

AUGUST  
2017

# Assessment of opportunities to deliver oral PrEP for women through private sector health care

*Kenya research findings*



# Introduction to this analysis

## BACKGROUND

- Kenya has **prioritized public-private partnerships** as part of national health sector planning to increase health care access
- However, Kenya's oral PrEP implementation framework has been **focused on the public health system** to date
- Currently, **oral PrEP delivery** is occurring through demonstration projects, the Bridge to Scale project, and individual HCW distribution
- The private sector has the **potential to expand access to oral PrEP and complement current government investment** for women and girls at risk for HIV, especially in those counties with high private sector utilization and high HIV incidence. As broader procurement and delivery plans are developed, the private sector could be considered in addition to the public sector.

## OBJECTIVE, SCOPE, AND METHODOLOGY

[FSG](#), as part of the [OPTIONS Consortium](#), reviewed existing publicly available literature and conducted interviews with relevant organizations to explore **two major questions (see slides 22 and 23 for a list of interviewees and research sources)**:

1. To what extent does **private sector health care reach** women and girls at risk for HIV?
  2. If so, what can be done to **leverage the opportunity** to deliver oral PrEP through the private sector?
- The **objective of this research** is to support planning by country governments, international donors, and implementing agencies by better understanding the opportunities and considerations for delivering oral PrEP through the private sector
  - As OPTIONS continues to support public sector oral PrEP introduction and planning, **it also endeavors to provide guidance to national governments** on the opportunity for a comprehensive approach to oral PrEP rollout across public and private sectors
  - This research **defines the private sector as all non-public channels** (e.g., NGO clinics / social franchises, private doctors / small clinics, commercial facilities, pharmacies, and faith based organizations)
  - Given OPTIONS' **focus on delivery** of oral PrEP, this research does not include financing, insurance, supply chain, and manufacturing

## NEXT STEPS

- This analysis will **inform discussions with NASCOP and the MOH on the national PPP framework**, targeted for development in 2017, and could also inform the development of a sustainable financing strategy for oral PrEP scale-up
- Research planned in 2017 and 2018 will improve understanding of **end user and provider perspectives** related to delivering PrEP through the private sector

# Key findings

## THE OPPORTUNITY TO DELIVER ORAL PREP

- **Women and girls are active users of the private sector** (including SRH, FP and HCT services) due to perceived greater convenience, higher quality service delivery and greater confidentiality compared to the public sector.
- The geographic distribution of private health care facilities **aligns with areas of high HIV incidence**; combining the Nairobi/Mombasa region counties with Kisumu in the lake region yields ~40% of all private sector outpatient visits and ~35% of all new HIV infections.
- Only ~5% of the population is covered by private insurance **with the vast majority paying out of pocket**. While out of pocket health expenditure has increased in recent years, it is still not sufficient to cover the **current high retail price of oral PrEP** (\$20-40/month).
- An effective private sector strategy should include a **portfolio of channels** capable of reaching populations with different income levels.
- **Partnerships between government and existing networks** will help ensure high quality and effective delivery across channels.

### *This analysis identified two delivery channels as high priority opportunities:*

1. **NGO clinics / social franchises** offer the **greatest opportunity to reach low-income women in urban and peri-urban centers** with high HIV incidence and private sector utilization (e.g., Nairobi/Mombasa regions and Kisumu). They bring expertise in providing integrated, acceptable SRH/FP/HCT services. However, their relatively limited scale and dependency on donor funding presents sustainability challenges. A next step could be to **initiate conversations with social franchise networks** that together reach ~400-500K people/year.
2. **Private doctors / small clinics** offer a **high priority opportunity to reach low-middle income women in urban and peri-urban centers** with high HIV incidence and private sector utilization (e.g., Nairobi/Mombasa regions and Kisumu). They offer **tiered pricing** and deliver services in line with **women's preferences**. However, they will require training in oral PrEP provision and strengthened patient monitoring systems to ensure effective high quality delivery. A next step could include initiating conversations with the Kenya Medical Association (KMA) that comprise 75% of all private doctors and have noted interest in adapting/developing HCW training and demand generation messaging.

### *The other three delivery channels were assessed to be lower priority but could form part of a broader portfolio approach:*

3. **Pharmacies** could provide information on oral PrEP to low-income women and girls that may not frequently use traditional health facilities. However, limited experience with HIV/HCT services and poor linkage to the healthcare system for Rx and testing creates risks.
4. **Commercial facilities** could reach high-income women and girls at risk for HIV in urban centers willing to pay the full cost of oral PrEP. However, this would likely be out of reach for most, limiting the potential impact on reducing annual new HIV infections with oral PrEP.
5. **FBOs** could reach low-income women in rural and urban informal settlement areas that may not have access to an alternative health facility. Their high capacity in HIV treatment also provides an opportunity to reach sero-discordant couples. However, limited alignment with areas of high HIV incidence and low acceptability poses challenges to women accessing this channel.

