CAB PrEP Introduction Situation Analysis in Eswatini

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Overview of PrEP Introduction Situation Analysis

- This document summarizes findings from the **national situation analysis** that can support the creation of a national biomedical HIV prevention platform.
- The situation analysis aims to clarify critical steps for the introduction of biomedical HIV prevention products.
- This analysis is based on several **inputs**, including a desk review, secondary research, interviews with key stakeholders in Eswatini.
- This analysis can be used by policymakers, implementers, and others **planning for introduction of CAB PrEP** in Eswatini.
- This analysis was completed by Afton Bloom leveraging the analysis conducted by MOSAIC Consortium partners Mann Global Health for the introduction of the CAB PrEP for ViiV Healthcare.
- Summaries of similar analyses for other HIV prevention methods and other countries are available on **PrEPWatch.org**.

Current situation of HIV prevention

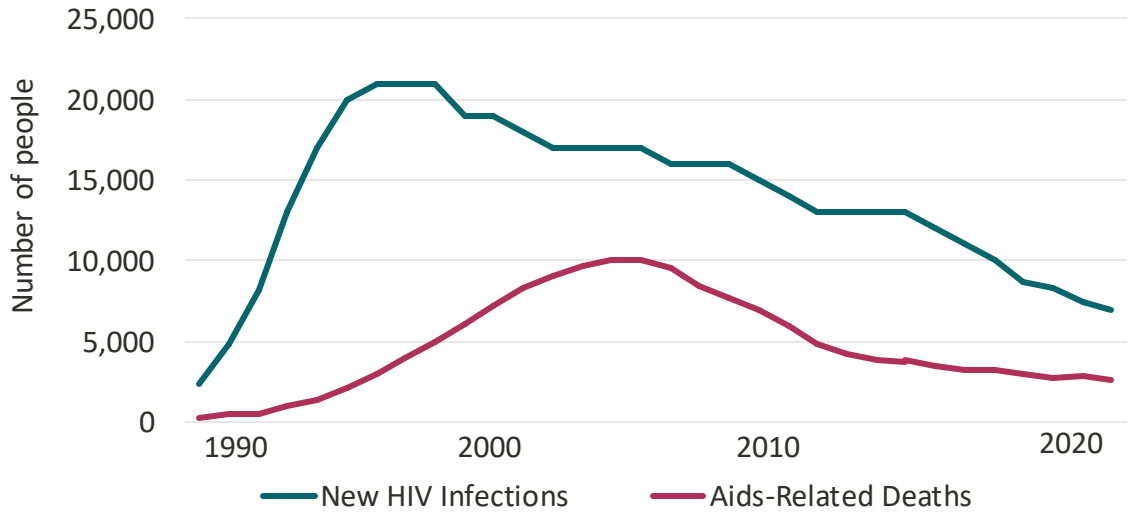
Findings for CAB PrEP introduction planning

Sources and notes

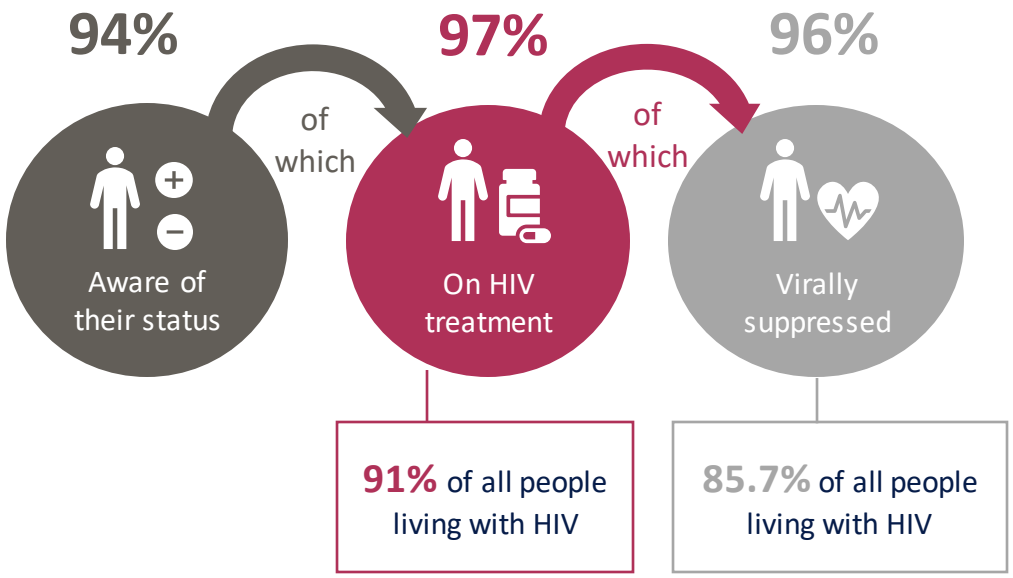
While Eswatini nears epidemic control, new infections remain high

- An estimated **215,200 people are living with HIV**, which remains the leading cause of death in Eswatini.[1]
- Annual HIV-related deaths have declined by an estimated **74% since 2005**, with an overall **reduction of new infections by 67%** since 1998.[2] An estimated 6,900 new infections occur annually, against an estimated 2,600 AIDS-related deaths.[3]
- Eswatini has **surpassed UNAIDS targets for treatment and viral suppression**, providing clear evidence of the effectiveness of the country's HIV testing and treatment programs.

HIV INCIDENCE AND AIDS RELATED DEATHS, ALL AGES, 1990-2020[1]



PROGRESS TOWARDS 95-95-95 GOALS, AGE 15 – 64, 2021[1]

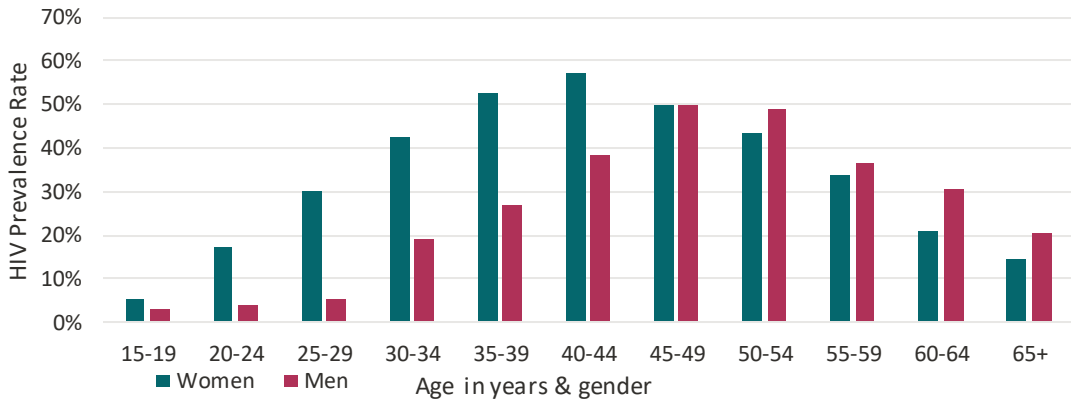


Sources: (1) Eswatini Country Operating Plan COP 2022; (2) UNAIDS Epidemiological Estimate 2021; (3) Eswatini SHIMS 3 2021 (https://phia.icap.columbia.edu/wp-content/uploads/2022/12/53059_14_SHIMS3_Summary-sheet-Web.pdf)

