Country Case Study: Peru

May 2019
Peru is an upper middle-income country that has made significant progress toward MDG targets.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2000</th>
<th>2016</th>
</tr>
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<tbody>
<tr>
<td>Population</td>
<td>25,914,879</td>
<td>32,165,485</td>
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<tr>
<td></td>
<td><em>Urban 73%</em></td>
<td><em>Urban 78%</em></td>
</tr>
<tr>
<td></td>
<td><em>Rural 27%</em></td>
<td><em>Rural 22%</em></td>
</tr>
<tr>
<td>GDP per capita</td>
<td>$1,997</td>
<td>$6,572</td>
</tr>
<tr>
<td>Life expectancy</td>
<td>70.5</td>
<td>75</td>
</tr>
<tr>
<td>Maternal Mortality Ratio</td>
<td>140 per 100,000 live births</td>
<td>68 per 100,000 live births</td>
</tr>
<tr>
<td>Under-5 Mortality Rate</td>
<td>38.7 per 1,000 live births</td>
<td>15.5 per 1,000 live births</td>
</tr>
<tr>
<td>Prevalence of stunting (% of children &lt;5)</td>
<td>31.3%</td>
<td>13.1%</td>
</tr>
<tr>
<td>Total Fertility Rate</td>
<td>2.9</td>
<td>2.4</td>
</tr>
</tbody>
</table>

Source: World Bank Data, 2019
Health expenditure (as % of GDP) has increased since 2000, but still remains under the regional average (7%).

Source: World Bank Data, 2019
Until recently, Peru was one of the few countries in Latin America facing a critical health workforce shortage.

<table>
<thead>
<tr>
<th>Health Worker Density (per 10,000 population)</th>
<th>Year 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total health workers</td>
<td>31.9</td>
</tr>
<tr>
<td>Medical doctors</td>
<td>12.8</td>
</tr>
<tr>
<td>Nursing personnel</td>
<td>14.1</td>
</tr>
<tr>
<td>Midwifery personnel</td>
<td>5.0</td>
</tr>
<tr>
<td>Total Community Health Agents (CHAs)</td>
<td>34,801</td>
</tr>
</tbody>
</table>

However, Peru’s health workforce is not evenly distributed across regional departments, and a lack of incentive structures has led to little retention of training health professionals within the public sector (75% of professionals who conclude the SERUMS Rural Internship Program migrate to other sectors).

3 out of 25 departments still have yet to meet the target threshold for health worker density (22.8 per 10,000).

Source: DIGEP/MINSA, 2017; DGPS/MINSA, 2013
Peru’s health system is fragmented between public and private sub-sectors. In 2016, 75.8% of Peru’s population was insured.

### Health Insurance Coverage (% of total population)

- **Comprehensive Health Insurance (SIS)**
  - **Type:** Subsidized / semi-contributory
  - **Beneficiaries:** Poor and workers in the informal sector (47% of total population)
  - **Finances:** Public treasury funds and payroll contributions (3%)
  - **Facilities:** EESS of MINSA / DIRESAs
  - **Coverage:** 47%

- **EsSalud**
  - **Type:** Contributory / social security
  - **Beneficiaries:** Formal employees and their dependents (24% of total population)
  - **Finances:** Payroll contributions (9%)
  - **Budget:** $263.5 million
  - **Facilities:** EsSalud network of facilities
  - **Coverage:** 24%

- **Armed Forces (FFAA) / Police (PNP)**
  - **Type:** Subsidized
  - **Beneficiaries:** Military, police, and their dependents (2-3% of total population)
  - **Finances:** Ministry of Defense, Ministry of Interior
  - **Facilities:** FFAA / PNP facilities
  - **Coverage:** 3%

- **Uninsured**
  - **Coverage:** 24%

Source: INEI, National Survey of Homes, 2017
Health governance in Peru is decentralized. CHAs serve as liaisons between their communities and health establishments, supervised by MINSA via regional health directorates.

