



# Service Delivery Strategy for the Dual Prevention Pill

October 2020

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- 1. Service Delivery Channel Selection Criteria and Phasing**
2. Service Delivery Channel Analysis
  - a. Kenya
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3. Recommendations for Phased Implementation and Pilot Design

# DPP Service Delivery (SD) Strategy proposes prioritized delivery channels to rapidly generate evidence during pilots and inform DPP scale-up

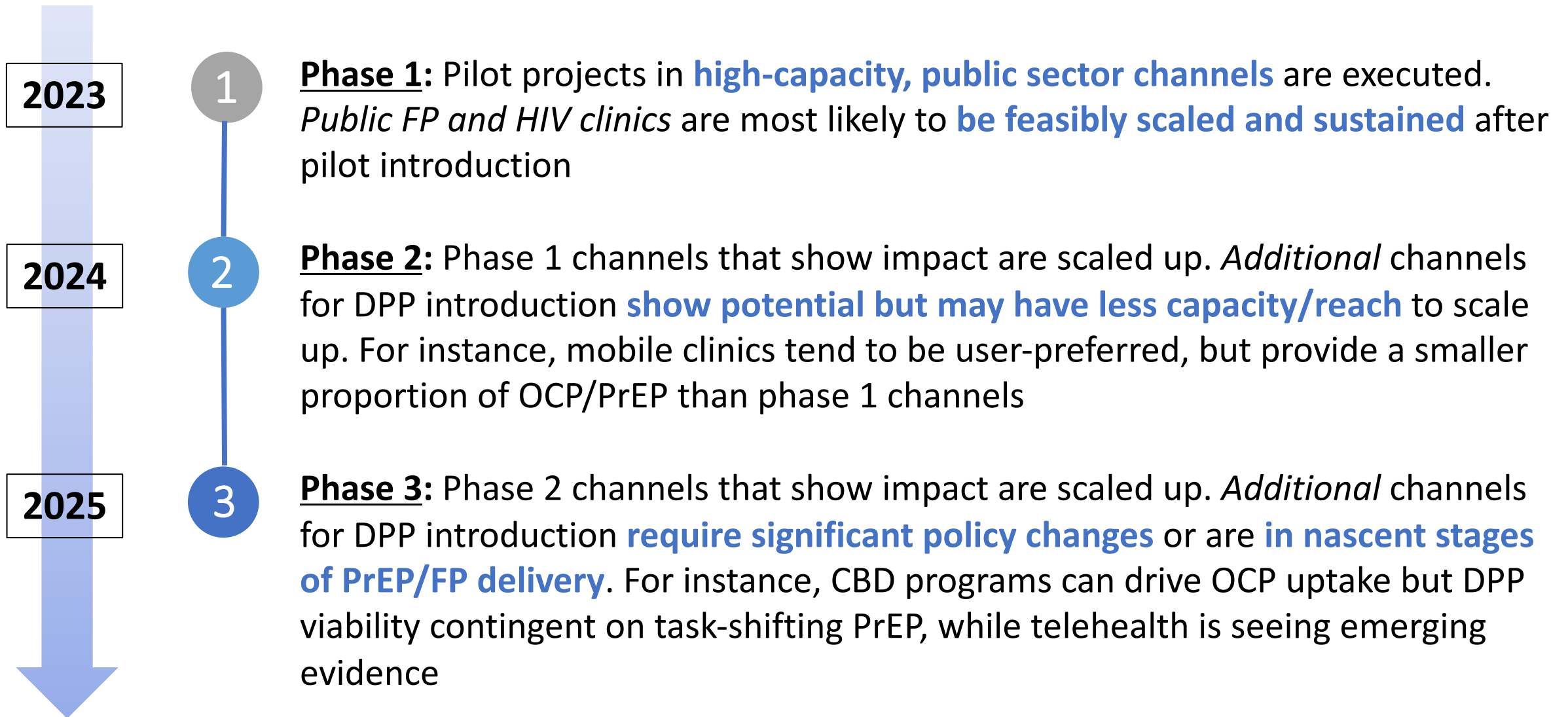
SD Strategy will inform:

- ✓ **Pilot project** design in Kenya, South Africa and Zimbabwe
- ✓ **Country-level adaptations** to optimize delivery channels
- ✓ **Service delivery investments** from donors and governments

SD Strategy is:

- ✓ **Iterative** and **responsive** to ongoing country decision-making and new evidence as it emerges
- ✓ **Intended to be adapted** to other countries/contexts
- ✓ **One component** of the broader Market Preparation & Introduction Strategy **for the DPP**, which will guide introduction planning efforts

A phased approach to introduction begins with strengthening existing health systems, followed by pilot projects in public HIV and FP clinics. Phases 2 and 3 will scale pilot channels and introduce new channels



Each phase is designed to assess and compare channels within and across countries. Public FP and HIV clinics recommended for Phase 1. Learnings generated from private sector and innovative models will dial in potential prior to introduction in later phases

