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ASSESSMENT OF HIV SERVICES FOR VENEZUELAN MIGRANTS

Local Health System Sustainability Project
Task Order 1, USAID Integrated Health Systems IDIQ

July 2022

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Local Health System Sustainability Project

The Local Health System Sustainability Project (LHSS) under government contract USAID Integrated Health Systems IDIQ (Indefinite Delivery - Indefinite Quantity) provides aid to low and middle-income countries in their transition to sustainable, self-financing health systems to support access to universal health coverage. The project works with partner countries and local stakeholders to reduce financial barriers to care and treatment, ensure equitable access to essential health services for all people, and improving the quality of health services. Led by Abt Associates, the five-year $209 million project will focus on building local capacity to strengthen health system performance and, in this way, support countries on their path to self-sufficiency and prosperity.

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Acronyms

AHF	AIDS Healthcare Foundation
AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-Retroviral Therapy
CBO	Community Based Organization
CCEFIRO	Association 'Building Paths of Hope Against Injustice, Rejection and Oblivion (Asociación Construyendo Caminos de Esperanza Frente a la Injusticia, el Rechazo y el Olvido)
CDC-Perú	National Center for Epidemiology, Prevention and Control Disease (Centro Nacional de Epidemiología, Prevención y Control de Enfermedades - CDC Perú) CONAMUSA National Multisectoral Health Coordinator (Coordinadora Nacional Multisectorial en Salud)
CPP	Temporary Permit to Stay Card (Carné de Permiso temporal de Permanencia)
DGIESP	General Directorate of Strategic Interventions in Public Health (Dirección General de Intervenciones Estratégicas en Salud Pública)
DIRESA	Regional Health Directorate (Dirección Regional de Salud)
DIRIS	Directorates of Integrated Health Networks (Direcciones de Redes Integradas de Salud)
DPVIH	Directorate of Prevention and Control of HIV-AIDS, Sexually Transmitted Diseases and Hepatitis (Dirección de Prevención y Control del VIH-SIDA, Enfermedades de Transmisión Sexual y Hepatitis, del Ministerio de Salud del Perú)
DPS	Personal Health Data (Datos Personales de Salud)
ENSAP	National School of Public Health (Escuela Nacional de Salud Pública)
EsSalud	Social Health Insurance (Seguro Social de Salud del Perú)
FISSAL	Intangible Solidarity Health Fund (Fondo Intangible Solidario de Salud)
GDP	Gross Domestic Product
HAART	Highly Active Anti-Retroviral Therapy
HF	Health Facility
HF ART	Health Facility Providing Anti-Retroviral Therapy
HIS	Health Information System (Sistema de Información en Salud)
HIV	Human Immunodeficiency Virus
HSAA	Health System Assessment Approach (Enfoque de Evaluación del Sistema de Salud)
HR	Human Resources
INEI	The National Statistics and Informatics Institute (Instituto Nacional de Estadística e Informática)

INS	The National Health Institute (Instituto Nacional de Salud)
IPRESS	Institutions Providing Health Services (Institución(es) Prestadora(s) de Servicios de Salud)
LHSS	Local Health System Sustainability Project
MSM	Men who have Sex with Men
MINSA	Ministry of Health (Ministerio de Salud del Perú)
NETLab	Information System of the National Network of Public Health Laboratories (Sistema de Información de la Red Nacional de Laboratorios de Salud Pública, INS, Perú)
NGO	Non-governmental organization
NOTI Web	Software of the National Notification System for the Epidemiological Surveillance System (Software para el Registro de Casos de Notificación al Sistema de Vigilancia Epidemiológica, MINSA, Perú)
OGTI	General Office of Information Technology (Oficina General de Tecnologías de la Información del MINSA)
PAHO	Pan American Health Organization
PIA	Institutional Initial Budget (Presupuesto Institucional de Apertura)
PLHA	People living with HIV/AIDS
PLHA vm	People living with HIV/AIDS - Venezuelan migrants
PpR	Results-Based Budgeting (Programa de Presupuesto por Resultados)
PpR 016	Results-Based Budgeting 0016, TB-HIV/AIDS (Programa de Presupuesto por Resultados 0016, TBC-VIH/Sida)
PrEP	Pre-Exposure Prophylaxis
PTP	Temporary Residence Permit (Permiso Temporal de Permanencia)
R4V	Interagency Coordination Platform for Refugees and Migrants (Plataforma de Coordinación Interagencial para Refugiados y Migrantes)
REUNIS	Unique National Health Information Repository (Repositorio Único Nacional de Información en Salud)
RM	Ministerial Decree (Resolución Ministerial)
RREE	Foreing Affairs(Relaciones Exteriores)
SINADEF	National Death Registry Information System (Sistema Informático Nacional de Defunciones)
SNS	National Health System (Sistema Nacional de Salud)
SIS	Comprehensive Health Insurance (Seguro Integral de Salud)
SUSALUD	The National Superintendence of Health (Superintendencia Nacional de Salud)
SVE	Epidemiologic Surveillance System (Sistema de Vigilancia Epidemiológica)
SW	Sexual Workers

SWOT	Matrix of Strengths, Weaknesses, Opportunities and Threats
TB	Tuberculosis
TW	Transgender Women
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNHCR	United Nations High Commissioner for Refugees
USAID	United States Agency for International Development
VMPH	Vice-Ministry of Public Health
YLD	years of healthy life lost due to disability
YLL	years of life lost due to premature mortality

Executive Summary

Due to Venezuela's economic and social crisis, an estimated 20% of its total population has left the country searching for humanitarian assistance, access to essential services, and employment opportunities. Approximately 1.5 million Venezuelan citizens have migrated to Peru. Around 8,000 Venezuelan migrants are people living with Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) - PLHA. A significant percentage of these migrants had reported that they stopped receiving medical treatment due to the crisis in their country of origin.

In Venezuela, the prevalence of HIV among the general population is 0.56%, whereas, in Peru, the prevalence of HIV is 0.3%. Despite their different prevalence rates, both HIV endemic countries share similarities. In both cases, HIV/AIDS is mainly sexually transmitted, and its prevalence is highest among Transgender Women (TM), Men who have Sex with Men (MSM), and Sex Workers (SW). The key populations at increased risk of HIV are young people from the most impoverished backgrounds. This population group has a low level of education, and its insertion in the labor market takes place in the informal economy. The majority of Venezuelan migrants arrive and access the labor market in this scenario of social marginalization. Both the lack of decent employment opportunities and the precariousness of informal work shape their search for alternatives to survive. These include sex work and, therefore, interaction with the population that bears a heavy burden and accounts for the largest numbers of the epidemic in Peru.

The Local Health System Sustainability Project (LHSS) in Peru has conducted a health system assessment focused on HIV care services for migrants. For this purpose, the Health System Assessment Approach (HSAA) methodology, which organizes the evaluation according to the health system components, was applied. The assessment comprised the review of secondary data sources; the interviews with key informants, users, and professionals who are responsible for Health Facilities (HF) that provide Antiretroviral Therapy (HF ART); observation visits to selected HF ART; and a self-administered survey to those responsible for HF ART in the country.

In addition to the interviews, the survey provided first-hand information on HIV care services. The survey was answered by 67 HF ART that attend to 32,050 PLHA. This comprises 39% of PLHA currently receiving ART in Peru. Among their ART population, 43 HF provide services to 2222 Venezuelan migrants living with HIV/AIDS (PLHA vm), and 66% of them are currently receiving ART in Peru. By using this methodology, key findings emerged:

Governance: The procedures for regularizing migratory status and obtaining a residence permit are characterized by their slow implementation and lack of predictability, even in applications for a residence permit on humanitarian grounds. Since the migrant population must obtain a residence permit before registering with the Comprehensive Health System (SIS), the requirements for their incorporation are restrictive and limit the overall coverage of the health insurance. As a result, only 2% of PLHA vm access the full range of SIS services. This situation occurs against the backdrop of legal vulnerability for Peruvian citizens and transgender migrants whose gender identity rights are not recognized by the state. Thus, transgender migrants face double discrimination.

Funding: The primary source of funding for HIV care services is the Results-Based Budgeting Project (PpR 016) which had maintained stable figures until 2020; however, the per capita

amount of PLHA on ART[1] has decreased by approximately 250% between 2016 and 2021, and by 2022, funds for the acquisition of ART drugs have been reduced by 65% in comparison with 2021. On the other hand, it was identified that the PrP 016 conception lacks focus on the proximal determinants of transmission risk factors within key populations, and it requires the generation of new products and HIV prevention, care and control strategies. The difficulties faced by PLHA when registering with the SIS generate out-of-pocket expenses, mainly to cover pre-ART screening and/or care and treatment of PLHA at the AIDS stage. Another difficulty related to the PpR is the lack of specific funding for Epidemiological Surveillance and other products such as agent services and community-based organizations.

Service Provision: The proportion of PLHA vm is marginal (7%) in relation to the total number of PLHA receiving ART in Peru. The rate of abandonment of ART among PLHA vm stands at 5%, an alarming rate at which abandonment occurs compared to the national population. A finding of greater importance is the high rate of tuberculosis (TB) coinfection among PLHA mv (15%), that is 30 times higher than the rate of coinfection among Peruvian PLHA in the same territory where these cases were registered.

Access to ART, even in the scenario of restricted access to the SIS, was facilitated by the entry rules for ART of the Ministry of Health's Directorate for the Prevention of HIV/AIDS, Sexually Transmitted Diseases and Hepatitis (DPVIH), which allow treatment without distinction of nationality and migratory status. This has made it possible for 97.5% of PLHA mv with an HIV-positive diagnosis to receive ART. The main barriers to the immediate initiation of ART in PLHA were:

Patient out-of-pocket costs for pre-ART screening (70%) due to difficulties accessing subsidized public insurance. These are caused by the delays in the migratory regularization programs and the obtention of a foreigner's ID card.

- Inconvenient opening hours for accessing ART services (41%)
- Waiting time at ART facilities
- Travel-related expenses

Regarding the situation of PLHA vm currently receiving ART, their condition was diagnosed at the first consultation: 55% had been previously diagnosed with HIV in Venezuela, approximately 26% had interrupted their ART for six or more months, and 23% were at the AIDS stage.

Regarding stigma and discrimination, those responsible for the HF ART stated that PLHA have reported that those affected by severe forms of the COVID-19 infection and who needed to be admitted to the hospital, 22% received low-quality care and were discriminated because of their sexual orientation, 9% felt discriminated because of their HIV diagnosis, and 7% felt discriminated because of their nationality. 67% of PLHA receiving ART discontinued their treatment due to the interruption of services in the context of the pandemic.

Human Resources: Only 64% of HF reported having the minimum team of professionals for comprehensive health care (physical and mental) in their ART services, and in general the HF ART reported a lack of human resources (HR) and high turnover rates, regardless of their level of seniority or the volume of patients who are PLHA in care. It was also found that there is a low-level updating in competencies for comprehensive care at the HF ART.

[1] For the calculation of this capita, the total amount of the HIV component (from the Results-Based Budgeting Project - PpR 016) is divided by the total number of PLHA on ART.

Information systems: MINSA lacks a system or platform that centralizes data on preventive care and its follow-up benefits. The ART service information managed by the DPVIH is based on manual records and a non-specialized, precarious, unstable, and vulnerable platform that hinders statistical recording and epidemiological analysis and is ineffective in duly safeguarding patient information confidentiality and integrity.

The evaluation identified that the HIV/AIDS Epidemiological Surveillance System (SVE) has an underreporting level of at least 33% of PLHA vm cases compared to the number of PLHA on ART. Epidemiological surveillance is not coordinated; several institutions are responsible for it (notification-based surveillance by the Directorate of Epidemiology, Behavioral Surveillance, and by the National Institute of Statistics and Informatics, genomic surveillance by the National Institute of Health, etc.). Likewise, surveillance is an activity without identifiable funding in the PpR, as it is considered part of the product Supervision, Monitoring, and Research.

Among the recommendations provided, a set of them is a priority and short-term oriented: (1) Propose an additional demand for funding the PpR 016 that ensures the financing of comprehensive care for PLHA and the purchase of ART drugs; (2) Facilitate the incorporation of migrants with HIV into the Comprehensive Health Insurance (SIS) by amending the Modifying Complementary Provision of Emergency Decree No. 017-2019 and the incorporation of the assumptions of health vulnerability (HIV, TB, Disability) established in Supreme Decree No. 002-2020-SA. In this way, migrants living with HIV are temporarily exempted from the requirement of holding a foreign card to register with the SIS for those causes; (3) Modify Administrative Directive No. 294-MINSA/2020/OGTI that establishes a restrictive framework defined by MINSA in the treatment of health-related personal data and, therefore, affects the exchange of information. The modification opens up the possibility of interoperability between the various information systems and records; (4) Develop a plan and directive for the management of the ART services that allow implementation of standards for organization and quality service; (5) Develop a capacity building program for HR, health professionals and administrative staff of the HF that apply ART to guarantee comprehensive and quality care, and reduce stigma and discrimination against PLHA, including migrants, which could be carried out by the National School of Public Health (ENSAP); (6) Issue a directive for the standardization of the nominal registry of the DPVIH, and implement the process in the HF ART.

1. Project Background

Since 2009, Venezuela has been experiencing a long-lasting socio-economic crisis. The search for medical care and the guarantee of the right to health and life has been the catalyst for a mass migration phenomenon. It is estimated that more than 5.5 million Venezuelans (approximately 20% of the total population) have left the country in search of humanitarian assistance, protection, and access to essential services and job opportunities (R4V, 2021).

In the Peruvian scenario, the HIV/AIDS epidemic is concentrated in key populations, mainly sexually transmitted (97.6%). Adult HIV prevalence in the general population was 0.3% in 2018. However, this is higher among MSM (10%), TW (30.6%), and SW (2.3%) (UNAIDS, 2019). According to the Epidemiological Surveillance System of the Peruvian Ministry of Health (MINSA), the epidemic is concentrated in the most densely populated coastal and rainforest areas: 80% of notifications come from the main cities in the regions of Lima, Callao, Loreto, La Libertad, Lambayeque, Piura and Ucayali. The curve of reported cases describes an upward trend of diagnosed cases between 2018 and 2019 (MINSA, 2021).

Various analyses of the epidemic show that new diagnoses continue to be concentrated in the vulnerable populations of TW, MSM, and SW. These are mainly young people from the most impoverished sectors, with less access to higher educational levels and whose labor insertion is within the informal economies. Most Venezuelan migrants arrive in this scenario of social marginalization, where they are incorporated into a situation of vulnerability and poverty. The lack of decent jobs and the precariousness of informal employment triggers the search for survival alternatives, including sex work and, therefore, interaction with the population that bears the heaviest burden of the epidemic in Peru.

In Peru, the ART was initiated in 2004 and is currently offered in 200 HF nationwide, covering approximately 87 000 PLHA receiving ART since the beginning of the program. It is estimated that about 10 280 new HIV cases have been prevented, with an annual average of 734 cases (Enriquez, 2020). The country has improved access to comprehensive HIV services and ART. Still, persistent obstacles affect especially PLHA mv who do not have a ‘regular’ migration status and experience multiple vulnerabilities arising from poverty, exclusion from the formal labor sector, and their gender identity.

In this context, the LHSS project in Peru supports the strengthening of the Peruvian government's health initiative to address the increasing demand for HIV care after the arrival of Venezuelan migrants living with HIV. As an initial step, the LHSS project, in close cooperation with the MINSA, has conducted a health system assessment focused on HIV services. Based on this analysis, organizational capacity needs will be identified, and recommendations will be proposed to improve the delivery of health services to Venezuelan migrants living with HIV.

