Power of Choice:

Operational Learnings from the Médecins Sans Frontières (MSF) implementation of LA PrEP

Executive Summary

PROBLEM

Access to long-acting (LA) pre-exposure prophylaxis (PrEP) is being undermined by overlapping corporate, policy, and funding failures. Gilead and ViiV, the developers of the currently available injectable LA PrEP products, have restricted access through limited licensing, high and non-transparent pricing, and continued control of supply. At the same time, cuts to the U.S. President's Emergency Fund for AIDS Relief (PEPFAR) and the Global Fund to Fight HIV, TB and Malaria (GFTAM), coupled with insufficient investment in community-led service delivery, are constraining the rollout of these highly effective HIV prevention options. Lastly, the removal of key population indicators from national HIV databases is obscuring the needs of those most affected by HIV. Without action to address these barriers, LA PrEP risks replicating longstanding inequities in access and availability.

KEY FINDINGS

Across Doctors Without Borders / Médecins Sans Frontières (MSF) programmes in Malawi, Mozambique, and Eswatini, injectable, long-acting cabotegravir (CAB-LA) consistently achieved approximately twice the persistence of daily oral PrEP, demonstrating the potential of long-acting prevention to overcome adherence challenges and reduce stigma. However, demand for both CAB-LA and long-acting lenacapavir (LEN) continues to outstrip supply, while implementation and persistence are constrained by structural and service-delivery barriers, including injection-site reactions, intimate partner violence (IPV), and disclosure concerns. Peer-led, community-based delivery models tailored to the needs of key populations achieved higher uptake and continuation. This highlights that equitable access depends not only on product availability but also on delivering services through trusted, differentiated models.

OPERATIONAL IMPLICATIONS

Scaling up long-acting HIV prevention requires a coordinated strategy that ensures uninterrupted access to LA PrEP during the transition to generic LEN. This includes:

1. **Preserving prevention choice** and CAB-LA as a transitional tool.
2. **Prioritising peer-led, community-based delivery models** to effectively reach key populations and address stigma, discrimination, and criminalisation.
3. **Supporting person-centred implementation** through proactive pain management of injection-site reactions, low-resource acute HIV infection (AHI) screening algorithms, and integrated screening for sexual and reproductive health (SRH) needs.

1. Context and Background

In 2025, MSF began implementing LA PrEP within the framework of expanding HIV prevention choice. This operational briefer reflects early implementation experiences and learnings from active and planned MSF project sites across 2025 and 2026.

1.1. Global LA PrEP Landscape & Access Barriers

LA PrEP, comprising injectable CAB-LA (every two months) and subcutaneous LEN (every six months), represents a transformative shift in HIV prevention. By removing daily adherence burdens and mitigating the potential stigma of keeping oral pill bottles, injectables offer enhanced privacy and improved persistence. LEN requires an oral loading dose of two tablets at initiation, which raises specific disclosure and safety concerns discussed below.

1.1a) Pricing, intellectual property and supply barriers

However, the global access architecture for LA PrEP remains highly constrained. Access to both CAB-LA and LEN is limited by restricted supply, intellectual property and licensing barriers, and unaffordable prices. For CAB-LA, reliance on a single supplier, delayed generic entry (anticipated to be 2028) and lack of price transparency have slowed equitable scale-up in low- and middle-income countries. For LEN, Gilead's voluntary licence with six generic manufacturers is an important step, but it excludes many middle-income countries—including most of Latin America, where HIV incidence is rising—and contains restrictive conditions, such as anti-diversion measures, that limit generic supply beyond the licensed territory and create barriers for humanitarian procurement. As Gilead remains the sole supplier of LEN until generic products become available, and at a US list price of $28 000 per year, many countries continue to face constrained supply and prices that are beyond the reach of their health systems. Without expanded licensing, increased supply, affordable pricing, and, where necessary, the use of legal and public-interest tools to overcome access barriers, millions of people, particularly in excluded middle-income countries and humanitarian settings will remain unable to benefit from this transformative HIV prevention tool.

1.1b) Funding Contractions and Data Erasure

These access crises coincide with severe cuts to PEPFAR and the GFATM. In multiple countries, PEPFAR restructuring has pressured national guidelines to remove key population indicators and language. This politically driven exclusion of key population indicators from national databases makes these groups epidemiologically invisible, threatening targeted programming and resource allocation.

1.2 MSF Implementation Site Profiles

MSF is supporting LA PrEP introduction across multiple sites. In late 2025 and early 2026, active implementation was underway at three sites (Malawi, Mozambique and Eswatini). Planned sites in Kenya, Honduras, and Zimbabwe contribute additional operational lessons.

