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Country Case Study: Peru

May 2019

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

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

Source: World Bank Data, 2019

Health expenditure (as % of GDP) has increased since 2000, but still remains under the regional average (7%)

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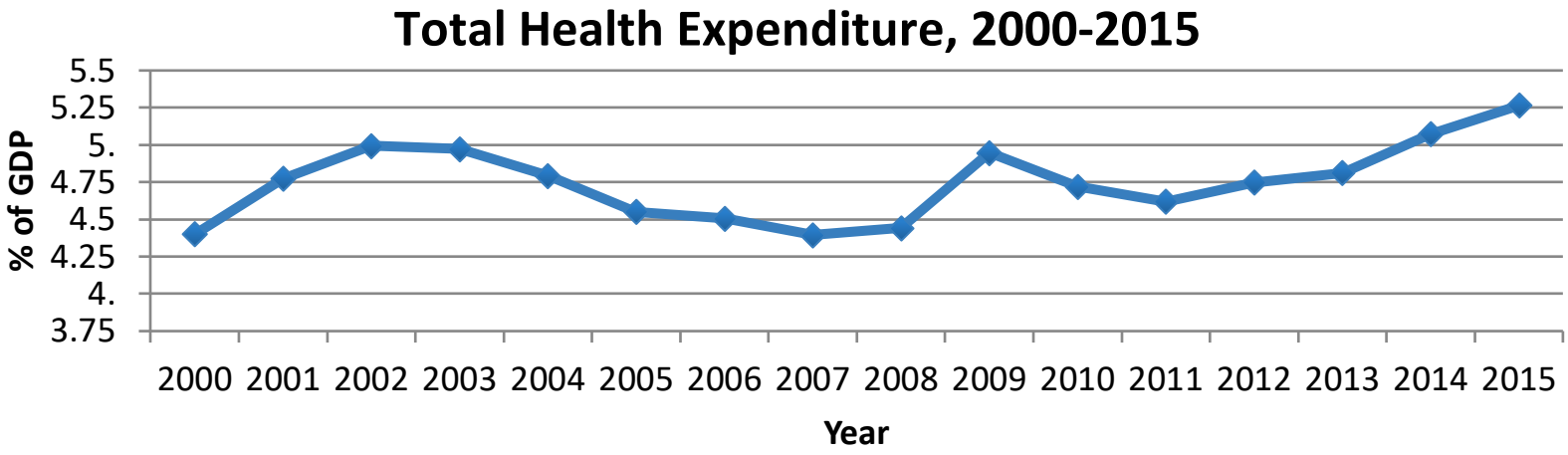

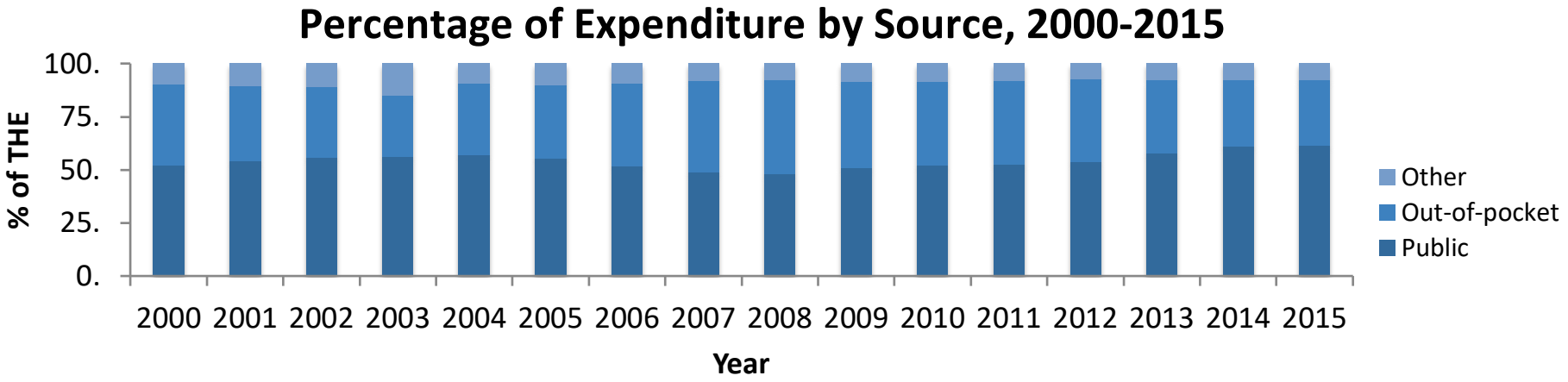

Source: World Bank Data, 2019

Until recently, Peru was one of the few countries in Latin America facing a critical health workforce shortage

