

# Evaluating the Impact of PEPFAR's Geographic Prioritization on Health Facilities in Central Support Counties in KENYA

In its FY15 Country Operational Plan, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) issued global guidance on its geographic prioritization (GP) process whereby PEPFAR-supported countries would target and prioritize high-burden areas, with the goal of achieving the UNAIDS 90-90-90 targets.<sup>1</sup> Specifically, the guidance classified sub-national areas based on PEPFAR's pursuant actions:

- **Scale-up counties:** Because these counties have the highest HIV burden, they would receive greater PEPFAR support for service delivery.
- **Maintenance counties:** These counties would receive PEPFAR support to provide a maintenance package of services.
- **Central support counties:** These are low-burden counties and would transition from PEPFAR support to the government or other donors.

This brief summarizes findings from our study in Kenya to understand the effects of PEPFAR's GP process on HIV and non-HIV services, as well as on the health system.\* The study's specific focus was on facilities transitioning from PEPFAR support to central support, usually to government sources. In Kenya, PEPFAR selected seven Northeastern counties to be transitioned to central support, covering 404 USAID facilities. These counties have a low HIV burden but also are large, remote areas with a low population density and ongoing security concerns that make it difficult to support a health system ecosystem, including lab networks, private sector facilities, and retention and motivation of health workers.

\*Project SOAR conducted a similar study in Uganda. See "Evaluating the impact of PEPFAR's geographic prioritization on health facilities transitioning to central support in Uganda" at [www.projsoar.org](http://www.projsoar.org).

## KEY MESSAGES

- The geographic prioritization (GP) process in Kenya was rapid, leaving little time for planning and implementation, which resulted in limited opportunities for counties and facilities transitioning to government support to prepare. Transition for orphans and vulnerable children had an extended timeline that allowed for more preparation.
- To date, trends in HIV and maternal, newborn, and child health service utilization at centrally supported facilities, relative to maintenance ones, remained steady throughout the transition in Kenya. However, clinician strikes during the post-GP period are a major confounder.
- We observed modest effects in HIV services, including discontinuation of antiretroviral therapy services in a few small facilities, and discontinuation of outreach in both central support and maintenance facilities. Central support facilities also reported negative effects on service quality and time spent on HIV care. Overall the effects of GP were larger at higher level facilities compared to smaller facilities.
- Health system effects were observed especially for health workers, including reductions in HIV training for health workers and increased staff turnover, and additional problems with transport and communication linked to lab services.
- Risks to service coverage will rise if needs for outreach, capacity building, and lab services (including quality assurance) are not addressed, putting the 90-90-90 goals in jeopardy in the transitioned region; more widespread effects should be investigated further.



The GP process started in 2015 and continued into 2017, with the majority of the selected facilities losing PEPFAR support by September 2016. Kenya's devolution took place three years before GP resulting in a division of responsibilities between counties and the national level, including for health programs, which had implications for GP.

