar a los interesados directos sobre áreas prioritarias que deben ser fortalecidas para un programa nacional de VIH/SIDA sostenible.

Los datos recolectados durante este estudio serán analizados e incluidos en un reporte para tesis de doctorado, así como artículos para la diseminación pública al finalizar el estudio. El estudio involucrará entrevistas y el análisis de literatura gris, así como artículos científicos.

Su participación en este estudio es importante para proporcionar su percepción sobre este proceso y su rol dentro de está transición. Se espera que esta entrevista no demorara más de dos horas.

Su participación
Su participación en este estudio es confidencial y totalmente voluntaria. La negativa para participar no involucrará ninguna multa o pérdida de beneficios. Así mismo, usted puede retirarse de este estudio cuando lo desee sin multa o pérdida de beneficios. Si accede a participar en este estudio, además de las observaciones generales, será invitado a participar en una entrevista para explorar su punto de vista en mayor detalle. Si usted lo permite, la entrevista puede ser grabada. No se prevé ningún riesgo o incomodidad producto de su participación en este estudio.

Como se asegurará la confidencialidad
Las transcripciones de las entrevistas solamente serán accesibles a la investigadora principal. La información obtenida por medio de entrevistas y observación será usada en forma agregada. Cuando se utilicen citas, ninguna referencia se incluirá de su nombre, edad, género o título de trabajo y toda cita textual solamente será incluida después de su consentimiento. Todas las transcripciones estarán bajo el control de la investigadora principal en un archivo seguro por la duración de la candidatura a doctorado. Luego de este período serán destruidas. No hay compensación económica por participar en este estudio.

Por favor no dude en contactar a la investigadora principal Ana Amaya (01-203-3300, Av. Amendariz 445, Lima 18, Perú) de tener alguna pregunta con respecto a la investigación y a sus derechos como participante en la investigación. También puede contactar a la DUICT (01-319-0000 anexo 2271) de tener alguna duda sobre sus derechos como participante en la investigación.

Participante:

_____(firma y nombre) _____(fecha)

Entrevistador:

_____(firma y nombre) _____ (fecha)

16 de Septiembre, 2011 Versión 01 (final)

Appendix 7: Consent form (English)

CONSENT FORM

Title:	**Aid (In)Dependence? Promoting long term sustainability in the response to HIV/AIDS – The Case of the Global Fund in Peru**
Principal Investigator	Ana B. Amaya Amaya
Email Address:	ana.amaya@lshtm.ac.uk
Telephone	+447587225794

You are being asked to take part in the above-mentioned research study. To join the study is voluntary. It is important that you understand this information so that you can make an informed choice about being in this research study. You have the right to ask, and have answered, any questions you may have about this research.

The purpose of this form is to allow for the use of your interview for research studies. Please fill in the form according to your wishes.

Please feel free to contact the main researcher if you have any concerns or further questions about the research.

Participant's Agreement

- I have read the information provided about this study and I understand what will be required of me.
- My questions concerning this study have been answered by the Principal Investigator.
- I understand that at any time I may withdraw from this study without giving a reason.
- I voluntarily agree to participate in this study.

I do / do not agree to participate in the study

_____(signed)

I do / do not agree for this interview to be tape recorded.

_____(signed)

I do / do not agree that the **name of the organisation** I represent is disclosed in the study report (but not my name)

_____(signed)

I do / do not agree that **the type of organisation** I represent (e.g. donor, NGO, government) is disclosed in the study report (but not my name or the name of the organisation)