This analysis aims to answer two major questions



**To what extent does private sector health care reach women and girls at risk for HIV?**



**What can be done to leverage the opportunity to deliver oral PrEP through the private sector?**

This analysis aims to answer two major questions



**To what extent does private sector health care reach women and girls at risk for HIV?**



**What can be done to leverage the opportunity to deliver oral PrEP through the private sector?**

*Further detail on this question is included in the following section*

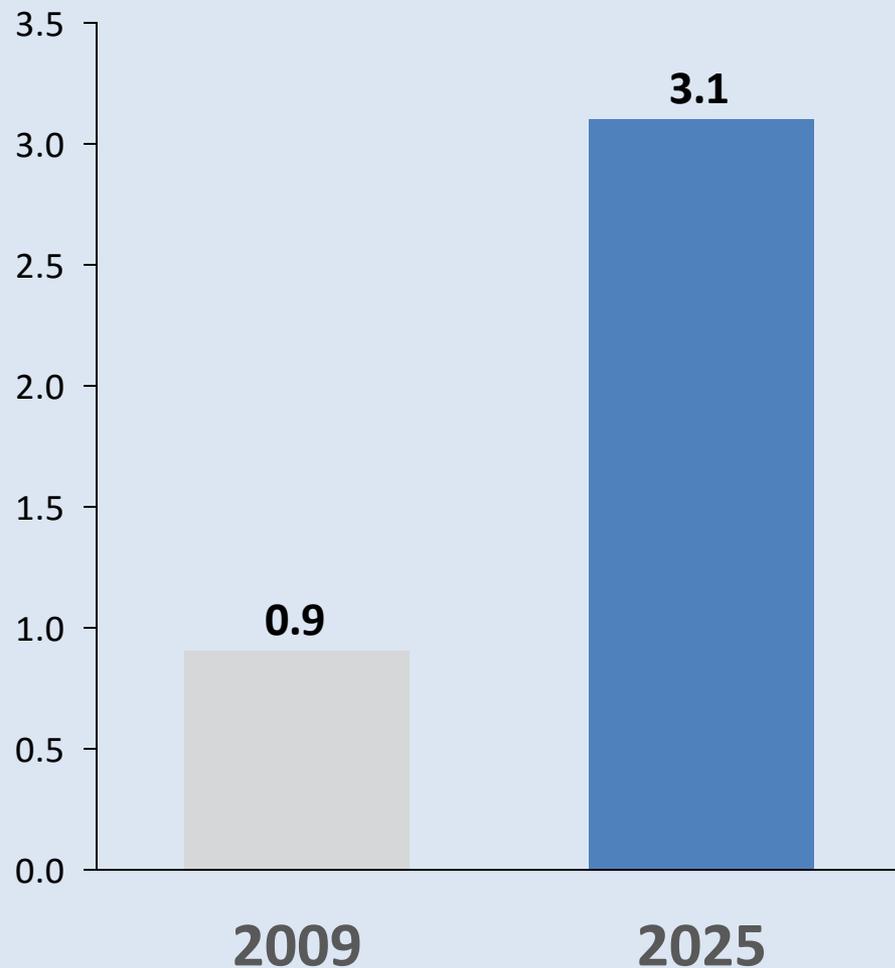
# Kenya's private sector is significant and expected to grow in the coming years



## Overview of current Kenyan private health sector and expected growth

- Over half of facilities are **private** and **nearly 40% of outpatient visits are through the private sector**
- Relative to the region, the **public sector plays a more limited role**, comprising ~35% of total health expenditure, compared to the African Region average of ~50%
- Nearly 80% of private sector health expenditure is paid for **out of pocket** and ~5% through **private health insurance** – demonstrating a **willingness to pay** for private health services
- From 2004-2014, **per capita annual private health expenditure grew 4X** (\$7 per person to ~\$30 per person) and this growth is expected to continue (*see right*)
- However, per capita health expenditure is low **relative to the annual price of oral PrEP** (~\$240-\$480 without tests) and **limited private health insurance coverage** (~5% ) will make it challenging to deliver PrEP without subsidy
- **Kenya's Vision 2030** contains specific strategies to develop the private healthcare sector, including public-private partnerships
- The private sector is **expected to continue to grow** in the coming years due to rising disposable income (especially in urban areas) and an improving regulatory climate

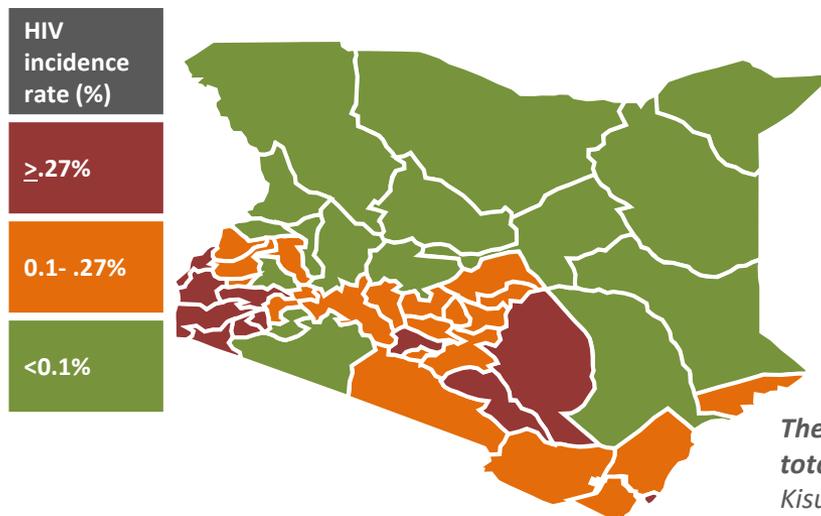
## Projected annual private sector health expenditure USD billions



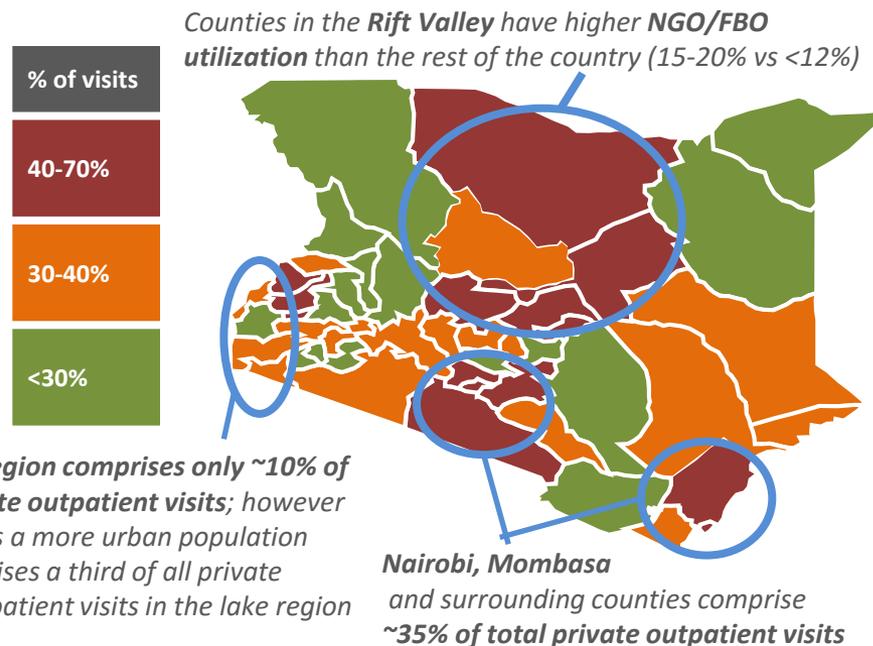
# Private sector utilization is high in urban areas of HIV incidence but low in the high-incidence lake region



