

Regional HIV-Related Policy Processes in Peru in the Context of the Peruvian National Decentralization Plan and Global Fund Support: Peru GHIN Study

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The implementation of large projects such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) represents a very significant investment in HIV/AIDS in Peru and a challenge to the administrative capacity of the country. To develop and implement the GFATM projects successfully requires new relationships between the public sector, civil society organizations, and vulnerable groups; however the analysis of these relationships and their impact on HIV/AIDS-related sustainable policies and policy changes is still pending. The objective of this paper is to explore the challenges that the national process of state decentralization in Peru presents to the constitution of regional multisectoral HIV-related coordination mechanisms (COREMUSAs) promoted by the GFATM and vice versa. With respect to HIV/AIDS-related policy, decentralization processes need to be strengthened and responsibilities and attributions of both national and regional government levels must be clearly defined. In those cases in which regional governments and civil society organizations were already active and organized, GFATM initiatives have generally helped to consolidate those processes. However when regional institutions were weak, GFATM projects did not trigger such processes.

INTRODUCTION

Since its inception in 2001 in response to the UNGASS Declaration of Commitment¹, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), together with other global HIV/AIDS initiatives such as the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the World Bank's Multi-Country AIDS Program, has dramatically increased resource allocation for HIV prevention and care in lower and middle-income countries.² In Peru, it has funded three proposals (Round two, five and six from 2003-2011) to work on HIV/AIDS initiatives, with a contribution of approximately US\$ 77 million. The implementation of these large projects represents a very significant investment in HIV/AIDS in Peru and a challenge to the administrative capacity of the country. It has already had and will continue to have an impact on the relationship between the organization of the response to the epidemic, the redistribution of public resources, and the quality of care offered to people living with HIV/AIDS.

Previous studies have shown that new relationships between the public sector, civil society organizations and vulnerable groups are required to develop and implement the GFATM projects.^{3 4} To better understand these relationships and their impact on HIV-related sustainable policies and policy changes, further inquiry into the challenges that the national process of state decentralization

presents to the constitution of regional multisectoral HIV-related coordination mechanisms (*COREMUSAs*) promoted by the GFATM and *vice versa* was necessary.

One of the key discussions around global HIV/AIDS initiatives is the extent to which the support they provide strengthens rather than weakens health systems.⁵ The aim of this study is to analyze the effects of elaboration and implementation of GFATM-funded projects on HIV-related policy and program formulation within the context of the Peruvian decentralization process and to ascertain whether both processes show synergies or conversely, remain disconnected or even antagonistic.

GLOBAL FUND MANDATES AND IMPLEMENTATION PROCESSES

The Global Fund model finances programs developed by the recipient countries that are line with national strategic health plans and priorities. The Fund's requirement that all areas of society with a stake in public health be involved in the proposal development process, including civil society and the private sector, ensures strong and comprehensive programs.⁶ However in practice, the extent to which this has occurred varies widely.

GFATM support has resulted in a range of different types of effects on health systems. Most studies have focused on the national level, where GFATM effects are initially felt, and most progress in aligning with national joint strategic planning processes has been achieved.⁷ Yet, there is little empirical evidence regarding effects at the district, facility and community levels within the health system and throughout other public sector systems.

Studies in Benin, Ethiopia and Malawi provide some evidence of GFATM processes contributing to both strengthening and exacerbating weaknesses of health systems depending on the country context, and the planning and implementation strategies adopted.⁸ Although global health initiatives did not initially consider health systems strengthening to be part of their mandate, they are now more willing to address system weaknesses that have been revealed through project implementation.⁹

The planning processes which countries have adopted to apply for and implement GFATM support appear highly centralized, even in rather decentralized contexts such as Malawi and Peru. A consequence of this leads to problems at the implementation stage due to lack of ownership at sub-national levels. Malawi, for example, benefited from an extensive national planning process that occurred prior to the initial GFATM call for proposals, and had involved sub-national stakeholders.¹⁰ In Peru the decentralization process began in 2004 when the first GFATM proposal was already being implemented.