1.2a) Malawi

- Active cohort project serving female sex workers (FSW) and sexually exploited minors in Dedza and Neno districts.
- Operates via mobile clinics across 16 hotspots with a multidisciplinary clinical team (nurse-midwife, medical officer, mental health counsellor, health promotion officer).

1.2b) Mozambique

- Active cohort project in Sofala Province (high HIV-burden transit corridor).
- Targets FSW, men who have sex with men (MSM), and transgender individuals through peer-driven outreach and community drop-in centres (DICs).
- Uses participant choice between oral and injectable PrEP.

1.3c) Eswatini

- Active project at Sitsandziwe Sexual Health Clinic in Manzini (industrial hub, highest global HIV prevalence).
- Serves youth and adults (predominantly 15-34 years), factory workers, transport operators, sex workers, sexual and gender minorities, and ex-prisoners, offering integrated, one-stop sexual health care.

The Sitsandziwe Clinic in Eswatini from which MSF offers HIV prevention services as part of the package of care.

2. Empirical Findings

The following empirical data points and qualitative insights represent preliminary findings extracted from active and planned MSF implementation sites.

2.1 Theme A: Persistence and Method

Across sites, long-acting prevention options were associated with higher persistence, strong user preference, and improved user experience compared with daily oral PrEP.

2.1 a) Quantitative Persistence Rates

In Eswatini, 84% of CAB-LA users returned for their second dose, and the return rate remained above 85% at subsequent visits, compared with only 27% persistence for daily oral PrEP. In Malawi (407 CAB-LA, 270 oral initiates), CAB-LA return rates (on-time ±7 days + delayed <1 month combined) improved from 59.2% (2nd injection) to 66.8% (3rd) and 75.8% (4th). In contrast, on-time oral PrEP return at the 2nd visit was 29.3%, with 38.7% lost to follow-up (LTFU). In Mozambique, 55% of CAB-LA users completed their 3rd injection, compared with 25% of oral PrEP users completing their 2nd refill.

2.1 b) Uptake and Stated Method Preferences

In Eswatini, 457 new initiations were recorded: 48% oral, 35% CAB-LA, and 24% event-driven PrEP (reflecting supply caps, not personal preference). When LEN became available, 20% of initiates switched to it, exclusively from prior CAB-LA users. In Malawi, initial preference for CAB-LA was 70.6%, but supply quotas forced a cap on first prescriptions at 56.6%. In Mozambique, CAB-LA was chosen by 86% overall (93% of FSW, 77% of MSM).

2.1 c) Qualitative Insights on User Experience

Qualitative focus groups across sites revealed that injectables provide "freedom and peace of mind" by avoiding the daily pill burden. Oral PrEP packaging was strongly associated with antiretroviral therapy (ART) stigma; individuals were observed discarding empty pill bottles in public areas to hide preventative use. However, some individuals delayed switching or uptake of newer methods due to information gaps and fears that products are "still under investigation." Additionally, FSW in Mozambique exhibited lower persistence than MSM/transgender cohorts, driven by high mobility (frequent travel to Zimbabwe and other communities).

2.2 Theme B: The Reality of Supply and Demand

However, achieving these persistence gains requires that supply consistently meets demand.

2.2 a) Stock-outs and Allocation Quotas

In Eswatini, a national CAB-LA stock-out occurred, forcing stabilized individuals to revert to oral PrEP and causing high rates of discontinuation. Eswatini's initial MSF allocation of only 70 LEN doses (received via the Global Fund) was exhausted within weeks. In Kenya, which received 20,000 national LEN doses in March 2026 (Nairobi County received 2,000), the MSF-supported Dandora Youth Friendly Clinic was allocated only 39 doses (later increased by 5, total 44) against an annual facility attendance of over 1,500 youth.

2.2 b) Expiry Risks and Procurement Inefficiencies

In Honduras, the national LEN rollout covers only 800 individuals across 14 sentinel sites combined, limiting per-site statistical power to fully evaluate a programme. In Zimbabwe, administrative constraints delayed implementation. Thus, 1,300 CAB-LA vials procured by MSF were expiring in August 2026, and 1,700 dapivirine vaginal rings are expiring in September 2026, necessitating urgent donation and procurement realignment.

2.2 c) Facility Demand and PEP/PrEP Ratios

In Kenya, the Dandora clinic recorded 868 HIV tests, 168 post-exposure prophylaxis (PEP) initiations, and only 8 oral PrEP initiations in 2024; and 1,556 HIV tests, 153 PEP, and 10 oral PrEP in 2025. Lavender House clinic recorded 227 HIV tests and 226 PEP in 2024, and 188 HIV tests and 188 PEP in 2025, showing high, persistent demand for post-exposure prevention over oral pre-exposure prophylaxis.