Phase	Kenya	South Africa	Zimbabwe
<b>Phase 1</b>	<ul style="list-style-type: none"> <li>Public FP clinics</li> <li>Public HIV clinics</li> </ul>	<ul style="list-style-type: none"> <li>Public FP clinics</li> <li>Public HIV clinics</li> </ul>	<ul style="list-style-type: none"> <li>Public FP clinics</li> <li>Public HIV clinics</li> </ul>
<b>Phase 2</b> <i>(additional channels)</i>	<ul style="list-style-type: none"> <li>Mobile clinics</li> <li>Social franchises/NGO clinics</li> <li>Pharmacies</li> <li>DICE/Pop-Specific Site</li> </ul>	<ul style="list-style-type: none"> <li>Mobile clinics</li> <li>Social franchises/NGO clinics</li> <li>Pharmacies</li> <li>DICE/Pop-Specific Site</li> </ul>	<ul style="list-style-type: none"> <li>Mobile clinics</li> <li>Pharmacies</li> <li>DICE/Pop-Specific Site</li> </ul>
<b>Phase 3</b> <i>(additional channels)</i>	<ul style="list-style-type: none"> <li>Private providers</li> <li>Telehealth</li> <li>Direct-to-Consumer</li> </ul>	<ul style="list-style-type: none"> <li>Private providers</li> <li>Universities</li> <li>Telehealth</li> <li>Direct-to-Consumer</li> </ul>	<ul style="list-style-type: none"> <li>CBD program</li> <li>Universities</li> <li>Telehealth</li> <li>Direct-to-Consumer</li> </ul>
<b>Policy Changes</b>	<ul style="list-style-type: none"> <li>PrEP prescribing, multi-month dispensing at public FP clinics and pharmacies</li> <li>Multi-month OCP dispensing (MMD)</li> <li>NHIF covers FP/PrEP</li> </ul>	<ul style="list-style-type: none"> <li>PrEP prescribing at public FP clinics</li> <li>PrEP prescribing, MMD at pharmacies</li> <li>NHI covers FP/PrEP, GPs included</li> </ul>	<ul style="list-style-type: none"> <li>PrEP prescribing at public FP clinics</li> <li>Align age of consent for PrEP/FP</li> <li>Task-shifting PrEP delivery to pharmacists, CHWs</li> </ul>

# Potential delivery channels were assessed using criteria to determine those most likely to generate evidence and scale to impact

CRITERIA	HIGH-OPPORTUNITY INDICATORS
<b>Alignment with User Behaviors &amp; Preferences</b>	<ul style="list-style-type: none"> <li>Where users access and initiate PrEP/FP (utilization)</li> <li>Where users <u>want</u> to receive services</li> </ul>
<b>Cost-effectiveness</b>	<ul style="list-style-type: none"> <li>Setting and services cost-effective</li> <li>Sustainable funding source exists</li> </ul>
<b>Health System Readiness</b>	<ul style="list-style-type: none"> <li>High <u>capacity</u> (# clients, sites, providers trained in HIV and FP)</li> <li>PrEP, FP, HTS available; few stockouts</li> <li>High level of/potential for integration</li> </ul>
<b>Strength of M&amp;E Systems</b>	<ul style="list-style-type: none"> <li>Indicators capture PrEP, FP, HTS, health outcomes</li> <li>Data links into national M&amp;E system</li> </ul>
<b>Scalability</b>	<ul style="list-style-type: none"> <li>Evidence of reach, effectiveness &amp; cost-effectiveness</li> <li>Sufficient human resources for health</li> <li>Quality assurance mechanisms exist</li> <li>High functioning procurement, M&amp;E systems aligned for HIV/FP commodities and reporting</li> </ul>

*Within each channel, criteria were categorized as low, medium or high risk/opportunity.*

Low opportunity/  
High risk/  
Not enough info

Medium  
opportunity/  
Medium risk

High opportunity/  
Low risk

HIV and FP clinics have greatest capacity to deliver & scale DPP in public sector; most likely to reach OCP/PrEP users. NGO models, pharmacies show most potential in Kenya, RSA

	Service Delivery Channel	Alignment with User Behaviors & Preferences	Cost-effectiveness	Health System Readiness	Strength of M&E Systems	Scalability	KENYA	SOUTH AFRICA	ZIMBABWE
Public	HIV Clinic						1	1	1
	FP Clinic						1	1	1
	DICE/Pop-Specific Site						2	2	2
	Mobile Clinic						2	2	2
	CBD Program						X	X	3
Private	Pharmacist (1st re-supply)						2	2	2
	NGO Model/ Social Franchising						2	2	X
	GP/Private Provider						3	3	X
	University						X	3	3
	Direct-to-Consumer (D2C)						3	3	3
	Telehealth						3	3	3

*\*Numbers in country columns correspond to the phase recommended to introduce DPP in that channel. "X" signifies channel will not be prioritized.*

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In Kenya, offer substantial support to users to counter stigma and low OCP use. Work with experienced PrEP partners to introduce DPP in high-capacity channels for HIV and FP in the public sector, then leverage private sector opportunities



**KEY USER INSIGHTS**

**OCP**

- **Low OCP use/high discontinuation & switching**
- **OCP users likely** married, older, urban, wealthier, have children

**PrEP**

- **SDC & FSW majority of PrEP users**
- Though **females <30 years account for greater share** of PrEP users, **AGYW remain below targets**
- **Continuation increases with age**; higher for those in SDCs
- **Societal stigma** major barrier to PrEP
- Personalized counseling, f/u reminders, syncing refills, PrEP support groups work



**RECOMMENDED DELIVERY CHANNELS**

**PHASE 1**

- Public FP clinic
- Public HIV clinic

**PHASE 2**

Public FP clinic & HIV clinic



- Mobile clinic
- Social franchise/NGO clinic
- Pharmacy
- DICE/Pop-Specific Site

**PHASE 3**

All impactful channels above






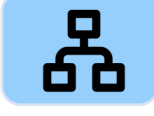



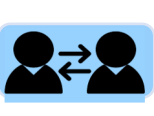

- Private Provider
- Telehealth
- D2C

**POLICY CHANGES**

- Multi-month OCP dispensing (MMD)
- PrEP prescribing, MMD at pharmacies
- NHIF covers FP/PrEP
- PrEP prescribing at public FP clinics
- Reduced PrEP clinical monitoring

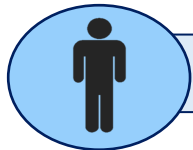
# In Kenya, public FP clinics reach OCP users and have begun to deliver PrEP. Public HIV clinics are primary PrEP channel, but may have limited reach due to stigma



