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THE CQUIN NETWORK

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Navigating HIV Service Prioritization in Challenging Times

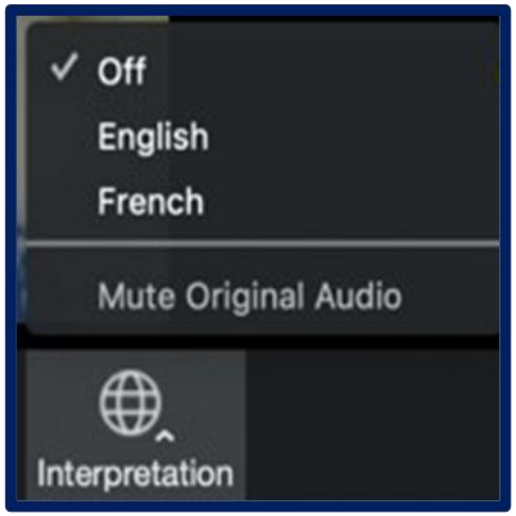
Country Experiences from a Shifting Landscape

August 12, 2025

Welcome/Bienvenue

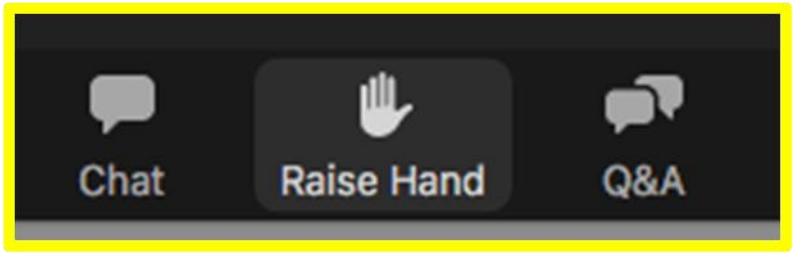
Maureen Syowai
Interim Program Director
CQUIN & HIVE
ICAP in Kenya

- Be sure you have selected the language of your choice using the “Interpretation” menu on the bottom of your screen.
- Assurez-vous d’avoir sélectionné la langue de votre choix à l’aide du menu <<Interprétation>> en bas de votre écran Zoom.



Housekeeping

- 90-minute webinar with framing presentations followed by a panel discussion with Q&A
- Please type questions in the Q&A box located on the toolbar at the bottom of your screen
- If you would prefer to speak, please use the “raise hand” function on the toolbar and we will unmute you so that you have control of your microphone
- If you are a French or English speaker, please ask your question in your language of choice and the interpreters will translate as needed
- Slides and recordings will be available on the CQUIN website (cquin.icap.columbia.edu)



Agenda

1. **Introductory Remarks**: Maureen Syowai, ICAP in Kenya
2. **HIV Service Prioritization and the IAS TIER Tool (Tool for Intervention Evaluation and Ranking)**
   - Anna Grimsrud, IAS
3. **Country Case Studies on HIV Service Prioritization**
   - **Mozambique Experience -** Isidoro Nobre, MOH Mozambique
   - **Eswatini Experience -** Sindy Matse, MOH Eswatini
4. **Panel Discussions and Q&A:**
   - Co-moderators: Rachel Mudekereza (ICAP/CQUIN) & Onyekachi Ukaejiofo ICAP/CQUIN)
     - Anna Grimsrud, IAS
     - Isidoro Nobre, MOH Mozambique
     - Sindy Matse, MOH Eswatini
     - Lindiwe Simelane, Dream Alive Eswatini
     - Papa Oumar Diagne, MOH Senegal
5. **Closing Remarks**

Presenters/Panelists

Anna Grimsrud
Senior Technical Advisor
International AIDS Society

Isidoro Nobre
DSD Coordinator
STI/HIV/AIDS Control Program
Ministry of Health, Mozambique

Sindy Matse
Program Manager
Eswatini National AIDS Program
Ministry of Health, Eswatini

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Post-CQUIN June Meeting Prioritization of HIV Services

Introductory Remarks

Maureen Syowai
Interim Program Director (CQUIN/HIVE)
ICAP in Kenya

Background to HIV Service Prioritization Across the CQUIN Network

- **Context:** Building on the discussions from the CQUIN June 2025 meeting, a package for HIV prioritization was shared across 21 countries in the CQUIN network.
- **Aim:** To develop country-led prioritization of HIV services and M&E indicators considering the epidemiological context and varying funding scenarios.

Meeting the Moment: Transforming the HIV Response in a Time of Change

June 10 - 12, 2025 | Johannesburg, South Africa

CQUIN June 2025 meeting

HIV Service Prioritization

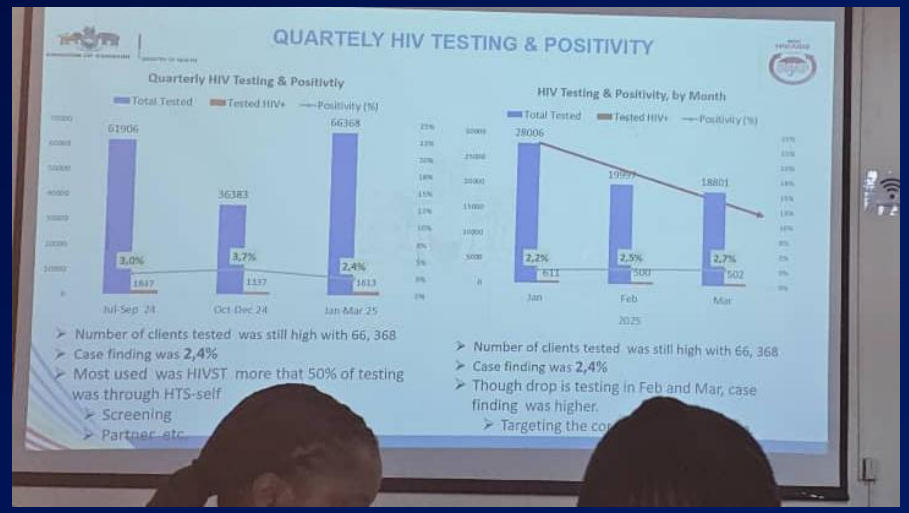
Progress

- **12 out of 21** countries have completed the initial HIV service prioritization.
- Prioritization feedback shared by **7** out of the 12 countries.
- Prioritization meetings scheduled for the month of August in 5 countries, with 4 countries yet to schedule their HIV service prioritization meeting.
- Ongoing TA provided based on country needs.

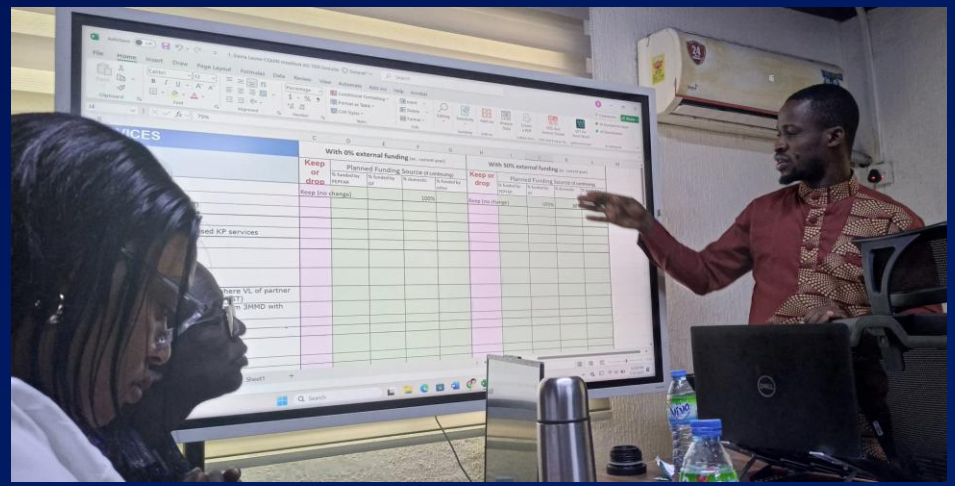
Webinar

- This webinar is the first of a two-part series of webinars on HIV service prioritization.
- Aimed at providing a platform for country teams to share their experiences and key lessons learned from conducting HIV service prioritization.

Eswatini



Sierra Leone



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Thank you

HIV service prioritization

and the TIER tool (Tool for Intervention Evaluation and Ranking)

Anna Grimsrud
12 August 2025
Navigating HIV service prioritization in challenging times
dsd@iasociety.org


If you don’t prioritize your own life,
someone else will.


