Private Sector Delivery Strategy for the Dual Prevention Pill: Kenya and Zimbabwe

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Abbreviations

AI	Artificial Intelligence	**MDPPZA**	Medical and Dental Private Practitioners of Zimbabwe Association
AIDS	Acquired Immuno Deficiency Syndrome	**M&E**	Monitoring and Evaluation
ART	Anti-Retroviral Therapy	**MOH**	Ministry of Health
BMGF	Bill & Melinda Gates Foundation	**MOHCC**	Ministry of Health and Child Care
CBO	Community Based Organization	**MOSAIC**	Maximizing Options to Advance Informed Choice for HIV Prevention
CHAI	Clinton Health Access Initiative	**MPT**	Multi-Purpose Prevention Technology
CHW	Community Health Worker	**MSK**	Marie Stopes Kenya
CIFF	Children's Investment Fund Foundation	**NASCOP**	National AIDS and STI Control Program
CME	Continuous Medical Education	**NGO**	Non-Governmental Organization
COC	Combined Oral Contraceptive	**NHIF**	National Hospital Insurance Fund
CPA	Community Pharmacies Association	**OC**	Oral Contraceptive
CPD	Continuous Professional Development	**OPHID**	Organization for Public Health Interventions and Development
DPP	Dual Prevention Pill	**PEP**	Post-Exposure Prophylaxis
D2C	Direct to Consumer	**PPP**	Public Private Partnership
EC	Emergency Contraceptives	**PrEP**	Pre-Exposure Prophylaxis
FBO	Faith Based Organization	**PSH**	Population Services for Health
FP	Family Planning	**PSZ**	Population Services Zimbabwe
HIV	Human Immunodeficiency Virus	**RCT**	Randomized Controlled Trial
HIVST	HIV Self-Test	**SAHCS**	Southern African HIV Clinicians Society
HCD	Human Centered Design	**SMS**	Short Message Service
IUD	Intrauterine Device	**SRH**	Sexual and Reproductive Health
JKUAT	Jomo Kenyatta University of Agriculture and Technology	**SRHR**	Sexual and Reproductive Health and Rights
KEMRI	Kenya Medical Research Institute	**STI**	Sexually Transmitted Infection
KEMSA	Kenya Medical Supplies Authority	**TWG**	Technical Working Group
KMET	Kenya Medical and Education Trust	**USSD**	Unstructured Supplementary Service Data
KMPDC	Kenya Medical Practitioners and Dentist	**UZ -CRTU**	University of Zimbabwe–Clinical Trials Research Unit
LVCT	LVCT Health	**ZHI**	Zimbabwe Health Interventions

1 Executive summary

In August 2019, the Dual Prevention Pill (DPP) Consortium[1] was formed to accelerate the development and introduction of a multipurpose prevention technology (MPT) for HIV and pregnancy prevention. The DPP is a daily pill containing oral pre-exposure prophylaxis (PrEP) and combined oral contraception (COC). It is one of a number of MPTs in the HIV prevention pipeline and is the furthest along in development. As the first MPT to go to market since male and female condoms, the DPP will provide evidence on whether access to an MPT increases uptake of HIV prevention, and aims to drive government and donor engagement and investments in other MPTs that are in the pipeline.

The DPP is still in development, but once approved, its introduction will ideally be prioritized in settings that demonstrate need (i.e. high HIV incidence and high unmet need for modern contraception), potential demand (i.e. current oral PrEP and contraceptive use) and an enabling policy and regulatory environment. Kenya, South Africa and Zimbabwe have been identified as initial countries for DPP rollout. As part of its development process, the DPP Consortium has initiated a number of studies and assessments to prepare for market entry, including the Service Delivery Strategy for the DPP (Kenya, South Africa and Zimbabwe) and the Private Sector Analysis for the DPP (Kenya and South Africa) in 2020, and the Market Preparation and Introduction Strategy in 2021.

Why a private sector delivery strategy is needed The private sector delivery strategy for the DPP has been developed to inform HIV and Sexual and Reproductive Health and Rights (SRHR) communities of practice how emerging evidence, investments and promising practices for delivering PrEP in the private sector, which better aligns with oral contraceptive (OC) delivery approaches, could impact delivery of the DPP and other MPTs. This strategy has been developed by building on the findings and recommendations from a scoping of the private sector delivery options for the DPP, which was carried out in 2022, as well as the previous studies and assessments carried out by the DPP Consortium in 2020 and 2021. The strategy recommends which private sector channels should be considered for the DPP in Kenya and Zimbabwe, as well as the order of rollout for particular channels and recommendations for pilot studies and partners with whom to work.

Recommended channels This strategy recommends which private sector delivery channels should be prioritized for a phased rollout of the DPP in Kenya and Zimbabwe. It is designed to be a living document that should be revisited and updated as new evidence emerges – both from ongoing studies and as private sector channels continue to grow and evolve. It should also be considered as a guide for other PrEP commodities and MPTs that will be delivered through the private sector, appreciating the similarity of issues and questions that need to be addressed to those of the DPP. The private sector channels recommended for the rollout of the DPP in each country are highlighted in Tables 1 and 2 below.

[1] A coalition of organizations, including AVAC, the Clinton Health Access Initiative (CHAI), Mann Global Health, Viatris, the Population Council and Medicines360 lead the DPP project. These efforts are supported by the Children's Investment Fund Foundation (CIFF), the Bill & Melinda Gates Foundation (BMGF), the US Agency for International Development (USAID), Catalyst Global and the HIV Prevention Trials Network (HPTN).

Kenya

Table 1: Private sector delivery channels identified for Kenya

Phase	Channel	Rationale
Phase 1: 2024 - 2025	**E-pharmacies**	New and rapidly growing channel in Kenya for SRH and HIV products, including OCs, emergency contraception (EC), HIV self-test (HIVST) kits, post-exposure prophylaxis (PEP) and PrEP and so provides an opportunity for initial rollout in Phase 1.
	Private providers	Including social franchises, non-governmental organizations (NGOs) and faith-based organizations (FBOs), which continue to be important delivery channels for SRH and HIV services.
	Pharmacies with links to telemedicine providers and private providers for dispensing	Extremely popular and discreet channel offering confidential and quick services and are often lower in cost than clinics. However, as PrEP initiation through pharmacies is still in a trial phase, it is not recommended that the DPP be initiated directly through pharmacies until the results of the trials are known, which is likely to be in Phase 2 (2026 – 2028) of the DPP's introduction.
Phase 2: 2026 - 2028	**Pharmacies – full initiation[2]**	
	Telemedicine	A growing entry point for SRH services including FP, PEP and ECs. Relatively new as a service delivery channel and systems and policies are still being developed.

Note: see glossary in Annex 1 for channel definitions

Zimbabwe

Table 2: Private sector delivery channels identified for Zimbabwe

Phase	Channel	Rationale
Phase 1: 2024 - 2025	**Commercial franchises**	Mainly owned and managed by or for medical insurance companies. Are a well-structured and managed network of facilities mostly in urban settings but who are significantly involved in family planning (FP) service delivery as well as HIV prevention, care and treatment services.
	Social franchises and NGO/FBO supported sites	Have been delivering FP services for many years and have well established networks of sites across the whole country.
	Networked private providers	Members of clinical private provider associations or networks and tend to own or manage standalone or small networks of clinics/facilities, and they provide services across the country.
Phase 2: 2026 - 2028	**Pharmacies**	Whilst a very popular source of OCs, the policy environment does not allow for pharmacists to dispense PrEP without a prescription, by which time it is anticipated that progress will have been made on task-shifting.
	Public-private partnerships (	The private health sector is extremely important for the future of sustainable, accessible, and equitable healthcare and partnering with the public sector is a way of ensuring government commodities can be distributed through the private sector.

[2] Full initiation will be possible once task-shifting to pharmacists for prescribing and dispensing is approved.

Headline recommendations

Kenya and Zimbabwe

- **Undertake research** to better understand cost and willingness to pay.
- **Work with the Ministries of Health** (MoHs) to determine system requirements for private sector channels to access the DPP for free or at a subsidized price through government supplies.
- **Engage with implementing partners, pharmacist bodies and the MoHs** to support task shifting to pharmacists and the development of relevant policies.
- **Work with in-country NGO partners** to determine the feasibility of using their networks for distribution of the DPP to private sector channels.
- **Create or utilize an existing technical working group** (TWG) to deliver the DPP via the private sector.
- **Create and lead a working group** to determine feasibility of bundling HIVST kit subsidies with the DPP subsidies.
- **Engage with organizations implementing online trainings** for PrEP service provision to determine feasibility of adapting them or creating similar tools for training providers on the DPP.

Kenya only

- **Develop agreements with PrEP and FP study investigators** for early access to study results to feed into the DPP planning.

Zimbabwe only

- **Conduct a pilot project** of a formal private provider and pharmacy telemedicine linkage system.

2 Introduction

This section provides a short summary on the rationale for the private sector delivery strategy for the DPP, the methodology for its development, as well as the limitations to the strategy's development.

2.1 The importance of the private sector for the delivery of the DPP

Since the initial private sector analysis for the DPP was conducted in 2020, the evidence on private sector channels has remained largely fragmented, and Zimbabwe's private sector was previously not scoped. COVID-19 contributed to the growth of self-care and technology-based private sector channels, including pharmacies, telemedicine, e-pharmacies, direct-to-consumer (D2C) and other innovations. These channels were not extensively scoped previously and were considered later-phase priorities for DPP rollout. However, due to the recent expansion of oral PrEP delivery in the private sector, they were prioritized as part of this strategy development because they might present greater, more immediate "get-ahead" opportunities for the delivery of the DPP than previously thought. In addition, since the previous private sector landscaping was carried out, new and important pilot studies on PrEP in the private sector have started, which could inform the delivery of the DPP through pharmacies and e-pharmacies earlier.[3] In-depth information on these pilot studies can be found in the 2022 landscaping report: Private Sector Opportunities for the DPP.