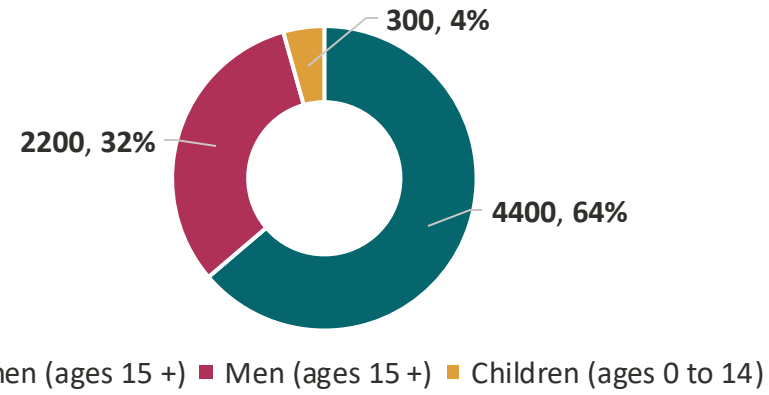
Young women remain at high risk for HIV

- **31.6% of women aged 15-49 years are HIV positive,** compared to **15.6%** of men of the same age.[1]
- **Young women are disproportionately affected**—women aged 20-24 years are over **three times more likely** than men of the same age to have HIV, **while** women aged 25-29 years are **six times more likely**.[1]
- Adolescent girls and young women (AGYW) 15-24 years comprise **38% of the total new infections in Eswatini.**[3]
- Prevalence is highest in **key populations (KPs)**, specifically among **female sex workers (FSWs) (59%),** and men who have sex with men (MSM) (21%). While no data exists for people who inject drugs (PWID) and transgender people, prevalence is thought to be high as well.[3]

HIV PREVALENCE BY SEX AND AGE, 2021 [2]



NEW HIV INFECTIONS, 2021 (estimated) [1]

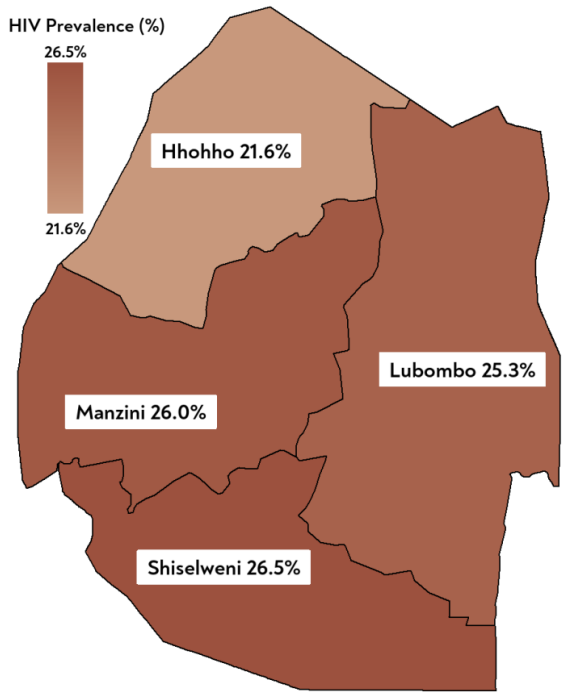


Sources: (1) UNAIDS Epidemiological Estimate 2021; (2) Eswatini SHIMS 32021; (3) PEPFAR Eswatini COP 2022.

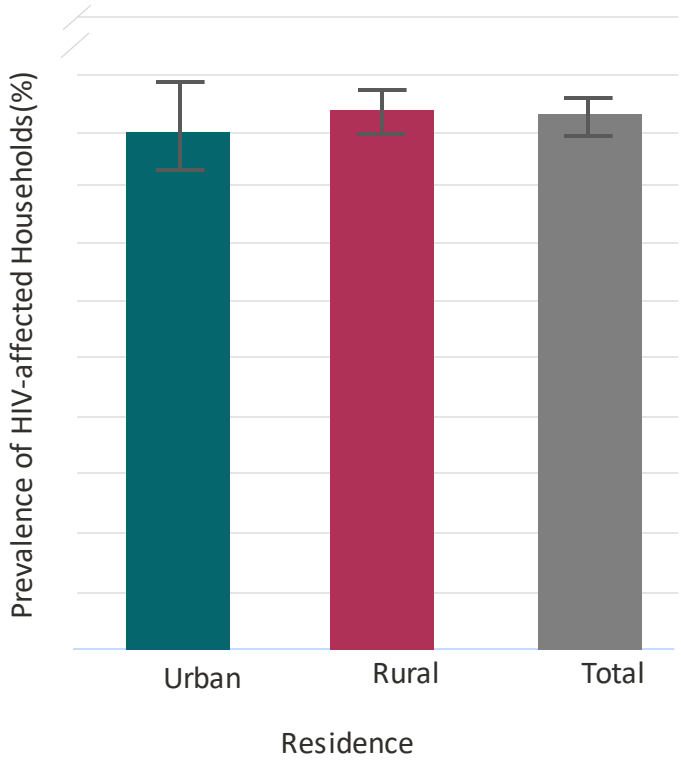
The HIV epidemic is relatively evenly distributed across Eswatini

- **HIV prevalence remains high in both urban and rural areas**, with a slightly higher prevalence in rural areas.
- **76% of the population lives in rural areas**; and the highest population density is the Manzini-Mbabane corridor.[2]
- Close to half (46.0%) of households in Eswatini have at least **one HIV-positive household member**.[3]
- The percentage of households with **two or more HIV-positive members is greater in rural areas** (31.8%) compared with urban areas (21.3%). [3]
- About one in three (35.3%) households had an HIV-positive head of household.[3]

ESTIMATED HIV PREVALENCE, ADULTS AGED 15-64 YEARS, BY REGION [1]



PREVALENCE OF HIV-AFFECTED HOUSEHOLDS BY RESIDENCE, 2016-2017 [2]



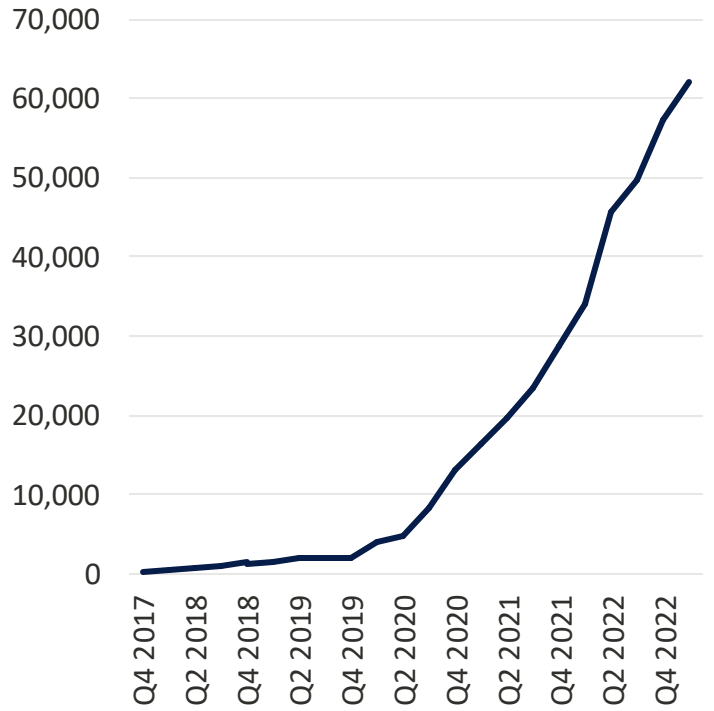
Sources: (1) Eswatini SHIMS 3 2021; (2) Eswatini SHIMS2 2017; (3) Swaziland HIV Incidence Measurement Survey (SHIMS) Final report.

Oral PrEP rollout in Eswatini has been largely successful, offering learning for the introduction of CAB PrEP

71,765 users have initiated oral PrEP since the program launched in 2017 (as of September 2023).

- PrEP was **rolled out in Eswatini in 2017 with relative success** especially in comparison to neighboring countries like Lesotho and Zimbabwe given Eswatini's relatively small population.
- The **MOH was very supporting of the introduction of oral PrEP** and led a coordinated rollout and scale-up through all public sector ART sites. This foundation for wide coverage and access to quality services was critical to program success. Furthermore, the MOH **opened eligibility to anyone interested in PrEP** (rather than limiting PrEP only to priority populations) which helped to normalize PrEP and reduce stigma among potential end users.
- While buy-in from healthcare workers (HCW) was a challenge at first, this was countered with training and sensitization for understanding the importance of PrEP. Now there is **broad adoption and buy-in for PrEP across HCWs and facilities**.
- There were some **issues with pill fatigue during the initial rollout** that have been addressed in part by Event Driven PrEP (ED-PrEP), which men are more likely to adopt.
- The **most significant growth in initiations came in 2022**, with the scale-up of youth friendly services as well as the integration of PrEP across sexual reproductive health services and sexually transmitted infections (STI) departments in all PrEP sites nationally. Integration of PrEP in mobile platforms has also resulted in an increase in uptake.