You can’t cross the sea merely by standing and staring at the water.
- Rabindranath Tagore

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The TIER tool – Tool for Intervention Evaluation and Ranking

What is it?

- An excel workbook; a structured framework for prioritizing components of an HIV programme across the cascade

Who is it for?

- National governments

What's the objective?

- Support countries in their planning and prioritization of HIV programme elements in the context of funding shifts

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The TIER includes three workbook sheets covering the HIV cascade:

A list of interventions to prioritize across these components of the HIV care cascade:

Treatment	Testing	Prevention
- ART continuity - Continuity OI prophylaxis - ART initiation (and re-initiation) - Viral load monitoring - OI management - AHD package - Integration - Tracking and tracing - Psychosocial support/Counselling	- Blood products - Facility-based - Network-based (including facility/virtual and community-based) - Community-based (virtual and in-person) - Recency testing	- Infant prophylaxis - PEP - Condoms - PrEP continuation - PrEP initiation (and re-initiation) - Harm reduction for people who inject drugs - VMMC

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The TIER tool – Tool for Intervention Evaluation and Ranking

- Provides **illustrative examples** of prioritization across four scenarios:
  - Scenario 1: A high-burden country achieving 95-95-95 targets across all populations
  - Scenario 2: A high-burden country achieving the targets but not across all populations
  - Scenario 3: A high-burden country not yet achieving one or more of the 95-95-95 targets
  - Scenario 4: A low-burden country not yet achieving one or more of the 95-95-95 targets

Progress towards the 95 targets is one contextual factor that may influence prioritization

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And each intervention has a suggested prioritization for each scenario

Three priority tiers

Minimum	Services that are critical to maintain for continuity of care and health outcomes
Standard	Important to sustain; should be reassessed frequently for continuation as funding allows
Optimal	To be supported when additional resources are secured or efficiencies gained

Plus:

Discontinue	Services that were previously provided, that are no longer important to provide and can be discontinued
Not applicable	Services that were not provided and will not be provided

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Example: Treatment – tracking and tracing

Component	Intervention	SCENARIO 1 A high-burden Limited, possi	SCENARIO 2 A high-burde Adolescent g	SCENARIO 3 A high-burden c Clinically unstab	SCENARIO 4 A low-burden co Clinically unstab
Tracking and tracing	Confirm contact details at every clinical visit or ART refill collection	Minimum	Minimum	Minimum	Minimum
	Conduct phone tracing for clients with abnormal lab results	Minimum	Minimum	Minimum	Minimum
	Conduct phone tracing for the following groups who have missed their scheduled appointment by more than 7/14/28 days: those with active OIs, (re)started ART stage 4, CD4 <200, children and adolescents, pregnant and breastfeeding women	Minimum	Minimum	Minimum	Minimum
	Conduct phone tracing for all who have missed their scheduled appointment by more than 28 days	Standard	Standard	Standard	Optimal
	Condcut home tracing if no response to calls for clients with abnormal lab results	Standard	Standard	Standard	Optimal
	Conduct home tracing if not response to phone calls: those with active OIs, (re)started ART stage 4, CD4 <200, children and adolescents, pregnant and breastfeeding women	Standard	Standard	Standard	Optimal
	Conduct home tracing if no response to phone calls for all who have missed their scheduled appointment by more than 28 days	Optimal	Optimal	Optimal	Optimal

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The TIER tool – Tool for Intervention Evaluation and Ranking

What the TIER adds

- A granular starting list of interventions across the cascade and within each component

- The opportunity to discuss the coverage and frequency of interventions

- Emphasizes the importance of **COUNTRY-LED** discussions and decisions on the minimum package
  - *Before looking at budget and donor considerations*

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What the TIER tool is NOT

- **It is not prescriptive** - but given as a guide with accompanying rationale
- **It does not include an exhaustive list of interventions** - but does have a list for your consideration (the list is a starting point based on WHO guidance and inputs from partners)

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HOW TO USE THIS TOOL

Step 1: Select your country scenario (based on the 95-95-95 targets)

Step 2: Define the stakeholder group that will be engaged in the country's prioritization.

Step 3: Gather relevant HIV programme data across the HIV cascade

Step 4: Conduct the prioritization exercise documenting rationale for decisions

Step 5: Review and adapt the list of interventions

Step 6: Review the "Summary" tab (describing the tiered packages) to support budgeting and further prioritization work

Select your country scenario: scenario overview tab

My country is:	COUNTRY NAME
My scenario is	SCENARIO 3

Select scenario from drop down

DON'T FORGET TO ENTER THE COUNTRY NAME IN CELL B4, AND SELECT THE MOST SIMILAR SCENARIO (CELL B3)

Details of the scenarios

Scenarios	Overview	Likely gaps
SCENARIO 1	A high-burden country achieving 95-95-95 targets across all populations	Limited, possibly some unsuppressed ART clients and some specific sub-segments that are generally underserved
SCENARIO 2	A high-burden country achieving the targets but not across all populations	Adolescent girls and young women, key populations, men
SCENARIO 3	A high-burden country not yet achieving one or more of the 95-95-95 targets	Clinically unstable/symptomatic, gaps in all population groups
SCENARIO 4	A low-burden country not yet acheiving one or more of the 95-95-95 targets	Clinically unstable/symptomatic, gaps in all population groups

These are illustrative examples of different scenarios with hypothetical gaps. In all settings, additional additional information on the specifics of the gaps - for testing, treatment and prevention - are going to be critical to appropriately prioritizing interventions.