- **Funding Source:** Undefined, current budget available via National Plan for Anemia
- **Scale:** ~34,000 total CHAs
- **Time:** Part-time volunteers
- **Interventions:** Maternal and child health, communicable (dengue, TB, malaria) and non-communicable diseases (diabetes, obesity), health education, community vigilance
- **Selection:** Elected by community authorities/leaders and selected in public swearing-in
- **Training:** 12 months (36-40 hours per module, 5 modules total)
- **Incentives:** Certificate; continuous training; credentials; recognition in public ceremonies
- **Health system linkage:** CHAs refer cases to EESS; EESS provide training, certification, supervision, and incentives for CHA performance

Source: Technical Document: Methodology for the training of CHAs, MINSA, 2012; National Institute of Statistics and Information (INEI), 2016
CHA activity in Peru dates back to the early 20th century, with limited MINSA coordination beginning in the 1990s. Donors ran largely independent CHA programs through the mid-2000s as the government placed increasing emphasis on primary health care.

- **1979**: “National Plan of Support for Primary Care” published by MINSA.
- **1994**: Pilot program initiated, promoting the co-management of local health services through the formation of Local Committees of Health Administration (CLAS), adapted from PAHO’s proposed SILOS (local health systems) strategy.
- **1995**: MINSA Resolution recognizes the labor of CHAs in support of DIRESAs.
- **1999**: Pilot program initiated, promoting the co-management of local health services through the formation of Local Committees of Health Administration (CLAS), adapted from PAHO’s proposed SILOS (local health systems) strategy.
- **2002**: Peru’s government begins a process of decentralization and transfer of health functions to regional governments.
- **2003**: Normative framework created, called “Model of Comprehensive Health Care” (MAIS), later changed to MAIS-BFC (Based in the Family and Community) in 2011.
- **2004**: Universal health insurance (AUS) regulatory framework introduced.
- **2005**: SIS public health insurance established.
- **2006**: Universal health insurance (AUS) regulatory framework introduced.
- **2007**: Universal health insurance (AUS) regulatory framework introduced.
- **2008**: Universal health insurance (AUS) regulatory framework introduced.
- **2009**: “The CHA Manual” published with focus on maternal and child (<5 years old) health.
- **2010**: Results based-financing programs introduced.
- **2011**: “National Plan to Strengthen Primary Level of Care 2011-2021” published.
- **2014**: “Orientations for strengthening the work of CHAs” published.
- **2018**: Law 30825 “Law that strengthens the work of CHAs.”
Despite recent efforts to push a primary health agenda, Peru lacks a coordinated, national strategy to organize the currently non-uniform and non-integrated CHA programs across communities.

“This system of attention should provide holistic, integrated and continuous care, and should locally resolve between 70 and 80% of the basic and most frequent, long-term health care needs among the country’s population” (National Plan for Strengthening Primary Level of Attention (2011-2021) by MINSA)

- Model of Comprehensive Health Care: 2003, updated 2011 - ongoing
- Articulated Nutritional Program (PAN) and Articulated Neonatal and Maternal Health Program (PSMN): piloted 2007, scaled up 2009 – ongoing
- Universal Health Care Framework: 2009
- Essential Health Coverage Plan (PEAS): 2009
- National Plan to Strengthen Primary Level of Care 2011-2021

In 2018, the Government of Peru approved Law No 30825 (“Law that strengthens the work of CHAs”), which reinforces policies surrounding the national registry of CHAs, training, and funding (to be elaborated). The stated goal is “to strengthen and consolidate the work of community health agents as key players in the implementation of the strategy of primary health care in their communities.”

Independent NGO-run community health programs have little integration with MINSA and EESS oriented CHA activity

<table>
<thead>
<tr>
<th>Name of Organization</th>
<th>CARE Perú</th>
<th>Cáritas</th>
<th>UNICEF</th>
<th>Prisma</th>
<th>Socios En Salud</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Regions served</strong></td>
<td>22 regions</td>
<td>50 dioceses across all regions</td>
<td>Huancavelica, Lima, Ucalayi, and Loreto</td>
<td>All regions</td>
<td>Lima Northern Cone</td>
</tr>
<tr>
<td><strong>Categories of services</strong></td>
<td>Social and economic inclusion, emergency response, health and nutrition</td>
<td>Health and nutrition, environment, citizenship, etc.</td>
<td>Rights, equity, opportunities, and health for children and adolescents</td>
<td>Communicable and non-communicable diseases</td>
<td>TB, maternal and child health, etc.</td>
</tr>
<tr>
<td><strong>Funding sources</strong></td>
<td>COSUDE, Bill &amp; Melinda Gates Foundation, Asociación UNACEM, etc.</td>
<td>Contributions from member organizations / private donations</td>
<td>Primarily voluntary contributions from governments (US, is largest donor)</td>
<td>International cooperation, private companies, universities</td>
<td>WHO, PIH, Global Fund, etc.</td>
</tr>
<tr>
<td><strong>Level of integration with national health system</strong></td>
<td>Influential in implementing and assessing local interventions for stunting; organized civil society (IDI); wrote CHA training methodology manual</td>
<td>Coordinate with government to prepare emergency disaster response; member of IDI</td>
<td>Allied with government and CSO; advocate for established, budgeted programs</td>
<td>Stronger integration with MINSA; execute pilot interventions and gather preliminary data</td>
<td>Some CHAs recruited from local MINSA-operated EESS</td>
</tr>
</tbody>
</table>
MINSA is primarily funded by domestic resources, with a small percentage of funds coming from external donors.