2.3 Theme C: Delivery Models and Structural Barriers

Where supply reaches individuals, the mode of delivery determines who is actually served.

2.3 a) Regulatory and Funding Constraints

In Zimbabwe, Medicines Control Authority (MCAZ) and Medical Research Council (MRCZ) ethics review board delays pushed back implementation, compressing the study timeline from 12 to 6 months and limiting participants to a single LEN dose. In Honduras, Global Fund constraints restricted LEN supply strictly to key populations, preventing a broader risk-assessment-based eligibility criteria proposed by the Ministry of Health (MOH). Furthermore, only MSF holds dapivirine rings in Honduras, requiring local donation to active sentinel sites.

2.3 b) Community Delivery vs. Facility Barriers

Qualitative data from active sites demonstrates that peer-driven, community-based DICs and mobile clinics outperform facility-based care. Sex worker networks and key populations reported high levels of trust and felt "freedom and safety" in community drop-in spaces, in contrast to Ministry of Health facilities where wait times, lack of privacy, and provider stigma discouraged attendance.

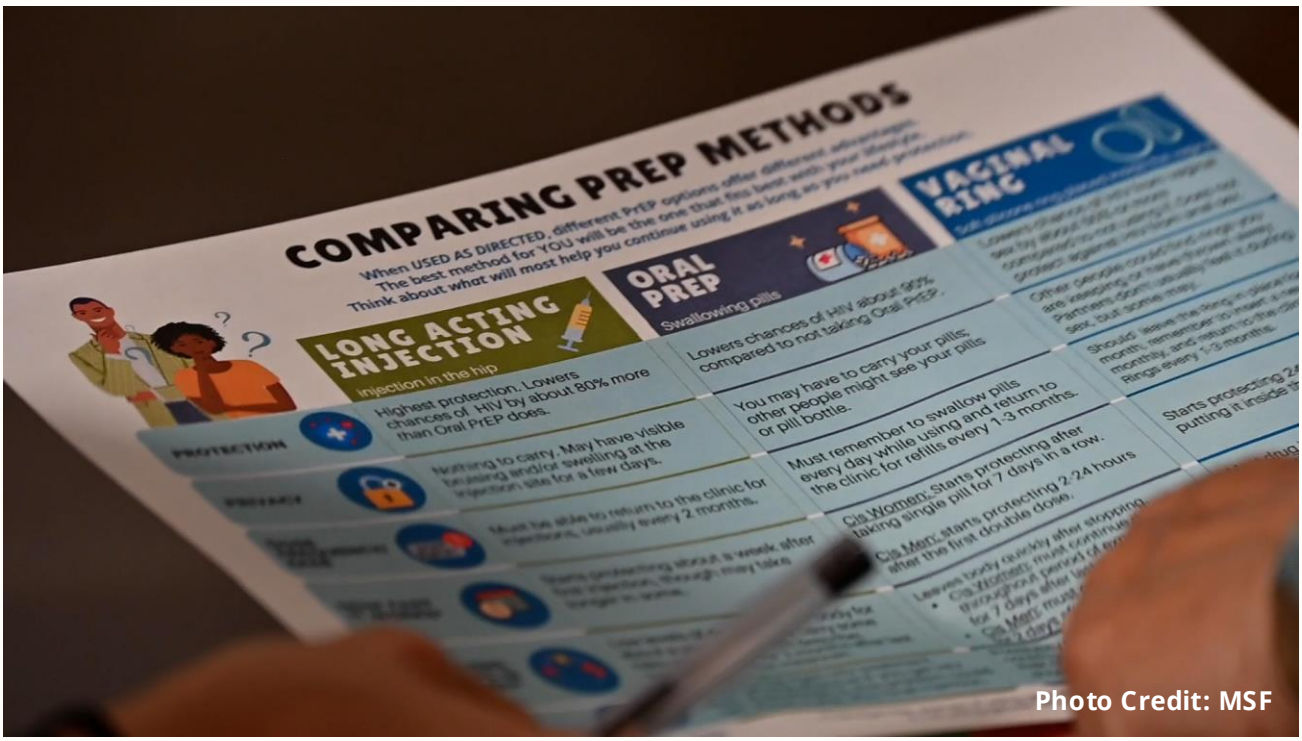

Photo Credit: MSF

A pamphlet explaining the different kinds of HIV prevention tools available

2.4 Theme D: Clinical Management, Side Effects, and Screening

The findings underscore the need for client-centred clinical management approaches, including effective pain management, robust AHI screening, and strategies to minimise disclosure and gender-based violence risks.