2. Methodology

2.1 Reference Framework

To meet the objectives of the joint work with MINSA, the Health System Assessment Approach (HSAA) v. 3.0 of the United States Agency for International Development (USAID), which has been widely used in the developing world to diagnose the performance of health systems and guide health sector planning, was used. The HSAA organizes the assessment of health systems across major system functions.

The following components were included in this diagnostic:

- Country and health system overview
- Service delivery
- Human resources
- Information systems
- Financing
- Governance

The component for medical products, vaccines, and technologies was developed in a specific assessment to be reported separately.

2.2 Objectives

2.2.1 General Objective

Identify needs in organizational capacity and develop recommendations to improve the delivery of HIV health services to Venezuelan migrants.

2.2.2 Specific Objectives

- Understand and document the system and health system-related functions for delivering HIV-related health services to the general population and Venezuelan migrants.
- Identify current factors that facilitate HIV-related services delivery, focusing on Venezuelan migrants.
- Assess the system's capacity to integrate migrants requiring HIV-related health services in a manner that considers their unique needs, including their incorporation into the SIS or other insurances that cover HIV-related health services.
- Provide recommendations to develop the technical, administrative, and coordination capacities of the Programme for Prevention and Control of HIV/AIDS and Sexually Transmitted Infections and Hepatitis (DIPRECE), and the Migration Unit of MINSA; Directorates of Integrated Health Networks (DIRIS) and facilities in Lima; Regional Health Directorate (DIRESA) and facilities at the subnational level, as well as other HIV care providers — Social Health Insurance (EsSalud), non-governmental organizations (NGOs) and others — for the planning and implementation of HIV-related health care, including Venezuelan migrants.

2.3 Gathering and Analysis of the Information

To address the different components of the evaluation, the following techniques were used:

- Review of secondary data sources (institutional reports, research data: theses, peer-reviewed scientific articles).
- Interviews with key informants (officials from MINSA, International Cooperation, civil society, and CBOs).
- Interviews with PLHA vm receiving ART.
- Interviews with workers and professionals in charge of the HF ART.
- Self-administered survey completed by those responsible for the HF ART in the country.
- Observation visits to the selected HF ART.

In all cases, informed consent was obtained to conduct and record the interviews. To conduct the interviews with HIV service users, a Data Security Plan was developed. Twenty-three key informant interviews were conducted, 6 with PLHA vm, and visits were made to 2 HF ARTs. The self-administered survey was answered by 67 (33%) of 200 HF ART in the country, which attend to a total 32,050 PLHA (39% of the total PLHA on ART in Peru). Forty-three of these HF had among their users PLHA vm (2222 PLHA vm corresponding to 66% of the PLHA vm receiving ART in Peru).

The information was then synthesized in the Strengths, Weaknesses, Opportunities, Threats (SWOT) matrix and a cause-effect diagram of the deficiencies of HIV services for Venezuelan migrants.

An evaluation follow-up group was formed to accompany the process and provide valuable feedback at all evaluation stages: methodology, review of findings, and recommendations. The group was composed of the Directorate of Prevention and Control of HIV-AIDS, Sexually Transmitted Diseases and Hepatitis (DPVIH), the National Superintendence of Health (SUSALUD), the Comprehensive Health Insurance (SIS), the Pan American Health Organization (PAHO), the Joint United Nations Program on HIV/AIDS (UNAIDS), the UN Refugee Agency (UNHCR), the AIDS Healthcare Foundation (AHF) and the National Multisectoral Health Coordinator (CONAMUSA).

3. Findings

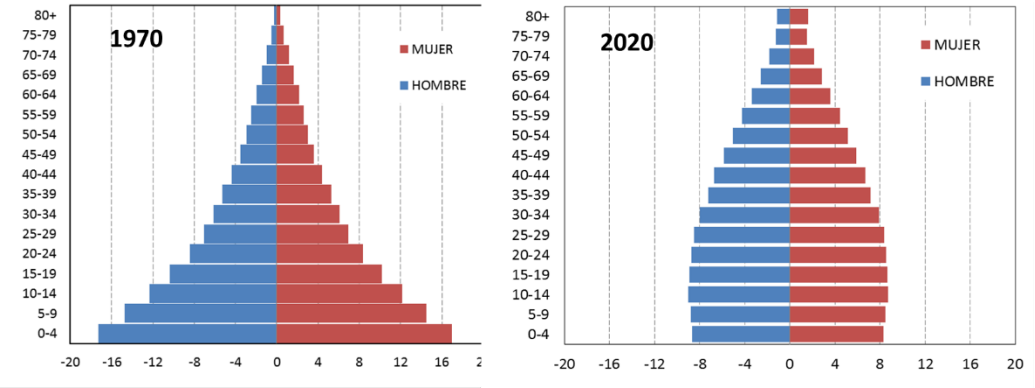
The review of scientific and institutional publications, surveys of health services that provide ART, interviews with key informants, staff responsible for the HF ART and PLHA vm, made it possible to identify the bottlenecks in the national response to HIV/AIDS. These aspects increase exponentially the risks of the migrant population, as they add additional challenges. Among the most adverse are discrimination and stigmatization based on nationality. The most relevant of the many findings, according to the opinion of the experts, are presented below.

3.1 Overview of the Country and its Health System

Peru has achieved significant improvement in its health indicators, mainly those linked to the Millennium Development Goals. Between 2000 and 2019, maternal mortality decreased from 185 to 62 per 100,000 live births, chronic child malnutrition decreased from 31.6% to 13.2%, and deliveries of rural pregnant women in health institutions increased from 24% to 81%.[2]

Peru's population pyramid has also narrowed (Graphic 1), showing progress in the country's demographic transition. Studies show a migration of the burden of disease from communicable and mother-and-child diseases to non-communicable diseases, reflecting the progression of the epidemiological transition.

Graphic 1. Peru: Population Pyramid 1970-2020



Source: Peru - National Institute of Statics and Informatics (INEI)

The most recent Burden of Disease Study in Peru showed that 5 315 558 YLD were lost in 2016. Among these, 66.2% were due to non-communicable diseases, 21.4% to communicable, perinatal, and nutritional diseases, and 12.5% to accidents and injuries. In population terms, 168.8 YLD were lost per 1,000 people in 2016.

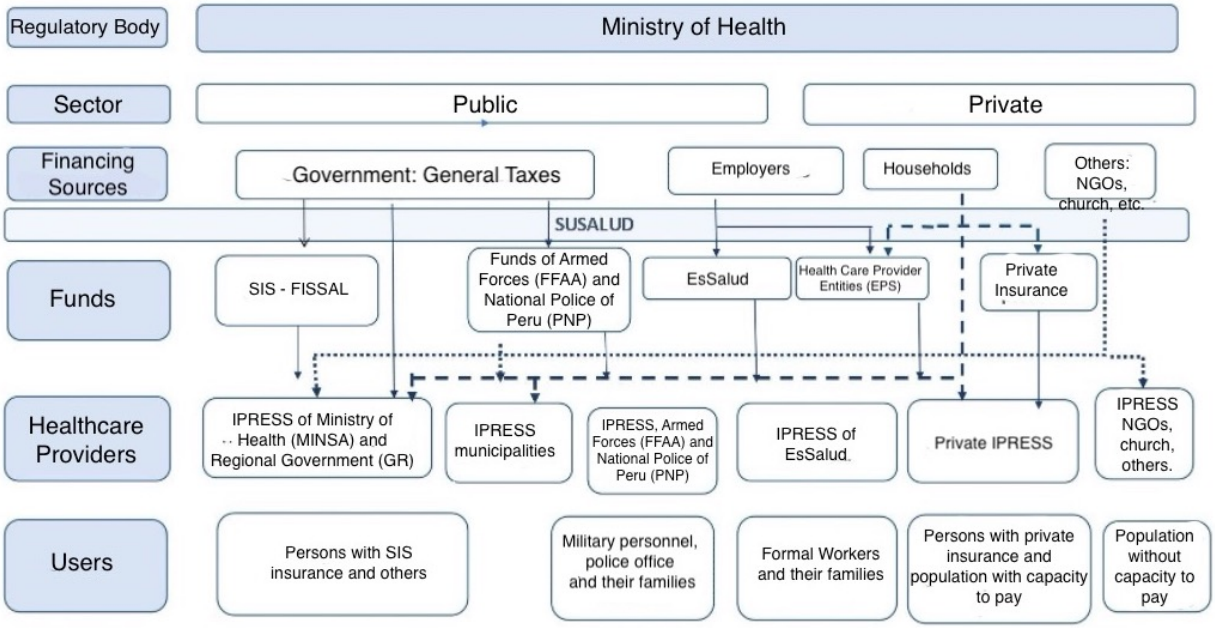
HIV caused the loss of 59 913 YLD (1.12% of the total YLD lost in Peru in 2016). 46% of the total YLD lost due to HIV was mainly caused by years of life lost due to premature mortality (YLL), ranking as the third most important single cause of premature mortality among communicable, perinatal, and nutritional diseases, and the 24th cause of premature mortality in general.

[2] In Giusti, P. El sector salud peruano y la pandemia del coronavirus [The Peruvian Health Sector and the coronovirus pandemic]. Presented at Latin American Studies Association-LASA. May 2021

The health sector is fragmented (Figure 1) and segmented. Fragmentation (multiple agencies providing similar services to different population groups) and segmentation (different funding levels for different population groups) cause inequities and inefficiencies in the country's healthcare system.

Additionally, in the first decade of this century, the functions of the national government were decentralized, and the health sector transferred functions to the regional governments (except Lima Metropolitana), which assumed the administration of public health and health services in their territories. However, the capacity of the regional governments to execute these functions is variable. Still, it requires much effort on the national government to improve the administrative capabilities of the Regional Health Directorates or their counterparts. When regional governments lack the necessary capacity, this becomes an issue for implementing policies and directives at the regional level in the country, which is evident in the care of migrants with HIV and PLHA in general.

Figure 1. Structure of the Health Sector in Peru – 2021



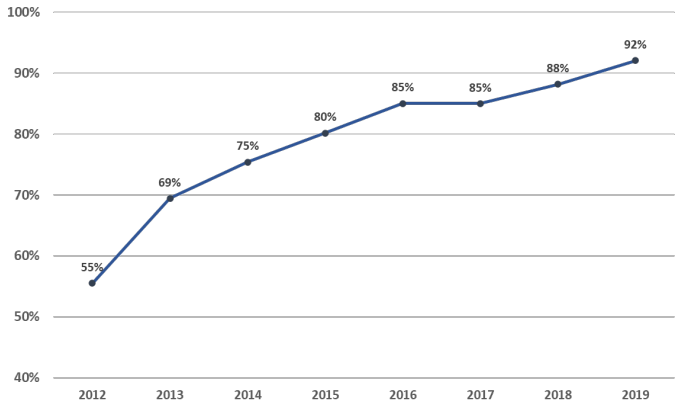
Source: El sector salud peruano y la pandemia de coronavirus [The Peruvian Health Sector and the Coronavirus Pandemic]. Presented at the Conference of the Latin American Studies Association-LASA. May, 2021

The Ministry of Health (MINSA) oversees the system, and the Superintendence of Health (SUSALUD) supervises insurers and providers throughout the country to safeguard the rights of all health service users. As can be seen in the graphic, there is a multiplicity of providers with different dependencies: those of MINSA, those of the Regional Governments, those of the Social Security (which depends on the Ministry of Labor), those of each of the Armed Forces and the National Police of Peru, those of the municipalities and, finally, those of the private sector. This multiplicity generates inefficiencies in providing services and limitations in their access.

The primary sources of financing are the Public Treasury through general taxes, employers through the payment of Social Security contributions, and households through out-of-pocket spending.

Health insurance coverage has increased significantly in the last decade, the population insured reaches 92%: 60% in the SIS, 29% in EsSalud, and the rest in other insurances (Graphics 2 and 3).

Graphic 2. Insurance Coverage – Peru 2012-2019



Source: Register of Insured People with SUSALUD

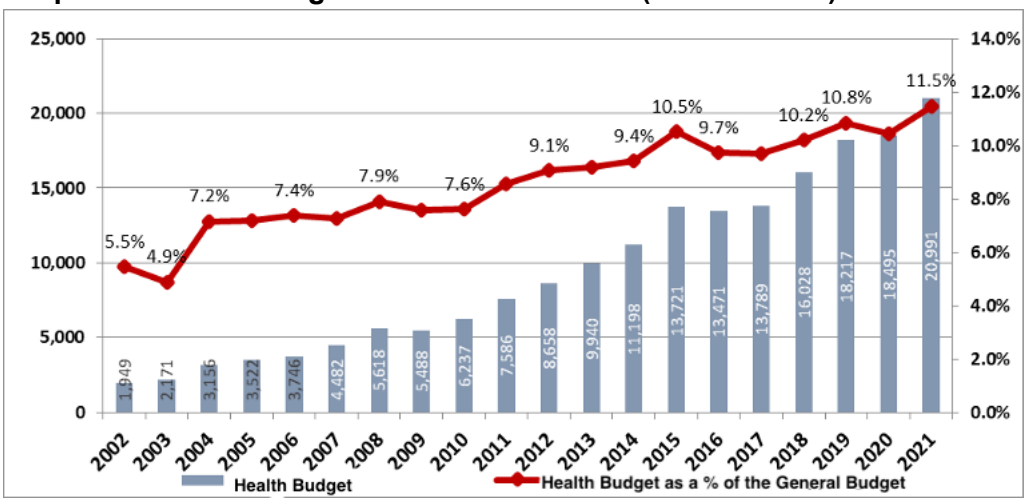
Graphic 3. Persons with insurance coverage, by insurance type – Peru 2020

Source: Register of persons with insurance coverage, SUSALUD.

The public budget allocated to health has increased tenfold between 2002 and 2021, from 1949 to 20,991 million soles, and its share as a percentage of the public budget has increased from 5.5% to 11.5% in the same period, which represents a significant fiscal effort (Graphic 4). However, expenditure on health as a percentage of GDP is still at 5.1%, below the average expenditure in Latin America (7.6%).

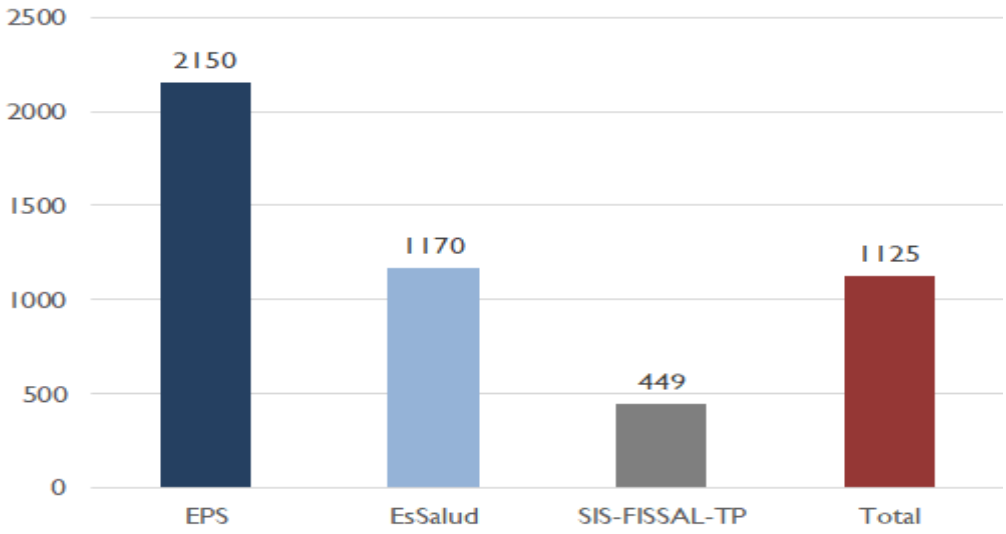
Despite advances in health outcomes, insurance coverage, and increased financing, the fragmentation and segmentation of the health system generate significant inequities by providing different benefits to various population groups with disparate resource allocations. Per capita expenditure (average expenditure per person) with SIS insurance - including FISSAL and the direct budget from the public treasury to health facilities - is less than half of the expenditure on persons with EsSalud insurance. However, for people with private insurance the expenditure doubled the EsSalud health spending (Graphic 5). Even among people with SIS insurance, there are important differences in health spending per insured person, according to their region (Graphic 6).