GFATM guidelines do not stipulate what role sub-national actors should play in developing or implementing GFATM proposals. This has led to problems as countries begin to implement GFATM -supported activities. In some cases, the GFATM work plans did not always match the regional priorities or needs.

Nevertheless regions were asked to implement additional activities with no additional support or budget provided for overall management.¹¹

While previous research has raised concerns about the alignment of GFATM processes with decentralized decision-making structures in-country, the demand for rapid outcomes – in terms of proposal development, program planning, and implementation – can easily undermine fragile decentralization processes as it is simply much quicker to centralize decision making. Furthermore the GFATM does not have any specific procedures or requirements that counter this tendency; for example, there is no requirement that actors from regional and district levels are included in the Country Coordinating Mechanisms (CCM). Finally, the diseases-specific nature of GFATM support may also reinforce a shift towards greater centralization: whereas regional and district health services are clearly responsible for the planning and implementation of the full range of health services provided within their region, Principal Receptors of GFATM grants are often heads of national disease control programs.¹²

In an effort to remain consistent with its own decentralization process, in Peru, the CCM has developed a number of features not seen elsewhere. The CCM has evolved a layered approach that includes the CCM or the National Multisectoral Coordination Mechanisms of Peru and several sub-groups known as COREMUSAs which are more regional level, multisectoral coordination mechanisms for HIV/AIDS, and TB.

THE STATE DECENTRALIZATION PROCESS IN PERU

According to the 2002 Framework Law for Decentralization,¹³ decentralization in Peru aims to achieve the country's comprehensive, harmonious, and sustainable development through the distribution of competencies and functions, and the balanced exercise of power among the three levels of government (National, Regional and Local) that benefit and include the participation of the population.

The decentralization model in place acknowledges the administrative, economic, productive, financial, revenue collection and fiscal dimensions that need to be distributed and shared among different governmental levels. The implementation of the current decentralization process¹⁴ began in 2004 focusing mostly on mechanisms for transferring administrative and managerial competencies to regional and local governments. Some ministries more proactively than others also began to define and plan their sector-specific decentralization plan and processes.

Within the health sector, the Ministry of Health (MINSA) began its decentralization process in 2005 based on a concerted plan¹⁵ for the progressive transfer of functions to regional and local governments. According to this plan, the Ministry of Health led a national consultation process for the formulation of the 2007–2011 National Concerted Plan that would include national as well as regional health priorities. Prior to the decentralization law, the Ministry of Health already administered an extended network of 7027 public health facilities in the country.

Health services facilities, classified in three levels according to the level of complexity of the health services they provide, were finally linked to a Regional Directorate of Health (DIRESA). Each DIRESA reported directly to the Central Ministry of Health Offices with no coordination/ communication with the regional government.

Once the decentralization process began, a significant step forward by MINSA has been the transfer of 124 functions and the incorporation of DIRESAs within the regional and local governments' administrative structure. Although this is the case for three regions in this study, the cases of Lima City (the capital of the country, and also of the region) and Callao are distinct because of their closeness to the central government. DIRESA Callao depended financially and politically on the national MINSA budget and was unable to accept new responsibilities without accompanying resources until 2008. Lima City still depends on MINSA.

From a political standpoint, the decentralization process is also concerned with democratization and social inclusion to increase citizens' participation in decision making and management of public affairs at local and regional levels.¹⁶ Thus, decentralization policies identify, among others, two mechanisms to allow for civil society organizations' active participation within the decision making process: Concerted Regional Development Plans (Planes de Desarrollo Regional Concertado) and Participatory Budgeting (Presupuestos Participativos).

The Concerted Regional Development Plans define strategic priorities for each region. According to Law 27902 and Law 27867, they are meant to become the main managerial and administrative instrument for medium- and long-term development of each region.¹⁷ They are expected to synthesize the results of a participatory and multisectoral analysis of the region's situation, and to propose a prioritized agenda to channel regional investment and expenses.