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Component

Interventions

Suggested prioritization

Comments

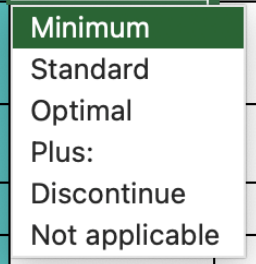
WHO recommendation, source, page number

Example: Treatment annex

Component	Intervention	SCENARIO 1 A high-burden Limited, possib	SCENARIO 2 A high-burde Adolescent g	SCENARIO 3 A high-burden c Clinically unstab	SCENARIO 4 A low-burden co Clinically unstab	Comments	WHO recommendation	Strength	Grade	Source
ART continuity	Provide uninterrupted ART treatment to ALL people who are already on ART, all populations and all regimens	Minimum	Minimum	Minimum	Minimum	Continuity of ART for all populations and all regimens to reduce mortality, morbidity and transmission; Population already	ART should be initiated for all people living with HIV regardless	Adults strong;	moderate; pregnant	https://www.who.int/publications/i/item/9789240031593
	Provide a minimum of 3MMD for all, unless clinically unwell (including re-engaging clients) with 6MMD preferred for those established on ART (for all over 5-years of age)	Minimum	Minimum	Minimum	Minimum	Maintain multi-month refills to reduce clinic visits and strong evidence for impact on retention and adherence	People established on ART should be offered refills of ART lasting 3–6 months, preferably six	Strong	Moderate to low	https://www.who.int/publications/i/item/9789240031593
	Conduct an annual quality clinical review if established on ART and virally suppressed with longest scripting period allowed 6-12 months	Minimum	Minimum	Minimum	Minimum	Extending the interval between clinical visits reduces burden on client and health system	People established on ART should be offered clinical visits every	Strong	Moderate	https://www.who.int/publications/i/item/9789240031593
	Enroll eligible clients in less-intensive DSD models	Minimum	Minimum	Minimum	Minimum	Maintaining DSD models for clients established on treatment	No formal WHO recommendation			https://www.who.int/publications/i/item/9789240031593
	Sustain individual DSD models based at facilities	Minimum	Minimum	Minimum	Minimum	Individual facility based models (e.g., fast track) should be	No formal WHO recommendation			https://www.who.int/publications/i/item/9789240031593
	Sustain individual DSD models for key populations not based at facilities	Standard	Standard	Standard	Standard	Models out of facility have been a foundation of key population services; these services have often been parallel to public	No formal WHO recommendation			https://www.who.int/publications/i/item/9789240031593
	Sustain group DSD models managed by clients	Minimum	Minimum	Minimum	Optimal	Group models managed by clients overcome challenges of	No formal WHO recommendation			https://www.who.int/publications/i/item/9789240031593
	Sustain group DSD models for adolescents managed by healthcare workers	Minimum	Minimum	Minimum	Standard	Group DSD models for adolescents e.g teen clubs have been demonstrated to support adherence and retention to ART.	Programmes should provide community support for people	Strong	Moderate	https://www.who.int/publications/i/item/9789240031593
	Susatin individual DSD models not based at facilities	Minimum	Minimum	Minimum	Optimal	Out of facility models often require some additional financing.	No WHO recommendation;			https://www.who.int/publications/i/item/9789240031593
	Sustain group DSD models managed by healthcare workers	Minimum	Minimum	Minimum	Standard	The ability to form group models in low prevalence settings will	Programmes should provide	Strong	Moderate	https://www.who.int/publications/i/item/9789240031593
	Actively support transfer all clients from facilities that are closing to preferred public sector facility with same day continuation of ART, minimum 3MMD, offer less-intensive DSD model without required transfer documentation	Minimum	Minimum	Minimum	Minimum	Clear policy for patients transferring care between facilities is required	No specific WHO recommendation			
Continuity OI prophylaxis	Provide cotrimoxazole prophylaxis to adults Stage 3 and 4 or CD4 <350. Note recommendation when to stop	Minimum	Minimum	Minimum	Minimum	Cotrimoxazole prophylaxis indicated for prevention of PCP, severe bacterial infections, TB and malaria. Note implementation	1. Starting Co-trimoxazole prophylaxis is recommended for	1.Strong; 2.	Moderate; 2. Low	https://www.who.int/publications/i/item/9789240031593
	Provide cotrimoxazole tp adults in settings where malaria and/or severe bacterial infections are highly prevalent, co-trimoxazole prophylaxis should beinitiated regardless of CD4 cell count or WHO stage; Note recommendation when to stop	Minimum	Minimum	Minimum	Minimum	Cotrimoxazole prophylaxis indicated for prevention of PCP, severe bacterial infections, TB and malaria. Note implementation for criteria for stopping cotrimoxazole	1. In settings where malaria and/or severe bacterial infections are highly prevalent, co-trimoxazole prophylaxis should	1.Conditional; 2. Conditional	1.Moderate; 2. Low	https://www.who.int/publications/i/item/9789240031593
	Provide cotrimoxazole to patients living with HIV and TB	Minimum	Minimum	Minimum	Minimum	Cotrimoxazole prophylaxis indicated for prevention of PCP,	Routine co-trimoxazole	Strong	High	https://www.who.int/publications/i/item/9789240031593
	Provide cotrimoxazole to children living with HIV; Note recommendation on when to stop	Minimum	Minimum	Minimum	Minimum	Cotrimoxazole prophylaxis indicated for prevention of PCP, severe bacterial infections, TB and malaria. Note implementation	Co-trimoxazole prophylaxis is recommended for infants,	1. Strong 2. Strong	Low 3. Moderate	https://www.who.int/publications/i/item/9789240031593
	Provide cotrimoxazole to HIV exposed infants; Note recommendation when to stop	Minimum	Minimum	Minimum	Minimum	Cotrimoxazole prophylaxis indicated for prevention of PCP, severe bacterial infections, TB and malaria. Note implementation	Co-trimoxazole prophylaxis is recommended for HIV-exposed	Strong	Low	https://www.who.int/publications/i/item/9789240031593
	Provide secondary fluconazole prophylaxis (maintenance); Note recommendation on when to stop	Minimum	Minimum	Minimum	Minimum	Fluconazole maintenance essential after treatment for cryptococcal meningitis but note implementation of criteria for	Fluconazole (200 mg daily for adults, 6 mg/kg per day for	Strong	High	https://apps.who.int/iris/bitstream/handle/10665/357088/9789240052178-eng.pdf?sequence=1
ART initiation (and re-initiation)	Initiate children under 5 years	Minimum	Minimum	Minimum	Minimum	ART initiation currently recommended for all regardless of CD4;	ART should be initiated for all	Adults	moderate;	https://www.who.int/publications/i/item/9789240031593
	Initiate pregnant and breastfeeding women	Minimum	Minimum	Minimum	Minimum	ART initiation currently recommended for all regardless of CD4;	ART should be initiated for all	Adults	moderate;	https://www.who.int/publications/i/item/9789240031593
	Initiate those with clinical signs and symptoms of HIV/AIDS or CD4<200 if known (AHD)	Minimum	Minimum	Minimum	Minimum	ART initiation currently recommended for all regardless of CD4; specific populations may need to be prioritized +/- use of CD4	ART should be initiated for all people living with HIV regardless	Adults strong;	moderate; pregnant	https://www.who.int/publications/i/item/9789240031593
	Initiate all people testing positive for HIV (new and re-engaging) and transferring	Minimum	Minimum	Minimum	Minimum	ART initiation currently recommended for all regardless of CD4; specific populations may need to be prioritized +/- use of CD4	ART should be initiated for all people living with HIV regardless	Adults strong;	moderate; pregnant	https://www.who.int/publications/i/item/9789240031593
	Initiate all people testing positive for HIV - stage 3 or 4 or if CD4 known or baseline CD4 (CD4 nadir) below 200/350/500	Minimum	Minimum	Minimum	Minimum	Threshold dependent on resources	ART should be initiated for all people living with HIV regardless	Adults strong;	moderate; pregnant	https://www.who.int/publications/i/item/9789240031593
	Initiate all people testing positive for HIV - stage 1 or 2 or if CD4 known or baseline CD4 (CD4 nadir) above 200/350/500	Minimum	Standard	Standard	Optimal	Threshold dependent on resources	ART should be initiated for all people living with HIV regardless	Adults strong;	moderate; pregnant	https://www.who.int/publications/i/item/9789240031593

Step 4: Prioritization + add rationale (annex provide WHO recommendation and comments)

Component	Intervention	SCENARIO 3	COUNTRY NAME	Rationale
ART continuity	Provide uninterrupted ART treatment to ALL people who are already on ART, all populations and all regimens	Minimum		
	Provide a minimum of 3MMD for all, unless clinically unwell (including re-engaging clients) with 6MMD preferred for those established on ART (for all over 5-years of age)	Minimum		
	Conduct an annual quality clinical review if established on ART and virally suppressed with longest scripting period allowed 6-12 months	Minimum		
	Enroll eligible clients in less-intensive DSD models	Minimum		
	Sustain individual DSD models based at facilities	Minimum		
	Sustain individual DSD models for key populations not based at facilities	Standard		
	Sustain group DSD models managed by clients	Minimum		
	Sustain group DSD models for adolescents managed by healthcare workers	Minimum		
	Susatin individual DSD models not based at facilities	Minimum		
	Sustain group DSD models managed by healthcare workers	Minimum		
	Actively support transfer all clients from facilities that are closing to preferred public sector facility with same day continuation of ART, minimum 3MMD, offer less-intensive DSD model without required transfer documentation	Minimum		



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Suggest start with “treatment”, proceed to “testing”

Component	Intervention	SCENARIO 3	COUNTRY NA	Rationale	
Blood products	Mandatory screening all blood products	Minimum			I
Facility-based	All people with signs/symptoms of at all facility entry points	Minimum			F
	Ante-natal first visit/ first test	Minimum			I
	Ante-natal additional test in third trimester/delivery	Minimum			I
	Post-natal testing for HIV negative breastfeeding women all: 6-monthly until 6-weeks post cessation	Minimum			I
	HIV exposed infants at 6 weeks and, if breastfeeding, at 6/9- & 18-month EPI visit	Minimum			I
	HIV exposed infants additional birth testing	Standard			I
	TB clients (newly diagnosed)	Minimum			H
	TB clients (presumptive TB)	Standard			H
	STI clients (new STI)	Minimum			I
	Hepatitis B or C (newly diagnosed)	Minimum			H
	Inpatient (new admission)	Minimum			S
	Children in malnutrition clinics	Minimum			K
	Children in immunization services after positive screening for possible exposure + missed 18 month testing	Standard			K
	All family planning clients at FP initiation	Minimum			S
	All family planning clients under 25 years at initiation and annually thereafter	Minimum			S
	All family planning clients at initiation + every second year + self-reported change in partnership	Standard			S
	All family planning clients at FP initiation and annually thereafter	Standard			S
	Self-initiated VCT/HIVST collection available (limit to annual/specific risk exposure)	Minimum			S
	VCT/HIVST collection available (any frequency)	Optimal			S
	PrEP users: 1 month after oral PrEP (re)initiation, then 6-monthly	Minimum			
	PrEP users: 1 month after oral PrEP (re)initiation, then 3-monthly	Optimal			
	VMMC clients	Minimum			

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And then “prevention” prioritization