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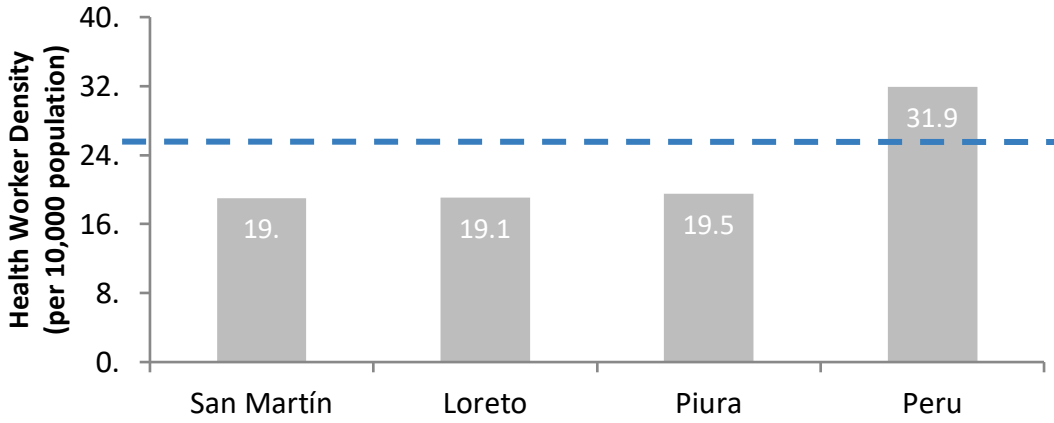
Health Worker Density (per 10,000 population)	Year 2017
Total health workers	**31.9**
Medical doctors	12.8
Nursing personnel	14.1
Midwifery personnel	5.0
Total Community Health Agents (CHAs)	**34,801**

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

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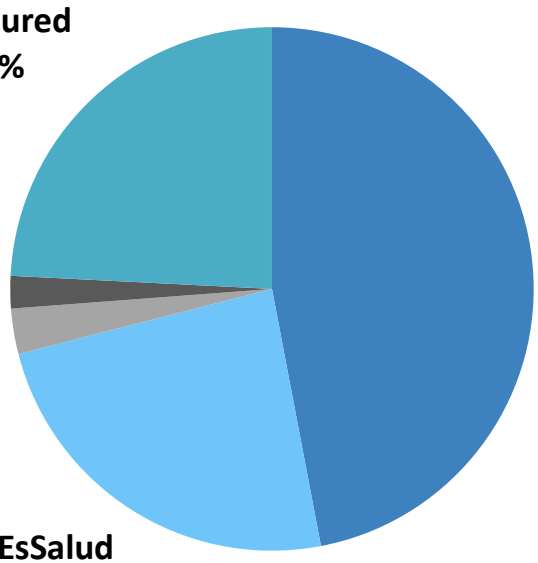
Health Insurance Coverage (% of total population)



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

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

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

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

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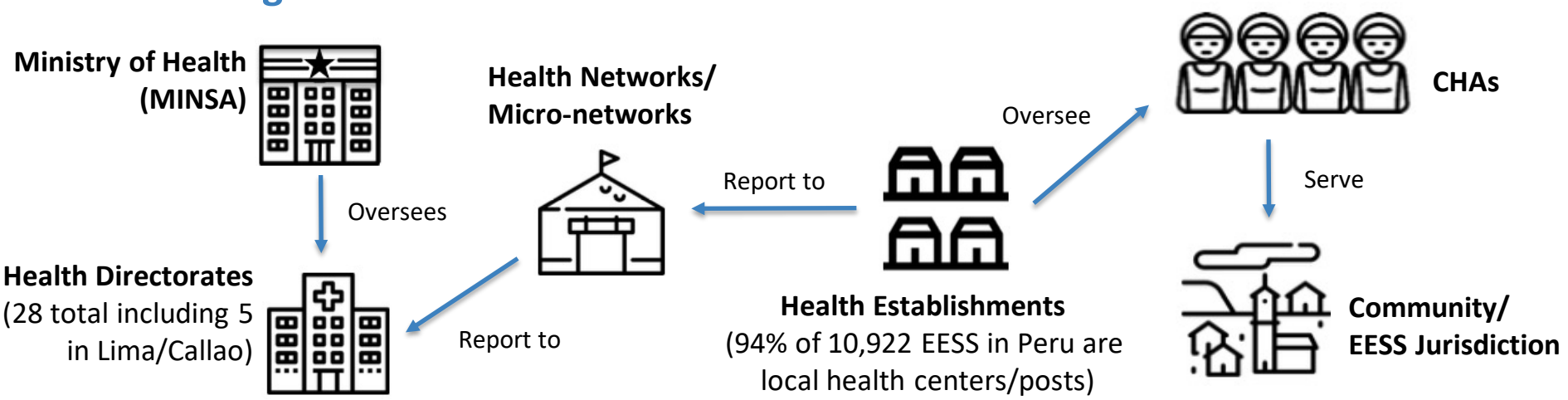