Once a plan is approved by local and regional participants, it will be the basis for the foundation of the participatory budget. The participatory budgeting process also implies analysis and priority-setting across all the plan's objectives to identify those that will be implemented with regional funds. Importantly, the regional budget is finalized and approved later by the regional government technical team and representatives of the Ministry of Economy and Finance based on the participatory budgeting results and historical records of the region's budgets. Hence, activities included in the Concerted Regional Development Plan and the Participatory Budget will be the ones with best opportunities to receive funding for implementation. Therefore, a good measure of regional acknowledgement of the epidemic and willingness to respond will be the existence of indicators related to HIV-related activities in the regional budget.

THE COUNTRY AND REGIONAL COORDINATION MECHANISMS (CONAMUSA AND COREMUSAS)

One of the objectives of the GFATM is to promote wider participation from civil society actors at national, regional and local levels and to increase the state's

accountability and commitment to ensure sustainable funding of HIV/AIDS treatment and other related initiatives.¹⁸ This became evident soon after the failed attempt by MINSA to get funding for the proposal submitted to the 1st round of funding. The GFATM made it clear that MINSA needed to summon other state ministries, representatives of civil society organizations, religious institutions, international cooperation agencies, NGOs and representatives of vulnerable populations to constitute the CCM (called CONAMUSA in Peru) to fulfill GFATM criteria of multisectorality.

In 2004, CONAMUSA officially became a consulting body to inform and coordinate the development of grant proposals, policy implementation, and program supervision under the technical and operational guidance of the Ministry of Health. All subsequent proposals to the GFATM were formally submitted by CONAMUSA, which to some extent allowed for the strengthening of its articulating role, the opportunity to change the way HIV/AIDS policies are conceived and planned, and the chance to develop a more participatory and inclusive governance space.

As one of its first tasks, CONAMUSA led the process of formulating the 2007-2011 HIV/AIDS Multisectoral Strategic Plan (PEM, Plan Estratégico Multisectoral) to set the objectives, strategies and goals in the fight against HIV. Later, this plan became part of MINSA's National Concerted Plan. In the context of a national decentralization process, the PEM identified two key institutions responsible in 2006 for the regional response to HIV/AIDS: the regional government – formally instituted by the Peruvian Constitution and the Decentralization Law- and the regional HIV/AIDS coordination mechanisms (COREMUSAs) – promoted by GFATM policies and included in the Peruvian Global Fund Projects Implementation.

The recently autonomous regional governments are therefore expected to perform roles and functions such as regional planning, intersectoral coordination, and educational and health care facilities management, and to provide the organizational structure needed for their plan's development.

The development of COREMUSAs has been uneven, depending greatly on the characteristics and stages of the decentralization process in each region and the articulation of other actors involved. Only the project funded in the 6th GFATM Round provided tools and resources to promote participation of COREMUSAs on the formulation and implementation of regional planning processes in the five regions studied, and to strengthen the capacities of affected populations and vulnerable communities to participate on the COREMUSAs.

MAIN RESEARCH QUESTION

The inclusion or omission of HIV-related activities in the Concerted Regional Development Plans and other policy documents of the five regions were analyzed considering the stages and actors involved in the policy formulation process. Since core perspectives on policy and systems research agree that the quality of and

access to information for decision making determines the soundness of problem identification, agenda setting, policy definition and implementation^{19,20} and that a wider representation of state and civil society institutions increases policy acceptance, institutional commitment and sustainability.²¹ The participation of social and political actors is identified at three levels within the policy formulation process: a) situational assessment and problem identification; b) goal and agenda setting; and c) incorporation of programs, projects or activities within the Concerted Regional Development Plan and their potential for implementation.

METHODS

This study is part of a wider study to analyze the effects of HIV-related collaboration between the Global Fund and the Peruvian State, civil society organizations and involved populations, on the effectiveness, accountability and sustainability of the national response to HIV/AIDS. Data collection was conducted in five different geopolitical regions: Lima, Callao, Loreto, Arequipa and Lambayeque. These regions were selected from the 26 in Peru to represent contexts of diverse geography, culture, HIV/AIDS prevalence, progress of decentralization in their regional governments, and cultural and political significance of HIV/AIDS. In all of them at least one HIV-focused project funded by GFATM was locally active.