2.4 a) Side Effect Prevalence and Pain Management

Injection site pain and localized lumps were the primary adverse events, reported by 22% of CAB-LA users in Mozambique and cited as a major driver of discontinuation. In Malawi, injection-site lumps affected the livelihoods of FSWs as visible side effects raised concerns among individuals and compromised income. Malawi shifted its pain protocol in August 2025, which led to a notable and immediate reduction in reported side effects. In Eswatini, qualitative reports indicated that LEN was associated with more prolonged discomfort, longer-lasting pain, and subcutaneous nodule formation compared to CAB-LA.

2.4 b) Acute HIV Infection (AHI) Screening

In Eswatini, one HIV seroconversion occurred where retrospective analysis confirmed that an acute HIV infection (AHI) was missed prior to initiation. In Mozambique, clinical symptom screening combined with a rapid diagnostic test (RDT) algorithm among symptom-negative individuals was evaluated, demonstrating a 99.5% negative predictive value (NPV) for ruling out AHI.

2.4 c) Gender-Based Violence and Disclosure Risks

Eswatini flagged severe disclosure and safety risks associated with LEN's oral loading dose. The two oral tablets are packaged in a large bottle that closely resembles standard ART packaging, risking unintended disclosure and IPV for female adolescents and women in abusive relationships.

A dose of CAB-LA - a long-acting injectable HIV pre-exposure prophylaxis - prepared for a client

3. Discussion and Operational Implications

3.1 Narrative Analysis of Operational Learnings

These early findings from MSF implementation projects provide critical insights for global policy. First, the data establishes that injectable PrEP markedly improves the chronic persistence limitations of daily oral PrEP, consistently doubling persistence across highly diverse settings. This advantage does not depend on the product alone; it needs to be unlocked by community-based, peer-led delivery models (such as DICs) that provide safety, reduce travel costs, and bypass the stigma of public clinics. Prematurely integrating these services into standard primary health facilities, driven by cost-saving donor agendas, risks losing engagement with key populations entirely.

Second, the severe mismatch between high demand and capped supplies (such as the 44-dose allocation in Dandora) represents a structural governance failure. It rations care in settings where HIV incidence demands scale-up, not restriction. In this context, CAB-LA serves as an essential programmatic bridge to maintain individuals in care during LEN shortages, preventing the clinical risks of forced return to oral PrEP. Finally, clinical success requires active operational solutions: pain protocols must be optimised, low-resource AHI screening must be standardised to prevent drug resistance, and packaging designs must respect personal safety and disclosure risks.

Miriam Mbwana, MSF's mental health counselor, talking to a sex worker in need of psychological support in Malawi.

3.2 A Rapid Review

MSF's operational findings demonstrate a significant persistence advantage for injectable PrEP over daily oral options, mirroring the efficacy trends from landmark clinical trials while highlighting distinct real-world implementation challenges. In the HIV Prevention Trials Network (HPTN) 083 and HPTN 084 randomised controlled trials, injectable CAB-LA demonstrated substantial superiority over daily oral tenofovir disoproxil fumarate/emtricitabine (TDF/FTC), reducing HIV acquisition risk by 66% in cisgender men/transgender women (Landovitz et al., 2021) and 89% in cisgender women (Delany-Moretlwe et al., 2022). More recently, the PURPOSE 1 and 2 trials reported near 100% efficacy for twice-yearly subcutaneous LEN in cisgender women, men who have sex with men and gender-diverse individuals (Bekker et al., 2024; Kelley et al., 2024). However, clinical trial environments, characterised by strict adherence support, do not fully reflect real-world persistence. While clinical trials reported high persistence, real-world oral PrEP persistence is notoriously low, dropping below 30% within six months. MSF's real-world data confirms that CAB-LA persistence is roughly double that of oral PrEP: achieving 84% return rates in Eswatini and 55% at the third injection in Mozambique. Nevertheless, these rates are lower than trial cohorts, highlighting the gap between clinical efficacy and real-world persistence.

Differentiated service delivery (DSD) models, such as DICs and mobile clinics, are critical to bridging this gap. DSD recommendations emphasise that community-led, peer-driven models are essential for reaching marginalised key populations by mitigating facility-based stigma and logistical barriers (World Health Organization [WHO], 2022). MSF's experience corroborates this: peer-led outreach at DICs in Mozambique and Malawi consistently outperformed facility-based care in persistence and safety.