- **Funding Source:** Undefined, current budget available via National Plan for Anemia
- **Scale:** ~34,000 total CHAs
- **Time:** Part-time volunteers
- **Interventions:** Maternal and child health, communicable (dengue, TB, malaria) and non-communicable diseases (diabetes, obesity), health education, 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

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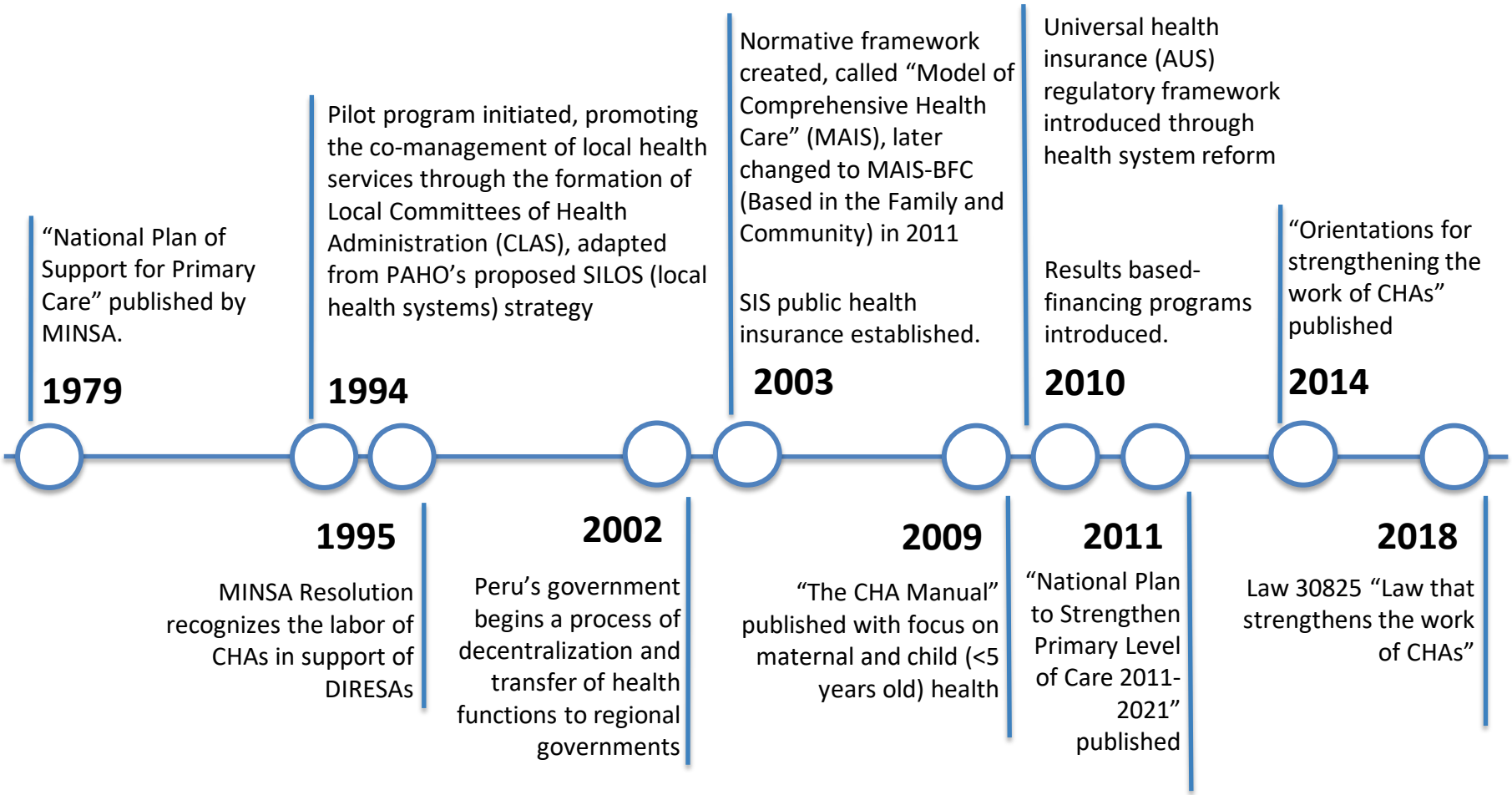