The regions of Lima (the metropolitan capital) and Callao (the neighboring port), account for 73% of AIDS cases reported over the past 25 years in Peru. By 2009, the Ministry of Health's Epidemiology Directorate reported that other regions with high HIV incidence include Loreto, La Libertad, Ica, Tumbes and Arequipa.

Peru is frequently characterized by its so-called 'natural regions': the coast, the Andean highlands and the Amazon rainforest, each geographically and culturally distinct. From the Amazonian rainforest, Loreto was selected because, in addition to its high HIV incidence, it hosts the main fluvial port in the country with important military and commercial activity, and shows an early multisectoral response to the epidemic. From the southern Andean highlands, Arequipa was chosen because it simultaneously demonstrates one of the highest HIV incidences and very little political commitment to fight the epidemic. Finally, from the northern coast Lambayeque was chosen because of the higher concentration of the epidemic in that geographical area as well as its early political response to the epidemic – which preceded the implementation of GFATM projects, and its advanced decentralization process.

Data were collected through semi-structured interviews with regional and national political leaders, regional and local health sector authorities and professionals, representatives of civil society organizations, and affected populations. Additionally, an analysis of regional policy documents and relevant legislation was completed in order to identify the presence or absence of HIV/AIDS initiatives in each region.

FINDINGS

Assessment Data and Problem Identification

Most of the information available regarding HIV is based on the official epidemiological surveillance system and, for Lambayeque and Loreto, other sentinel studies, all of which mainly report health services performance and STI / HIV prevalence rates.²² Additional regional studies conducted to support intervention plans have been promoted by NGOs or international cooperation agencies without active participation of regional governments.

In Lambayeque interviewees²³ showed concern for the lack of studies to identify social determinants and other non-epidemiological factors associated with HIV that are relevant to prevention initiatives. This information gap is also aggravated by the disproportionate number of studies conducted on urban areas and by the design of programs and interventions from Lima. In Loreto for example, the chief of the DIRESA explained that some cultural and social practices in its region are so different from other regions that “the interventions designed and recommended by the National MINSA STS/HIV Strategy (for implementation elsewhere) are impossible to implement and become inapplicable”.²⁴

Although in regions like Loreto, GFATM projects have included funds for baseline studies to learn more about epidemic characteristics,²⁵ the information is usually not available in time for planning purposes. Some of the interviewees in Lambayeque revealed that the GFATM projects require inclusion of social organizations within the COREMUSA and as sub-recipient agents to implement the projects, but their participation in both governmental and non-governmental projects limited their autonomy and time to produce qualitative information relevant for policy making.

Lima and Callao are different from other regions because of their closeness to the national government and their historic accumulation of resources (financial, technical, educational, and structural) and political power. Moreover, the two regions account for over 70% of HIV cases registered in the country, and therefore had the highest volume of HIV data.

As a result, most of the evidence base for the proposals submitted to the GFATM and the national multisectoral plan was generated with a focus on the epidemic in Lima and Callao, its population and the resources available.

National and Regional Agenda Setting

The analysis of four Concerted Regional Development Plans (Arequipa, Callao, Loreto and Lambayeque) shows that such plans may be failing to ensure a well-organized response to the epidemic as part of their agenda, which would indicate the inadequacy of efforts by the Ministry of Health, NGOs, and civil society organizations to promote this inclusion. Alternatively it could be argued that

despite these efforts, in most regions HIV, alongside other health problems, is not recognized as a health or political priority for decision makers; or that the active presence of the Regional Directorates of Health continues to be identified with the central Ministry of Health rather than as part of the Regional Governments. This suggests that the decentralization process needs to be strengthened to avoid parallel structures and miscommunication.

In the case of Lambayeque,^{26,27} despite several attempts, none of the policy documents reviewed prioritized activities related to the HIV epidemic. Partial explanations can be found in the lack of regional technical capacity to identify strategies for positioning this issue on the agenda; or the limited availability and reduced number of researchers and activists able to participate in either the COREMUSA as required by the GFATM, the regional government participatory spaces, or both.

