



The End of the HIV Epidemic Is Within Reach

MSF teams in Eswatini report success with long-acting PrEP, which could be a turning point in ending the HIV epidemic.

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Long-acting pre-exposure prophylaxis has the potential to end the [HIV](#) epidemic, but only if the people who need it can get it. Doctors Without Borders/Médecins Sans Frontières (MSF) is supporting a roll-out campaign of an injectable treatment in four countries in southern Africa, including [Eswatini](#). The recent [U.S. aid cuts](#) and withdrawal of PEPFAR funding, however, mean that there is uncertainty that people will be able to access treatment beyond [rollout doses](#).

The long-standing HIV epidemic in Africa

Around 40 million people around the world live with HIV. Although the burden of the epidemic continues to vary between countries, the African continent remains severely affected, with 1 in 30 adults affected by the virus. In Africa, HIV is a generalized epidemic, particularly impacting women and [key populations](#), a group defined by UNAIDS as groups of people at increased risk of HIV, including sex workers, people who use drugs, men who have sex with men, and LGBTQI+ people, including transgender and gender non-binary people. Members of these communities are not only at increased risk of contracting HIV, but also of being targeted with violence based on who they are.

Over the last few years, progress has been made in the fight against HIV using new tools. A vaginal ring and oral pre-exposure prophylaxis (the treatment known as PrEP) have given people ways to protect themselves before becoming exposed to the virus. But oral PrEP has its challenges.

“One of the main barriers to people using oral PrEP currently is the fact that they have to take tablets every day,” says Antonio Flores, senior advisor on HIV and tuberculosis (TB) at MSF’s Southern Africa Medical Unit. This ‘pill burden’ has contributed to the HIV prevalence, which remains high.

Understanding the social landscape

In Eswatini, HIV remains the leading cause of death. An estimated one-quarter of people live with

HIV, and nearly a third of women aged 15-49 are HIV-positive. Social stigma exacerbates the problem, resulting in low uptake of oral PrEP: Only 11% of eligible people take PrEP and only a quarter of those in treatment come back for refills.

“In a qualitative study we did, we learned that gender and social norms influence health-seeking behavior,” says Sinikiwe Dlamini, MSF’s data entry operator at [Sitsandziwe Clinic](#) in Eswatini. “Eswatini, being quite a traditional country culturally—where men are the leaders in society—means everything for a woman ... will have to be agreed upon by the male partner.”

“The packaging of the oral PrEP that we have in the country is almost the same as ARV [antiretrovirals for treatment of HIV],” says Majuba Mambo, an MSF nurse at Sitsandziwe. This can result in discrimination due to the stigma of HIV. “Some women feel they have to hide their medication bottles.”

CAB-LA rollout begins

Cabotegravir (CAB-LA) is one of the new long-acting injectables, which provides pre-exposure protection for two months. A six-month option is currently awaiting FDA approval and a recommendation by the World Health Organization. The rollout has started in a number of countries supported by [PEPFAR, the US President’s Emergency Plan for AIDS Relief](#).

“MSF secured a number of doses of CAB-LA, but the plan is that once the MSF rollout is ready, it will be handed over to the Ministry of Health,” says Flores.

The [dismantling of U.S.-funded aid](#) and uncertainty around funding for programs like PEPFAR—which support HIV prevention, testing, and treatment—is making it more difficult for people to access medical tools like CAB-LA. MSF does not receive U.S. government funding, but many of the organizations working with MSF have relied on this funding, which can impact our work.

“This is a very rapidly evolving situation, and our role is changing as a result,” says Flores.

We have the tools to end HIV, but access challenges remain

It is hard to overstate the potential impact of the long-acting injectable PrEP.

The initial response to has been excellent: “In the first month more than 20 clients started on CAB-LA,” says Mambo. “They are saying it is private; they can take it discreetly.”

People don’t have to worry about daily adherence because it has a two-month window. Plus, long-acting prophylaxis is 80 percent more effective than the oral alternative, adds Flores.

“We expect injectable PrEP to be a game-changer, and we don’t use this term lightly,” says Flores. “Injectable PrEP has the potential to end the HIV epidemic, but it will only end the HIV epidemic if people are getting it,” says Flores. “We know from the study data and from early implementation that we would reduce new infections drastically.”

Flores adds, “We have seen over the years a decline in HIV incidence among high-risk populations. So, we know that there is potential in PrEP. We have ended other diseases with [vaccines](#), and we can end this epidemic with an injectable drug that is given every few months. But people have to have access.”

Advocating for access to injectable PrEP

“We need to focus on the populations at high risk and remember that some of these populations are actually criminalized,” says Flores. “You do have a higher burden of HIV in key populations: men who have sex with men, transgender women and men, sex workers. So these are very vulnerable populations to HIV, and are very vulnerable to criminalization. Our role as MSF is really to support countries where it is possible to advocate for access, and engage in discussions about how to make access sustainable,” says Flores.

“If there is wide access to injectable PrEP, we can end the epidemic because we’re going to control it. Twenty-five years ago, ARVs did change the epidemic, and now we can really stop the epidemic if people have access to these new tools.”

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