# Private Sector Market Assessment: Eswatini

SEPTEMBER 2023

SIVINQABA

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USAID
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MOSAIC
Maximizing Options to Advance Informed Choice for HIV Prevention

MOH
HIV /AIDS
SNAP
SWAZILAND NATIONAL AIDS PROGRAM

# Table of contents

# Acronyms

| | |
|---|---|
| **AGYW** | Adolescent Girls and Young Women |
| **ART** | Anti-Retroviral Therapy |
| **ARV** | Antiretroviral |
| **CAB PrEP** | Cabotegravir Long-Acting |
| **DSD** | Differentiated Service Delivery |
| **EC** | Emergency Contraception |
| **EpiC** | Meeting Targets and Maintaining Epidemic Control |
| **FBO** | Faith-Based Organization |
| **FP** | Family Planning |
| **GoE** | Government of Eswatini |
| **HCW** | Health Care Worker |
| **HTS** | HIV Testing Services |
| **KP** | Key Population |
| **MoH** | Ministry of Health |
| **MSM** | Men who have Sex with Men |
| **MoU** | Memorandum of Understanding |
| **NGO** | Non-Governmental Organization |
| **OOP** | Out-of-Pocket |
| **PPP** | Public-Private Partnership |
| **PrEP** | Pre-Exposure Prophylaxis |
| **PrEP ring** | Dapivirine vaginal ring |
| **SRH** | Sexual and Reproductive Health |
| **SW** | Sex Worker |
| **TB** | Tuberculosis |

# 1

# SCOPE, APPROACH, AND RATIONALE

# Private sector market assessment

## Rationale

| | |
|---|---|
| **WHAT is the goal of this work?** | This market assessment explores the opportunities and barriers to leveraging private sector channels to expand access to new and existing pre-exposure prophylaxis (PrEP) methods, including oral PrEP, the dapivirine vaginal ring (PrEP ring), and long-acting cabotegravir (CAB PrEP). |
| **WHY is this work needed?** | PrEP delivery is primarily driven by the public sector. However, differentiated service delivery (DSD) models that engage the private sector present a real opportunity to achieve sustainability, scale, and program effectiveness. |
| **HOW is "private sector" defined?** | The commercial or business entities that typically charge a fee for service. Faith-based organizations (FBOs) and non-governmental organizations (NGOs) are out of scope. |
| **WHO is this work for?** | National HIV programs, private sector stakeholders (including pharmacy and provider associations), donors, and implementers. |

## Methods

### Stakeholder interviews

We conducted 29 key informant interviews with stakeholders including government entities, private providers, implementing organizations, and civil society. Several interviews included more than one stakeholder (February–April 2023).

### Desk review

We reviewed over 25 documents, including epidemiological data, policy documents, and previous assessments in Eswatini. Much of this documentation was grey and/or project literature.

### Consultative workshop

We reviewed a preliminary draft of the analysis with experts at FHI 360 in Eswatini to identify key gaps and areas for further exploration and analysis, as well as priority setting for Year 2 (Y2) of MOSAIC.

# Our hypothesis

Private sector engagement can drive reductions in HIV incidence **by making services more accessible and reducing public sector burden.**


Private sector engagement can also provide pathways to **more sustainable PrEP delivery** by...

1. Tapping into third-party financing, such as medical aid schemes or corporate financing
2. Using existing commercial infrastructure and systems (e.g., supply chain and outlets)
3. Proving to commercial actors the value of independent investment in the delivery of HIV prevention services

# Each channel was analyzed to assess its ability to deliver expanded access to PrEP, in line with our hypothesis

**Channel overview**

- What is the size and reach of the channel?
- What are the channel characteristics, including organization and regulation, potential and populations served?

**Experience with public-private partnerships (PPPs) in channel**

- How has the channel been engaged in previous PPPs to improve public health?
- What are the key learnings from this experience?

**User acceptability and provider capacity factors**

- Does the channel meet the needs of users?
- What capabilities do channels have to serve users with PrEP methods?

*This framework draws upon the US Agency for International Development (USAID)/OPTIONS OPTIONS Plan 4 PrEP Toolkit: Private Health Sector Landscape.*

# User acceptability and provider capacity were further analyzed according to the following factors

| User acceptability factors | |
|---|---|
| **Acceptability and accessibility** | Channel is perceived by users as meeting their needs and being within reach. |
| **Affordability** | Products and services offered through this channel are affordable for users in need of HIV methods with a range of income levels. |
| **Product portfolio** | Other products that are relevant to users vulnerable to HIV (e.g., HIV testing, oral PrEP, family planning) are offered through this channel. |

| Provider capacity factors | |
|---|---|
| **HIV testing and user support** | The HIV testing services and prevention counseling required to initiate and support effective use are feasible within the channel. |
| **HCW capacity** | Channel has healthcare workers (HCWs) on staff who can initiate PrEP use (including injections) and support follow-up. |
| **Facility requirements** | Channel has private space for users to receive counseling or deliver PrEP injections. |

*This framework draws upon the USAID/OPTIONS Oral PrEP Introduction Planning Toolkit.*

# Key recommendations based on our analysis

*(These recommendations are applicable to all partners in Eswatini and should not be considered as solely for MOSAIC partners)*

## 1 Build on existing clinic-based PPP models supporting ART and introduce PrEP initiation and resupply

Ministry of Health (MoH) partnerships supporting the delivery of public sector anti-retroviral therapy (ART) can be be leveraged to expand PrEP delivery. Memoranda of understanding (MoUs) and a system of supply and reporting already exist. Introduction of PrEP is an opportunity to address existing bottlenecks and challenges, such as gaps in reporting. Although reach will be limited, engagement with a trusted channel will provide an opportunity to address MoH concerns of engaging the private sector before advocacy for expansion in other channels such as pharmacies.

## 2 Build on existing DSD interventions to expand PrEP resupply into pharmacies

Early wins in clinics can be leveraged to advocate for expanded engagement of pharmacies. Pharmacies, particularly those in chains which are better organized and likely to adhere to guidance, offer the greatest opportunity for expanded access. Concerns about quality of care and pricing have tempered plans to introduce oral PrEP resupply in pharmacies to date. Regulatory issues in pharmacies also need to be resolved (i.e., building MoH capacity to register and oversee pharmacists and pharmacies that have been licensed). Advocacy with the government can support introduction of CAB PrEP in pharmacies via policy changes and placement of qualified cadres within high-volume facilities. Chain pharmacies attached to clinic and nurses can be engaged to initiate and resupply PrEP.

## 3 Invest now to build the enabling environment for future sustainability

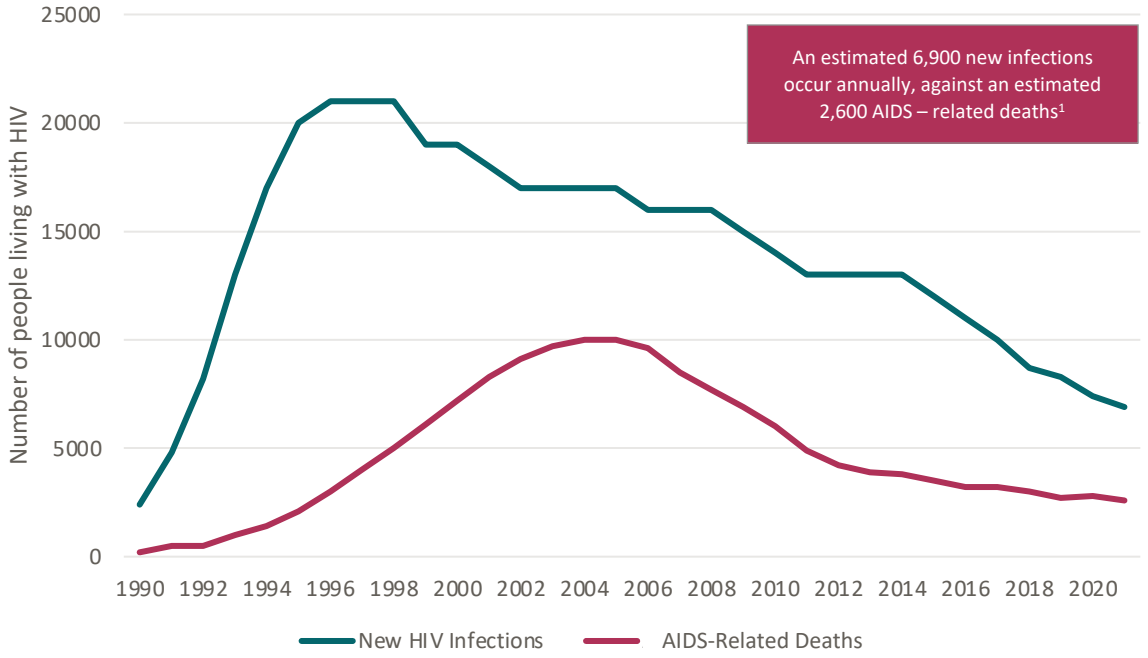
The pharmaceutical sector, in particular, has significant gaps oversight and regulation, demonstrated by the gap in pharmacies licensed by the Medical and Dental Council and those registered (and regulated) by the MoH. Resolving regulatory and oversight issues will enable the government to leverage private sector channels while addressing concerns of reporting and quality of care.