The cases of Arequipa²⁸⁻²⁹ and Lima differ in the sense that, while they do have their COREMUSAs, their members have not participated in any of the decentralized processes organized by the respective regional governments. These have resulted in very general formulae for “implementation of the Multisectoral Strategic Plan” and “strengthening of the epidemiological surveillance of STI and HIV and AIDS” in their regional plans, which leave many practical gaps unresolved. In these regions, despite the fact that interviewees recognized the importance of fighting the epidemic at a discursive level, no progress has been made yet to allow this inclusion and articulation at a programmatic level.

Conversely, Lambayeque and Callao³⁰ have made significant efforts to include the response to the epidemic in their Concerted Development Plan. This attempt has been more explicit in Callao, where concrete items have been included at the level of specific objectives and activities for the medium-term strengthening of the HIV intervention strategy.

The case of Loreto is peculiar because the regional government is playing a key in articulating the role among different sectors at the COREMUSA. In 2007, the formulation of a regional multisectoral strategic plan for Loreto³¹ was initiated through a participatory process. It included “regional HIV policy guidelines on HIV”, universal access to comprehensive prevention and care services, health promotion, and protection against discrimination based on HIV status or sexual orientation.

Despite the different levels of articulation attempted between regional governments and COREMUSAs (with the exception of Callao and Loreto) in the last few years none have been able to incorporate initiatives against HIV as a high priority in their regional multisectoral strategic plans. Interestingly Callao and Loreto, who show more advanced policies and specific plans, have reached this point due to the leadership and commitment of their regional governments, which were influenced by regional social movements and not directly related to COREMUSA advocacy.

Resource Allocation for Implementation

The few regions that have succeeded in incorporating the response to HIV in their Regional Development Plans have faced difficulties trying to include the few activities proposed in the Regional Participatory Budgets. In most cases, health projects are related to improvements in local infrastructure and quality of the health care services which for the most part can be associated with the care of people affected by the disease. In Arequipa and Loreto, the National Budget Allocation System (SNIP) criteria and procedures imposed by the Ministry of Finance are identified as obstacles for efficient implementation of activities included in their own Regional Development Plans.

Even in the Callao region in which the epidemic is identified as a soaring health priority, no entry has been allocated for HIV/AIDS-related activities in the Participatory Budget. This could be explained in part by the state of the decentralization process at the financial level. While the decentralization process promotes some regional autonomy to allocate resources through the Participatory Budgeting, the final decision continues to be made by the Ministry of Finance technocrats who prioritize infrastructural expending. Not surprisingly, regional public budgets have so far allocated very limited resources to indirect HIV-related activities.

Social and Political Actors

The Lambayeque and Loreto cases represent distinct contexts for the constitution of their COREMUSA and multisectoral participation in the fight against HIV. Previous participatory experiences in Lambayeque had incorporated vulnerable and affected populations as well as other civil society organizations, researchers, NGOs, and regional public health institutions in what was called Mesa de Concertación contra el VIH y SIDA (Mechanism for consensus-building in the fight against HIV) to identify and prioritize actions to enhance prevention, and confront discrimination and violence from health and police personnel. As a result of this, the political will of the regional government, and pressure from people living with HIV, an active multisectoral body was formed prior to the arrival of GFATM projects.³²

As for Loreto, the constitution of the *Red Sida Loreto* in 2003 and support received through activities implemented by the GFATM-funded projects, facilitated the incorporation of the health and education sectors, the Armed Forces and Police Committee for HIV Prevention and Control (COPRECOS), civil society organizations and representatives of people living with HIV and AIDS in its COREMUSA. Later on, the commitment of Loreto with the decentralization process motivated the creation of local branches of COREMUSA. Consequently, COREMUSAs in regions such as Lambayeque and Loreto have made important contributions to developing a regional multisectoral strategic plan involving many

regional players with an important and active presence of the Regional Government.

Despite the aim to incorporate broader social participation in policy formulation and decision making, civil society representatives are more critical of those processes. For example, while the multisectoral strategic plan was widely approved at a National Consultation Forum, many stakeholders consider that it was for the most part formulated by consultants from the Ministry of Health with input from only 4 regions.