Infant prophylaxis	Infant prophylaxis (AZT and NVP); High risk first 6 weeks	Minimum		
	Infant prophylaxis (AZT or NVP); High risk weeks 6-12	Minimum		
	Infant prophylaxis (AZT or NVP); Low risk	Minimum		
PEP	Facility-based post exposure prophylaxis (PEP) as per national guidance	Minimum		
	Community-based PEP availability - GBV services, maintained community-based KP services	Minimum		
Condoms	Facility-based condom (and lubricant) availability	Minimum		
	Community collection points for condom (and lubricant) for key populations	Minimum		
	Community collection points for condom (and lubricant) for all populations	Standard		
PrEP continuation	Facility based oral PrEP maintenance for key populations, known sero discordant where VL of partner with regular use - minimum 3MMD with testing every 6 months (including with HIVTST)	Minimum		
	Facility based oral PrEP maintenance for pregnant and breastfeeding women- minimum 3MMD with testing every 6 months (including with HIVTST)	Minimum		
	Facility based oral PrEP maintenance for other populations with regular use - minimum 3MMD with testing every 6 months (including with HIVTST)	Standard		
	Annual clinical PrEP review for PrEP maintenance for those with regular use, including STI screening and treatment and HIV test	Minimum		
	6-monthly clinical PrEP review for PrEP maintenance for those with regular use	Optimal		
	Individual DSD models based at facilities for PrEP maintenance	Standard		
	Individual out-of-facility PrEP maintenance (through existing and maintained out-of-facility DSD treatment locations), including refill collection and HIVST	Standard		
	Provide PrEP refills throught virtual delivery models	Optimal		
	Adherence and behaviour risk reduction counselling at every clinical visit	Optimal		
	Provide continuation of dapivirine vaginal ring for PrEP	Optimal		

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Step 6: Review the “summary” tab to support additional work

- Summary tab will describe the minimum, standard and optimal packages
- This can then be followed by budgeting to understand the resources required for each tier
- As well as modelling to assess the impact of different prioritizations on outcomes (e.g., new infections, mortality, etc.)

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The PATHS – Planning and Action Toolbox for HIV Sustainability

What is it?

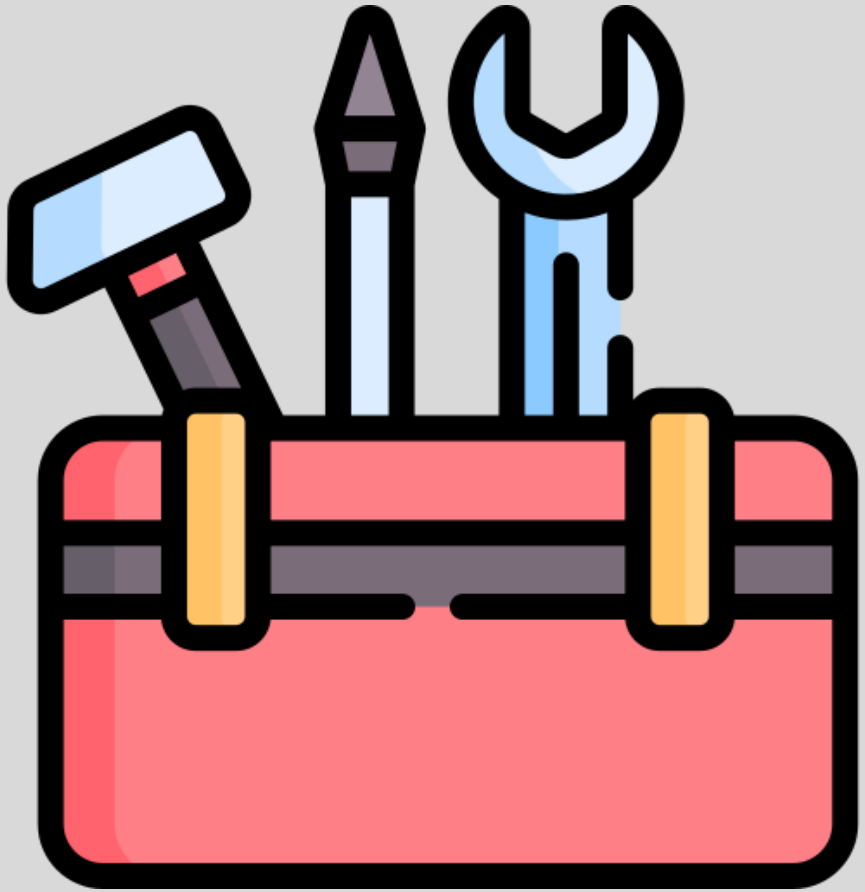
- A rapidly deployable compendium of resources

Who is it for?

- National governments

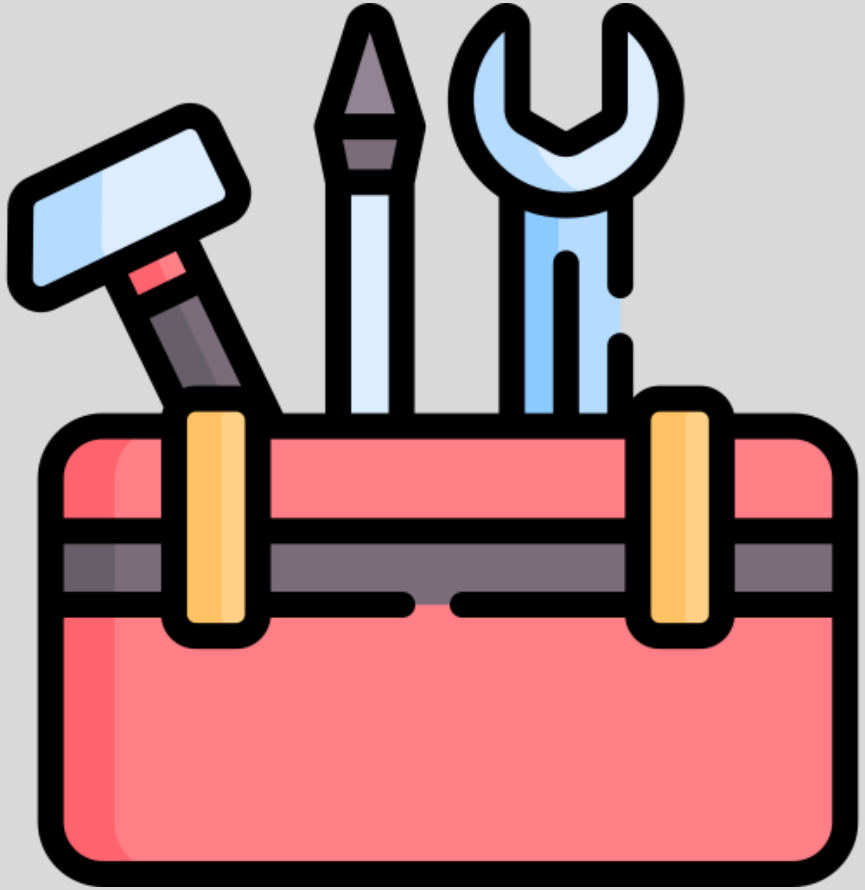
What's the objective?

- Support responding to unexpected reductions in HIV funding by enabling swift reassessment and reorganization of HIV systems and services



The PATHS – Planning and Action Toolbox for HIV Sustainability

…accessible online and updated regularly as new tools are developed – ensuring it remains a dynamic, evolving resource”



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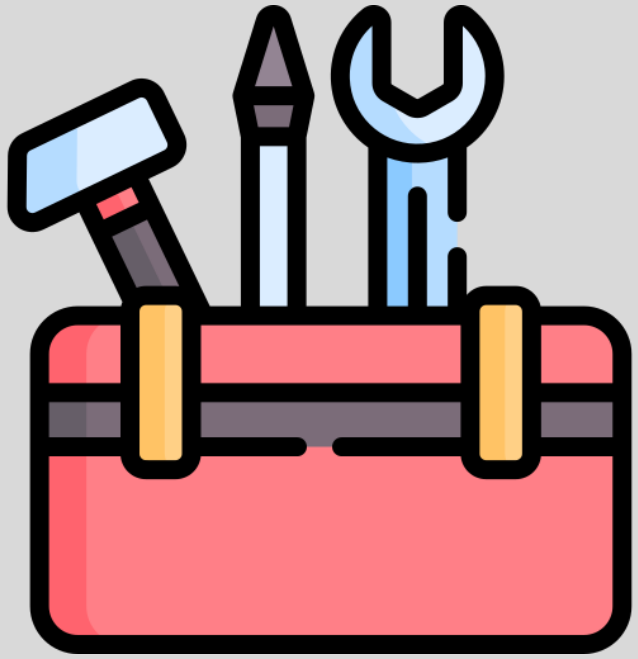
Access and download the PATHS and TIER tool

- TIER – English
- TIER – French
- TIER – Portuguese
- TIER – Spanish
- PATHS (English only)

(*Versions 30 July*)

All those resources are available on the IAS DSD website via this link bit.ly/HIV_PATH and the QR code.



