Evaluating the Impact of PEPFAR’s Geographic Prioritization on Centrally Supported Health Facilities

Daniela C. Rodríguez
Ligia Paina
Jess Wilhelm
Caroline Mackenzie
Moses Mukuru
Freddie Ssengooba
Henry Zakumumpa
Sara Bennett
Evaluating the Impact of PEPFAR’s Geographic Prioritization on Centrally Supported Health Facilities

Daniela C. Rodríguez, Ligia Paina, Jess Wilhelm & Sara Bennett
Johns Hopkins Bloomberg School of Public Health

Caroline Mackenzie
Ipsos Kenya

Moses Mukuru, Freddie Ssengooba, Henry Zakumumpa
Makerere School of Public Health, Uganda
Project SOAR (Cooperative Agreement AID-OAA-A-14-00060) is made possible by the generous support of the American people through the United States President’s Emergency Plan for AIDS Relief and the United States Agency for International Development (USAID). The contents of this guidance document are the sole responsibility of Project SOAR and the Population Council and do not necessarily reflect the views of USAID or the United States Government.

Through operations research, Project SOAR will determine how best to address challenges and gaps that remain in the delivery of HIV and AIDS care and support, treatment, and prevention services. Project SOAR will produce a large, multifaceted body of high-quality evidence to guide the planning and implementation of HIV and AIDS programs and policies. Led by the Population Council, Project SOAR is implemented in collaboration with Avenir Health, Elizabeth Glaser Pediatric AIDS Foundation, Johns Hopkins University, Palladium, and The University of North Carolina.

The Population Council confronts critical health and development issues—from stopping the spread of HIV to improving reproductive health and ensuring that young people lead full and productive lives. Through biomedical, social science and public health research in about 50 countries, the Council works with our partners to deliver solutions that lead to more effective policies, programs, and technologies to improve lives worldwide. Established in 1952 and headquartered in New York, the Council is a nongovernmental, nonprofit organization with an international board of trustees.

The Johns Hopkins Bloomberg School of Public Health has a big mission: Protecting Health, Saving Lives—Millions at a Time. Since its founding in 1916, the Bloomberg School has advanced research, education and practice to create solutions to public health problems around the world. Faculty, staff and students have helped eradicate smallpox, made water safe to drink, improved child survival, reduced the spread of HIV and uncovered the dangers of tobacco smoke. Researchers and scientists are now discovering ways to eliminate malaria, increase healthy behavior, reduce the toll of chronic disease, improve the health of mothers and infants, and change the biology of aging. Every day, the Bloomberg School works to keep millions around the world safe from illness and injury by pioneering new research, deploying knowledge in the field and educating tomorrow’s public health leaders.

Published in March 2019. ©2019 The Population Council, Inc.

# TABLE OF CONTENTS

ACKNOWLEDGMENTS .................................................................................................................. ii

ACRONYMS .................................................................................................................................. iii

EXECUTIVE SUMMARY .............................................................................................................. 1
  Introduction ............................................................................................................................... 1
  Study objectives ......................................................................................................................... 1
  Study design and methods ......................................................................................................... 1
  Results ....................................................................................................................................... 2
  Conclusions and implications ................................................................................................. 4

INTRODUCTION ........................................................................................................................... 5

STUDY GOALS, AIMS, AND METHODS .................................................................................... 8
  Research goals and objectives ................................................................................................. 8
  Study design ............................................................................................................................. 8
  Data collection and analytical methods ................................................................................... 9

RESULTS .................................................................................................................................. 22
  Process of implementing the geographic prioritization process ........................................... 22
  Effects of geographic prioritization on service delivery ......................................................... 29

DISCUSSION ............................................................................................................................... 44
  Summary of key findings ......................................................................................................... 44
  Limitations ............................................................................................................................... 45
  Implications: Factors supporting a smooth and sustainable transition ................................... 46

CONCLUSIONS ........................................................................................................................... 49

REFERENCES ............................................................................................................................. 50

APPENDIX: TRANSITION TIMELINES .................................................................................... 51
  Timeline of geographic prioritization in Kenya ........................................................................ 52
  Timeline of geographic prioritization in Uganda ...................................................................... 53
ACKNOWLEDGMENTS

The research team would like to acknowledge and thank the study participants, especially those individuals living with HIV, who gave generously of their time and experience without which this study would not have been possible. We also want to acknowledge key study team members: Mary Qiu, who supported and participated in data collection and analysis in both countries; Robina Komuhendo, who participated in data collection in Uganda; and Ezinne Eze-Ajoku and Alexandra Searle for their work on analyzing case study data for Kenya and Uganda, respectively. The team also recognizes the extraordinary effort of the in-country research teams led by Caroline Mackenzie of Ipsos-Kenya and Freddie Ssengooba of the Makerere University School of Public Health.
ACRONYMS

ANC  Antenatal care
APHIAPlus  AIDS, Population and Health Integrated Assistance
ART  Antiretroviral therapy
CDC  US Centers for Disease Control
COP  Country Operating Plan
CS  Central support
CSO  Civil society organization
DHIS2  District Health Information System 2.0
EPCMD  Ending preventable child and maternal deaths
FGD  Focus group discussion
GP  Geographic pivot
GoU  Government of Uganda
HC  Health center
HIV  Human immunodeficiency virus
HMIS  Health management and information systems
HRHIS  Human resource for health information system
HTC  HIV testing and counseling
iHRIS  Integrated human resources information system
IOM  Institute of Medicine
IP  Implementing partner
iPSL  Integrated PEPFAR site list
IRR  Incidence rate ratio
MNCH  Maternal, neonatal, and child health
MoH  Ministry of Health
MSH  Management Sciences for Health
MEEPP  Monitoring and evaluation of the Emergency President’s Plan
NACC  National AIDS Control Council (Kenya)
NASCOP  National AIDS and STI Control Program (Kenya)
OPD  Outpatient department
OR  Odds ratio
OVC  Orphans and vulnerable children
PEPFAR  United States President’s Emergency Plan for AIDS Relief
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PFP</td>
<td>Private for-profit</td>
</tr>
<tr>
<td>PLHIV</td>
<td>People living with HIV</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of mother-to-child transmission</td>
</tr>
<tr>
<td>PNC</td>
<td>Postnatal care</td>
</tr>
<tr>
<td>PNFP</td>
<td>Private not-for-profit</td>
</tr>
<tr>
<td>RHITES-E</td>
<td>Regional Health Integration to Enhance Services—Eastern Uganda</td>
</tr>
<tr>
<td>RMNCH</td>
<td>Reproductive, maternal, neonatal, and child health</td>
</tr>
<tr>
<td>SNU</td>
<td>Sub-national unit</td>
</tr>
<tr>
<td>STAR-E</td>
<td>Strengthening TB &amp; HIV/AIDS Response in Eastern Uganda</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Program on HIV/AIDS</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>USG</td>
<td>United States Government</td>
</tr>
<tr>
<td>VMMC</td>
<td>Voluntary medical male circumcision</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

INTRODUCTION

The FY15 Country Operational Plan (COP) for United States Agency for International Development (USAID) missions included a “geographic prioritization process,” whereby countries supported by the United States President’s Emergency Plan for AIDS Relief (PEPFAR) were to target and prioritize high-burden areas with the goal of achieving the UNAIDS 90–90–90 targets. Three different categories of support for sub-national units were identified: scale-up, maintenance, and central support. This study, conducted by Johns Hopkins University and partners through USAID-funded Project SOAR, sought to understand the effects of the geographic prioritization (GP) strategy in Kenya and Uganda, with a specific focus on centrally supported facilities. In particular, it sought to understand how the transition from PEPFAR support to central government support, or support from other funders, affected the delivery and coverage of HIV services, as well as priority non-HIV services, especially those relevant to ending preventable child and maternal deaths (EPCMD).

STUDY OBJECTIVES

1. Document the process of implementing the PEPFAR GP strategy in Kenya and Uganda, with a particular focus on the implementation strategies pursued in centrally supported sub-national units and facilities.

2. Determine the change in (i) key HIV service indicators and (ii) select non-HIV service indicators over time, associated with implementation of the PEPFAR GP strategy in centrally supported facilities.

3. Explore health system changes among centrally supported facilities (e.g., shifts in health workforce, pharmaceutical supply, lab services, supportive supervision) over time associated with implementation of the PEPFAR GP strategy, and explore how these health system changes affected service delivery and demand for HIV and non-HIV services.

4. Identify strategies and factors that have either supported or hindered a smooth and sustainable transition of sub-national units and sites to central support.

STUDY DESIGN AND METHODS

In each study country we conducted a mixed methods observational study comprising three different study components:

1. Component 1 tracked the detailed design and implementation of the GP strategy, drawing on document review and qualitative in-depth interviews. This component was essential to understand differences between countries in strategy design, plans for rolling out the strategy,
and how actual implementation differed from design. This component informed later analyses (for example, regarding the timing of the implementation of the strategy).

2. Component 2 investigated changes in (i) HIV and non-HIV service indicators and (ii) health system indicators, associated with the shift to central support in specific facilities. We conducted a structured facility survey in each country approximately 8–12 months after the shift to central support to understand process effects within facilities and matched this with service delivery data from routine information systems.

3. Component 3 employed qualitative case studies in a small number of purposively selected facilities at two different points in time, so as to understand the longer term and dynamic effects associated with transition. The case studies combined multiple sources of primary data (particularly interviews and focus group discussions) with routine data on service delivery and (where available) human resources to present a comprehensive picture of transition.

RESULTS

The process of implementation

- GP implementation suffered from poor planning and short timelines

USAID Missions in Kenya and Uganda adopted somewhat different approaches to transitioning facilities to central support. In Kenya, seven counties (out of 47) were designated to transition to central support. These counties were located primarily in the Northern Arid Lands, and all facilities within them were transitioned. No facilities outside these counties were transitioned. In Uganda, 10 districts were fully transitioned to central support. In addition, a further 700–800 facilities outside of these districts (i.e., in maintenance or scale-up districts) were transitioned to central support, about 40 percent of which were privately owned.

Stakeholders in both countries, especially at the sub-national level, reported inadequate communication about the process for implementing the GP, and that, together with highly ambitious timelines, they observed implementation challenges such as lack of notice given to transitioning facilities, unclear definition of responsibilities for different actors post-transition, and lack of alignment with budget cycles. In practice, USAID implementing partners led the communication and implementation process.

While USAID post-transition support was planned in both countries, primarily through regional mechanisms, in Uganda it took some time for small but critical details regarding how this support would flow to be worked out. In Kenya, the site support was not delivered as planned, leading to USAID asking its implementing partner to resume support for a specified period of time.

Impact of GP on service delivery

- Negative effects on HIV and non-HIV service delivery as a result of GP were minimal, according to routine data analysis
• HIV outreach was negatively affected by the GP and other PEPFAR policies whose implementation coincided or overlapped with the GP
• Facility in-charges raised concerns about emergent effects on HIV and non-HIV service delivery

Transition largely did not impact the variety of HIV services that facilities offered, with two important exceptions. Outreach services in both countries were negatively affected by the GP, and in Kenya a number of smaller level-2 facilities stopped offering ART services as a consequence of GP.

We found no significant difference in trends in service volume between centrally supported facilities and maintenance facilities for the following HIV services: HIV testing and counseling, patients currently on ART, and cohort retention. We also considered potential impacts on non-HIV services, primarily for maternal and child health. While we found a few small but significant differences in non-HIV services trends between centrally supported and maintenance facilities, these could be explained by confounding factors. Our broad conclusion is that overall, currently there is no clear evidence from routine service data that HIV or non-HIV service volume was negatively affected by transitioning to central support.

Facility in-charges expressed negative opinions regarding the impact of the GP on the quality and accessibility of services. For both HIV and non-HIV services, in-charges at centrally supported facilities were more likely to report that service accessibility and quality had declined (at least for some population groups), than in-charges at maintenance facilities.

Health system effects
• Health workers in CS facilities received less support & training
• There were disruptions to the laboratory system due to GP

Across both countries, GP had widespread implications for the health workforce in centrally supported facilities (compared to those in maintenance facilities) leading to a decline in on-the-job training for staff, less time spent on HIV, fewer staff receiving salaries from PEPFAR, and a decline in outreach allowances. Despite these changes, we found no differences in motivation between health workers in centrally supported and maintenance facilities.

Laboratory services, that were meant to benefit from above-site support post-transition, faced a number of challenges immediately after transition, such as accessing transport to get samples to the laboratory and lack of phone data for receiving results. However, during the second round of data collection, many of these challenges were being addressed. We found little impact of the GP on drug supply, or on health management and information systems.

