

Evaluating the Impact of PEPFAR's Geographic Prioritization on Health Facilities Transitioning to Central Support in UGANDA

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.¹ Specifically, the guidance classified districts based on PEPFAR's pursuant actions:

- Scale-up districts: Those having the highest HIV burden would receive additional PEPFAR support for service delivery.
- Maintenance districts: These would receive PEPFAR support to provide a package of services to maintain the current level of response.
- Central support districts: Those having the lowest HIV burden would transition from PEPFAR support for service delivery to the government of Uganda or possibly other donors.

This brief summarizes findings from Uganda on understanding the effects of PEPFAR's GP process on HIV and non-HIV services, as well as on the health system, in areas supported by U.S. Agency for International Development (USAID) implementing partners (IPs).^{*} The study's specific focus is on central support districts and facilities transitioning from PEPFAR/USAID support to the Government of Uganda. The facilities PEPFAR selected to transition to central support included all of those from 10 Northern and Eastern districts, as well as about

^{*}Project SOAR conducted a similar study in Kenya. See "Evaluating the impact of PEPFAR's geographic prioritization on health facilities in central support counties in Kenya" at www.projsoar.org.

KEY MESSAGES

- Respondents generally agreed that the criteria used for deciding which facilities to transition were appropriate, but expressed concern about the reliability of the data used in some cases.
- Trends in HIV and maternal, newborn, and child health service utilization at centrally supported facilities relative to maintenance ones, remained steady throughout the transition.
- There were clear effects on health systems, most notably negative implications for lab testing, human resources (loss of training, staff, and incentives), and substantial losses on the provision of outreach services, which over time could translate into impacts on service coverage.
- We found no evidence of other actors stepping in to support transitioned facilities, though some facilities reported receiving more supervision from the district health teams.

700 additional facilities located in scale-up and maintenance districts throughout the country (see map illustrating the transition and the study sites). The GP started in 2015 and continued into 2018, with the majority of the selected facilities losing PEPFAR support in 2017.



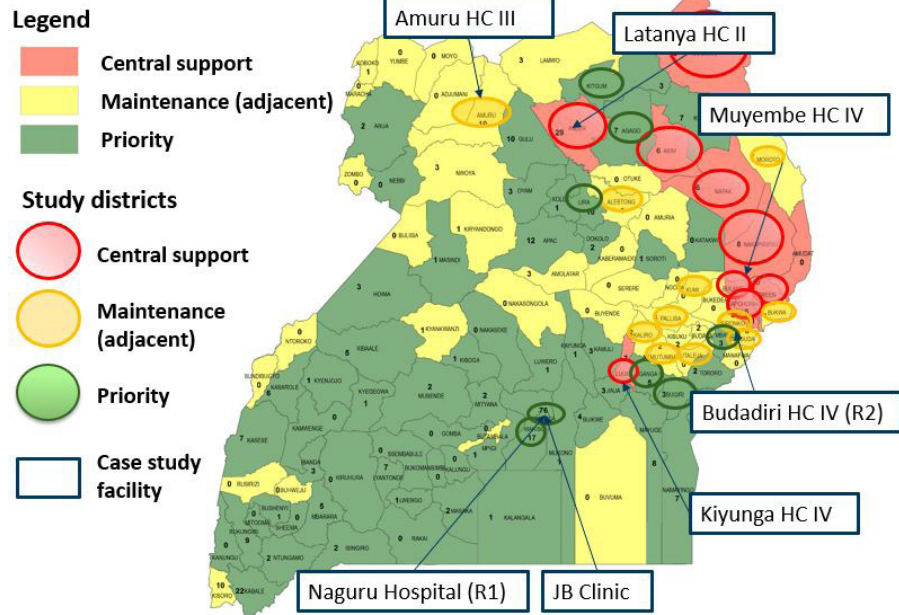
METHODS

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 process.
- 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, maintenance, and scale up districts in Uganda



Note: The numbers next to district names represent the number of PEPFAR/USAID-supported facilities transitioned to central support, in a particular district.

Note: Two rounds of data (R1 and R2) were collected at case study facilities unless otherwise specified.

Table 1 Study overview

Objective	Methodology	Sample
 <p>Document GP implementation</p>	<p>Document review</p> <p>Key informant interviews: USG, MOH, civil society, IPs.</p>	<p>Round 1: 23 stakeholders (April/May 2017)</p> <p>Round 2: 14 stakeholders (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 to track shifts in systems and service delivery</p> <p>Time series analysis of service outcomes based on extraction of DHIS2* and HRHIS data** from central support and maintenance facilities only</p>	<p>262 facilities in 28 districts</p> <p>DHIS2 data on HIV and select non-HIV services (October 2014–December 2017)</p> <p>HRHIS facility audit data for public facilities (December 2015–December 2017)</p>
 <p>Explore changes in health systems as a result of GP and how this has affected both HIV and non-HIV service delivery</p>	<p>Longitudinal case studies of selected facilities based on in-depth interviews with facility in-charges, district-level officials, and IP program officers</p>	<p>Round 1: 5 central support + 1 maintenance facilities</p> <p>Round 2: 4 central support + 2 maintenance facilities***</p>

*District health information system; **Human Resource Health Information System; ***One of these facilities was originally characterized as “maintenance” but had reported some loss of support.