Graphic 4. Public Budget in Health 2002-2021 (million soles)



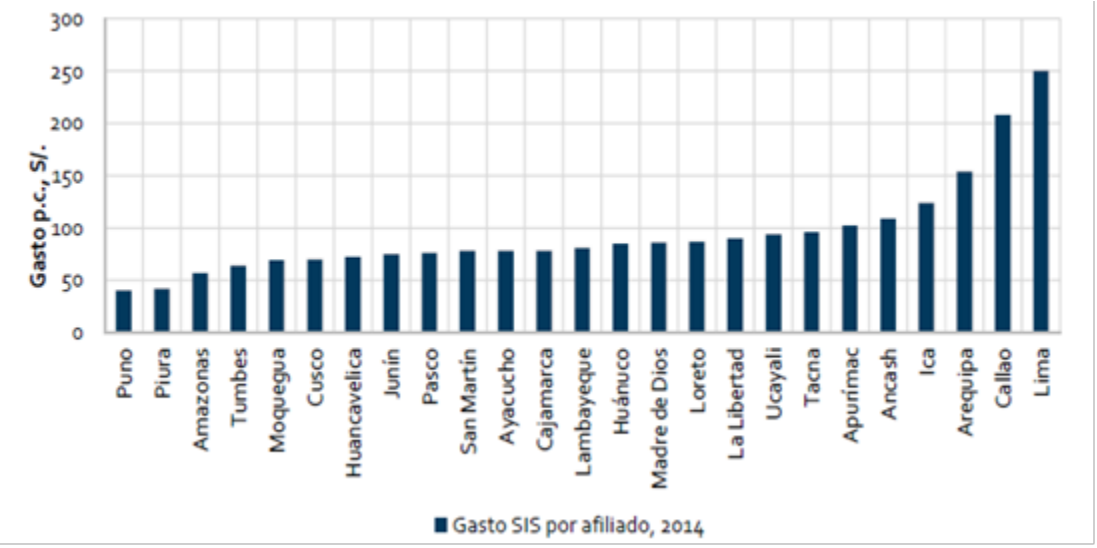
Source: Ministry of Economy. Public Consult.

Graphic 5. Average health expenditure per capita, by type of insurance (soles) - Peru 2019



Source: SUSALUD, EsSalud, SIS, MEF, INEI. Elaborated by A. Portocarrero

Graphic 6. Departmental variation in expenditure per person registered in SIS – Peru 2014



Source: World Bank (2016), Health Financing in Peru.

In addition, inefficiency is generated by the different modes of contracting providers. This lack of standardization in management and the disconnectedness of information systems is reflected in quality issues. On top of this, there are difficulties arising from the decentralized sector. Another government level must implement policies and directives —the regional government— but it does not always have the necessary capabilities for this task.

HIV/AIDS services are financed primarily through the PpR (see below), which covers the necessary expenses for screening, diagnosis, antiretroviral medicines, follow-up tests, and infection prevention. Costs incurred for medical consultations, pre-treatment laboratory tests, hospitalizations, and other services not detailed in the PpR are financed by the SIS if the PLHA is registered; otherwise, the person must assume these expenses.

3.2 Governance

The assessment of governance aspects related to HIV services for Venezuelan migrants was addressed at two levels: migration sector policy and its regulations, and health sector policy and its regulations.

1. **The procedure for regularizing migratory status and obtaining a residence permit is characterized by its slow implementation and unpredictability, even for obtaining the residency on humanitarian grounds.**

It is estimated that by the end of 2021, there will be approximately 1.5 million Venezuelan migrants in Peruvian territory, primarily young adults. Despite this significant number, by the end of 2020, the Executive Secretariat of the Special Commission for Refugees reported that it had recognized the refugee status of only 882 Venezuelans (Ministry of Foreign Affairs, 2020) and that there was a high demand for migration procedures that exceeded the installed capacity of the Ministry of Foreign Affairs -for the examination and processing of refugee applications-. This situation is also visible in the National Superintendence of Migration -for processing Temporary Permit to Stay (PTP), Temporary Permit to Stay Card (CPP). Migratory procedures — for refugees, PTP, CPP — demand cumbersome, time-consuming and costly requirements for

migrants, limiting the timely regularization of migratory status. Even the granting of Humanitarian Migratory Status, for which the Ministry of Foreign Affairs established the "Guidelines for the granting and extension of Humanitarian Migratory Status" approved by Ministerial Resolution (RM) No. 0207-2021/RE, does not establish deadlines for compliance with the procedure that culminates in the granting of humanitarian migratory status.

In the opinion of external cooperation professionals working directly in the field with Venezuelan migrants:

> *"(…) when one requests the migratory status for vulnerability, sometimes one cannot wait, not even a week. And then, it takes 3, 4, 5, 6 months,...6 months more or less, that's the standard real-time procedure. So many times, it is too late because the person died due to the state of vulnerability."*
>
> *(Key informant: external cooperation professional 19.08.2021)*

2. **Restrictive regulations for SIS inscription limit the access of PLHA vm to public health insurance, reflected in the low rate (2%) of PLHA vm with SIS insurance.**

Data from the Comprehensive Health Insurance (SIS), last updated on May 31st, 2021, reported 93 944 Venezuelan people with SIS insurance, which corresponds to 7.2% of the Venezuelan migrant population in Peru. In this group population, only 87 people are living with HIV (SIS, May 2021). These SIS figures contrast with the information provided by the DPVIH, which reports having 3 375 PLHA vm receiving treatment in its databases (DPVIH, June 2021). This means that only 2% of the Venezuelan migrant PLHA currently receiving ART are covered by public health insurance. Venezuelan migrants continue to experience problems accessing health insurance. This is due, initially, to the fact that national legislation only provides this benefit under the condition of residency, which, in the case of migrants, is acquired only with the foreigner card, but not with the refugee applicant's card or the temporary permit to stay (CPP). Although this situation has been identified since 2018, no appropriate solution nor humanitarian response mechanisms have been generated (IDEH, 2018).

3. **The state's failure to provide legal recognition to gender identity rights exposes Peruvian and migrant transgender populations to double discrimination.**

The transgender women population faces striking inequalities when exercising their rights and accessing health services. In 2013, in Peru, it was reported that 89% of TW were uninsured, 50% were forced to abandon their studies, only 3% had access to a formal job, and around 70% supported themselves economically through sex work. In 2020, under Emergency Decree 017-2019 and through an administrative procedure, the SIS provided public health insurance to all Peruvians who remained uninsured. However, the effective insurance coverage percentage for TW is unknown. HIV surveillance studies conducted in vulnerable populations found that approximately 30% of transgender women are living with HIV. According to UNAIDS, the life expectancy of the transgender population in Latin America is 35 years.

In March 2021, the Women and Family Commission of Congress approved the Gender Identity previous legal report, which will allow transgender people to register their gender identity on their identity national card and thus, the possibility of exercising their rights. The debate on this bill and its approval in the plenary assembly of Congress are still pending. The legal recognition of the gender identity of TW will be an essential step in addressing the discrimination faced by this group population. Although it will ensure access to health services and HIV/AIDS services, it is insufficient.

Populations vulnerable to HIV, especially migrants, and PLHA are not covered by Social Protection Programs (SPP). In general, there is a lack of State recognition of the populations at greater risk of HIV and their social needs to guarantee the whole exercise of their rights to life and health, promote equal opportunities, and reduce their vulnerabilities.

The inclusion of people at greater risk of HIV —including migrants — in social protection programs would reduce their exposure to HIV. Sex work becomes a form of survival against the backdrop of economic crisis and the absence of income to meet basic needs. In the case of PLHA, adherence to the treatment would increase because a PLHA with poor nutrition is more likely to experience medication side effects, which affects medication-taking behavior. Additionally, by receiving the financial support, they can afford the travel-related expenses, an identified barrier to accessing treatment services.

Existing social protection programs that could cover the needs of this population are:

- Vaso de Leche – 'Glass of Milk': Local government program that provides food support to those affected by tuberculosis (Canasta PAN TBC).
- JUNTOS – National Programme of Direct Support to the Poorest: Conditional cash transfer program (S/.100 per month) to provide assistance to the poorest households in order to ensure access to preventive maternal and child health care and reduce school dropout.
- National Solidarity Assistance Program 'Pension 65': Financial subsidy (S/. 250 bi-monthly) to adults over 65 years of age living in vulnerable situations without an income that meets their basic needs.

None of these programs include PLHA (migrants and non-migrants) at greater risk of HIV in the category of vulnerable populations (e.g., transgender women) or those at the AIDS stage, whose reduced access to work limits the possibility of meeting their basic needs.

It is estimated that providing a basic food basket, similar to the one received by tuberculosis patients, to PLHA at the AIDS stage would cost 44.3 million soles per year. This is equivalent to 55% of the amount allocated for tuberculosis patients.

Migrants are not included in any of these programs, which puts them at a disadvantage compared to nationals. Thus, they are more exposed to problems such as chronic child malnutrition, lack of access to maternal and child health services, malnutrition in those affected by TB, school dropout, and elderly abandonment. A specific case of this omission that must be highlighted is that of orphan children with HIV.

The CBO activists who were interviewed identified the main issues:

> *"The problem in Peru is that the social vulnerability of people with HIV is not recognized..., a social determinants approach is not taken into account, and nothing is done to resolve the situation... In countries such as Argentina, Brazil, and Bolivia, there are social protection programs that help people to avoid a bad ending, especially for those who suffer extreme discrimination, such as transgender women... this [Peru] is the country of great inequalities: economic, social, political and cultural."*
>
> *(Key Informant: Activist CBO, 16.08.2021)*

4. **Multiple stakeholders involved in HIV management, within and outside the Ministry of Health, are an opportunity for MINSA to improve.**

The General Directorate of Strategic Interventions in Public Health (DGIESP) of MINSA includes the Directorate for Prevention and Control of HIV/AIDS, Sexually Transmitted Diseases and Hepatitis (DPVIH), which is responsible for identifying and coordinating strategic interventions for the prevention, control, and risk and damage reduction of HIV/AIDS, as well as formulating and implementing policies, standards, guidelines and other documents on early detection and timely treatment of HIV/AIDS and other complementary actions.

Other MINSA directorates or units also participate in the decision-making processes and the execution of activities in the prevention, control, and risk and damage reduction of HIV/AIDS. These are the National Center for Epidemiology, Disease Prevention and Control (CDC) and the National Institute of Health, the head of the country's entire public health laboratory system.

The DPVIH must act as a conciliator and coordinator to implement follow-up activities such as epidemiological surveillance or monitoring studies of ART patients.

On the other hand, the decentralized management of health services and public health interventions implies that regional governments play a significant role in the implementation of policies and regulations, from the preparation of the budget in the corresponding PR to the expenditures, whether in preventive activities or in ensuring the quality of care for vulnerable populations and PLHA.

In the area of migrants, the Ministry of Health created the Migrant Functional Unit under the Vice-Ministry of Public Health to make viable the different strategies that the ministry needs to implement for this population. Although this unit went through a period of operational problems due to the change of government, it is now active again.

Another space that should be considered for decision making is the National Multisectoral Health Coordinator (CONAMUSA), which plays the role of the Country Coordination Mechanism (CCM). This institution was created as a requirement for the presentation and execution of projects of the Global Fund to Fight AIDS, Tuberculosis, and Malaria and is chaired by the Vice-Ministry of Public Health. It comprises representatives of MINSA, international cooperation, universities, non-governmental organizations, and representatives of affected and vulnerable populations. Its function is to monitor the fulfillment of the objectives and goals of the Global Fund projects and promote spaces for consultation and develop plans and programs aimed at reducing the number of cases and the impact of HIV/AIDS, TB and malaria.

Cooperating partners such as PAHO, UNAIDS, UNHCR, and the institutions funded by them are also a significant opportunity for technical assistance to MINSA and advocacy for improving HIV care services.

3.3 Funding

In Peru, the budget for health priorities, defined by the Ministry of Health, is allocated through the Budget by Results. This links the allocation of resources to measurable outputs and outcomes in the population and prevents it from being used for other purposes. Thus, to obtain funding for an activity such as HIV screening tests, this action must be evidence-based, cost-covered, and included as a by-product of the respective budget program. Only then a target can be defined and the required funding is obtained. The most important funding source for the national response and HIV care is the PpR 016, which includes TB and HIV prevention, care, and control actions (Table 1). In 2021, the HIV/AIDS component budget was approximately S/. 313,487,484 for all levels of the system. According to PpR evaluations, the funding for Program 016 is equivalent to 4% of the total budget of the sector (MINSA, 2019). PpR funds are allocated

to collective health actions, and because of their social externalities, they also fund treatments and laboratory tests for case evolution of chronic communicable diseases. Individual health is financed by the SIS (e.g., treatment of disease complications). The SIS has no information regarding the funding of procedures or care for specific conditions and diseases such as HIV/AIDS.

Table 1. HIV Products in PpR 016 – TB y HIV

Budget Codes	Description	Distribution of budgetary execution Year 2020
3043952	Family with healthy practices for HIV/AIDS and tuberculosis prevention	12%
3043958	Population informed about correct use of condoms to prevent sexually transmitted infections and HIV/AIDS	5%
3043959	Adults and youths receive counselling and screening for sexually transmitted infections and HIV/AIDS	24%
3043960	Adolescent population informed about sexually transmitted infections and HIV/AIDS	5%
3043961	High-risk population receives information and preventive care	11%
3043969	People diagnosed with HIV/AIDS attending services and receiving comprehensive care.	36%
3043970	Reactive pregnant women and children exposed to HIV/AIDS receive timely treatment	6%

Source: Ministry of Economy and Finance, 2021.

1. **As of 2021, overcoming the funding gap to achieve 90-90-90 HIV/AIDS control coverage requires a tripling of the historical HIV/AIDS budget in the PpR.**

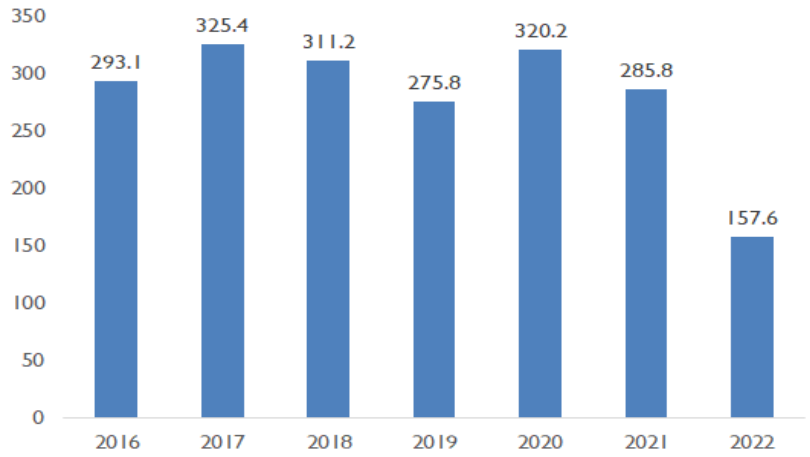
In 2018, a group of researchers with the sponsorship of the World Bank assessed the funding gap in relation to the goals set out in the Multisectoral HIV Strategic Plan. They estimated that to achieve the 90-90-90 HIV targets by 2020, US$345 million was required. This amount represents 2.8 times the current budget. Additionally, to achieve 95% ART coverage, the budget should reach US$700 million, which means a budget 7.6 times greater than the current budget (Prieto et al., 2018).