In neither country were financial data available at the facility level, so it was not possible to draw conclusions about the financial status of the facilities. However, it was clear that in some cases where districts (Uganda) or counties (Kenya) wanted to step in and provide additional support to replace what was lost, their budgetary envelope did not permit this. In both countries, there was evidence that private sector facilities resorted to user charges to replace some of the lost support.
CONCLUSIONS AND IMPLICATIONS

Overall, we found relatively few negative effects upon HIV or non-HIV services at the time of the study, despite reported challenges in consistency and communication in the GP implementation process. Further, effects on health systems appeared manageable, although it is difficult to predict how the observed health workforce impacts will influence services in the longer term. The views of facility in-charges were considerably more negative than service data suggest; we do not know whether this was due to them detecting emergent differences that would accumulate and prove problematic over time, or whether they expressed negative opinions so as to encourage the re-entry of USAID support. Overall, we note a number of limitations with this study (including particularly confounding factors, and a relatively brief post-transition period) that may affect the robustness of our results.

In terms of implications, we recommend that in future transitions, USAID, as well as PEPFAR and other development partners considering transition, schedule longer time frames and clearer plans to support both communication of the transition process and implementation. We also recommend that greater attention be paid to how the loss of support for outreach affects targets over time, particularly the ability to retain patients on treatment. Finally, our sample of private sector facilities is relatively small, but in some respects private facilities appear to have experienced the effects of transition more negatively, both in terms of introducing charging for services, and dropping particular types of service. It would be helpful to have a clear view on how critical private sector participation is to the HIV response, and therefore whether to be concerned about these findings.
INTRODUCTION

Phase III of the United States President’s Emergency Plan for AIDS Relief (PEPFAR 3.0), launched in 2014, has as its focus “Sustainable Control of the Epidemic.” PEPFAR 3.0 aims to bring control to the epidemic by “pivoting to a data-driven approach that strategically targets geographic areas and populations” where investments can bring the greatest impact. A specific set of inter-related action agendas including impact, efficiency, sustainability, partnership, and human rights are employed to support epidemic control by significantly improving HIV-related outcomes in countries most affected by the HIV epidemic.

These action areas stem in part from the 2008 Lantos-Hyde Reauthorization Bill that placed a strong emphasis on sustainability, as well as the results of a four-year Institute of Medicine (IOM) evaluation of the effectiveness of PEPFAR initiated in 2008. IOM evaluation findings (IOM 2013), which are reflected in the PEPFAR 3.0 strategy, highlighted the need to:

- Plan program portfolios and the allocation of limited resources, in collaboration with partner country stakeholders, to be more strategic, targeted, and coordinated in order to reach identified targeted outcomes, with implementation flexibility at the country level.

- Enhance support for long-term systems strengthening, capacity building, and decision-making processes to achieve sustainable HIV programs. Refine monitoring, evaluation, and research to adapt to this transition from direct support for programs and services to technical assistance in systems strengthening, capacity building, and sustainability.

The FY15 Country Operational Plan (COP) guidance for United States Agency for International Development (USAID) missions presented the “geographic prioritization process” within the pivot strategy, whereby PEPFAR-supported countries were to target and prioritize high burden areas with the goal of achieving the UNAIDS 90–90–90 targets. Specifically, global guidance identified the following classification of sub-national units (SNUs) (such as districts or counties) and pursuant actions:

- Scale-up SNUs: SNUs with the highest burden location and populations will receive a package of services designed to accelerate progress toward at least 80 percent antiretroviral treatment (ART) coverage in a subset of high-burden locations and populations.

- Maintenance SNUs: will receive a package of services provided by PEPFAR that are different in each country, including passive enrollment via HIV testing and counseling on request or as indicated by clinical symptomology, care and treatment services for people living with HIV (PLHIV), and essential laboratory services for PLHIV. As the high burden scale-up districts are saturated, sustained districts will be aggressively scaled to reach 90–90–90 goals by 2020.

- Central support (CS) SNUs (SNUs which have reached certain PEPFAR-defined targets): site-specific activities will transition to government or other support by no later than March 2016 (as stated in the global guidance).

---

1By 2020, 90 percent of all people living with HIV will know their HIV status. By 2020, 90 percent of all people with diagnosed HIV infection will receive sustained antiretroviral therapy. By 2020, 90 percent of all people receiving antiretroviral therapy will have viral suppression.
Within these SNU categorizations, site classifications were permitted to vary based on location, planned performance, surrounding disease burden, patient volume, and other sources of funding support. Thus, for example, within a maintenance SNU, specific sites may be centrally supported or scheduled to be scaled up.

This study, conducted by Johns Hopkins University and partners through the USAID-funded Project SOAR, sought to understand the effects of the geographic prioritization (GP) strategy in select sub-Saharan African countries, namely Kenya and Uganda, with a specific focus on centrally supported facilities. In particular, it sought to understand how the transition from PEPFAR support to central government support, or support from other funders, affected the delivery and coverage of HIV services, as well as priority non-HIV services, especially those relevant to ending preventable child and maternal deaths (EPCMD). While the effects on HIV services may be direct and more obvious, it was anticipated that the transition to CS could affect non-HIV services in a facility. For example, the GP strategy might influence different aspects of the health system (such as staff motivation, staff training, staff time allocation, reliable drug supply, or budgets) or via shifts in patient care-seeking behavior that could in turn affect the mix of cases being received at a facility. This study was designed to capture both anticipated and unanticipated effects in service outcomes, as well as how the shift in support affected the health systems through which services are delivered.

While other studies have sought to understand the effects of the cessation of development partner support to HIV/AIDS programs (Bennett et al. 2015, Gotsadze et al. 2015, Vogus and Graff 2015; Brundage 2011) few of these studies have been empirically robust, and all have focused on programs where there is total development partner withdrawal from the program, rather than a geographic focusing such as that which has occurred under the PEPFAR geographic pivot. Further, none of these studies has sought to understand how diminishing support for HIV services may affect other services such as maternal, neonatal, and child health.

**Overview of geographic prioritization in Kenya and Uganda**

While FY15 COP guidance set out the broad parameters of the GP strategy, details around how the strategy was to be implemented varied across different settings.

**Kenya** is subdivided into 47 counties, of which 20 were identified as scale-up counties (eight with earlier, more aggressive targets), 20 as maintenance counties, and seven as counties to be transitioned to CS. Assignments to investment categories were based on burden of disease and how much PEPFAR support was directed to the county. The seven CS counties are primarily located in the Northern Arid Lands plus one coastal county: Garissa, Isiolo, Lamu (coastal), Mandera, Marsabit, Tana River, and Wajir. All facilities in Kenya were consistently designated as either scale-up, maintenance, or CS based on their county’s investment category. According to documentation from the USAID Mission, 413 facilities were located in CS counties and were, thus, transitioning to CS. USAID had been supporting 404 of those 413 (USAID supports 3,516 facilities overall). Thus, almost 100 percent of CS facilities were USAID supported. It was initially planned that transition to CS would be completed by the end of September 2016.
Of the 112 districts in Uganda, the majority (61) were identified as scale-up districts, with 40 maintenance districts, and 10 CS districts. CS districts were identified by an algorithm that considered HIV prevalence (most transition districts have HIV prevalence less than 0.6 percent) and the extent of gaps in service delivery. These districts were largely in the east of the country, and included Abim, Amudat, Bulambuli, Kaabong, Kapchorwa, Kween, Luuka, Nakapiripirit, Napak, and Pader, all but one of which (Amudat) were USAID supported. Amudat was managed by the Department of Defense. Of note and unlike Kenya, facilities in Uganda were not consistently designated to the same category as the district within which they were located. For example, some facilities within non-CS districts were also designated as CS. CS facilities (in non-transitioning districts) were identified as facilities that had very low levels of PMTCT, ART, and VMMC. Overall, out of approximately 2,500 total USAID-supported facilities, the GP was intended to transition PEPFAR support for about 100 USAID facilities housed in the 10 CS districts as well as 700–800 PEPFAR facilities based in maintenance or scale-up districts. While the reported numbers of facilities outside of the 10 districts, to be transitioned to CS varied over time, approximately 60 percent of the facilities were USAID-supported, and close to 40 percent of them were privately owned (split roughly equally between for-profit and not-for-profit). In many CS districts, while PEPFAR had historically provided very low levels of funding, USAID and PEPFAR planned to retain regional level mechanisms for support. According to the Ugandan COP, Strategic Direction 2015, support to CS districts and site was meant to be complete by the end of September 2016.
RESEARCH GOALS AND OBJECTIVES

The overall goal of this research was to provide timely guidance to USAID and other USG partners regarding the process of implementing the GP strategy and the association of implementing this strategy with changes in health systems, and on HIV and non-HIV service provision, uptake, and other key indicators. It was anticipated that this information would both help inform USG implementation plans related to the GP strategy and, ultimately, provide a comprehensive evaluation of the effects of the strategy in CS facilities.

This Project SOAR study was closely coordinated with a parallel study implemented by MEASURE Evaluation, which sought to document the effects of the strategy across all three types of SNUAs as well as bring a specific focus to the consequences for the reliability and validity of data collected in national health information systems. Based on agreements with MEASURE Evaluation and USAID, the SOAR study sought to (i) focus on the facility rather than the district or county level, and (ii) focus solely on those facilities transitioning to CS.

Accordingly, the specific objectives of the SOAR study were as follows:

1. Document the process of implementing the PEPFAR GP strategy in Kenya and Uganda, with a particular focus on the implementation strategies pursued in CS SNUAs and facilities.
2. Determine the change in (i) key HIV service indicators and (ii) select non-HIV service indicators over time, associated with implementation of the PEPFAR GP strategy in CS facilities.
3. Explore health system changes among CS facilities (e.g., shifts in health workforce, pharmaceutical supply, lab services, supportive supervision) over time associated with implementation of the PEPFAR GP strategy, and explore how these health system changes affected service delivery and demand for HIV and non-HIV services.
4. Identify strategies and factors that have either supported or hindered a smooth and sustainable transition of SNUAs and sites to CS.

STUDY DESIGN

Kenya and Uganda were selected for this study primarily because the timing of their prioritization processes aligned with the study period, and the respective USAID Missions demonstrated interest in the study and its findings. Kenya and Uganda also provide opportunities to consider other factors that may play into the success of the GP strategy. For example, Kenya has recently adopted a far-reaching devolution strategy placing much responsibility for financing...
and management of health services in the hands of county governments. While Uganda has a relatively decentralized health system, the decentralization has taken the form of deconcentration, not devolution, thus the central Ministry of Health (MoH) has delegated specific responsibilities to decentralized district health management teams (not local government). Further, and as described below, there are differences in the nature of the GP strategy with the transitioning Kenyan facilities being entirely within the CS counties, whereas in Uganda there were many CS facilities in scale-up or maintenance districts.

In each country we conducted a mixed methods observational study comprising three different study components.

Component 1 sought to track the detailed design and implementation of the GP strategy in each study country, drawing on a combination of document review and qualitative in-depth interviews. This component was essential to understand differences between countries in strategy design, plans for rolling out the strategy, and how actual implementation differed from design. This component informed later analyses (for example, regarding the timing of the implementation of the strategy).

Component 2 sought to investigate changes in (i) HIV and non-HIV service indicators and (ii) health system indicators, associated with the shift to CS in specific facilities. While many service delivery indicators were available through routine health information systems, these data sources did not capture more detailed process indicators (for example, around frequency of supervision, training opportunities, access to laboratory services). Accordingly, we conducted a structured facility survey in each country approximately 8–12 months after the shift to CS to try to understand process effects within facilities and matched this with service delivery data from routine information systems.

Component 3 further supplemented the primarily quantitative analysis of Component 2 through qualitative case studies in a small number of purposively-selected facilities, which were largely ones that had shifted to CS. These case studies combined multiple sources of primary data (particularly interviews and focus group discussions) with routine data on service delivery and (where available) human resources to present a comprehensive picture of transition. Component 3 involved two repeated rounds of data collection in each facility to enable an understanding of the longer-term trajectories of these facilities.

DATA COLLECTION AND ANALYTICAL METHODS

We present data collection and analytical methods by study component.

Component 1—Documentation of implementation

Description

This component aimed to describe the nature of the GP strategy and plans for its implementation, with a particular focus on CS SNU5S and facilities. The component sought to understand in more
detail the rationale for the GP design; how the strategy was implemented; the relative roles of USG agencies, implementing partners, and country stakeholders; and the extent of coordination and communication among USG agencies, and between USG, local government, and other stakeholders (e.g., donors, implementing partners, civil society). In addition to providing an initial picture of implementation plans, we also tracked how these plans changed through the implementation process. This component also sought to document any other major initiatives or external circumstances likely to affect HIV and non-HIV indicators.

Data sources

The primary sources of data were (i) document review and (ii) national-level interviews. For each country, the team reviewed pertinent documents regarding the GP strategy, particularly the GP process and its implementation, including USG documents such as COPs, strategy papers and agreements with implementing partners, where available. We also reviewed relevant government documents such as health strategies, HIV national strategies and plans, and agreements with other donors such as supported Global Fund proposals.

Document review was supplemented by two rounds of semi-structured interviews (May 2017 and November 2017) with national-level key informants in each country. Informants were purposively selected from USG agencies, implementing partners, and relevant units of the national government. Table 1 summarizes the number of interviews and types of respondents in each country.