Clinical management in real-world settings also requires adaptation. In trials, injection site reactions (ISRs) were reported by up to 80% of CAB-LA users and frequently for LEN (primarily subcutaneous nodules). MSF projects confirm that ISR pain and lumps are drivers of dropout. However, MSF demonstrates that active management, such as Malawi's pain protocol shift, can mitigate this barrier, a finding not evident from publications.

Finally, ruling out acute HIV infection (AHI) is critical to prevent selecting for drug-resistant mutations (Marzinke et al., 2021). MSF projects developed pragmatic, low-resource algorithms to detect AHI as alternatives to the expensive laboratory-based viral load assays used in clinical trials. Mozambique's use of clinical symptom screening combined with rapid diagnostic tests (RDTs) yielded a 99.5% negative predictive value, offering a highly effective and scalable alternative for resource-constrained national programmes.

3.3 Questions for Further Exploration

These open questions remain priorities for MSF and partners to investigate collaboratively:

How can community-based, peer-driven models be sustainably funded and integrated when national programmes rely heavily on external donor funding and face pressure to integrate services into facilities to reduce costs?

How can self-care and self-management approaches be safely integrated into LA PrEP programmes to improve access, convenience and persistence while maintaining quality of care?

How can we better harmonize data collection and definitions of "uptake" and "persistence" across diverse contexts and methods to enable meaningful comparison and learning?

What testing algorithms and pharmacovigilance systems are needed at programme level to detect breakthrough HIV infections in LA PrEP users early enough to prevent drug resistance, particularly integrase inhibitor cross-resistance from CAB-LA, in settings without routine access to HIV RNA testing?

What regulatory and service delivery adaptations are required to ensure adolescent girls and boys and young individuals under 18 can independently access and remain on LA PrEP, given that age-of-consent laws, provider gatekeeping, and the clinic-based nature of injectables create compounding barriers for the population at highest risk?

3.4 Call to Action

Accelerate equitable access to LA PrEP

Pharmaceutical manufacturers should expand the voluntary license to include all low- and middle-income countries. Governments, donors, and pharmaceutical manufacturers should ensure sustainable supply. Governments and civil society should use legal pathways such as TRIPS flexibilities to overcome intellectual property barriers where needed, while promoting pricing transparency.

Prioritise community-led delivery and key populations

Governments and donors should invest in differentiated, peer-led, and community-based delivery models, avoid premature integration into conventional primary healthcare, and ensure that key populations remain visible within national HIV strategies, data monitoring systems, and quantification processes.

Secure sustainable supply and preserve prevention choice

Donors, governments and pharmaceutical manufacturers should increase supply of LA PrEP, maintain CAB-LA as a critical bridge, and preserve meaningful prevention choice by enabling individuals to initiate, continue, or switch between options according to their needs.

Ensure high-quality, person-centred implementation

Governments should include proactive pain management and intensive peer counselling to address injection-site reactions early, adopt clinical symptom screening with RDTs as a pragmatic algorithm to rule out AHI (demonstrating that expensive laboratory-based viral load testing is not required), and integrate screening for IPV and disclosure risk within sexual and reproductive health (SRH) services. Pharmaceutical manufacturers should offer discreet packaging solutions for the LEN loading dose.

MSF calls on pharmaceutical originators, governments, donors and civil society to immediately enact these measures.

4. List of Acronyms & References

4.1 List of Acronyms

- **AHI** Acute HIV Infection
- **ART** Antiretroviral Therapy
- **CAB-LA** Long-acting Injectable Cabotegravir
- **DIC** Drop-In Centre
- **DSD** Differentiated Service Delivery
- **FSW** Female Sex Workers
- **HPTN** HIV Prevention Trials Network
- **IPV** Intimate Partner Violence
- **ISR** Injection Site Reaction
- **LA PrEP** Long-Acting Pre-Exposure Prophylaxis
- **LEN** Lenacapavir
- **LTFU** Lost to Follow-Up
- **MCAZ** Medicines Control Authority of Zimbabwe
- **MOH** Ministry of Health
- **MPP** Medicines Patent Pool
- **MRCZ** Medical Research Council of Zimbabwe
- **MSM** Men Who Have Sex with Men
- **NPV** Negative Predictive Value
- **PAHO** Pan American Health Organization
- **PEP** Post-Exposure Prophylaxis
- **PEPFAR** U.S. President's Emergency Plan for AIDS Relief
- **PrEP** Pre-Exposure Prophylaxis
- **RDT** Rapid Diagnostic Test
- **TDF/FTC** Tenofovir Disoproxil Fumarate / Emtricitabine
- **TRIPS** Trade-Related Aspects of Intellectual Property Rights
- **WHO** World Health Organization

4.2 References and Sources

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