2. **There is a decreasing trend in the PpR per capita for HIV. In the approved budget for 2022, the MINSA Institutional Initial Budget (PIA) for TB-HIV PpR is reduced by 45% compared to 2021.**

The funding of the PpR has remained remarkably unchanged over the years. This is a situation of progressive decline if one considers that this funding is calculated based on the number of people attended and the ART system, which is growing every year (Graphic 8). This situation is aggravated when in the budget approved for 2022, MINSA's Institutional Initial Budget (PIA) for the TB-HIV PpR is reduced by 45% concerning the 2021 PIA (Graphic 7).

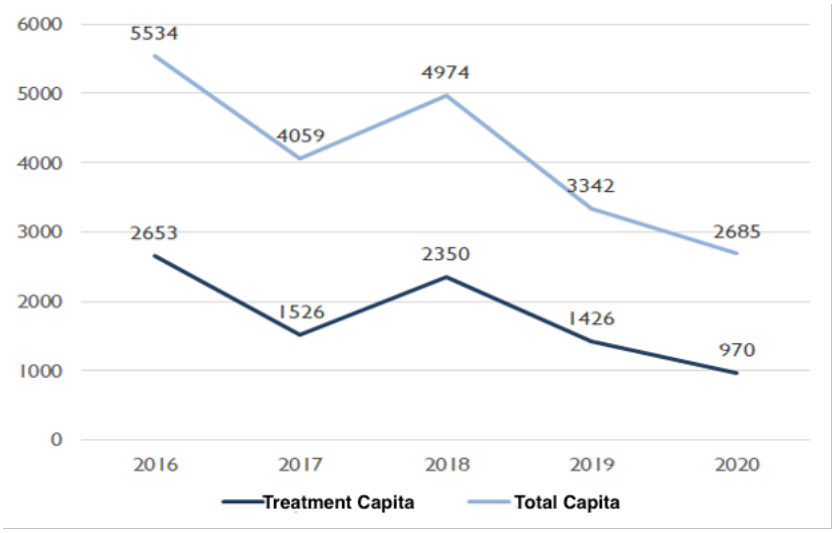
Most critically, the budget has been reduced by about S/.81 million in the budgetary product that ensures antiretroviral treatment. With the reduction applied, the annual capita for people receiving ART in 2022 would be US$127. This amount is three times less than the amount calculated (US$ 409) by Veronica Vargas for the World Bank in a 2015 evaluation. Her research was based on drugs purchased by the National Center for Strategic Health Resources Supply and expenditures on laboratory tests and medical care to control PLHA receiving ART (Vargas, 2015).

Graphic 7. Initial Budgetary Programme 016 TB-VIH (million soles) – MINSA, Perú 2016-2022



Source: Portal of Economic Transparency of the Ministry of Economic and Finance (MEF), Public Consultation 2016-2021 and Public Sector Budget Law for the Fiscal Year 2022. Own Work.

Graphic 8. HIV PpR per capita* – Peru 2016-2020



Source: Portal of Economic Transparency of the Ministry of Economic and Finance (MEF), Public Consultation 2016-2020 DPVIH-MINSA. Own Work.
** Capita in relation to PLHA receiving treatment.*

3. **Venezuelan migrant PLHA without the SIS insurance generate out-of-pocket expenses to cover screening tests before ART. The cost of these tests is equivalent to at least two weeks of work for a migrant. The prices of care and treatment for PLHA at the AIDS stage can be catastrophic.**

According to the Universal Health Insurance Framework Law, the SIS covers people living in poverty as long as they hold a National Identity Card and foreign residents as long as they have a Foreigner's Identity Card (MINSA, 2010). Recent legal provisions authorize the subsidized regime to cover people with health vulnerability, regardless of their poverty status. This concept of vulnerability includes HIV (MINSA, 2020). Difficulties for registering in the SIS, such as the requirement of a resident's migratory status document, cause out-of-pocket expenses for Venezuelan migrants without a foreigner's card who need to access unsubsidized health services, including examinations before the ART.

PLHA receive ART through the treatment program funded by the PpR; however, this program does not cover medical control care or inter-consultations that may be necessary to assess any associated health conditions. Nor does it cover care, hospitalization, examinations, or medications during the AIDS phase.

The out-of-pocket expenses of the Pre-ART exams assumed by the users are around S/.150. It can go up to around S/.1200 in the case of diagnostic imaging and others (calculated based on the rates of public providers). Considering that among PLHA vm, 83.7% earn a salary lower than the minimum living wage (Asociación Construyendo Caminos de Esperanza Frente a la Injusticia, el Rechazo y el Olvido, 2021), these costs can be equivalent to at least the earnings of one to two weeks of work. This is emphasized by the professionals involved in the management of comprehensive care for PLHA:

> *“Actually, the PpR only covers strategic interventions, rapid diagnostic tests, viral load monitoring, and other particular procedures. However, consultation, specialized care, general baseline laboratory tests, hospitalization, and complications treatment would already be included as part of the SIS coverage. When you are not registered with the SIS, the problem is that PLHA have to pay for it out of their pocket."*
>
> *(Key informant: health professional in management of comprehensive care for PLHA, 19.08.2021)*

4. **Third-generation epidemiological surveillance and other strategic products for HIV care and response, such as agents and community-based organizations services, do not have specific or sustained funding in the PpR, despite their proven high effectiveness.**

The current design of PpR 016 lacks a population-based approach to epidemic control. It does not incorporate the funding of epidemiological surveillance in a modern third-generation logic which includes monitoring administrative records of health services, surveillance based on notification systems, behavioral surveillance through population-based surveys, population-based surveillance studies of the situation and epidemiological changes in the different vulnerable subpopulations, and molecular surveillance, among others, that contribute to improving national understanding and response. In the Product: Common Actions (3000001); Activity 5004433: Monitoring, supervision, evaluation and control of HIV/AIDS - Tuberculosis, there is only the activity of case notification.

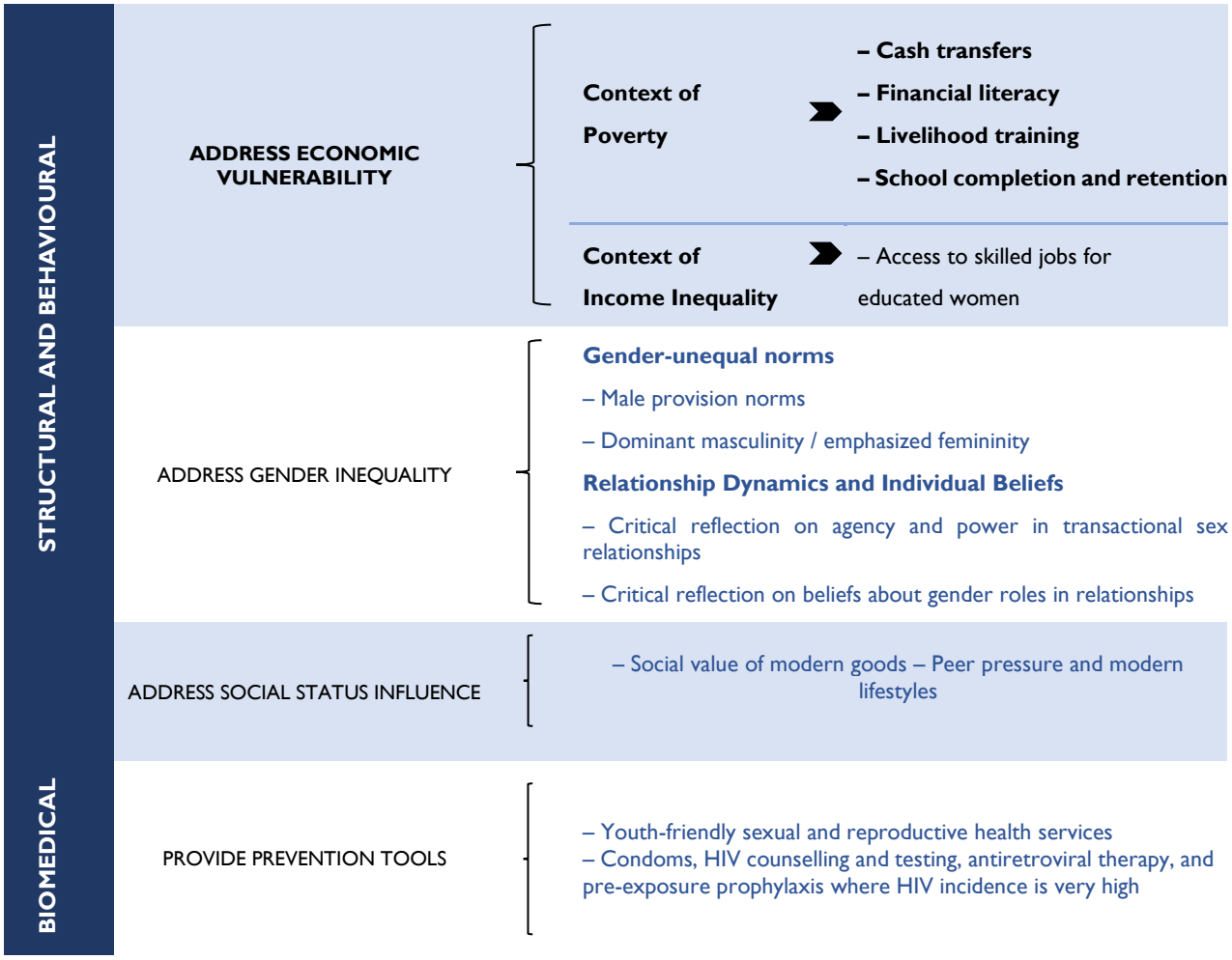
Strategic products such as peer-to-peer HIV counseling and linkage to improve access for vulnerable populations have not been incorporated into the normative and financing frameworks.

5. **Funding for HIV prevention and control in PpR 016 is based on a heteronormative conception. Therefore, it must be modified to focus more on key populations (TWM MSM, and SW) and the generation of new products and strategies that target their proximal determinants and risk factors.**

The control program approach incorporates a biomedical perspective to the PpR and omits essential aspects of the dynamics of social reproduction of HIV/AIDS in Peru. These require strategies and actions from various sectors of the State to address the social determinants that drive the epidemic in society and the most affected populations due to their vulnerability. The current design of the PpR does not include products, by-products, or actions that respond to the risk factors and determinants associated with HIV in the transgender population or the exercise of transactional sex. Several studies examining populations' vulnerability and their exposure to HIV risk raise the need for interventions on proximal determinants of HIV. The intervention model shown in Figure 2 is an example of this. It proposes strategies to address the economic vulnerability, gender inequality, and the influence of social status: school retention, livelihood and career training, access to decent work, empowerment, and resilience in the face of social discrimination. In the opinion of representatives of the intersectoral coordination platforms:

> *“What we have perceived is that the agenda is again fundamentally sanitary for HIV, and that is because the exercise of rights, of access to care and treatment for people with HIV, have not been ensured or strengthened. But we are staying in that health agenda that is very strong. We are neglecting the whole prevention agenda, and neglecting the multifactorial dimension of health problems, of sexual health, of people’s health with their diversities and vulnerabilities."*
>
> *(Key informant: CONAMUSA officer, 19.08.202*

Figure 2. Multicomponent Intervention model related to transactional sex for HIV prevention – UNAIDS, 2018



Source: UNAIDS (2018). Transactional Sex and HIV Risk: From Analysis to Action. Geneva: The Joint United Nations Programme on HIV/AIDS.

3.4 Service Provision

The legal basis for the prevention, care and treatment of HIV/AIDS in Peru is to be found in Law No. 28243 of 2004, which extends and modifies the Law No. 26626 (CONTRASIDA Law) from 1996. On this basis, rules were issued to regulate the provision of HIV/AIDS prevention, care and treatment services in health facilities. The response to HIV is focused on actions that revolve around health facilities, with limited action on social determinants. Moreover, the national response has little involvement of communities from vulnerable populations.

The results of HIV control activities can be seen in the continuum ("cascade") of HIV care, in which there are significant gaps in relation to the outcomes that should ideally be achieved. The DPVIH analyzed this cascade of care and reported that by 2014, 64% of estimated PLHA would have been diagnosed, but only 46% were receiving ART, and only 36% had viral suppression. For that year, the gaps were: 19 917 PLHA who did not know about their diagnosis, 25 078 who did not access treatment, and 25 633 who did not achieve viral suppression. Among Venezuelan migrants, it is estimated that by 2022, between 0.6% and 0.7% will be living with HIV, that is, between 7,200 and 8,400 Venezuelan migrants living with HIV in Peru. Of these,

62% would know their diagnosis, and 65 to 76% of migrants with a diagnosis will have access to treatment. Data on achieved viral suppression remain unknown.

1. **In Peru, Venezuelan migrants are a small proportion (7%) of the total number of PLHA receiving ART.**

Among HF ART that participated in the survey, 32,050 PLHA receiving ART (nationals and migrants) were registered, 7% (2,222) of whom were PHLA vm. According to DPVIH, care demand in HF and ART for PLHA vm has been absorbed without major difficulties due to the existence of installed capacities and availability of drugs with stock safety margins of about 20% of PLHA receiving ART. Although in this period (2017-2021), the ART stock margin forecast contributed to managing the additional demand for medicines, future planning should consider growth based on greater efforts in screening vulnerable national and Venezuelan migrant populations.

2. **The ART entry regulations that allow treatment to all people, regardless of their nationality and migratory status, have made it possible for 97.5% of diagnosed PLHA who accessed health services to start ART, despite not being registered with the public health insurance system.**

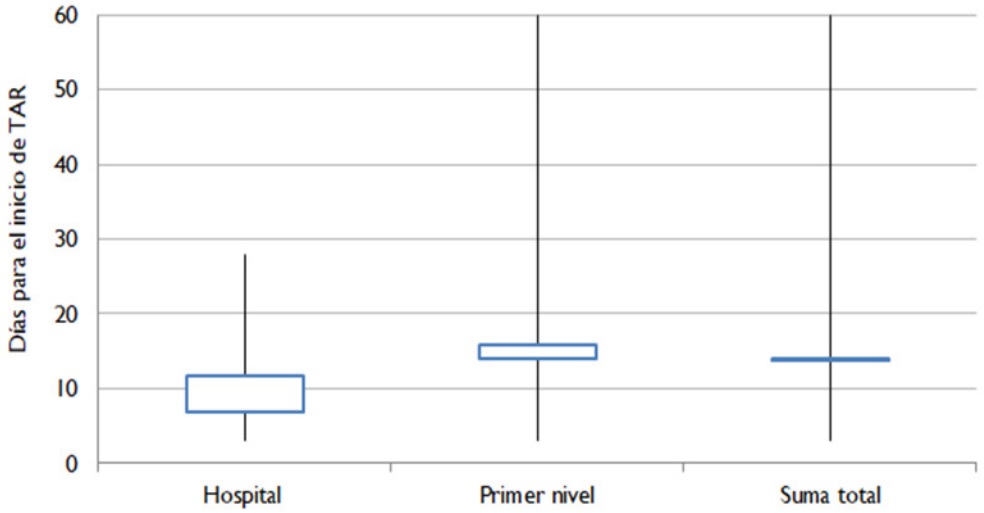
In contrast to the barriers to registering with the SIS, the ART norms issued by the DPVIH facilitate access to treatment (funded by the PpR) for everyone, regardless of their migratory status. As a result, nearly 3,500 PLHA vm are receiving ART, although only 2.5% (89 PLHA vm) are covered by the SIS.