Source: Technical Document: Orientations for strengthening the work of the community health agent, MINSA, 2014

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

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> "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)*

Policy

- 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
- National Plan for the Reduction and Maternal Child Anemia and Chronic Child Malnutrition in Peru: 2017 - 2021

Governance

- Peruvian Ministry of Health (MINSA)
  - General Directorate of Health Promotion (DGPS)
  - General Directorate of Health Personnel (DIGEP)
- Regional Health Directorates (DIRESA/DISA/GERESA)
- Local Municipalities, Health Networks and Micro-networks
- Ministry of Economy and Finances (MEF)
- Ministry of Education
  - National System of Evaluation, Accreditation, and Certification of Educational Quality (SINEACE)

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."

Source: National Plan for Strengthening Primary Level of Attention (2011-2021), MINSA, 2011

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

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

Source: Organization websites and key interviews

MINSA is primarily funded by domestic resources, with a small percentage of funds coming from external donors

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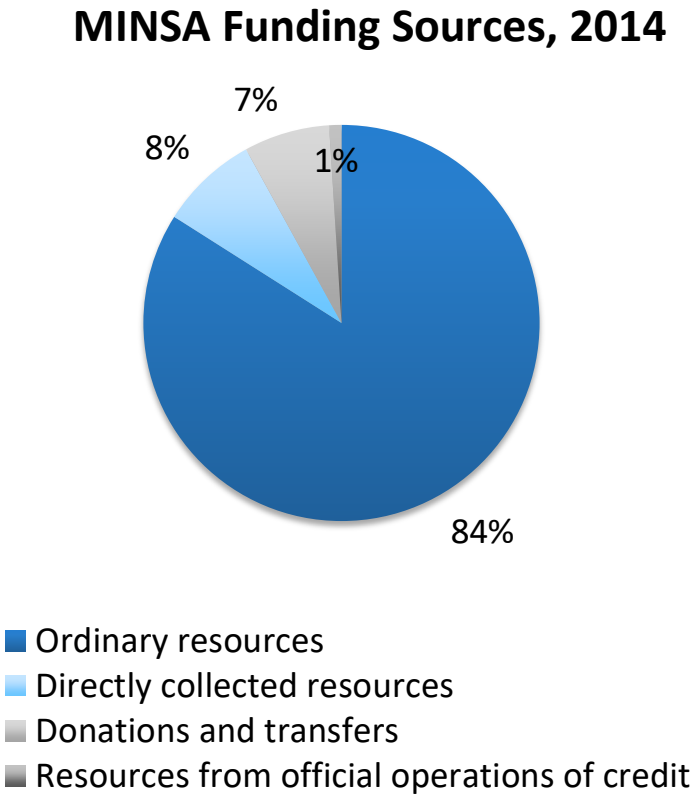