2.2 Landscaping of private sector opportunities for the DPP, 2022

The landscaping of private sector opportunities for the DPP was carried out between March and July 2022 through a comprehensive desk review of the available literature and data, complemented by in-country primary data collection and scoping of private sector channels. As the DPP is still in development, the private sector channels that were assessed were selected based on the existing oral PrEP and OC delivery landscape, as these are the channels that will determine where the DPP can be delivered. While the scoping explored all the main private sector delivery channels, it focused more deeply on pharmacies, telemedicine, e-pharmacies, D2C and other innovations. The scoping also considered other cross-cutting themes, which are critical to the delivery of the DPP, including: policy and regulation; public-private coordination; monitoring and evaluation (M&E); supply chain; financing and scalability. Key market criteria which were determined to be critical for the rollout of the DPP were used to analyze each potential private sector channel (Box 1). Eighty-five interviews were held with key informants in Kenya, South Africa and Zimbabwe, as well as the regional and global levels. Interviews were held with national and sub-national governments, including MoH and their departments responsible for FP and HIV prevention, as well as donors, technical implementing partners and key private sector organizations and representatives. The findings comprise the report on Private Sector Delivery Opportunities for the DPP: Kenya, South Africa and Zimbabwe, which contains initial private sector channel recommendations for each country.

[3] In Kenya, the Bill and Melinda Gates Foundation (BMGF) is funding a series of pilots and trials of PrEP in both physical "brick-and-mortar" pharmacies as well as in an e-pharmacy.

Box 1. Inclusion criteria

a. **Overall opportunity:** Whether the delivery channel is recommended for each country
b. **Policy and regulation:** The formal policies, strategies, plans, regulations and guidelines that are in place to support the effective delivery of PrEP and OCs, the DPP and other MPTs
c. **Public-private coordination:** The extent to which the public and private sector actively and effectively plan and coordinate their activities to support the delivery of PrEP and OCs, and the extent to which they might coordinate around the DPP and MPT delivery
d. **M&E:** The extent to which market data on PrEP and OCs is currently being monitored, tracked and available – and subsequently shared and used to improve overall delivery
e. **Supply chain:** The availability of PrEP and OCs through the public and private sectors, and the overall strength and reliability of the country's supply chain system
f. **Financing:** The extent to which the DPP will need to be subsidized in order for demand and use of the product to be significant
g. **Scalability:** The extent to which the delivery channel could be scaled (depending on and incorporating a range of factors, including the pricing of product, continued support from donors, the extent to which markets remain balanced and healthy, and several other considerations)
h. **Sustainability:** To what degree the channel is or might be financially sustainable in the future (depending on and incorporating a range of factors, including the pricing of product, continued support from donors, the extent to which markets remain balanced and healthy, and increased and maintained demand for products, among others)
i. **Geographic coverage:** The extent to which the channel reaches across the country, including urban and rural locations and clients

Each channel was scored using these criteria as either "recommended", "has potential" or "does not currently have potential." The initial recommendations for each country can be seen in Table 3 below, with further detail available in the landscaping report. The channels identified in Table 3 were then further scoped between October and December 2022, leading to the ultimate recommendation of private sector channels - elaborated in sections 3.1 and 3.2 below.

It is also important to note that whilst the scope of this work included the development of the private sector delivery strategy for Kenya, South Africa and Zimbabwe, and that further interviews were carried out with key stakeholders in South Africa, the final strategy for South Africa is not included in this document because at the time of writing the final discussions for strategy development in South Africa were pending. This strategy therefore focuses on Kenya and Zimbabwe only.

Box 2. Key highlights from Private Sector Opportunities for the DPP, 2022

In Kenya and South Africa, pharmacies, telemedicine providers (including e-pharmacies), and networked private providers were identified as having the greatest potential to deliver and scale the DPP in the private sector, with pharmacies and networked private providers also showing the greatest potential in Zimbabwe, along with public-private partnerships (PPPs). These channels were recommended for a more in-depth assessment to confirm their viability as private sector channels for the DPP and to determine in which phase of the rollout of the DPP they should be introduced.

Table 3. Snapshot of scoped private sector delivery channels in each country, combined with market and other key criteria and considerations, 2022

Scoped delivery channels		Direct to consumer channels																		Indirect to consumer/ access through a third party											
		Pharmacy			E-pharmacy			Telehealth			Tele-medicine			Community distribution			Mobile outreach			NGO			FBO			Private network clinics			Social franchise networks		
Country		K	SA	Z	K	SA	Z	K	SA	Z	K	SA	Z	K	SA	Z	K	SA	Z	K	SA	Z	K	SA	Z	K	SA	Z	K	SA	Z
Recommended for DPP delivery		Green	Green	Green	Green	Yellow	Red	Green	Yellow	Yellow	Yellow	Green	Red	Red	Red	Green	Red	Red	Green	Green	Yellow	Green	Green	Yellow	Green	Green	Green	Green	Green	Green	Green
Market considerations	Policy and regulation	Yellow	Yellow	Yellow	Yellow	Red	Red	Yellow	Yellow	Yellow	Yellow	Yellow	Red	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green
	Public-private coordination	Yellow	Green	Green	Yellow	Red	Red	Red	Red	Yellow	Red	Yellow	Red	Yellow	Green	Green	Yellow	Green	Green	Green	Green	Green	Green	Green	Green	Yellow	Yellow	Green	Green	Yellow	Green
	M&E	Red	Green	Green	Red	Yellow	Red	Red	Red	Red	Red	Yellow	Red	Yellow	Green	Green	Yellow	Green	Green	Green	Green	Green	Green	Green	Green	Yellow	Yellow	Green	Yellow	Yellow	Green
	Supply chain	Yellow	Yellow	Yellow	Yellow	Yellow	Red	Yellow	Yellow	Yellow	Yellow	Yellow	Red	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
	Financing	Yellow	Yellow	Yellow	Yellow	Yellow	Red	Yellow	Yellow	Yellow	Yellow	Yellow	Red	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Other key criteria	Scalability	Green	Green	Yellow	Yellow	Yellow	Red	Yellow	Yellow	Yellow	Yellow	Yellow	Red	Red	Red	Yellow	Yellow	Red	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
	Sustainability	Green	Green	Yellow	Green	Green	Red	Yellow	Yellow	Yellow	Yellow	Yellow	Red	Red	Red	Yellow	Red	Red	Yellow	Red	Red	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Red	Yellow	Yellow
	Geographic coverage	Green	Green	Green	Green	Yellow	Red	Yellow	Yellow	Red	Yellow	Yellow	Red	Red	Red	Yellow	Red	Red	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow

Legend	K = Kenya	SA = South Africa	Z = Zimbabwe	Recommended channel for the delivery of the DPP/performs highly against market criteria and other key criteria	Has potential, but not currently a recommended channel for the delivery of the DPP/performs averagely against market criteria and other key criteria	Does not currently have much potential and not recommended for the delivery of the DPP/performs poorly against market criteria and other key criteria

2.3 Scope of the strategy development

The private sector delivery strategy has been developed to better understand the emerging evidence and promising practices for delivering PrEP in the private sector and its implications for the DPP and other MPTs to better align with OC delivery approaches. The information gathered during the 2022 private sector scoping has been used to define the DPP private sector delivery strategy and reflects advances in the private sector, telemedicine, D2C and other novel approaches in Kenya and Zimbabwe. Findings provide up-to-date and on-the-ground insights and experiences with PrEP and OCs, present localized views and opinions and scope prioritized private sector channels.

2.4 Strategy methodology summary

Initial channel recommendations from the 2022 landscaping were refined through an additional 15 interviews with key private sector stakeholders between October and December 2022. Interviews were targeted to key individuals and partners that could provide the most strategic thinking, as well as those who could be potential implementers in the rollout of the DPP.

A deeper review of subsidy models and information around willingness-to-pay was also sourced and was a key aspect of these additional interviews. These included interviews with partners supporting projects with either public sector commodities distributed through the private sector, or who manage and support the distribution of subsidized commodities through the private sector.

Stakeholder consultation meetings were held in Kenya and Zimbabwe in January and February 2023. The objectives of the meetings were to review and provide feedback on the findings to date; agree on the recommended private sector channels and phasing and identify key partners and actions that the DPP Consortium could consider in preparation for the 2024 rollout of the DPP. These consultation meetings included participants from private sector channels, implementing partners, medical professional bodies and the MoH. In Kenya, a single consultation meeting was held. In Zimbabwe, three separate consultations were held: a) with networked private providers, including pharmacies; b) implementing partners, academics and donors, and; c) advocacy groups and AVAC Fellows.[4]

2.5 Strategy methodology limitations

One of the major limitations – during both the initial landscaping of private sector channels and the more in-depth assessment – is accessing data on both the uptake of SRH and HIV commodities in the private sector, as well as data on pricing of commodities and how this is determined. As the success of the DPP in the private sector will be centered not just on how accessible it is in different channels, but also its price, having data on how commodities are priced as well as their utilization is paramount. The lack of willingness-to-pay studies for PrEP in the private sector, which could be used as a guide for pricing of the DPP, was continually raised by stakeholders as a key challenge and barrier to determining cost of the DPP in private sector channels. Without this critical information, recommendations for pricing of the DPP and commodity management models were not possible to include in this strategy.

[4] The AVAC Advocacy Fellows Program, launched in 2009, fosters a network of deeply informed, skilled and confident advocates to strengthen and expand advocacy for HIV prevention locally, regionally and globally. In the decade since its launch, 85 Advocacy Fellows from 14 countries in Africa and Asia have participated.

3 Recommended private sector service delivery channels

This strategy proposes which private sector channels could be prioritized for phased rollout of the DPP in Kenya and Zimbabwe. It is anticipated that the strategy will be used to inform the development of pilot initiatives, or phasing of projects, in each of the two countries, and to guide strategic conversations in-country to prepare for the introduction of the DPP. The private sector delivery strategy should serve as a living document and the phasing of private sector channels should be updated as new evidence emerges and ongoing and complementary research, such as private sector PrEP studies, are completed. The strategy should also be considered a guide for the introduction of other MPTs and other PrEP commodities through the private sector, which will need to address many of the same questions. The private sector channels recommended for the rollout of the DPP are highlighted in Table 4.

Table 4: Private sector delivery channels identified for each country

Kenya	Zimbabwe
Phase 1: 2024-2025 • E-pharmacies • Private providers • Pharmacies with links to telemedicine providers and private providers for dispensing	**Phase 1: 2024-2025** • Commercial franchises • Social franchises & NGO/FBO supported sites • Networked private providers
Phase 2: 2026-2028 • Pharmacies – full initiation • Telemedicine	**Phase 2: 2026-2028** • Pharmacies • Public-private partnerships

Note: see glossary in Annex 1 for channel definitions

3.1 Kenya

After the initial scoping of private sector channels in Kenya, further interviews and in-depth discussions were held with key private sector providers, which further developed the thinking around the recommendations for the private sector channels in Kenya. These were refined further through a consultation meeting that had representatives from all private sector channels as well as the MoH. The private sector delivery channels for Kenya, along with their recommended phasing and some key assumptions, are summarized below in Table 5.