As noted above, the costs of evaluation and diagnosis before ART are not covered by the system. To afford the costs of these exams, PLHA vm generate out-of-pocket expenses or find subsidies from NGOs or international cooperation.

3. **The percentage of PLHA Venezuelan migrants waiting to start ART is low and the average time to start ART for a PLHA vm was 14 days.**

The PLHA vm waiting to start ART accounted for 5% of the total migrant population of PLHA on ART in the survey. This is a relatively low percentage compared to what was expected due to the difficulties in paying for pre-ART screening tests caused by the lack of access to public health insurance described above. After a Venezuelan migrant receives an HIV-positive diagnosis, the average time to start ART was 14 days (12 days in hospitals, 16 days in HF of first level), but it can extend up to 60 days (see Graphic 9). These figures may vary according to the geographic location of the HF

Graphic 9. Average time and other measures of tendency during initiation of ART treatment in PLHA vm, by HF ART level –Peru, September 2021



Source: Survey HIV Integral Attention Service in Venezuelan Migrants. Peru, september 2021. Own Work.

4. **Approximately half (55%) of the PLHA vm currently on ART had received a previous HIV-positive diagnosis in Venezuela. Among the PLHA vm diagnosed in Peru, half were diagnosed by a Community Based Organization.**

According to the report by the staff responsible for the participating HF, slightly more than half (55%) of the PLHA vm on ART were diagnosed in Venezuela, 26% of the PLHA were diagnosed in Peru by a CBO, and 15% by a HF of the first level of care. According to this survey, half of the PLHA diagnosed with HIV in Peru and currently receiving ART would have been tested through a CBO. Vulnerable population CBOs seem to play an important role in the contact, screening, diagnosis, and linkage of PLHA to the HF ART. According to CBO activists:

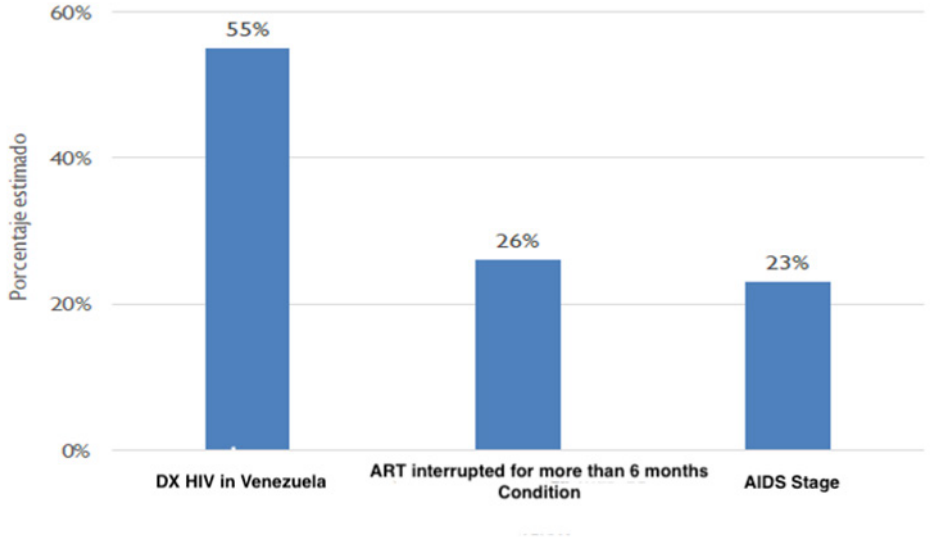
> *"We have to understand that the epidemic unfolds in key populations; we have to work with men who have sex with men, with transgender women, with transgender people, because when there are interventions, they look for community houses, and these places do have reach to the population, they will get the population to go to those spaces in a thousand ways so that they manage to do the screening. These spaces are visited for condoms and rapid tests or any type of information. Even Venezuelan people also seek those services and are friendlier when they are among peers."*
>
> *(Key informant: CBO activist, 16.8.2021)*

5. **Approximately one in four PLHA vm that arrived at their first visit in a HF ART in Peru had interrupted their antiretroviral treatment for six or more months (26%) and at the AIDS stage (23%).**

According to estimated figures by those responsible for the HF ART, the status of PLHA vm at the first consultation in the HF revealed that one in four (26%) came after 6-or-more-months treatment interruption of ART, and 23% arrived at the AIDS stage (See Graphic 10). The impact

on the health system in Peru is reflected in higher costs of care and a potential increase in mortality rates.

Graphic 10. Health condition of PLHA Venezuelan Migrant in the first consultation at HF ART– Peru, september 2021

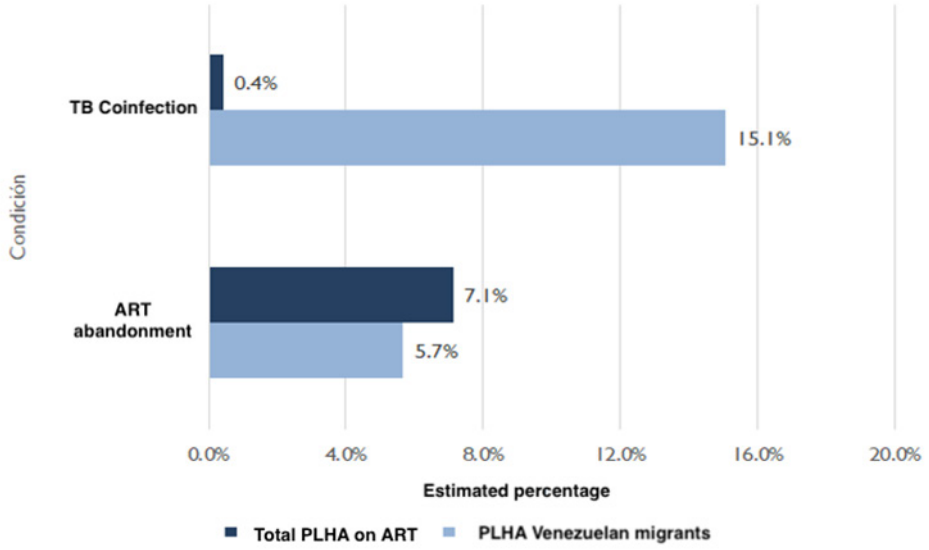


Source: Survey HIV Integral Attention Service in Venezuelan Migrants. Peru, September 2021. Own Work.

6. A high rate of TB coinfection (15%) was found among PLHA vm, more than 30 times the rate among Peruvian PLHA in the same HF ART participating in the survey.

The HF ART reported that 15% (335) of PLHA vm were diagnosed with TB coinfection. The figure for TB coinfection among Peruvian PLHA in the same HF was 0.4% (see Graphic 11). This figure is striking for its magnitude and should be investigated by the DPVIH in the final report of HF ART.

Graphic 11. Abandonments and TB co-infection among PLHA national citizens and PLHA vm receiving ART – Peru, September 2021



Source: Survey HIV Integral Attention Service in Venezuelan Migrants. Peru, September 2021. Own Work.

7. The rate of ART interruption among PLHA vm is high.

The HF reported that for the 3-year period 2018 -2021, 5% of PLHA vm abandoned ART. This figure is interesting compared to the ART abandonment rate by national citizens (7%) during the 17 years since the beginning of ART (2004- 2021). As the survey did not implement a cohort-based monitoring and evaluation methodology, there is no abandonment figure by annual time slices or subpopulations according to sexual orientation. The key informants specify that abandonment rates would be associated with the fact that, on the one hand, this population continues to migrate within the country or abroad and, on the other hand, with the absence of a linkage mechanism between the health facilities where they can receive care.

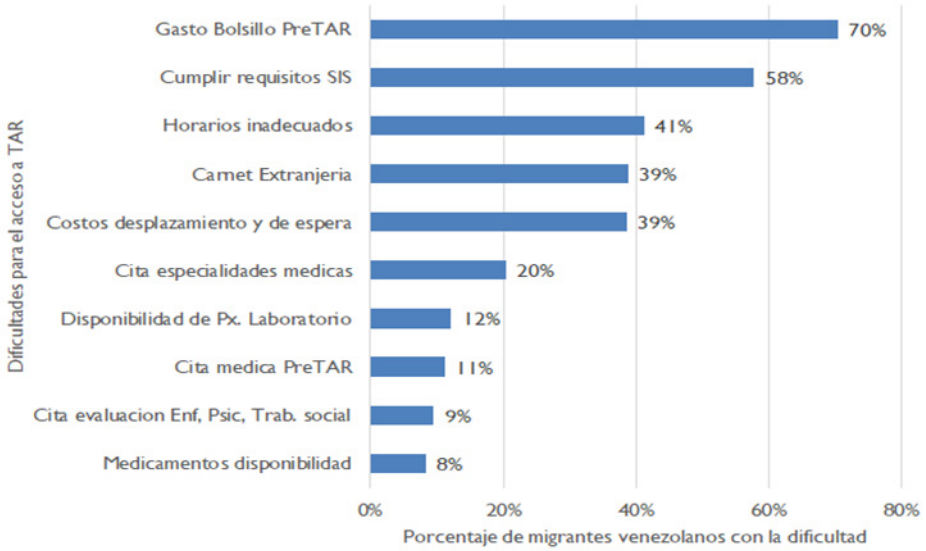
8. The main barriers to ART immediate start for PLHA vm are the out-of-pocket expenses for pre-ART exams (70%), the restrictive SIS registration requirements (58%), and the delay in obtaining the Foreign Registration Card (38%). In addition, organizational problems such as inconvenient schedules were reported in 41% of the cases.

According to the estimates of those responsible for the HF ART, the main difficulties faced by the PLHA in accessing ART are out-of-pocket expenses for Pre ART exams (70%), which are perceived as a direct consequence of problems in registering with the SIS (58%) and which depends, to a large extent, on obtaining the Foreigner Card (39%). Another set of issues linked to the organization of the ART service was also identified: poor schedules (41%), waiting time (time off work) and travel-related costs (38%), and difficulties in receiving specialized assessments (20%). It should be noted that the lack of availability of medications was reported in only 8% of cases.

"At the health center, they asked me for many tests that cost up to S/.1000, S/.1200 so that they could treat you. In other words, after the doctor attended to you, he asked for many tests to provide the treatment and the foundation got a contact and they did the tests themselves".

(Key Informant: user, 1.9. 2021)

Graphic 12. Barriers to starting ART in PLHA vm – Peru, september 2021



Source: Survey HIV Integral Attention Service in Venezuelan Migrants. Peru, September 2021. Own Work.

9. PLHA vm affected by the COVID-19 and who required hospital-based care, as reported by those in charge of the HF ART, stated that 22% suffered discrimination because of their sexual orientation and received poor quality of care.

Among PLHA vm affected by the COVID-19 infection and who received hospital-based care, 22.6% reported discrimination because of their sexual orientation, 8.8% because of their HIV diagnosis, and 6.6% because of their nationality.

"The girl (nurse) told me: "yes, we are first; second, us; and third, us. So, you are taking away part of the Peruvian citizen's attention," and I replied to her: "but we have never said that one person must take the place of another". Then she said it to everyone waiting for the consultation. I mean, there were around 15 people, 8 were Venezuelan people, and she was upset. She told me: "Oh! this is crowded with foreigners, I mean, they are taking away our health care."

(Key Informant: user, 27.09.2021

10. There are procedures and mechanisms for updating comprehensive HIV care based on evidence and aligned with the international policy of immediate treatment. However, the incorporation of pre-exposure prophylaxis lags.

The regulations for ART are contained in the Technical Health Standard for the comprehensive care of adults with HIV infection (NTS N°169-MINSA/2020/DGIESP), which has periodically updates by a national committee of experts. Currently, the standard is aligned with international

recommendations for ART immediate initiation after diagnosis. However, there is a significant delay in the promulgation and updating of other regulations.

Regulations to be issued:

- Pre-exposure prophylaxis (PrEP).
- Directive for the organization and management and quality standards in HF ART.
- Specific planning to intervene in areas with the highest concentration of cases.

Regulations to be updated:

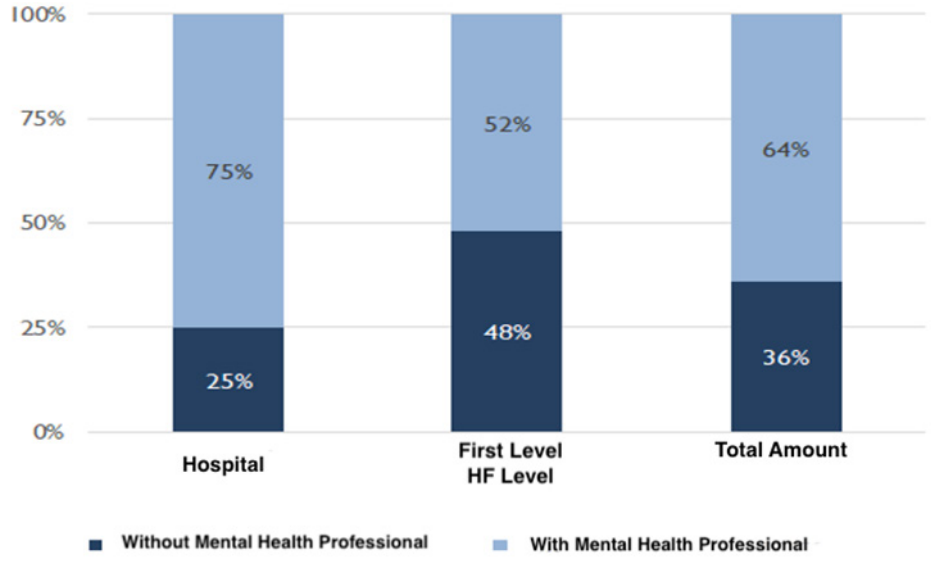
- Standard for articulating the Peer Educator Counselor Service for People Living with HIV/AIDS.
- Peer Educator Promoters in Vulnerable Populations to prevent sexually transmitted infections and HIV/AIDS; from the Technical Document: STI/HIV and AIDS Counseling; Health Directive No. 030-MINSA/DGSP-V.01.
- Health Directive for Periodic Health Care for Sex Workers and MSM.
- Technical Health Standard for Epidemiological Surveillance in Public Health of Human Immunodeficiency Virus Infection (HIV) and Sexually Transmitted Infections (STI) in Peru.

3.5 Human Resources

1. **Only 64% of the HF report that they have the minimum number of health professionals required in a team for comprehensive health care (physical and mental) in their ART services.**

The average number of health professionals in HF ART in hospitals and primary care facilities was 7 and 5, respectively. Despite these strengths, the survey also found that in the HF ART, only 64% report having the minimum range of professionals (physician, nurse, midwife, pharmaceutical chemist, biologist or medical technologist, and psychologist) as required in a team for comprehensive health care (physical and mental) in their ART services (75% of hospitals, 52% of the first level) (see Graphic 13). In addition, they reported a lack of HR and a high staff turnover as issues in the HF ART, regardless of their level of experience or volume of PLHA receiving care.