# 2 THE CONTEXT: HIV AND PREP IN ESWATINI

# While Eswatini nears epidemic control, new infections remain high

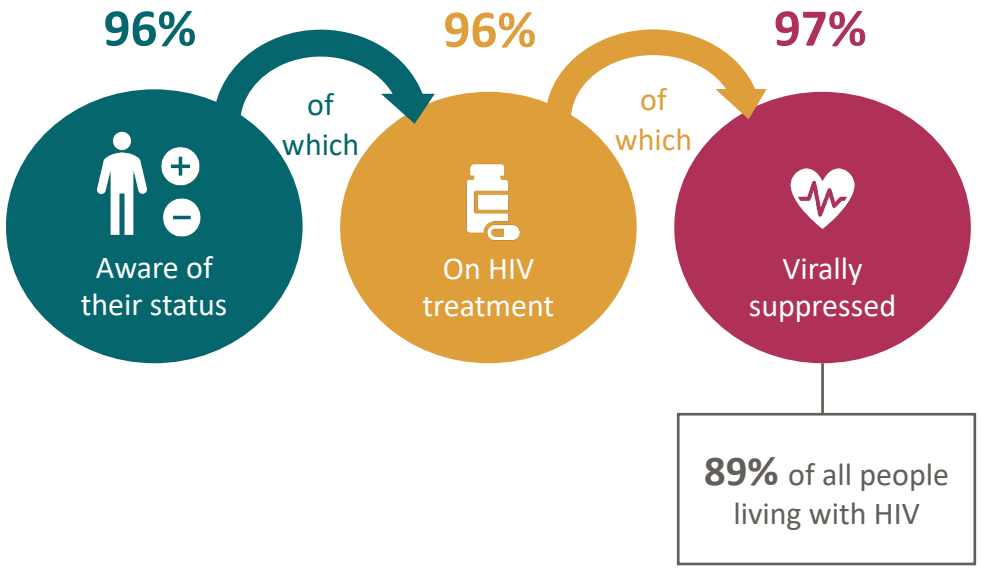
- Annual HIV-related deaths have declined by an estimated **74% since 2005,** with an overall reduction **of new infections by 67%** since 1998.[1]
- An estimated 215,200 people in Eswatini are living with HIV, which remains the leading cause of death.[2]
- Eswatini is one of the few countries to meet 95-95-95 targets in sub-Saharan Africa.

## HIV INCIDENCE AND AIDS-RELATED DEATH, ALL AGES, 1990–2020[1]




## PROGRESS AGAINST 95-95-95 GOALS, AGE 15–64, 2021[2]

Eswatini is **one of only two countries** that has achieved 95-95-95 fast track targets




*(1) UNAIDS Epidemiological Estimate 2021; (2) Eswatini Country Operating Plan COP 2022; (3) Eswatini PHIA 2022*

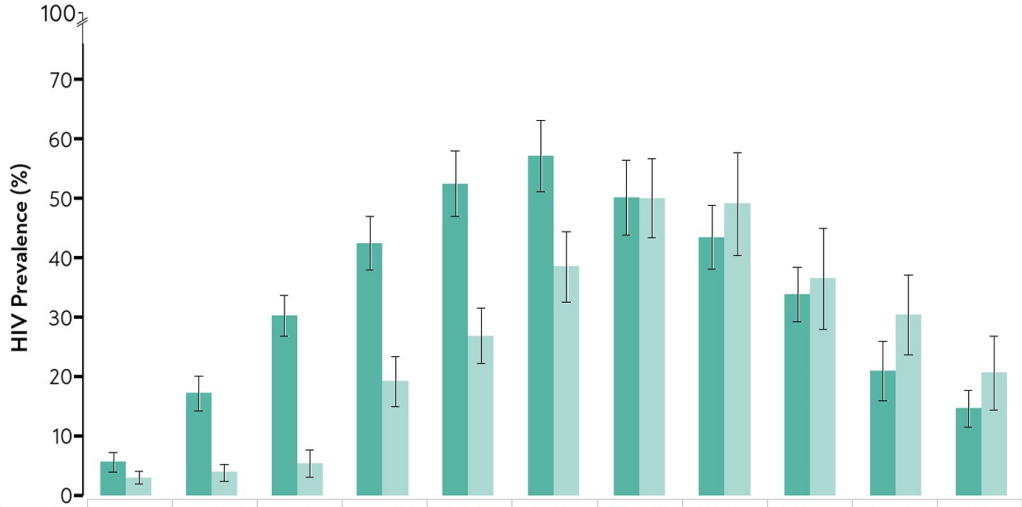
# Young women are disproportionately impacted by HIV

- HIV **disproportionately affects women** in Eswatini - 36% of women over 15 years old are living with HIV, compared to 19% of men.[1] Of new HIV infections in 2021, **women's infection rates were seven times higher than men.[2]**

- Sex discrepancies are particularly acute among young people; the prevalence among women aged 15– 19 years is nearly **two times higher** than among men in the same age bracket, and the prevalence among women aged 20–24 years **is over four times higher** than men in the same age bracket.[2]

- Adolescent girls and young women (AGYW) aged 15–24 years have the highest incidence of new infections among women, comprising **38% of overall new infections in Eswatini.**[3]

**HIV PREVALENCE BY GENDER AND AGE, 2021[2]**




| Ages (years) | 15-19 | 20-24 | 25-29 | 30-34 | 35-39 | 40-44 | 45-49 | 50-54 | 55-59 | 60-64 | 65+ |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Women | 5.6% | 17.2% | 30.3% | 42.5% | 52.5% | 57.2% | 50.1% | 43.5% | 33.8% | 21.0% | 14.7% |
| Men | 3.0% | 3.9% | 5.4% | 19.2% | 26.9% | 38.5% | 50.0% | 49.2% | 36.5% | 30.4% | 20.7% |

Error bars represent 95% CIs.

*(1) UNAIDS Epidemiological Estimate 2021; (2) Eswatini Population-based HIV Impact Assessment PHIA 2022; (3) UNAIDS, the state of HIV prevention in Eswatini 2021*

# Increasing HIV prevalence among men who have sex with men (MSM) and sex workers (SWs)

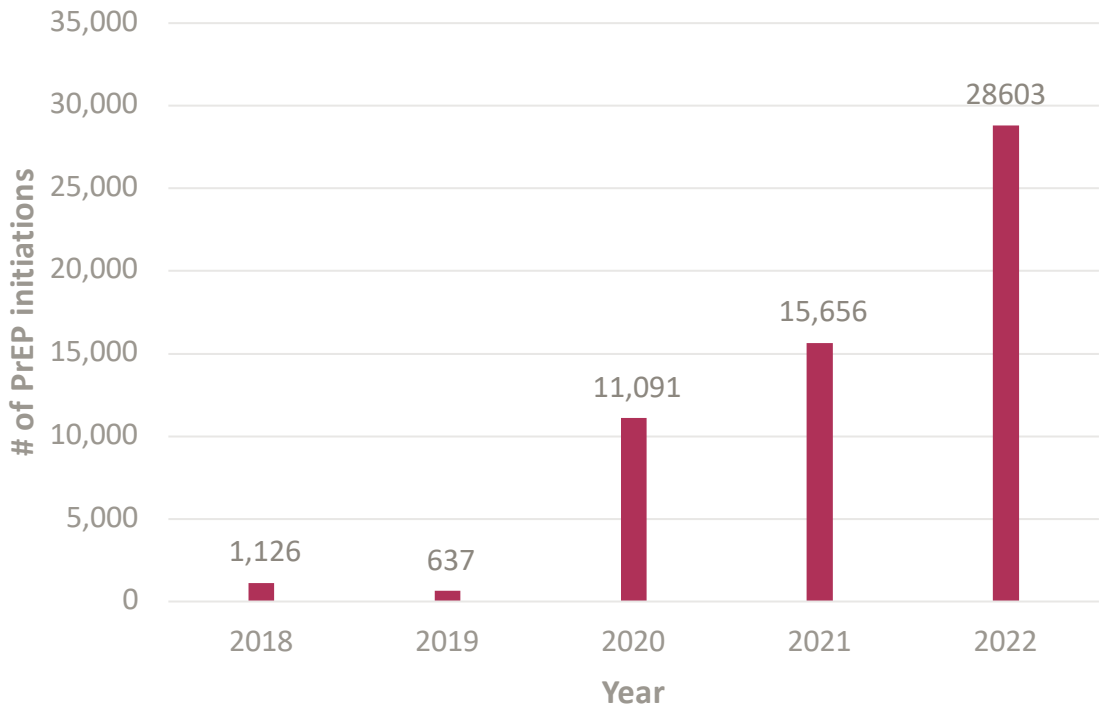
- High HIV prevalence among SW, MSM, and transgender people.
- Despite a relatively small population of MSM, nearly a quarter are living with HIV.[1]
- Prevalence among MSM and SW has increased since 2020.[2]
- Target number of new key populations (KPs) initiated on PrEP will increase from 2,328 in COP21 to 2,829 in COP22.[1]