Table 5: Private sector delivery channels recommended for Kenya

Timeline	Phase	Channel	Assumptions
2024-2025	1	E-pharmacies with prescribing capabilities	• E-pharmacy PrEP study demonstrates that PrEP can be safely delivered via e-pharmacies and e-pharmacies continue to provide HIV prevention commodities • Relevant systems are in place to receive subsidized or free MoH commodities
		Private providers, including social franchises	• Those currently involved in HIV prevention, care and treatment engaged and networked with relevant pharmacies for smooth referral for prescribing • Relevant systems in place to receive subsidized or free MoH commodities • Social franchises remain interested in the DPP, as they are not currently significantly involved in PrEP distribution and focus on FP methods, including OCs
		Pharmacies with links to telemedicine providers and private providers for prescribing	• Relationships between pharmacies and telemedicine companies continue to develop and formalize • Relevant systems are in place to receive subsidized or free MoH commodities
2026-2028	2	Pharmacies – full initiation[5]	• Pharmacy PrEP studies show viability of initiating PrEP and receive relevant approvals and pharmacists approved for initiation
		Telemedicine	• Authorized to dispense or have developed relationships and systems with laboratories and pharmacies for seamless, inclusive service provision for clients

Further detail on the selection and phasing of these channels is expanded upon below.

3.1.1 E-Pharmacies

E-pharmacies are selected as part of Phase 1 rollout of the DPP due to their current growth in the private sector market and because they are an increasingly popular access point for SRH and HIV commodities such as EC, HIVST kits, PEP and OCs. However, there are still some disadvantages to this channel as an entry point for the DPP, as seen below in Table 6.

[5] Full initiation implies that pharmacies are able to prescribe and initiate the DPP, rather than only dispensing it with a prescription from another provider.

Table 6: Advantages and disadvantages of e-pharmacies initiating the DPP

Advantages	Disadvantages
• **Growing entry point** for SRH and HIV services; accessible online 24/7 for ordering with longer opening hours for consultations than private providers (e.g. 8am to 10pm for MYDAWA), with country-wide reach	• **PrEP only accessed with a prescription** so only feasible for e-pharmacies with access to a clinician for prescribing
• **Currently distribute OCs, ECs, HIVST kits, PEP and PrEP** (subsidized PEP and PrEP only accessible in MYDAWA as part of the e-pharmacy pilot)	• **Only feasible for those with access to a smartphone or computer** (43% of adults access the internet)[6]
• **Discreet, with no face-to-face engagement,** therefore reducing fear of stigma and discrimination	• **Only feasible for those with ability and/or willingness to pay for delivery costs** on top of the price of the commodity, but still a relatively cost-effective channel for users compared to private providers
• **PrEP service provision trial underway,** which will provide key insights and lessons learned for the DPP through e-Pharmacies	• **Dependent on results of e-pharmacy PrEP trial** and MoH approving PrEP dispensing through e-pharmacies
• **Use of Artificial Intelligence (AI) for verification of HIVSTs being piloted** to ensure no user-error of test interpretation results prior to PrEP initiation and at refill	• **If MoH does not approve AI for HIVSTs verification post-pilot phase**, remote verification becomes significantly more challenging

MYDAWA, Kenya's largest online pharmacy, was initially set up as a purely commercial business, but due to the high demand they received from customers for SRH products, they have expanded into this area. MYDAWA has an in-house online clinical team which provides telemedicine services that are accessible between 8am and 10pm daily and prescribes products after consultation, risk assessment and HIV testing where required. It sells 25% of HIVST kits in Kenya, the largest market share, indicating that HIV prevention users are accessing products through this platform. It was also part of a study which showed that removal of a subsidy for HIVST kits significantly decreased online sales of both oral-fluid and blood-based HIVST kits in Kenya.[7] This shows that willingness to pay for HIV prevention services may be lower than the cost to deliver them, providing evidence that a subsidy for the DPP and other PrEP and MPT commodities is likely to be needed.

A consortium of organizations, including MYDAWA, Fred Hutch Cancer Center, Jomo Kenyatta University, Kenya Medical Research Institute, Partners in Health & Research Development, University of Washington, Audere and Jhpiego, and funded by the BMGF, are carrying out a pilot that will optimize a virtual care model for the delivery of oral PrEP through MYDAWA's e-pharmacy, with the aim of creating an end-to-end customer service for PrEP clients. PrEP users will follow the standard of care guidelines for PrEP refills and will need to re-test for HIV at the relevant time points. PrEP commodities come through the public sector, and BMGF subsidizes the costs of HIVST kits. The pilot study began in October 2022 and is anticipated to end in September 2023.

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[6] Hootsuite. Digital in 2020 - Kenya [Internet]. 2020. Available online: https://datareportal.com/reports/digital-2020-kenya

[7] O Ekwunife, C Culquichicon et al: Removal of a subsidy for HIV self-testing kits reduces online sales in Kenya; Poster Presentation 930, CROI 2023.

E-pharmacies are a relatively cost-effective channel for users as they currently do not have the consultation fees that they would incur at a private provider (this may change after the e-Pharmacy PrEP study), although there is a delivery charge, which is currently US$8 through MYDAWA for clients within Nairobi. This is significantly cheaper than a consultation fee for a private provider (US$15 – $30), and also takes significantly less time than waiting at a public sector facility. These considerations are important for users who have the ability and willingness to pay a small fee and may view time saved as a trade-off. MYDAWA are also exploring opportunities to study and understand the demand for FP products through an online pharmacy, and if it is possible to enable conversions to FP products using telehealth consultations.

Other pharmacy chains that are growing their e-pharmacy business in Kenya, such as Good Life, Pharmaplus, Kasha and others who also have online channels and access to an online clinician for prescribing are also key organizations in the e-pharmacy channel.

Kasha is a femtech platform that offers a wide range of services specifically for women, such as pharmaceuticals, sexual health products, menstrual care and beauty and body products through its Unstructured Supplementary Service Data (USSD)[8] platform, WhatsApp chat and call center hotline. Due to high demand, it has developed a virtual contraceptive forum where women can access information on different contraceptive methods and, as part of their USSD platform and WhatsApp chat, they can speak to a nurse for further information on products. It also has a network of agents in the community who raise awareness on their products. Similar to MYDAWA, HIVST kits are among their best performing products and given their partnerships with other private sector organizations such as Marie Stopes Kenya, they are well placed to also be part of the rollout of the DPP.

Commercial pharmacy chains, such as Goodlife and Pharmaplus, which combined have over 100 pharmacies across Kenya, have platforms that allow clients to submit their prescription for home delivery. This opportunity to order prescribed pharmaceuticals online rather than having to go directly into a pharmacy has grown significantly since COVID-19, with both of these traditionally brick-and-mortar pharmacy companies expanding this way in the last few years.

Although e-pharmacies are a growing market for HIV and SRH products, the ultimate decision on whether they can distribute the DPP, and other PrEP commodities and MPTs, will be based on the outcomes of the e-pharmacy PrEP study and whether the MoH approves its dispensing through this channel outside of a study phase. In anticipation of a positive result from the trials – and to ensure that any lessons learnt during the study are built into plans for DPP rollout through this channel – it is recommended that the DPP Consortium develop an agreement with the pharmacy and e-pharmacy PrEP study investigators to have early access to study results so they can feed into the planning for the DPP.

3.1.2 Pharmacies

Pharmacies have been selected to be part of both Phase 1 and Phase 2 rollout of the DPP, given their current popularity as an entry point for healthcare.

[8] A USSD platform is a Global Systems for Mobile Communications (GSM) protocol that is used to send text messages. It is a menu based information system.

Table 7: Advantages and disadvantages of pharmacies dispensing and initiating the DPP

Advantages	Disadvantages
• **Popular entry point for healthcare** for the majority of the population, including the poorest, due to their convenience and often longer opening hours than facilities, shorter waiting times than public sector facilities and wide geographic coverage	• **PrEP only accessed with a prescription** except in the RCT sites, so only initially feasible for dispensing or for pharmacies with a direct connection to a telemedicine provider or prescribing clinician or nurse
• **Currently distribute OCs, ECs, HIVSTs, PEP and PrEP** (prescription required for OCs, PEP and PrEP)	• **Pre-initiation testing and a prescription currently required** for first round of OCs, PEP and PrEP
• **Discreet, accessible and are perceived to be less judgmental and less stigmatizing**	• **Current cost of PrEP in the private sector prohibitive for most of the population.** Those with an ability to pay may not be willing to pay. Current cost of a monthly cycle of PrEP in pharmacies is between US $45 and $80
• **Walk-in users could access the DPP directly from pharmacies** with a link to a telemedicine or onsite provider	• **Only feasible for those pharmacies with a formal link to a telemedicine or onsite provider,** posing challenges for walk-in users to pharmacies without these links
• **By dispensing the DPP to users, pharmacies will become familiar with the commodity** and be able to advocate further for direct initiation opportunities	• **Pharmacies may be pressured to dispense without a prescription,** so close monitoring will be essential
• **PrEP pharmacy RCT underway,** which will provide key insights and lessons learned for the DPP through pharmacies	• **Dependent on results of pharmacy PrEP RCT** and MoH approving PrEP initiation through pharmacies
• **Use of AI for verification of HIVSTs being piloted** to ensure no user-error of test interpretation results prior to initiation	• **If MoH does not approve AI for HIVSTs verification post-pilot phase**, alternative methods of verification required and may require additional piloting, further delaying the approval for pharmacy full initiation

Whilst 60 physical "brick and mortar" pharmacies are involved in the pharmacy PrEP randomized control trial (RCT) that is taking place in multiple sites in Kenya, the results are not anticipated until the end of 2024. This does not allow sufficient time for the results to be used to inform policy and planning prior to the anticipated rollout of the DPP. It is therefore recommended that initial planning for pharmacy distribution of the DPP should be considered in pharmacies only where there is a direct link to a telemedicine provider, on-site clinician or nurse who can prescribe the DPP, as well as dispensing of the DPP prescribed by private physicians. Most of the large pharmacy chains in Kenya, such as Goodlife and Pharmaplus (who has over 100 pharmacies between them countrywide), as well as many private owned pharmacies, now have links with telemedicine providers that enable walk-in clients to speak to a clinician when a prescription is required prior to the pharmacist dispensing the medication.