Graphic 13. Proportion of HF with the minimum range of professionals for comprehensive health care in their ART services - Peru, September 2021



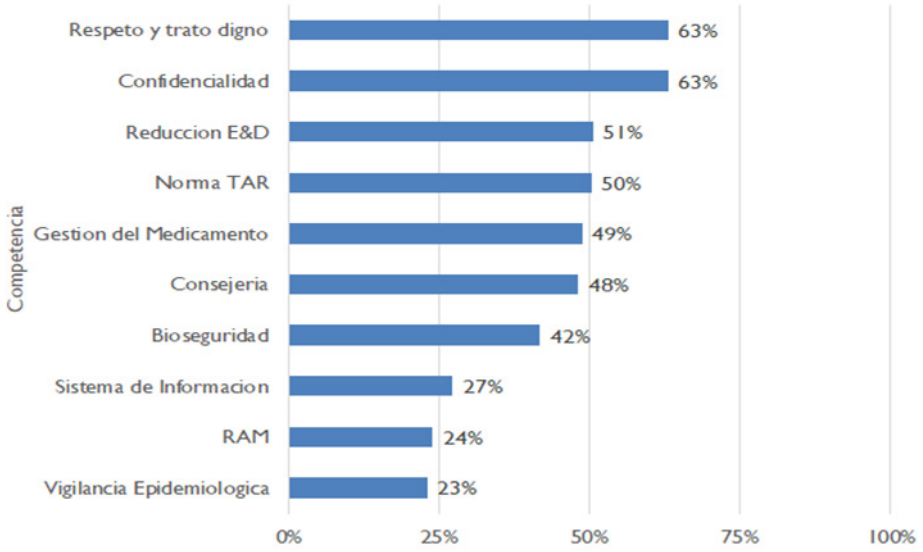
Source: Survey HIV Integral Attention Service in Venezuelan Migrants. Peru, September 2021. Own Work.

2. Less than 50% of the HR of the HF ART have up-to-date competencies for comprehensive care and do not have a certified training program.

The survey explored the updating level of HR in the competencies required for comprehensive care and management of the ART service during the last 3 years. It was found that the competencies in which staff had been trained the least were those related to adverse drug reactions (47%), management of the information system (48%), control of the epidemiological surveillance system (52%), and competencies for stigma reduction and discrimination (62%). The updating level varies according to the HF level and the length of time since the ART service was implemented. In HF ART, with less than one year since ART implementation, the level of up-to-date competencies is less than 50% of their HR (see Graphic 14). ENSAP, DPVIH, and HF reported that they lacked a formal training and professional development plan of HR in HIV services. There were no training plans, training activities were developed under the initiative and programming of the HF ART itself, and training was not certified.

> *"The people who work in this health center have to take a course on human relations. They are dealing with people who have medical conditions, others have a more delicate clinical condition, and therefore, the workers are people who must learn how to deal with people".*
>
> *(Key informant: user, 26.9.2021)*

Graphic 14. Proportion of updated HR according to competency for comprehensive care in ART services implemented since 1 year ago or less- Peru, September 2021



Source: Survey HIV Integral Attention Service in Venezuelan Migrants. Peru, September 2021. Own Work

3.6 Information System

The health information system is fragmented and managed by different subsectors, and even within them by various units. These deficiencies generate dispersed information and impede the report of representative and high-quality data. This has an impact on the consolidation of regional and national data.

1. **The Ministry of Health lacks an information system or platform that centralizes data on HIV preventive care and follow-up services to allow their interoperability.**

Routine data collection relating to HIV service provision is institutionalized, but the system is disorganized and non-automated. The ART registration system of the DPVIH is Excel-based, unstable, precarious, and fragmented. Different variables are recorded in forms administered by the National Center for Epidemiology, Prevention and Disease Control (CDC Peru), the National Health Institute (INS), and even the General Office of Information Technology (OGTI), which manages the Health Information System, and the SIS. The system does not include key variables such as gender identity (and, if this is recorded on paper forms at the local level, it is not standardized). The databases of the different institutions, even when they have standard identifiers, have not developed algorithms to interoperate (and before that, to control the quality of the data recorded). Nor has the necessary data structure been defined to generate the different indicators required by the institutions and, especially, by the DPVIH to monitor PLHA.

2. **A restrictive regulatory framework defined by MINSA in Administrative Directive No. 294-MINSA/2020/OGTI, hinders the exchange of information considered personal.**

One of the significant challenges to overcome in the development of interoperability in health, especially in the case of HIV, is the restrictive regulatory framework that hinders the exchange of information considered personal and the regulations generated by the OGTI in this regard.

The directive should be modified due to the restrictive terms it proposes, such as a structure that sends only aggregated data.[3] It does not allow the construction of nominal lists containing Personal Health Data (DPS) of patients, whether they receive treatment from the state. In addition, the directive stipulates that the DPS are only available and duly safeguarded in public, private and mixed HF where each patient receives care, thus respecting the purpose for which they were collected. It is worth noting that this last concept is not part of the law and is a restrictive interpretation of OGTI concerning the nature of the establishment or institution that "provides care." Thus, it limits the benefit of clinical care and ignores other services such as, for example, those provided by referral laboratories for specialized diagnosis or treatment programs of priority public health. These require follow-up actions and sometimes recovery of cases in the community, etc. This situation impacts the appropriate management of ART since, from a collective health approach, the most significant limitation is the lack of nominal data on which to build and follow up treatment cohorts.

As expressed by professionals of the Information System about the restrictions for the exchange of HIV information:

> *"Today we have a regulation approved by MINSA, which expressly prohibits the exchange of personal health data, including clinical, epidemiological data, etc., between health facilities in the same network. It is forbidden unless there is prior informed consent, that is, handwritten authorization from the patient. But that is madness; there is no way for me to know beforehand that I am going to get sick and that the other facility will need my data and that I should previously give the authorization consent because I do not know if I am going to get sick. I do not know what information the other health facility will need. There is no way of knowing, but currently, the Peruvian regulation assumes that. That, for example, is a great barrier to the integration and implementation of all these systems in the present time."*
>
> *(Key informant: information systems professional, 12.08.2021*

3.7 Epidemiological Surveillance

1. **The HIV/AIDS Epidemiological Surveillance System, based on case notification, has an underreporting level of at least 33% of cases of PLHA vm considering the case notification rates among PLHA receiving ART.**

As of June 2021, the Epidemiological Surveillance System of the Ministry of Health has recorded a total of 144,517 people with HIV or AIDS since the first case of the epidemic was identified in Peru (1983). Of these, 2270 (1.57%) correspond to Venezuelan migrants. According to the DPVIH, on the same date, 3475 cases of PLHA vm were registered in HF ART across the 25 departments of the country. If all cases reported to the surveillance system were among PLHA currently receiving ART, the underreporting of cases of PLHA vm would be 33.39%.

2. **The limited epidemiological analysis is a barrier to the creation and reporting of indicators to monitor the response and control of the epidemic in vulnerable subpopulations, including migrants.**

[3] This directive defines the data frame as a structure of variable data where each row corresponds to a given case or observation, and every column of a table represents a particular variable.

The Epidemiological Surveillance System, although it maintains a consistent report on the HIV situation - published in epidemiological bulletins and on an electronic dashboard on the web page of the General Directorate of Epidemiology, Prevention and Disease Control - does not include among its variables of analysis those referring to subpopulations by gender orientation. It reports only data on biological sex and the mode of transmission. Similarly, since the emergence of the mass migration of Venezuelan citizens, neither nationality nor migratory status has been included as a variable of analysis. Thus, epidemiological surveillance analyses based on case notification do not accurately report HIV behavior and patterns in key populations.

3. **Lack of a third-generation Epidemiological Surveillance System that includes the assessment of the epidemiological situation and its evolution at the level of subpopulations. This system should be molecular and applied to the administrative records of health services and based on a notification system, which improves the national response and HIV services.**

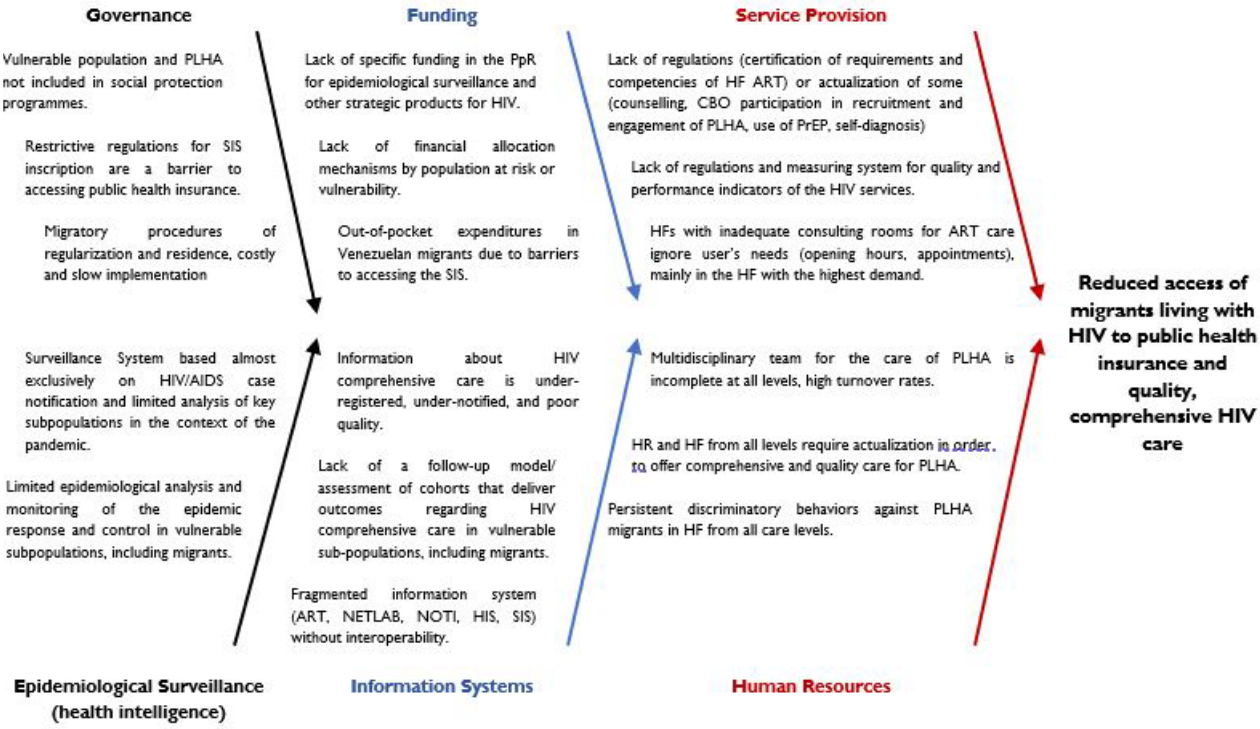
Despite the country's experience in implementing different surveillance models, sustainability of HIV surveillance has not been achieved. There are several actors legitimized over time in the implementation of surveillance, such as researching NGOs that conducted several incidence and prevalence studies in vulnerable populations; the INS, which conducts surveillance of HIV genotype and phylogenetic tree, and genetic surveillance of drug resistance; the National Institute of Statistics and Informatics (INEI), which administers behavioral surveys using population-based studies (although the survey needs to be complemented to develop one focused on vulnerable populations and report more accurate indicators); the Epidemiology Directorate, which conducts surveillance by notification, modeling of the HIV epidemic and has constant information analysis practices, to which should be added the analysis of mortality based on data from the National Death Registry Information (SINADEF). The current regulation only conditionally establishes the implementation of each surveillance and does not establish the frequency of its implementation in vulnerable subpopulations and regions of the country. The central issue is the need for a consensual design of a new Surveillance System Model that, on the one hand, identifies products, funding sources, and modern management strategies for implementation with the participation of other institutions —academia and private sector— and on the other, establishes the timing and periodicity of surveillance implementation.

4. Cause and Effect Analysis

This analysis identified the main problem: "Reduced access of PHLA migrants to public health insurance, and comprehensive and quality HIV/AIDS care." The root causes of the main weaknesses and threats observed in the SWOT matrix were examined. Based on this, a cause-effect diagram of the challenges faced by Venezuelan migrants when accessing HIV/AIDS services was developed, identifying the bottlenecks of the different components of the health system and the HIV/AIDS services (See Figure 3).

This scheme provides a graphic summary to facilitate the understanding of the complexity of the problem we are analyzing.

Figure 3. Cause and Effect Analysis of "Reduced Access of HIV migrants to Public Health Insurance and Comprehensive and Quality HIV/AIDS Care", by Component - Peru, September 2021



Source: Own Work

Problem (Effect):	
"Reduced Access of HIV Migrants to Public Health Insurance and Comprehensive and Quality HIV/AIDS Care".	
Component	**Cause**
Governance	• Migratory procedures for regularization and residency, their implementation is slow and expensive (Gov.) • Restrictive SIS regulations during registration limit access to public health insurance (Gov.) • Migrants, PLHA and vulnerable population are not included in Social Protection Programs that would reduce their exposure to risk (Gov.)
Financing	• Out-of-pocket expenses for Venezuelan migrants (due to difficulties in registering with the SIS), to cover pre-ART exams and/or care and treatment of PLHA at the AIDS phase (F, Gov., SP). • Lack of financial allocation mechanisms of the PpR, related to PLHA receiving ART, population at risk or according to vulnerability, and that guarantee stable financing of care and response to HIV (F, Gov., SP). • Epidemiological surveillance and other strategic products for HIV care and response, such as services of community agents and organizations. They do not have specific funding in the PpR (F, Gov, SP).
Service Provision	• HF with consultation rooms that are inadequate for ART care and that do not consider the needs of users (schedules of care, appointments) mainly in the HF with the highest demand or recently implemented (SP). • Lack/updating of norms and procedures for improvements in comprehensive HIV prevention and care (counseling, CBO participation in recruitment and engagement of PLHA; use of PREP, self-diagnosis) (SP). • Lack of regulations and system for measuring quality and performance indicators of HIV care services (SP).
Human Resources	• Multidisciplinary team for the care of PLHA is incomplete and has high turnover rates in HF from all levels (HR, SP). • Human resources in HF from all levels, partially/insufficiently trained for comprehensive and quality care for PLHA(HR, SP). • Persistence of discriminatory behaviors towards migrants and PLHA in HF from all levels (HR, SP).
Information Systems	• Weak monitoring of process and outcome indicators of comprehensive HIV care in vulnerable subpopulations, including migrants (Inf Sys, SP). • Lack of a monitoring/assessment model of cohorts that delivers results about comprehensive HIV care in vulnerable subpopulations, including migrants (Sist Inf., SP). • Fragmented information system (ART, NETLAB, NOTI, HIS, SIS), without interoperability, insufficient for identification of vulnerable populations (gender identity, migrants) (Inf Sys., SP).
Epidemiological Surveillance	• Limited epidemiological analysis (Inf Sys., SP) is a barrier to the creation and reporting of indicators to monitor the response and control of the epidemic in vulnerable subpopulations, including migrants.

5. Recommendations

The main recommendations for the various components are included. The system, as it is currently designed, does not work efficiently. Regulatory changes are required to implement the necessary adjustments to improve its performance. For this reason, there are several proposals for the issuance of standards or modification of existing ones.