	CHANNEL	PROS	CONS	PHASE
	FP clinic	<ul style="list-style-type: none"> <li>40% access OCP; modest PrEP uptake, <b>higher uptake among women 24+ and OCP users</b></li> <li>Well-scaled already and cost-effective</li> </ul>	<ul style="list-style-type: none"> <li>Provision of PrEP in FP clinics still limited due to historic siloes, little PrEP scale-up outside CCCs</li> <li>FP providers need training in PrEP/ART provision</li> </ul>	1
	HIV clinic	<ul style="list-style-type: none"> <li>Strong uptake of PrEP and FP, esp. among SDCs</li> <li>Providers trained in ART, likely also FP</li> </ul>	<ul style="list-style-type: none"> <li>Stigma persists, esp. outside of SDCs</li> <li>PrEP scale-up nascent in public HIV clinics</li> <li>PrEP M&amp;E a challenge, reporting increased 10% to 54%</li> </ul>	1
	DICE/Pop-specific site	<ul style="list-style-type: none"> <li>81% Jilinde clients started PrEP in DICES</li> <li>Tend to integrate HIV/SRH services</li> </ul>	<ul style="list-style-type: none"> <li>Sites tend to be smaller, donor-dependent</li> <li>Less geared toward general population</li> </ul>	2
	Social franchise/ NGO clinic	<ul style="list-style-type: none"> <li>~5 social franchises, supporting 1,000+ clinics</li> <li>Likely uses EMR, linked to DHIS2, public system</li> </ul>	<ul style="list-style-type: none"> <li>Transitioning to “facilitative” role; can impact delivery</li> <li>Highly donor dependent, reliant on subsidy</li> </ul>	2
	Mobile clinic	<ul style="list-style-type: none"> <li>~67% public SDPs have either mobile outreach team or CHWs</li> </ul>	<ul style="list-style-type: none"> <li>Reach of model, # providers may be limited</li> <li>Labor/cost-intensive to scale; viable if has high uptake</li> </ul>	2
	Pharmacy	<ul style="list-style-type: none"> <li>47% access OCP in pharmacies</li> <li>UW PrEP pilot may pave way for PrEP delivery</li> </ul>	<ul style="list-style-type: none"> <li>Re-supply gaining momentum but can't offer PrEP yet</li> <li>Pharmacists would need training to counsel, prescribe</li> </ul>	2
	Private provider	<ul style="list-style-type: none"> <li>High access (&gt;3,000/63% private facilities)</li> <li>10% access OCP via private providers</li> </ul>	<ul style="list-style-type: none"> <li>Prescribe, sell modest level of ART, PrEP, likely lower reach than pharmacies; providers will need HIV training</li> </ul>	3
	Telehealth	<ul style="list-style-type: none"> <li>Proof-of-concept (for primary healthcare, not PrEP) shown to work, is on rise due to COVID-19</li> </ul>	<ul style="list-style-type: none"> <li>Cannot be fully virtual; clients must access labs/ pharmacies in person (no mail-based options); low reach</li> </ul>	3
	D2C	<ul style="list-style-type: none"> <li>Could increase access and decrease stigma for those with resources to purchase directly</li> </ul>	<ul style="list-style-type: none"> <li>Few to no options shipping to Kenya; cost prohibitive for most; risks accessing meds with no health screening</li> </ul>	3



In South Africa, counseling and continuation support will be key, as few women use OCP/PrEP. Most providers require training, with added support to pharmacists



### KEY USER INSIGHTS

#### OCP



- **Higher rates OCP** use among older women
- **33% OCP users discontinue** in 12 mos.
- Informed choice and counseling on range of FP methods lacking

#### PrEP



- Low PrEP awareness, limiting uptake
- **Women age 35+ consistently have highest PrEP continuation rates** and women age 19-24 have the lowest (2.2 avg. months)



### RECOMMENDED DELIVERY CHANNELS

#### PHASE 1

- Public FP clinic
- Public HIV clinic

#### PHASE 2

Public FP clinic  
Public HIV clinic



- Social franchise/NGO clinic
- Mobile clinic
- Pharmacy
- DICE/Pop-specific site

#### PHASE 3

All impactful channels above






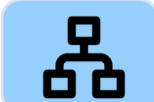






- Private Provider
- University
- Telehealth
- D2C

#### POLICY CHANGES

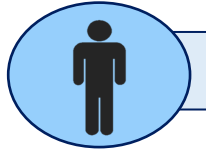
- PrEP prescribing, MMD at pharmacies
- NHI covers FP/PrEP, GPs included
- PrEP prescribing at public FP clinics
- Reduced PrEP clinical monitoring

In South Africa, national PrEP scale-up will position HIV clinics to deliver DPP at scale. Most OCP obtained in public sector, making FP clinics a natural entry point