ORAL PrEP INITIATIONS, 2017-2023 [1]



Sources: (1) PrEP Watch, 2021.

Oral PrEP implementing partners in Eswatini

There are a number of implementing partners focused on HIV prevention and oral PrEP in Eswatini.

	Organization	Areas of Expertise
1.	**Cabrini Ministries**	• Community partner
2.	**Coordinating Assembly of Non-Governmental Organizations (CANGO)**	• Umbrella body for CSO; coordinates CSO efforts in HIV prevention and treatment
3.	**Elizabeth Glaiser Pediatric AIDS Foundation (ASPIRE Project)**	• Service delivery partner working in two regions – Hhohho and Shiselweni. • Implementation with AGYW and KPs, currently implementing the USAID-funded DISCOVER-Health Project
4.	**FHI 360**	• Development of training curriculum; training; working with community partners • Clinical implementing partner for key populations (KPs)
5.	**Georgetown University**	• Service delivery technical partner working in two regions – Lumbombo, Manzini • Support in development of guidelines, SOPs, and other guidance documents
6.	**Health Plus 4 Men (HP4M)**	• Demand creation for HIV services among MSM in Hhohho and Shiselweni; manages KP drop-in-centers (DICs) at Mbabane and Manzini
7.	**House of Our Pride (HOOP)**	• Demand creation for HIV services among MSM in Manzini and Lubombo
8.	**ICAP**	• Clinical trials studies for CAB PrEP (HPTN 084)
9.	**Luke Commission**	• One of the largest clinical partners offering free healthcare in fixed sites as well as outreach across Eswatini, especially for those living in poor and remote areas (high PrEP uptake numbers)
10.	**PACT**	• Capacity development for all KP-led partners and providing DREAMS services
11.	**Population Services International**	• Demand creation, social marketing of HIV self-testing
12.	**Rock of Hope**	• Stigma reduction in health and police facilities; Going Online; development of IEC materials in all four regions of Eswatini, targeting all KPs
13.	**URC**	• Works with the military
14.	**Voice of Our Voices (VOOV)**	• Demand creation for HIV clinical services among FSWs in all four regions of Eswatini
15.	**World Vision**	• Works closely with the communities, partners, faith leaders, government departments, parastatals, international agencies, and civil society
16.	**Young Heroes**	• Works with OVC, especially AYP; DREAMS community partner

CAB PrEP is an opportunity to expand the reach of HIV prevention interventions to populations in need

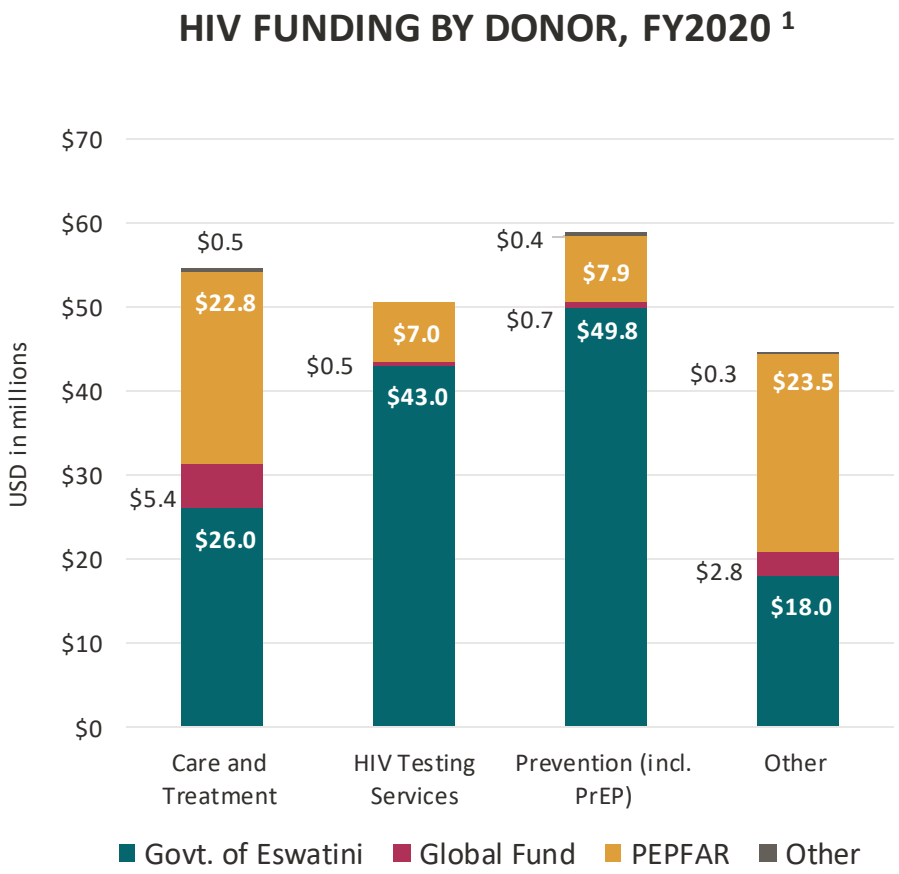
- CAB PrEP is seen as an **important and promising product** to add to the mix of prevention products and interventions available in Eswatini.
- Facilities are likely to **target AGYW** for the initial outreach.

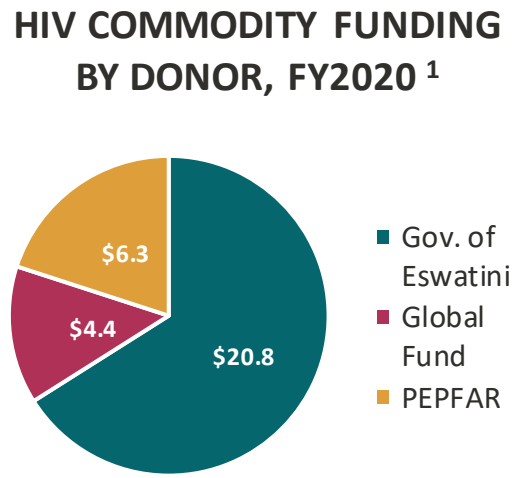
Priority groups	Who are they?	Population Size Estimates/Prevalence Rate[1]	Considerations for the introduction of CAB PrEP
Key populations	• Female sex workers (FSW) • Men who have sex with men (MSM) • Trans and nonbinary people (TNBP) • People who inject drugs (PWIDs) • Men in confined spaces e.g., prisoners and miners	• FSW: 7,100; 59% • MSM: 4,000; 21% • TNBP: 1,269; N/A* • PWIDs: 119; N/A • Prisoners: NA; N/A	• HIV prevalence is exceptionally high in KPs. A number of myths and misconception persist with KP (and all populations). • Users often conflate PrEP with treatment, and there is stigma associated with taking PrEP because of behaviors not condoned by society and linkages to being HIV positive.
Other focus populations	• Adolescent girls and young women (AGYW) • Young men and boys • Women (25+ years) • Pregnant and breastfeeding people (PBFP) • Serodifferent couples (SDCs)	• AGYW: 117,876; 14% • Young men and boys: N/A; N/A • Women: 251,333; 41.2%	• HIV prevalence among AGYW between the ages of 15-24 years (14%) is four times higher than their male counterparts (4%). The trend of HIV prevalence for women's higher prevalence than their male counterparts continues until the age of 45 years. • CAB PrEP rollout will likely focus on AGYW and young boys. • In a country as high prevalence as Eswatini, ensuring recently diagnosed serodifferent couples is important, particularly in partnerships where partners may not be regularly taking ARVs.