## HIV Incidence Rates by County, NASCOP, 2016



## Outpatient Private Visits, MOH Kenya, 2013

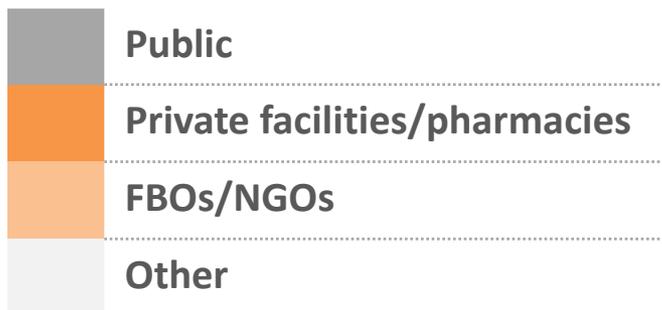
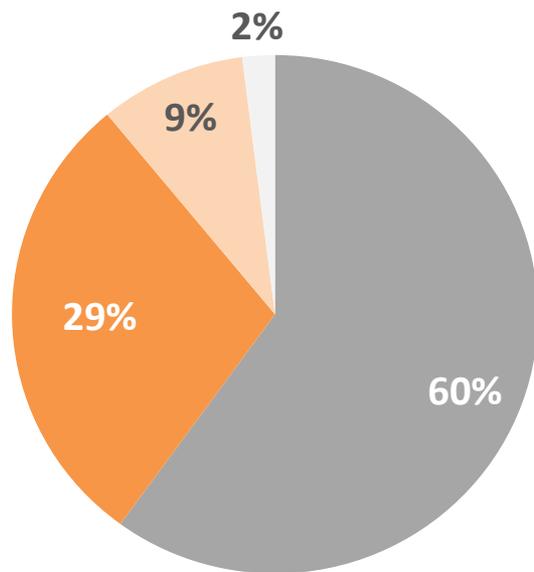


- Use of private facilities is **higher (3x more outpatient visits)** in urban areas compared to rural areas
- Women and girls who are at risk for HIV would be most easily reached in counties with high urban population shares, high HIV incidence, high number of new HIV infections and high private sector utilization
- There is a high level of private sector utilization in the urban areas of Nairobi/Mombasa region counties (Nairobi, Kiambu, Machakos, Mombasa and Kilifi) and Kisumu in the lake region where there is also significant HIV incidence and a high number of new HIV infections:
  - Each of these counties exhibit **above national average private sector utilization (> 38%)**
  - Each of these counties exhibit **medium-high HIV incidence levels (> 0.15%)**
  - Each of these counties exhibit **high new HIV infection levels (> 1,500 annual new HIV infections)**
  - Combining these counties **yields ~40% of all private sector outpatient visits and ~35% of all new HIV infections**

# Women and girls at risk for HIV are likely active users of the private sector



## Female use by type of facility, 2013



## High utilization of private antenatal, HCT, FP, SRH services among women signals potential demand for oral PrEP in the private sector

- In urban areas, 25% (40% in Nairobi) of women choose the private sector for **antenatal care** and 23% (44% in Nairobi) of **deliveries** take place at a private health facility
- 25% of women receive **HCT services** via the private sector
- 50% of private **providers offer HCT services**
- According to MOH officials, **20-25% of all family planning (FP) commodities are distributed by the government through the private sector**
- A significant percentage (20-40%) of women and girls access **FP/SRH services** in the private sector; with higher rates of access in urban areas
- According to the latest demographic health survey, **nearly 60% of women who use the birth control pill access it from the private sector** (primarily pharmacies), and ~35% of those that use IUDs and injectables access them from the private sector (primarily hospitals/clinics)
- A study among clients who purchased **emergency contraceptives** from private pharmacies in urban areas of Kenya shows that **about three-fourths were young women between ages 20 and 29**
- An additional study found that **when young women are offered long-lasting contraception methods (e.g., IUDs) from NGO managed social franchises, they are more likely to use them compared to public sector**
- Recent data from across Sub-Saharan Africa indicates that **62% of unmarried young women use the private sector for FP products**

# Women choose the private sector for convenience, affordability and confidentiality



## Driver

## Description

## Perspectives

### Convenience

- Easy facility access
- Short wait times
- Long opening hours
- Multiple service offerings

“There are long queues in some of the public sector facilities. Those people **who can afford other services and don’t want to wait to go to the public sector will choose the private sector**”  
– *NGO service provider*

### Quality

- Consistent availability of equipment and medicines
- Consistent provider availability
- Highly trained HCWs

“The main reasons driving people to the private sector is a **perception that private sector services are of higher quality** and will have the medicines they need”  
– *Private doctor association*

### Confidentiality

- Positive provider attitude and behaviors
- Ability to access SRH and HCT services in a safe and discreet way
- Ability to build strong and ongoing relationship with individual private provider

“**Confidentiality is the top reason** for why women and girls would go to the private sector”  
– *Pharmacy network*



# Key Findings: To what extent does private sector health care reach women and girls at risk for HIV?

1. **Half of all health facilities are private** and nearly 40% of all outpatient health visits are conducted in the private sector
2. **Private sector utilization is strong in high-HIV incidence urban areas, but weak in most counties in the high incidence lake region**; high-incidence counties near Nairobi and Mombasa and Kisumu have high private sector utilization; these counties include 35% of all new HIV infections and 40% of all private sector outpatient visits
3. Overall, 38% of women use the private sector and the high utilization (20-40%) of private HCT, FP, and SRH services **signals potential demand for oral PrEP in the private sector**
4. Women and girls **prefer private health sector services** because they view them as more convenient, of higher quality and more acceptable compared to public sector health services