<table>
<thead>
<tr>
<th>Respondent type</th>
<th>Kenya Round 1</th>
<th>Kenyan Round 2</th>
<th>Uganda Round 1*</th>
<th>Uganda Round 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>USG agencies</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Implementing partners</td>
<td>3</td>
<td>4</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>Civil society organizations</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>—</td>
<td>—</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
<td>11</td>
<td>26</td>
<td>14</td>
</tr>
</tbody>
</table>

*Includes 22 key informant interviews and 1 group interview with a team of 4 IP members

Data analysis

Based upon the document review and interviews, a timeline of critical activities (both planned and already implemented) was constructed (see Appendix).

The semi-structured interviews were audiotaped, transcribed, and systematically coded using a thematic analysis approach. Key domains of interest included how and when decisions around GP were made; how communications around GP took place across actors and levels of the health system; how prioritization was implemented, including formal plans; which actors were involved in prioritization and how their relationships changed over time, etc. Analysis was first conducted...
separately by country; later, cross-country comparisons were used to identify common and divergent themes.

Component 2—Facility surveys & routine data analysis
We conducted facility surveys and gathered District Health Information System (DHIS2) data in Uganda and Kenya as well as collected Human Resource Information System (HRIS) data for Uganda only. The DHIS2 is an online database for reporting national health management information system (HMIS) data collected by the health system. HRHIS is the name for Uganda’s version of the HRIS system. Aggregate district and facility level staffing data are publicly reported in Uganda. In Kenya, these data are not made public, unlike in Uganda, and our request to access iHRIS, Kenya’s version of HRIS, was denied by the MoH.

Facility survey: Kenya
The facility survey was conducted in Kenya between May and June 2017. Ipsos Kenya fielded the survey. We sampled from facilities identified by USAID as PEPFAR-supported in seven counties intended to be transitioned to CS (Garissa, Isiolo, Lamu, Mandera, Marsabit, Tana River, Wajir) and four adjacent counties that were classified as “maintenance” (Embu, Laikipia, Samburu, Tharaka Nithi). Due to security concerns near the border with Somalia, we excluded areas identified as insecure by Ipsos. These included Wajir East, Fafi and Hulugho districts of Garissa; Mandera South & Central, and the Chalbi desert area of Marsabit (Figure 1). As a result, 64 facilities out of the 404 PEPFAR facilities in the CS counties were excluded from sampling. None of the 223 initially PEPFAR-supported facilities in the adjacent maintenance counties were excluded for security reasons.

The sample frame of 563 facilities was divided into 33 clusters (18 in CS counties and 15 in adjacent maintenance counties). Stratified random sampling was used to select 18 clusters (12 in CS and 6 in adjacent counties). By chance, no clusters were selected from Samburu County. Three level-5 facilities (Embu Provincial Hospital, Garissa Provincial Hospital, Isiolo Provincial Hospital) were purposively selected. Level-5 facilities were provincial hospitals, which had the highest level of care outside of national referral hospitals in Nairobi. These facilities had large HIV programs. However, most facilities were level-2 (dispensaries) and level-3 (health centers) that have fewer HIV services.

Within selected clusters, all facilities that were level-4 (District hospitals) and all level-2 and level-3 facilities reporting more than 10

![Figure 1  Facility survey and case study sites in Kenya](Image)
patients on ART in 2015 were selected. We then selected a random sample of 70 percent of the remaining facilities within the cluster.

The number of clusters and facilities was chosen as a result of 1,000 Monte Carlo simulations (Muthén and Muthén 2009). In each simulation, we apply hypothetical scenarios to the data and sample repeatedly to determine in what proportion of simulations we are able to detect the hypothetical “truth” from our sample, i.e., the power. We sought to have 80 percent power to detect a shift in responses among the CS facilities of 30 percent of sampled facilities with a 4:1 ratio of yes-to-no compared to no-to-yes changes at a 5 percent Type-I error level. This required a sample of 147 facilities in the seven CS counties. We also sought to achieve a 2:1 ratio of CS to maintenance facilities to allow for comparisons both between CS and maintenance facilities and among CS facilities. Therefore, we added six maintenance county clusters for a total of 18 clusters and 230 facilities.

Lacking data on reasonable expected non-response rates prior to this study, we opted to identify replacement facilities in Kenya rather than to oversample. We selected one or more replacements for each sampled facility from unused facilities in the sample frame. Replacements were drawn first from facilities with the same ownership category (private not-for-profits [PNFP], private for-profit [PFP], or government), level, and cluster. When replacements with these characteristics were unavailable, we selected replacements within one level difference (e.g., level 3 for level 2), similar ownership (private and PNFP vs. government), or the same level and ownership from nearby clusters. A total of 30 replacements were used.

In the analysis, we adjusted for the clustered selection and stratification using the svy commands in Stata, with weights to account for oversampling. Replacements were assigned to the cluster of the facility that they replaced. However, replacement facilities were treated as coming from the strata to which they belonged (e.g., if an ART facility with more than 10 patients was replaced with a non-ART facility, the replacement would be included in the non-ART strata). Additionally, the dataset contains the replacement facility’s covariate data (e.g., level, ownership).

Among the 230 facilities, 37 reported never having had support from PEPFAR and were excluded from further analysis. Of the remaining 193 facilities, 136 had been transitioned to CS support and 57 had been maintained on PEPFAR support (Table 2). Not all CS county facilities reported transition and some maintenance county facilities reported transition. However, among CS facilities, 83 percent were located in CS counties compared to 21 percent in maintenance counties. Despite oversampling, most facilities in the unweighted sample were level-2 (64 percent). The majority of facilities were also government-owned (84 percent).

Ipsos enumerators conducted interviews with in-charges at health facilities outside of normal working hours. Due to the ongoing Kenyan nurses’ strike (June–November 2017), some nurses were interviewed away from facilities, including at their homes. The majority of primary respondents were nursing officers (69 percent), with a minority of clinical officers (17 percent).

---

2During fielding of the survey, the security situation in El Wak, Mandera County was deemed too precarious for data collection, requiring 7 replacements. Three other facilities (one in Lamu, one in Garissa, and one in Marsabit) were also excluded because of local insecurity or access issues. In 14 facilities, there were no staff knowledgeable about the pre-transition situation to interview. Six facilities were either closed permanently or temporarily, or were not open following two visits.
Other cadres of respondents included HIV testing and counseling (HTC) counselors (3 percent), community health workers (3 percent), and medical officers (2 percent). A third of respondents had worked at the index facilities for longer than five years and 31 percent for 2–5 years. Only 11 percent of respondents had worked at the facilities for less than one year. Whenever primary respondents lacked information on a particular topic, secondary respondents knowledgeable about the topic were sought from within the health facility.

The survey comprised questions concerning the profile of the respondent; how the facility had been prepared for transition (for example in terms of when they first heard about the transition); facility in-charge perspectives on both the impact of the transition on services and facility operations, and shifts that had taken place since the transition date in (i) drugs, commodities, and laboratory services, (ii) supervision, (iii) human resources, and (iv) finance and budget. The draft survey was piloted in four facilities, and adjustments were made prior to full implementation. In smaller facilities, interviews were conducted with facility in-charges, or their acting replacements. In larger facilities, multiple respondents (in-charge, director of the HIV clinic, financial representative) contributed to the survey. Interviews were conducted using a standardized instrument that assessed past and current support for, and the status of, HIV and reproductive, maternal, neonatal and child health (RMNCH) care, laboratory, drugs, finances, and human resources at the facility.

In the final part of the survey, the enumerators randomly selected 1–3 workers at each facility from a list of health workers that provide HIV services who were present on the day of the survey and administered individual questionnaires to them which asked about non-salary incentives, changes in work time allocation since transition, motivation, and job satisfaction. The secondary questionnaire was administered to workers in private, away from other staff. The secondary respondents could include the primary respondents. A total of 400 individual interview responses were collected. In 43 percent of facilities, there was only one possible respondent present. Only in 20 percent of facilities could three respondents participate. This is not surprising because half of health facilities reported two or fewer workers involved with HIV care.
Nearly all facilities reported transitioning during the latter half of 2016 (Figure 2). Early transitions before 2016 were more common in CS counties than in the adjacent counties. Many early transitioned facilities were located in Mandera County, where security has been an issue for several years prior to transition.

Figure 2  Transition dates for sampled facilities in Kenya, by county type

Facility survey: Uganda
The facility survey was conducted in Uganda in July and August of 2017. The survey sample frame was drawn from health facilities identified by USAID as PEPFAR-supported in FY2015 (Figure 3). The list designated each facility as either maintenance, scale-up, or CS. For logistical reasons, we limited the sampling area for this survey to 40 districts in Northern and Eastern Uganda, as well as Kampala and Wakiso districts. This part of Uganda contained 9 of 10 CS districts (Amudat district lacked USAID facilities), a large proportion of CS private for-profit facilities, as well as the majority of facilities designated for maintenance.

The target sample size of 250 was identified through Monte Carlo simulations, as in Kenya. All facilities not designated for scale-up in the 42 districts were included in the sample frame. We selected facilities from the sampling frame using stratified random sampling design with four strata: (1) 40 percent random sampling transition facilities in Kampala and Wakiso, (2) 100 percent selection of all districts containing transitioning health center (HC) level-IVs and/or hospitals, (3) random sampling of 11 out of 18 districts that were designated as CS or maintenance but did not contain transitioning HC level-IVs or hospitals, and (4) random sampling of six out of 14 scale-up districts. Within selected districts from strata 2 to 4, all facilities identified as PEPFAR-supported at baseline were included in the sample. Using this process, a total of 275 facilities were included in the sample. Another two facilities that had been purposively selected for case studies were also included in this sample for a total of 277. Unlike in Kenya, we did not use replacements in Uganda. Rather, we estimated 10 percent non-response to achieve a
final sample of roughly 250.

Enumerators were able to complete surveys at 262 facilities. Of the 262 facilities surveyed, 36 claimed to have had no PEPFAR support within the past three years and were excluded from the analysis, 204 reported having been transitioned, and 22 reported continuing to receive PEPFAR support. This was contrary to what was expected, due both to the 36 sites with no recent PEPFAR support and the larger than expected proportion of sites reporting transition. From follow-up interviews with implementing partners (IPs) and USAID, we determined that as many as 60 of the transitioned facilities were experiencing a break in support between IPs lasting for about 9 to 12 months. As these facilities reported similar processes and impacts as those that were genuinely transitioned, we have included them as CS facilities in this analysis.

Enumerators supervised by Makerere University School of Public Health fielded the facility survey in Uganda. As in Kenya, the survey was fielded to the in-charges in small facilities and to multiple respondents in large facilities. Also, two to three individuals involved in HIV care who were present on the day of the survey were asked to participate in an individual interview, with nearly the same questionnaire as in Kenya. A total of 479 individual interviews were completed. The Ugandan version of the survey instrument included more questions on support lost to improve identification of transition facilities, a streamlined financial section, and an additional question on changes in satisfaction in the individual questionnaire.

---

Of the 15 facilities that could not be surveyed, nine had closed permanently, two were closed for construction, two facilities were identified as duplicate records, one (a private for profit facility) refused to participate in the survey, and one was not accessible on account of hazardous road conditions.
The majority of sampled facilities were public (70 percent) (Table 3). Private facilities were roughly equally split among private for profit (15 percent) and faith-based/PNFP (15 percent). The majority of facilities (63 percent) were health center IIIs, which are the lowest level of facility allowed to provide ART in Uganda. Among PEPFAR facilities surveyed, 24 percent were either HC II, private clinics, or of unknown levels. These facilities generally do not have medical or clinical officers or provide ART or deliveries. Despite oversampling, only 12 percent of facilities were HC IV or hospitals, but 73 percent of facilities offered ART prior to transition and 85 percent of facilities offered vaginal deliveries. In Kenya, the proportions were 55 percent and 83 percent, respectively. In addition, the majority of both transitioned and maintained sites reported receiving support from PEPFAR IPs for a variety of services currently or prior to transition: 65 percent reported receiving assistance for supervision, outreach, training, and laboratory, and 22 percent reported receiving support for three of the four services.