Sources: (1) Eswatini PEPFAR COP 2022
Note: * Data not available

Funding contributions towards HIV

- **Total investment in Eswatini for HIV was estimated at $207.9M** of which $14.2M (7%) was allocated for prevention and $50M (24%) for testing, based on figures from 2020 and 2022* .
- **The Government of the Kingdom of Eswatini (GKoE) is the largest contributor of HIV funding in Eswatini**, contributing about 56% of the total budget for HIV ($116.4M).
- PEPFAR (contributing 38%, $79 M) and GF (6%, $12.4M) are the major external donors.
- 15% ($31.5M) of total HIV funding in Eswatini supports commodity procurement, mostly driven by funding for ARVs including oral PrEP. 60% ($18.9M) goes to ARVs.
- **The GKoE is the largest funder of commodities** (66%), with PEPFAR and GF contributing 20% and 14% of commodities, respectively. GKoE funds 93% of all ARVs.
- COP23 planning ended in Q3 of 2023. COP23 is currently being implemented as of October 2023.





* NOTE: PEPFAR, GF, and other categories are populated with 2022 data, but this has been triangulated with the latest data available on government expenditure for 2020. Also, commodities are a subset of the total investment profile.

Sources: (1) Eswatini PEPFAR COP 2022

Current situation of HIV prevention

Findings for CAB PrEP introduction planning

Sources and notes

Key findings from stakeholder consultations

- **HIV incidence remains high among young women, primarily due to pill burden.** Stakeholders hope that the integration of the long-acting injectable will help counter some of the stigma and social barriers associated with PrEP use that has deterred AGYW from adhering and effectively using PrEP. However, stigma around injectables will need to be addressed in sensitization efforts.
- Eswatini intends to introduce CAB PrEP as a prevention choice starting in April 2024 with the arrival of **2,000 vials from PEPFAR to reach ~333 end users.** Additional doses are expected for approximately 5,165 people. Initial CAB PrEP doses will likely be offered to AGYW (25-34 years), KPs, and males at high risk.
- The Eswatini National AIDS Program (ENAP), supported by the PrEP core team, is developing a **roadmap to support product introduction plans**. Discussions are ongoing to determine the best approach to introduce CAB PrEP. Stakeholders are leaning toward a tightly managed small scale "pilot" to inform a phased rollout in order to ensure that anticipated demand does not outstrip supply for CAB PrEP.
- Stakeholders anticipate that efforts to **rollout CAB PrEP products can easily be integrated within the existing supply chain for storage and distribution** of PrEP products that the GKoE's Central Medical Stores (CMS) oversees. Improvements are underway to establish stronger coordination between facilities and CMS through the digitalization of the logistics management and information systems (LMIS).
- There are some concerns that the **restrained human resources for health** in Eswatini may cause difficulties for CAB PrEP rollout. Currently Eswatini is facing a hiring freeze of HCWs, especially nurses, due to economic recession.
- PEPFAR implementing partners will play an important role in the demonstration projects. Site selection will include a small number (~12) of facilities mixed with outreach targeting AGYW and young boys and men.
- **Questions remain around affordability of CAB PrEP**. Some stakeholders have concerns around financial sustainability for CAB PrEP to be offered as an "additional choice".

CAB PrEP introduction framework

This value chain framework has been used across countries to support planning for the introduction of PrEP products. It identifies necessary steps for PrEP introduction and scale-up across five major categories and across priority delivery channels. It can also be used to track progress toward introduction of various PrEP products by different partners.

Value Chain for PrEP

PLANNING & BUDGETING

National and subnational plans are established to introduce and scale-up PrEP products.

SUPPLY CHAIN MANAGEMENT

PrEP products are available and distributed in sufficient quantity to meet projected demand via priority delivery channels.

DELIVERY PLATFORMS

PrEP products are delivered by trained providers in priority delivery channels to effectively reach end users.

UPTAKE & EFFECTIVE USE

End users know about and understand PrEP products and know how to access and effectively use them.

MONITORING, EVALUATION, & LEARNING

PrEP products are effectively integrated into national, subnational, facility, community, and program monitoring systems.

Factors assessed in the CAB PrEP introduction framework

The CAB PrEP introduction framework use the following factors below to assess the current situation for oral PrEP and considerations to introduce CAB PrEP in Eswatini. On this slide are the color ratings for each of these factors in based on the analysis outlined in the following slides.

PLANNING & BUDGETING	SUPPLY CHAIN MANAGEMENT	DELIVERY PLATFORMS	UPTAKE & EFFECTIVE USE	MONITORING, EVALUATION, & LEARNING
Plans, systems, and processes to support service integration across priority delivery channels, including reproductive health/family planning and private sector providers/pharmacies				
Convene new or existing subcommittee or task team within HIV prevention or PrEP **technical working groups.**	**Register** CAB PrEP and include it on the national essential medicines list, if needed.	Dedicate resources to conduct regular **HIV tests, initiate PrEP, and support ongoing CAB PrEP use.**	Develop and implement **demand generation strategies** that include CAB PrEP promotion.	Update or establish **integrated monitoring tools** to support data collection and analysis on PrEP use across multiple products.
Identify **focus populations and set targets** to inform CAB PrEP planning.	Update **supply chain guidelines and logistics systems** to include CAB PrEP.	Develop trainings and materials for **health care workers** on CAB PrEP.	Address social norms/stigma to build **community and partner acceptance** of CAB PrEP use.	Establish systems for **pharmacovigilance** and to monitor drug resistance.
Engage **community stakeholders** to inform planning for CAB PrEP rollout.	Conduct **forecasting and/or quantification** to determine estimated demand and inform procurement of CAB PrEP.	Establish **referral systems** to link clients from other channels to sites providing CAB PrEP.	Develop **information and tools for clients** to support product choice.	Conduct **implementation science** research to inform policy and scale-up.
Include CAB PrEP in national HIV prevention and other relevant **plans and policies** (e.g., HIV testing, FP).	Establish **procurement, commodity monitoring, and distribution** for CAB PrEP and associated materials.	Integrate support for **partner communication** and services for intimate partner violence response.	Support **effective use** of CAB PrEP.	
Issue standard **clinical guidelines** for delivery and use of CAB PrEP.	Establish **storage and distribution systems** that maintain temperature controls for CAB PrEP.			
Develop an **implementation plan and budget** to guide initial introduction and scale-up of CAB PrEP.				

COLOR KEY

- Opportunity to easily build on oral PrEP rollout
- Will require new effort, but no anticipated challenges
- Requires significant consideration specifically for CAB PrEP

Eswatini situation analysis summary findings

Findings from the Eswatini situation analysis are summarized below, with details included on the following slides.

PLANNING & BUDGETING

- ENAP, supported by the PrEP core team, provides **overall leadership of the PrEP program**.
- Initial introduction of CAB PrEP will be through a phased rollout that initially **targets AGYW** due to limited availability of the product and a high anticipated demand from all end user groups.
- ENAP is currently building a **roadmap outlining key steps to introduce new HIV products**. The Integrated HIV Management Guidelines mention CAB PrEP and is based on World Health Organization (WHO) guidance. The PrEP core team is revising the PrEP implementation framework, targeting completion by Dec 2023.
- **PEPFAR has committed to procuring 2,000 doses of CAB PrEP for 2024/25**. It is anticipated that the MOH through the GF grant will procure an additional 8,344 doses for years 2 and 3.

SUPPLY CHAIN MANAGEMENT

- CAB PrEP has **yet to be added registered** for use in Eswatini.
- CAB PrEP can be **easily added to existing supply chain systems**, overseen by the CMS.
- **Stock outs of government-funded commodities have been a challenge** during initial oral PrEP rollout which have been addressed with improved forecasting through PrEP-it and the digitalization of the LMIS.

DELIVERY PLATFORMS

- MOH is recommending **integrating CAB PrEP into existing oral PrEP delivery points** to support HIV prevention informed choice for users.
- The PrEP core team will work closely with the MOSAIC and EGPAF team to **develop training curriculum** and cascade training to Mentors and Clinic Supervisors, who train HCW. Mentors and Facility Supervisors will cascade training to other HCWs.
- CAB PrEP can be easily integrated into existing oral PrEP programming in all public service delivery sites, including HIV / ART clinics, HTS services, outpatient departments (OPD), and SRH / FP / MCH services.

