

The Private Sector

Extending the Reach of Provider-Initiated HIV Testing and Counseling in Kenya



Penelope Riseborough, JSI

As part of Kenya's national HIV strategy, health care providers are adopting provider-initiated testing and counseling to increase their patients' knowledge of HIV status.

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In a small town in Kenya's Western Province, sugar cane is king. Two giant sugar cane plantations provide jobs and generate heavy truck traffic that fills the hot air with dust. In the center of town is a small strip of shops and businesses: vegetable sellers, a tailor, and a bar. Tucked in among them is the town's primary private health clinic, which serves up to 20 patients a day. The simple cement structure has two rooms with a pit latrine in back, worn bench seats, paper registers—no computer, no laboratory—and a very basic “pharmacy”: some plastic medicine bottles on a bookshelf.

Although the clinic is very modest, the aging physician who owns and operates it is a dynamo. Dr. George (a pseudonym), who retired from the public health system after 20 years of service, is an energetic, committed man who speaks quickly and emphatically. He knows the town and its inhabitants well; this is where he grew up and has remained for most of his 60-plus years. His mission is to serve his neighbors, but he is intensely aware that despite his years of experience, he needs more training to help his clients who are infected with HIV.

“I never learned HIV management, and we still did not know much when I was at the district hospital,” he said. “But I see patients every day who look to me for answers. I need to learn because it is affecting my community. We [private physicians] want training!”

Dr. George is typical of independent, private, for profit providers in Western Province, Kenya. Like him, many are among the older

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WHAT DO PRIVATE HEALTH PROVIDERS SEE AS THE ADVANTAGES OF PITC?

- PITC captures patients who would not seek out HIV services.
- Patients appreciate HIV testing and counseling being offered as part of a package of care when visiting the clinic for other services.
- Patients have an established and trusting relationship with private providers, making PITC acceptable in the private sector.
- The five-day PITC training is shorter than the three-week VCT training, making it more feasible for providers to close a clinic to attend training.
- Unlike VCT, which requires its own room, PITC takes place in the same consultation room where the client is first seen, which makes it easier for even small private clinics to adhere to standards.

generation of clinical staff, medical officers, and nurses who retired from the public sector and are now operating community clinics of their own. Other types of private facilities include large for profit hospitals, company-run workplace clinics that serve employees and the surrounding community, and hospitals and community clinics run by faith-based organizations.

Many staff at these private facilities lack formal training in HIV diagnosis and management, and those who have been trained need refresher courses. Every day, they see firsthand how HIV affects their communities, so when the opportunity arises to develop new skills, many jump at the chance.

Dr. George is one of 200 private health providers who, since 2008, participate in provider-initiated testing and counseling (PITC) training facilitated by the AIDS, Population, and Health Integrated Assistance Program in Western Province (APHIA II Western, or A2W). In fact, he closes his doors and forgoes several days of income so that he can attend workshops. Since he started training, Dr. George counsels and tests approximately 15 clients per month. Most of his clients come to the clinic for a variety of reasons, but usually not for HIV testing.

“PITC is better than voluntary counseling and testing [VCT],” he says. “Instead of watching my patients come and go with the same illnesses over and over, I never miss an opportunity to help them know their [HIV] status.”

Provider-Initiated Testing and Counseling: Part of Kenya’s National HIV Strategy

The Government of Kenya seeks to reach one of its universal access targets—that 80 percent of Kenyans know their HIV status—by the end of 2010. According to the 2007 Kenya AIDS Indicator Survey, HIV prevalence among adults aged 15 to 49 years is 5.7 percent among Kenyans and 4.9 percent in Western Province. Nearly 67 percent of Kenyans have never been tested for HIV, and 84 percent of people

living with HIV are unaware of their status. The disparity in testing rates between urban and rural residents is noteworthy: 50 percent of urban residents have received HIV testing at least once, compared to 30 percent in rural areas like Western Province (Republic of Kenya 2007). To close the gap, Kenya is using PITC as one strategy to address its generalized HIV epidemic.