| KPs | Population size estimates[3]/prevalence | Considerations |
|---|---|---|
| Female sex workers | 12,796 / 59% | The punitive laws around lesbian, gay, bisexual, transgender, queer persons, and sex work, and use of injectable drugs continue to block effective responses for HIV prevention among these populations. |
| MSM | 4,325 / 21% | |
| People who inject drugs | 100 / unknown | |
| Transgender people | 150 / 41% | |

*(1) Eswatini COP 2022; (2) UNAIDS Epidemiological Estimate 2021; (3) Programmatic data provided by FHI 360, verified during PrEP-IT meeting (the average population size was considered for previous 3 years (2020,2021,2022))*

# PrEP coverage is increasing

Annual PrEP initiations, 2018–2022[1]




*As a reference, Zimbabwe had just over 50,000 cumulative users in the same time period, while Lesotho had just over 25,000 cumulative users through 2022.*

**57,340** Cumulative PrEP initiations since program inception; most significant growth came in 2022. Initiations in Eswatini compare favorably to Lesotho and Zimbabwe given the significantly higher populations in both countries.

**137%** U.S. President's Emergency Fund for AIDS Relief PrEP targets were exceeded in 2022 (target was 20,993).

**57%** Increase in PrEP targets for AGYW (7,359 in COP21 to 11,577 in COP22) and 21% increase for KPs from 2,328 in COP21 to 2,829 in COP22.

**Key success:** The MoH was supportive of product introduction and led coordination of rollout and scale-up through all public sector ART sites. This was the foundation for quality coverage and access.

**2022 priorities** included increasing youth-friendly services through facilities and mobile platforms, and integrated linkages with FP and sexually transmitted infection services.

*(1) PrEPWatch, Eswatini [cited 2022, March 9]*

# PrEP Program Performance

## *Despite strong performance, challenges impact new and prevention effective use*

### Data for decision making

- **Poor data availability -** especially in the private sector – limits ability to monitor and produce insights that improve PrEP program performance.

### Gaps in service delivery

- Where service delivery points have expanded (i.e. mobile clinics and drop-in centers) they are limited to KP and DREAMS supported AGYW.
- **PrEP packaging linked to antiretrovirals (ARVs).**

### Health system challenges

- **Supply challenges** for commodities and frequent stock-outs in the public sector**.**
- **Trained personnel are** primarily in the public sector, limiting ability of private sector HCWs to participate.
- Stigma perpetuated by HCWs (e.g., belief that PrEP promotes promiscuity).

### Myths and misconceptions

- **Users conflate PrEP with treatment.**
- **Stigma** associated with taking PrEP with behaviors not condoned by society and linkages to being HIV positive.

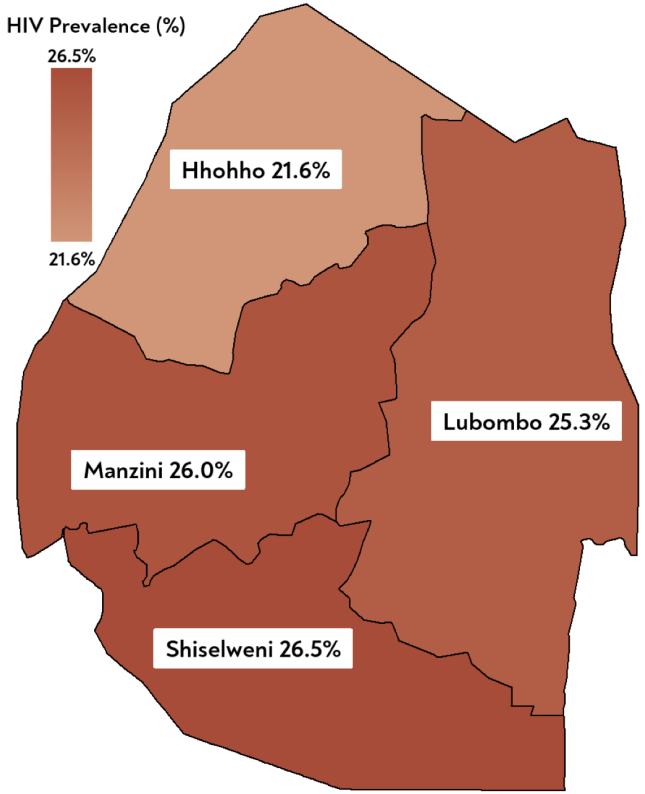
# As new PrEP products enter Eswatini, there are expanded opportunities for increased access

| Product | Type | Frequency | Efficacy | Provider/facility requirements |
|---|---|---|---|---|
| **Approved - widely available** | | | | |
| **Oral PrEP** (TDF/FTC or TDF/3TC) | Oral pill | Daily or event-driven | ±90% risk reduction when used as prescribed | ▪ **Prescription by nurse** or higher<br>▪ Resupply on prescription by lower-level provider<br>▪ **Private space for counseling, initiations, and refills** in line with guidance<br>▪ HIV testing<br>▪ Referrals |
| **Conditional approval - not available beyond a few Medecins San Frontieres sites and soon the MOSAIC study** | | | | |
| **Dapivirine vaginal ring** (PrEP ring) | Vaginal ring | Monthly | 35% risk reduction in Phase III trials; about 50% risk reduction with consistent use in open-label extension studies | ▪ **Prescription by nurse** or higher<br>▪ Private space for demonstration/first insertion and counseling in line with guidance (initiations)<br>▪ HIV testing<br>▪ Referrals |
| **Approved - not yet available but planned for implementation science** | | | | |
| **Cabotegravir long-acting** (CAB PrEP) | Injection | Every two months (after two initiation doses, one month apart) | 89% higher effectiveness in cisgender women compared to oral PrEP; 69% higher effectiveness in cisgender men and transgender women who have sex with men compared to oral PrEP | ▪ **Prescription by nurse** or higher<br>▪ **Ability to inject** (currently nurse or higher)<br>▪ **Private space for injection in buttocks** and counseling in line with guidance<br>▪ HIV testing<br>▪ Referrals |

*Slide credit: MOSAIC*

# HIV burden is high in rural areas, which have limited private sector reach

- **76% of the population lives in rural areas;** the highest population density is the Manzini-Mbabane corridor.[1]
- Close to half (46.0%) of households in Eswatini have at least **one HIV-positive household member.[2]**
- The burden of HIV is higher in rural areas; the percentage of households with **two or more HIV-positive members is greater in rural areas** (31.8%) compared with urban areas (21.3%).[2]
- About one in three (35.3%) households had an HIV-positive head of household.[2]




- **Many ART clients already use private facilities** as they offer ease of access due to shorter travel time, faster services, more convenient hours, and better-quality services.
- Manzini and Hhohho report the most private sector facilities.

*(1) Eswatini COP22; (2) Swaziland HIV Incidence Measurement Survey (SHIMS)2 Final report;*

# 3

# ANALYSIS OF PRIVATE SECTOR CHANNELS IN ESWATINI

Three primary commercial private sector channels present opportunities for the delivery of PrEP methods, including oral PrEP, the PrEP ring, and CAB PrEP.