For dispensing of the DPP that has been prescribed by a private physician, the users would have to pay the consultation fee for seeing the private physician to obtain their prescription to initiate the DPP. This could range from approximately US $15-30 depending on the location of the provider. However, if the user was to access the DPP as a direct walk-in client to a pharmacy who has a direct link to a telemedicine provider, this consultation fee would be lower. Fees for telemedicine providers vary, with some charging a fee per consultation and others charging a monthly or annual subscription, but fees are significantly lower than those of facility-based private providers. For example, HealthX Africa, a

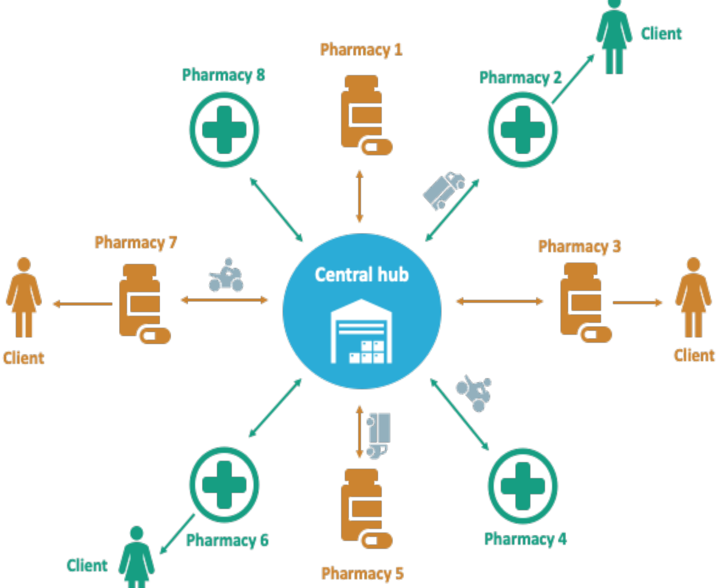
respected and growing Kenyan telemedicine company, is developing its formal relationship with pharmacies, charges US $2.70 for a month's access to the service.

The results of the pharmacy PrEP RCT will provide critical insights on opportunities for the DPP to be initiated and prescribed directly through pharmacies, including how clients would be counselled and tested for HIV prior to initiation. As the results of the RCT are due at the end of 2024, it is recommended that full initiation of the DPP in pharmacies be considered for Phase 2, when the lessons learnt from the RCT can be utilized to plan appropriately.

Part of the RCT involves assessing willingness to pay for PrEP through pharmacies, which will provide crucial insight for planning for the DPP, other PrEP commodities and other MPTs through direct pharmacy distribution. In this arm of the RCT, the pricing of PrEP will be US $2 to cover the costs of the pharmacist's time for service provision through community pharmacies, equivalent to a user fee. This does not include the cost of the commodity, which is provided for free during the study, or the cost of the HIVST kits. Still, this price is significantly lower than that of a private provider and also lower than that of a telemedicine provider, although this price may be different if mainstream, chain pharmacies were to roll out PrEP or the DPP.

During stakeholder consultations, in response to an initial market size estimate for the DPP,[9] it was recommended that not all pharmacies be selected for dispensing of the DPP, as volumes anticipated to be dispensed may not be sufficient to make it a worthy business proposition for all pharmacies.

Figure 1: Hub and spoke model of dispensing



Instead, they recommended a "hub and spoke" model for pharmacy dispensing, as shown. In Figure 1, whereby selected key pharmacies in anticipated high demand areas are selected, and users of the DPP be directed to those pharmacies through demand generation activities and by the prescribing clinicians.

Engagement with Maisha Meds could be advantageous for the DPP as their insights would support identifying pharmacies and locations in Kenya that are strategic to include in a hub-and-spoke model. Maisha Meds could also be a potential partner for assessing clients' willingness to pay and designing and implementing subsidy models, given their significant network of facilities and their ongoing programmes on FP and HIV prevention. With support from CIFF, Maisha Meds manages a digital platform that offers subsidized FP commodities at pharmacies and clinics across Kenya, reimburses providers and tracks their dispensation to verified patients. Through this project, in 2021, Maisha Meds supported technology platforms for 875 facilities

[9] Begg L, Brodsky R, Friedland B, Mathur S, Sailer J, Creasy G. Estimating the market size for a dual prevention pill: adding contraception to pre-exposure prophylaxis (PrEP) to increase uptake. BMJ Sex Reprod Health. 2021 Jul;47(3):166-172. doi: 10.1136/bmjsrh-2020-200662. Epub 2020 Jul 31. PMID: 32737137; PMCID: PMC8292580.

which resulted in 2.6 million patient encounters and directly paid for FP services for approximately 30,000 clients in 154 facilities across Kenya.[10] CIFF is also funding Maisha Meds to carry out a RCT to study the mechanisms that lead to the adoption of a new sub-cutaneous, self-administered injectable contraceptive (DMPA-SC) that can be self-administered, with one of the objectives to study the effectiveness of subsidies on the adoption of the commodity. In addition, Maisha Meds is looking at geographic analysis for efficiencies in healthcare subsidies, by combining mappings of disease burden, relative wealth/socioeconomic status and access to healthcare to identify areas that need subsidized health commodities and precise calibration of subsidies based on economic needs. Partnering with Maisha Meds could therefore also assist the DPP Consortium with identifying areas to be prioritized with subsidized commodities through the private sector, and the level of subsidy required.

The outcomes of the PrEP pharmacy RCT are crucial in determining the feasibility for whether the DPP, and other PrEP commodities and MPTs, can be initiated through pharmacies and whether the MoH approves its prescription and initiation through pharmacies outside of a study phase. It is recommended that the DPP Consortium works closely with the study consortium partners[11] and the MoH during the trials to ensure results and lessons learned during the study are known and used to support final decisions on the DPP rollout through pharmacies. This would include supporting modification of task sharing guidelines to allow pharmacists to prescribe PrEP as well as determining any reporting and quality assurance requirements.

3.1.3 Private providers and social franchises

Private providers and social franchises are selected for Phase 1 rollout of the DPP, as they have been engaged in FP and HIV activities for numerous years and many, particularly social franchises, have systems in place to distribute and report on the use of FP and HIV commodities, including PrEP either received through the MoH or subsidized commodities from donors.

Private providers and social franchises include NGOs, community-based organizations (CBOs) and FBO-managed or supported sites, as well as networked social franchises and other private facility networks, with coverage across the country, even in rural areas. For many clients, they are an important point of health care delivery, particularly for FP services.

[10] https://maishameds.org/2022/03/17/geographic-analysis-for-efficiency-in-healthcare-subsidies/#_ftn1

[11] The pharmacy PrEP RCT is funded by BMGF with partners including Fred Hutch Cancer Center, Kenya Medical Research Institute, Jomo Kenyatta University, Partners in Health & Research Development, University of Washington and Jhpiego.

Table 8: Advantages and disadvantages of private providers/social franchises initiating the DPP

Advantages	Disadvantages
• **Social franchises, NGO and FBO clinics are well known across the country** and have been providing FP and HIV services for many years	• **Private providers outside of social franchise and NGO/FBO clinics are not as engaged** in HIV prevention, care and treatment service provision
• **Currently initiate many FP methods**	• **Social franchises often focus on long-acting FP methods,** not short-term methods such as OCs, so significant support with demand generation for the DPP would be required for clients to know social franchises as a reliable and accessible access point for the DPP
• **Many social franchise and networked sites have community health workers (CHWs)** who provide home and community-based outreach services, which provides an opportunity to access potential users outside of facilities and distribute refills	• **PrEP has not been rolled out significantly through social franchises or private providers,** so additional pre-rollout engagement would be required in this channel
• **All required policies exist** and the only requirement would be additional training on PrEP initiation	• **Users may find cost of consultation fee on top of cost of commodity prohibitive**
• **Many social franchises and NGO/FBO clinics have systems in place** to report to MoH or to funders of subsidized commodities. MoH or subsidized commodities can only be distributed to sites who are able to report on uptake and consumption using the appropriate documentation	• **For non-NGO/FBO supported sites, reporting requirements to MoH or funders of subsidized commodities are considered cumbersome,** and quality of reporting is unclear, meaning that the MoH or funders will not distribute to them if they cannot provide quality data on uptake.

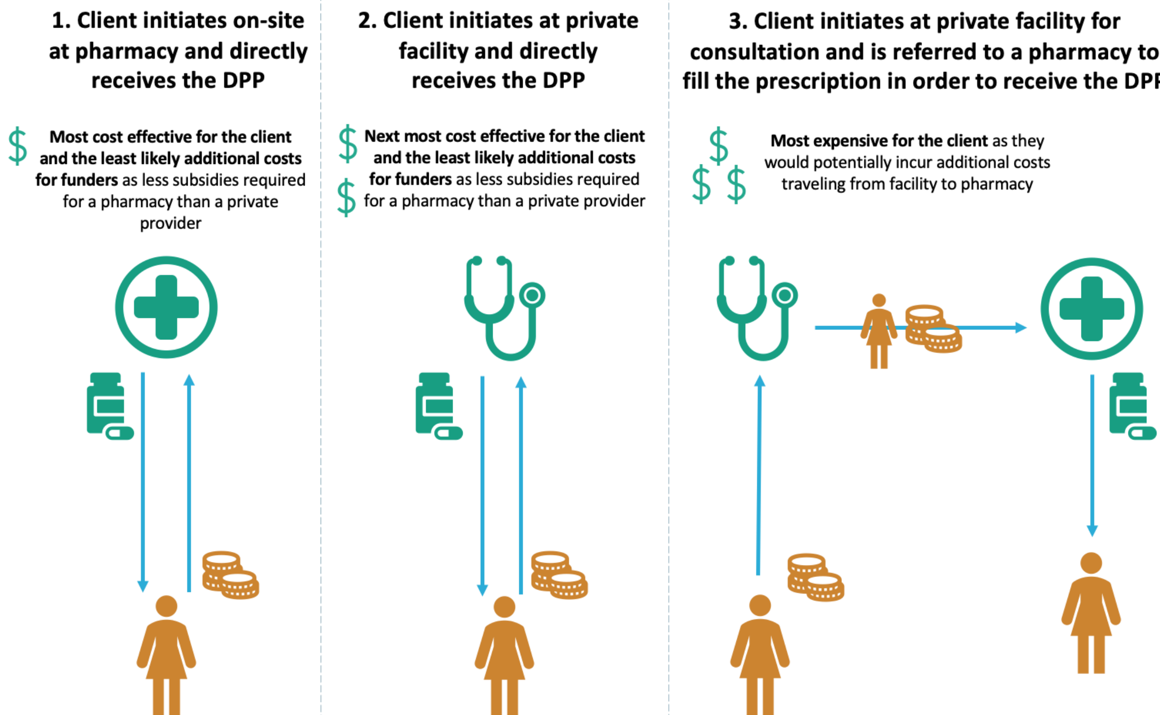
Box 3: Cost of consultation fees may be prohibitive