Contact us

dsd@iasociety.org

Complete the feedback form

bit.ly/HIV_PATH

National Approach to HIV service Prioritization in Mozambique: An Overview

Isidoro Nobre

DSD Coordinator STI/HIV/AIDS Control Program

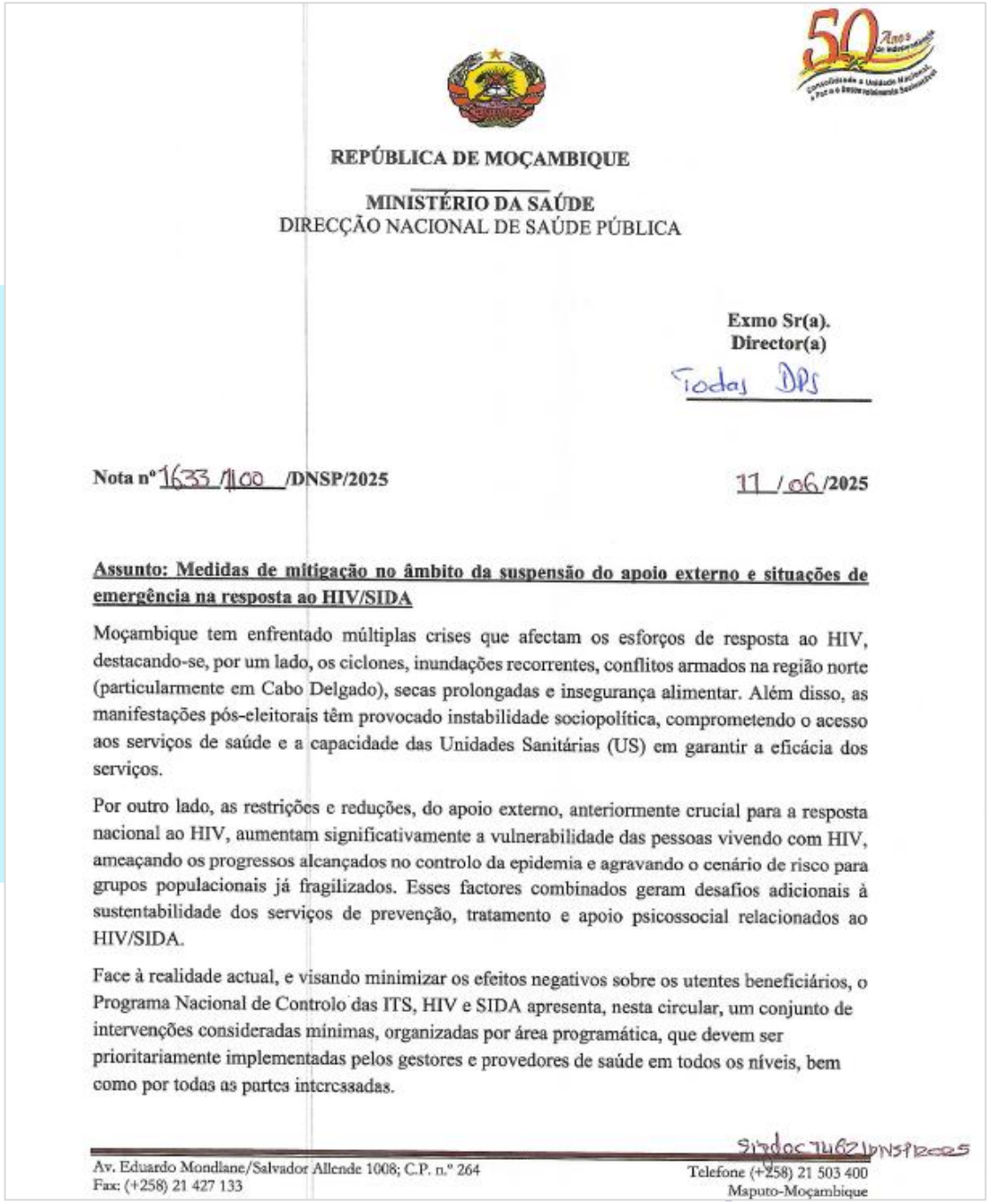
Ministry of Health, Mozambique

Presentation Outline

- Background
- Prioritization planning, process and results
- M&E indicator prioritization
- Lessons learnt
- Next steps and technical assistance needs

Background: Mozambique Response to the Funding Pause

- Developed a national guidance document outlining service continuity strategies
- Identified essential services & processes to maintain service delivery
- Paused activities listed in the stop work order (e.g., community activities, some integration support – mainly in USAID-supported provinces)
- Final program decisions (incl. EMR) pending confirmation of next COP funding levels



REPÚBLICA DE MOÇAMBIQUE

MINISTÉRIO DA SAÚDE
DIRECÇÃO NACIONAL DE SAÚDE PÚBLICA

Exmo Sr(a).
Director(a)
Todas DPS

Nota nº 1633/100 /DNSP/2025 11/06/2025

Assunto: Medidas de mitigação no âmbito da suspensão do apoio externo e situações de emergência na resposta ao HIV/SIDA

Moçambique tem enfrentado múltiplas crises que afectam os esforços de resposta ao HIV, destacando-se, por um lado, os ciclones, inundações recorrentes, conflitos armados na região norte (particularmente em Cabo Delgado), secas prolongadas e insegurança alimentar. Além disso, as manifestações pós-eleitorais têm provocado instabilidade sociopolítica, comprometendo o acesso aos serviços de saúde e a capacidade das Unidades Sanitárias (US) em garantir a eficácia dos serviços.

Por outro lado, as restrições e reduções, do apoio externo, anteriormente crucial para a resposta nacional ao HIV, aumentam significativamente a vulnerabilidade das pessoas vivendo com HIV, ameaçando os progressos alcançados no controlo da epidemia e agravando o cenário de risco para grupos populacionais já fragilizados. Esses factores combinados geram desafios adicionais à sustentabilidade dos serviços de prevenção, tratamento e apoio psicossocial relacionados ao HIV/SIDA.

Face à realidade actual, e visando minimizar os efeitos negativos sobre os utentes beneficiários, o Programa Nacional de Controlo das ITS, HIV e SIDA apresenta, nesta circular, um conjunto de intervenções consideradas mínimas, organizadas por área programática, que devem ser prioritariamente implementadas pelos gestores e provedores de saúde em todos os níveis, bem como por todas as partes interessadas.