Table 3  Unweighted facility characteristics, Uganda facility survey

<table>
<thead>
<tr>
<th>Facility level</th>
<th>Maintenance No.</th>
<th>%</th>
<th>CS No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>HC II or N/A</td>
<td>6</td>
<td>27.3</td>
<td>50</td>
<td>24.5</td>
</tr>
<tr>
<td>HC III</td>
<td>12</td>
<td>54.5</td>
<td>131</td>
<td>64.2</td>
</tr>
<tr>
<td>HC IV</td>
<td>1</td>
<td>4.5</td>
<td>14</td>
<td>6.9</td>
</tr>
<tr>
<td>Hospital</td>
<td>3</td>
<td>13.6</td>
<td>9</td>
<td>4.4</td>
</tr>
<tr>
<td>Facility ownership</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private</td>
<td>2</td>
<td>9.1</td>
<td>31</td>
<td>15.2</td>
</tr>
<tr>
<td>Public</td>
<td>16</td>
<td>72.7</td>
<td>143</td>
<td>70.1</td>
</tr>
<tr>
<td>Private not-for-profit</td>
<td>4</td>
<td>18.2</td>
<td>30</td>
<td>14.7</td>
</tr>
<tr>
<td>PEPFAR district classification</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintenance</td>
<td>10</td>
<td>45.5</td>
<td>97</td>
<td>47.5</td>
</tr>
<tr>
<td>Scale-up</td>
<td>3</td>
<td>13.6</td>
<td>42</td>
<td>20.6</td>
</tr>
<tr>
<td>Central support</td>
<td>9</td>
<td>40.9</td>
<td>65</td>
<td>31.9</td>
</tr>
<tr>
<td>Year of transition</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Before or in 2015</td>
<td></td>
<td></td>
<td>60</td>
<td>29.4</td>
</tr>
<tr>
<td>2016</td>
<td></td>
<td></td>
<td>74</td>
<td>36.3</td>
</tr>
<tr>
<td>2017</td>
<td></td>
<td></td>
<td>70</td>
<td>34.3</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
<td>100</td>
<td>204</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The transition dates for CS facilities varied widely (Figure 4). Late transitions taking place in early 2017 were often supported by Management Sciences for Health/Strengthening TB & HIV/AIDS Response-Eastern (STAR-E), an IP whose contract expired in early 2017. Some of these represent genuine transitions, while others were expected to begin receiving support from the replacement Regional Health Integration to Enhance Services—Eastern Uganda (RHITES-E) project. Early transitions in 2013–2014 preceded PEPFAR GP, but were still identified as transitioning due to GP. These were mostly low-volume sites, including many private for profits, as well as facilities in Luuka, a CS district.
Routine health information data: Kenya and Uganda

We extracted DHIS2 data for PEPFAR facilities in Uganda and Kenya. In Uganda, we extracted data for all reporting facilities. However, in Kenya, we only extracted data for facilities located in the 10 survey counties (Embu, Garissa, Laikipia, Lamu, Mandera, Marsabit, Tana River, Tharaka Nithi, Wajir). In Uganda, we were provided with a list of all PEPFAR facilities with transition status identified. However, in Kenya, we only received a list of PEPFAR facilities without identification of transition status at the site level. Therefore, we limited our sample to facilities reporting either transition to CS or maintenance in our facility survey.

In addition to HIV health services, we also examined delivery of select non-HIV services. We anticipated that support provided by PEPFAR IPs might have direct and indirect impacts on non-HIV services. Many PEPFAR IPs (e.g., APHIAPlus in Kenya) provide support to both maternal, neonatal and child health (MNCH) and HIV/AIDS services. Indirectly, increasing PMTCT and early infant diagnosis requires high utilization of antenatal care (ANC) and post-natal care (PNC) by women and newborns. Facility upgrades and service quality improvements benefit HIV as well as non-HIV services. Alternatively, PEPFAR supervision and incentives, may crowd-out MNCH care by promoting staff to engage in more HIV care.

Table 4 presents data on indicators and source data reports and data fields for each country. The data extracted cover the period October 2013 to December 2017.

Following extraction, we merged each country’s data to lists of PEPFAR-supported facilities as of FY 2014 supplied by USAID missions using integrated PEPFAR Site List identifiers (iPSL_ID) fields. The Uganda DHIS2 has no unique facility identifier, but we were able to match facility records using a linking key compiled by the Uganda M&E contractor (previously, Monitoring and Evaluation of the Emergency President’s Plan, MEEPP) project (personal communication). We performed manual checking and matching to identify and address any issues in matching. In Kenya and
Uganda, we merged our facility survey data to the DHIS2 data, but we present the results of the more powerful analysis of all PEPFAR sites in Uganda.

We defined facilities that reported to DHIS2 at least two times during the period (October 2013 to June 2016) and at least two times during the post-period (July 2016 to December 2017) as having enough data for analysis. At the outset of the project, July 2016 was our best guess for when transition would be completed. As most facilities are either non-reporters or good reporters, more stringent criteria would not change the number of facilities considerably.

We performed a minimalist data cleaning with the goal of removing highly out-of-range data values that could bias the analysis. With no “Gold Standard,” we cannot expect to identify or remove all erroneous values caused by over or under-reporting. Therefore, we opted to remove the most extreme high values. We took the average of each field by facility and identified large outlier values relative to the facility means. We also checked the largest 1–5 percent of cases to look for improbably high values given the facility size. Less than 1 percent of cases were excluded for most indicators; however, for cohort retention in Uganda we excluded 9 percent of cases for quality issues.

We restricted our analysis to CS and maintenance facilities. In Uganda, we identified CS and maintenance facilities for DHIS2 analysis using data provided by USAID on the intended transition status for facilities. Therefore, we considered the DHIS2 analysis as intention to treat. However, in Kenya, we did not have a list of facilities transitioned actually to CS outside of the seven CS counties. Therefore, we used the transition status reported by facilities themselves within both maintenance and CS counties.
To analyze the data, we used a difference-in-difference in trend analysis (hereafter referred to as "trend analysis") as well as a conventional difference-in-difference (hereafter “D-in-D” for short) in level analysis. D-in-D in trend compared the change from pre-transition to post-transition slopes of trend curves for CS facilities to the change for maintenance facilities. Doing so controlled not only for differing baseline trends but also for secular impacts on trends that are common to maintenance and CS facilities, such as budget changes. D-in-D in level only compared the average difference between post and pre-transition for CS to the difference for maintenance. It controlled for secular changes, but not differing baseline trends.

Component 3—Longitudinal case studies

Description

We employed longitudinal case studies of purposively selected, CS facilities to examine how prepared facilities were for transition, how the transition affected the health system and service delivery, including both anticipated and unanticipated consequences, and how different actors within the health system, including communities and key populations, experienced transition. This approach can provide a holistic and in-depth investigation of the transition process over time (Yin 2013), including consideration of how different actors adapt to transition, and also helps to explain the findings from Component 2.

We conducted case studies in six or seven CS facilities in each country. These case study facilities were purposively selected to reflect variation across the country in relevant factors such as:

- Level of the health system
- SNU type: CS or maintenance
- Volume of patients receiving ART
- Public and private (for profit and non-profit) ownership (in Uganda)

Table 5 presents a summary of the longitudinal case study samples for each country. Case study facilities were selected from the study sample being used for the facility survey, and we ensured that survey data would be available at all case study sites. The locations of case study sites are identified for Kenya and Uganda in Figures 1 and 3, respectively. Since there are no unique patient identifiers in the HMIS in either country, we were unable to track care seeking behavior for affected patients. Instead we sought to understand the consequences of the geographical prioritization strategy on HIV/AIDS service users through in-depth interviews with clients as part of the longitudinal case studies.

Data sources

For each case study facility, we conducted two rounds of semi-structured interviews with key informants and sex-disaggregated focus group discussions (FGDs) with patients (May and November 2017). Semi-structured interviews focused on stakeholders involved in the facility and/or HIV services in the SNU. Respondents included county or district health management teams, health facility managers, health workers, and implementing partners. FGDs with patients were sex-segregated to ensure comfort of participants in responding honestly.
In Uganda, we conducted a total of 62 semi-structured interviews (31 in each round, with overlap) and 15 FGDs (6 in round 1 and 9 in round 2). In Kenya we conducted a total of 36 semi-structured interviews (16 in Round 1 and 20 in Round 2, with overlap) and 22 FGDs (11 per round).

### Analysis

The semi-structured interviews and FGDs were audiotaped, transcribed, translated as needed, and systematically coded using a thematic analysis approach. Domains of interest include

---

No FGDs with male patients were conducted in Mandera in either round because no patients were willing to attend.
changes to service delivery post-transition, shifts in care seeking among the patient population, relationships between different stakeholders and communication between them, and positive and negative consequences emerging from transition and strategies arising to address them, among others.

Each case study facility was analyzed and summarized as a whole, followed by cross-case comparisons within each country to identify common experiences across facilities. Cross-country comparison was conducted at the end to understand broader commonalities in experiences. Results from the case studies were contrasted with quantitative results to illuminate findings in both areas and develop a holistic view of the prioritization process.

**Ethical review**

The protocol for this study was submitted for review to the JHSPH Institutional Review Board where it was classified as non-human subjects, and exempted from review. The protocol was also submitted to and approved by the AMREF Ethics and Scientific Review Committee (AMREF/P325-2017) in Kenya and the Makerere University, College of Health Sciences, Higher Degrees and Research Ethics committee (Protocol 481) in Uganda.
RESULTS

Results are presented according to the objectives set out above, with the fourth objective (identifying factors that facilitate a smooth and sustainable transition) being addressed in the discussion. Results from different components were triangulated and are presented in a synthetic way to give a comprehensive picture of GP.

PROCESS OF IMPLEMENTING THE GEOGRAPHIC PRIORITIZATION PROCESS

Our stated objective for this component of the research was to document the process of implementing the PEPFAR GP strategy in Kenya and Uganda, with a particular focus on the implementation strategies pursued in CS SNUs and facilities. However, due to the unpredictability of the GP launch and implementation, as well as study delays, we were not able to fully observe the implementation process. Furthermore, the communication about the GP and planning and preparation aspects emerged as critical in both contexts, setting the scene and providing critical insights for better understanding how the GP was conceptualized in each setting and implemented at the local level.

In the sections below we elaborate, for each study country, on the communications around the launch of the GP, planning and preparation for implementation, and post-transition support. In addition, we explore emerging themes for each country.

Kenya

PEPFAR-Kenya’s GP plan initially allocated counties between the four investment categories (aggressive scale-up, saturation scale-up, maintenance, CS) but these allocations are now revised every year during COP planning. In COP17, a new status (attained) was added. Although the seven counties assigned to CS have not changed (Garissa, Isiolo, Lamu, Mandera, Marsabit, Tana River, Wajir), there has been movement between counties in maintenance, scale-up, and attained. Under the initial allocation, CS counties accounted for 1 percent of burden, maintenance for 10 percent, and scale-up for 80 percent.

Communication about GP

Almost all national and county level interview respondents reported being aware of GP at the time of their interview and understood that GP was prioritizing investments by burden of disease. There were more mixed reports among facilities and very few patients were aware of GP, although this is not surprising. Interview respondents recognized that GP aligned with a recent government strategy released by Kenya’s National AIDS Control Council (NACC) and National AIDS/STD Control Programme (NASCOP) in June 2014, the Kenya HIV Prevention Revolution Road Map (Kenyan Ministry of Health 2014), which outlined an approach focused on population-driven GP between
counties (low, medium, high based on HIV incidence), among other issues. However, some respondents—including county, facility, and civil society—criticized GP because it contributed to historical county marginalization and raised doubts about the accuracy of the data used to develop the plan.

The main criticism of the GP across stakeholder groups interviewed was the short timeframe from announcement to implementation (see Appendix for GP timeline). The initial announcement for GP was made as part of USG’s 2015 COP process in late 2015, but this triggered a protracted negotiation period with government on the specifics of GP, especially because the proposed timeline overlapped with the Kenyan fiscal year, severely limiting the government’s ability to replace the lost support. High-level negotiations took place past mid-2016 and resulted in several changes:

- Shift away from facility-based allocation to county-based allocations for CS
- Extension of the transition deadline from December 2015 to September 2016
- Retaining services for orphans and vulnerable children (OVC) for a longer period
- Agreement on a package of support from IPs targeted at the county level (above-site support) including support for commodities, lab networks, data review, and planning

These negotiations, which addressed the very core of which facilities were to be transitioned, resulted in considerable delays to the original implementation timeline.

According to interviewees, USG informed IPs about GP and they became responsible for informing counties of the upcoming shifts without backing from PEPFAR or the national government, although that had not been the intention. IPs expected counties to inform facilities, but that did not happen consistently, and some facilities were unaware until support ceased. Twenty five percent of facilities in our survey reported advance notice of GP and of those, they only received 1.2 months’ notice on average. It was not until September 2016 that the PEPFAR Coordinator’s Office was able to reach out to counties directly and advise them about GP, but by that point the IP had already ceased support.

Planning and preparation

There was widespread agreement across interviewees that planning for the GP was lacking. They indicated that PEPFAR’s focus on GP planning had been around COP planning, but the execution and roll-out of the GP itself was not formally planned. In fact, no written plan for carrying out GP was developed. Consequently, very little preparation and support was in place for implementing GP, and IPs were left to lead the implementation on their own. The IP had drawn down its support by August/September 2016.

At the same time as GP, USAID prioritized its support for RMNCH to focus on 11 priority counties across Kenya (none in CS) so a number of counties lost support for RMNCH services rather unexpectedly and without warning starting in October 2016. USG respondents indicated that RMNCH prioritization took into account investments from other partners in the region, including the UN, as well as access and security concerns that made CS counties more difficult for USAID to support effectively. This shift was not well communicated or received by counties.
other initiatives by the government were taking place simultaneously with GP, including efforts to improve service integration, and the Beyond Zero campaign spearheaded by the First Lady to establish mobile clinics (or ambulances) in counties.