UPTAKE & EFFECTIVE USE

- Eswatini launched **The National PrEP Communications, Advocacy and Behavior Change Strategy** in Feb 2023, which offers guidance on key audiences for PrEP (including CAB PrEP) and messaging.
- **There is a concern that demand may outstrip supply** during the initial rollout of CAB PrEP; this is a a major concern for the national program and implementers. Therefore, **IEC materials for CAB PrEP will focus on supporting provider counselling** for end users to understand prevention choice.
- **PrEP adherence continues to be a major challenge**, however there are hopes that CAB PrEP will help address some of barriers that end users face (e.g., stigma or pill burden, etc.).

MONITORING, EVALUATION, & LEARNING

- Eswatini is in the process of **integrating CAB PrEP indicators** into the current Management Information System.
- PrEP is currently being monitored through both paper-based and electronic systems.
- **MOSAIC will support the MOH with HIV drug resistance monitoring**. A national HIVDR system for CAB PrEP will be needed.

Planning & budgeting key steps

	Current situation of oral PrEP	What is needed to introduce CAB PrEP
Convene new or existing subcommittee or task team within HIV prevention or PrEP **technical working groups.**	• The coordination of HIV response at national, provincial, district, and community level is led by the Eswatini National AIDS Programme (ENAP). • The HIV Prevention Technical Working Group (TWG) has three taskforces including the PrEP core team who is involved in planning and coordination for all PrEP activities, the Supply Chain Co-Chair, and the Demand Creation Co-Chair.	• The PrEP core team is currently working on the revised PrEP implementation framework and will be involved in planning the rollout of CAB PrEP. • The PrEP core team will also work closely with implementing partners to develop the training curriculum.
Identify **focus populations and set targets** to inform CAB PrEP planning.	• Oral PrEP targets were initially set using PEPFAR numbers; however now Eswatini is one of the first countries to use the PrEP-IT tool to set national PrEP targets.	• It is expected that CAB PrEP phased rollout will initially target AGYW due to limited availability of the product and a high anticipated demand from all end user groups.
Engage **community stakeholders** to inform planning for CAB PrEP rollout.	• MOH conducted an assessment of end users including AGYW, FSW, and different subgroups among men to inform PrEP programming. • Civil society organizations (CSO) played a key role in the rollout of oral PrEP nationally, leveraging organizations involved in the Linkages Project. Each CSO focused on a certain population group and supported initiation, demand generation, and navigating clients to clinical services.	• There are many CSOs involved in the implementation of oral PrEP that can be leveraged to inform planning for CAB PrEP. • AGYW CSOs and KP networks will be important to engage in order to ensure their voices are incorporated into rolling out CAB PrEP as well as sensitizing communities on CAB PrEP.
Include CAB PrEP in national HIV prevention and other relevant **plans and policies** (e.g., HIV testing, FP).	• The Eswatini National Health Sector Response to HIV Strategic Plan (2023-2027) serves as the roadmap for the introduction of oral PrEP and the new HIV prevention methods. • Eswatini PrEP Implementation Guidelines (2023) provides information on how to start clients on PrEP, management of clients on PrEP, and documentation and data management.	• The PrEP core team is integrating CAB PrEP into the strategic plans and implementation guidelines. • The New Product Introduction Roadmap is a standard roadmap for the introduction of new products in the country to ensure an efficient, timely adoption and transition process; the roadmap will help guide the introduction of CAB PrEP.
Issue standard **clinical guidelines** for delivery and use of CAB PrEP.	• The Eswatini Integrated HIV Management Guidelines (2022) include oral PrEP as well as the new PrEP methods.	• CAB PrEP is already included in the Integrated HIV Guidelines. • A training curriculum is in development, however training HCWs will not begin until just before CAB PrEP implementation begins.
Develop an **implementation plan and budget** to guide initial introduction and scale-up of CAB PrEP.	• The MOH is in the process of developing the third edition of the PrEP implementation framework. • A key lesson from oral PrEP implementation was to introduce new products through a phased approach, informing rollout based on lessons learned. • In terms of a budget for PrEP, the GKoE is the largest contributor of HIV funding in Eswatini, contributing 56% of the total budget for HIV ($116.4M). PEPFAR (contributing 38%, $79 M) and GF (6%, $12.4M) are the major external donors.	• For years 1 and 2 of the rollout, PEPFAR has committed to procuring 2,000 doses of CAB PrEP for 2024/25. It is anticipated that the MOH through the GF grant will procure an additional 8,344 doses for years 2 and 3. • Stakeholders would prefer to conduct a pilot (vs. implementation science study). • The CAB PrEP - Specific Product Implementation Plans are currently under development to outline outlining where, how, when, and for whom CAB PrEP will be introduced. Implementation plans will outline target populations, implementation sites, and partners and draw on experience of the CATALYST study happening in other MOSAIC countries as well as lessons learned from oral PrEP. • Budgets need to include related CAB PrEP commodities- needles, syringes, etc.

Supply chain management key steps

	Current situation of oral PrEP	What is needed to introduce CAB PrEP
Register CAB PrEP and include it on the national essential medicines list, if needed.	• The Central Medical Stores (CMS), with guidance from MOH, is responsible for registering new products in the Essential Medicines List (EML). • If product comes in through PEPFAR, MOH will need to apply for tax exemption once a new product is registered. However, if it comes in through CMS, no tax exemption is required.	• CAB PrEP has not yet been approved for use in Eswatini. • The completed Comprehensive HIV Management Guidelines includes a section that will help facilitate CAB PrEP to be added to the EML.
Update **supply chain guidelines and logistics systems** to include PrEP products.	• All HIV commodities are supplied through PEPFAR, GFATM or the MoH through the Central Medical Stores (CMS).	• It will be important to bring CMS along early in planning for CAB PrEP as the body responsible to integrate new products into existing systems.
Conduct **forecasting and/or quantification** to determine estimated demand and inform procurement of CAB PrEP.	• Chemonics as the GHSC PSM lead is a strong MOH partner providing technical assistance to support forecasting and quantification. • Quantification of HIV commodities done for a projected three-year period, based on various factors including population size estimates and disease burden, among others. • There were some challenges in forecasting during the initial rollout of PrEP due to difficulties in knowing how long end users would be on PrEP. The initial rollout used PEPFAR targets for forecasting, which has now been updated and improved using the PrEP-it tool.	• Quantification is done for PrEP commodities overall and not based on a specific product form, which may need to change with the introduction of CAB PrEP. • Forecasting is likely to be greatly complicated with the introduction of CAB PrEP initially on a limited basis and unknown rates of uptake between oral PrEP, the injectable, and the dapivirine ring.
Establish **procurement, commodity monitoring, and distribution** for CAB PrEP and associated materials.	• The GKoE is the primary procurer of ARVs (and oral PrEP). Health commodities (include FP) are procured, warehoused, and distributed by the CMS, which uses the GF procurement system, Wambo, for GF-funded commodities. • CMS distributes directly to facilities on a "pull" system for most commodities. GHSC-PSM supports CMS with the warehouse information management system (NAVISON) at the central-level and supports the data management unit (DMU) for end-to-end data for distribution. • There have been challenges with stock outs of government-funded commodities, and stakeholders hope that the digitalization of the LMIS should improve coordination between the CMS and facilities so up to date numbers on stock levels across facilities are available. • GHSC-PSM also leads the procurement of PEPFAR-funded commodities and works closely with CMS to ensure that waivers are given for funded/donated commodities. All PEPFAR and GF-funded commodities are warehoused and distributed by CMS-implementing facilities at the regional level. • Each partner has a different lead time for procurement. Stakeholders note that there have been challenges with long lead times resulting with short expiration dates (e.g., particularly The Global Fund's system Wambo).	• CAB PrEP can most likely be easily integrated within these systems, however the challenges around stock outs experienced during oral PrEP scale up will need to be addressed as CAB PrEP is introduced. • Procurement Planning Meetings occur annually to develop a procurement plan with delivery timelines. Financial requirements are estimated and matched to funding commitments, which, in turn, helps to identify funding gaps. • Stakeholders also note the importance of ensuring adequate supply of HIV testing kits and other associated products (e.g., VL reagents and consumables, etc.) across delivery sites. There may be some challenges around the availability of syringes and needles within delivery sites as well.
Establish **storage and distribution systems** that maintain temperature controls for CAB PrEP.	• *Not applicable for oral PrEP.*	• Delivery sites will need to be trained on proper storage of CAB PrEP; however, there are no challenges anticipated given facilities have the capacity to maintain temperature controls.