**MINSA Funding Sources, 2014**

- Ordinary resources: 84%
- Directly collected resources: 7%
- Donations and transfers: 1%
- Resources from official operations of credit: 8%

**Channel 1: Domestic Resources**
- Flows via Ministry of Economy and Finances.
- Ordinary resources derive from general tax revenues. Directly collected resources derive from income generated by public entities through the sale of goods or provision of services.

**Channel 2: Donor Resources**
- Flows via Ministry of Health.
- International support from donors and multilaterals has decreased since Peru became considered as an upper middle-income country in 2009.

Specific costing analysis of the origin and destination of funding flows for community health programs has yet to take place...

Source: MEF, 2014
Currently, government funding for CHA activities is available through the National Plan for the Reduction and Control of Maternal and Child Anemia and Chronic Child Malnutrition in Peru: 2017-2021.

Budget for Articulated Nutritional Program, by strategic activity (Total: $475,738,834.80 USD)

- Intestinal parasite treatment: 2%
- Anemia prevention (pregnant women): 32%
- Anemia treatment (children under 3 yrs old): 2%
- Anemia prevention (children under 3 yrs old): 16%
- CRED (Control of Growth and Development): 20%
- Acute diarrhoeal diseases: 6%
- Acute respiratory infections: 10%
- Vaccinations: 32%
- Training for local government actors, social organizations, and educational institutions: 3%
- Nutrition education: 3%
- Hygiene and sanitation: 4%

Budget for Articulated Neonatal and Maternal Health Program, by strategic activity (Total: $61,655,587.50 USD)

- Adolescent health services: 92%
- Prenatal care: 8%

Key lessons have emerged from Peru’s CHA program:

1. In the past two decades, Peru has achieved dramatic reductions in maternal, neonatal, and child mortality **despite a weak CHA agenda** that lacks integration with the country’s formal health system.

2. A highly **decentralized system of health governance** allows for the overarching governing body, MINSA, to set national priorities while directorates in each department tailor plans and strategies to regional needs.

3. In the wake of decreased donor funding, NGOs in Peru have played a powerful role in **evidence-based advocacy** by proving the efficacy of community-based approaches through the use of pilot data, in order to influence and hold the government accountable for pro-poor health programming.

4. The **lack of a strong overarching policy and strategic community health plan** has translated to poor coordination and little integration across communities and municipalities where CHA activities are carried out by both MINSA and NGO actors, who fail to align priorities. Without a defined plan and budget, separate from other strategic health plans (i.e. anemia), a costing analysis of CHA programs cannot be performed.

5. An **absence of financial incentives for CHAs** and their persistent designation of volunteer status has resulted in lower participation and reduced numbers of CHAs across the country, in recent decades.

6. Financial sustainability to meet the need for community health program expansion is challenged by **slow growth in domestic health expenditure and general public spending**. There is a need to assess Peru’s fiscal space to determine opportunities for expanding public revenue to support health spending, particularly in the face of a growing dual burden of disease.
Experts interviewed for this case study

- Lilia Cabrera - Project Coordinator, Prisma
- Ofelia Alencastre Mamani - Specialist in Health Promotion, Directorate of Indigenous or Native Peoples, Ministry of Health of Peru (MINSA)
- Ofelia - Community Health Worker, Socios En Salud, District of Raúl Porras Barrenacha (Carabayllo, Lima)
- Jesús - Director, Asociación de Promotoras de Salud de Las Pampas de San Juan de Miraflores (Association of Health Promoters in Las Pampas, San Juan de Miraflores, Lima)
- Dr. Luis Huicho - Professor, Universidad Peruana Cayetano Heredia (Lima, Peru)
- Enric Jané and Kevin Ho - Exemplars in Global Health Team