	CHANNEL	PROS	CONS	PHASE
	FP clinic	<ul style="list-style-type: none"> <li>75% access OCP in public sector</li> <li>FP entry point to PrEP for AGYW &amp; vice-versa; higher uptake together</li> </ul>	<ul style="list-style-type: none"> <li>Provision of PrEP in FP clinics still limited due to historic siloes, little PrEP scale-up outside CCCs</li> <li>FP providers need training in PrEP/ART provision</li> </ul>	1
	HIV clinic	<ul style="list-style-type: none"> <li>PrEP scale-up to all geographies/pops underway</li> <li>Sites capacitated, well-resourced w/donor support</li> </ul>	<ul style="list-style-type: none"> <li>Low PrEP uptake among DPP target pop; limited FP here</li> <li>Need to train providers on OCP dispensing, promotion</li> </ul>	1
	DICE/Pop-specific site	<ul style="list-style-type: none"> <li>AGYW sites highest HTS, PrEP initiation rates</li> <li>Tend to be youth-friendly, offer flexible hours</li> </ul>	<ul style="list-style-type: none"> <li>Lower AGYW OCP use</li> <li>Nurses must be NIMART-trained to provide PrEP</li> </ul>	2
	Social franchise/ NGO clinic	<ul style="list-style-type: none"> <li>50% clients on OCP in Unjani clinics</li> <li>~70 clinics, 40k clients/mo; plans to scale to 1m</li> </ul>	<ul style="list-style-type: none"> <li>PrEP delivery currently limited; possibly lower Rol</li> <li>Highly donor dependent, rely on subsidy</li> </ul>	2
	Mobile clinic	<ul style="list-style-type: none"> <li>FP use or initiation fosters same-day PrEP start; highly user-preferred. Strong reach in Cape Town</li> </ul>	<ul style="list-style-type: none"> <li>2% OCP and FP accessed here; reach may be limited</li> <li>Labor/cost-intensive to scale; viable if has high uptake</li> </ul>	2
	Pharmacy	<ul style="list-style-type: none"> <li>16% access OCP in pharmacies</li> <li>71% community pharmas, likely to see DPP pops</li> </ul>	<ul style="list-style-type: none"> <li>Scale contingent on ability to prescribe PrEP; pharmacists would need training; 3<sup>rd</sup> party payer needed</li> </ul>	2
	Private provider	<ul style="list-style-type: none"> <li>6% access OCP via private providers</li> <li>SAHIVCS initiated training for PrEP; NHI priority</li> </ul>	<ul style="list-style-type: none"> <li>Prescribe/sell some ART, PrEP, but training needed</li> <li>Fewer (24%) consult private sector when ill/injured</li> </ul>	3
	University	<ul style="list-style-type: none"> <li>Campus clinics provide FP and range of services; Heaids supports to ensure quality care</li> </ul>	<ul style="list-style-type: none"> <li>Only 2% access PrEP in universities</li> </ul>	3
	Telehealth	<ul style="list-style-type: none"> <li>Existing guidelines; mobile app interventions increased FP knowledge, ART/PrEP adherence</li> </ul>	<ul style="list-style-type: none"> <li>Guidelines restricted to existing provider-client relationship, meds accessed via pharmacies; low reach</li> </ul>	3
	D2C	<ul style="list-style-type: none"> <li>Could increase access and decrease stigma for those with resources to purchase directly</li> </ul>	<ul style="list-style-type: none"> <li>Few options shipping to South Africa; cost prohibitive for most; risks accessing meds with no health screening</li> </ul>	3

# In Zimbabwe, clearly and thoroughly promoting DPP will be needed to reach women. Partner with orgs that support public sector clinics as entry point for phase 1 channels



## KEY USER INSIGHTS

**OCP**

- **OCP use highest** in married women 20-39, but low risk perception
- **OCP discontinuation, switching** due to stockouts
- Relative OCP use decreases slightly with age

**PrEP**

- **AGYW 30%** of PrEP initiations in 2020
- While AGYW are growing % of PrEP initiations, **KPs remain primary target pops for MOHCC**
- **HTS is well-promoted**; potential DPP entry point to counter general low PrEP awareness



## RECOMMENDED DELIVERY CHANNELS

**PHASE 1**

- Public FP clinic
- Public HIV clinic

**PHASE 2**

- Public FP clinic & HIV clinic +
- Mobile clinic
  - Pharmacy
  - DICE/Pop-Specific Site

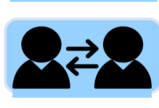
**PHASE 3**

- All impactful channels above +
- CBD Program
  - University
  - Telehealth
  - D2C

**POLICY CHANGES**

- Task-shifting PrEP delivery to pharmacists, CHWs
- Align age of consent for PrEP/FP
- PrEP prescribing at public FP clinics
- Reduced PrEP clinical monitoring

# In Zimbabwe, introducing DPP in public FP and HIV clinics builds on existing delivery channels with high capacity and broadens scope of potential users



CHANNEL	PROS	CONS	PHASE
<b>FP clinic</b>	<ul style="list-style-type: none"> <li>• <b>60% access OCP in public sector.</b> FP more readily available than HIV services</li> <li>• <b>PrEP delivery</b> at high-volume ZNFPC sites</li> </ul>	<ul style="list-style-type: none"> <li>• Low provider PrEP awareness; referrals after negative HIV test uncommon. Will need training.</li> <li>• Limited resources to scale PrEP</li> </ul>	<b>1</b>
<b>HIV clinic</b>	<ul style="list-style-type: none"> <li>• Primary delivery channel for PrEP, FP generally well-integrated – well-placed to scale</li> <li>• Nurses have basic FP training</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Stigma persists</b>, esp. outside of SDCs</li> <li>• PrEP scale-up slower. Dependent on partner support, but generally better-funded than SRH</li> </ul>	<b>1</b>
<b>DICE/Pop-specific site</b>	<ul style="list-style-type: none"> <li>• <b>High PrEP continuation</b>; successful at reaching youth; user-preferred; tend to integrate HIV/SRH</li> </ul>	<ul style="list-style-type: none"> <li>• Sites tend to be <b>smaller, donor-dependent</b></li> <li>• Less geared toward general population</li> </ul>	<b>2</b>
<b>Mobile clinic</b>	<ul style="list-style-type: none"> <li>• <b>4% access OCP</b> in mobile clinics; women 2x more likely to access FP via mobile services</li> <li>• <b>Effective at reaching</b> new FP clients, AGYW, FSW</li> </ul>	<ul style="list-style-type: none"> <li>• Training on PrEP needed; not typically offered</li> <li>• Likely less opportunity to scale</li> </ul>	<b>2</b>
<b>Pharmacy</b>	<ul style="list-style-type: none"> <li>• <b>25% access OCP</b> in pharmacies; available OTC</li> <li>• Pharmacists can provide HTS, counsel on PrEP</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Small % pop can afford PrEP prices</b>; stockouts common</li> <li>• Macroeconomic issues may limit delivery</li> </ul>	<b>2</b>
<b>CBD Program</b>	<ul style="list-style-type: none"> <li>• <b>5% access OCP</b> via village health worker (VHW); established CBD program through ZNFPC</li> <li>• New FP users <b>increased by 4% each month</b></li> </ul>	<ul style="list-style-type: none"> <li>• No PrEP currently offered; task-shifting needed</li> <li>• FP stockouts a challenge</li> </ul>	<b>2</b>
<b>University</b>	<ul style="list-style-type: none"> <li>• <b>80% students who use FP</b> obtain from uni clinics</li> <li>• OCP and injectables subsidized</li> </ul>	<ul style="list-style-type: none"> <li>• PrEP largely not available; providers would need training</li> </ul>	<b>3</b>
<b>Telehealth</b>	<ul style="list-style-type: none"> <li>• large RCT in Manicaland Province underway, could show proof of concept for telehealth</li> </ul>	<ul style="list-style-type: none"> <li>• <b>No current telehealth guidelines, power outages and limited internet coverage</b> in rural areas</li> </ul>	<b>3</b>
<b>D2C</b>	<ul style="list-style-type: none"> <li>• Could increase access and decrease stigma for those with resources to purchase directly</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Few to no options for shipping; cost prohibitive for most</b>; risks accessing meds with no health screening</li> </ul>	<b>3</b>