Delivery platforms key steps

	Current situation of oral PrEP	What is needed to introduce CAB PrEP
Dedicate resources to conduct regular **HIV tests, initiate PrEP, and support ongoing CAB PrEP use.**	• Oral PrEP is available within all public service delivery points, including HIV / ART clinics, outpatient departments (OPD), Maternal and Child Health (family planning and ANC clinics) and community-based models (DREAMS, mobile clinics, DICs). • Facilities have been doing well to screen clients for PrEP eligibility. • Initially there were some difficulties for HIV testing within the communities requiring clients to see a HTS counsellor, however HIV self-testing has improved uptake at the community-level. • HIV test kit supply is adequate and widely available. However, there have been some issues with stock outs for oral PrEP and HIV testing for government-funded commodities.	• Stakeholders anticipate that CAB PrEP can be easily integrated into existing PrEP programming. • CAB PrEP integration will most likely focus on public HIV facilities during initial rollout, however there is desire to integrate CAB into community-based settings through the DREAMS program (see next slide for more details).
Develop trainings and materials for **health care workers** on CAB PrEP.	• Most qualified HCWs are already familiar with and trained on oral PrEP and service delivery considerations. • The PrEP core team develops a training curriculum, receiving input from core team leads such as the FHI 360 MOSAIC team and EGPAF. • Stakeholders also raised concerns around the restrained human resources for health in Eswatini. The freeze of hiring of HCWs, especially nurses, due to economic recession may cause difficulties for PrEP programming (particularly for the integration of new PrEP methods).	• The PrEP core team and MOSAIC are developing the training curriculum for the new PrEP methods, which will be cascaded down to implementing facilities. • The limited number of facilities rolling out CAB PrEP will enable a rapid cascade directly to training mentors, HCWs, and nursing supervisors who will be important to later cascade training to other health facilities during scale-up. • Stakeholders do not anticipate challenges for training HCWs to administer CAB PrEP. Training should inform HCWs on how to administer intramuscular (IM) injections, how to properly store CAB PrEP, how to support end users for follow-up visits and continued PrEP use, as well as waste management of the injection materials (e.g., syringes). • However, provider attitudes towards AGYW, including biases toward young women initiating PrEP, need to be actively addressed during training with ongoing support efforts.
Establish **referral systems** to link clients from other channels to sites providing CAB PrEP.	• PrEP is available directly within all public service delivery points. • HTS sites that offer risk assessment for PrEP also make referrals to service points.	• Referral systems will have an increasing importance if CAB PrEP is only available within limited facilities during initial rollout. • Furthermore, referrals will be needed in TB services for oral PrEP due to CAB PrEP and TB medication contraindications.
Integrate support for **partner communication** and services for intimate partner violence response.	• Fears of intimate partner violence (IPV) have been a deterrent for priority populations from continuing PrEP, particularly for PBFP. • Integration of IPV counselling within PrEP access points is recommended but not yet widely operationalized.	• Screening for IPV and support systems to mitigate against IPV should be included within all provider training for PrEP.

Potential delivery channels for CAB PrEP

DELIVERY PLATFORMS

Plans, systems, and processes to support service integration across priority delivery channels, including reproductive health/family planning and private sector providers/pharmacies

	Current situation of oral PrEP	What is needed to introduce CAB PrEP
Integration in **public sector HIV services**	• Oral PrEP is available in all public service delivery points, with a national rollout across all ART sites in 2022. • Oral PrEP is also available in STI services and has referral networks through HTS counsellors. • Youth friendly services in public facilities and mobile sites were rolled out in 2022.	• The initial quantities of CAB PrEP are limited and will be offered to AGYW in select sites as a priority population. • Managing/controlling demand for CAB PrEP will be a challenge. • All service delivery points that give injections and have trained nurses can easily be leveraged for CAB PrEP administration following additional training on CAB PrEP. • HTS sites that offer risk assessment for PrEP can refer potential CAB PrEP clients to service points.
Integration in **public sector FP / SRH / MCH health services**	• Oral PrEP has been integrated in FP and ANC clinics, reaching primarily AGYW and PBFP.	• FP / SRH / MCH services are a great channel to reach AGYW as well as PBFP who will likely be initial priority populations. They also reach general populations and SDCs when larger rollout would initiate. • These services have HCWs who could be easily trained to administer CAB PrEP; providers may require training to support AGYW with youth-friendly counselling. • FP commodities leverage the same supply chain as HIV products through the CMS.

Integration in **NGO clinics / social franchises**	• Several United States Government (USG) partners provide oral PrEP in nonprofit clinics such as:
	  • EGPAF supports implementation in Mansini and Lumbobo through the ASPIRE project
	  • Georgetown University supports implementation in the other two regions, Hhohho and Shiselweni.
		• NGO clinics or social franchise models could be an opportunity for more affordable / free services. Cost is a bit higher than public sector, but lower than private sector with subsidized services (more affordable for all income levels).
		• These services have HCWs who could be easily trained to administer CAB PrEP; providers may require training to support AGYW with youth-friendly counselling.
		• However, there is limited scale due to dependency on subsidized products or donor funding.

Integration in **community-based models** (e.g., FBOs, drop-in-centers, mobile, DREAMS, etc.)	• PEPFAR supports oral PrEP integration in Determined, Resilient, Empowered, AIDS-free, Mentored and Safe partnership (DREAMS) sites focused on AGYW. • Youth friendly PrEP services were rolled out in mobile sites in 2022.	• These community-based models are key drivers for uptake of PrEP among specific populations and will be instrumental for integration of CAB PrEP. Initial priority for CAB PrEP will likely be AGYW and especially those who are engaged in sex work. • Only light training of HCWs (e.g., nurses in DREAMS and DICs) for the sensitization of CAB PrEP is needed. • Supply constraints and decisions related to who will be offered the product could lead to unmet demand. • Sites are highly donor-dependent and high-cost models.
Integration in **private sector clinics and pharmacies**	• Private health facilities already offer ART services with public sector commodities, which could be leverage for PrEP.	• There is an opportunity for MOH when scaling up to consider expanding access to private hospitals and clinics that already offer ART. • Monitoring and data management would be a challenge to get from the private sector as they do not report using the government tools/systems unless they are receiving commodities.

Potential delivery channels for CAB PrEP

For the introduction of CAB PrEP, there is an opportunity to integrate the injection within existing oral PrEP services in all public service delivery sites, including HIV / ART clinics, HTS services, outpatient departments (OPD), and SRH / FP / MCH services. Following the initial phased rollout, CAB PrEP could also expand into existing community-based models (DREAMS, mobile clinics, etc.).