To strengthen regional participation and COREMUSAs, and to contribute to the decentralization process, objectives 4.1 and 4.2 of the 6th round project sought the integration of the Multisectoral Strategic Plan within the Regional Annual Strategic Plans, thereby trying to articulate the national health objectives and the regional priorities. Implementation of these objectives was assigned to the MINSA's National HIV/STI Sanitary Strategy which, together with CONAMUSA, decided to skip the longer yet more legitimate process of formulating Regional Multisectoral Strategic Plans and asked the regions to develop Annual Operations Plans, in an attempt to facilitate the on-site implementation of already approved GFATM projects. Regional discontent was expressed through including the formulation of Regional Multisectoral Strategic Plans within their regional POAs.

While the 6th Round project proposed strategies seeking to promote greater participation of regional actors at the policy formulation and implementation levels, once in place, regional actors' participation was limited to the completion of activities without regional managerial provisions. In Lima, where CONAMUSA is located, the creation of a COREMUSA in 2005 resulted from an attempt to meet GFATM requirements and not of a regional process.³³ Although it has developed few actions according to its own regional plan, all of them are implemented by national public health institutions and the municipal government, with very limited participation of other social and public sectors.

The interviewees in Arequipa, Lima and Callao also expressed that the Regional Multisectoral Strategic Plans are still limited instruments not reflecting the extent of the regional problems and needs. Furthermore, interviewees from regional public institutions considered that there is a mismatch between the formal local and regional mechanisms to develop plans, assume responsibilities, and include activities in their regional and institutional budgets, and the processes followed to formulate the National Multisectoral Strategic Plan and prepare the 6th Round proposal.

Sustainability of GFATM-funded Activities

When assessing the sustainability of actions initiated with the support of the GFATM in the context of the decentralization process, one of the main concerns is the heterogeneous administrative and political capacity of regional governments. While decentralization's legislation and implementation is mostly concerned with the progressive development of regional capacities and transfer of resources, the

implementation of GFATM projects appears to operate on tight time frameworks, leading to the contract of independent institutional consortia that fail to harmonize their activities with the regional plan, and to share with the regional government the lessons learned from implementation and evaluation needed for sustainability in the future.

In addition to the weak financial commitment from regional governments to continue the programs initiated, the construction of administrative, managerial and political capacities among social and governmental institutions, both local and regional, still needs to be achieved.

In Lambayeque for example, there is no reference in the regional budget to ensure continuity of any of the GFTAM initiatives. Although the COREMUSAs studied are constituted, and in most cases headed, by regional government and DIRESA representatives, they have been overwhelmed with the implementation of GFATM projects and have not been able to harmonize their objectives and functions with the regional plans or the government structure. Interviewees from Loreto also express regret that the implementation of GFATM projects has hindered opportunities to analyze, supervise, and evaluate the experience of the COREMUSA as a newly developed multisectoral space.³⁴

DISCUSSION

In terms of the information and data regionally available, significant efforts from NGOs, cooperation agencies, and academia have been made to collect data that could be important in the design of regional responses to the epidemic. However, such studies have had little influence in the formulation of strategies for intervention at the regional level. For the most part, interventions are based on epidemiologic data centrally produced by the national-level General Directorate of Epidemiology.

As for HIV-related policy, the decentralization processes need to be strengthened (including CONAMUSA's own decentralization process), and responsibilities and attributions of both national and regional governments need to be defined. Participation channels of civil society institutions and community actors must be established. At one level, regional governments need to incorporate DIRESAs and other state institutions within their administrative and managerial structure, while at another level, they have to negotiate with the national government for the political, administrative and financial autonomy they need to be able to develop and implement their plans.

While Peru's policy documents allocate substantial decision-making powers to decentralized actors at the regional level, as the broader decentralization literature suggests, those powers are often contentious and contested particularly by those actors whose power it diminishes.³⁵ Since the regional government budgets still need to be approved by the national government, and the processes followed by both levels to prioritize activities are not completely compatible, financial dependence clearly means this is most difficult to achieve.

A strong limitation of the COREMUSA is also the lack of access to resources to ensure its smooth and autonomous operation. As several interviewees have pointed out, this financial limitation and the role assumed by the regional government have influenced the balance between technical and political priorities and autonomy achieved by the COREMUSA.