# Why engage the commercial private sector to expand access to PrEP products?[1]

| | |
|---|---|
|  | For **users**, the private sector is perceived to offer **confidentiality, convenience,** and **flexibility,** presenting clients with a **higher quality experience** — especially KPs, AGYW, and women at risk of HIV. |
|  | For **private providers**, offering PrEP allows them to expand their value proposition by offering choice and **holistic services** that attract and retain clients. |
|  | Private sector models have **demonstrated some success** in shifting **burden off the public sector** with programs supporting condoms and PPP models for HIV/tuberculosis (TB). |
|  | **The MoH** has demonstrated some **experience and commitment to partnering with the private sector** to deliver HIV prevention and treatment services. |

> *Private facilities are very willing to offer ART and PrEP dispensing for a small consultation fee as they see the benefit of gaining new customers for other products.*
>
> *- MoH official*

*(1) PrEP distribution in pharmacies: a systematic review https://bmjopen.bmj.com/content/12/2/e054121, project literature*

# Several populations can benefit from private sector PrEP delivery

| Potential population segments | What suggests that the private sector may improve access? |
|---|---|
| **Cisgender women**<br><br>*AGYW, especially in specific urban areas* | ▪ Secondary analysis of a randomized trial found that of those who initiated PrEP, preferred delivery settings were outpatient services (31%), HTS (26%), FP (21%), and antenatal services (14%). [1]<br>▪ For university students, the private sector offers more convenient operating hours to accommodate busy work and school schedules, especially for refills.<br>▪ AGYW in secondary school cannot access services at school due to Ministry of Education restrictions.<br>▪ AGYW reported that the private sector offers more discretion and less judgmental healthcare providers (a recent survey found that 27% of AGYW who discontinued PrEP did so after a bad encounter with a healthcare provider).[2]<br>▪ Limited information suggest uptake of sexual and reproductive health (SRH) services in the private sector: private pharmacies are believed to be a primary source for emergency contraception (EC) among young women/AGYW.<br>▪ Workers often lack the flexibility to leave their jobs to attend a clinic during open hours; convenience of the private sector would be paramount. |
| **KPs** *(MSM, female sex workers, TG)* | ▪ A dearth of information on KPs limited analysis, but secondary information and insights from the region indicate a preference by some KPs for private outlets that offer greater convenience (longer working hours located to home and work), greater acceptability and reduced stigma, and perceived higher quality of care. |
| **Men** | ▪ While data are lacking, stakeholders report concern that men are being "left behind" by current PrEP programs as men are less likely to access primary healthcare services that are oriented toward women.[3]<br>▪ Men, who typically have poor health seeking behavior, are likely to prefer the convenience and confidentiality of private outlets and are more likely to participate in the formal employment sector and thus have medical aid/insurance. |

**KEY DATA GAP: Where users access PrEP - and general health seeking behaviors across the board - is a challenge in Eswatini.** Data on private sector use among AGYW are limited. Anecdotally, stakeholders report targeted use of private sector channels (especially pharmacies) for contraception and menstrual health products, particularly EC. Further work with AGYW populations needs to validate these findings.

*(1) Inghels, et al. PrEP uptake and delivery setting preferences among clients visiting six healthcare facilities in Eswatini, 2022; (2) Chakare et al. HIV risk perception and salience, 2020; (3) Stender S. and Rozario A., "Khotla Bophelong Bo Botle": a gathering of men for health, 2020*

# Eswatini's health infrastructure

- **The Eswatini health sector is organized in a four-tier system.**[1] The informal sector consists of traditional health practitioners and other unregulated, unregistered service providers. The formal health sector is based on the concepts of primary health care and decentralization.[2]
- Public health units **concentrate on provision of primary health care services** and constitute the base for outreach services while **health centers** have traditionally focused on **curative and in-patient care** and primary health care.[1]
- **Clinics are divided into Type A** (not offering maternity services) **and Type B** (offer maternity services).[1] **About 95 clinics, or nearly half, are private.**
- **NGO-managed facilities (including FBOs)**, constitute 60% of health facilities.
- **While the MoH reports 60 registered pharmacies**, a non-published report cited **446 retail pharmacies were licensed between 2009 and 2022 of which 241 had been newly-licensed or had renewed their licenses in 2022**.

1 national referral hospital
5 regional referral hospitals
3 specialized hospitals
**9 private hospitals**

5 health centers
7 public health units
231 clinics total
**80 private clinics owned by doctors**
**15 private clinics owned by nurses**
65 specialized clinics

Community-based care supported by rural health motivators, FBOs, volunteers, and traditional practitioners

*(1) Eswatini SARA 2017; (2) WHO Country Cooperation Strategy at a glance 2018; (3) Eswatini Country Report*

# Human resources for health

- **Eswatini is experiencing a critical professional HCW shortage with only 1.95 nurses/midwives per 1,000 population and 0.24 physicians per 1,000 population.** Shortages of qualified staff have been described as a barrier to PrEP implementation in sub-Saharan Africa.[1]
- **Shortages of staff also result in costly interruptions of workflow.** On average, PrEP initiation required 29 minutes of HCW time, 16 minutes for PrEP follow-up. Interruptions of the workflow added, on average, 3.4 minutes to the time HCWs need for a given number of PrEP activities. The cost of an interrupted workflow was estimated at $0.048–0.87 depending on whose time need increased.[2]

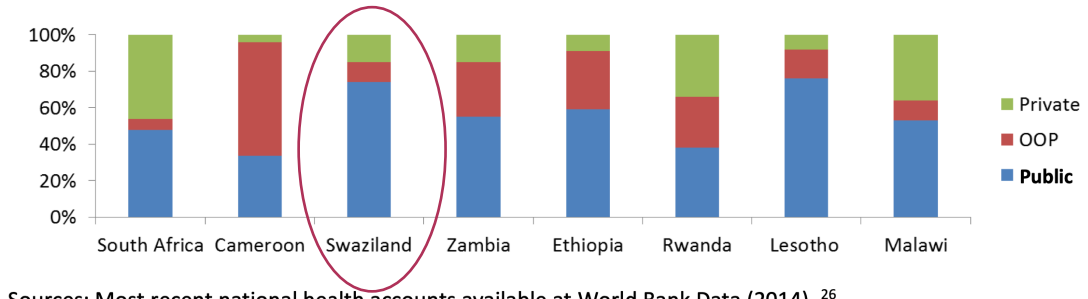
## Eswatini health workforce data[1]

| Category of clinician | Number (2018) |
|---|---|
| Physicians | 278 |
| Nurses and midwives | 2,218 |
| Pharmacists and Technicians | 281 |
| Laboratory Technicians | 370 |
| Community Health Workers | 6,324 |

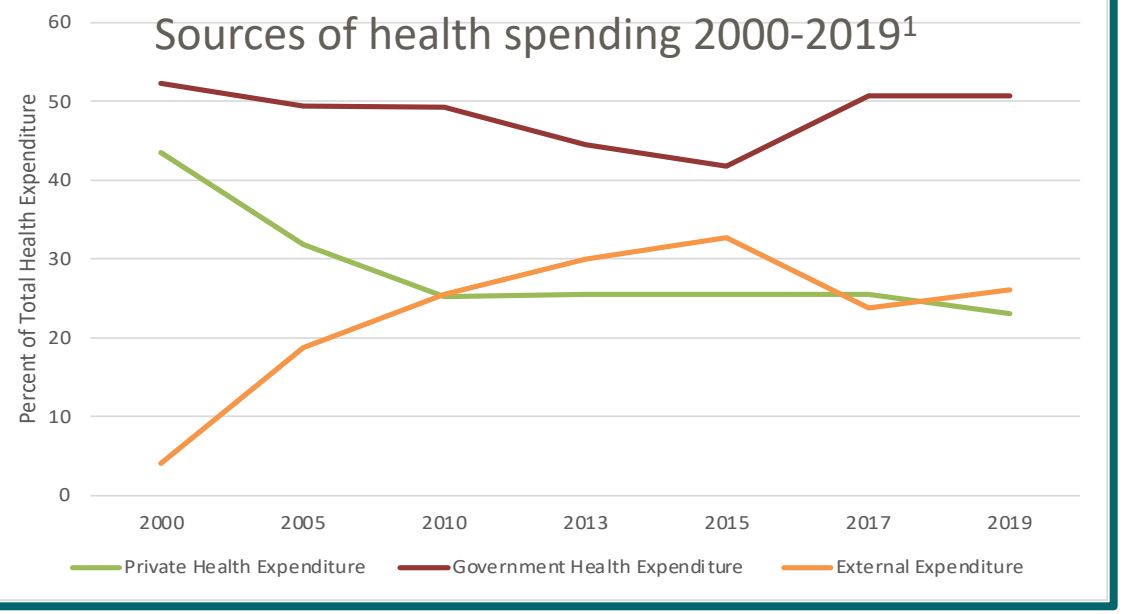
*(1) WHO 2021 The State of the Health Workforce in the WHO African Region p.62 (2) Kohler et al., 2022*

# OOP spending on healthcare in Eswatini is relatively low compared to neighboring countries

*Figure 2.1: Funding sources for health—country comparison*




Sources: Most recent national health accounts available at World Bank Data (2014). [26]