## There is an opportunity to deliver PrEP through the private sector

- Delivery of oral PrEP could **expand access and coverage to women and girls** who primarily use the private sector and could **lower the burden** on the public sector
- However, limited private insurance and low per capita private sector health expenditure means that many **will not be able to afford oral PrEP without subsidy**
  - *The current retail price of oral PrEP is \$20-40/month while current contraceptives (i.e. the contraceptive daily pill) cost only \$1-2/month*
- The significant rates at which women access contraceptives and HCT from the private sector, as well as the presence of private sector facilities in some regions with high HIV incidence suggest that the **private sector can play an important role** in enabling access to oral PrEP for women and girls at risk of HIV

***The following slides provide an initial analysis on the opportunities and considerations for delivering PrEP through specific private sector channels***

This analysis aims to answer two major questions

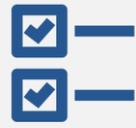


**To what extent does private sector health care reach women and girls at risk for HIV?**



**What can be done to leverage the opportunity to deliver oral PrEP through the private sector?**

*Further detail on this question is included in the following section*

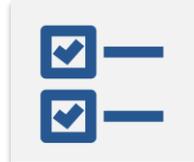


# This analysis includes five private health channels

| Channel                          | Description   | Additional detail  | Key organizations  | PrEP delivery  |
|----------------------------------|---|--|--|--|
| NGO Clinics / Social Franchises  | Private not-for-profit facilities funded by local organizations or international donors, including social franchise models. <i>This analysis focuses primarily on NGO-managed social franchises.</i>      | <ul style="list-style-type: none"> <li>Highly organized networks with family planning (FP) and HIV capabilities, trained HCWs, advanced patient tracking, integration with public health system, and quality standards enforcement</li> <li>MS-Kenya and PSK provide comprehensive FP/HIV services while KMET and FHI focus on HIV care and treatment</li> <li>MS-Kenya operates in 90% of counties; reaches ~200k/ year</li> <li>PSK operates in 80% of counties; reaches ~200k/year</li> </ul>   | <ul style="list-style-type: none"> <li>PSK- Tunza</li> <li>MS-Kenya Amua Kisumu Medical and Education Trust</li> <li>Haduma Poa</li> <li>FHI Gold Star</li> <li>LVCT Health</li> </ul> | <ul style="list-style-type: none"> <li>JHPIEGO Bridge to Scale (PSK-Tunza)</li> <li>DREAMS, Partners Demonstration Project</li> <li>LVCT Health IPCP Project (PrEP for key populations)</li> </ul> |
| Commercial Facilities            | Large private for-profit clinics and hospitals with laboratory services (Kenya KEPH level 3)  | <ul style="list-style-type: none"> <li>No strong professional associations or coordinating bodies</li> <li>Small clinic networks provide comprehensive range of specialty health services that are largely only available to wealthier segments with insurance</li> </ul>  | <ul style="list-style-type: none"> <li>Avenue Healthcare</li> <li>Aga Khan</li> <li>Gertrude's Clinics</li> </ul>  | None   |
| Private Doctors                  | Private doctors who either work in smaller for-profit facilities (KEPH level 2) or manage their own independent practices   | <ul style="list-style-type: none"> <li>Strong professional associations/coordinating bodies with expertise in HCW training and guideline dissemination</li> <li>Interest in oral PrEP to increase foot traffic and deepen customer relationships; use tiered pricing</li> <li>KMA noted interest in demand generation and PPPs for oral PrEP delivery/training of HCW</li> </ul>   | <ul style="list-style-type: none"> <li>Kenya Medical Association (KMA)</li> <li>Kenya Healthcare Federation (KHF)</li> <li>Kenya Assoc. of Private Hospitals</li> </ul>                | <ul style="list-style-type: none"> <li>Private doctors are providing PrEP, but no systematic data on distribution</li> </ul>   |
| Pharmacies                       | Small unregistered (i.e. no gov't oversight) stores and larger registered (i.e. gov't oversight) pharmacy networks in which individuals can purchase medicine; may or may not be managed by a trained HCW | <ul style="list-style-type: none"> <li>Pharmaceutical Society of Kenya is the only large scale network- reaching ~10-15% of pharmacies with education, common standards and public policy advocacy activities</li> <li>GoodLife targets middle-income urban; reaches ~600k/year</li> <li>Variable service quality, limited regulation and weak linkages to healthcare system, but potential to offer PrEP information</li> <li>Use tiered pricing to reach different income levels</li> <li>HIV self-testing and information on oral PrEP could increase foot traffic and deepen customer relationships</li> </ul> | <ul style="list-style-type: none"> <li>Pharmaceutical Society of Kenya</li> <li>GoodLife Pharmacies</li> <li>PharmNet</li> </ul>   | None   |
| Faith Based Organizations (FBOs) | Private facilities affiliated with religious institutions, including church networks and mission hospitals that provide subsidized/free services  | <ul style="list-style-type: none"> <li>Highly organized networks with strong supply chain management and advanced patient tracking systems</li> <li>While FP distribution is limited due to perceptions of healthcare worker stigma, recently expanded HCT provision demonstrates interest in HIV prevention</li> </ul>  | <ul style="list-style-type: none"> <li>Kenya Conference of Catholic Bishops</li> <li>Christian Health Association of Kenya</li> </ul>  | None   |

Sources: Chakraborty, et. al., 2016; UCSF, 2010; Leapfrog Investments, 2017; Barden-O'Fallon, Janine, 2017; FSG interviews and analysis; Organization Websites;

# We assessed each channel by its ability to effectively provide oral PrEP to women and girls at risk for HIV



## Private sector channel assessment framework

1

Can women at high-risk for HIV access this channel?

| Factor               | Definition  |
|----------------------|---|
| <b>Acceptability</b> | Women and girls at risk for HIV are comfortable with accessing family planning and other sexual and reproductive health services through this channel |
| <b>Affordability</b> | Services are affordable for women and girls at risk for HIV with a range of income levels   |
| <b>Proximity</b>     | Sufficient number of facilities located in regions with high HIV incidence for women and girls  |

2

Does this channel have the capacity to deliver oral PrEP?