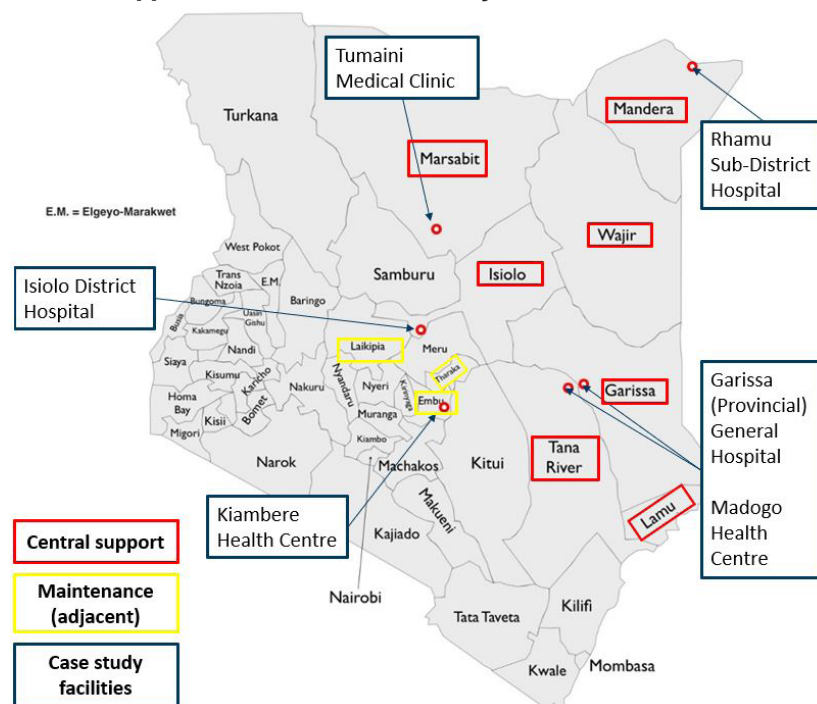
## METHODS

The goals of our study were to:




- Provide timely guidance to U.S. Government (USG) partners on implementing PEPFAR's GP process, including the strategies and factors that have either supported or hindered a smooth and sustainable transition.
- Identify associations with changes in health systems, HIV and non-HIV service provision/uptake, and other key indicators in USAID-supported facilities transitioning to central support.

Table 1 provides an overview of the study.

### Central support and maintenance study counties



**Table 1 Study overview**

Objective	Methodology	Sample
 <p>Document GP implementation</p>	<p>Document review</p> <p>Key informant interviews: USG, Kenyan Ministry of Health, civil society, implementing partners (IPs)</p>	<p>23 interviews</p> <p>2 rounds (May and November 2017)</p>
 <p>Determine changes in key HIV and non-HIV service indicators associated with GP over a 3-year period (2014–2017)</p>	<p>Facility survey (May–July 2017) to track shifts in systems and service delivery</p> <p>Time series analysis of service outcomes based on extraction of DHIS2*(Oct 2013–Nov 2017)</p>	<p>230 facilities (7 central support counties and 3 maintenance facilities)</p> <p>76–85 percent of central support and 91–95 percent of maintenance facilities</p>
 <p>Explore changes in health systems as a result of GP and how this has affected HIV and non-HIV service delivery</p>	<p>Longitudinal case studies of selected facilities based on in-depth interviews with facility in-charges, county-level officials, and IP program officers</p>	<p>5 central support + 1 maintenance facilities</p> <p>2 rounds (May and November 2017)</p>

\*District health information system

## RESULTS

### How the GP process was implemented

There was consensus within the government on the value of GP because it aligned with Kenya's 2014 National HIV Prevention Revolution Roadmap. Yet, most county, facility, and civil society respondents criticized the GP approach because it reflected broader marginalization of central support counties.

Communications about GP were difficult resulting in high-level engagement between PEPFAR and government actors, especially because the initial timeline was not aligned with the government budget cycle. Notable outcomes of the negotiations included a plan to offer specific "above-site" support for lab networks, reporting and planning directed at counties, and a separate extended timeline for orphans and vulnerable children (OVC) services. There was little involvement of sub-national actors in negotiations, so IPs were on the front line of informing counties and facilities of the upcoming shifts.

Across stakeholder groups, the main criticisms of the GP process were the short time frame from announcement to implementation, and the lack of a formal plan. Communication about the transition happened almost simultaneously with changes in support. Our survey findings show that only 25 percent of central support facilities were informed in advance of the transition. And they received, on average, only 1.2 months notice. Further, county officials indicated having little to no preparation time for the GP. Transition for OVC was the exception with an additional year for implementation, which smoothed the process.

In practice, above-site support from the IP to the counties was not delivered as planned. After data suggested declines in services, the IP returned to eight high-volume facilities (in six counties) in May 2017 to offer targeted support. This return, labeled a "rescue package" by local respondents, lasted until late 2017 when the IP withdrew again.

### Service delivery effects

We observed no significant effects of the transition on trends in service utilization for most HIV services, including for HIV testing and linkage to antiretroviral treatment (ART) services. However, the number

of patients currently on ART increased slightly in central support facilities relative to maintenance ones. However, two widespread clinician strikes took place after transition presenting considerable confounders. No significant effects were observed for non-HIV service utilization.