Channel 1: Domestic Resources

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

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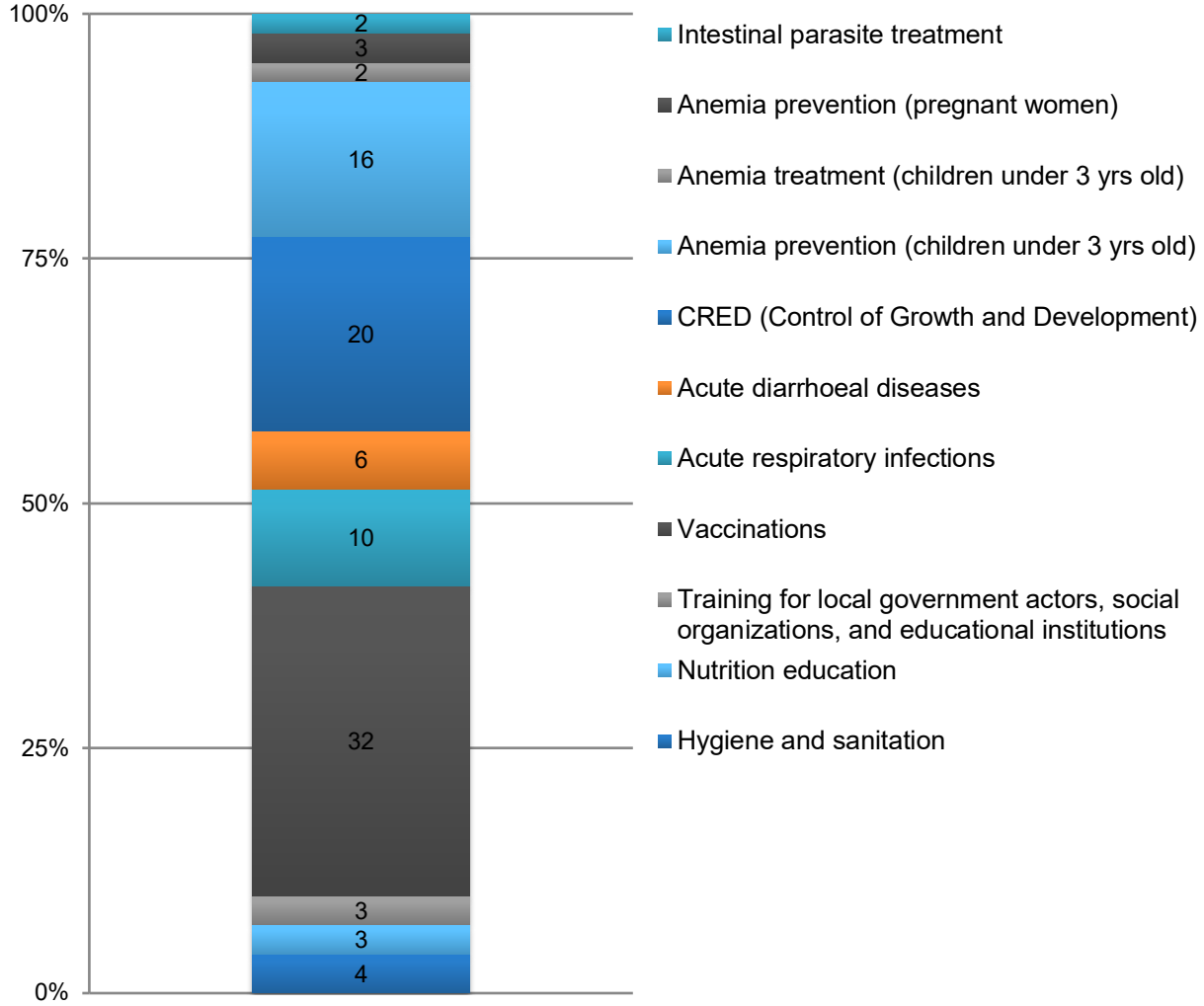
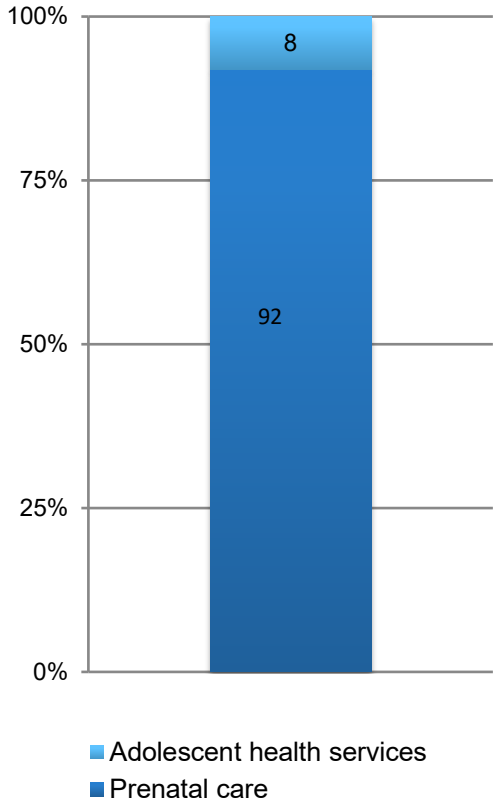
Budget for Articulated Nutritional Program, by strategic activity (Total: $475,738,834.80 USD)



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



Source: Technical Document: National Plan for the Reduction and Control of Maternal Child Anemia and Chronic Child Malnutrition in Peru: 2017-2021, MINSA, 2017

Key lessons have emerged from Peru's CHA program:

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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

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- 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