| Factor  | Definition   |
|---|--|
| <b>HIV counselling and testing services (HCT)</b> | Channel currently offers HIV counselling and testing services                                    |
| <b>Healthcare workers (HCW)</b>                   | Channel has healthcare workers on staff who can prescribe and support adherence to oral PrEP     |
| <b>Ability to provide necessary follow-up</b>     | Channel enables oral PrEP users to easily follow-up for prescription pick-up and ongoing testing |

*The following slides will assess the delivery channels along these two dimensions*

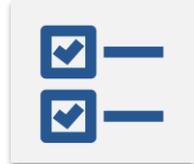
# Pharmacies and private doctors are the most accessible; other channels face tradeoffs between access and affordability



## 1 Can women and girls at high-risk for HIV access this channel?

| Delivery channel                       | Acceptability<br><i>Women and girls are comfortable with accessing SRH/FP services at this channel</i>  | Affordability<br><i>Women and girls could afford oral PrEP through this channel</i>   | Proximity<br><i>Significant presence of this channel in regions with high HIV incidence</i>   |
|--|---|---|---|
| <b>NGO Clinics / Social Franchises</b> | <b>Attractive SRH / FP service point</b> , as they train providers to deliver quality, standardized care without stigma; deep expertise in providing SRH/FP and HCT services to high-risk women | <ul style="list-style-type: none"> <li>• <b>Low cost/free; affordable</b></li> <li>• General FP products cost \$1-3</li> <li>• Study found that PSK Tunza charges \$5-20 per IUD</li> </ul>   | <ul style="list-style-type: none"> <li>• <b>Medium access but aligned to areas of HIV incidence</b></li> <li>• 352 facilities nationally (7% of all private facilities) in both urban and peri-urban</li> <li>• ~400-500k visits per year for all populations</li> <li>• Facilities located in areas of high HIV incidence</li> </ul>                       |
| <b>Commercial Facilities</b>           | <b>Attractive SRH / FP service point</b> for women and girls. 20% who access family planning use private commercial facilities (10% who use pill / 30% who use IUD).                            | <ul style="list-style-type: none"> <li>• <b>High cost; unaffordable</b></li> <li>• General FP products cost \$1-3</li> <li>• Charge up to \$75 per IUD</li> </ul>   | <ul style="list-style-type: none"> <li>• <b>Medium access but aligned to areas of HIV incidence</b></li> <li>• 427 facilities across Kenya (9% of private facilities)</li> <li>• Primarily urban</li> <li>• ~650k visits per year for all populations</li> <li>• Facilities located in areas of high HIV incidence</li> </ul>                               |
| <b>Private Doctors</b>                 | <b>Attractive SRH / FP service point</b> for women and girls. 20% who access FP use private small clinics (10% who use pill / 30% who use IUD).   | <ul style="list-style-type: none"> <li>• <b>Med-high cost; affordable because offer tiered pricing</b></li> <li>• General FP products cost \$1-3</li> <li>• Charge up to \$75 per IUD but offer price flexibility based on user willingness to pay</li> </ul> | <ul style="list-style-type: none"> <li>• <b>High access and aligned to areas of HIV incidence</b></li> <li>• 3,127 facilities nationally (63% of private facilities)</li> <li>• Primarily urban and peri-urban</li> <li>• ~4,000 private doctors; ~1m visits per year for all pops.</li> <li>• Facilities located in areas of high HIV incidence</li> </ul> |
| <b>Pharmacies</b>                      | <b>Attractive FP service point</b> for young women (10% of women who access FP use pharmacies; 45% who use pill use pharmacies; 0% who use IUDs use pharmacies)                                 | <ul style="list-style-type: none"> <li>• <b>Low cost; affordable</b></li> <li>• General FP products cost \$1-3</li> </ul>   | <ul style="list-style-type: none"> <li>• <b>High access and aligned to areas of HIV incidence</b></li> <li>• ~5k total; ~2k registered and 3k unregistered</li> <li>• At least 1.2m visits per year for all populations</li> <li>• Primarily urban; some second tier in rural areas</li> <li>• Facilities located in areas of high HIV incidence</li> </ul> |
| <b>FBOs</b>                            | <b>Unattractive SRH/FP service point</b> for women and girls (2% of women who access FP, use FBOs; <1% who use pill use FBOs; 3% who use IUDs use FBOs)   | <ul style="list-style-type: none"> <li>• <b>Low cost/free; affordable</b></li> <li>• General FP products cost \$1-3</li> <li>• <i>Cost of IUDs are unknown</i></li> </ul>   | <ul style="list-style-type: none"> <li>• <b>Medium access but not aligned to areas of HIV incid.</b></li> <li>• 1,030 facilities nationally (14% of private facilities)</li> <li>• ~800k visits per year for all populations</li> <li>• Overwhelmingly rural; peri-urban</li> <li>• Facilities located in areas of low HIV incidence</li> </ul>             |

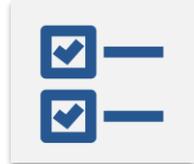
# NGOs and commercial facilities are likely the highest capacity channels