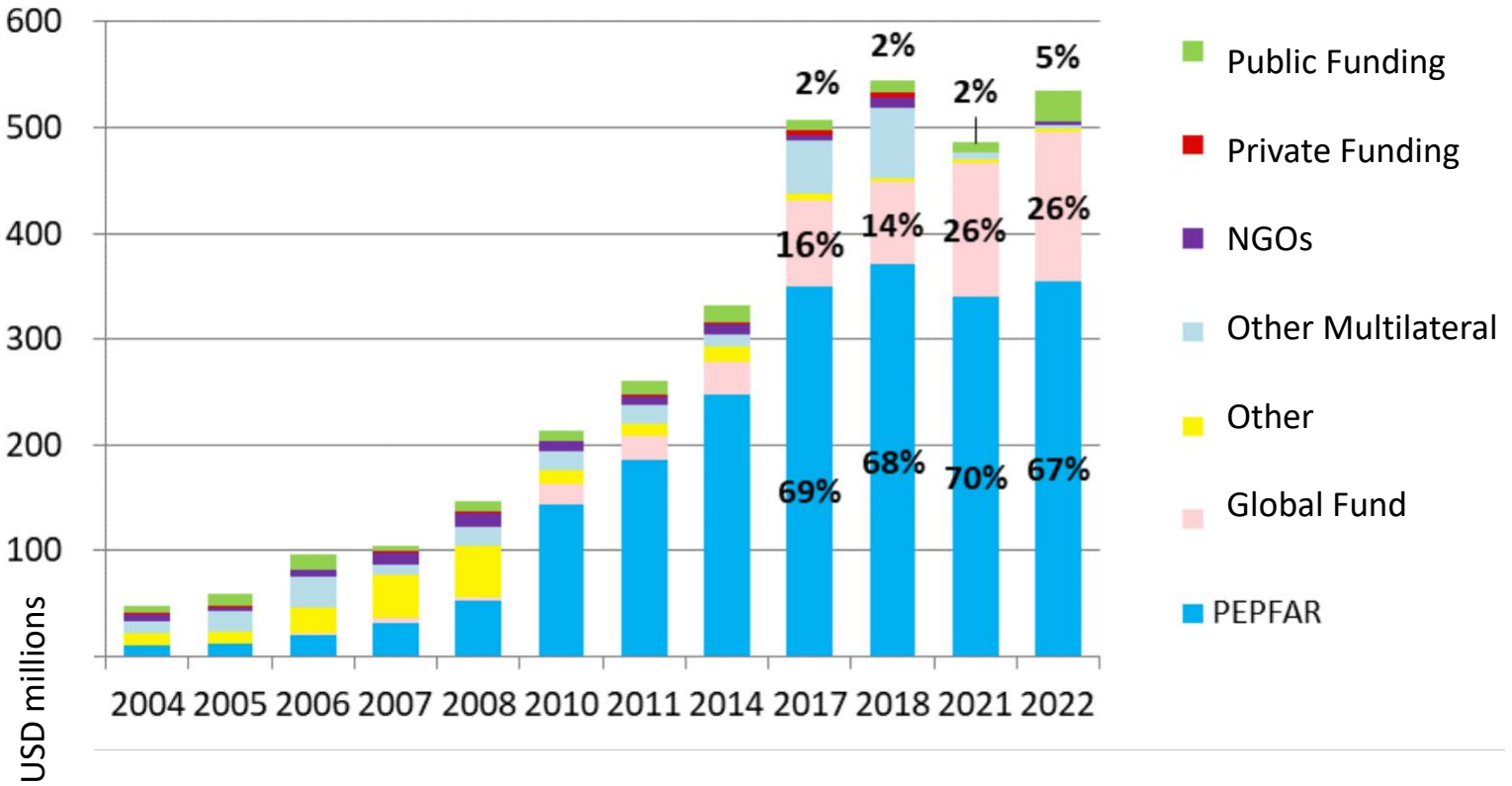
Sirdos 7462/DNSP/2025

Av. Eduardo Mondlane/Salvador Allende 1008; C.P. n.º 264
Fax: (+258) 21 427 133

Telefone (+258) 21 503 400
Maputo-Moçambique

Funding Context and Scenarios

- GoM share: ~$26M of $536M spent in 2022 (mostly HRH)
- Public funding limitations → 0% scenario very restrictive
- Exercise included 0%, 30%, 70% funding levels
- 70% scenario considered most realistic



Pre-Prioritization Planning

1. Planning for the prioritization exercise:
    a) Scheduling the meeting and selecting the venue
    b) Who was invited?
    c) Who funded the meeting?
    d) What resources/documents/data did you gather ahead of the meeting?
2. Highlight how routine, modelling, and costing data informed decision making during the prioritization exercise
3. How has HIV M&E indicator prioritization aligned to the national HIV service prioritization?

Post-June 2025 CQUIN Meeting Actions and Outcomes…1

- **Follow-Up and Initial Prioritization:**
  - Held two follow-up meetings in plenary to agree on prioritized, modified, or dropped interventions across all program areas: Care & Treatment, Testing, Prevention, PMTCT, Supply Chain, and M&E
  - Initial prioritization exercise: Budget estimates focused on commodities only, excluding HRH and systems costs
  - Budget distribution basis: Used proportions from the *2022 National AIDS Spending Assessment* — 50% allocated to Care & Treatment, 20% to Testing and 17% to HIV Prevention

2026	TOTAL Budget	Prevention (17%)	C&T (50%)	Testing (20%)
0%	**$ 8,700,000**	$ 1,700,000	$ 5,000,000	$ 2,000,000
30%	**$ 55,401,968**	$ 9,418,335	$ 27,700,984	$ 11,080,394
70%	**$ 129,271,260**	$ 21,976,114	$ 64,635,630	$ 25,854,252

- **Technical Working Group [TWG] Engagement**
  - Convened a day-long TWG meeting to present and discuss the initial draft
  - Participants: Civil society, donors, and implementing partners in prevention, testing and care & treatment
  - Purpose: To jointly review and refine the HIV program's initial recommendations for alignment and feasibility

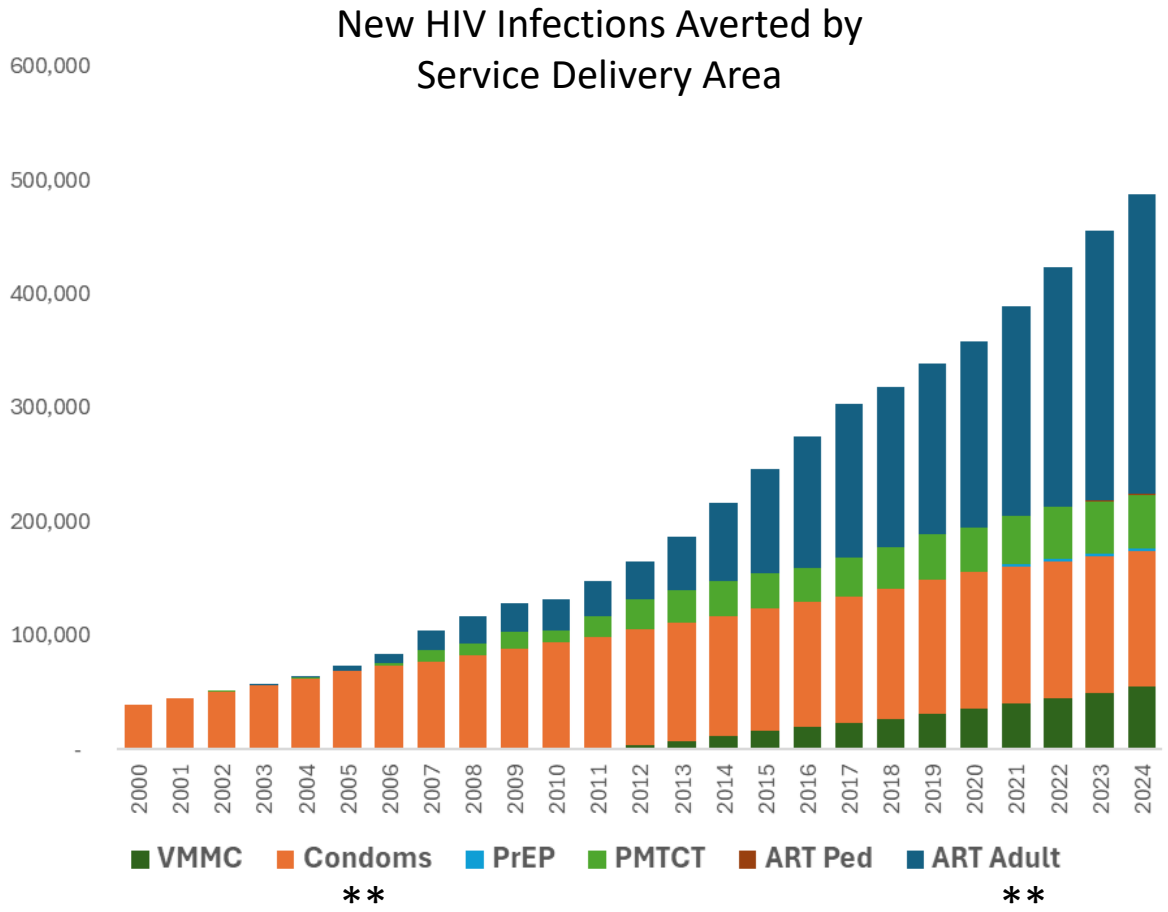
Post-June 2025 CQUIN Meeting Actions and Outcomes….2

Data and Budget Analysis

- Focus areas: Budget projections, 2022 National AIDS Spending Assessment, and current national norms
- Pre-budget release activity: Assessing the impact of interventions on new HIV infections
- Initial findings (since 2000):
  - 5.2 million infections averted, large contributions from:
    - Condom Use (2.3 million)
    - Adult ART (1.97 million)

***These two interventions emerged as the most effective.*

***Data review is ongoing to optimize activity costs*



Results of the Preliminary Modelling for Impact: GOALS Model

Program Area Prioritization…1

HIV Testing

Areas prioritized:

0% funding scenario	30% funding scenario:
• All HIV symptomatic • Testing for inpatient, TB and STI positive individuals • Mandatory screening for blood donors • Index testing • Testing for pregnant women and HIV exposed infants	• All HIV symptomatic • Testing for inpatient, TB and STI positive individuals • Mandatory screening for blood donors • Testing pregnant/ Breastfeeding women and HIV exposed infants