The OVC program had a completely different approach. USAID issued a separate 1-year contract to the 4Children project (managed by Catholic Relief Services [CRS]) to conduct assessments and prepare a structured transition process for six out of the seven transitioning counties (not including Lamu). The additional support and resources were targeted at raising awareness across local stakeholders about OVC services to be transitioned, developing linkages between actors with a responsibility for OVC services (e.g., county government, Department of Children’s Services), and building capacity among local actors to identify, support, and graduate OVC families. Although the timeline was tight, they were able to accomplish most of their goals, and CRS has used these learnings to modify its approaches elsewhere.

**Post-transition support**

The package of above-site support that had been agreed at the outset was not delivered as planned due to limitations on the IP’s funding and staff capacity. By April 2017, indicators from CS counties suggested that services were declining and the IP proposed—and USAID approved—a return to eight high-volume facilities in six CS counties. In fact, USG and IP respondents recognized that they had not realized the level of effort necessary to provide those services, especially given the remoteness of the CS counties, and were adjusting as they went along.

The return, referred to locally as a “rescue package,” started in May/June 2017 and lasted until the end of 2017 when the IP’s contract ended. The IP provided much needed office supplies, supplementary lay counselors for testing, lab networking, data bundles for information upload, phone cards for defaulter tracing, etc; however, it was expected that improvements would drop off once the IP left again.

Civil society organizations (CSOs) reported having to reduce their own outreach efforts due to limited support from external partners, especially as prioritization between counties became the norm. There were reports of local CSOs in CS counties, primarily religiously affiliated, making an effort to engage communities about their responsibilities around HIV prevention, care, and treatment, as well as OVCs.

In terms of post-transition support from government agencies, NACC had been doing sensitivity analyses to examine the financing needed if PEPFAR withdrew from specific counties, and NASCOP, given its mandate to provide technical assistance, was meant to advise counties, but there were inconsistent reports from interviewees about whether this was really happening.

**Accountability, transparency, devolution, and GP**

A theme that emerged from the data was accountability and transparency around the GP. CSOs felt that formal agreements between development partners and the government, like PEPFAR’s Partnership Framework agreement and Global Fund’s counterpart financing requirements, had created a space for civil society to demand government’s compliance with its commitments. Interestingly, the lack of a formal plan for GP was seen as a problematic for many reasons. CSOs
felt that without such a plan it was difficult for them to hold government accountable to stepping up its support for transitioned counties and activities, and it also undermined the ability of the Ministry of Health to advocate for more funding.

Issues around transparency of decisions and planning for GP were raised by multiple interviewees. In particular, county actors questioned why there were not involved in decisions, or even informed, about GP when it would affect them so acutely. National level officials saw GP as a national/higher level decision that should not affect counties because channels of funding would not be changing in a functional way so participation and information were not necessary. However, the support provided by IPs was not functionally replaced, including outreach, and counties were at a loss of how to replace such support on short notice.

Implementation of the GP was also made more complex by the relatively recent devolution of health systems governance in Kenya, and ongoing confusion around roles. Whereas county respondents see HIV, TB, and malaria as national public health programs that the federal level will support, in reality the national role is limited. Respondents indicated a number of functions previously undertaken by IPs, including capacity building and consumer protection (ensuring quality of commodities), where there was lack of clarity about which level of government was responsible.

Interviewees expressed widespread expectation that government actors would step in to support CS counties replacing support previously received from IPs, but this had not happened or not happened fully. Counties frequently recognized their responsibility but did not have the budget to replace PEPFAR support due to limited resources. Although CS counties were not prepared for GP some were more willing or able to take on the changes. Counties like Isiolo and Marsabit were described as being interested in taking on leadership roles in ensuring services continued to be delivered; others, like Tana River, were much weaker in terms of implementing existing services, and unable to take on responsibility for overall support. Many respondents raised the challenges of getting CS county governments to prioritize HIV in light of many other competing issues with higher burden and profile.

Uganda

In Uganda, the GP policy was first introduced by PEPFAR in 2015, to be implemented as part of COP15 (FY 2015–2016). In practice, the implementation of the GP took place over a couple of years, with none of the CS sites receiving further support beyond September 2018 (COP17).

In Uganda, around the time of the GP (2015–18) there were two additional PEPFAR policies that complicated understanding of the GP. These were the:

- Reorganization of CDC and USAID geographies so as to achieve one agency per region, and one IP per district (motivated by the difficulty in attributing results to one partner and needing to reduce the number of partners per district in order to increase efficiency).

The geographic reorganization led to the termination of contracts and new procurements to support an integrated, regional approach. In many instances respondents were confused between
the regionalization or rationalization process, changes in IP contracts more broadly, and the GP. While shifts between IPs should be seamless and, at most, leave facilities with gaps in support no longer than a quarter, procurement delays frequently led to gaps as long as one year.

The categorization of districts has changed somewhat with each COP iteration, with the latest including also a category of attained to designate scale-up districts expected to maintain or achieve 80 percent ART coverage by the end of FY18.

**Communication about GP**

PEPFAR Uganda communicated pivot plans with certain MOH representatives, including those at the National HIV/AIDS Control Program. In principle, almost all study respondents at the national level agreed with the rationale behind the prioritization and the criteria used, though several questioned the reliability of the data on which the classification was made. Though PEPFAR’s expectation was that the MOH would communicate and coordinate the transition with the districts and facilities in question, this role was largely taken up by USAID IPs and the GP was not formally communicated to districts or facilities by the MOH. Although national-level respondents were aware of the transition, our interview respondents reported little to no coordination, except for instances of engagement with the National AIDS Control Program. Furthermore, the GP was not aligned with Government of Uganda (GoU) budget cycles and none of the government officials that we spoke with had any substantive knowledge about how the GP was being implemented. Although open communication channels between USAID PEPFAR and the GoU exist around the COP planning, data cleaning and analysis, and health workforce issues, such channels did not exist for transition implementation and related issues. IPs were much more in tune with details about the transition, in terms of the rationale, criteria used, and process used for implementing the transition. It is likely that facilities that were transitioned as a result of a project termination were not notified at all about the GP.

**Planning and preparation**

PEPFAR initially proposed a “Transition Team” to bring together inter-agency actors and MOH technical experts to guide the implementation of the GP, keep key stakeholders informed, and review data regularly. The Transition team was not institutionalized, partly because MOH and USAID both did not anticipate the GP to have significant effects. Further, no written plan or strategy for transition was elaborated.

IPs communicated about transition with 81 percent of the CS facilities included in our survey and, on average, gave them three months notice. IPs held meetings with most of the district leaders with whom they worked, to support the process and assist in the development of district work plans for activities post-transition. IPs appeared to initiate such strategies themselves rather than following guidance from PEPFAR or USAID Uganda.

Throughout the planning and preparation, study respondents reported little to no coordination and collaboration between USAID/PEPFAR and other development partners, with the exception of Northern Karamoja, where United Nations Children’s Fund and Doctors with Africa CUAMM were the main partners and there was little USAID support prior to transition.
Implementation

The implementation of the GP varied according to a couple of factors. First, in Northern districts, PEPFAR had provided relatively little project support prior to the GP; PEPFAR support ended as projects ended or reduced gradually through project bridges and extensions. Districts were not prepared to transition and it is possible that they were not explicitly told much about GP beyond the end of the project. Second, the transition of sites outside of the 10 CS districts is not very clear. In some districts, such as those in Eastern Uganda, the integrated RHITES-E projects were intended to provide some support. However, if a CS facility was getting additional resources from IPs, these facilities could not be PEPFAR funded. Often, the extent to which CS facilities received any IP support also depended on the overall relationship of the IP with a particular district, as well as of the district capacity to engage with IPs. In RHITES-E areas, through the integrated approach, MNCH support continued even without PEPFAR funding.

Third, much less information was available about this process of site transition—i.e., the facilities shifting to CS outside of the 10 CS districts. As most of the sites slotted for CS outside of the 10 districts were private for-profit sites, generally at the HCl level, there were concerns that without PEPFAR support, many of these sites would not be able to provide ART and possibly there would be a large loss to follow-up. Our respondents shared conflicting information about whether site transition took place or not.

Finally, respondents did not identify channels of regular communication among PEPFAR and GoU regarding the implementation of transition and specific monitoring of CS facilities.

Post-transition support

CS districts and sites were supposed to lose all direct service delivery and facility-based technical assistance, but to maintain certain types of above-site, district-level support. CS districts and facilities should have continued to receive lab support through a network of regional hubs, supported by PEPFAR.

While there was no direct support for training post-transition, individuals from CS districts and sites continued to be invited to PEPFAR-supported trainings. IPs could support regional trainers, job aids, printed materials, and at times, transport out of the district. Regional support could also be provided through non-PEPFAR routes. For example, when CS district representatives are attending a training on MNCH, that training might also touch on PMTCT and the IP would provide tools, job aids, etc.

Community-based outreach support for HIV and AIDS testing and treatment was lost by a significant number of facilities across investment categories; this was likely due to delayed effects of the technical pivot, and outreach support was not covered through any post-transition support mechanisms. Support for MNCH services continued in CS districts, as long as such districts were part of the integrated programs.

Data use and monitoring

PEPFAR and the MOH engage in regional data review meetings. However, it is unclear whether these are intended to include data at the site level and whether CS sites are included. The
monitoring of CS sites would be reliant on DHIS2 data, to which most private for-profit facilities
do not report, and, more broadly the Uganda Population HIV Impact Assessment, which captures
HIV/AIDS prevalence. Due to challenges in capturing data from private for-profit facilities, it is
unclear whether any monitoring of such sites takes place.

Similarities & differences across countries

**GP design**

Although everyone recognized the value of epidemiologically-targeted prioritization, GP in both
countries was typically driven by COP/OGAC requirements, not local realities. Vulnerable SNUs
and facilities were often dropped, without strong district/county support in place. This was further
exacerbated by rapid and overlapping PEPFAR policy changes, including short policy windows, no
coordination, and little planning, particularly in Uganda (e.g., GP, rationalization, technical pivot).

These two countries allowed us to contrast two very different approaches to transition. Kenya
pursued an SNU-based allocation (i.e., by county) while Uganda was mixed—district and site-
based (i.e., by facility). SNU-based allocation provided more clarity for all parties about which sites
would transition but meant that PEPFAR had limited presence post-transition to continue above-
site support or influence local actors. Site-based allocation, in conjunction with Uganda’s shift to
integrated implementation, resulted in piggybacking of support, but the boundaries of support
were fuzzier and harder to understand.

**Implementation**

The major coordination and implementation issues described above, including timing,
preparation, and actor coordination or lack thereof, were common to both countries and also
manifested in specific issues such as timing not being aligned with national budget cycles, the
lack of written plan for GP which limited ability to track accountabilities, and GP being carried
out too quickly, especially in Kenya. In Uganda there appears to have been slightly more advance
notice and some IP support for district-level post-transition, suggesting more preparation. Across
both countries, because a written plan or strategy for transition was not elaborated between
PEPFAR and the country governments, we identified a missed opportunity to define roles and
responsibilities among the various stakeholders, as well as to align the GP with Government of
Kenya and GoU processes.

IPs in both countries were left to plan and execute GP with limited direction from PEPFAR or their
national government. In Uganda, this resulted in a fragmented execution due to the number of
IPs involved, procurement delays, and other policy shifts being implemented at the same time.
In Kenya implementation was more cohesive because only two IPs were involved, but then one
returned for about five months which may have caused confusion.

The constantly changing profile of the IP contracts created difficulties on the ground and presents
risks in the future. Kenya is de-integrating its contracts to separate HIV from maternal and child
health; water, sanitation, and hygiene (WASH); etc. in order to protect other programs from
the frequent changes in the HIV portfolio, but it is resulting in less flexibility for IPs and fewer
opportunities to support broad-based health systems strengthening. Conversely, USAID/Uganda is procuring regional, integrated programs in order to leverage funding across health and disease areas to support systems strengthening. Additionally, in Uganda, USAID and CDC reorganized in order to improve coordination at the district level. This rationalization/regionalization led to shifts between CDC and USAID IPs, and, consequently, some shifts in the approach to and package of support. Likewise, target-based performance assessment (e.g., testing, treatment) is changing the nature of IP support. Finally, frequent policy changes are affecting the trust between local county/district officials and IPs.

**Negotiations**

In both Kenya and Uganda, GP was negotiated at the national level with the assumption that changes were not substantial and local government would step in or work it out. In fact, there was no involvement of sub-national stakeholders, and very limited investment in planning and strengthening of institutions.