- **Patients in Eswatini spend less out-of-pocket (OOP) and on private health expenses than most of their regional counterparts;** the government contributes the largest proportion of funding for health expenses, indicating a fairly small private health insurance presence.[1]

- Annual per person spending on health is $282. The breakdown of sources of health expenditure is:
  - $138 from government spending;
  - $77 from development assistance for health);[2]
  - $37 from pre-paid private spending; and
  - **$29 from OOP spending.**

*(1) World Development Indicators; (2) IHME 2019*

# Private facilities were analyzed as three distinct channels

*Three primary commercial private sector channels present opportunities for the delivery of PrEP methods, including oral PrEP, the PrEP ring, and CAB PrEP*

*Private health facilities, especially pharmacies, are perceived to be accessible to most people. Due to frequent drug shortages in the public sector, many people buy their medication at private pharmacies.*

| Private pharmacies | Private clinics | Private hospitals |
|---|---|---|
| **Number:** ~60 registered and ~240 licensed facilities<br><br>• **Registered and non-registered** private pharmacies offer prescribed and over-the-counter medicines.<br>• Some provide **basic health services** such as blood pressure or blood sugar checks if staffing capacity/ qualification is adequate. | **Number:** ~95<br><br>Generally smaller, for-profit facilities are primarily operated by doctors (and some nurses) and offer basic primary healthcare services, primarily on an outpatient basis; they often cater to higher wealth quintiles. | **Number:** Nine<br><br>Primarily operating in urban settings and offering higher level of referral care. Curative focus generally not a great fit for products like PrEP. |

# Pharmacies have potential to increase reach

## Potential role: *Continuation/resupply*

- Pharmacies bring reach, but registration and oversight gaps persist. New legislation and structures to clarify how pharmacies are registered and regulated may present positive opportunities to strengthen the pharmacy channel.
- Chains are seen as desirable to work with as their aspiration to protect their brand and access to resources (cash to support inventories, access to higher level cadres of staff, training) means an ability to adhere to national guidelines.

| Channel scale | Populations served | Coordination and regulation |
|---|---|---|
| • **While the MoH reports 60 registered pharmacists**, a non-published report cited 446 retail pharmacies were **licensed** between 2009 and 2022.<br>• Chains include the South Africa-based Clicks, Linkmed, Sound Health, and Genesis. | • Imperfect data indicate pharmacies are well dispersed throughout the country - although concentrated in urban areas.<br>• They are favored by marginalized populations, youth, and men.<br>• With regular drug stock-outs in the public facilities, pharmacies are often patronized by people paying OOP and those on medical aid. | • The new **Pharmacy Bill** was recently passed in parliament which includes establishment of the Pharmacy Council as oversight body to fairly, effectively, and efficiently regulate the sector and pharmacists. That bill has yet to be operationalized.<br>• The Ministry of Commerce, Industry and Trade issues business licenses to pharmacies,<br>• While the MoH **requires a registered pharmacist to operate the pharmacy**, it is inconsistently enforced.<br>• Less than half of licensed pharmacies are supported by an MoH registered pharmacist.[2]<br>• Pharmaceutical personnel are **accredited/registered by the Eswatini Medical and Dental Council**.<br>• The **Kingdom of Eswatini Retail Pharmacy Association** is a nascent organization with a promising mandate to advocate for the welfare of pharmacists and good pharmacy practice in Eswatini. |

*(1) Shambira G, Suleman F. Retail pharmacy prescription medicines' availability, prices and affordability in Eswatini. Afr J Prim Health Care Fam Med. 2021 Sep 15;13(1):e1-e11. doi: 10.4102/phcfm.v13i1.2986. PMID: 34636605; PMCID: PMC8517741; (2) Eswatini Country Report, unpublished study by Catalyst*

# Pharmacy acceptability and capacity factors

***Pharmacies align with user needs, but staff capacity and facility space need to be addressed***

**Key**

- High potential
- Modest potential/constraints
- Limited potential/greater constraints

## Acceptability factors
***Does the channel meet the needs of users?***

### Acceptability and accessibility

- Pharmacies **bring convenience** through longer working hours and geographic proximity to users.
- Just over half of pharmacies do not require a fee for ART provision.[1]

### Affordability

- Pharmacies are accessed by people with medical aid, **but mostly cater to out of pocket payers**.
- An average consultation fee of 15 SZL (w/range of 1—50) was suggested by pharmacies (less than 1 USD). This is perceived affordable to populations accessing care in the private sector.[1]

### Product portfolio

- Pharmacies serve an important role in provision of family planning, especially EC for younger women.
- Programs have established experience in distributing HIV self-test kits.
- Some key informants suggested individuals to to private pharmacies when public sites are stocked out.

## Capacity factors
***Do providers have the capabilities to serve the user?***

### HIV testing and user support

- Pharmacies can conduct **risk assessments and refer clients** for PrEP initiation and HIV testing.
- **Self tests are not currently accepted to initiate** PrEP.
- Larger chain pharmacies often staff nurses, who can provide HIV testing. Other pharmacies can refer clients to labs for HIV testing.

### HCWs

- Pharmacists cannot prescribe, administer injections, or draw blood for testing.
- Oral PrEP refills can be managed under existing regulations; initiation of oral PrEP would require task shifting (or placing a nurse on staff in pharmacies).
- Lack of formal training programs for pharmacists was cited as a barrier to engagement.

### Facility requirements

- Space limitations make it difficult for ensuring privacy for counseling and gluteal injections required for CAB PrEP.
- 83% of pharmacies in the EPIC study reported private space available for counseling.[1]
- Over half of pharmacies reported using an electronic dispensing system and over 80% reported having a computer with internet.[1]

*(1) EpiC Decentralized Distribution of ARVs in the Private Pharmacies in Eswatini DDD Rapid Assessment*

# Private clinics present an “easy win” to increase access to PrEP

**Potential role**: ***Full package of counselling, testing, initiation continuation/resupply***

- Eswatini has engaged the private sector through **PPP to support HIV/TB service delivery**, but services are not yet optimal
- **Challenges of reporting** in delivery of HIV/TB services
- The National Health Strategic Plan II references PPP, and highlights the government’s commitment to work with private sector stakeholders, but a **PPP framework has not yet been developed**.

| Channel scale | Populations served | Coordination and regulation |
|---|---|---|
| • **95 clinics, (**about half the clinics in Eswatini) are private.[1] | • Population accessing care in the private sector tend to be in urban/peri-urban areas and are enrolled in medical aid schemes or can afford to pay more OOP. | • Private clinics must be registered with the Medical and Dentists Council of Eswatini.<br>• To participate in medical aid schemes within their facilities, they must register with the Board of Health Care Funders in South Africa and be evaluated and approved by the Health Services Accreditation of Southern Africa. |

*(1) Eswatini SARA 2017*

# ART and TB delivery via private hospitals and clinics

Many private sector facilities are already accredited by the government to offer ART services, an obvious starting point to expand their offering to include PrEP. Data was not available citing the number of clients accessing ART in the private sector (or even the exact number of private facilities participating), whether some clinics were more effective at resupply than others, or the perceptions of the program by providers or clients. A modest number of private providers sell branded ARVs and PrEP to clients.

## *Delivery of ART through private clinics*

- ***Provider selection:*** There are no specific criteria to identify facilities to participate. However, private providers who are interested in offering ART can approach the MoH and request to be accredited. Once accredited, they receive a facility number which they use to receive commodities from the MoH.
- ***Training****: A*fter accreditation*,* private providers are trained by the MoH and linked to central medical stores to receive commodities.
- ***Client support:*** Some general practitioners follow up with clients through lay staff in their practice. The level of support is not mandated.
- ***Provider compensation/user fees:*** Drugs are provided free of charge, and the provider charges the client a small consultation fee.
- ***Product supply***: All private sector providers participating in the program are linked to the central medical stores to receive commodities.
- ***Reporting:*** Clinics report on commodities used to the central medical stores. The private facilities also fill in MoH registers, parallel to their own data systems.
- ***Key learnings:*** Although there is no MoU to govern the movement of commodities from the public sector to the private sector, the accreditation process seems to work well, and private providers have been submitting reports. It is possible that this same process could be applied to pharmacies.

## *Private provision of TB (ended)*

- ***Mechanism:*** *About 68 private* facilities are engaged for **TB services, accounting for about 39% of TB management.** Interested private clinics approach MoH requesting to offer ART/ TB services. MoH assesses and accredits the facilities that demonstrate readiness to offer services, and health workers are trained by the MoH. Facilities collect commodities from central medical stores and report on a monthly basis using MoH registers.
- ***User fees:*** Providers charged a small consultation fee.
- ***Current status:*** *Not ongoing. Project by Medecins sans Frontiers ended.*
- ***Key learnings:*** Project demonstrated the capacity of private providers capacity to screen and initiate clients on TB treatment.