## 2

### Does this channel have the capacity to deliver oral PrEP?

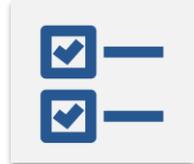
| Delivery channel                       | <i>HIV Counseling and Testing (HCT) Services</i><br>Currently offers HCT services  | <i>Healthcare Workers (HCW): Channel</i><br>has HCW who can prescribe and support adherence to oral PrEP  | <i>Ability to provide necessary follow-up</i><br>Enables PrEP users to easily follow-up for prescription pick-up and testing   |
|--|--|---|--|
| <b>NGO Clinics / Social Franchises</b> | <ul style="list-style-type: none"> <li>• <b>Significant experience and expertise in providing HCT services on-site</b> (i.e. PSK-Tunza conducts &gt; 100k HIV tests/year)</li> <li>• Strong <b>expertise in integrating HCT and FP services for women and girls</b></li> </ul> | <ul style="list-style-type: none"> <li>• Have <b>HCW on-site</b> that could prescribe oral PrEP and support adherence</li> <li>• Strong <b>expertise in providing services to women and girls</b></li> </ul>                              | <ul style="list-style-type: none"> <li>• Advanced patient tracking systems support <b>strong follow-up and referral for testing/monitoring</b></li> </ul>  |
| <b>Commercial Facilities</b>           | <ul style="list-style-type: none"> <li>• <b>50% of all commercial providers</b> provide HCT services</li> <li>• Women <b>feel comfortable accessing HCT services</b> due to perceived confidentiality</li> </ul>   | <ul style="list-style-type: none"> <li>• <b>Have HCW on-site</b> that could prescribe oral PrEP and support adherence</li> <li>• Strong <b>expertise in providing services to women and girls</b></li> </ul>                              | <ul style="list-style-type: none"> <li>• <b>Strong on-site follow-up capacity, with prescription, ongoing testing and monitoring</b></li> </ul>  |
| <b>Private Doctors</b>                 | <ul style="list-style-type: none"> <li>• <b>50% of all commercial providers</b> provide HCT services; <b>limited HIV specialization</b></li> <li>• Women <b>feel comfortable accessing HCT services</b> due to perceived confidentiality</li> </ul>                            | <ul style="list-style-type: none"> <li>• <b>HCW capacity</b> to prescribe oral PrEP and support adherence, but <b>limited HIV specialization</b></li> <li>• <b>Associations could coordinate HCW training on HIV/oral PrEP</b></li> </ul> | <ul style="list-style-type: none"> <li>• <b>Strong follow up support for Rx but limited lab on site / referral for testing and monitoring</b></li> <li>• Strong medical associations could <b>support effective monitoring systems</b></li> </ul>        |
| <b>Pharmacies</b>                      | <ul style="list-style-type: none"> <li>• <b>Most do not provide HCT on-site</b> but some provide self-testing kits</li> <li>• Very limited specialization in addressing issues around <b>HCT stigma that women and girls may face</b></li> </ul>                               | <ul style="list-style-type: none"> <li>• <b>Often no HCW on staff</b> to prescribe oral PrEP or support adherence</li> </ul>  | <ul style="list-style-type: none"> <li>• Lack of <b>patient tracking and resistance monitoring creates risks</b></li> <li>• Could be good information dissemination point for young women (who regularly use for FP) and link to oral PrEP Rx</li> </ul> |
| <b>FBOs</b>                            | <ul style="list-style-type: none"> <li>• <b>Recent expansion of HCT services</b></li> <li>• A five year (2011-2016) CDC and PEPFAR funded scale up of HIV services among Kenyan FBOs led to a 4x increase in HCT, reaching ~3 million people in 5 years</li> </ul>             | <ul style="list-style-type: none"> <li>• <b>More limited HCW</b> capacity to prescribe oral PrEP and monitor adherence</li> </ul>   | <ul style="list-style-type: none"> <li>• Advanced patient tracking systems support <b>strong follow-up and referral for testing/monitoring</b></li> </ul>  |



# Assessment of each channel across these factors highlight opportunities to deliver oral PrEP

| Delivery channel                       | 1 Can women and girls at high-risk for HIV access this channel? |   |   | 2 Does this channel have the capacity to deliver oral PrEP?       |  |   |
|--|---|---|---|---|--|---|
|  | Acceptability   | Affordability   | Proximity   | HCT   | HCW  | Follow-up   |
| <b>NGO Clinics / Social Franchises</b> | Strong Expertise Providing SRH/FP Services                      | Target low-income with low-cost/ free services            | Medium access / high alignment with HIV incidence | Regularly offers HCT services on-site                             | HCW can prescribe/ support adherence               | High capacity patient testing, tracking and referral mechanisms         |
| <b>Commercial Facilities</b>           | High current use for SRH/FP                                     | High-cost; only affordable for wealthy populations        | Medium access / high alignment with HIV incidence | Regularly offers HCT services on-site                             | HCW can prescribe/ support adherence               | High on-site capacity patient testing, tracking and referral mechanisms |
| <b>Private Doctors</b>                 | High current use for SRH/FP                                     | Med-high cost; commonly offer tiered pricing              | High access / high alignment with HIV incidence   | Regularly offers HCT on-site; at times limited HIV specialization | Limited HCW capacity related to HIV specialization | High capacity Rx follow up limited referral for testing                 |
| <b>Pharmacies</b>                      | High current use for SRH/FP                                     | Affordable to a range of income levels                    | High access / high alignment with HIV incidence   | Provide self-testing kits but no on-site HCT services             | Often do not have HCW services on-site             | Limited patient testing, tracking and referral mechanisms               |
| <b>FBOs</b>                            | Low current use for SRH   | Offer many services for free; focused on rural low-income | Medium access / not aligned with HIV incidence    | Recent expansion of HCT services                                  | Limited HCW capacity due to heavy volume           | High capacity patient testing, tracking and referral mechanisms         |

| Key | Highly accessible to most women | Accessible to some women | Inaccessible to most women | Strong capacity | Moderate capacity | Low capacity |
|-----|---------------------------------|--------------------------|----------------------------|-----------------|-------------------|--------------|
|     |                                 |                          |                            |                 |                   |              |



# Two channels offer the most opportunity to reach women with oral PrEP

| Delivery channel                | 1 Can women at high-risk for HIV access this channel? |               |           | 2 Does this channel have the capacity to deliver oral PrEP? |        |           | Opportunity to deliver PrEP  |
|---------------------------------|---|---------------|-----------|---|--------|-----------|--|
|                                 | Acceptability   | Affordability | Proximity | HCT   | HCW    | Follow-up |  |
| NGO Clinics / Social Franchises | High  | High          | Medium    | High  | High   | High      | <b>HIGH OPPORTUNITY</b> <ul style="list-style-type: none"> <li>Effectively deliver affordable HIV/SRH services without stigma</li> <li>Strong capacity to deliver PrEP</li> </ul>  |
| Commercial Facilities           | High  | Low           | Medium    | High  | High   | High      | <b>MEDIUM OPPORTUNITY</b> <ul style="list-style-type: none"> <li>Unaffordable prices/urban focus limit accessibility beyond wealthy populations</li> <li>Strong capacity to deliver PrEP</li> </ul>  |
| Private Doctors                 | High  | High          | High      | High  | Medium | Medium    | <b>HIGH OPPORTUNITY</b> <ul style="list-style-type: none"> <li>High reach and acceptability; more affordable than commercial facilities</li> <li>Limited capacity for follow up</li> </ul>   |
| Pharmacies                      | High  | High          | High      | Low   | Low    | Low       | <b>MEDIUM OPPORTUNITY</b> <ul style="list-style-type: none"> <li>High reach, acceptable to end users</li> <li>Lack of trained HCWs with Rx capability, but could be an effective information dissemination point</li> </ul>                        |
| FBOs                            | Low   | High          | Medium    | High  | High   | High      | <b>MEDIUM OPPORTUNITY</b> <ul style="list-style-type: none"> <li>Limited acceptability but critical service point in rural areas/informal settlements</li> <li>Strong HIV care and HCT services; high capacity to reach sero-discordant</li> </ul> |