As in many countries, VCT has been the traditional way for individuals to learn their HIV status. However, barriers limit uptake of HIV testing, including low perceived risk for HIV: about 47 percent of Kenyans who reported never having been tested said they did not consider themselves to be at risk for HIV (Republic of Kenya 2007). To overcome these challenges, Kenya's Ministry of Health (MOH) implemented PITC because too few people were seeking VCT, which was impeding progress toward the universal access targets. Individuals starting antiretroviral therapy (ART) did not fully benefit from the life-saving treatment because they tested late in the course of HIV infection. Policymakers realized that there were many missed opportunities within the health sector for an earlier diagnosis.



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In 2004, the Kenyan Government issued guidance on PITC (National AIDS and STI Control Programme [NASCO] 2004), which contributed to subsequent guidelines issued in 2007 by the World Health Organization (WHO) and the Joint U.N. Programme on HIV/AIDS (UNAIDS) recommending that all patients in generalized epidemics be routinely tested for HIV at health facilities regardless of the reason for their visit (WHO and UNAIDS 2007). In 2008, the Kenya MOH mandated PITC throughout the health sector (NASCO 2008).

Getting the Private Sector Involved in Provider-Initiated Testing and Counseling: The APHIA II Western Project

Kenya has one of the most developed private health sectors in the region. The private sector in Western Province comprises a range of health care workers, including nurses, clinical officers, midwives, doctors, pharmacists, and laboratory technicians, working in a variety of settings from small, private for profit clinics and pharmacies in rural settings, to large, privately owned, full-service hospitals and company-run clinics (Barnes et al. 2010). Estimates of the private health care market in Kenya top 20 billion Kenyan shillings (approximately US\$2.7 billion), and the private sector owns nearly two-thirds of health facilities in Kenya (Barnes et al. 2010). In Kenya, 45 percent of the lowest-income quintile and 49 percent of rural residents receive their care from private for profit providers (International Finance Corporation 2007). The private sector plays a large role for Kenyans in many disease areas, including HIV

testing and counseling; half of women and over a third of men go to private providers for HIV testing (Barnes et al. 2010).

To tap into the potential reach of the private sector, the A2W project includes components to build capacity among private providers. A2W is a four-year (2006 to 2010) PEPFAR-funded project implemented through the U.S. Agency for International Development by the Program for Appropriate Technology in Health (PATH) to promote adoption of healthier behaviors among Western Province residents and increase use of health services, including HIV services. PATH leads implementation of the A2W project, and BroadReach Healthcare provides facilitation management for all private sector activities. A2W's mandate is to support service delivery in the public sector, as well as improve the capacity of the private sector to offer HIV services, emphasizing PITC. A2W's focus on the private sector includes stand-alone, for profit community clinics and mission-based clinics, private for profit hospitals and mission hospitals, and company-run health care facilities.

A2W implementers were aware that there were not enough government health facilities to effectively cover the 4.68 million residents living in Western Province. They also knew that the population relies heavily on the private sector for health services. At the start of the project, A2W conducted a mapping exercise of private providers and confirmed that the private sector provides a substantial portion of health services in Western Province. The exercise also revealed that private providers' priorities are training and accreditation for HIV counseling, testing, and treatment. Yet opportunities for such training were lacking.

To fill the gap, A2W now offers logistical support to the MOH and NASCOP to provide training for

private providers using the standardized national PITC curriculum. A2W also facilitates periodic stakeholder meetings in each district, where private providers and district health officials meet to troubleshoot challenges and discuss lessons learned. Post-training, providers have access to donor-funded test kits through the public sector. A2W initiates the connection between private providers and the commodity supply organization, but providers are responsible for maintaining access to kits thereafter through regular reporting to the suppliers.

Although district health offices are responsible for providing supportive supervision for all health facilities in both the public and private district, resource constraints have historically limited the amount of supportive supervision given to private providers. To strengthen PITC-related activities, A2W provides logistical support for district health officials conducting supportive supervision visits at private facilities. A2W implements numerous other strategies, including some that enhance PITC uptake, such as community mobilization for HIV testing and health education for communities and families, and strengthening the delivery of HIV care and treatment.