**EFFECTS OF GEOGRAPHIC PRIORITIZATION ON SERVICE DELIVERY**

**HIV service delivery impacts**

**Discontinuation of HIV services**

Information on the services offered at facilities came predominantly from our facility surveys. Transition largely did not impact the variety of HIV services that facilities offered, with two important exceptions. In Uganda, 52 percent of CS facilities that previously provided HIV outreach discontinued outreach after transition compared to just 4 percent of maintenance facilities (p<0.001). In Kenya, discontinuation of outreach occurred in roughly equal proportion among CS and maintenance facilities that provided it (39 percent and 36 percent, respectively). Outreach for HIV includes both patient identification (outreach testing) and patient adherence activities undertaken outside of health facilities. The findings from the facility survey were confirmed from the longitudinal case studies and national-level interviews.

For ART, eight CS facilities (10 percent of the CS facilities providing ART before transition) in Kenya discontinued ART compared to 0 maintenance facilities surveyed (Fisher’s Exact Test p = 0.10). Most facilities (n=6) were level-2 facilities in remote areas (3 Wajir, 2 Mandera, 1 Garissa, and 1 Isiolo). Transition from PEPFAR was the most commonly cited reason for discontinuation. Only two CS facilities (0 maintenance) in Uganda, both level HC IIs, discontinued ART. There were few discontinuations of other HIV services (e.g., HTC, PMTCT, viral load) and no significant differences between CS and maintenance in either Uganda or Kenya.

**Effects on perceived access and quality of HIV services**

In our facility survey, we asked in-charges’ perspectives on the change in access and quality for HIV services since transition. The proportion reporting worsening access and quality since the
transition date was significantly higher for CS facilities than maintenance facilities in both Kenya and Uganda (Table 6). The differences in perceptions between CS and maintenance facilities were larger in Uganda than in Kenya, which may be due to the higher amount of baseline support received by CS facilities in Uganda compared to Kenya or the greater impact of strikes on services in maintenance facilities in Kenya. In-charges were more likely to identify declines in HIV access for the poorest patients, which may reflect the declining outreach in CS facilities in Uganda and in CS and maintenance facilities in Kenya.

### Table 6  In-charge reported access and quality of HIV services, by country

<table>
<thead>
<tr>
<th>HIV access and quality</th>
<th>CS</th>
<th>Maintenance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Uganda</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average patient access to HIV services</td>
<td>44°</td>
<td>3</td>
</tr>
<tr>
<td>Poorest patient access</td>
<td>52°</td>
<td>8</td>
</tr>
<tr>
<td>Key pop access</td>
<td>40°</td>
<td>8</td>
</tr>
<tr>
<td>Quality of HIV care</td>
<td>36°</td>
<td>0</td>
</tr>
<tr>
<td>Sample size</td>
<td>N=204</td>
<td>N=19</td>
</tr>
<tr>
<td><strong>Kenya</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average patient access to HIV services</td>
<td>36°</td>
<td>11</td>
</tr>
<tr>
<td>Poorest patient access</td>
<td>42°</td>
<td>26</td>
</tr>
<tr>
<td>Key pop access</td>
<td>27°</td>
<td>17</td>
</tr>
<tr>
<td>Quality of HIV care</td>
<td>27°</td>
<td>5</td>
</tr>
<tr>
<td>Sample size</td>
<td>N = 136</td>
<td>N=57</td>
</tr>
</tbody>
</table>

*Denotes that the Chi-square test p-value for “Worse/Much Worse, Same, Better/Much Better” is significant at the 5% level.

### Effects on HIV service volume

Data on service volume came exclusively from DHIS2. Among HIV services reported to DHIS2, we prioritized three that were available and fairly consistent across both countries: number of HTC performed, number current on ART, and 12-month cohort retention in HIV care. Each indicator touches on a different component of the 90–90–90 goals: HTC identifies PLHIV, initiation on treatment expands the pool of patients currently on ART, and retention in ART care is necessary for long-term viral suppression. The quality of reporting for rare events, such as testing and diagnosis of HIV-exposed infants, was poorer and the measures harder to analyze.

In Uganda, reported transition dates varied widely from 2013 to mid-2017, which made interpretation of the findings more difficult. However, levels and trends from October 2016–December 2017 can largely be considered as representative of the post-transition period. For the pre-transition period, we identify the period prior to the initiation of the GP in FY2016 (October 2013–September 2015).

In Kenya, the clarity of late 2016 as a transition point made the interpretation of trends less complex, but the clinician strikes (doctors’ December 2016–March 2017; nurses’ June–
November 2017) affected levels of services provided. Importantly, the strikes seemed to have a larger impact on CS facilities than on maintenance, as well as highly variable impacts on different services. We therefore exclude data from months that were entirely made up of strikes, which reduces the duration of the post-transition period from 15 to 7 months. However, service volume outside of strike periods may still have been affected by strikes. In addition, APHIAPlus IMARISHA (the IP) re-entered six of seven CS counties for three months (August–October 2017), which included hiring 11 HTC counselors at high-volume facilities.

Overall, HTC declined in both CS and maintenance facilities since transition in Kenya and Uganda. In Kenya, trend analysis was IRR = 1.021 (95 percent CI: 0.990 – 1.05; p=0.188) excluding strike months. This suggests that CS facilities’ change in trend was 2.1 percent/month higher than maintenance facilities, although this is not significantly different (Figure 5). In Uganda, HTC has been declining since 2015 in both CS and maintenance facilities (Figure 6). Trend analysis reveals no significant difference between CS and maintenance (IRR = 0.974; 0.945 – 1.004; p=0.094).

Figure 5  Trends in HTC per facility per month in Kenya

Note: “D” indicates the doctor’s strike (December 2016 – March 2017) and “N” the nurses’ strike (June – November 2017).
For current patients on ART, there were no significant differences from baseline trends for either CS or maintenance facilities in Uganda (IRR = 0.988; 95 percent C.I. 0.961–1.017; p=0.422) (Figure 7). Both facility types continued on their respective pre-transition trend lines. There was a major increase, nearly double, for both CS and maintenance facilities in the average number current on ART at reporting facilities. In Kenya, the number on ART in maintenance facilities...
plateaued around the time of transition, but increased modestly in CS (IRR = 1.024; 1.001 –1.047; p=0.038) after previously declining (Figure 8). It is unclear whether or not the trend reversed at the end of 2017.

**Figure 8  Trends in current on ART in Kenya**

![Figure 8 Trends in current on ART in Kenya](image)

Note: “D” indicates the doctor’s strike (December 2016 – March 2017) and “N” the nurses’ strike (June – November 2017).

Cohort retention in first-line ART at 12 months declined in both Uganda (Figure 9) and Kenya (Figure 10). The level of decline did not differ between CS and maintenance facilities in either country, suggesting that factors other than the GP were involved. For Kenya, excluding strike months, the cohort retention declined 1 percentage point more in CS than in maintenance (-1.0; 95 percent CI: 2.1, 0.1; p=0.089). In Uganda, the CS facilities had declines that were 1.9 percentage points greater (-1.9; -5.8, 1.9; p=0.331). The decline in cohort retention across investment categories is a cause for concern. However, HIV cohort data were the most limited data for the HIV dataset. In Kenya, we were only able to include data from 68 facilities (out of 86 for current on ART), with 70 percent of months missing. In Uganda, we had data for 472 out of 482 ART facilities, with 33 percent of data missing.

Overall, there was no evidence from DHIS2 that HIV service delivery was negatively affected by transition. There are, however, limitations in this methodology, including low power to detect epidemiologically important but quantitatively small differences and the inability to control for population at risk. It is also true that we have only about one year of post-transition data to analyze. Service delivery impacts may have been delayed by temporary coping mechanisms or accumulated skills and trust among staff and patients that could deteriorate over time.
Perceived effects of GP on HIV services

Across both Kenya and Uganda, the predominant concern from case study facility, county/district level staff, and HIV clients related to the effects of the GP upon HIV services was the loss of support for outreach. This loss of support was linked to a number of related issues, most...
notably the loss of financial support for contract workers such as linkage facilitators in Uganda and outreach workers and expert patients in Kenya, but also reduced allowances for transport and, to a lesser extent, challenges in the lab network (discussed further below). In Kenya, it was noted that the loss of outreach support had affected the ability of facilities to conduct default tracing. Health staff assumed this would translate into increases in the number of patients lost to follow-up (although there was no clear evidence of this at the time). Respondents in some Kenyan centrally supported facilities also suggested that there was a drop off in testing, particularly among hard to reach populations, such as nomads, and patients who faced high stigma in accessing services in HIV services health facilities. There were also complaints in Kenya of the loss of dedicated HIV counselors affecting privacy, and concerns that new staff hired by the county were less responsive to patients. While respondents in Uganda similarly noted a widespread impact of the GP on outreach services, they also identified some positive changes; for example, some patients noted improvements in the efficiency of services and in health worker attitudes.

**Private sector impacts**

In Uganda, 38 percent of PEPFAR facilities identified for transition were private facilities. These include private not-for-profits (PNFPs), which vary from small to large and offer comparable HIV services to government facilities, and private for profits (PFPs), which mostly only offer HTC. We wanted to compare the effects of transition to CS by facility ownership. In Uganda, 30 percent of the facility survey sample was private compared to only 16 percent of our sample in Kenya. Therefore, we restricted analysis of differential impacts on private and public facilities to Uganda.

The private sector also has had a large role in HIV service provision in Uganda. In 2011, 18 percent of women who received an HIV test in the past year, and 31 percent of urban and 29 percent of the richest quintile of women, received the test from a private provider. According to DHIS2 data, 28 percent of people receiving ART in 2015 obtained it from a private provider, almost entirely PNFPs (O’Hanlon et al. 2017).

From the facility survey, CS PNFPs were more likely to report declining frequency of supervision (OR = 2.51, 1.456–4.319, p=0.002) and loss of staff (OR = 5.886, 2.914–11.887, p<0.001) in Uganda. However, PNFPs were less likely than public facilities to report a decline in HIV service quality (OR = 0.491; 0.301–1.385; p=0.006) and reported more staff training days per worker per year since transition (2.73 days; 1.54–4.84). PNFPs’ distance from government could explain these findings: they are less likely to get supervision from district health offices and less able to move IP-supported staff onto the government payroll, but they have more discretionary funding that can be used to maintain quality and access to trainings. PFPs were more likely to discontinue outreach (OR=3.029; 1.325–6.925; p=0.011) and report declining time allocated to HIV care (3.012, 1.161–7.817, p=0.025), suggesting less engagement in HIV care.

Comparing DHIS2 data for public and private PNFP facilities for the three main HIV services, we find some significant differences-in-differences. CS PFPs had a decline in HTC relative to similar public CS facilities (adjusted Incidence Rate Ratio = 0.659; 0.537–0.804; p<0.001) but the difference in HTC between PNFPs and public CS facilities was neither large nor significant. For current on ART and cohort retention, we only had enough data to compare PNFPs to public facilities. There were no significant D-in-Ds for either current on ART or cohort retention.
These findings suggest that CS PNFPs are maintaining their HIV services as well as public CS facilities, but they are doing so with less supervision and staff. Public CS facilities are actually reporting poorer outcomes than PNFPs in terms of quality and training. Both findings raise questions about the long-term sustainability of HIV services in the private sector that we cannot answer with available data.

For PFPs, there is some evidence that transition resulted in decreased HIV service delivery, which can be directly observed through HTC. To the extent that clients do go elsewhere for HIV testing, this may have no impact on Uganda’s epidemic. Consolidation of HTC in facilities that also provide ART could have benefits for continuity of care. However, PFPs’ large role in providing HTC in the past and their popularity among urban and higher socioeconomic status clients may result in patients forgoing HIV testing altogether.

**Non-HIV service delivery impacts**

In the facility survey, we asked about the facility’s MNCH services. Few facilities discontinued providing MNCH-specific services (delivery, ANC, immunization, nutrition, child health clinic), and there were no significant differences between rates of discontinuation in CS and maintenance in either Uganda or Kenya. However, CS facility in-charges report worse access to MNCH services in both countries (Table 7). In Uganda, CS facilities were significantly more likely to report worsening access and quality of MNCH since transition. In Kenya, CS facilities were less likely to report improvements in patient MNCH access and quality (e.g., 38 percent CS vs. 61 percent maintenance, p<0.001). However, the differences in proportions reporting worsening access and quality are smaller. Comparing across the three response categories (“worse/much worse,” “same,” “better/much better”), the chi-square test was significant for Kenya as well as Uganda.