The cost of a consultation fee to initiate the DPP may be prohibitive for users, especially if they are also paying for the commodity itself and the HIVST kit. A consultation fee for a facility-based private provider alone can range between US $15 and $40, not including the cost of the commodity and ancillary services. Social franchises often charge a lower consultation fee, around US $8, and frequently charge a combined fee for commodity and consultation, which starts from approximately US $2.40 for OCs. Social franchises are extremely conscious of the price sensitivities in Kenya and have learnt from experience that adjusting prices too high means losing clients. PS Kenya, for example, found that removing a subsidy on HIVST kits changed the price from US $1.50 to US $6.20 resulted in a drop in sales from 9,000 to 1,200 per month.[12] For the DPP, a bundled pricing for commodity and consultation would be recommended, although the social franchise may require additional financing from a donor to keep the bundled cost low and attractive to users.

[12] Lessons from country level: best practices for FP introduction in the private sector – Kenya. PS Kenya presentation, October 12, 2022

Given that the cost of the DPP may be higher via private providers relative to other channels, and the interviews and consultations revealed concerns that demand for the DPP through this channel may not be as high as through social franchises, e-pharmacies or pharmacies, it would be more strategic and efficient for only selected providers who are anticipated to see high volumes of clients for the DPP to stock the commodity on-site. As small private providers outside of social franchises and NGO/FBO supported sites do not currently see high volumes of clients requesting PrEP, it could be assumed that the same would apply to the DPP unless there are significant subsidies not just for the commodity but also for consultation fees. Based on this, it may be more efficient and cost-effective for commodity distribution for small private providers not to stock the commodity but to prescribe and refer to specific pharmacies or providers stocking the DPP for dispensing, as can be seen in Figure 2. The identification of appropriate pharmacies will need to be carried out during the market introduction planning phase prior to DPP rollout to ensure prescribing physicians know where they can refer their clients to pick up the commodity or to arrange delivery to the client.

Figure 2: Dispensing of the DPP through pharmacies and facilities



In addition to their support to social franchises, some key NGO partners, such as PS Kenya, Marie Stopes Kenya and DKT have licenses for importing FP commodities into the country. They also have relationships with pharmaceutical commodity distributors and pharmacies as well as other private sector channels through whom they distribute their socially marketed commodities. These NGOs should be considered as a potential route to deliver the DPP in the private sector, either as a full-priced commodity or, as recommended in section 3.3.1, a subsidized commodity, as they already have reliable distribution and reporting systems in place. It is therefore recommended that the DPP Consortium engages with NGO partners such as PS Kenya, Marie Stopes Kenya and DKT to determine the feasibility of using their networks for the distribution of the DPP to private sector channels.

3.1.4 Telemedicine

Telemedicine is recommended as a Phase 2 channel, as platforms do not currently have dispensing capabilities and little or no experience in HIV prevention, care and treatment. Regulations for telemedicine are also not fully in place, with the national and county eHealth Bills still to be passed.

Table 9: Advantages and disadvantages of telemedicine providers initiating the DPP

Advantages	Disadvantages
• **Rapidly growing channel** that embraces new technologies for improved service delivery	• **National and County eHealth Bills not yet passed** so regulatory framework not fully in place
• **Currently receive many requests for FP and HIV services**	• **Most providers not trained in HIV services** and currently refer to other service providers
• **Many are building relationships and networks with reputable laboratories and pharmacies** to ensure more seamless, holistic services to their clients	• **Currently do not have a system for verifying HIVSTs** which would make the initiation of DPP users challenging
• **Discreet, accessible, with no face-to-face engagement,** reducing fear of stigma and discrimination	• **Users may find cost of consultation fee on top of cost of commodity prohibitive,** therefore reducing demand and use
• **Generally, have well-managed internal reporting and monitoring systems** so could be utilized for monitoring uptake and demand for forecasting	• **For the majority, no systems in place or willingness for reporting to MoH or funders** (currently only two out of over 40 businesses report to MoH)
• **Consultation fees significantly lower than those for facility-based providers,** with prices starting at US $2.70 for a month of consultations vs US $15 for a single visit to a facility-based provider	• **Additional costs may be required beyond consultation,** i.e., services for HIV testing or for accessing the DPP through a prescription at a pharmacy

As telemedicine companies report many requests from clients for ECs and PEP, as well as other FP and HIV commodities, they represent a practical entry point for potential DPP users, as the telemedicine provider can present the DPP as an appropriate commodity for clients when they connect for a consultation for ECs, PEP or other FP or PrEP commodities. They are also a constantly evolving and growing channel, embracing new technologies and willing to try new and improved approaches, and are likely to have further developed their systems and processes to be able to directly prescribe and dispense commodities by the start of Phase 2. Zuri Health for example, has expanded its telemedicine services from a short message service (SMS) platform to also provide WhatsApp and other app-based services as well as a continuous care program on subscription. Having seen a gap in holistic client service provision, they have also expanded to have an in-house pharmacy and laboratory service as well as to provide medical home visits for those who require them. They currently sell HIVST kits and OCs as part of their pharmacy products, and report that 50% of their SMS requests are for FP products.

HealthX Africa provides subscription-based telemedicine to individuals, companies and through medical insurance companies. Through its network of laboratories and pharmacies, it is able to arrange at-home tests, including HIVSTs well as home delivery for prescription medication. It is expanding to also provide virtual clinics and a “hospital-at-home” program. It has an FP screening and counseling system and sees spikes in calls on the weekend for ECs and PEP, and is able to prescribe and refer clients to facilities for these commodities.

The price of a consultation through a telemedicine provider varies, from around US $1 for a one-off consultation to approximately US $3.80 for a month’s access, and is significantly cheaper than that of a facility-based private provider, making telemedicine more financially appealing to users accessing the DPP through physicians.

Even though they have been selected for Phase 2, it is recommended that telemedicine partners be engaged early to explore their willingness as an initiating channel for the DPP, before or during Phase 1.

The DPP Consortium could consider working with one or two selected telemedicine companies, such as HealthX Africa and/or Zuri Health, who are already providing FP services and seeing demand for HIV prevention services, and are continually growing their business offering to respond to client demand, to discuss options for piloting the DPP through telemedicine as part of Phase 1 rollout.

3.2 Zimbabwe

After the initial scoping of private sector channels in Zimbabwe, in-depth discussions were held with various private sector providers, culminating in three consultations with:

a. Networked private providers, including pharmacies and implementing partners
b. NGO implementing partners, academics and donors engaged in FP and HIV prevention, care and treatment
c. Members of civil society organizations involved HIV prevention and treatment advocacy.

From the consultations, it was clear that private sector stakeholders are interested in supporting the rollout of the DPP, as well as other PrEP commodities and MPTs, but important work is still required to develop and build the systems and ecosystem necessary to support broad, country-wide private sector rollout of the DPP – as well as other PrEP and MPT commodities – in Zimbabwe. Ongoing and continuous planning and dialogue that builds on these initial consultations is needed with key stakeholders and the Ministry of Health and Child Care (MoHCC) to ensure that a fully functioning ecosystem is in place to support the rollout of the DPP. This includes engagement with the MoHCC to discuss options for public-private partnerships (PPPs), particularly now that they have launched their Strategic Framework for Tuberculosis and HIV Prevention, Treatment, Care and Support Public-Private-Partnership, 2021-2025 (TB and HIV PPP Strategic Framework), signaling an opportunity for further engagement in this area. It would be advised for the DPP Consortium to work through an organization such as OPHID, Pangaea Zimbabwe Aids Trust (PZAT) and/or other implementing partners based on their coverage and scope of work (i.e., population-based coverage and existing presence within communities) for cost-efficiencies and/or implementing partners with experience in outreach to key populations, given they are already engaging MoHCC around PPPs for HIV care and treatment.

The following private sector channels in Table 10 are recommended for the rollout of the DPP in Zimbabwe, but as outlined below, significant preparatory work using Human-Centered Design (HCD) approaches and in collaboration with local academic institutions will be required for each channel.

Table 10: Private sector delivery channels recommended for Zimbabwe

Timeline	Phase	Channel	Assumptions
2024-2025	1	Commercial franchises	• Interest in engaging on HIV and FP programming continues
		Social franchises and NGO/FBO supported sites	• Willingness to expand service offerings for new commodities continues
		Networked private providers with dispensing through pharmacies	• Enthusiasm to provide HIV prevention services, and to become a private sector channel for the DPP continues, as no significant involvement in HIV programming to date • Working relationship with Community Pharmacies Association (CPA) is strengthened and built upon to ensure appropriate referrals for dispensing
2026-2028	2	Pharmacies - full initiation	• Task-shifting to pharmacists will be approved by the MoHCC[13]
		PPPs across all private sector channels	• MoHCC implements its PPP strategy

Further detail on each of these channels, as well as the support and preparation work required to ensure their readiness for the DPP, is discussed below.

3.2.1 Commercial franchises

Commercial franchises are a new and growing sector in Zimbabwe and are made up of private clinic and hospital chains as well as facilities and clinics set up and managed by medical insurance agents and providers. Examples include CIMAS, CitiMed and CareNet.