# Private clinic acceptability and capacity factors

***Affordability is a challenge, but high capacity make private clinics important as new PrEP methods are introduced***

**Key**

- High potential
- Modest potential/constraints
- Limited potential/greater constraints

## Acceptability factors
***Does the channel meet the needs of users?***

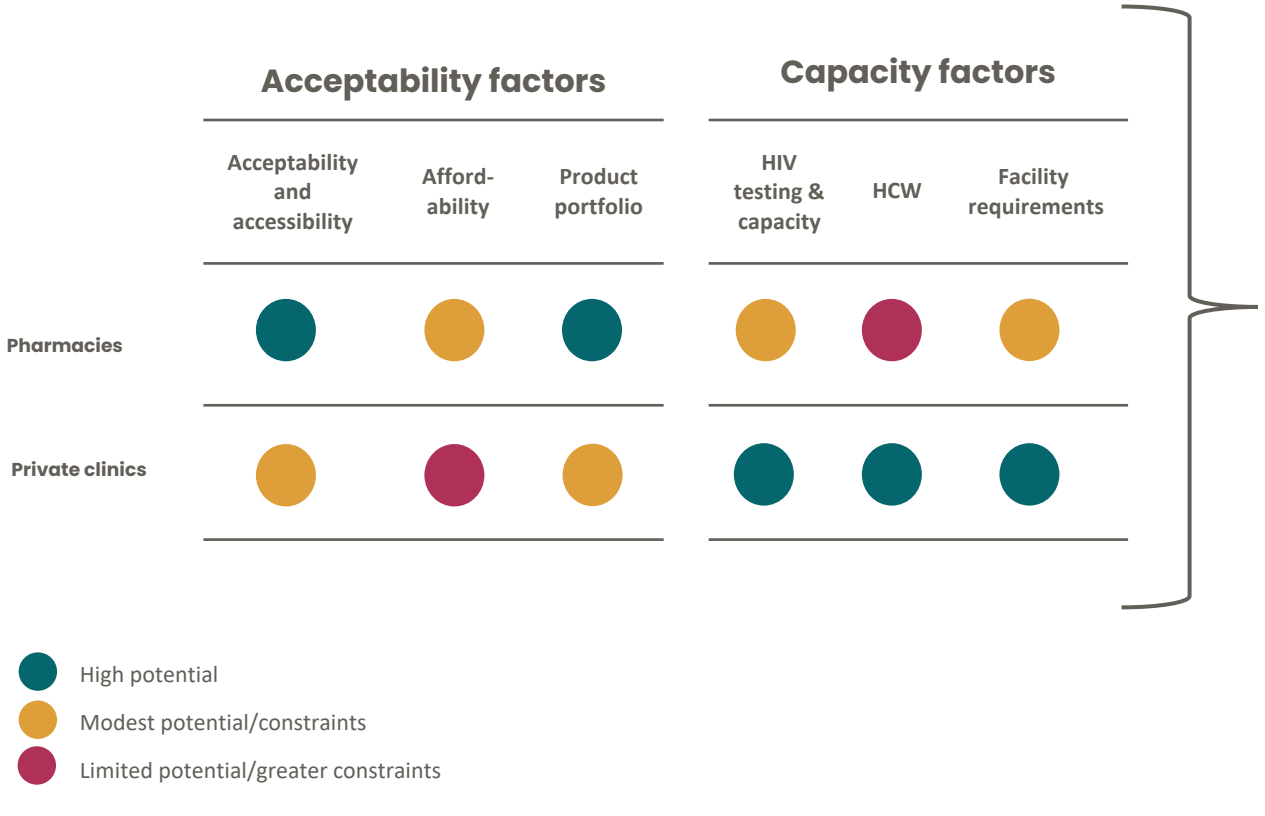
| | | |
|---|---|---|
| **Acceptability and accessibility** | • Generally located in urban and peri urban areas.<br>• Services perceived to be of good quality. | Modest potential/constraints |
| **Affordability** | • Services and consultation fees are perceived as out of reach for populations without medical aid or disposable income.<br>• Public distribution of ART commodities through private clinics has enabled affordable access. | Limited potential/greater constraints |
| **Product portfolio** | • Private providers offer ART, PrEP, and PEP services<br>• Other SRH services are also provided by private clinics. | Modest potential/constraints |

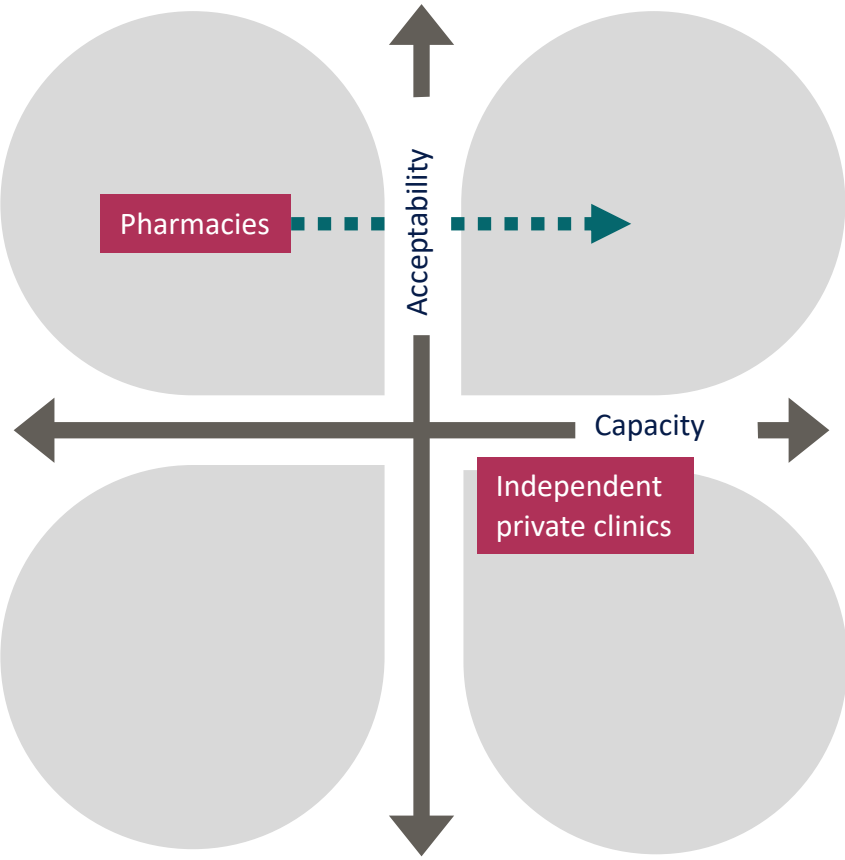
## Capacity factors
***Do providers have the capabilities to serve the user?***

| | | |
|---|---|---|
| **HIV testing & user support** | • Private clinics (doctor- and nurse-led) offer HTS and manage relevant laboratory tests; they can also offer the required user support.<br>• Some clinics have a doctor visiting two or three times a week. | High potential |
| **HCWs** | • Doctors and nurses bring training for SRH services.<br>• Accreditation of private clinics by MoH allow clinics to access commodities<br>• Oversight and enforcement of guidelines are difficult, as MoH lacks capacity and resources. This weakens the overall accreditation system. | High potential |
| **Facility requirements** | • Most facilities include a private room, which can be used for counseling and administration (e.g., injections).<br>• The accreditation system ensures adequate stock management and waste management. | High potential |

# Channel analysis summary

- On the diagram below, acceptability (from the user perspective) is subjectively measured on the y axis and capacity on the x axis.
- Independent private clinics have capacity and existing partnership models with the MoH for ART services and have demonstrated they increase affordable access to treatment. Those already offering ART services should be considered for **immediate engagement as PrEP initiation facilities**.
- Private pharmacies are promising but challenges on regulation require close support to ensure capacity is sufficient and government concerns and regulatory issues are addressed. Near-term potential exists to engage pharmacies **to offer drug refill services**.