	Access assessment			Capacity assessment		
Service delivery channels	**Reach to HIV-negative priority populations**	**Affordability of services for a range of income levels**	**Offers oral PrEP or other relevant products (e.g., condoms, FP, HIV testing)**	**Existing HIV counseling and testing services**	**HCW capacity to administer CAB PrEP injections and support follow-up**	**Link to national supply chain and temperature-controlled storage for CAB PrEP**
Public sector HIV services	High; limited by stigma for groups outside of SDCs	Very high; government funded free services	Very high; HCWs trained to provide SRH services	Very high; HIVST available in all facilities	High; however experiencing HCW shortages	Medium; intermittent PrEP stock outs of government-funded commodities
Public sector SRH / FP/ MCH health services	Medium; strong reach to HIV neg women; however not viewed as youth-friendly	Very high; government funded free services	High	Medium; HCWs trained on HIV prevention and PrEP	High; already offer IM injections	Medium; intermittent PrEP stock outs of government-funded commodities
NGO clinics / social franchises	High; particularly for KPs and AGYW	High; free services available through donor support or at a low cost	Very high; wide number of PrEP implementing organizations	High	High	Medium; possible risk of stock outs if using national supply chain
Community-based models (e.g., FBOs, mobile, DICs, DREAMS, etc.)	Very high; particularly for youth-friendly services, AGYW and KPs	Medium; services offered for free with donor support but is high-cost programming	High; many differentiated models available for oral PrEP	High	High; nurses available within DREAMS and DICs	Medium; possible risk of stock outs if using national supply chain and lack of temperature controls in mobile sites
Private sector clinics and pharmacies	Medium; wide access to general population but limited access to KPs	Limited; out of pocket payments mostly required	Limited; possibility in pharmacies for resupply but cannot initiate PrEP	Limited; lack of standardized training in HIV services	Medium; can administer IM injections but need training on PrEP methods	Limited; supply of ART and PrEP is modest and less accessible for resupply

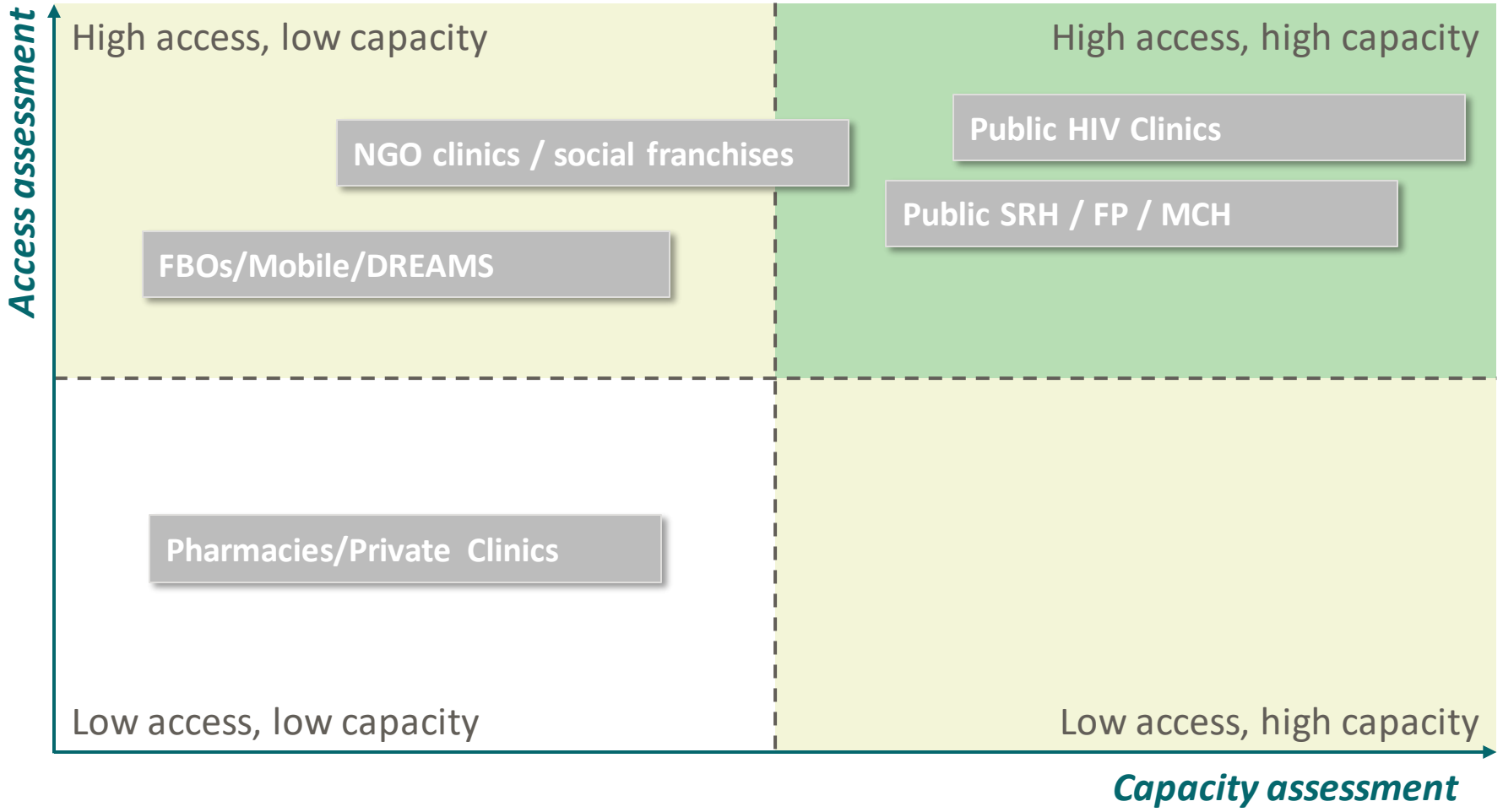
Rating key Very high / high access or capacity Medium access or capacity Limited access or capacity

Prioritizing delivery channels for CAB PrEP

DELIVERY PLATFORMS

- Bringing together the access and capacity dimensions allows us to assess delivery channels against **both criteria**
- The channels in the **upper right corner** have both high capacity to integrate CAB PrEP within HIV prevention services and high access to priority HIV negative populations who would benefit from CAB PrEP
- Channels in the **upper left** have less capacity to integrate CAB PrEP, but have high access to priority HIV negative populations
- Channels in the **lower right** have less access to priority HIV negative populations but have high capacity to integrate CAB PrEP
- Channels in the **lower left** have neither the capacity or reach to effectively integrate CAB PrEP

Delivery channel prioritization



Uptake & effective use key steps

	Current situation of oral PrEP	What is needed to introduce CAB PrEP
Develop and implement **demand generation strategies** that include CAB PrEP promotion.	• The Eswatini National PrEP Communication, Advocacy and Behavior Change Strategy was launched in January 2023. It provides guiding principles, objectives, and strategic approaches for communication as well as identifies target populations for PrEP, key messages, channels, and coordination of stakeholders. • During the initial rollout of oral PrEP, the Global Fund and PEPFAR-funded initiatives advanced demand generation for priority populations (AGYW and KPs). Also, CSO partners coordinated to focus on a certain group and supported initiation, demand generation, and navigating clients to clinical services.	• There is an opportunity to build on the existing communication plans as well as demand generation campaigns to integrate CAB PrEP. • In general, there is a need for more demand generation that promotes product choice and the use of PrEP agnostic of the product form. • The Global Fund has made an application to continue supporting demand generation at the national level.
Address social norms/stigma to build **community and partner acceptance** of CAB PrEP use.	• There continues to be high stigma associated with oral PrEP, particularly linked to stigma on ARVs due to the pill packaging. The improved packing of the combi prevention with condoms helped address this. • Furthermore, misconceptions on the use and benefits of PrEP persist, particularly among young KPs who questioned “why take a pill to avoid taking another pill”. • Initial rollout of oral PrEP focused on women, and so there was a higher uptake among females. However, this created challenges when leaving out male partners who are often responsible for decision-making around medical services and family planning. Greater male engagement will be important moving forward. • There is a need for greater education at the community level on HIV prevention methods, especially for PBFP as well as male partners in order to mitigate against GBV.	• Injectable will address some of the stigma concerns with improved discretionand privacy for the injectable form of CAB PrEP. • However, injectables can be taken with apprehension, e.g., men stigmatize injectable contraception and have misconceptions on “how [contraceptive injectables] change women pyschologically and sexually”. There will be a need for social behavior change communication to counter all myths and misconceptions.
Develop **information and tools for clients** to support product choice.	• There are many IEC tools available for oral PrEP as well as radio campaigns, jingles, screens at traffic lights, posters and online platforms. • PrEP ambassadors have also helped increase uptake for young people at the community level. • Implementing partners responsible for PrEP delivery sites also run their own campaigns on the ground at the community-level based, using key messages from the MOH.	• IEC materials will need to help change perception on injections as well as educate people on CAB PrEP and its potential side effects.
Support **effective use** of CAB PrEP.	• There is good awareness of PrEP for AGYW and KPs, however there is still need to improve the community awareness on HIV prevention products and where to find access locations. • Nevertheless, HIV incidence remains high, and the main issue is adherence. Women agree to initiate PrEP, but they do not believe they are at risk.	• Stakeholders hope that the long-acting injectable form of CAB PrEP will help with the issue of adherence; however, there will be a need for education on the issue of drug resistance with potential misuse.