Table 11: Advantages and disadvantages of commercial franchises initiating the DPP

Advantages	Disadvantages
• **Growing entry point** for service provision for those covered by medical insurance	• **Only feasible for those with medical insurance** or willingness and ability to pay out of pocket • **Located mostly in Harare and Bulawayo,** so not accessible to users outside of the main cities
• **Staffed with many cadres of clinical personnel** so can easily and efficiently provide all requirements from screening, risk assessment and HIV testing through to prescribing and initiation	• **Most have not been involved in PrEP service delivery** so could require significant training and capacity-building prior to initiation
• **Have efficient data, quality assurance and monitoring systems,** so would be able to provide accurate and timely reporting on uptake and demand	• **Most have no relationship with the MoHCC** so integrating systems for reporting to the MoHCC should they be allowed to distribute a government commodity could be challenging

[13] The Community Pharmacies Association has been working with the MoHCC to allow pharmacists to initiate PrEP, which requires that task-shifting for pharmacists be approved.

Commercial franchises have become extremely popular in urban and peri-urban settings among those who have medical insurance and/or are able to pay user fees with their disposable income, as they are often cheaper for users than standalone private providers. Monthly membership costs can range from as little as US $7 per month per beneficiary, up to US $180 per month depending on the plan. In many cases, they provide a 'one-stop' shop for all medical needs, as opposed to the public sector, where HIV testing and treatment services are free but involve long wait times, perceived lack of anonymity, are siloed into specific units (i.e., opportunistic infections/antiretroviral therapy, general wards) and are perceived to provide reduced quality of care due to limited human resources and high workload. While for these reasons, commercial franchises are recommended for Phase 1 rollout of the DPP, these facilities and clinics are predominantly based in Harare and Bulawayo and therefore this channel would only be appropriate for those who are living in or close to the main cities in the country, have medical insurance coverage (approximately 5% of the population[14]) or choose to access these private facilities.

As is shown in Table 11, HIV prevention, care and treatment is a new area for many commercial franchises, except a few who have existing agreements with the MoHCC, such as CitiMed. However, through the interviews and consultations, commercial franchises have shown a strong interest in being involved in the rollout of the DPP (and other PrEP and MPT commodities) and are keen to be engaged further in planning for DPP introduction in the private sector. Lessons learnt from CitiMed on providing HIV services through a commercial facility should be utilized to support other commercial franchises to prepare to roll out the DPP.

3.2.2 Social franchises and NGO/FBO-supported sites

Social franchises, including NGO- and FBO-supported sites, have been recommended for Phase 1 rollout of the DPP, as they have been engaged in FP and HIV activities for numerous years and have systems in place to distribute and report on use of commodities either received through the MoHCC or as subsidized commodities from donors.

[14] Labour and Economic Development Research Institute of Zimbabwe (LEDRIZ), 2022.

Table 12: Advantages and disadvantages of social franchises and NGO/FBO supported sites initiating the DPP

Advantages	Disadvantages
• **Social franchises, NGO and FBO clinics are popular access points for SRHR and HIV services,** are well established and respected	• **PrEP has not been rolled out significantly through social franchises,** so additional pre-rollout engagement required
• **Currently initiate many FP methods,** and have structures and systems in place to be able to roll out new commodities	• **Social franchises often focus on long-acting FP methods,** not short-term methods such as OCs
• **Many social franchise and NGO/FBO sites provide community-based and outreach services,** providing additional opportunity for accessing potential users and distributing refills	• **Funding for social franchises has decreased in recent years** with some franchises ceasing operations and donor subsidies decreasing
• **All required policies exist** and only requirement would be additional training	• **Users may find cost of consultation fee on top of cost of commodity prohibitive**
• **Many social franchises and NGO/FBO clinics have MoUs with the MoHCC** to receive and distribute MoHCC commodities	• **PPPs are not common in Zimbabwe** although the launch of the MoHCC PPP strategic framework should improve this

Social franchises and NGO/FBO-supported sites have broad coverage across the country, including rural areas, and are well-known and reputable. Their pricing is often significantly lower than private providers, due to receiving subsidized commodities and other financial, equipment, commodity and consumable support from funders, and as in Kenya, they provide bundled pricing for a consultation and commodity, which can be cheaper for the user, although it can add extra costs onto a funder.

In addition to the work they do to support social franchises, some key NGO partners, such as Population Services Zimbabwe and Population Solutions for Health (PSH) Zimbabwe, who both have MoUs with the MoHCC, also have importing licenses for pharmaceutical commodities. Given their strong relationships with the MoHCC as well as their ability to directly import FP commodities, they should be considered as a potential route for the DPP to reach the private sector, either as a full-priced commodity or, as recommended, a subsidized commodity, as they already have reliable distribution and reporting systems in place. They also have well-organized and managed channels for distributing FP commodities through the private sector and strong relationships with pharmaceutical commodity distributors and pharmacies, through whom they currently distribute socially-marketed commodities.

3.2.3 Networked private providers with dispensing through pharmacies

There are strong and well-managed membership networks of private providers in Zimbabwe, such as the Medical and Dental Private Practitioners of Zimbabwe Association (MDPPZA) and the Community Pharmacies Association (CPA).

Table 13: Advantages and disadvantages of networked private providers initiating the DPP

Advantages	Disadvantages
• **Strong private body practitioner networks** who can mobilize and coordinate with their members	• **Need to develop more formal structures with pharmacy networks** and between providers and pharmacists for a smoother initiation and dispensing process
• **Currently initiate all FP methods,** both short-term such as OCs and injectables and long-acting methods such as IUDs and implants	• **Private providers are not as engaged in HIV care and treatment service provision** compared to social franchises or the public sector
• **Coverage across the country**, from high density areas to rural parts of the country, ensuring equitable coverage	• **Users may find cost of consultation fee on top of cost of commodity prohibitive**
• **All required policies exist.** Only additional training would be required	• **Do not have reporting systems or structures** to MoHCC or funders and may find the additional requirements cumbersome and time-consuming

These networks have already been engaged in discussions around the feasibility of supporting the rollout of the DPP through private providers and see the opportunity that they can bring to clients as they report regular requests from clients for ECs, PEP and PrEP, all of which can be used as opportunities to introduce the DPP. Whilst they have not been significantly involved in wide-scale HIV prevention, care and treatment provision, they have been providing FP services to clients for many years and know the need for private sector involvement in HIV prevention is critical. Given their lack of involvement in HIV prevention to date, they would require significant training; however, this could be carried out as part of their regular Continuous Medical Education (CME) programmes and facilitated through their networks. As they are well-networked and organized, facilitating this should be relatively straightforward, as long as sufficient time is allocated during the planning and preparation for the rollout of the DPP in Zimbabwe and financial support for training development available.

Currently, to access SRH services from private providers, users pay a consultation fee which varies with ranges from US $2 for a private clinic in a high density area to US $80 for a private practitioner/specialist in an affluent, low-density suburb, which may be prohibitive for many users, particularly if they are paying for the commodity and HIVST. A subsidized commodity with a price-controlled HIVST would make paying a consultation fee to access the DPP through a private provider more accessible.

Selected pharmacies that are easily accessible from private providers prescribing the DPP should be engaged as dispensers of the DPP. This can be facilitated through the CPA, which expressed a keen interest to be engaged in DPP rollout. The MDPPZA and the CPA have also requested support to be able to create a more formal telemedicine-type link between private providers and pharmacies, so that potential users of the DPP who visit a pharmacy seeking the DPP (or other PrEP or MPT commodities) can be connected to a private provider for initiation without having to leave the pharmacy. This would be done by linking a pharmacy directly to a network of private providers who are constantly available through an app or WhatsApp network so that any walk-in client can have a consultation on-site. This would be an opportunity to support the development of systems that could have a significant impact on HIV and SRH service provision through the private sector.

Since private provider networks cannot independently cover the costs of training, systems design and testing of such telemedicine channels, a pilot project at a very small scale is recommended, with iterative learning to assess and improve cost-effectiveness. Implementing partners who work within the FP/HIV prevention and treatment space can play an important role in disseminating current MoHCC

guidelines, overseeing the initial program design and facilitating monitoring and evaluation of such networked partnerships, with the ultimate goal to improve implementation (which includes transition to oversight purely by private providers for sustainability and transition away from donor-funded costs over time).

Early engagement is particularly important for private providers and dispensing pharmacies in Zimbabwe as they have not been significantly involved in PrEP provision and dispensing and would need a long lead time to prepare and arrange their systems and providers. This would include identifying providers, facilities and pharmacies in potential high-demand areas, ensuring that training not only on the DPP but other HIV prevention methods is provided (as when the DPP is rolled out through private providers, it can be expected that interest in other methods is likely to increase too), ensuring that the appropriate supply chain and reporting systems are in place as well as engaging private providers in technical working group meetings that cover the DPP, as part of country-wide ecosystem-building for private sector participation in HIV prevention activities.

3.2.4 Pharmacies – full initiation

Pharmacies have been recommended as a Phase 2 channel for full initiation of the DPP.

Table 14: Advantages and disadvantages of pharmacies initiating the DPP

Advantages	Disadvantages
• **A popular entry point for healthcare** for the majority of the population, including the poorest, due to their shorter waiting times than the public sector, convenient locations and longer opening hours	• **PrEP only accessed with a prescription** so only initially feasible for dispensing (unless a connection with private providers can be established through a telemedicine-type link)
• **Currently distribute OCs, ECs, HIVSTs, PEP and PrEP** (prescription required for PEP and PrEP)	• **Current cost of PrEP in the private sector prohibitive for most of the population (approx. US $20),** so uptake has been low
• **Discreet, accessible and perceived to be less judgmental and less stigmatizing**	• **A high concentration of pharmacies are based in and around the main cities**, so less access for populations in rural areas
• **Willingness of pharmacists and pharmacy bodies to initiate the DPP** (and other PEP, PrEP and MPT commodities), as shown by efforts to engage the MoHCC on task-shifting	• **Resistance from private providers to have pharmacists initiate the DPP (and PrEP)**, as they see that their business would be taken away by the pharmacists
• **Would make accessing the DPP (and other PEP, PrEP and MPT commodities) much easier** and potentially quicker for users	• **Task-shifting discussions between CPA and MoHCC stalled**

Since 2021, the CPA has been working with the government to allow pharmacies to initiate PrEP through task-shifting of prescribing and initiating PrEP to pharmacists; however, this work has been paused whilst the MoHCC has been developing its TB and HIV PPP Strategic Framework. With the launch of this Strategic Framework in early 2023, it is hoped that there is now a platform for the re-engagement of CPA and other pharmacy bodies with the MoHCC on supporting task-shifting PrEP delivery to pharmacists. Private providers also need to support task-shifting and understand its importance to avoid them contesting the process and attempting to block it.