Central support facility in-charges were significantly more likely than maintenance in-charges to report declines in access to HIV care across population groups, and declines in quality across HIV services. Likewise, central support facility in-charges reported significantly worsening access to maternal, newborn, and child health (MNCH) care relative to maintenance in-charges. Notably, larger facilities fared worse.

Eight central support facilities discontinued ART after transition representing 10 percent of facilities providing ART, but there was no discontinuation of other clinical HIV and non-HIV services. There was widespread discontinuation of outreach across central support (39 percent) and maintenance (36 percent) facilities.

National and case study respondents reported that declines in community outreach and counseling were common as IP-supported staff (e.g., expert patients) were not continued by the counties. HIV counseling and testing have been affected by loss of outreach staff and transportation support. Given high levels of stigma and low access to facilities in central support counties, there are concerns that problems with treatment adherence as well as HIV prevalence will emerge.

“ This is a community where stigma is very high. Convincing somebody to undergo HIV testing is not an easy thing. If you do not conduct outreach, the number of clients who are going to come to voluntary counseling and testing is very low.

—Government representative, Mandera

“ Since May [2017], many clients were lost to follow up. Even today we cannot trace them. We don't know where they are, whether they went to other facilities or whether they died, we cannot give a report about that.

—Health worker, Marsabit

## Effects on health systems

There were effects of the transition on the health workforce, specifically:

- **Time use patterns:** In-charges at centrally supported facilities were significantly more likely to report that health workers spent less time on HIV services and more time on MNCH services.
- **Training:** Across multiple measures centrally supported facilities had less access to HIV training than maintenance facilities.
- **Supervision:** Supervision of HIV services as well as MNCH services has become significantly less frequent at centrally supported facilities.
- **Staff turnover:** Centrally supported facilities reported greater staff turnover, including loss of volunteer and regular staff, termination of positions, and more vacant positions than maintenance facilities.

The study also examined effects of the transition on other health system aspects including commodity supply, laboratory support, health information systems, health financing, and governance. There were significant effects of the transition to central support on specific indicators in these domains. For example, centrally supported facilities reported disruptions in viral load testing and early infant diagnosis due to loss of support for transport of samples and data bundles to download results. Although facility in-charges reported greater involvement from county officials, there was widespread concern that central support county governments were not prioritizing HIV programs because of low HIV burden.

## CONCLUSIONS AND IMPLICATIONS

Trends in service utilization at centrally supported facilities remained steady throughout the transition relative to maintenance facilities, though co-occurring clinician strikes are major confounders. We observed several immediate and significant impacts on service delivery as a direct result of losing PEPFAR funding. In-charges at centrally supported facilities reported (1) substantial declines in outreach across facilities, (2) delays in viral load

testing, and (3) declines in quality and time spent on HIV care. There were also clear effects on health systems, most notably human resources. There is a risk that these trends may translate into impacts on service coverage.

The overall process of GP benefitted from the alignment between the GP approach and ongoing national plans for county-based prioritization, and PEPFAR's willingness to negotiate on the specifics of the GP. While there are no current plans for further transitions in Kenya, we raise a number of considerations that should be applied to future efforts of this nature:

- More advanced planning and communication about the transition would be helpful, and in particular, there is a need to clarify changing roles for government at different levels of the health system.
- Engagement with sub-national actors at the front line of service delivery is critical in order to prepare for changes and anticipate gaps.
- Intensified support should be offered to larger facilities that tend to struggle more during transition.
- Central support counties will need ongoing support for lab networks as well as implementation of new policies, such as "test and start."
- The effects of declines in outreach services on achieving the 90-90-90 targets should be considered.
- Active monitoring of centrally supported counties should be intensified to catch back-sliding.
- Planning should start early for how future transitions of counties and facilities to government support will be handled once HIV targets are attained.

## REFERENCE

<sup>1</sup>UNAIDS. 2014. "90-90-90: An ambitious treatment target to help end the AIDS epidemic." Geneva: UNAIDS.

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