Monitoring, evaluation & learning key steps

	Current situation of oral PrEP	What is needed to introduce CAB PrEP
Update or establish **integrated monitoring tools** to support data collection and analysis on PrEP use across multiple products.	• Eswatini is currently using an electronic health information system alongside paper-based tools to collect data on service delivery, as well as commodity distribution, for oral PrEP. The transition to electronic tools is still underway and hindered by provider reluctancy to stop stop using paper-based registers. • NAVISON is an important system that supports supply chain management and triggers re-ordering for oral PrEP.	• The PrEP core team is in the process of incorporating CAB PrEP indicators into the existing M&E framework and tools.
Establish systems for **pharmacovigilance** and to monitor drug resistance.	• Oral PrEP has been included in MOH pharmacovigilance systems. • MOSAIC supports MOH-led national HIV Drug Resistance monitoring for PrEP.	• CAB PrEP will need to be included within the existing MoH pharmacovigilance system. • MOSAIC is monitoring for HIV DR within all PrEP access points in Eswatini until January 2026. Thereafter, then will need to see how to set up national HIV DR monitoring.
Conduct **implementation science** research to inform policy and scale-up.	• Oral PrEP implementation began with a small-scale and phased rollout to inform implementation planning at a larger scale. • Phase 1 of oral PrEP rollout focused on public ART facilities with high volumes of potential end users, then phase 2 focused on medium volume facilities. While there were some initial challenges at first for provider buy-in, the phased approach allowed to target HCW training and sensitization so that providers understood the importance of PrEP. • Major success for MOH to open eligibility to anyone interested in PrEP (rather than excluding only for priority populations), which helped to normalize PrEP and reduce stigma.	• The MOH does not feel that a demonstration study is needed and that CAB PrEP can be integrated within existing oral PrEP programming in a ”pilot”. A small CAB PrEP pilot in a limited number of facilities will help understand challenges and successes in order to inform scale up.

Current situation of HIV prevention

Findings for CAB PrEP introduction planning

Sources and notes

Note on terminology

In efforts to be more precise and not contribute to the stigmatization of people living with HIV or those who may benefit from HIV prevention products, we have made a few language shifts:

- **Serodifferent instead of serodiscordant**. This change reinforces that while the HIV status of people can be different, it does not put them in discord. It is completely okay for people to have different HIV serostatuses.
- **Minimizing use of the terms "risk" and "risky."** The terms can have so many different definitions and may stigmatize certain behaviors, impose labels on clients, or stigmatize living with HIV itself.
- Using **gender-neutral terms when text is not specifically about gender**. The terms are more inclusive of various gender identities.

Acronyms

AIDS	Acquired immunodeficiency syndrome
AGYW	Adolescent girls and young women
ANC	Antenatal care
ART	Antiretroviral Therapy
ARV	Antiretroviral
AYP	Adolescent and young people
CAB PrEP	Long-acting cabotegravir PrEP
CDC	United States Centers for Disease Control and Prevention
CMS	Central Medical Stores (CMS)
CSO	Civil society organization
DMU	Data Management Unit
DREAMS	DREAMS Initiative (Determined, resilient, empowered, AIDS-free, mentored, and safe)
DSD	Differentiated service delivery
ED	Event driven PrEP
EML	Essential Medicines List
ENAP	Eswatini National AIDS Program
FP	Family planning
FSW	Female Sex Worker
GBV	Gender-based violence
GF	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GHSC	USAID Global Health Supply Chain Program
GKoE	Government of the Kingdom of Eswatini
HCW	Healthcare workers
HIV	Human Immunodeficiency Virus
HTS	HIV testing services
IEC	Information, education, and communication
IPV	Intimate partner violence
KP	Key population
LMIS	Logistics management and information systems
MCH	Maternal and child health
MOH	Ministry of Health
MOU	Memorandum of understanding
MSM	Men who have sex with men
NAVISON	Warehouse information management system
OPD	Outpatient departments
PEPFAR	President's Emergency Plan for AIDS Relief
PrEP	Pre-exposure prophylaxis
PWID	People who inject drugs
SRH	Sexual and reproductive health
STI	Sexually transmitted infections
TNBP	Trans and nonbinary people
TWG	Technical Working Group
USAID	United States Agency for International Development
USG	United States Government
WHO	World Health Organization

Key stakeholders interviewed

Interviews were conducted by Mann Global Health in partnership with Viiv Healthcare

	NAME	TITLE	ORGANIZATION
1	Sindy Matse	National PrEP/KP Coordinator	Ministry of Health
2	Fortunate Bhembe	Deputy Director Pharmaceuticals	Ministry of Health
3	Rejoice Nkambule	Deputy Director Public Health	Ministry of Health
4	Nicholas Kisyeri	DSD Coordinator	Ministry of Health
5	Fikile Ngwenya	ENAP Pharmacy	Ministry of Health
6	Lenhle Dube	HTS	Ministry of Health
7	Setsabile Gul	National M & E Coordinator	Ministry of Health
8	Bongani Masango	VMMC and Prevention Coordinator	Eswatini National AIDS Program
9	Gezani Mamba	Technical Advisor	Elizabeth Glazer Pediatric AIDS Foundation
10	Dr. Rhinos	George Town University	Georgetown University
11	Dr. Bernard Kerschberger	Country Director	MSF
12	Edwin Mabhena	Medical Activities Manager	MSF
13	Ralisele Nthethe	Pharmacist	Link Pharmacy (Mbabane Woodlands)
14	Garikai Shambira	Director	LinkMed Pharmacy
15	Nomakhwezi Mathunjwa	Pharmcist	Swazi Pharm
16	Zanele Dlamini	Nurse	The Clinic Group
17	Maggie Khanyile	Operations and Clinical Manager	SwaziMed
18	Chantell Hulett	Technical Lead Prevention	PACT
19	Dr. Endale Tilahun	Country Director	PSI Eswatini
20	Khulekani Magongo	Young heroes	Young Heroes
21	Lungile Khumalo	VooV	VooV
22	Dr. Jabuliso Lukhele	Senior Medical Advisor HIV prevention	USAID
23	Dr. Michelle Adler	Country Director	CDC
24	Dr. Nomthandazo Lukhele	WHO	WHO
25	Dr. Advocate Dlamini	Global Fund/CCM	Global Fund/CCM
26	Nokuthula Mdluli	UNICEF	UNICEF
27	Sive Dlamini	Retail Pharmacy Association	Retail Pharmacy Association

Key stakeholders interviewed

Interviews were conducted by Mann Global Health in partnership with Viiv Healthcare

	NAME	TITLE	ORGANIZATION
28	Priyani Mahaliyana	Registrar	Medical and Dental Council
29	Thobile Dlamini	Eswatini Business Health & Wellness	Eswatini Business Health & Wellness
30	Dr. Rhinos Chekenyere	Senior Clinical Advisor	Georgetown University
31	Gezani Mamba	Health Services Manager	ASPIRE Project
32	Anita Hettema	Technical Advisor Biomedical Prevention	FHI 360-MOSAIC
33	Dr. Njabuliso Lukhele	Senior Medical Officer	PEPFAR-USAID
34	Phumzile Mndzebele	National HIV/TB Senior Program Officer	PEPFAR-CDC
35	Lenhle Dube	HTS Coordinator	MOH-ENAP
36	Arleta Ndlela	GMU Director	CANGO
37	Dr. Bongani Masango	Voluntary Medical Male Circumcision Coordinator	MOH-ENAP
38	Mazwi Mavuso	Acting Country Director	NERCHA
39	Dr. Nyakallang Moyo	Program Management Specialist	PEPFAR-USAID
40	Dr. Harriet Nuwagaba-Biribonwoba	Research Director	ICAP
41	Sindy Matse	Program Manager	MOH
42	Timothy Rosche	Eswatini Country Director	PSM (Chemonics)

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