The authorization of pharmacies to initiate the DPP would provide a cheaper private sector channel for users than the other channels described, as pharmacies do not charge consultation fees, although they may charge a user fee depending on how the DPP is priced. As PrEP is not currently initiated through pharmacies, there is no comparative information on this to guide what a user fee for the DPP may be, but it would be expected to be lower than the cost of a consultation with a private provider.

As task-shifting has significant potential for other PrEP and MPT commodities to be initiated through pharmacies, it is important for the DPP Consortium (either directly or through a local implementing organization) to work with the CPA to support the task-shifting initiative.

3.2.5 Public-private partnerships across all private sector channels

Currently in Zimbabwe the only feasible option for the DPP to be rolled out through the private sector is through a route directly from manufacturer to private sector channels via intermediaries that are non-governmental. For the majority of the private sector channels discussed above, with perhaps the exception of some social franchise sites, there would be no distribution of government commodities through those channels. However, given the importance of the private sector in the future of sustainable, accessible and equitable healthcare in Zimbabwe, support to strengthen opportunities for PPPs for the DPP is strongly recommended. The TB and HIV PPP Strategic Framework is expected to reinvigorate MoHCC support for public-private partnerships. The proposed strategies will provide useful models for effective systems for private sector engagement, and introduction of systems to ensure safeguards of public commodities. This could be done through local partners such as OPHID, who are already working with the MoHCC on PPPs, and could be extended to support pilot or operational research work for the DPP.

The creation of a DPP private sector technical working group, with participation from all private sector channels as well as the MoHCC is recommended so that cross channel relationships are built, lessons shared and learnt and gaps in support identified.

3.3 Cross-cutting considerations

3.3.1 Financing and cost models

It is not yet known what the manufacturing or retail costs of the DPP will be. However, given that the current cost of PrEP through the private sector (currently between US $45 and $80 in Kenya and approximately US $20 in Zimbabwe) is above the anticipated willingness to pay of most potential users, it is unlikely that a non-subsidized commodity will be successful through the private sector. The cost of HIVST kits will also need to be considered, which can range from US $2 to $10 depending on the brand and whether it is subsidized, as well as any other clinical requirements for initiation as stipulated by local guidance which may need to be considered for subsidies as well. It is currently known that for many FP and HIV commodities, a price between approximately US $1 and $2 is generally acceptable,[15] with sales dropping significantly when pricing is above this level. However, this is based on other commodities, such as HIVST kits and OCs, and not an MPT, so conducting a willingness to pay study for the DPP is strongly advised to understand the acceptable level of pricing for the DPP and the required ancillary testing and services through the private sector. Engagement with Maisha Meds at this point, with results from their CIFF funded DMPA-SC RCT could also provide some useful insight into effectiveness of subsidies on the adoption of a new product and the role of incentives in the quality of FP counseling and adoption of a new product, at the pharmacy level.

[15] Based on feedback from partners involved in FP commodity distribution through the private sector in Kenya.

A willingness to pay study in the recommended private sector channels would determine both clients' and providers' willingness to pay – the latter to provide commodities which may require additional resources (such as human resources (HR), storage, client visit times for counselling and monitoring/reporting, training time, quality assurance) in different contexts (i.e., urban or rural settings) – in order to have context-appropriate and feasible rollout plans. Once the pricing of the DPP and willingness to pay is known, decisions can be made on how the DPP should be priced and to what extent it might need to be subsidized through the private sector.

Three options currently exist (Table 15) and are also applicable for determining the pricing of subsidization of other forms of PrEP or other MPTs through the private sector. For all the models, it would still need to be determined how HIVST kits and other required testing would be managed, and if a fixed or bundled price would be utilized.

Table 15: Options for pricing of the DPP through the private sector

Option	Benefits	Risks/Challenges
1. Fully priced DPP sold directly through the private sector	This option would **require the least management with little or no reporting to funders and MoH**, as the DPP would be purely treated as any other pharmaceutical commodity in terms of purchasing and distribution.	**The price of the DPP would be too high** for most/many users, therefore reducing demand significantly. The cost of unsubsidized pricing for HIVSTs and pregnancy tests, if required, **further increases the cost of initiating the DPP** through the private sector. Adding the price of a consultation fee on top of the commodity price **would further push the total pricing outside the willingness to pay of most**, if not all, potential users. **Uptake would be hard to track and manage as there would be no reporting to MoH or funders**, as the DPP would be managed by the providers like any other directly purchased commodity. This in turn would be a challenge for forecasting demand through the private sector.
2. DPP provided for free to the private sector from the public sector, with the user paying a consultation or user fee to the private provider	**Free commodities would ensure wider uptake through the private sector**, as additional cost could be minimal, depending on the channel (private providers charging a consultation fee may be higher than an e-pharmacy, brick-and-mortar pharmacy or social franchise)	**A reporting and accountability system would need to be in place.** This could be seen as cumbersome, time-consuming and an added expense for the provider, as their time taken for reporting takes them away from their other profit-making tasks. Often, reporting systems for MoH are not compatible with internal organizational systems, so there is duplication of paperwork, sometimes using manual and not electronic systems. Free commodities are potentially open to abuse/fraud, with private providers taking commodities that are meant to be provided for free and selling them at a cost, either through their facility or informal channels. In Kenya, working through an organization such as Maisha Meds in pharmacies, MYDAWA for e-pharmacies and PS Kenya or MS Kenya could limit this as the Maisha Meds platform has a strong fraud alert system. In addition, working through a licensed importer

Option	Benefits	Risks/Challenges
	Providers and implementers would be able to track uptake and demand for forecasting as systems for reporting will be in place	and distributor such as PS Kenya or MS Kenya or in Zimbabwe, working through PSZ or PSH could also help with limiting abuse/fraud, as their systems have been developed to flag any inconsistencies in distribution and sales data.
3. DPP sold to the private sector at a subsidized price with a fixed or recommended retail price	**Providers would determine the user and consultation fees** **Fixed pricing could ensure commodity pricing is within willingness to pay** abilities **Providers and implementers would be able to track uptake and demand for forecasting** as systems for reporting will be in place	If providers charge a high user or consultation fee, it could push the total cost of accessing the DPP above willingness to pay even if the pricing of the commodity itself is within willingness to pay. Planning on subsidization would therefore need to consider potential additional payments or subsidies for the providers to overcome this. As in option 2 above, a reporting and accountability system would need to be in place. As in option 2 above, subsidized commodities could be potentially open to abuse/fraud, so working through trusted partners who have systems in place to manage and oversee commodity distribution is strongly recommended.

In addition to the cost of the DPP, whether or not it is subsidized, there are other cost considerations for both the user, channel provider and potential funder. A summary of the cost implications per channel is outlined in Table 16.

Table 16: Cost considerations and implications per private sector channel

Country	Channel	Cost considerations	Implications
KENYA	E-pharmacies	1. Potential **consultation fee** with clinician (currently free, but may change after PrEP trial) 2. **Multiple delivery fees** - for both HIVST kit and the DPP	1. **Cheaper for users than private providers,** but subsidy may be required if fee introduced 2. **More expensive than pharmacy** (delivery fee), but time-saving
	Private providers	1. **Consultation fee** charged on top of HIVST kit and the DPP 2. Social franchises often have a **lower consultation fee** 3. Additional costs for user to collect the DPP if not stocked	1. **Cost of consultation fee likely prohibitive** 2. May require subsidy to provider 3. Social franchises can bundle consultation fee with the DPP to reduce cost to user
	Pharmacies with links to telemedicine providers and private providers for dispensing	1. **Consultation fee** likely to be charged by consulting prescriber 2. **No delivery fees** 3. Only one visit required for user (less transport costs)	1. **Cheaper for users than private providers** if subsidized consultation fee would be less than private providers 2. Convenient and quick for users, saving them time
	Pharmacies – full initiation	1. **No consultation fee** – may be a small user fee 2. **No delivery fees**	1. **Likely the cheapest option** as user fee would be minimal and no delivery fees 2. Consider subsidy to pharmacy to eliminate user fee
	Telemedicine	1. **Consultation fee** but not as high private providers 2. Cost of consultation often includes follow up 3. **Multiple delivery fees** – for both HIVST kit and the DPP	1. **Cheaper for users than private providers** 2. More expensive than a pharmacy with consultation fee 3. Convenient and quick for user, saving them time
ZIMBABWE	Commercial franchises	1. **Consultation fees covered through monthly membership** 2. Often paid through medical insurance so not out of pocket 3. For uninsured, consultation fee applies	1. **Cheaper for users than private providers** but insurance may require a subsidy 2. Would use up some of insurance benefits 3. More expensive than a pharmacy
	Social franchises and NGO/FBO supported sites	1. **Consultation fees** lower than private providers and commercial franchises 2. **No delivery fees** 3. Can import the DPP directly, reducing mark up on the DPP	1. **Likely to require subsidies to providers to ensure lower fees** 2. Can bundle price of HIVST kit and the DPP with consultation to lower fee
	Networked private providers	1. **Consultation fees** charged on top of HIVST kit and the DPP 2. Potential additional costs for user to collect prescription if not stocked by provider	1. **Cost of consultation fee on top of HIVST kit and the DPP likely to be prohibitive for many users** 2. May require subsidy to provider on top of DPP and HIVST kit subsidy
	Pharmacies	1. **No consultation fee** – minor user fee only 2. **No delivery fees**	1. **Would be the cheapest option** 2. May require small subsidy to pharmacy for consultation costs

3.3.2 Training and supportive technologies

Along with considerations for the public sector, plans for training all providers need to be put in place prior to the launch of the DPP. For many providers, this could be an upgrade of training on PrEP initiation. However, because the private sector has not been significantly involved in the rollout of PrEP, a more comprehensive training that covers the provision of PrEP as well as the DPP would be required for many providers. Thought needs to be given to how this could be done in an efficient and low-cost way that is also not time-consuming for private sector providers, as a lengthy training means time away from their business. This would deter them, as if they are not able to operate their business or see clients, they will typically be out-of-pocket financially. The cost of developing and providing the trainings will also need to be covered, as private providers would be reluctant to cover the cost of the training themselves unless it was heavily subsidized.