To facilitate HIV testing in the private sector, providers who receive PITC training register with the district health management team (DHMT) to ensure their inclusion on the master list for HIV test kits. Providers report that some DHMTs also offer access to other commodities, such as gloves, gauze, and registers for reporting information and data. Private providers who offer PITC report their HIV testing and counseling data to the DHMT once they receive test kits. Private providers cannot charge patients for HIV testing and counseling, yet they report getting involved with A2W for a number of reasons: the potential to increase their business, interest in gaining

knowledge through training, community service, and as a stepping stone to expanded service offerings such as ART management.

As a program funded by U.S. President's Emergency Plan for AIDS Relief (PEPFAR), it is worth noting that many A2W program components align with PEPFAR II strategies to build local capacity and sustainability. PEPFAR is working to transition from an emergency response to sustainable, country-owned programs. The A2W project, with its focus on building capacity among private providers through training and strengthening the health system in Western Province through public-private partnerships, is helping to reach PEPFAR II goals.

What Worked Well

Several successes emerged from the involvement of private sector providers in PITC. Extending PITC through private providers has proven to be a mutually beneficial system for both the private and public sectors: private providers gain access to MOH resources, including supplies, training, and supervision, while the government expands access and moves toward reaching national HIV testing targets.

Extension of services: The government estimates that the private sector provides approximately 50 percent of the health care in the country, representing an essential channel for providing preventive and outpatient services to communities throughout Kenya. By extending training opportunities, commodities, and supportive supervision to the private sector, communities have more opportunities for HIV testing and counseling and more access to HIV care and support.



Women and children at a clinic in Kakamega, Western Province.

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With A2W support, the MOH sends DHMTs to monitor the private sector to assess quality of service delivery and offer supportive supervision and technical assistance across a range of health issues. According to those private providers interviewed, DHMTs come to the clinic with a checklist for a particular disease area, speak with providers and patients, ask if they can assist with any supplies or reporting tools, and provide direction in areas that they see need improvement. For quality assurance of counseling, health officials reported conducting brief exit interviews with patients about their counseling experience. For quality assurance of testing, providers reported sending every tenth test to the national lab, as per NASCOP guidelines. Private providers reported enthusiasm about training opportunities, even if they lost income by shutting down their facilities for the five-day training period.

Relationship building: Private sector involvement in PITC has strengthened the relationship between the private sector and district and national health officials. Prior to A2W, the level of trust between the private and public sectors was low, with private providers reportedly

shutting down their facilities at the sight of MOH officers because of concerns that the ministry was coming to close the practice. As one private provider reported:

They used to threaten that if they come to your clinic and something is missing they will close you down. If you were caught with their reporting tools, you were liable. But now we are seeing much more partnership: more commodities, more knowledge sharing. The relationship is much improved.

In fostering a new sense of trust between the two sectors, A2W has created opportunities for private providers to routinely offer new services to their patients with the support and consensus of the MOH. As one proprietor of a small private community clinic put it:

The relationship is now good. [Public health officials] have put us [private clinic owners] on the board so we can learn what the government is doing, and what they want, so we can follow their instructions.

Referrals and patient retention: A2W, in partnership with district health offices, equips private providers with referral forms, which were previously unavailable in the private sector. When a client tests positive for HIV in the private sector, providers send clients with referral forms to a public facility of the client's choice for further testing and initiation of treatment. Different providers use different mechanisms for follow-up, but one common referral system was described by the clinical officer in charge at a private clinic:

Most of the patients want to go to Malava [the nearest district hospital] for follow-up. When I go to Malava to deliver reports, I check on my referrals by looking at the referral forms,

which they keep on record. Sometimes Malava will call me to let me know my patient was received.

Some private providers admitted they were hesitant to refer clients to public facilities, fearing permanent loss of clients to the public sector. However, private providers in Western Province found that clients return to them for non-HIV-related care or to report back with an update. This is seen as a win-win situation, giving private providers an opportunity to follow-up on the referral and on treatment adherence without losing a paying client. In some smaller districts, public health officers reported calling individual private providers to confirm that their patient had arrived at the referral facility. According to a district AIDS/sexually transmitted infection (STI) control officer:

The [private] provider writes a referral and calls me to tell me he is sending a patient to [the public facility], so we don't lose patients. If the patient does not reach the facility, I would call the private to get contact information for the patient, but so far we have captured every patient who has been referred.