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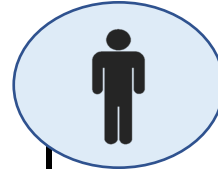
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Across countries, pilot projects aim to understand potential impact of the DPP; feasibility to deliver the DPP in various channels; and DPP users



## IMPACT/OUTCOME MEASURES

- **Uptake/continuation** of DPP compared to PrEP/FP methods offered
- **New initiations** of PrEP/FP via DPP uptake
- **% switching** to DPP from PrEP/other FP methods
- **Cost/cost-effectiveness** of delivering DPP
- **Net health impact** on FP/HIV outcomes



## USER CONSIDERATIONS

- **Leading with FP** drives PrEP uptake
- **Side effects** are a barrier to continuing OCP/PrEP use
- **Older women have higher rates of OCP** use, PrEP continuation
- **Adherence** to daily pill a challenge
- **Women change** contraception methods over life cycle



# Illustrative Questions for Pilot Project Design

- How does **DPP uptake/continuation** compare across pilot sites, channels, other methods, different segments of women?
  - What are **clinical outcomes** of the DPP (i.e. sero-conversions, pregnancy, side effects, STI incidence)?
  - What is **cost/cost-effectiveness** of delivering the DPP in each setting?
  - What is **optimal positioning** of the DPP vs. other FP/Px methods?
- What are characteristics of women that initiate the DPP in each setting?
  - What are common reasons for discontinuation or switching? What support do women need if HIV or pregnancy status changes while on the DPP?
  - What motivates or inhibits providers to offer the DPP to a client?
  - What training, supervision, other support are required for providers to correctly deliver the DPP?
  - What is optimal clinic flow, mix of cadres, hours and areas of operation to maximize reaching clients with DPP?

# In the near-term, there are critical activities that can prepare for and inform the design of pilot implementation

## ACTIVITIES

## SYSTEMS STRENGTHENING

## PILOT PROJECT

### PROVIDERS & USERS



- **Train more providers** to deliver integrated HIV/SRH services in FP and HIV clinics
- **Expand demand generation** activities for PrEP

- **Conduct HCD research with women and providers** to understand motivators, barriers, biases
- **Develop, test and refine** provider behavior change interventions, job aids/decision & screening tools
- **Identify optimal clinic flow** for DPP delivery
- **Develop counseling messages** that build on existing FP/PrEP counseling

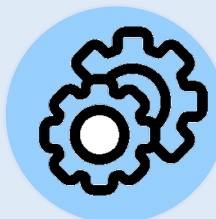
### M&E



- **Facilitate integration** of PrEP/FP programmatic data at national and facility levels

- **Conduct modeling** to hone service utilization estimates
- **Develop/adapt M&E tools** to support facility data collection
- **Identify appropriate indicators** to measure success

### ENABLING ENVIRONMENT



- **TA to MOH to adapt guidelines** to allow for MMD, task-shifting of PrEP; **strengthen coordination mechanisms** for integrated delivery

- **Review and package** learnings, data and tools from PrEP and FP implementation
- **Design/embed sub-study** on demand generation

*These activities are illustrative and do not represent all activities that will be undertaken.*

**ANNEX**

# Purpose, Methods & Limitations of Analysis

## Purpose

To inform prioritization of service delivery channels for DPP pilot projects and scale-up

## Methods

- Literature reviews
- Key informant interviews
- Review of available data

## Limitations

- Limited recent data on PrEP/OCP provision by specific service delivery points
- Limited recent literature on OCP delivery (greater focus on LARCs)
- Limited private sector data on PrEP and OCP provision
- Limited evidence on telehealth, direct-to-consumer channels in focus countries
- PrEP delivery is being scaled rapidly; data is thus subject to change