At the national level, CONAMUSA is still reluctant to more actively include its regional counterparts. This is particularly evident in regional perspectives about the project funded in the 6th GFATM Financing Round: it seems that, among those responsible for the proposal, legitimacy was established by the fact that it was based on the Multisectoral Strategic Plan in whose formulation and approval the regions participated. Regional informants, however, establish that regional participation in the project formulation was needed as well. Some try to further explain the centralized project formulation based on the equally centralized administrative structures still present, the concentration of qualified professionals in the capital city, and the short timeframe established by GFATM procedures.

In Lambayeque and Loreto the COREMUSAs, as spaces representing civil society organizations and the state, have demonstrated that participation of regional governments can become very significant, and that such participation increases the likelihood of incorporation of the HIV response into regional plans.

The potential of COREMUSAs as a multisectoral space to articulate the regional HIV response is widely recognized. The incorporation of regional actors and responses to fight HIV/AIDS would allow integrating GFATM initiatives into their own broader health, educational and social plans, promoting ownership and sustainability over time, even if GFATM projects discontinue.

As we demonstrate here, however, their development and strengthening need to be consistent with regional governments' frameworks and procedures. COREMUSAs' lack of a free-standing legal status and financial autonomy is a limitation that threatens their sustainability and capacity to build a strong space from where to negotiate with the regional government. Indeed, the response to the epidemic, particularly as expressed in Global Fund projects, has little or no linkages with the regional management tools. The decentralization process is probably still very incipient and actors involved from both public and private institutions ignore the strategic importance of managerial and political collaboration for the long term impact of their activities in the fight against HIV/AIDS.

Depending on the stage and strength of the decentralization process in each region, the GFATM projects have contributed to the regional governments' assumption of new responsibilities in the response to the epidemic. In those cases in which the regional governments and civil society organizations were already active and organized, GFATM initiatives have generally helped to consolidate those processes. But where regional institutions were weak, GFATM projects did not trigger such processes.

GFATM guidelines should propose and stipulate what role sub-national level actors should play in developing and implementing GFATM proposals. Procedures

to incorporate their initiatives and participation should also be clearly defined to ensure projects actually incorporate and respond to national and local needs and expectations of public, private and civil society actors involved. The Peruvian initiative to constitute COREMUSAs is the first step in this direction.

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- ²⁴Interview with the Director of the Regional Directorate of Health in Loreto.
- ²⁵See for example: Ferrando, Alicia, and Carlos Manrique de Lara. *Línea de base y final en 46 localidades rurales y 18 centros educativos del proyecto. Espaciamiento óptimo de nacimientos en Loreto. Opiniones y actitudes en comunidades en Loreto, Perú*. Pathfinder International, 2004.
- ²⁶Gobierno Regional de Lambayeque. "Plan Regional Concertado Lambayeque 2010." 2006.
- ²⁷Dirección Regional de Salud de Lambayeque. "Plan Operativo Institucional 2008." Chiclayo, 2007.
- ²⁸Gobierno Regional de Arequipa. "Plan Estratégico de Desarrollo Regional Concertado 2003-2011." 2003.
- ²⁹Gobierno Regional de Arequipa. "Plan Regional de Salud Arequipa 2008-2015." 2007.
- ³⁰Gobierno Regional del Callao. "Plan de Desarrollo Concertado Región Callao 2003-2011." 2003.
- ³¹COREMUSA Loreto, DIRESA Loreto. *Plan Estratégico Multisectorial Regional de Loreto 2008-2012*. Loreto, 2007.
- ³²Interview with the President of the region, and the President of COREMUSA and Manager of Social Development in the regional government.
- ³³Interview with COREMUSA Lima representative.
- ³⁴Interviews with Coordinator of *Estrategia Sanitaria ITS VIH/SIDA* in Loreto, member of the ART team at the Hospital Las Mercedes in Lambayeque, officials at the DIRESA in Lambayeque.
- ³⁵Brinkerhoff, D and Leighton, C. *Decentralization and Health Sector Reform. Insights for Implementers series*. Bethesda, MD: Partners for Health Reformplus, Abt Associates Inc., 2002.