Private providers record patient testing results in standard registers, which help monitor data for the district.

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Improved data collection: All private providers trained in PITC are required to report monthly to the DHMT using the same reporting tools that the public sector uses. Including private sector providers increases indicator reporting to meet district and provincial targets. Using standardized forms also helps identify problems with test kits, misdiagnosis, and high rates of discordant results, and ensures quality of testing and data.

Comprehensive programming: Program implementers believe that A2W activities contribute positively to overall uptake of PITC. Some examples of implemented programming include training community health volunteers to conduct health dialogue sessions on HIV, to support community theater troupes that perform HIV-related skits, to initiate peer family activities that encourage family discussions about health, to host radio programs about counseling and testing, and to publish a newsletter about health. Through these programs, communities experience an increased awareness of HIV and the importance of testing.

Challenges

Commodities: One of the biggest challenges to PITC among private providers is the intermittent supply of test kits. While stockouts are a perennial issue in Kenya, both private providers and MOH officials reported that the public sector gets priority to receive commodities when they become available. Shortages of supplies also affect MOH staff and private clinicians, who spend valuable time running between health centers looking for extra stock to borrow or redistribute during stockouts.

New delivery procedures also cause delays. The DHMT was previously involved in the

commodity supply system. The DHMT was familiar with facilities in Western Province and could encourage reporting by offering supplies to those who reported; this would allow them to come to better understand the workload of each facility. Efforts have been made to improve supply chain management so that commodities are now sent directly to health facilities, bypassing the DHMT. While the new system promises to lead to improvements, at times a lack of coordination between facilities and the supplier creates challenges to regular commodity supply.

Reporting: While overall reporting from private providers has improved, it is not without its challenges. Private providers struggle to submit the time-consuming monthly reports required by the MOH. Reporting is important because it enhances future efforts toward private sector commodity management and improves the integrity of data for HIV testing. But little effort has been put into training private providers in how to use the reporting tools. DHMTs sometimes receive data on the number of patients tested, but without consumption data for test kits. Without reliable consumption data, the district is unable to monitor stock usage and procure the right number of test kits.

Costs: Because HIV services in Kenya are mandated as free, private providers are faced with the challenge of offering HIV testing and counseling at no cost. Some of the private providers in smaller clinics reported that additional “hidden” costs are a burden that could affect their long-term ability to provide testing services. Hidden costs include time spent counseling that could be used with a paying client; consumables such as gloves and cotton, which are not included in test kits; costs associated with travel to the district hospital

CHALLENGES IN PITC WITH THE PRIVATE SECTOR INCLUDE:

- Commodity stockouts
- Insufficient MOH supervision
- Heavy clinician workload and lack of time to provide PITC
- Stigma affecting client uptake of services
- Inconsistent consumption of commodities reporting
- Limited training for private providers on reporting tools.

for training or to pick up supplies; and cell phone air time for communicating with public health officials and others to follow-up on a referral or request commodities.

Although private providers say they are satisfied with the A2W program, their new PITC skills, and access to free test kits and occasionally other public sector commodities, they complain that the hidden costs were not transparent to them when they began their training for the program. None of the providers feel that they could recoup some of these expenses from clients because clients are aware that HIV testing is free. According to a clinical officer at a private, for profit clinic:

The consultation fee for anything other than HIV is 100 kshs [approximately USD\$1.23]. Treatment cost and fees vary, depending on the treatment. I think people would pay a little for HIV services, but the problem is they are used to them [HIV services] being free and they know they are free in the public facilities, so if I charge a fee they will go elsewhere.

