PEPFAR

U.S. President's Emergency Plan for AIDS Relief

USAID FROM THE AMERICAN PEOPLE | HEALTH POLICY INITIATIVE

Investing In HIV Services While Building Kenya's Health System: PEPFAR's Support To Prevent Mother-to-Child HIV Transmission

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AIDS 2012 - Turning the Tide Together

Implicit rationale for the study

"Over the next five years, USAID will need to **strike a new balance between providing services and strengthening health systems**, leveraging our still-prominent role and expertise to help countries experiencing an economic transition to design better health systems for a more equitable and sustainable future. "

USAID Global Health Strategic Framework
April 2012 (Page 5, last paragraph)

Our study spans two phases of PEPFAR

PEPFAR I

- 2003 - 2008
- **Emergency Response**
- Scale up high-quality HIV services to the largest number of beneficiaries in the shortest time possible

PEPFAR II

- 2009 – 2014
- **Expanded Focus**
- continued scale up of program services supplemented by a focus on strengthening health systems by developing local capacity, country ownership, as well as systems & infrastructure

Methodology

- **Kenya** case study, focus on USAID
- Specific interventions:
  1. **PMTCT** (current results): 2005-2010
  2. Adult ART (forthcoming): 2007-2011
- Data collected from two implementers: **FHI360** and **EGPAF**
- Study period: 2005 – 2010
- Program expenditure review ***+*** Output analysis & impact analysis
- Data required
  - Expenditure data from FHI360 and EGPAF: direct expenses* and overhead (HQ and Kenya). Costs include STTA (HQ and Kenya)
  - Service delivery statistics for PMTCT
  - Facility lists
  - Interviews with key staff

Research Questions

- What was the trend in PEPFAR expenditures related to the PMTCT program in Kenya during PEPFAR-I and PEPFAR-II across service delivery (SD) and health system strengthening (HSS)?
- What was the increase or decrease in unit expenditure over the period, as disaggregated by SD and HSS, given the following denominators?
  1. *per HIV-infected mother provided with ARVs*
  2. *per infant HIV infection averted*

Support to SD vs. HSS: classification of expenditures

		Definition	Examples of Costs
Support to service delivery		Activities that exclusively facilitate the provision of PMTCT at the point of service delivery.	· Training on the delivery of PMTCT services · Printing of client registers · Distribution of HIV test kits and reagents
Support to Health System Strengthening	**Country Ownership**	Activities that promote country-led planning and program implementation.	· Support to District Health Management Teams · Assistance to national HIV strategic planning
	Capacity Building for Health System Strengthening	Training programs that build skills in areas adjacent to PMTCT service delivery.	Training for · Commodities management · MCH/PMTCT integration · Quality improvement
	Strengthening of Support Systems and Infrastructure	Investments in capital and logistics within the general health system which additionally benefit PMTCT services.	· Purchase and training on CD4 equipment · Renovation of facility sites · Assistance with M&E strategy · Technical assistance for revision of tools and protocols

Rapid scale-up of service delivery at FHI360 and EGPAF supported sites

PEPFAR I

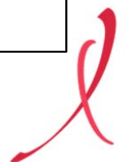
PEPFAR II

4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0

Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4

2005 2006 2007 2008 2009 2010

Quarterly number of HIV-positive mothers receiving antiretroviral drugs (left axis)



Rapid increase in impact through FHI360 and EGPAF supported sites

Annual number of infant infections averted (est.)

2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0

2005 2006 2007 2008 2009 2010

Source: Authors' calculations (see online supplementary appendix)

Unit Expenditure per HIV-positive mother provided with ARVs - 1

Unit Expenditure (USD)

$600
$500
$400
$300
$200
$100
$-

2005 2006 2007 2009 2010

Service Delivery Sustainability

* For 2010, the unit expenditure on commodities & logistics support via PEPFAR was approximately an additional $48 per mother reached

Unit Expenditure per HIV-positive mother provided ARVs – 2 *(proportions)*

Source: Authors' calculations

Unit Expenditure* per Infant Infection Averted

$8,000
$7,000
$6,000
$5,000
$4,000
$3,000
$2,000
$1,000
$-

2005
2006
2007
2009
2010

Service Delivery
Sustainability

* Excludes expenditure on commodities & logistics support

Findings

From 2005 to 2010 in Kenya:

- The number of HIV+ mothers reached with ARVs **increased by 700%**
- The number of infant infections averted **increased by 520%**
- Unit expenditure per HIV+ mother reached with ARVs **declined 52%**
- Unit expenditure per infant HIV infection averted **declined 66%**
- The HSS proportion of expenditures **increased 33%**
- There is no evidence to suggest that investing in HSS impeded the rapid scale-up of PMTCT services

Thank you