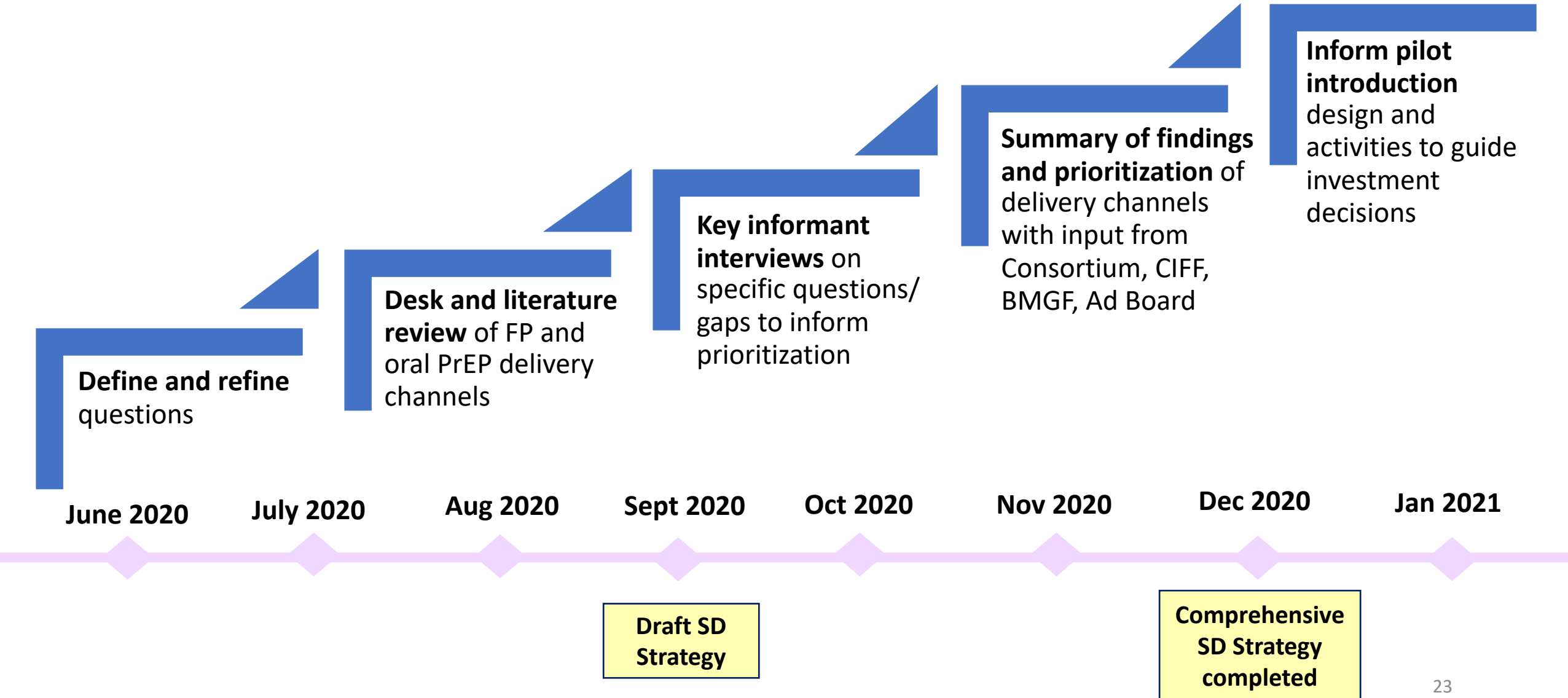
# Research Limitations

	Public (medical)	Public (non-medical)	Private sector
<b>Oral Contraception</b>	<ul style="list-style-type: none"> <li>Greater focus in recent lit on injectables, LARCs and FP generally, rather than OCP</li> <li>Service delivery settings often part of intervention description; not primary objective of studies</li> </ul>	<ul style="list-style-type: none"> <li>Pre-dates PrEP by decades; outdated</li> <li>Greater focus on LARCs</li> <li>Focused on proving safety/feasibility/non-inferiority of task-shifting to CHWs, not service delivery setting</li> </ul>	<ul style="list-style-type: none"> <li>Dated research limited on OCP - consumer and provider preferences and behaviors.</li> </ul>
<b>Oral PrEP</b>	<ul style="list-style-type: none"> <li>Some PrEP research outside HIV clinics, but limited</li> <li>PrEP not always integrated w/FP, even for target pops, i.e. FSW, SDCs</li> </ul>	<ul style="list-style-type: none"> <li>Non-facility based provision still nascent and research limited</li> </ul>	<ul style="list-style-type: none"> <li>Very little data available on private sector provision of PrEP</li> </ul>
<b>Priority Population and Geography</b>	<ul style="list-style-type: none"> <li>Many FP studies focused on postpartum women, not a viable target pop for DPP</li> <li>PrEP studies focus on AGYW, other high-risk pops; not women of repro age</li> </ul>	<ul style="list-style-type: none"> <li>No recent studies on community provision of OCP in DPP countries</li> <li>OCP research focuses on women of repro age whereas oral PrEP on AGYW</li> </ul>	<ul style="list-style-type: none"> <li>PrEP studies focus on AGYW, other high-risk pops; not women of repro age.</li> </ul>
<b>Policies and Programs</b>	<ul style="list-style-type: none"> <li>Research on effects of policies/laws and programs on access to health services is primarily descriptive and qualitative, rather than quantitative.</li> <li>Not much insight into effects of policies/laws and programs on specific service delivery channels</li> </ul>		

# Experts and Primary Studies Consulted

- CHAI Country Teams
- Ivan Kotze, South African Pharmaceutical Society
- Francois Venter, University of Wits, South African Medical Association; South African HIV/AIDS Clinicians Society
- Andy Gray, Pharmaceutical Sciences, University of KZN; National Essential Medicines List
- Sham Moodly/Natalie Martyn, ICPA/Jackie Maima, ICPA; Pharmacy Council
- Ernest Darkoh, BroadReach Healthcare
- Ian Sanne, Right to Care
- Saiqa Mullick, Director of Implementation Science, Wits RHI
- Joseph Murungu, Senior Technical Advisor, Pangaea Zimbabwe AIDS Trust (PZAT)
- Ministry of Health, Kenya (NAS COP, Department of Family Health)
- PriYA
- Partners Scale Up
- Partners Demonstration Project
- Jilinde
- Project PrEP
- POWER
- DTHF Youth Centre
- Shaz! Hub
- ZNFPC PrEP pilot study
- PREPARE study
- DIFFER study
- CAPRISA 008
- Girl Power study
- Various systematic reviews