Staying up-to-date: Although most private providers are affiliated with a professional association (such as the Kenya Medical Association or the Kenya Clinical Officer Association), they are often the last to be informed about changes to practices, policies, treatment protocols, and requirements for HIV prevention, care, and treatment. A systematic mechanism for ensuring that providers are updated does not currently exist because none of the professional associations host updates or training for their members. Several districts in Western Province began to invite private providers to updates and training sessions, yet there is little or no financial support for transport or a daily stipend to sustain these activities. The capacity of professional associations to become more involved in updates and training is evolving. Continuing medical education efforts are being developed, which will enable future opportunities. A district AIDS/STI control officer said:

The guidelines change so fast, before you implement the previous guidelines there are new ones out. It leaves people confused, and it is a real challenge to stay up on updates and training for everyone in the district.

Sustainability: It is unclear whether PITC in the private sector can be sustained over the long term. Without project and donor support, funding constraints will limit the MOH's ability to provide supplies,

training opportunities, and supervision for the private sector. Private providers question their ability to provide testing services if they have to procure the test kits themselves. One private provider said:

HIV test kits have always been free. If I didn't receive tests for free, I would see if I could buy them. But I doubt I would be able to offer [testing] if I did not receive kits for free.

Providers feel that offering free HIV testing and counseling to willing clients is an additional workload that reduces valuable time they could otherwise spend on other patients willing to pay for health services. Private providers also struggle with high staff turnover in their facilities; once staff members get additional training, including PITC, they seek better employment with their new, marketable skills.

Recommendations

Drawing on both the successes and challenges of A2W's experience, the following recommendations are for programs seeking to implement PITC in the private sector.

Create PITC policy at the national level: Programs or donors should involve the MOH from the beginning of the strategic planning process. PITC programs should be designed within the existing structures of the MOH. One lesson learned from Kenya is that it is valuable to have a national PITC policy with guidelines in place. This policy should address which cadres of health care workers are permitted to conduct PITC, as well as elaborate standardized protocols for putting PITC into practice. While Kenya does have national PITC policy, there does not appear to be a policy to guide retesting patients, although there was variability in whether patients referred by private providers to other facilities were tested again for HIV, and what form of HIV results were acceptable to preclude retesting (i.e., written or oral). The MOH should seek to establish a clear policy on when to retest for both the private and public sectors in order to efficiently use limited HIV testing resources.

An enabling policy environment is critical to support the launch and implementation of PITC among private providers. As the A2W experience demonstrates, policies ranging from the inclusion of the private sector in the supply chain to MOH supervision of all players in the health sector are critical to supporting successful involvement of the private sector. Coordination of activities within the private

KEY POLICY CONSIDERATIONS:

- National policy on PITC
- Policy on MOH supervision to include the private sector
- Policy on written test results to reduce the need for retesting of clients referred from the private sector
- Policy on commodity distribution to include the private sector.

sector should be included in the MOH's scope of work. Once these policies are set, MOH officials can consider strategies to encourage private sector involvement in district health activities.

Include private providers in training and education: Deliberate inclusion of private sector facilities in training will ensure their active participation and involvement. One standardized PITC curriculum should be used for the private and public sectors, and national MOH trainers should train both sectors. Public sector facilities that offer continuing medical education opportunities should enroll private providers in the catchment area. This will give these providers an opportunity to build relationships and to learn from and be mentored by their MOH counterparts. PITC should be included in the preservice curriculum for all cadres of health care providers.

Streamline commodities management at the national level: Commodity management should be streamlined from the national level and should consider engaging the DHMT, which is familiar with the facilities in each district. Registration of private providers and assignment of a national service delivery point number (similar to those for the public sector facilities) will facilitate the inclusion of private facilities in a national commodity and logistics system. This will help ensure that private providers are accounted for when planning commodity distribution. Private providers need to comply with the consumption reporting requirements to provide information on stock levels, stock use, and stock replenishment needs.