# Recommendations of high potential channels to support PrEP service delivery in the private sector

| | Private clinics | Pharmacies | Smart lockers (explored as Differentiated Service Delivery) |
|---|---|---|---|
| Opportunities | • Facilities already delivering ART services<br>• Facilities already conducting HTS<br>• Modest adjustments to ART program could expand to include PrEP | • 43 pharmacies offering HIV self-testing<br>• High potential for pharmacies located in a clinic | • Lockers currently in public facilities, but there are plans to put them within workplaces and private pharmacies<br>• Currently offer ART pick-up |
| Challenges to address | • Adherence to agreed cost of HIV services for public sector<br>• Training of HCWs<br>• Role of clinics to support PrEP (accessibility)<br>• Reporting to MoH | • Adherence to agreed cost of HIV services for public sector<br>• Training of Pharmacists<br>• Reporting to MoH<br>• Business case to incorporate PrEP for pharmacists | • Cost of smart locker out of reach to private providers<br>• For donated lockers, the space availability in private facilities may be a challenge |

# Support required for private sector to deliver PrEP

1. **Map facilities** to identify high potential outlets and align programs, geography with population and need
2. **Assessment and accreditation of private facilities** to participate in a PrEP program (and access public sector supply)
3. **Train & support providers**
4. Develop tailored product information, standard operating procedures, counseling, and tools fit for private sector purpose
5. Link to **central medical stores for commodity delivery / collection and refill,** and referrals to public facilities (for those that test positive).
6. **Supportive supervision** (e.g., coaching, detailing)
7. **Invest and roll out systems** for reporting and collecting data of services provided

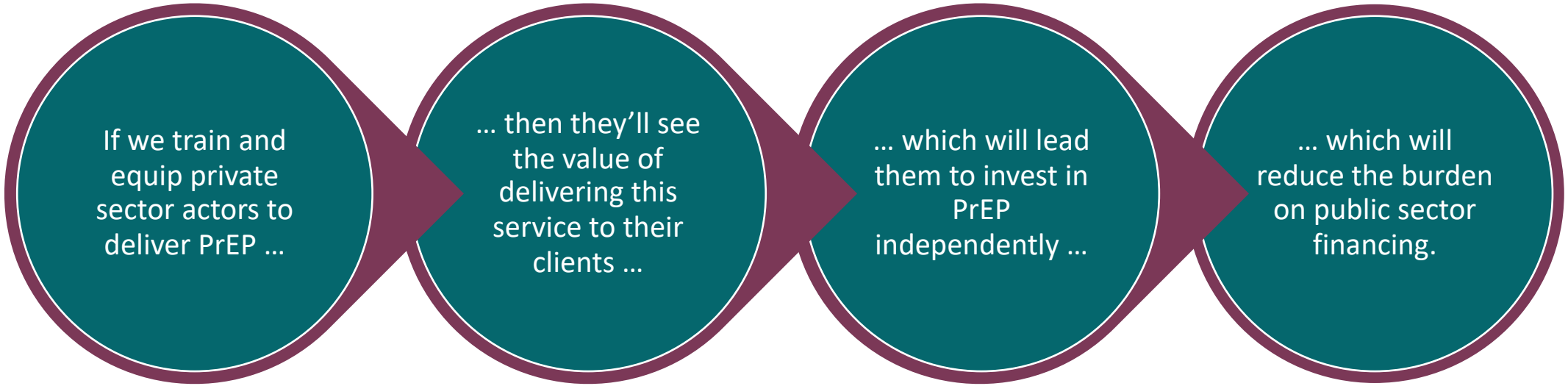
# 4

# ENABLING ENVIRONMENT

The success of private sector channels will be driven, in part, by policy, coordination. and financing activities that build an enabling environment for delivery.

# Stakeholders often cite the promise of the private sector to drive sustainable delivery of HIV services

*This theory of sustainability holds that…*




*This assumes significant facilitators in the enabling environment that are not currently present. Investments today need to build the enabling environment for future sustainability.*

# Creating an enabling environment for private provider engagement is important to support sustained delivery of PrEP

| Potential activity | Pharmacy | Private clinics/ hospitals |
|---|---|---|
| **1. Strengthen the regulatory environment supporting pharmacies to ensure adherence to quality drug dispensing** | | |
| Support implementation of the new **Pharmacy Bill** recently passed in parliament, which includes establishment of the Pharmacy Council as oversight body to fairly, effectively, and efficiently regulate the sector and pharmacists. | X | |
| **Link** Pharmacy Council at MoH with the Pharmacy Association to identify how to support quality of care and advocate for engagement of trained workforce. | X | |
| Engage an independent organization / NGO to facilitate, support, and coordinate rollout of PrEP in the private sector. | X | X |
| Develop a viable reporting system that private providers can use to efficiently report data on PrEP services. | X | X |
| **2. Training of pharmacists on PrEP, counseling, and reporting** | | |
| Support assessment and accreditation of private providers offering PrEP and assess capacity of their staff, and adapt tools for private providers | X | X |
| Continue to support supervision of providers to ensure adherence to guidelines. | X | X |

# 5

# RECOMMENDATIONS AND NEXT STEPS

# Key recommendations based on our analysis

*(These recommendations are applicable to all partners in Eswatini and should not be considered as solely for MOSAIC partners)*

1

## Build on existing clinic-based PPP models supporting ART and introduce PrEP initiation and resupply

Ministry of Health (MoH) partnerships supporting the delivery of public sector anti-retroviral therapy (ART) can be be leveraged to expand PrEP delivery. Memoranda of understanding (MoUs) and a system of supply and reporting already exist. Introduction of PrEP is an opportunity to address existing bottlenecks and challenges, such as gaps in reporting. Although reach will be limited, engagement with a trusted channel will provide an opportunity to address MoH concerns of engaging the private sector before advocacy for expansion in other channels such as pharmacies.

2

## Build on existing DSD interventions to expand PrEP resupply into pharmacies

Early wins in clinics can be leveraged to advocate for expanded engagement of pharmacies. Pharmacies, particularly those in chains which are better organized and likely to adhere to guidance, offer the greatest opportunity for expanded access. Concerns about quality of care and pricing have tempered plans to introduce oral PrEP resupply in pharmacies to date. Regulatory issues in pharmacies also need to be resolved (i.e., building MoH capacity to register and oversee pharmacists and pharmacies that have been licensed). Advocacy with the government can support introduction of CAB PrEP in pharmacies via policy changes and placement of qualified cadres within high-volume facilities.  Chain pharmacies attached to clinic and nurses can be engaged to initiate and resupply PrEP.

3

## Invest now to build the enabling environment for future sustainability

The pharmaceutical sector, in particular, has significant gaps oversight and regulation, demonstrated by the gap in pharmacists registered by the Medical and Dental Council and those registered (and regulated) by the MoH. Resolving regulatory and oversight issues will enable the government to leverage private sector channels while addressing concerns of reporting and quality of care.

# Effective engagement of private sector channels to deliver HIV prevention choice will require multiple steps over time

Our analysis suggests an opportunity for engagement of both private sector channels to deliver sustainable HIV prevention choice and access to users. Clinics offer immediate opportunity and reach, while pharmacies are important in the longer run once regulatory issues are addressed.

In the three stages below, we outline key steps for effective engagement and expansion of each channel. Execution will require that all stakeholders play a role, including MoH, implementers, and provider associations. Respective roles should be considered by the MoH, the PrEP Technical Working Group, or other coordinating bodies. MOSAIC may play a role in these stages, where and as appropriate.

## STAGE 1

### Expand the ART clinical model to include PrEP through robust private clinic engagement and test the value proposition of private clinics

#### Action items

- Clarify reach and the programmatic impact of the existing ART model through private clinics.
- If potential exists, work with an intermediary to engage private providers in PrEP initiation via improved standardization of existing MoH structures.
- Conduct a process evaluation to address provider retention and user continuation challenges in private clinics and clarify the value proposition to private providers.
- Explore efforts to subsidize consultation fees, strengthening the potential of the model to reach lower-income clients.
- Introduce PrEP ring and CAB PrEP in existing clinics.
- Support national demand generation activities; increased demand for PrEP nationally will provide a demand signal to private providers.
- Design a formal PPP model through which the government may subsidize consultation fees.

## STAGE 2

### Develop a pharmacy model starting with chains that are more likely to adhere to policies and regulations

#### Action items

- Map pharmacies and clarify the differential between registered pharmacies and licensed facilities to better understand potential for impact.
- Build capacity of private pharmacies as PrEP refill/resupply sites starting with registered pharmacies and chain pharmacies that do not have either a clinic or a counselling room.
- Develop demand estimates and potential costing element into a future model.
- Design and launch model for PrEP resupply in high-performing pharmacies starting with chains.

## STAGE 3

### Pivot model design to accommodate CAB PrEP introduction and start preparation for eventual Government of Eswatini (GoE) contracting

#### Action items

- Expand existing engagement models to include CAB PrEP.
- Advocate for task shifting PrEP initiation to pharmacists based on pilot findings.
- Engage with team at MoH to outline eventual transition to GoE contracting.
- Explore feasibility of CAB PrEP in pharmacies drawing on the Eswatini implementation science work.