# DPP SD Strategy analyzes available evidence to decide which delivery channels to prioritize for DPP introduction and scale-up



In Kenya, public FP clinics reach OCP users and have begun to deliver PrEP. Public HIV clinics are primary PrEP channel, but stigma may limit reach



Channel	OCP delivery	PrEP delivery	Potential # users	Alignment w/ User Behaviors & Preferences	Cost-effectiveness	Health System Readiness	Strength of M&E Systems	Scalability	Policy changes required	Phase rec
<b>FP/MCH/PMTCT clinic</b>	40% of OCP users	14% of PrEP SD points	High	Modest PrEP uptake, <b>higher among women (24+), OCP users</b> ; continuation increases w/age	Costs <b>decreased 38%</b> when PrEP integrated into FP clinics run by MOH	Provision of PrEP in FP clinics still limited; <b>FP providers need training</b> in PrEP/ART provision	FP M&E reporting quite strong, but no age/SDP disaggregation	<b>Well-scaled already</b> ; likely to reach target users	MMD for OCP; PrEP prescribing at public FP clinics	<b>1</b>
<b>HIV clinic</b>		57% of PrEP SD points	Medium	<b>Strong uptake of PrEP and FP, esp. among SDCs</b> , highest % PrEP users; high retention; stigma persists	Cost savings for more effective FP use, economies of scale	<b>Scaling PrEP</b> in 24 HIV clinics potential entry point; <b>Providers trained in ART, likely also FP</b>	PrEP M&E a challenge, reporting increased 10% to 54%	Scale-up of PrEP underway; fewer provider training barriers	Reduced clinical monitoring for PrEP	<b>1</b>





**PHASE 2/3**

**DICEs/safe spaces** deliver substantial proportion of PrEP; **pharmacies** would be promising channel for OCP users to access DPP once permitted to prescribe PrEP

Channel	OCP delivery	PrEP delivery	Potential # users	Alignment w/ User Behaviors & Preferences	Cost-effectiveness	Health System Readiness	Strength of M&E Systems	Scalability	Policy changes required	Phase rec
<b>DICE/AGYW safe space</b>		29% (4% DICES, 25% safe spaces)	Medium	<b>High uptake, esp. for younger women;</b> high client satisfaction	Integrated sites cost-effective but often donor \$	Tend to integrate HIV/SRH services; Providers often trained on 1-stop shop services	Donor \$ can require more reporting but little avail info	Sites smaller, but models likely to reach target pops		<b>2</b>
<b>Social franchise/ NGO/FBO clinic</b>	1% of OCP users		Low	Recruited to <b>align to needs of women,</b> but <b>data mixed</b> on quality of care, reach, uptake	<b>Highly donor dependent,</b> reliant on subsidy; high start-up/ops costs	~5 social franchises, <b>supporting 1,000+ clinics;</b> Providers well-trained; seen as friendly, convenient, high quality	<b>Likely enrolled in EMR,</b> linked to DHIS2 & public systems	Model transitioning to “facilitative” role; can impact direct delivery		<b>2</b>
<b>Mobile clinic</b>	<1% of OCP users		Low	High user preference; effective at PrEP delivery	Likely cost-effective to add DPP to units	~ <b>67% public SDPs</b> have mobile outreach team or CHWs; but reach may be limited	Data can be inconsistent, incomplete	Labor/cost-intensive to scale; viable if has high uptake		<b>2</b>
<b>Pharmacy or shop</b>	47% OCP users	Yes but limited	High	Main OCP SDP; accessible, discreet, convenient, quality	Opp for broad reach but 3 <sup>rd</sup> party payer needed	Re-supply gaining momentum; Need training to counsel, prescribe	Many by hand, very difficult to access	Future opps to support initiation	PrEP prescribing, MMD	<b>2</b>
<b>GPs and private clinics</b>	10% OCP users	Yes but limited	Medium	Modest OCP access here	NHIF does not yet cover FP/PrEP	Prescribe, sell modest level of ART, PrEP; Few have HIV experience	Many still have paper systems; DHIS2 growing	Lower reach than pharma	NHIF covers FP, PrEP	<b>3</b>
<b>Telehealth</b>			Low			Proof of concept (primary care, COVID)		Lower reach		<b>3</b>
<b>D2C</b>			Low							<b>3</b>
<b>CBD</b>	1% of OCP users	Not avail	Low	Use of all FP methods increased 5x via CHEWs	Underfunded; resource constraints	Established FP CBD program through MOH; FP stockouts	Limited info available	Task-shifting PrEP needed	Task-shifting PrEP delivery	<b>X</b>

In South Africa, national PrEP scale-up will position HIV clinics to deliver DPP at scale. Most OCP obtained in public sector, making FP clinics a natural entry point



Channel	OCP delivery	PrEP delivery	Potential # users	Alignment w/ User Behaviors & Preferences	Cost-effectiveness	Health System Readiness	Strength of M&E Systems	Scalability	Policy changes required	Phase rec
<b>FP/MCH/PMTCT clinic</b>	75% of OCP users		High	<b>FP entry point to PrEP for AGYW &amp; vice-versa; higher uptake together</b>	Well-established FP sites with broad reach	Provision of PrEP in FP clinics still limited; <b>FP providers need training</b> in PrEP/ART provision	Strong DHIS reporting system	<b>Well-scaled already</b> ; likely to reach target users		1
<b>HIV clinic</b>	Yes but limited		High	<b>Low PrEP uptake among DPP target pop</b> to-date; limited FP here	Well-resourced w/external donor support	Sites typically capacitated; need to train HIV providers on OCP dispensing, promotion	Strong M&E reporting system; QA for HIV in place	<b>PrEP scale-up to all geographies and populations underway</b>		1

**PHASE 2/3** Public AGYW-focused sites help drive PrEP initiations. Pharmacies provide considerable % of OCP, and will provide PrEP refills