When asked about specific services in Kenya, in-charges were more likely to report improving quality of ANC and nutrition programs in maintenance, but there were no significant differences

### Table 7  MNCH access and quality in Uganda and Kenya (Facility survey)

<table>
<thead>
<tr>
<th>MNCH access and quality</th>
<th>% reporting worsening</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CS</td>
<td>Maintenance</td>
<td></td>
</tr>
<tr>
<td><strong>Uganda</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average patient access to MNCH services</td>
<td>24*</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Poorest patient access to MNCH</td>
<td>31*</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Quality of MNCH services</td>
<td>20*</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Sample size</td>
<td>N = 204</td>
<td>N = 19</td>
<td></td>
</tr>
<tr>
<td><strong>Kenya</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average patient access to MNCH services</td>
<td>20*</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Poorest patient access to MNCH</td>
<td>25*</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Quality of MNCH services</td>
<td>23*</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Sample size</td>
<td>N = 136</td>
<td>N=57</td>
<td></td>
</tr>
</tbody>
</table>

*Denotes that the Chi-square test p-value for worse/much worse, same, better/much better is significant at the 5 percent level
for delivery, child health, and immunizations. In Uganda, all five MNCH services were perceived to be improving less in CS than in maintenance.

We also extracted DHIS2 data for a variety of non-HIV services. These included total outpatient department visits (OPD), total number of ANC visits, ratio of ANC4+ to ANC1 visits (Uganda), ratio of ANC4 to ANC1 visits (Kenya), HIV & syphilis testing in ANC (Kenya), IPT-2nd dose in ANC (Uganda), number of facility deliveries, number of fully immunized children (Kenya), and DPT3/Pentavalent3 immunization. We could only identify a few significant differences in trend analysis. We discuss trends for OPD visits, ANC4+/ANC ratios, and facility deliveries in this report.

As the need for MNCH services depends on fertility rates and we lacked facility catchment birthrate data, we could not effectively control for changing population needs due to changing fertility. Therefore, we had to assume that fertility trends were parallel in maintenance and CS facility catchment areas. In Kenya, we had the same issues with clinician strikes as mentioned previously; however, some MNCH outcomes, particularly facility deliveries, appear to have been more affected than HIV services.

In Kenya, OPD visits declined in both maintenance and CS facilities, particularly during strike months. Trend analysis did not show a significant difference-in-difference in trend (IRR=1.003; 0.993–1.013; p=0.566). Figure 11 shows the trends in OPD visits for Kenya.

**Figure 11  Trends in OPD visits per facility per month in Kenya**

![Graph showing OPD visits per facility per month in Kenya](image)

Note: “D” indicates the doctor’s strike (December 2016 – March 2017) and “N” the nurses’ strike (June – November 2017).

In Uganda, OPD declined more in CS than in maintenance: IRR = 0.989 (95 percent CI: 0.980, 0.998; p=0.020). Figure 12 shows the trends in OPD visits for Uganda. However, this decline was only significant in Central Uganda, which indicates that it is unlikely it was due to GP alone.
ANC completion among those who initiate ANC has been improving over time in both Kenya (except for after strikes), where we proxy through the ratio of ANC4/ANC1, and in Uganda, using the ratio ANC4+/ANC1. However, there were no significant difference-in-difference in ANC4(+)/ANC1 ratios in either Kenya or Uganda.

Facility deliveries are a priority outcome for many USAID programs, as quality skilled birth attendance is recognized as critical intervention for reduction of maternal and neonatal mortality. The number of facility deliveries has increased over time in both maintenance and CS facilities in Uganda at nearly constant rates. Due to difficulties fitting a negative binomial or Poisson regression model, we used a Gaussian model, which showed no significant difference in the trends for CS and maintenance facilities (Figure 13).

In Kenya, facility deliveries increased as well up until the 2016–2017 clinician strikes, which had a substantial impact on both CS and maintenance facilities. The trend analysis IRR=0.984 (0.969–0.999; p=0.045) favored CS facilities, but this was likely confounded by strikes (Figure 14). The impact of the strikes seemed to be larger for maintenance facilities.

The longitudinal case studies did not reveal any particular concerns about the quality or accessibility of non-HIV services and how they had been affected by the GP.

**Health system effects of geographic prioritization**

**Health workforce impacts**

We gauged impacts on health workers at CS and maintenance facilities through the facility survey and, in Uganda, through the HRHIS facility audit data. The facility survey provides information on
size of the workforce, terminations, vacancies, turnover, absenteeism, salary support, non-salary support, training, worker time-allocation, worker motivation, and job satisfaction. From the HRHIS data, we only obtained the number of workers employed at public facilities, by cadre.
Among the most commonly reported impacts of transition was a decline in training. In Uganda, 79 percent of workers in CS facilities reported reduced time spent in trainings compared to 34 percent of maintenance workers (p<0.001). The number of training-days since transition per worker per year was –1.6 days fewer in CS (p=0.070). Among CS facilities, 77 percent reported that inability to attend trainings had occurred as a result of transition. In Kenya, workers in CS facilities were less likely to report increased time spent on training, but not more likely to report declines. In Kenya, CS facilities were significantly less likely to have had workers attend a HIV training since transition (OR = 0.403; 0.236–0.688; p<0.001), controlling for level, ownership, and size of HIV workforce. Among CS facility in-charges, 73 percent reported inability to attend training has resulted from transition.

Worker time-allocation also changed for care provided. In Uganda, 32 percent of workers in CS facilities reported spending less time on HIV care and 55 percent reported spending more time on non-HIV care vs. 11 percent and 43 percent, respectively, for maintenance. CS facility workers in Kenya are less likely to report increased time spent on either HIV or MNCH care vs. maintenance facility workers.

There was a decline in the proportion of HIV workers receiving salaries from PEPFAR IP in both Kenya and Uganda. In Uganda, the decline in CS was from 19 percent to 5 percent and from 19 percent to 9 percent in maintenance (D-in-D: p-value=0.086). In Kenya, the proportion declined from 2.7 percent to 1.3 percent in CS and from 14.1 percent to 13.8 percent in maintenance, which was not significantly different.

The proportion of salaries paid by PEPFAR IPs does not account for positions that were terminated following the withdrawal of PEPFAR support. In Uganda, 26 percent of CS facilities reported terminating staff following transition vs. 0 percent of maintenance (p=0.005). In Kenya, 12 percent of CS facilities reported terminating staff versus 1 percent of maintenance facilities (p=0.004).

In addition to terminations, CS facilities had higher vacancy ratios in Kenya (OR=2.34; 95 percent C.I.: 1.22–4.50, p=0.011). However, CS facilities in Uganda did not report higher vacancy ratios (OR=0.80; 0.39–1.62; p=0.537) or turnover. Higher vacancies ratios in CS facilities in Kenya may reflect difficulties identifying staff in remote northeastern Kenya rather than an effect of transition. There was no significant difference in the proportion of HIV workers who were absent without reason in either Uganda or Kenya.

Workers were asked about non-salary incentives they receive for outreach or bonuses/top-ups. In Kenya, 97 percent of CS workers reporting bonus/top-ups report that they have declined/disappeared compared to 40 percent of maintenance workers (p=0.005). For outreach allowances, the difference of 97 percent vs. 79 percent was not statistically significant. In Uganda, bonuses/top-ups declined or disappeared for 97 percent of CS workers and 100 percent of maintenance workers. However, outreach allowances declined/disappeared for 94 percent of CS workers receiving them vs. 25 percent of maintenance workers (p<0.001). These trends suggest that top-ups are being scaled back in maintenance facilities in Kenya and eliminated in Uganda.
Despite the loss of non-salary support and opportunities for training, worker’s motivation, on a 10-item scale, did not differ significantly between maintenance and transition facilities in either country. On a 5-item Likert-type scale, job satisfaction was slightly lower in CS facilities in Uganda (67 percent vs. 74 percent satisfied or extremely satisfied), but not significantly different. However, 27 percent CS facility workers report declining satisfaction vs. 0 percent of maintenance facility workers (p<0.001). In Kenya, there was almost no difference in job satisfaction.

From the HRHIS facility audits, we were able to plot trends and analyze changes in staffing ratios at public facilities in Uganda (Figure 15). We examined trends for all cadre, nurses/midwives, medical/clinical officers, and laboratory/admin support staff. Comparing 2015 and December 2017 staffing levels, no significant difference-in-differences were identified. For example, controlling for region and level of facility, the change in ratio of filled/approved positions for all cadres was not significantly different for CS vs. maintenance: –0.8 percentage points (p=0.617). The staffing ratio has been increasing in Uganda, especially during the 2016/17 Uganda fiscal year when the health budget was increased from UGS 1.3 billion to 1.8 billion (Uganda MoFPED 2016). However, by the end of 2017, staffing levels declined back to their levels in early 2016.

![Figure 15 Ratio of filled to approved posts in public facilities in Uganda](image)

**Laboratory service and drug supply**

The impact of the transition to CS on laboratory services and drug supply was examined primarily through the facility survey, which assessed the perspectives of the facility in-charges on changes since transition, and also collected objective information regarding drug availability, stockouts, and laboratory services.

Facility in-charges in both countries suggested that there had been negative effects of the transition to CS on the pharmaceutical supply system. They indicated that transition had resulted
in delays in drug orders (35 percent respondents Uganda; 43 percent Kenya), laboratory stockouts (52 percent Uganda; 47 percent Kenya), and lack of access to specialized testing (52 percent in both countries).

However, when actual stockouts of drugs on the day of the survey were examined, in Kenya transition facilities were not significantly more likely than maintenance to report stock-outs of any one of the 12 tracer commodities. In Uganda a significant difference was found with day-of-survey stockouts for one or more tracer commodities being higher in transition compared to maintenance facilities (59 percent vs. 41 percent, p=0.046); however, it was found that this difference was mostly due to TB commodities.

The facility survey asked about the ability of the facility to conduct a variety of laboratory services on the day of the survey, including viral load testing, rapid diagnostic tests for malaria, and rapid syphilis testing. Across both Kenya and Uganda there were relatively small and insignificant differences between transition facilities and CS facilities in terms of their ability to provide these services. However, transition facilities in both countries reported significantly higher disruption of viral load testing compared to maintenance facilities (in Uganda 23 percent vs. 5 percent, p=0.002; in Kenya 35 percent vs 5 percent p=0.010) and in Uganda there was also a significantly higher likelihood of transition facilities experiencing disruptions in their ability to conduct sputum testing for TB (22 percent vs. 6 percent, p=0.026).

Case studies shed further light on these challenges. While in both countries transition facilities were supposed to be able to draw upon the services of a regional laboratory hub, in practice, laboratory services suffered significantly during the transition period. Challenges related to factors such as a lack of salary support for hub riders (transporting samples to labs) and expenses associated with operating the motorbikes that the hub riders use (e.g., breakdown, transferring deeds, funding for fuel). In Kenya, lack of funding to cover data packages for health staff in order for them to be able to receive lab results from the lab hub was also a challenge. Finally, these logistical problems were exacerbated by the simultaneous roll out of test and start policies, leading to high workloads for laboratories. In both countries, these problems seemed somewhat temporary, and though they had not been completely resolved by the time of the second round of case study data collection, the situation was much improved.

Health management and information systems (HMIS)

Overall the effects of transition on reporting to the HMIS appeared modest. Twenty-eight percent of facility in-charges in Kenya and 22 percent of facility in-charges in Uganda reported delays in HMIS submission as a consequence of transition; however, this percentage was relatively low compared to other factors where facility-in-charges were asked to report consequences of transition. Smaller facilities were more likely to report delays in submission compared to larger ones.

In Kenya, IPs reported providing technical support, tools (i.e., printed forms), and transport back and forth between reporting levels to facilitate HMIS reporting. Some of the CS case study facilities reported reduced availability of reporting tools and transport of reports between levels. However, maintenance case study facilities had retained technical support but also lost transport support, which affected frequency of reporting.
More detailed analysis regarding how district investment category affects the quality of data is being conducted by MEASURE Evaluation.

**Finance and governance**

Financial issues were a major concern to facility in-charges in both Kenya and Uganda, but this appeared to be the case for both maintenance and CS facilities. While PEPFAR did not provide direct support to district or facility budgets, it did provide support for health worker salaries, laboratory supplies, drugs (though much of this was Global Fund supported), and transport.

Unfortunately, facility level budgets were not available, and much PEPFAR support is not reflected in government budgets, so it is difficult to provide accurate financial comparisons. In both Kenya and Uganda in-charges at CS facilities reported that county or district level staff were providing more support (51 percent Kenya; 59 percent Uganda) and were more involved in the day-to-day operations of the facility (53 percent Kenya; 64 percent Uganda). However, respondents in case studies reported that in financial terms there were constraints upon the support that sub-national units could provide. For example, while it was assumed in both countries that local government or the MOH would take up responsibilities of departing IPs, in many cases it was not financially feasible for the county or district to replace salary top-ups, or salaries for contract outreach workers. County and district staff often sought to help facilities cope with the loss of support, through for example transferring staff from one facility to another, but were clearly financially constrained and unable to fully replace lost support.

While relatively few private facilities were included in the case studies, these sites in both countries sought to replace lost income through increasing user fees for HIV services and/or drugs; however, respondents observed that this was likely to have negative consequences for patient demand.