Clearly outline cost considerations with private providers: In most low-income countries, HIV services are typically provided for free in the public sector. Program planners involving private providers who rely on paying clients to sustain their business must consider the additional

costs—both financial and human resource—involved in delivering PITC, even when test kits are provided for free. There are options for dealing with the additional costs, which must begin with transparency on the part of program planners about all required expenses. Test kits could be bundled together with consumables, such as gloves, cotton, spirit, and bleach, to minimize the expense to private providers who are unable to transfer the cost of consumables to their patients. Alternatively, consumables that are not included in the test kit but are necessary to deliver high-quality HIV testing should be considered a part of the private sector cost-share. When program planners approach providers about their willingness to offer PITC, they should clearly outline all costs so providers can decide what they will support versus what the program or district supports.

Where possible, programs should consider charging private providers a training fee to share the costs. Some providers indicated that they would be willing to financially contribute to training costs, although most agreed that they would be unable to cover the entire cost. When asked how much providers would pay to participate in trainings, the medical director of a large company clinic said, “I think management is willing to spend whatever we are told.” Even the proprietor of a small private clinic said, “I would pay if it was money I could manage.”

Establish reporting and linkages systems with the private sector: To adequately capture the important contribution of the private sector, the reporting requirements expected of public facilities should also be expected of private sector facilities, which means reporting tools must be made available to them. The MOH should develop standard operating procedures for private and public health sector reporting and data management,

which DHMTs should supervise during regular supportive supervision visits. All training and update opportunities offered in tool use, data management, monitoring, and evaluation should be made available to the private sector. Again, private providers could be asked to supply their own transport to the training or pay a small training fee to share the cost of this effort.

Fully integrate private providers for enhanced sustainability: A2W made an effort to develop a sustainable program by building local capacity among a variety of cadres of private providers in a range of settings. Like A2W, program planners should create linkages between private providers and public health officials, facilitating public-private partnerships that might outlast the project. They should involve private providers in the supply chain systems, as well as in the planning process at local and national levels. Even with this effort, there are challenges to sustainability: without a commitment from local and national leadership that includes specific financial support for the inclusion of the private health sector, it will be difficult to maintain private sector engagement.



Health care provider with a female patient.

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Future Programming: Opportunities

Cost-share: By closing their clinics to attend the five-day training program, private providers may view themselves as sharing in the cost of expanding HIV testing and counseling. Most of the providers interviewed, independent of clinic size or type, reported they were willing to cover what they could afford to attend trainings. Fees might be charged on a sliding scale so that large company facilities can subsidize small community clinics, or providers could be asked to cover their own accommodations, leaving the choice and standard of lodging up to the participant. Cost-sharing has the potential to build capacity within the private sector without prohibitive expense.

Scaling up: Some private providers expressed interest in ART accreditation to increase patient follow-up and adherence, and as a response to client requests. Although they understand that ART management presents challenges similar to testing and counseling because clients consider them to be “free” services, private providers are eager to learn new skills and serve their communities. If a reliable commodities management system can be maintained, private providers may contribute substantially to increasing the proportion of people who can access treatment.

Professional associations: An untapped potential exists within the various professional associations to provide (for a fee) continuing medical education for the private and public sectors, possibly creating a sustainable business model.

Beyond HIV: Interviews with private and public actors in HIV-related fields highlighted that involving private sector representatives in

the planning and ongoing execution of testing and counseling activities improved collaboration, coordination, and commodities management. This type of information and responsibility sharing could be leveraged to reach a range of MOH health goals and strategies, beyond HIV programming.

Other considerations for future programming:

There are many issues that could not be explored in depth in this case study but are applicable to programs seeking to involve private providers. Additional considerations for future programming that merit mention include the following:

- Exposing providers who will be trained in any facet of HIV testing and counseling to PITC (e.g., VCT, prevention of mother-to-child transmission), regardless of whether they have had specific PITC training. Programmers might reconsider the length of PITC training for providers already trained in testing and counseling, potentially shortening the five-day training course.
- As the private sector becomes a valuable actor in reaching national health targets, developing opportunities for private clinics to become comprehensive HIV care centers, particularly for facilities offering HIV testing to pregnant women. Private providers interviewed expressed concerns about having to refer pregnant women living with HIV to other sites for prophylaxis. Yet scale-up depends on the availability of a reliable supply management system for such items as prophylaxis and involvement of private providers in training to offer adequate treatment.
- To alleviate human resource shortages in private clinics, shifting the responsibility for PITC to lay counselors can provide relief to overburdened private providers.
- In settings where staffing is limited, making PITC a priority for clients who may have symptoms of HIV or who may be pregnant, for children born to mothers living with HIV, and for patients with tuberculosis and/or STIs.
- For program implementation, including at least one clinician with program management skills on staff to enhance supportive supervision exercises and PITC training.
- Considering support to professional associations to develop an organizational structure within the private sector to facilitate updates, sharing of information, and general communication among providers and public health officials.
- Conducting simultaneous behavior change communication activities that address stigma and encourage health-seeking behavior, particularly HIV testing and counseling. ■

REFERENCES

Barnes, J., B. O'Hanlon, F. Feeley, et al. 2010. *Private Health Sector Assessment in Kenya*. World Bank Working Paper No. 193. Washington, DC: The International Bank for Reconstruction and Development/The World Bank. Available at http://pdf.usaid.gov/pdf_docs/PNADS739.pdf (accessed October 2010).

International Finance Corporation. 2007. *The Business of Health in Africa: Partnering with the Private Sector to Improve People's Lives*. Washington, DC: International Finance Corporation. Available at www.ifc.org/ifcext/healthinfrica.nsf/Content/FullReport (accessed October 2010).

Kenya National AIDS and STI Control Programme (NASCO). 2004. *Guidelines for HIV Testing in Clinical Settings*. Nairobi: Ministry of Health, Republic of Kenya.

Kenya NASCO. 2008. *Guidelines for HIV Testing and Counselling in Kenya*. Nairobi: NASCO.

Republic of Kenya. 2007. *Kenya AIDS Indicator Survey*. Available at www.aidskenya.org/public_site/webroot/cache/article/file/Official_KAIS_Report_20091.pdf (accessed October 2010).

World Health Organization (WHO) and Joint U.N. Programme on HIV/AIDS (UNAIDS). 2007. *Guidance on Provider-Initiated HIV Testing and Counseling in Health Facilities*. Geneva: WHO. Available at www.who.int/hiv/topics/vct/PITCguidelines.pdf (accessed August 2010).

RESOURCES

APHIA II Western Project. 2010. APHIA II Western Program Data. Accessed on-site via program database. May 2010.

APHIA II Western Project. 2008–2010. *APHIA II Western Quarterly and Yearly Reports to USAID*

2008 – 2010. Available at www.aphia2kenya.org/index.php?option=com_docman&Itemid=912 (accessed August 2010).

Brockway, G. 2007. Routine Testing for HIV/AIDS in Sub-Saharan Africa: A Philosopher's Perspective. *Studies in Family Planning* 38(4):279–83.

Kenya National AIDS Control Council. 2009. *Kenya HIV Prevention Response and Modes of Transmission Analysis*. Available at <http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1103037153392/KenyaMOT22March09Final.pdf> (accessed August 2010).

Kenya National AIDS Control Council. 2009. *Kenya National AIDS Strategic Plan (2009/10 - 2012/13): Delivering on Universal Access to Services*. Available at www.hennet.or.ke/downloads/knasp_iii_document.pdf (accessed August 2010).

Leon, N., P. Naidoo, C. Mathews, et al. 2010. The Impact of Provider-initiated (Opt-out) HIV Testing and Counseling of Patients with Sexually Transmitted Infection in Cape Town, South Africa: A Controlled Trial. *Implementation Science* 5(8):1–11.

Medley, A. M., and C. E. Kennedy. 2010. Provider Challenges in Implementing Antenatal Provider Initiated Testing and Counseling Programs in Uganda. *AIDS Education and Prevention* 22(2):87–99.

NASCO. 2007. *Skills Training in Provider Initiated Testing and Counseling in the Clinical Setting: Coursebook for Trainers*. Nairobi: NASCO.

Rennie, S., and F. Behets. 2006. Desperately Seeking Targets: The Ethics of Routine HIV Testing in Low Income Countries. *Bulletin of the World Health Organization* 84:52–57.

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