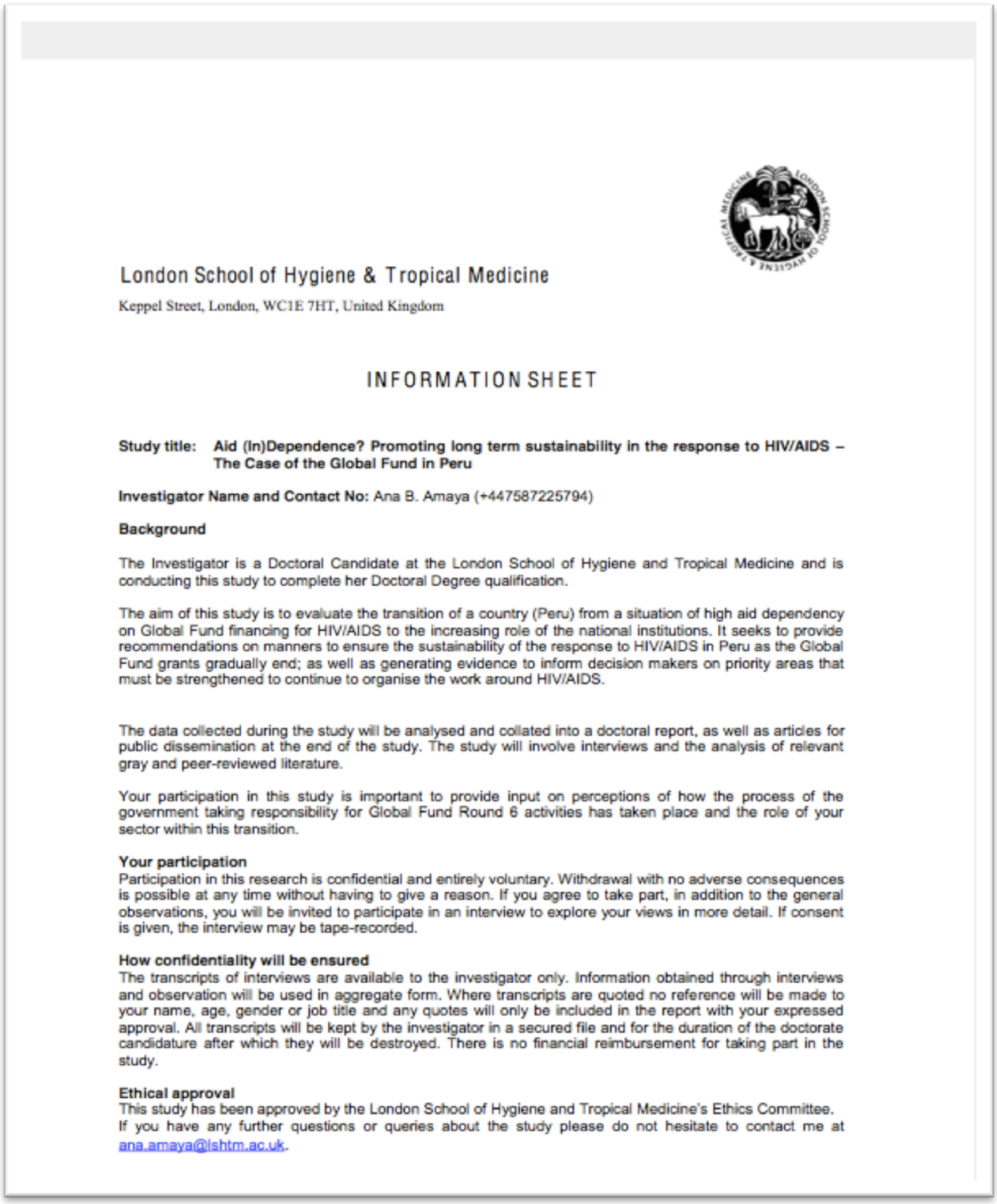
_____(signed)

I do / do not agree to quotes or other results arising from my participation in the study being included, even anonymously in any reports about the study

_____(signed)

Date _____

Appendix 8: Information sheet



London School of Hygiene & Tropical Medicine

Keppel Street, London, WC1E 7HT, United Kingdom

INFORMATION SHEET

Study title: **Aid (In)Dependence? Promoting long term sustainability in the response to HIV/AIDS – The Case of the Global Fund in Peru**

Investigator Name and Contact No: Ana B. Amaya (+447587225794)

Background

The Investigator is a Doctoral Candidate at the London School of Hygiene and Tropical Medicine and is conducting this study to complete her Doctoral Degree qualification.

The aim of this study is to evaluate the transition of a country (Peru) from a situation of high aid dependency on Global Fund financing for HIV/AIDS to the increasing role of the national institutions. It seeks to provide recommendations on manners to ensure the sustainability of the response to HIV/AIDS in Peru as the Global Fund grants gradually end; as well as generating evidence to inform decision makers on priority areas that must be strengthened to continue to organise the work around HIV/AIDS.

The data collected during the study will be analysed and collated into a doctoral report, as well as articles for public dissemination at the end of the study. The study will involve interviews and the analysis of relevant gray and peer-reviewed literature.

Your participation in this study is important to provide input on perceptions of how the process of the government taking responsibility for Global Fund Round 6 activities has taken place and the role of your sector within this transition.

Your participation

Participation in this research is confidential and entirely voluntary. Withdrawal with no adverse consequences is possible at any time without having to give a reason. If you agree to take part, in addition to the general observations, you will be invited to participate in an interview to explore your views in more detail. If consent is given, the interview may be tape-recorded.

How confidentiality will be ensured

The transcripts of interviews are available to the investigator only. Information obtained through interviews and observation will be used in aggregate form. Where transcripts are quoted no reference will be made to your name, age, gender or job title and any quotes will only be included in the report with your expressed approval. All transcripts will be kept by the investigator in a secured file and for the duration of the doctorate candidature after which they will be destroyed. There is no financial reimbursement for taking part in the study.

Ethical approval

This study has been approved by the London School of Hygiene and Tropical Medicine's Ethics Committee. If you have any further questions or queries about the study please do not hesitate to contact me at ana.amaya@lshtm.ac.uk.