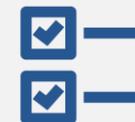


# Each channel reaches different people; a portfolio approach can expand oral PrEP coverage across populations

A portfolio approach includes **a mix of channels** that reach populations of different income levels and geographies with oral PrEP delivery and information dissemination. A strategic implementation plan can **prioritize those channels that serve different market segments** to create a comprehensive strategy that expands oral PrEP coverage **in regions of high HIV incidence**.

| Delivery channel                  | Near-term opportunity to deliver PrEP | Market segment   | Recommended action steps  |
|-----------------------------------|---------------------------------------|--|---|
| NGO Clinics/<br>Social Franchises | HIGH OPPORTUNITY                      | Younger low-income urban women without insurance who are likely only able to afford to pay a small amount of money out of pocket   | <i>Details for action steps on following slides</i>   |
| Commercial facilities             | MEDIUM OPPORTUNITY                    | Older high-income urban women with insurance (2-3% of population) or who are able to pay full cost out of pocket   | Ensure commercial clinic networks have access to oral PrEP guidelines and HCW training opportunities  |
| Private Doctors                   | HIGH OPPORTUNITY                      | A broad spectrum of low to middle income urban women with or without insurance who are able to pay some money out of pocket  | <i>Details for action steps on following slides</i>   |
| Pharmacies                        | MEDIUM OPPORTUNITY                    | Younger low to middle income urban women without insurance who are unlikely to seek out healthcare services from a facility; could be an information dissemination point | Co-develop a strategy to disseminate information and build understanding and demand for oral PrEP among high-risk populations (e.g., those seeking family planning, HIV self-testing) |
| FBOs                              | MEDIUM OPPORTUNITY                    | Older low-income women living in rural areas and informal settlements who are likely only able to afford to pay a small amount of money out of pocket                    | Ensure FBO groups have access to oral PrEP guidelines and HCW training opportunities  |

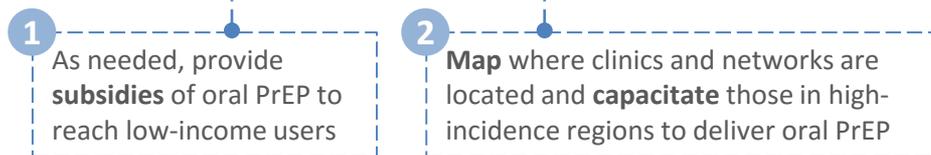
# NGO Clinics / Social Franchises: Implementation considerations



## Current capacity and gaps

| Can women/girls at high-risk for HIV access this channel? |  |   | Does this channel have the capacity to deliver oral PrEP? |                                      |   |
|---|--|---|---|--------------------------------------|---|
| Acceptability   | Affordability                                  | Proximity   | HCT   | HCW                                  | Follow-up   |
| STRONG EXPERTISE PROVIDING SRH/FP SERVICES                | TARGET LOW-INCOME WITH LOW-COST/ FREE SERVICES | MEDIUM ACCESS / HIGH ALIGNMENT WITH HIV INCIDENCE | REGULARLY OFFER HCT ON-SITE                               | HCW CAN PRESCRIBE/ SUPPORT ADHERENCE | HIGH CAPACITY PATIENT TESTING, TRACKING AND REFERRAL MECHANISMS |

## Potential next steps

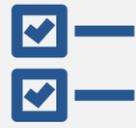


## Potential partners

- **PSK- Tunza Network:** Social franchise network that is made up of pharmacies, clinics and providers that deliver FP, SRH and HIV services; operates in 90% of counties; reaches ~200k people (all populations) per year
- **MS-Kenya Amua Network:** Social franchise network that engages private providers in underserved areas to provide FP, SRH, and HIV services ; operates in 80% of counties; reaches ~200K people (all populations) per year
- **KMET Network:** Social franchise network that provides MNCH, HIV, and nutrition programming; reaches 50k people (all populations) per year
- **FHI Goldstar Network:** Social franchise network with 117 private sector health facilities that provide HIV care and treatment, SRH, FP, and HCT

## Considerations

- **Priority geographies:** Urban and peri-urban centers with high HIV incidence, such as those located in the counties that make up the Nairobi and Mombasa metro regions (e.g., Nairobi, Mombasa, Kiambu, Kilifi, and Machakos) and Kisumu in the lake region
- **Incentives** for this channel to collaborate:
  - Increase **traffic, sales volumes, and deepen customer relationships** as patients return for PrEP and related services
  - **Increase access to donor funding streams** for integrated HIV prevention products and services
  - **Reduce the number of new HIV infections** for women and girls at risk for HIV