5.1 Governance

1. **Facilitate the incorporation of Venezuelan migrants living with HIV into the SIS. There are two main ways to achieve this:**

    a. **Adapt the Complementary Modifying Provision of Emergency Decree No. 017-2019 to incorporate the assumptions of health vulnerability (HIV, TB, Disability), established in Supreme Decree No. 002-2020-SA, and facilitate the SIS registration of PLHA vm.**

For PLHA vm to register with Comprehensive Health Insurance, lifting the restrictions established by the SIS regulations is necessary. One option is the amendment (or "update") of the Complementary Modifying Provision of Emergency Decree No. 017-2019, which introduces measures for universal health coverage, incorporating the assumptions of health vulnerability established in Supreme Decree No. 002-2020-SA. This Supreme Decree regulates the First Final Complementary Provision of Legislative Decree N° 1346, which sets provisions to optimize the services funded through the SIS. It is required to include the PTP or refugee applicant card and other documents issued by the competent authority as valid identity documents for registering with the SIS.

This is a legal modification, so the proposal may be an initiative of the Ministry of Health or the Congress of the Republic. This modification could be made in the short term if there is the political will. Then the corresponding SIS directive should be issued, and the norm should be promulgated at the national level to be implemented in the health services.

    b. **Modify the "Guidelines for granting and renewing Humanitarian Migratory Status," approved by RM N° 0207-2021/RE, to improve the procedure and predictability of the concession of the humanitarian migratory status of residence by the Ministry of Foreign Affairs (MRE).**

These amendments require establishing deadlines for the procedure -since currently there are no deadlines- and incorporating this benefit regardless of the legal status of the migrant — currently it is exclusive for Venezuelan persons who have applied for refugee status—. In addition, these amendments should clarify the specific guidelines to standardize the conditions for accessing humanitarian migratory status in articles 5.1.1, 5.1.3, and 6.3. In this case, the health vulnerability assumptions established in Supreme Decree No. 002-2020-SA, mentioned in the previous point, must also be incorporated. These regulatory modifications depend on the Ministry of Foreign Affairs and may take more time.

    c. **It is necessary to incorporate a mechanism for greater participation of the actors involved in defining plans and regulations, from advisory and cooperating organizations to CBOs and patient associations.**

5.2 Financing

1. **Recover and increase funding for PpR 016 TB-HIV/AIDS, using per-capita allocation criteria to guarantee ART, comprehensive care, and strategic interventions.**

Through an additional demand, MINSA should request the repositioning of its 168 million soles funding, as a minimum, in order to maintain per capita budget at 2016 levels. Since then, the funding has been decreasing, despite the increasing demand of TB-HIV treatment. The Ministry of Health should coordinate the corresponding arrangements with the Ministry of Economic.

Allocating the budget to new surveillance actions for interventions in key populations requires defining new products of PpR 016 TB-HIV/AIDS, focusing on population control of the epidemic. Modify the conceptual model, problem tree, and analysis of the logic matrix[4] of the Budgetary Program.

This approach becomes fundamentally biomedical and heteronormative, without being able to respond, for example, to a conceptual model of HIV sexual transmission risk factors in the female transgender population in Peru. The PpR should incorporate new products focused on: addressing social determinants in key populations (especially Transgender Women, Sex Workers) and incorporate funding for third-generation epidemiological surveillance and research. This can be based on this: Output: Common actions (3000001); Activity 5004433: Monitoring, Supervision, Evaluation and Control of HIV/AIDS - Tuberculosis should be broken down to incorporate Activity 5004433 into Epidemiological Surveillance and Evaluation.

2. **Enable the purchase of services from CBOs and implement targeting strategies for key populations. To this end, it is necessary to modify the operational definitions of the PpR 016 TB-HIV/AIDS Products.**

It is recommended that the operational definitions of the PpR outputs be modified to incorporate greater participation of key populations and implement "targeting" strategies at both the subpopulation and territorial levels. For example, purchase of services from CBOs and civil society organizations, including services of "peer promoters."

To achieve this, CBOs should certify their community institutional capacities in counseling and screening, emotional support and promotion of adherence, human rights advocacy, and battling stigmatization and discrimination.

[4] The current model is based on: Boerma JT (2005) Integrating demographic and epidemiological approaches to research on HIV/AIDS: the proximate-determinants framework. J Infect Dis. 2005 Feb 1;191 Suppl 1:S61-7

Table 2. Output, Byproduct, Activity, Operational Definition, and Programming Criteria that could be modified to incorporate the Provision of Prevention and Screening Services by CBOs - Peru, September 2021

Product	Byproduct	Activity	Delivery Modality	Person in charge of delivery	Programming Criteria
Population at high-risk for HIV receives information and preventive care. (3043961)	Byproduct 1: 4396101 Populations of MSM, SW, transgender and other identities of sexual diversity receiving HIV/STI preventive care.	Activity1: 5000071 Provide information and preventive care to population at high-risk for HIV.	Differentiate: Preventive care is received in community spaces where populations interact (sites of sex work, socialization, recreation, among others). The delivery of services outside health facilities may be provided by CBOs and NGOs, under service contracts.	Current: Health staff is required to undergo training of at least 24 hours once a year. Modify: Community Based Organizations registered as IPRESS vs organizations providing preventive specialized service (SUNARP, OSCE) with trained peer educators certified by ENSAP.	Current programming criteria: Additional 10% of population at high-risk of HIV screened for HIV in the previous year. Modify: Additional 25% of population at high-risk of HIV.

Source: PpR 016.

3. Provide the SIS with the necessary resources to offer health coverage to Venezuelan migrants living with HIV.

In May 2021, only 87 (2.5%) out of 3475 PLHA vm registered in ART services were part of the Comprehensive Health Insurance.

For this year, 2021, the per capita allocation of the SIS is S/ 89 per year. Therefore, it is estimated that the incorporation of Venezuelan migrants living with HIV who remain uninsured will cost between S/ 301,532 and S/ 747,600, depending on the number of PLHA currently on ART (3475) or the estimated total number of PLHA living in Peru (8400). This figure represents between 0.013% and 0.033% of the Modified Institutional Budget of the SIS for 2021, that is, 2223 million soles to cover 25,231,910 insured persons.

It is worth mentioning that the capita per person insured with the SIS (as in the case of any insurance) is incorporated into a pool of resources used to afford the care required by the insured patient. In the case of people with HIV, the SIS and FISSAL cover all the expenses needed for specialized care, laboratory tests (other than those for ART follow-up), hospitalization, or any other health care not necessarily related to their HIV status.

5.3 Service Provision

1. Improve HIV prevention and comprehensive care strategies (counseling, participation of CBOs in the recruitment and linkage of PLHA, telemedicine, use of PrEP, self-testing) by updating current norms and procedures.

New approaches to engaging vulnerable populations need to be incorporated, either as community-based organizations or as individuals in the role of peer educators and linkers. Community-based services support public health services by filling a critical gap: they work effectively with vulnerable populations, provide support services that reinforce the care supplied

by HF, or expand the reach of health services in the community. As found in this report, this is the case for CBOs that diagnose a significant proportion of new PLHA vm and link them to the health system. Similarly, the use of different methods and technologies for screening —including self-administered tests— the offer of tests —such as assisted partner notification and the 'snowballing' technique— and counseling can be incorporated. Pre-exposure prophylaxis, which consists of administering drugs to people at risk of HIV infection, prevents them from acquiring the virus.

2. **Focus the interventions in the areas of high concentration of populations vulnerable to HIV infection through the development and implementation of an Intervention Plan for the Prevention and Control of HIV/AIDS in Metropolitan Lima and high-priority regions, 2023-2025.**

One way to reduce HIV transmission is by concentrating actions on key populations such as MSM and transgender women, and in cities —and urban areas— where the highest percentage of new cases are registered. To this end, it is recommended that DPVIH develop an "HIV/AIDS Prevention and Control Intervention Plan in Metropolitan Lima and High-Priority Regions". The framework of this plan should be the accelerated action for combination HIV prevention (UNAIDS, 2015). UNAIDS defines combination HIV prevention as the set of rights and evidence-based community-based programs that promote a combination of biomedical, behavioral, and structural interventions designed to meet the HIV prevention needs of specific individuals and communities.

To build it, it is suggested to focus on districts and progressively advance to the identification of hotspots (clusters of transmission) and, to the extent that there is support from health professionals or trained community agents, to identify, investigate and screen the contact networks of index cases. To improve the methodology and results, mapping can be implemented as a tool to reach key populations. This could be developed in the following steps: (1) focus on the key areas: clusters of transmission, of incident cases (Hotspots); (2) perform a standard mapping of social spaces of key populations based on key informants (positive cases, recovered dropouts) and their close contacts, using the PLACE methodology - Priorities for Local AIDS Control Efforts, and (3) establish extended networks, to obtain a more efficient mapping. The PLACE methodology consists of identifying and assessing multiple levels of HIV risk through interviews with key populations.

In MINSA, there is a history of similar interventions, such as the "Plan for Intervention in Areas at Higher Risk of Transmission (Background: Plan TBC, 2018)" and funding is available from centrally managed resources. This could be implemented in one or two years, depending on the support received from MINSA and the role of DPVIH, responsible for its development.

3. **Development of an administration plan/program for ART services that allow managing standards of organization and quality of service (currently 200 EESS ART).**

The DPVIH strategy to improve access to ART has focused on reducing the concentration at the first-level HF. Being an activity of high-strategic importance, the organization and quality of the service must be guaranteed. To this end, it is possible to develop a plan or program for the management of the ART services that will allow managing standards service in terms of quality and organization. It is also necessary to issue a Directive on Standards, organization and management of HF and develop supervision activities to measure the effort to achieve quality care. The financing to ensure that all HF comply with the standards should be managed through the PpR 016 or as additional funding for regional governments. Currently, the DPVIH does not have indicators to measure the performance of preventive, care and treatment services. In its

place, some indicators of production, epidemiology, and PpR expenditures are monitored. Based on UNAIDS recommendations and international experiences, incorporating a component for measuring quality and performance indicators for HIV care services into the current regulations is suggested.

5.4 Human Resources

1. **Improve the capacities of the health, care and administrative staff to provide comprehensive and quality care, including reducing stigma and discrimination against PLHA and migrants. To this end, an HR capacity-building plan should be developed for HF's health professionals and administrative staff (Certified Program with ENSAP participation).**

It is necessary to develop an HR capacity building plan for professionals in health care assisting the HIV services that include topics such as counseling, reduction of stigma and discrimination (with a focus on vulnerable population and migrants), dignified treatment, culturally appropriate care, ART, Adverse Drug Reactions (ADR), among others.

It is also necessary to carry out a capacity-building process for HIV prevention professionals at the local and regional levels on drug management, epidemiological surveillance, information systems, and basic data analysis. Training could also focus on other support areas such as monitoring techniques, mapping, evaluation, DPVIH management: regional and local coordination, territorial strategies, and preventive interventions in Hotspot.

Within the plan above, a line of work to reduce stigma and discrimination of vulnerable, affected, and migrant populations should be considered with the authorities, administrative officials, and support staff of HF ART and CERITS activities.

5.5 Information Systems

1. **Standardization of the DPVIH nominal registry (currently in Excel) in the short term.**

Currently, the data of PLHA receiving ART is recorded in Excel spreadsheets and follows a format provided by DPVIH (local levels have incorporated new variables into the form). The nominal registry is not standardized, and this is a crucial activity for the organization of follow-up cohorts. In the short term, DPVIH would need to make an "inventory" of new variables that the HF have been registering in order to assess their incorporation into an online system centralized in DPVIH. It would also be necessary to provide security for data protection, access, and privileges of use and the added value: tabulation algorithms and production of automated reports. At the local level, it would be required to migrate the records of approximately 82,000 PLHA on ART, attended in 200 HF, to this online system. The product should be a nominal database centralized in DPVIH, capable of interoperating and providing real-time consultation at the national level, and analysis of the information at the local level.

It is essential, thus, to implement the HIV prevention and care database repository in the Unique National Health Information Repository (REUNIS); implement in REUNIS (RM 350-2015 MINSA) the HIV prevention and care database repository from the different subsystems linked to HIV care; design the data model and indicators, data frames, flow and periodicity of information, of HIV prevention and care (International Cooperation, DPVIH, VMSP). The standardization of this system requires that all related data (from the different subsystems) be registered nominally and articulated through standard identifiers. Based on the articulated data (Unique Repository or HIV Datawarehouse), it is possible to develop a dashboard to monitor

and manage the HIV preventive response, care, and control. At the "micro-area" level, this dashboard will render visibility to statistical (graphs) and geospatial (maps) data with hotspots of HIV prevalence and incidence, screening coverage, and cascade compliance, and it will stratify the information by key population types, among other described variables.

2. **Development of the methodology of organizations by cohorts of comprehensive care for PLHA to assess the effectiveness of ART.**

The effectiveness of the program (DPVIH ART), measured in terms of coverage, adherence and effect on viral load and patient status, can be assessed through the organization of follow-up cohorts. Under a treatment-focused approach, there could be several criteria for entry into a cohort. One could be the year of treatment initiation. Cases may be subdivided into groups according to the treatment schedule. The clinical data in the Single Form of ART, which is managed in the HF that delivers ART, was recorded (in both physically and online documents) using the following variables: treatment regimen, laboratory tests, especially viral load results, clinical evaluations, treatment adherence, attendance at evaluations, adverse drug reactions, non-attendance and abandonment of drug deliveries, diagnosis of diseases and/or complications (especially those potentially associated with drugs), death. The recorded data should produce indicators of the care and others related to the effectiveness of the program, from screening, identification of confirmed cases, linkage to care and initiation of treatment, treatment adherence, viral load undetectability, and adverse indicators such as treatment abandonment, and mortality. These indicators can be automatically produced and updated through a dashboard and linked to the implementation of accelerated action plans for combination HIV prevention.

Important monitoring models at the geographic level and by vulnerable subpopulations can be consulted in the Ending the AIDS Epidemic (ETE)[5] Initiative in New York State, USA. (https://etedashboardny.org/data/prevalence-and-care/hiv-care-cascades/nyc/).

5.6 Epidemiological Surveillance

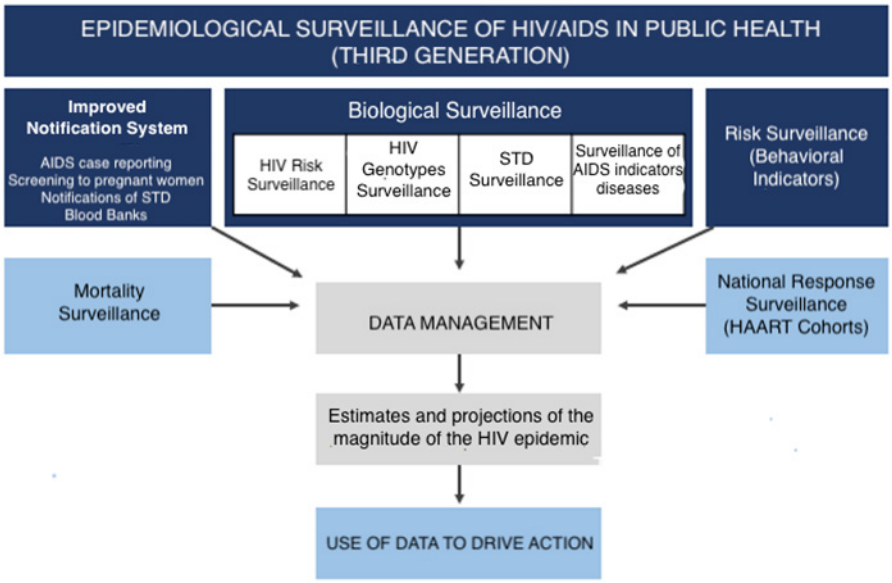
1. **Design of a third-generation epidemiological surveillance system (including monitoring of administrative health care records, surveillance based on a notification system, behavioral surveillance through population-based surveys, population-based surveillance studies of the epidemiological situation and its changes, and molecular surveillance) that will contribute to improving the national response and services in the fight against HIV.**

It is necessary to issue —and modernize— a Technical Standard for HIV Surveillance that incorporates all surveillance initiatives (CDC, INS, DPVIH), including activities in PpR to ensure financing and sustainability, new management schemes for the components, such as nationally approved protocols, and development by specialized organizations (e.g., agreement with INEI for population-based behavioral surveys, with NGOs for prevalence studies, and with universities for genotyping). As shown in Figure 4, the surveillance system should include, in addition to case notification: biological surveillance of risks –or behavioral indicators– mortality surveillance, and surveillance of HAART cohorts.