With 70% considered the most practicable external funding scenario, most interventions will remain unchanged, while some will require adaptations

Rationale:

- Historically with the highest positivity rate or vulnerable populations (children and pregnant women)

Areas deprioritized:

- Community-level HIV testing and outreach
- Integrated testing into Family planning provision

Note: Many items in the testing sheet were not applicable (such as community based self testing collection points) in Mozambique

Program Area Prioritization…2

HIV Prevention

Areas prioritized:

0% funding scenario	30% funding scenario
• Infant prophylaxis • Facility- based Post exposure prophylaxis (PEP) • Facility-based condom distribution	• Infant prophylaxis • Facility- based Post exposure prophylaxis (PEP) • Oral PrEP for pregnant and breastfeeding women, sero-discordant couples, Key Populations and AGYW based on risk assessment. • Facility-based condom distribution

With 70% considered the most practicable external funding scenario, most interventions will remain unchanged, while some will require adaptations

Rationale:

- Prevention funding is most limited; prioritization mostly followed SWO-approved populations (P/BFW) for PrEP, with minor adjustments. Mozambique has a high vertical transmission rate (~12%) so preventing new positives in this population is a priority

Areas deprioritized:

- Harm reduction activities
- PrEP for all other populations
- Community-based condom distribution by lay counselors

Program Area Prioritization…3

Care & Treatment

Areas prioritized:

0% funding scenario	30% funding scenario
• Continuity of OI prophylaxis • TB treatment • Contact information and psychosocial support (no direct budget implication) • ART initiation for children, pregnant/breastfeeding women (P/BFW) and RoC with AHD	• All activities under 0% scenario • ART for all eligible RoC • Cryptococcal treatment • 3MMD with some modifications

With 70% considered the most practicable external funding scenario, most interventions will remain unchanged, while some will require adaptations

Rationale:

- Very limited public funding means most community-based activities (including DSD models) are deprioritized
- AHD package and integration activities also deprioritized due to high costs
- Budget-dependent activities (e.g., viral load testing, tracking and tracing) excluded from 0% and 30% funding scenarios

Areas deprioritized: AHD package, Integration activities, tracking and tracing, some OI management, VL testing and community DSD models

Clinical Service Package Prioritization

THIS IS A DRAFT FOR CONSIDERATION AND INPUTS					
HIV programme	Component	Orcamento	Intervention (50% do orcamento)	0% $5,000,000	30% $27,700,500	70% $64,635,629
	ART continuity		Uninterrupted ART treatment to ALL people who are already on ART, all populations and all regimens	Nivel 3	Nivel 2	Nivel 2
			Minimum of 3MMD for all, unless clinically unwell (including re-engaging clients) with 6MMD preferred for those established on ART (for all over 5-years of age)	Nivel 3	Nivel 2	Nivel 2
			Annual quality clinical review if established on ART and virally suppressed with longest scripting period allowed 6-12 months	Nivel 3	Nivel 3	Nivel 3
			Less-intensive DSD models:			
			Enroll eligible clients in less intensive DSD models	Nivel 3	Nivel 2	Nivel 2
			Individual DSD models based at facility sustained	Nivel 1	Nivel 1	Nivel 1
			Individual DSD models for key populations not based at facility sustained	Nivel 3	Nivel 3	Nivel 3
			Group DSD models managed by clients sustained	Nivel 3	Nivel 3	Nivel 2
			Group DSD models for adolescents managed by healthcare workers sustained	Nivel 3	Nivel 3	Nivel 3
			Individual DSD models not based at facility sustained	Nivel 3	Nivel 3	Nivel 3
			Group DSD models managed by healthcare workers sustained	Nivel 3	Nivel 3	Nivel 3
			Actively support transfer all clients from facilities that are closing to preferred public sector facility with same day continuation of ART, minimum 3MMD, offer less-intensive DSD model without required transfer documentation	N/A	N/A	N/A
	Continuity OI prophylaxi		Cotrimoxazole prophylaxis to all eligible patients	Nivel 1	Nivel 1	Nivel 1
			Secondary fluconazole prophylaxis	Nivel 1	Nivel 1	Nivel 1
	ART initiation (and re-initiation)	##########	Children under 5 years	Nivel 2	Nivel 2	Nivel 1
		$ 946,128	Pregnant and breastfeeding women	Nivel 2	Nivel 2	Nivel 1
			Clinical signs and symptoms of HIV/AIDS or CD4<200 if known (AHD)	Nivel 2	Nivel 2	Nivel 2
			All people tested positive for HIV (new and re-engaging) and transferring	Nivel 2	Nivel 2	Nivel 2
			All people tested positive for HIV - stage 3 or 4 or if CD4 known or baseline CD4 (CD4 nadir) below 200/350/500	Nivel 2	Nivel 2	Nivel 2
			All people tested positive for HIV - stage 1 or 2 or if CD4 known or baseline CD4 (CD4 nadir) above 200/350/500	Nivel 2	Nivel 2	Nivel 2

The prioritization document showing the initial sections of the care and treatment tab

	Testing			Prevention			Care and Treatment		
	0%	30%	70%	0%	30%	70%	0%	30%	70%
Level 1	9	12	23	1	2	8	10	10	12
Level 2	5	8	6	2	13	12	7	13	28
Level 3	21	15	6	24	12	7	39	33	16
Total		35			27			56	

	Testing			Prevention			Care and Treatment		
	0%	30%	70%	0%	30%	70%	0%	30%	70%
Level 1	26%	34%	66%	4%	7%	30%	18%	18%	21%
Level 2	14%	23%	17%	7%	48%	44%	13%	23%	50%
Level 3	60%	43%	17%	89%	44%	26%	70%	59%	29%

Level 1: Essential Services – to maintain as currently implemented

Level 2: Services to continue with modifications

Level 3: Services to stop

M&E Indicator Prioritization

Scope: 29 indicators reviewed across prevention, testing and treatment – under 0% and 50% funding scenarios

Preliminary Indicator Prioritization Decisions:

- **HIV Prevention:** 4/4 indicators retained → aligns with upstream prevention focus
- **HTS:** 4/5 indicators retained. With 0% funding, self-testing may be discontinued. Thus, not to be reported
- **ART:** 4/7 indicators retained. Dropped CD4 disaggregation and AHD treatment cascade tracking (for lack of an EMR) but will still report AHD enrollment numbers (No. currently on follow-up)
- **VTP:** 6/6 indicator retained. ARV prophylaxis for HEI at birth is not reported in DHIS2
- **TB:** 2/2 indicators retained. TPT completion is not currently reported
- **Viral Load:** 3/3 indicators retained→ strong priority maintained

Overall: *Most core indicators retained; deprioritization mainly due to data feasibility constraints under potential paper-based reporting*

From Prioritization to Action Amid Funding Uncertainty

Follow-up Actions from the Joint Prioritization Exercise:

- Align Global Fund financing and implementation plans with the defined priorities
- Reallocate resources to higher-impact interventions (e.g., index testing)
- Share prioritization results with PEPFAR, WHO, UNICEF, and civil society for technical and strategic alignment
- Define strategies for training, supervision, and targeted demand creation in line with the agreed priorities

Considerations on Funding Uncertainty:

- PEPFAR funding levels for the country are still unknown; discussions were theoretical and based on hypothetical figures
- As a result, the exercise was theoretical and may not reflect the reality of these funding levels
- Once the actual budget is shared, the country will need to revisit and potentially revise the assumptions used in this exercise
- With real programs at stake, discussions are expected to be more challenging and may require returning to initial assumptions, despite the groundwork laid

Next Steps and Technical Assistance Needs

- **Data analysis and use:** Strengthen capacity to analyze and use programmatic and surveillance data for evidence-based decision-making
- **Service integration:** Develop tools and guidelines to effectively guide the integration of HIV, TB, NCDs, and other priority health services
- **Demand creation:** Engage community actors beyond traditional community-based organizations (e.g., religious leaders, traditional leaders, local volunteers) and promote innovative approaches to community mobilization

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Thank you!
Obrigado!