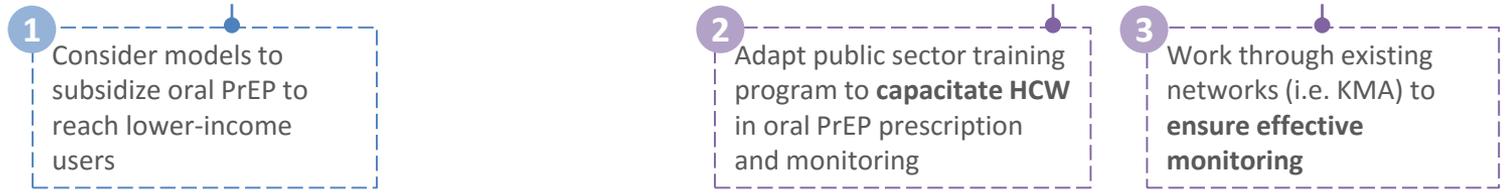


# Private Doctors: Implementation considerations

## Current capacity and gaps

| Can women/girls at high-risk for HIV access this channel? |  |  | Does this channel have the capacity to deliver oral PrEP?         |  |   |
|---|--|--|---|--|---|
| Acceptability   | Affordability                                | Proximity                                      | HCT   | HCW  | Follow-up   |
| HIGH CURRENT USE FOR SRH                                  | MED-HIGH COST; COMMONLY OFFER TIERED PRICING | HIGH ACCESS/ HIGH ALIGNMENT WITH HIV INCIDENCE | REGULARLY OFFERS HCT ON-SITE; AT TIMES LIMITED HIV SPECIALIZATION | LIMITED HCW CAPACITY RELATED TO HIV SPECIALIZATION | HIGH CAPACITY RX FOLLOW UP LIMITED REFERRAL FOR TESTING |

## Potential next steps



## Potential partners

- **Kenya Medical Association (KMA):** A voluntary membership organization that represents approximately 3,000 private doctors or 75% of the total number of private doctors in Kenya. Promotes high quality care through standards, guidelines, and HCW training.
- **Kenya Association of Private Hospitals (KAPH):** A voluntary membership organization that represents approximately 1,500 small and medium sized hospitals and clinics.
- **Kenya Healthcare Federation (KHF):** A private sector membership-based organization and serves as the health sector board of the Kenya Private Sector Alliance (KEPSA). Founded in 2004, the Federation has a membership of 75+ organizations.
- **Kenya Medical Practitioners Board (KMPB):** Regulatory authority that also provides training and education

## Considerations

- **Priority geographies:** Urban and peri-urban centers with high HIV incidence, such as those located in the counties that make up the Nairobi and Mombasa metro regions (e.g., Nairobi, Mombasa, Kiambu, Kilifi, and Machakos) and Kisumu in the lake region
- **Incentives** of private doctors to offer oral PrEP: (1) Increase **traffic, sales volumes and deepen customer relationships** as patients return for PrEP and related services; (2) **Increase access to donor funding streams** for integrated HIV prevention products and services ; (3) **Reduce the number of new HIV infections** for women and girls at risk for HIV

# APPENDIX

# Interview List

| Organization   | Name and Title  |
|--|---|
| Private Sector Program for Health (PSP4H) <i>DFID</i>                            | Ron Ashkin<br><i>Strategy Advisor</i>                             |
| Strengthening Health Outcomes Through the Private Sector (SHOPS)<br><i>USAID</i> | Mbogo Bunyi<br><i>ABT Associates</i>                              |
| JHPIEGO<br><i>Bridge to Scale/ BMGF</i>  | Eunice Mutisya<br><i>Project Manager</i>                          |
| PS-Kenya<br><i>PSK Tunza Network</i>   | Sylvia Wamuhu<br><i>Franchise and Partnerships Manager</i>        |
| FHI Gold Star  | Peter Mworgoro<br><i>Country Director</i>                         |
| Kenya Healthcare Federation (KHF)  | Dr. Amit Thakker<br><i>Chair</i>                                  |
| GoodLife Pharmacies  | Robert Kimbui<br><i>Chief Pharmacist</i>                          |
| Pharmaceutical Society of Kenya (PSK)  | Laban Kariuki<br><i>CEO</i>                                       |
| Kenya Medical Association (KMA)  | Dr. Stella Boisre<br><i>Executive Director</i>                    |
| LVCT Health  | Dr. Michael Kiragu<br><i>Technical advisor for HIV prevention</i> |

# Research Sources

- Kenya Healthcare Federation. *Kenya Healthcare Sector: Opportunities for the Dutch Life Sciences & Health Sector*, 2016.
- USAID. *Kenya Demographic Health Survey*, 2014.
- MOH/Government of Kenya. *Kenya Household Health Expenditure and Utilization Study*, 2013.
- MOH/Government of Kenya. *Master Health Facilities List*, 2015.
- MOH/NASCOP. *Master Health Facilities List*, 2015.
- WHO. *Global Health Expenditures Database*, 2014.
- UCSF. *Haduma Poa Health Network/Kisumu Medical and Education Trust*, 2010.
- UCSF. *Tunza Health Network/Clinical Social Franchise Case Study Seroies*. 2010.
- CSIS. *Family Planning and Women's Health in Kenya: The Impacts of U.S. Investments*, 2015.
- USAID/SHOPS/PEPFAR-Kenya. *Kenya Program Profile*, 2015.
- USAID/SHOPS/PEPFAR-Kenya. *Private Sector Perspectives in Kenya*, 2015.
- USAID/PEPFAR- Kenya/Health Policy Project/MOH. *Exploring 10 Years of Health Service Cost and Use in Kenya*, 2015.
- USAID/Abt Associates. *Reaching the Urban Poor and Middle Class in Kenya with Quality Care-LiveWell Case Study*, 2014.
- Leapfrog Investments. *Goodlife Pharmacy- Redefining Healthcare in East Africa*, 2017.
- Private Sector Innovation Programme for Health (PS4PH). *A Formative Survey of the Private Health Sector in the Context of the Working Poor*, 2014.
- Open Capital Advisors. *The Next 33M: How the Private Sector is Reforming Care for Kenya's Mass Market*, 2012.
- Center for Health Market Innovations (CHMI). *Translating Lessons from the Kenyan Healthcare Landscape*, 2015.
- Corroon, et al. *Key Role of Drug Shops and Pharmacies for Family Planning in Urban Kenya and Nigeria*, 2016.
- Chakraborty et.al. *Evaluating the Impact of Social Franchising on Family Planning Use in Kenya*, *Journal of Health, Population and Nutrition*, PlosOne, 2016.
- Barden-O'Fallon, Janine. *Availability of family planning services and quality of counseling by faith-based organizations: a three country comparative analysis*, *Reproductive Health*, BioMed, 2017.
- Johnson et.al. *The role of private health providers in HIV testing: analysis of data from 18 countries*, *International Journal for Equity in Health*, BioMed, 2014.