One option is to explore the opportunity for online training, similar to the trainings provided in South Africa by the Southern African HIV Clinicians Society (SAHCS). The training offered by SAHCS is provided through ongoing accredited continuous professional development (CPD) classes and webinars and leads to formal certification. This could be a worthy investment for trainings for other PrEP and MPT commodities. PS Kenya also provides trainings via WhatsApp, which is another potential option. There are currently no remote training opportunities in Zimbabwe, but the options for online training or WhatsApp-based trainings should still be explored.

Other supportive technologies beyond training should be considered for supporting screening, risk assessment, demand generation and identification of DPP providers. These tools include the MOSAIC/CATALYST user journey tool being developed which already has a provision for the DPP. This tool is currently being used at the facility level to support PrEP decision-making and counseling in the CATAYLST product introduction study (oral PrEP, dapivirine vaginal ring, CAB for PrEP) and expected to launch in Q2 2023. Tools that have the ability to assist with screening and risk assessment prior to initiation of the DPP (or other PrEP or MPT commodities) are also important to explore, as these could be extremely beneficial for reducing the time required for private sector providers prior to initiation, which is an added incentive.

4 Recommended actions and partners

There are various recommended actions and suggested partners to prepare for the rollout of the DPP in the private sector by country in 2024, as presented in Table 17 below.

Table 17: 2023 – 2024 roadmap to preparing for the private sector delivery of the DPP

Country	Market Consideration	Recommendation	Cost	Recommended Partner	2023				2024			
					Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Kenya	Financing	Conduct a willingness to pay study across different potential client groups (e.g. rural/urban) and private sector channels	Major (US $100k +)	Independent research agency Maisha Meds for identifying willingness to pay through pharmacies								
	Financing	Conduct a costing study with the different private sector channels to determine additional subsidies or payments that may be required to ensure consultation fees or user fees are within the levels of willingness to pay	Major (US $100k +)	Independent research agency								
	Policy/regulation	Develop an agreement with the pharmacy and e-pharmacy PrEP study investigators to have early access to study results so they can feed into the planning for the DPP	Minor (staff time)	MYDAWA, Jhpiego and lead study investigator								
	Financing	Develop an agreement with Maisha Meds to have early access to their CIFF funded DMPA-SC RCT results, which will provide key lessons on effectiveness of subsidies	Minor (staff time)	Maisha Meds								
	Public private coordination, Monitoring and evaluation, Supply chain	Work with MoH to determine supply chain, distribution and reporting requirements for private sector channels to access the DPP through government supplies and to report on usage and uptake	Medium (staff time and potential consultant costs)	PS Kenya, MSK, Jhpiego Ministry of Health								

Country	Market Consideration	Recommendation	Cost	Recommended Partner	2023				2024			
					Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Policy/regulation, Public private coordination	Create or utilize an existing technical working group, with participation from all selected private sector channels so that cross-channel relationships are built, lessons shared and learnt and gaps in support identified	Minor (staff time and meeting costs)	Implementing partner			■	■	■	■	■	■
	Policy/regulation	Engage with Jhpiego to identify additional support required for working with with GoK to increase support for pharmacy-based delivery and modifying task-sharing guidelines to allow pharmacists to prescribe PrEP	Minor	Jhpiego					■	■	■	■
	Supply chain	Work with PS Kenya and Marie Stopes Kenya to determine feasibility of using their networks for distribution of the DPP to private sector channels	Minor (staff time)	PS Kenya, Marie Stopes Kenya					■	■		
	Financing, Supply chain	Create and support a working group to determine whether HIVST kit subsidies will be bundled with the subsidies for the DPP to ensure uniform pricing for HIVSTs	Minor (staff time and meeting costs)	PS Kenya, Maisha Meds						■	■	
Zimbabwe	**Financing**	Conduct a willingness to pay study across different potential client groups (e.g. rural/urban) and private sector channels	Major (US $100k +)	Independent research agency			■	■	■	■		
	Financing	Conduct a costing study with the different private sector channels to determine additional subsidies or payments that may be required to ensure consultation fees or user fees are within the levels of willingness to pay	Major (US $100k +)	Independent research agency			■	■	■	■		
	Supply chain	Work with PSH and PSZ to determine feasibility of using their networks for distribution of the DPP to private sector channels	Minor (staff time)	PSH and PSZ			■	■	■	■	■	■
	Public private coordination, Monitoring and evaluation, Supply chain	Work with the MoHCC to discuss options for PPPs and to determine supply chain, distribution and reporting requirements for private sector channels to access the DPP through government supplies and to report on usage and uptake	Medium (staff time and potential consultant costs)	OPHID, PZAT and/or other implementing partners			■	■	■	■	■	■

Country	Market Consideration	Recommendation	Cost	Recommended Partner	2023				2024			
					Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Policy/regulation, Public private coordination	Create or utilize an existing technical working group, with participation from all selected private sector channels so that cross-channel relationships are built, lessons shared and learnt and gaps in support identified	Minor (staff time and meeting costs)	OPHID, PZAT and/or other implementing partners								
	Cross-cutting (M&E, Supply chain, Policy/ regulation)	Conduct a pilot project with the MDPPZA and the CPA to create a more formal telemedicine type link between private providers and pharmacies.	Major (US $100k +)	OPHID, PZAT and/or other implementing partners								
	Policy/regulation	Engage with the CPA to support task-shifting to pharmacists policy development	Minor (staff time)	CPA and OPHID								
	Financing, Supply chain	Create and lead a working group to determine whether HIVST kit subsidies will be bundled with the subsidies for the DPP to ensure uniform pricing for HIVSTs	Minor (staff time and meeting costs)									
Kenya and Zimbabwe	**Policy/regulation**	Engage with organizations implementing online trainings for PrEP service provision (SAHCS, PS Kenya) to determine if these could be adapted or developed for training providers on the DPP	Minor (staff time and meeting costs)	SAHCS, PS Kenya								

Annex 1 Glossary of terms for private sector delivery channels

Channel	Definition
E-pharmacy	A virtual shop or dispensary where drugs and products are prepared or sold online and dispensed by direct delivery to clients through various means including post, courier service and other newer methods such as "drop-off lockers." The drugs and health products that an e-pharmacy can provide differs between countries and is dependent on national laws and regulations.
Pharmacy	A physical private shop or dispensary where medicinal drugs are prepared or sold to clients over the counter. The drugs and health products that a pharmacy can provide differs between countries and is dependent on national laws and regulations. In Kenya, many of the pharmacies now have formalized links with telemedicine providers so that walk-in clients can access a clinician's services via telemedicine from within the pharmacy.
Networked private providers	A group of private clinicians, clinics and hospitals that make up an association or network. Such networks can be run by one company which runs several clinics or hospitals, or they can be part of private sector associations.
Commercial franchise	A network of private clinic and hospital chains or facilities and clinics set up and managed by medical insurance agents and providers.
Social franchises and NGO/FBO supported sites	Private clinics that are part of a branded and franchised chain or network. Typically these private networks are supported by a third party, which is often an NGO. NGOs also provide health services through numerous channels, including hospitals and clinics, mobile outreach services, community distribution and, in some cases, provide support to other private providers such as franchised networks. Many NGOs provide health services in urban and semi-urban areas.
Telemedicine	The provision of healthcare remotely by means of telecommunications technology for the purpose of providing remote health assessments, healthcare and therapeutic interventions. Some telemedicine companies are also dispensing pharmaceutical products including FP commodities.

Annex 2 List of organizations and individuals interviewed and who participated in the consultation meetings

Multi-country

- FHI 360
- MOSAIC Project
- Jhpiego
- CHAI
- Audere

Kenya

National & sub national governments, MoH, regulatory bodies, logistics & supply bodies

- KEMSA
- NASCOP
- NHIF
- Kenya Medical Association
- Kenya Pharmaceutical Association
- Pharmaceutical Association of Kenya
- Pharmacies and Poisons Board
- Country Youth Advisory Council
- Nursing Council of Kenya
- Clinical Officers Association
- SUPKEM

Key donors and development partners, implementing agencies

- Bill and Melinda Gates Foundation
- USAID
- FHI 360
- Jhpiego
- LVCT Health
- KEMRI
- WACI Health

Private sector organizations, networks and associations

- Access Afya
- Penda Health
- Kenya Association of Private Hospitals
- Kenya Healthcare Federation

Pharmacies and drug shops

- Maisha Meds
- Goodlife Pharmacy
- Lifemed Pharmacy
- MYDAWA

Telehealth

- HealthXAfrica
- Zuri Health
- Byon8

- Kasha
- Aviro
- Triggerise

NGOs & FBOs with a focus on community-based distribution & mobile outreach
- Marie Stopes Kenya
- PS Kenya
- KMET
- Tunza

Zimbabwe

National & sub national governments, MoH, regulatory bodies, logistics & supply bodies/organizations
- USAID Global Health Supply Chain Program Procurement and Supply Management (GHSC-PSM) (previously Chemonics)
- MoHCC

Key donors and development partners, implementing agencies
- Pangaea Zimbabwe AIDS Trust (PZAT)
- The Organization for Public Health Interventions and Development (OPHID)
- CHAI

Private sector organizations, networks and associations
- Medical and Dental Private Practitioners of Zimbabwe Association (MDPPZA)
- Premier Services Medical Services
- Private Doctors
- Private Nurses
- Private Midwives
- Citmed Hospital
- Zimbabwe HIV Clinicians Society

Pharmacies and drug shops
- Supermed Pharmacy
- M&M Friendly Care Pharmacy
- BR Pharmacy
- Community Pharmacies Association
- Private Pharmacists

Telehealth
- Zimbabwe Telemedicine Network

NGOs & FBOs with a focus on community-based distribution & mobile outreach
- The Centre for Sexual Health and HIV/AIDS Research Zimbabwe (CeSHHAR)
- London School of Hygiene and Tropical Medicine (LSHTM)
- The Organization for Public Health Interventions and Development (OPHID)
- Population Services for Health (PSH) – formerly PSI Zimbabwe
- University of Zimbabwe – Clinical Trials Research Unit (UZ-CRTU)
- Zimbabwe Health Interventions (ZHI)
- Population Services Zimbabwe (PSZ) – an affiliate of MSI Choices