More generally, the process of GP revealed existing weaknesses in governance systems. For example, in Uganda, challenges in supporting transitioned health facilities appeared greater in relatively new districts, where management and governance capacity was still weak. In Kenya, devolution took place shortly before GP, and so relationships and accountabilities between government levels were still evolving. At the local level, there appeared to be considerable confusion about how roles and responsibilities for “national programs” (e.g., HIV, TB, malaria) were allocated and who was responsible for providing technical support.
DISCUSSION

SUMMARY OF KEY FINDINGS

GP implementation suffered from poor planning and short timelines

Our findings indicate that in both countries the transition process was poorly planned, poorly communicated, and subject to unexpected shifts (such as the “rescue package” in Kenya). The challenges around implementing the GP were exacerbated by the very tight proposed timelines—which were not met in either country—and compounded by multiple other simultaneous policy shifts, which together were difficult for countries to absorb. While the failures to coordinate and communicate effectively occurred both within USG and national government, the actors that bore the brunt of the consequences were district and county officials who often sought to step in to alleviate potential negative effects of transition, without support or adequate prior planning. Our data suggest that while district and county officials aimed to provide support to CS facilities, their budgetary situation and, in some cases, district/country capacity rendered them unable to replace support previously provided by IPs. Overall, with some singular exceptions, the support lost when facilities transitioned to CS was not replaced either by additional government allocations or by support from other partners.

Negative effects on HIV and non-HIV service delivery as a result of GP were minimal, according to routine data analysis

Perhaps the most critical measure for assessing the effects of GP is the extent to which it has affected service volume and coverage. Our analysis suggests that at the time of this study there was no clear evidence that HIV service delivery had been negatively affected by the GP. While we observed some modest effects in terms of service discontinuation, those facilities which had ceased to provide HIV services (such as ART and HTC), were typically small facilities with low patient load, and, in Uganda, private for-profit facilities. Further in terms of (i) HTC volumes, (ii) current on ART, and (iii) 12-month cohort retention in HIV care, there were no significant differences in trends between CS and maintenance facilities. We also investigated potential effects that the GP had on non-HIV services. Again, based on DHIS2 data, there appeared no strong evidence that non-HIV service trends at CS facilities were any different to those in maintenance facilities, after controlling for other effects (such as regional location, and, in Kenya, the health worker strikes).

HIV outreach was negatively affected by the GP and other PEPFAR policies whose implementation coincided or overlapped with the GP

In Kenya, outreach services in both CS and maintenance facilities had been discontinued in roughly equal proportions, suggesting that the GP may not be the primary cause and rather other policies such as the technical pivot had led to this change. By contrast, in Uganda there were significant differences in the cessation of outreach services between CS and maintenance sites.
Facility in-charges raised concerns about emergent effects on HIV and non-HIV service delivery

Despite the evidence cited above suggesting that the effects of GP on service delivery were small, facility in-charges in CS facilities in both countries were consistently more likely to suggest that HIV service accessibility had declined and MNCH services had failed to improve since transition, compared to in-charges at maintenance facilities. It is difficult to know how to explain the disparities between facility in-charges’ rather negative view of the effects of transition on their facilities, compared to the more balanced picture coming from DHIS2 data and objective measures in the facility survey. While it is possible that facility in-charges saw the survey as a potential route to register complaints about the loss of support so as to change the situation, and therefore had an incentive to exaggerate negative effects felt, it is also possible that by virtue of their position on the ground, they are able to detect small changes that over time may lead to negative effects on service delivery.

Health workers in CS facilities received less support & training

Facility in-charges at CS facilities also noted a collection of effects on health workforce (compared to maintenance facilities), including reduced HIV training for health workers, less time spent by health workers on HIV, and loss of non-salary support for health workers.

There were disruptions to the laboratory system due to GP

Specific aspects of the laboratory system (especially viral load testing) appeared to have been disrupted by transition, and in-charges at CS facilities also suggested that they had experienced more lab stockouts since transition and poorer access to specialist lab testing. Some of these problems, however, appear to have been mitigated by the time of the second round of data collection.

LIMITATIONS

This study had a number of limitations. First, the study took place in a dynamic and complex real world context, where it was frequently difficult to discern the differential effects of the multiple PEPFAR changes that were taking place, including GP, the introduction of test and treat, the technical pivot, and, in Uganda, the process of rationalization or regionalization. Further, there were a number of significant non-PEPFAR changes, most notably the health worker strike in Kenya, that are also likely to have confounded findings. While our qualitative work sought to determine in a more granular fashion the effects of different policies, the presence of multiple policy initiatives means that we need to be cautious about attributing causality.

Further, given relatively small sample sizes, we had low power to detect epidemiologically important differences and were unable to control for different populations at risk. We also had only about one year of post-transition data to analyze. Service delivery impacts may have been delayed by temporary coping mechanisms or accumulated skills and trust among staff and patients that could deteriorate gradually over time.
Other important limitations include the limited number of interviews conducted with government policy makers, especially in Kenya; the challenges faced in Uganda identifying facilities that had actually transitioned (versus those that had merely had a contract break); and the limited number of private facilities in the sample. While our evidence indicated that PFPs and PNFPs experienced transition differently and with larger effects, given small sample sizes it was difficult to conclude on this point.

**IMPLICATIONS: FACTORS SUPPORTING A SMOOTH AND SUSTAINABLE TRANSITION**

As already noted, while no new major transitions are planned by PEPFAR, we believe that this study has broader significance, being relevant to smaller scale transitions (such as IP decisions to drop sites between contracts, shifts between more integrated approaches to providing HIV services and less integrated ones, and possible transitions around “attained status”), as well as other larger scale transitions that other development partners (such as the Global Fund) may be planning. It makes sense, therefore, to draw lessons from this study regarding how best to support smooth and sustainable transitions in the future.

**Transition process**

*Advanced planning and communication builds trust between partners*

The GP was planned relatively quickly and initially was meant to take place over a relatively short window of time. Little attention was paid to the details of how support would be transferred or how decisions regarding transition were communicated to CS facilities, and as a consequence many of the shifts related to transition happened in a rather ad hoc way. Although there was not clear evidence suggesting detrimental effects of transition upon services, more advanced planning and communication about transition would be helpful in order to ensure that the process builds, rather than undermines, trust and that all partners are adequately prepared for the new roles that they must take on. Better planning and communication may also help to avoid back-sliding (such as the “rescue plan” in Kenya), and the disruption that this brings. The transition program for OVC, managed by CRS, was a positive example in this regard.

*Clear government responsibilities at different levels of the health system are needed*

As part of the overall planning process it is important to clarify government responsibilities at different levels of the health system in handling the response. In both of our study countries, HIV is a national as well as a local level responsibility, but counties and districts were not involved in negotiations about transition and were inadequately prepared to take on new roles. Further, CSOs suggested that publicly available agreements that make government responsibilities transparent help them to do their job through holding government accountable and advocating for particular services. In Kenya, CSOs mentioned the PEPFAR Partnership Framework as a good example of the type of agreement that had been helpful to them.
Establish guidelines, goals, and responsibilities for monitoring transition

In both Kenya and Uganda there was relatively weak monitoring of the GP (other than this study), and in particular the effects upon CS facilities. Greater attention should be paid to establishing clear monitoring guidelines for transition (before, during, and after the transition process). For example, greater clarity around which of the routinely collected indicators can act as sentinels for local shifts in the HIV/AIDS epidemic would be helpful. Furthermore, examining prevalence alone could mask emerging, rapid shifts in the epidemic, particularly for people who would not regularly access services. Many private sector facilities, particularly PFPs, do not report into routine data systems, and, depending on the extent to which they are thought to be critical to epidemic control, it may be necessary to consider alternative approaches to tracking what is going on in the private sector.

Monitoring of CS facilities is critical, but there also need to be plans in place for what to do if CS areas start to backslide in services or indicators. While sometimes USAID can be reactive, for example, rapidly supporting the rescue package in Kenya, this kind of unplanned intervention can be hazardous in terms of signaling the seriousness of intent to transition, and is not an excuse for lack of planning around transition in the first place.

Managing effects

Focus attention on facilities receiving greater support

It is clear that the most significant effects of transition are felt by larger facilities, which typically have received greater support prior to transition. In terms of preparing facilities for transition, supporting them through transition, and monitoring effects, it would be efficient to focus resources on these larger facilities.

Laboratory networks can be very sensitive to transition-related disruptions

We noted that in our first round of data collection, CS facilities were facing considerable challenges related to laboratory services. While regional lab networks were meant to facilitate lab services even for transitioned facilities, in practice there were small issues, notably transport and data, which had disrupted access to lab services. Several of these problems appeared to have been at least partially resolved by the time of the second round of data collection, but this example points to the need to plan carefully and think through systems from end to end.

Private facilities need different consideration during transition

Unfortunately, given sample sizes it is difficult for us to present conclusive evidence about the situation of private health care facilities through the transition process. Most of our evidence comes from Uganda, and it appears that in this context at least, private facilities experienced transition differently from public ones, primarily because they were less able to access government resources and support. This played out differently in PNFP facilities and PFP ones. While PNFP lost staff and supervision support, they appeared to be able to maintain services and service quality, whereas PFP facilities were considerably more likely to cease providing HIV services after transition. Private facilities, both PNFP and PFP, resorted to user fees as a means
to replace lost resources. More thought should be given to how critical private providers are to the HIV/AIDS response, and how lost services, or charging for services in the private sector, may affect overall accessibility to care and the continuity of care.

**Loss of outreach services may affect reaching treatment targets**

Finally, local health systems have not been able to fully replace the community-based outreach previously supported by PEPFAR/USAID. We are concerned about how the loss of community outreach services may affect prospects for achieving 90–90–90 targets, especially in regions transitioned as a whole. The case studies suggested multiple ways in which outreach helped to maintain HIV-positive people on treatment, and how loss of outreach, especially in remote, sparsely populated regions, could affect retention.
CONCLUSIONS

As PEPFAR, as well as other development partners, seeks to achieve greater efficiency with limited resources, there are likely to be ongoing efforts to target resources. These measures will entail withdrawing support from particular services or populations. In many regards our study is reassuring, as it suggests that, in the short term at least, the refocusing of PEPFAR support in Kenya and Uganda through the GP did not have widespread negative effects upon services in those settings which lost support. We note, however, that this was a relatively short-term study and that there may already be processes at work that could lead to negative, lagged effects. For example, training of health workers in CS sites had declined, and over time this may affect competencies, motivation, and quality of care. Indeed, this was hinted at by the facility in-charge who responded to our survey. It is particularly important, therefore, to have clear plans in place for the monitoring of services and HIV incidence and prevalence in transitioned areas.

In both of our study contexts, respondents expressed concern about poor planning of the GP and hurried execution. It is important that in the rush to achieve targets, USG does not compromise principles of collaboration, joint planning with government, and continued trusting relationships that form the basis for a successful transition. A slower, more planned approach, and particularly one that reaches out to actors at the sub-national level, will be key in this respect.
REFERENCES


APPENDIX

TRANSITION TIMELINES
## TIMELINE OF GEOGRAPHIC PRIORITIZATION IN KENYA

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Geographic prioritization appears on PEPFAR documents in COP15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>COP15 (Oct 2015–Sep 2016) discusses prioritization between counties and presents the allocation of counties between investment categories. Confirmed by D32 USAID.</td>
</tr>
<tr>
<td>OGAC cable</td>
<td></td>
<td></td>
<td>Oct</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Initial deadline for withdrawal for HIV and PMTCT testing is Dec 2015.</td>
</tr>
<tr>
<td>PEPFAR informs NACC/NASCOP, others</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NACC/NASCOP informs counties</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Letter from Council of Governors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>USAID informs IPs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IP communicates with CS counties</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cessation of activities starts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>APHIAPlus Imarisha support to CS counties ends</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Aug</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PEPFAR Coordinator's Office communicates with CS counties</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Sep</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revised deadline for withdrawal from CS counties</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Sep</td>
<td></td>
<td></td>
<td>COP16 Guidance (dated Dec 2015) states Sep 2016 as end date, with extension to Mar 2017 possible.</td>
</tr>
<tr>
<td>APHIAPlus Imarisha submits proposal for limited re-entry to CS countries, with focus on high volume facilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Apr</td>
<td></td>
<td></td>
</tr>
<tr>
<td>APHIAPlus Imarisha restarts support to 6 CS counties</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>May: Marsabit and Isiolo June: Garissa, Wajir, Mandera and Tana River</td>
</tr>
<tr>
<td>APHIAPlus Imarisha ceases support to CS counties again</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>OVC-specific</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OVC contract issued</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Sep</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OVC transition activities start</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Apr</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OVC transition date for withdrawal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Sep</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4cs contract for supporting OVC extended but not direct support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Sep</td>
<td></td>
<td></td>
<td></td>
<td>Focus is technical assistance to county actors to finalize household graduations (Sep 2017–Sep 2018)</td>
</tr>
</tbody>
</table>
TIMELINE OF GEOGRAPHIC PRIORITIZATION IN UGANDA

- Technical pivot
- Geographic prioritization
- Rationalization
- Integration
- Procurement and IP changes

Planned duration
Actual duration
 Interruption