RESULTS

How the GP process was implemented

Respondents generally agreed that the criteria used for deciding which facilities to transition, such as HIV prevalence and HIV testing yield, were appropriate. However, some expressed concern about the reliability of the monitoring data used for this decision.

The situation on the ground was muddled by other PEPFAR policy shifts in Uganda, including the technical pivot, which refocused efforts from prevention to treatment, and a process of regionalization whereby USG agencies coordinated among themselves to assign one agency per region and one IP per district. In addition, USAID moved from a model of vertical projects (e.g., one for HIV/AIDS, one for maternal, newborn and child health [MNCH]) to an integrated approach. Associated with this, USAID issued calls for regional projects, whose procurements were at times delayed, resulting in breaks between implementing mechanisms that translated into gaps in support at the district and facility level.

Much of the communications and preparation for the GP were left to the IPs. While PEPFAR-Uganda intended to set up a joint Transition Working Group with Ugandan Ministry of Health counterparts, it was never established. We observed substantial variation in how the transition was implemented, related to factors such as the capacity of the district health team, type and intensity of the PEPFAR support provided, and whether the transition affected the whole district or a facility alone.

During the study, there were no signs of other actors stepping in to support HIV/AIDS services in transitioned facilities, though some of them reported receiving more supervision from district health teams.

Service delivery effects

We observed no significant effects of the transition on trends in service utilization for most HIV services, including for HIV testing, linkage to and retention in antiretroviral treatment services. However, in-charges at central support facilities were significantly more likely to report declines in the quality of HIV services than in-charges at maintenance facilities.

They were also more likely to report a decline in access to HIV care, possibly driven by substantive loss of support for outreach services. More than half (52 percent) of centrally supported facilities that had provided outreach services reported a cessation of this service, compared to 4 percent of maintenance facilities. Declines in outreach occurred due to the loss of financial and non-financial incentives to lay health workers such as expert clients, mentor mothers, and linkage facilitators.

We observed no effects of the transition on trends in MNCH services, including antenatal care, immunization, deliveries, nutrition, and child health services. In-charges surveyed perceived the quality of MNCH services to be improving more in maintenance than centrally supported sites.

Overall, the effects of the GP varied considerably by facility and geographic area. Larger facilities that had more support previously saw greater effects. While analysis is ongoing, effects on private health care facilities were also more marked.

Effects on health systems

There were significant 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 training, and more time on provision of clinical services; and less time on HIV services, while more on MNCH services.
- **Training:** Across multiple measures it was apparent that centrally supported facilities had less access to HIV training than maintenance facilities.
- **Supervision:** Supervision of HIV services has become significantly less frequent at transitioned facilities, but in-charges also reported that district health teams now provide more supportive supervision.
- **Incentives and motivation:** We found no difference in motivation between health workers in centrally supported versus maintenance facilities, but health workers in centrally supported facilities were more likely to have lost outreach allowances.

The study also examined effects of the transition on drug supply, laboratory support, health information systems, and health financing. There were certain significant effects of the transition to central support on specific indicators in these domains. For example, centrally-supported facilities reported lack of access to specialized testing such as viral load largely due to initial disruptions in the regional laboratory network. IPs had previously helped in transferring drugs between facilities that had a surplus to those with reduced supplies, and this support was also lost.

CONCLUSIONS AND IMPLICATIONS

Trends in service utilization at centrally supported facilities remained steady throughout the transition relative to maintenance facilities. However, there were clear effects of the transition on health systems, most notably human resources for health. Over time, there is a risk that these trends may translate into impacts on service coverage. Further, in-charges at centrally supported facilities perceived that the quality and accessibility of HIV/AIDS services had declined, even though this was not supported by the available routine health information data.

We observed an immediate and significant impact on outreach at centrally supported facilities, as well as some decline in maintenance facilities, as a direct result of losing PEPFAR funding.

While there are no current plans for further transitions in Uganda, we draw a number of lessons which should be considered when planning and implementing 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.
- Intensified support should be offered to larger facilities and private facilities that tend to struggle more during transition.

- While some of the early challenges with the lab networks appear to have been resolved, this remains a somewhat problematic area that both government and USAID should invest in.
- The effects of declines in outreach services on achieving the 90-90-90 targets should be carefully considered.
- Active monitoring of centrally supported districts should be intensified to catch back-sliding
- Planning should start early for how future transitions of districts and facilities to government support will be handled once targets are attained.

REFERENCE

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

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