# An intermediary brings uniformity to rollout and reduce the burden on government to provide oversight of providers

- The MoH conducts assessments and accreditation of the private providers on their capacity to offer services who are then trained and linked to central medical stores to receive commodities directly.
- Most private providers are working in partnership with an NGO like Georgetown University that provides technical support to worksite facilities and reporting.

**RECOMMENDATION**

Private sector engagement for PrEP delivery would be managed through an intermediary organization, such as an NGO, who would harmonize rollout to participating providers and ensure quality of services and adherence to guidelines as well as reporting. An intermediary body would also be more agile in resolving any issues that arise in implementation. This would remove the government's burden of dealing with individual private providers.

| Key outsourcing challenge | Immediate implications for the PrEP market |
|---|---|
| Lack of a regulatory framework to govern public private engagement. | 1. Engagement with registered pharmacies and clinics that are currently partnering with MoH on ART service delivery. |
| Funding for the intermediary body to carry out the work. | 1. Work with existing NGOs that are already supporting private providers.<br>2. Document the impact of pilots, focusing not only on health outcomes, but also on the success or failure of management processes. |

# Develop a PPP Framework to support private providers as a channel to increase access to HIV prevention services and products

A framework would strengthen the trust in the private sector and support increased access to PrEP and other prevention services for sustainability. It would also ensure improved capacity of private providers to offer quality services.

| Challenges | RECOMMENDATIONS<br>**Private sector engagement for PrEP delivery can begin immediately with providers that are currently offering ART services and under the current model of accrediting private providers and linking them to central medical stores for commodities. Within the current policy, registered pharmacies can be trained as drug refill centers charging a minimal consultation fee.** | |
|---|---|---|
| • There is currently no pharmacy council to give direct oversight; pharmacists are currently licensed with the Medical and Dental Council and pharmacists are registered with the MoH.<br>• Reporting by private providers is a big challenge.<br>• General mistrust of private sector needs to be addressed to support effective partnerships.<br>• The capacity of providers in offering HIV ART/PrEP is a challenge as they may not always be aware of new guidelines and products.<br>• Unregistered pharmacists are profit-driven at the expense of quality of care to clients. | 1 | Ensure the **framework for engaging private providers is clearly captured in the ART and PrEP implementation guidelines.** |
| | 2 | **Engage an oversight body** to oversee rollout of PrEP in the private sector including identification, assessment, and accreditation of private clinics, hospitals, and pharmacies as well as training. The oversight body would also conduct quality assurance of services offered in the private sector. |
| | 3 | **Capacity building** of private providers on PrEP guidelines and service delivery as well as harmonized reporting. Demand creation to include services conducted by the private providers. |
| | 4 | **Commodities –** ensure that private providers are linked to and can access commodities from central medical stores. |

# Private sector access to free public commodities is important until third-party financing is widely available

- The majority of private sector health payments are OOP payments; medical aid schemes currently have limited reach
- OOP payments can be significant, even if drugs are supplied by the public sector, due to consultation fees.

**RECOMMENDATIONS**

Early private sector engagement will require third-party subsidy via donor funding in the absence of private providers accessing public commodities. In the long-term, this subsidy should shift to the GoE via contracted services. For a small percentage of the population, OOP payments may remain a feasible form of financing.

## 1 Contract services through the GoE

***Payment method:*** No direct OOP payment; MoH (or implementers) pays facility for services rendered.
***Expected population reached:*** AGYW, most of whom may have need but lack financial resources.
***Unmet need:*** Qualitative data underscore that AGYW perceive that the private sector offers increased convenience and discretion, as well as reduced stigma; private sector engagement can reach users who cannot or will not access public clinics for PrEP.
***Opportunity:*** Contracting would maximize public health impact by reducing cost barriers; initial financial support would come from donors with potential to transition to the GoE as contracting mechanisms are strengthened and evidence of impact is generated.

## 2 Reach higher wealth quintiles with ability to pay OOP

***Payment method:*** OOP.
***Expected population reached:*** Higher wealth quintiles with ability to pay (e.g., 4$^{th}$ and 5$^{th}$ quintiles).
***Unmet need:*** HIV prevalence is high across wealth quintiles in Eswatini, reaching 23.9% and 17.1% in the highest quintiles (4$^{th}$ quintile has second highest prevalence overall). These same quintiles reported the lowest self-report of prior PrEP use, despite high awareness.
***Opportunity:*** Delivery in private clinics via OOP payments could expand access, but overall public health impact would be limited.

# Key informants for the analysis

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*Photo Credit: MOSAIC Consortium*

# 6

# ANNEX

A virtual dissemination and validation meeting on 27 July 2023 presented findings and solicited input on the draft Private Sector Market Assessment for PrEP. The virtual meeting was attended by 25 stakeholders including representatives from the MOH, USAID/PEPFAR, implementing partners, the private sector, and from end-user communities. Key recommendations are presented in this annex.

# Outcomes from Validation Meeting (1 of 2)

The table below provides a summary of the challenges raised by stakeholders, and proposed considerations and solutions to address the challenges. In general, considerable enthusiasm exists for introducing PrEP through the private sector.

| Challenges | Considerations & Solutions |
|---|---|
| **Capacity building and support to providers** | |
| - How would **pharmacy staff be engaged** (i.e. identified, recruited, trained, supported?)<br>- The **capacity/ability of pharmacy technicians** to identify and manage side effects. | - Need for a clear and formal defined **partnership between MOH and private providers.**<br>- **Training and mentoring on PrEP** to ensure continuous support is provided.<br>- **Various councils need to be engaged;** pharmacy association is new, pharmacy council not yet established and unlikely to be established in next year or two. **"Self-regulation" of pharmacies** (w/support of the Retail Pharmacy Association) is an opportunity. |
| **Reporting, M&E and data considerations** | |
| - How to **support reporting,** collect and harmonize data?<br>- **Managing information and data security** (confidentiality related to users and providers.)<br>- **Reporting commodity data** is just as important as reporting **patient data** and the private sector is not good at reporting # of patients, regimen they are on, etc.)<br>- **Complexity of reporting on PrEP** (when users come on and off the product, or event driven PrEP) is even greater than treatment.<br>- **Retesting to monitor seroconversion** (resistance issues). How does that happen? Does private sector have capacity to report and/or will they report? | - Support providers to use **CMIS light** so data is available and reported to MOH for accountability and monitoring of programs. Data sharing is important.<br>- **Establish SoPs** to manage data security.<br>- **Develop incentives** for a private pharmacy to provide data?<br>- **Oversight is required to ensure provision of quality services** and prevent stock-outs.<br>- Opportunity to **improve guidelines in the public sector** and adapt to private sector to ensure alignment. |

# Outcomes from Validation Meeting (2 of 2)

The table below provides a summary of the challenges raised by stakeholders, and proposed considerations and solutions to address the challenges. In general, considerable enthusiasm exists for introducing PrEP through the private sector.

| Challenges | Considerations & Solutions |
|---|---|
| **Supporting quality of products and care** | |
| - Challenges to **maintain quality of the product and services** provided to clients.<br>- How to **control use of product, including re-packing, re-branding?** How to ensure private sector products do not compete with public products? | - **Rely on partnerships** between MOH and pharmacies to monitor adherence to guidelines.<br>- **Education sessions.**<br>- **Explore role of social marketing** to ensure quality of product.<br>- Opportunity to **improve guidelines in the public sector** and adapt to private sector to ensure alignment. |
| **Supply Chain** | |
| - How to **diversify the supply chain** so that PrEP is able to meet the demand of the private sector and ensure consistent supply. | - Rely on **partnership with MOH.** |
| **Support for demand-side Interventions** | |
| - **Demand side interventions** to ensure the consumers are informed about the full service. | - Use **local media** to ensure customers know services are available at private pharmacies and consumers understand the importance and safety of PrEP if provided by a proper channel and used correctly.<br>- **Engaging clients would help with reducing stigma.**<br>- Support for private pharmacies. PrEP intervention should focus on reducing stigma to ensure customers have a good experience. |
| **Clarifying the comparative advantage of public and commercial sector's ability to pay** | |
| - **Comparative advantage of private sector** if product is offered free in public sector. How/why will users access PrEP in private sector?<br>- **Issue of cost and subsidy** – Important to design and understand the model factoring in the role of subsidy.<br>- Pricing of the product in line with free product in public sector to ensure the ability to pay by priority populations | - Closely manage pricing, ensure it is in line with (if not the same as) public sector products |