[5] Morne, J. E., Tesoriero, J. M., Martin, E. G., et al. (2020). Ending the HIV Epidemic: New York's Quest to Become the First State to Reduce HIV Prevalence. Public Health Reports (Washington, D.C.: 1974), 135(1_suppl), 65S–74S. https://doi.org/10.1177/0033354920917403

This collaborative work between the different institutions should lead to the generation of data used in a panel control. This dashboard will measure and estimate the magnitude of the HIV epidemic in the country to take action under the logic depicted in the following graphic:

Figure 4. Third-Generation Model of Epidemiological Surveillance of HIV/AIDS – Peru



Source: General Directorate of Epidemiology - Ministry of Health Peru.

5.7 Conclusion

To sum up, Venezuelan migrants living with HIV in Peru have access to ART treatment with additional limitations to those faced by national PLHA, such as the out-of-pocket expenses for required tests before starting treatment, payment for medical consultations, and care for complications. This situation results from severe limitations in access to public insurance related to their migratory status. They also suffer additional discrimination due to their nationality. The HIV care system has many opportunities for improvement, from the need to update its prevention and surveillance strategies, the organization of treatment services, the information system, and the assignment and training of the staff. All of them are at greater risk due to the budget reduction approved for 2022. Thus, all changes implemented will improve the health care services for Venezuelan migrants and nationals living with HIV.

Annex 1: Matrix of Strengths, Opportunities, Weaknesses and Threats (SWOT) applied to the HIV services for Venezuelan migrants

SWOT Analysis of Governance

Strengths	Weaknesses
• **Migratory regulation** that allows **regularization and humanitarian residence** due to health vulnerability.	• **The Peruvian State does not recognize the right to self-perceived gender identity** and therefore, **exposes transgender migrants to double discrimination.** • **The Peruvian State does not recognise the sexual and reproductive rights of adolescents** and therefore, **limits access to health services.** • **Difficulties in the implementation of regulations for obtaining resident status limit** migrants in the full exercise of their **social and economic rights** • **Underuse of coordination mechanisms** with other sectors **for the implementation of policies and standards** of care. • **Weakening of civil society leadership for advocacy and creation of** the health **policy agenda.** • **Instability and constant changes** of authorities **limit the development of institutional policy initiatives** in response to HIV.
Opportunities	**Threats**
• Incorporation of the **concept of health vulnerability** for the **affiliation to public health insurance** serves as a **platform for the recognition of other** social protection **rights.** • **Political objectives and actions** for HIV care in the migrant population **can be included in the Multisectoral Strategic Plan (PEM) for HIV**, in process of approval.	• **Uncertainty about future government actions affects the social protection of migrants. This risk is generated by the positions taken by the new government.**

SWOT Analysis of Funding

Strengths	Weaknesses
• The medication budget is not affected by budgetary adjustments. • The new Essential Health Insurance Plan, which includes all the provisions required for the management of HIV/AIDS. • PpR funding, stable and with progressive growth, results-oriented, with no nationality restrictions.	• **Requirement of a resident's migratory status limits access to public insurance and creates economic barriers.** • Out-of-pocket expenses in the population without SIS insurance, for required pre-ART tests which delays the start of treatment. • Competition for funding granted by the PpR with TB care.
Opportunities	**Threats**
• Civil society institutions that provide a financial support network for expenses in pre-ART examinations and hospitalizations, avoiding out-of-pocket expenses for migrants. • International cooperation funding of social support network for migrants.	• COVID-19 economic crisis. • Employment barriers for migrants.

SWOT Analysis of Service Provision

Strengths	Weaknesses
• **PpR financing without nationality restrictions guarantees comprehensive HIV care and treatment.** • **Requirements to initiate ART** that would allow access to all people regardless of their migratory status. • **Procedures and mechanisms for updating** comprehensive **HIV care aligned with international treatment policies.** • **Decentralization process** of HIV treatment that reaches 200 HF and is currently in expansion (plans, standards and treatment, spaces and schedules, referrals, and regulatory procedures).	• Regulatory limitation for access to Comprehensive Health Insurance for migrants in a situation of health vulnerability impedes timely access to health services. • Absence of procedures for channeling -and providing medical support- during the process of obtaining resident status due to health vulnerability. • Precarious system of referral, counter-referral and follow-up of the service. • Lack of suitable spaces for care that guarantee the privacy rights of PLHA. • Some HF do not consider user needs (hours of service, appointments). • Lack of laboratory or efficient networking systems. • Lack of effective supervision for HF performing screening and treatment activities. • Stigma and discrimination in HF affect quality and access to health services. • Some HF do not implement counseling as the standard for people who are screened. • Some HF do not provide mental health support to PLHA. • Lack of plans and interventions in high-HIV burden areas and populations limits care for at-risk migrants.

	• Lack of adequate planning and tools for ART service assessment. • Absence of implementation plan and strengthening of the laboratory network. • Lack of contingency plans in the Laboratory Network that caused the loss of samples for Viral Load testing (due to shortage of supplies). • Lack of a system for measuring quality and performance indicators of service. • Supervisory body SUSALUD does not include specialized assessments in its operational plan.
Opportunities	**Threats**
• **Successful experiences in decentralized HIV care** (CERITSS and Hospitals) that facilitate access to migrants and can be replicated. • **Existence of civil society and community-based organizations that support screening and linkage** of PLHA, including migrants, which can be expanded. • **Health technologies that facilitate HIV self-diagnosis and prevention** that can be incorporated into regulatory frameworks and funding. • Support to INS to improve its molecular epidemiological processing and analysis capacity for genotyping.	• **High turnover and limited training of staff** working in HIV care. • **Limited provision of supplies and medicines due to the major disruptions in production and logistic services in the context of the pandemic.**

SWOT Analysis of Human Resources

Strengths	Weaknesses
• Teams with extensive experience in HIV care.	• Absence of HR development plan. • Some HF do not have complete HR teams for comprehensive care. • **Limited training and updating** of staff working in HIV care services. • Stigmatizing and discriminatory behavior on the part of the care teams. • Low training capacity of specialists in infectious disease care.
Opportunities	**Threats**
• Participation of the National School of Public Health (ENSAP) motivates staff due to its official certification capacity. • Implementation of Telehealth systems for care.	• **High turnover** of staff working in HIV care.

SWOT Analysis of Information Systems

Strengths	Weaknesses
• Data on nationality is registered.	• Information system for comprehensive HIV care services is not specialized, unstable, precarious, and fragmented (Excel). • Rudimentary interoperability between the different information systems within MINSA, and other health care sub-sectors. • Absence of key variables such as gender identity. • Absence of standardization of the budget classification scheme of the different subsectors, which impedes the monitoring of expenditures at national level. • Absence of equipment for data recording at the point of care. • Lack of agreement on the use of common identifiers that would allow the follow-up of treatment cohorts. • Databases without disaggregation dimensions prevent competent analysis and construction of indicators for monitoring the response and status of the epidemic. • Health services at the local level do not have access to integrated patient data. • The surveillance system is restricted to reporting and does not include international recommendations for second-generation surveillance. • Under-registration and Under-notification • Sexual identity registration is not standardized.
Opportunities	**Threats**
• Current and planned interoperability projects to facilitate system interoperability. • REUNIS platform provides open data for disaggregated analysis of information. • Interest of international cooperation in information systems investment.	• Restrictive regulatory framework that prevents exchange of information considered personal. • Organizational structure of MINSA doesn't allow to manage common needs and responses.

Annex 2. Institutions that participated in the interviews

N°	DATE	SECTOR	INSTITUTION
1	12-Ago	Cooperation	ONUSIDA
2	12-Ago	Governmental	OGIS - INS
3	13-Ago	Cooperation	ICAP
4	13-Ago	Governmental	OGPMM - MINSA
5	13-Ago	Governmental	SIS
6	16-Ago	Civil Society	CCEFIRO
7	16-18-Ago	Governmental	CDC - MINSA
8	18-Ago	Civil Society	Via Libre
9	18-Ago	Civil Society	PROSA
10	19-Ago	Multisectorial	CONAMUSA
11	19-Ago	Governmental	DPVIH - MINSA
12	19-Ago	Cooperation	ACNUR
13	20-Ago	Cooperation	OPS
14	25-Ago	Governmental	INS
15	27-Ago	Cooperation	AHF
16	2-Set	Civil Society	MCC Ángeles en Acción
17	5-Set	Governmental	EsSalud
18	7-Set	Governmental	DIRIS Lima Norte
19	9-Set	Governmental	ENSAP - MINSA
20	10-Set	Governmental	OIDT- OGTI MINSA
21	13-Set	Governmental	GERESA Lambayeque
22	13-Set	Governmental	Hospital Regional Lambayeque
23	13-Set	Governmental	Hospital Ferreñafe

Annex 3. Health Facilities ART that completed the online survey

N°	Administration	Health facility type	DIRESA / GERESA	Health facility name
1	Public	HF level I-4 or I-3	Lima Sur	Centro de Salud Pedro A. López Guillén
2	Public	HF level I-4 or I-3	Pasco	Centro de Salud Puerto Bermúdez
3	Public	HF level I-4 or I-3	Lima sur	Centro Materno Infantil San José
4	Public	Hospital	Lima Norte	Hospital Cayetano Heredia
5	Public	Hospital	Pasco	Hospital General Ernesto Germán Guzmán Gonzáles
6	Public	EESS nivel I-4 or I-3	Pasco	Centro de Salud Iscozacin Palcazu
7	Public	EESS nivel I-4 or I-3	Piura	Centro de Salud Huancabamba
8	Public	EESS nivel I-4 or I-3	Huánuco	Centro de Salud Aucayacu
9	Public	Hospital	Huánuco	Hospital Tingo María
10	Private	HF level I-4 or I-3	Lima Centro	Vía Libre
11	Public	Hospital	Cusco	Hospital Nacional Adolfo Guevara Velasco
12	Public	HF level I-4 or I-3	Lima Este	Centro de Salud Madre Teresa de Calcuta
13	Public	Hospital	Ica	Hospital San José de Chincha
14	Public	Hospital	Piura	Hospital Nuestra Señora de las Mercedes de Paita
15	Public	Hospital	Lima Sur	Hospital María Auxiliadora
16	Public	Hospital	La Libertad	Hospital Belén de Trujillo
17	Public	HF level I-2	Cajamarca	Centro de Salud La Grama
18	Public	Hospital	Lima Este	Hospital Nacional Hipólito Unanue
19	Public	Hospital	Loreto	Hospital Iquitos César Garayar García
20	Public	HF level I-4 or I-3	Lima Sur	Centro de Salud San Juan de Miraflores
21	Public	HF level I-4 or I-3	Arequipa	Hospital III Goyeneche
22	Public	Hospital	Loreto	Hospital II-1 Contamana
23	Public	HF level I-2	Loreto	Dirección de Red de Salud Alto Amazonas
24	Public	Hospital	Apurímac	Hospital Sub Regional de Andahuaylas

N°	Administration	Health facility type	DIRESA / GERESA	Health facility name
25	Public	Hospital	Moquegua	Hospital Regional Moquegua
26	Public	HF level I-4 or I-3	Amazonas	Centro de Salud Imaza
27	Public	HF level I-4 or I-3	Lima Este	Centro de Salud San Carlos
28	Public	HF level I-4 or I-3	Cajamarca	Puesto de Salud Matibamba
29	Public	HF level I-4 or I-3	Cajamarca	Centro de Salud Ichocan
30	Public	HF level I-4 or I-3	Tumbes	Centro de salud Zarumilla
31	Public	HF level I-4 or I-3	Piura	Centro de Salud Tambogrande
32	Public	Hospital	Junín	H. R. D. C. Q. Daniel Alcides Carrión
33	Public	HF level I-4 or I-3	Cajamarca	Centro de Salud San Marcos
34	Public	HF level I-4 or I-3	Piura	Centro de Salud II Talara
35	Public	Hospital	Pura	Hospital de Apoyo II -2 Sullana
36	Public	Hospital	Puno	Hospital Regional "Manuel Nuñez Butrón"
37	Public	HF level I-4 or I-3	Piura	Centro de Salud Máncora
38	Public	Hospital	Lima Provincia	Hospital de Huaral San Juan Bautista
39	Public	Hospital	Lima Norte	Hospital Carlos Lanfranco La Hoz
40	Public	Hospital	La Libertad	Hospital Provincial de Ascope
41	Private	HF level I-4 or I-3	Lima Centro	INMENSA
42	Public	Hospital	Cajamarca	Hospital de Apoyo General Celendín
43	Public	HF level I-4 or I-3	Lima Centro	Centro de salud san Martín de Porres
44	Public	HF level I-4 or I-3	Lima norte	Centro Materno Infantil Sureños
45	Public	HF level I-4 or I-3	Moquegua	Centro de Salud Alto Ilo
46	Public	Hospital	Lambayeque	Hospital Regional Lambayeque
47	Public	Hospital	Lima Provincia	Hospital de Chancay "Dr. Hidalgo Atoche López"
48	Public	Hospital	Amazonas	Hospital Regional Virgen de Fátima
49	Public	HF level I-4 or I-3	Callao	Centro de Salud de Referencia de ITS, VIH y SIDA (CERITS) “Alberto Barton”
50	Public	Hospital	Callao	Centro Médico Naval

N°	Administration	Health facility type	DIRESA / GERESA	Health facility name
51	Public	Hospital	Puno	Hospital Rafael Ortiz Ravinez
52	Public	Hospital	Puno	Hospital Lucio Aldazabal Pauca
53	Public	Hospital	Callao	Hospital Nacional Daniel A. Carrión
54	Public	HF level I-4 or I-3	Lima Norte	Centro Materno Infantil Tahuantinsuyo Bajo
55	Public	HF level I-4 or I-3	Lima Sur	Centro Materno Infantil Virgen del Carmen
56	Public	Hospital	Lambayeque	Hospital Regional Docente La Mercedes Chiclayo
57	Public	Hospital	La Libertad	Hospital de Apoyo de Chepén
58	Private	HF level I-4 or I-3	Lima Centro	Asociación Civil Impacta Salud y Educación
59	Pública	HF level I-4 or I-3	Ucayali	Centro de Salud Aguaytía
60	Pública	Hospital	Puno	Hospital de Apoyo de Yunguyo
61	Public	Hospital	Arequipa	Hospital Camaná
62	Public	Hospital	Cajamarca	Hospital de Apoyo Cajabamba
63	Public	Hospital	La Libertad	Hospital Tomas Lafora
64	Public	HF level I-4 or I-3	Cajamarca	Centro de Salud La Tulpuna
65	Public	HF level I-1	Cajamarca	Puesto de Salud Micaela Bastidas
66	Public	Hospital	Cajamarca	Hospital General Jaén

Annex 4. Health Facility Visits

DIRIS	Administration	Institution Name
Lima Norte	Public	Hospital Nacional Cayetano Heredia
Lima Norte	Public	Centro de Salud México

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