Channel	OCP delivery	PrEP delivery	Potential # users	Alignment w/ User Behaviors & Preferences	Cost-effectiveness	Health System Readiness	Strength of M&E Systems	Scalability	Policy changes required	Phase rec
<b>AGYW, FSW-specific sites</b>		23% FSW; 64% AGYW	High	<b>Highest HTS (250k), PrEP (50k) initiation rates of PrEP sites</b> , lower AGYW OCP use. Girls <18 had 4x more FP visits to YF clinic vs. public clinic	Often donor-supported	YF, flex hours, but all services not always offered; Nurses must be NIMART-trained to provide PrEP	Decent HIV reporting	Proven high-capacity for HTS, PrEP		1
<b>Mobile clinic</b>	2% of OCP users		Medium	<b>FP use or initiation fosters same-day PrEP start</b> ; highly preferred. Strong reach in Cape Town; links to 24 fixed facilities	Cost-effective to operate mobile units	Reach of model and #, cadres of providers may be limited; likely easy to add DPP	Data can be inconsistent, incomplete	Labor/cost-intensive to scale; viable if channel has high uptake		2
<b>Social franchise/ NGO clinic</b>	1% of OCP users		Medium	50% clients on OCP in Unjani clinics; higher than nat'l #	Highly donor dependent, rely on subsidy	~70 clinics, 40,000 clients/ mo; PrEP limited; Providers well-trained	Limited data visibility in private sect	Aim to engage 1 million clients; possibly low Rol		2
<b>Pharmacy or shop</b>	16% of OCP users		High	PrEP re-supply gaining momentum; NHI priority	Opp for broad reach but 3 <sup>rd</sup> party payer needed	Accessible w/high reach; only manage tx after initial script; pharmacists require training/support to prescribe	M&E rarely integrated w/ hospital or provider systems	Scale contingent on ability to prescribe PrEP; priority for NHI coverage	PrEP prescribing, MMD; NHI covers FP/ PrEP	2
<b>GP/Private Provider</b>	6% of OCP users		Medium						GPs included in NHI	3
<b>University</b>		2% PrEP users	Low							3
<b>Telehealth</b>			Low							3
<b>D2C</b>			Low							3 <sup>27</sup>

# In Zimbabwe, introducing DPP in public FP and HIV clinics builds on existing delivery channels with high capacity and broadens scope of potential users



Channel	OCP delivery	PrEP delivery	Potential # users	Alignment w/ User Behaviors & Preferences	Cost-effectiveness	Health System Readiness	Strength of M&E Systems	Scalability	Policy changes required	Phase rec
<b>FP/MCH/ PMTCT clinic</b>	60% of OCP users (40% via rural health center)	Yes but limited	High	<b>Decent PrEP uptake, continuation of FP users;</b> higher % SDC, 26-40 years. OCP linked w/PrEP continuation	FP program has 55% resource gap, made up w/user fees	FP more readily available than HIV services; <b>PrEP delivered at high-volume ZNFPC sites;</b> Low provider PrEP awareness; referrals after negative HIV test uncommon. Need training.	Strong M&E systems for HIV and FP	Limited resources to scale PrEP but infrastructure in place	Align age of consent for PrEP and FP	<b>1</b>
<b>HIV clinic</b>		Yes	Medium	<b>Likely to reach PrEP target pops,</b> esp. SDC. <b>Stigma persistent;</b> women reluctant to go for Px	Dependent on partner support; generally better-funded than SRH	Primary delivery channel for PrEP, FP generally well-integrated; Nurses have basic FP training	ePMS covers 80% ART clients. Rolling out EHR for PrEP	Since PrEP/FP offered, <b>well-placed to scale</b>		<b>1</b>

DICEs/population-specific sites show high PrEP continuation and are user-preferred. Pharmacies are OCP source but PrEP not yet affordable and stockouts common



Channel	OCP delivery	PrEP delivery	Potential # users	Alignment w/ User Behaviors & Preferences	Cost-effectiveness	Health System Readiness	Strength of M&E Systems	Scalability	Policy changes required	Phase rec
<b>DICE/Pop-Specific Site</b>		Yes	Medium	High PrEP continuation; successful at reaching youth; user-preferred	Integrated sites cost-effective but often donor \$	Tend to integrate HIV/SRH services; Providers often trained on 1-stop shop services	Donor \$ can require more reporting but little avail info	Sites smaller, but models likely to reach target pops		<b>2</b>
<b>Mobile clinic</b>	4% of OCP users		Medium	<b>Effective at reaching</b> new FP clients, AGYW, FSW, women with less education	Cost-effective to operate units	Potentially less reach, but high rural OCP/FP demand; Training on PrEP needed; not typically offered	Data can be inconsistent, incomplete	Likely less opportunity to scale		<b>2</b>
<b>Pharmacy or shop</b>	25% OCP accessed here	Yes but limited	High	OCP access common but <b>small % pop can afford prices</b> for PrEP	DPP would need to be heavily subsidized	OCP avail OTC; PrEP refills avail but stockouts common; pharmacists can provide HTS, counsel on PrEP; creatinine tests, PrEP not offered	Private sector reporting is limited; gaps for FP, HIV	Scale contingent on ability to prescribe PrEP	Task-shift PrEP delivery	<b>2</b>
<b>CBD Program</b>	5% VHW	Not avail	Medium	Effective at FP delivery; new FP users <b>increased 4% each month</b>	Lower implementation costs	Established program via ZNFPC but PrEP not offered; FP stockouts	Limited info available	Task-shifting PrEP needed	Task-shift PrEP delivery	<b>3</b>
<b>University</b>			Low							<b>3</b>
<b>Telehealth</b>			Low							<b>3</b>
<b>D2C</b>			Low							<b>3</b>
<b>GP/Private Provider</b>	5.5% of OCP users		Medium							<b>X</b>