National Approach to HIV Service Prioritization in Eswatini: An Overview

Sindy Matse
Program Manager
Eswatini National AIDS Program

Presentation Outline

- Background
- Strategic planning: process and outcomes
- Challenges
- Identifying TA needs
- Next steps

Background

- Eswatini has made significant **progress toward HIV epidemic control**, with a major reduction in HIV incidence, high ART coverage, and viral suppression. However, the country is now navigating a challenging funding landscape marked by:
  - **Declining donor support** (GF $33M to $30M, Stop work order for key stakeholders supporting HIV prevention services)
  - Stagnant or limited domestic funding
  - Increased pressure to sustain services with fewer resources
- To address these challenges, **Eswatini conducted a national HIV services prioritization exercise—following the June 2025 CQUIN Network Meeting—using the IAS TIER and CQUIN-modified TIER tools.**
- This process supports data-driven decision-making, ensures efficient use of resources, and strengthens coordination between government and donors.

Rationale for the Prioritization

Rationale for Prioritization/Objective

- Aligning limited resources with high-impact interventions
- Maintaining essential HIV services despite budget constraints
- Supporting evidence-based national planning and donor engagement

Tools Used in the Process

- **IAS TIER Tool:** epidemiological and programmatic prioritization: **Eswatini = Category 2**
- **CQUIN-Modified TIER Tool:** service delivery and cost-effectiveness lens
- Technical support from Eswatini stakeholders

***CDC,ICAP/CQUIN,WHO, CHAI and other partners*

Prioritization Process in Eswatini (1)

Step 1: Virtual sensitization of core team meeting (9/07/2025)

- Initial orientation for key stakeholders
- Introduced the purpose, tools, and methodology
- Built shared understanding before in-person engagement

Step 2: National prioritization stakeholder meeting (17/07/2025)

- In-person meeting with ~80 participants
- Included MOH departments, civil society, partners, sectors
- Participants split into 3 technical groups led by ENAP thematic heads:
    1. Prevention
    2. Testing
    3. Care & Treatment (C&T)

Each group applied the IAS TIER Tool and the CQUIN-Modified TIER Tool to prioritize services

Prioritization Process in Eswatini (2)

Step 3: Core Team Review - (23-24/07/2025)

- Smaller group of 20 national (mainly MOH, partners and civil society rep)
- Finalized prioritization outputs and validated key decisions
- Ensured technical accuracy and strategic alignment

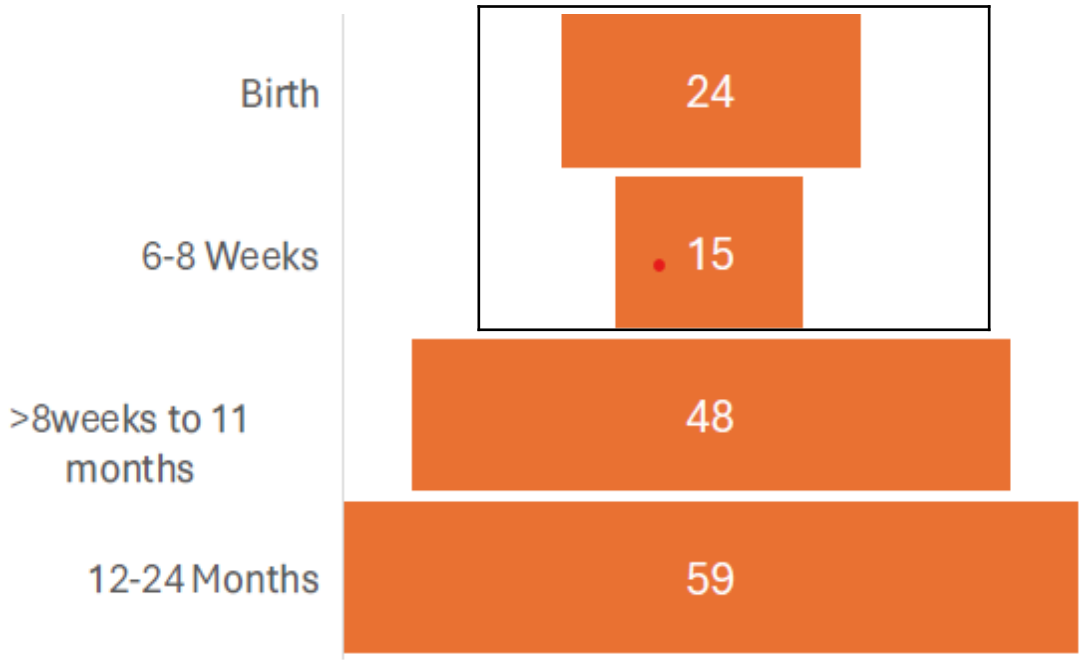
Step 4: Reporting and Documentation

- A comprehensive report compiled
- Included prioritization results, and strategic report – shared with stakeholders including the CQUIN team
- To inform national planning and donor coordination

Prioritization Process in Eswatini (3)

Data driven decision making using programmatic data

New HIV Infections in Infants Aged 0-24 Months - 2024



Data Sources : 2023 & 2024, Sexual & Reproduction Health Reports

Birth testing is considered a priority and remains part of the minimum package of services, with no changes made.

Rationale: HIV infection in infants can occur during pregnancy, childbirth, or breastfeeding. The number of HIV-infected newborns remains significant. In Eswatini, data from 2024 show that the identification rate of HIV-positive infants at birth was higher (24) than at 6–8 weeks (15), reinforcing the importance of maintaining birth testing as a key strategy.

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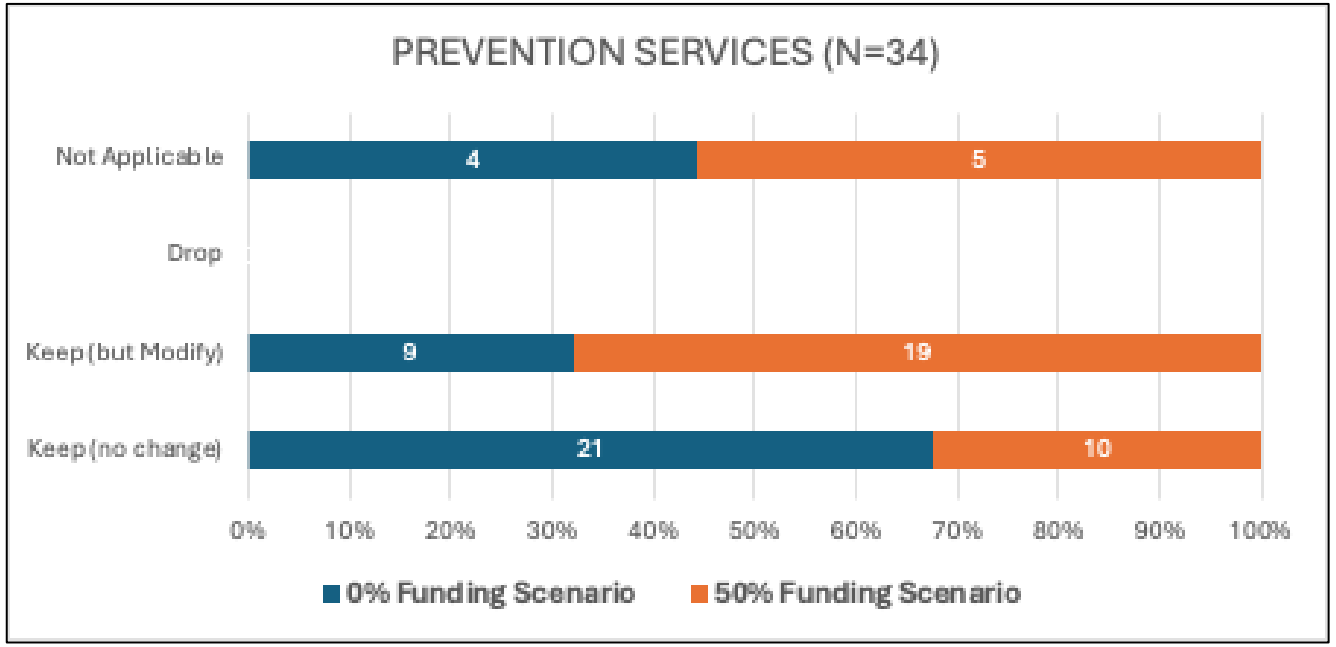
Prioritization Process in Eswatini (4)

Key Outcomes of the Prioritization

- List of high-priority interventions identified
- Populations and settings prioritized
- Low-priority services flagged for de-emphasis or integration

HIV *Prevention* Prioritization



No services were deprioritized in either funding scenario, demonstrating Eswatini's strong commitment to preserving all prevention interventions. [Turning off the tap]

HIV *Testing Prioritization*

Deprioritized services <u>in both</u> funding scenarios:

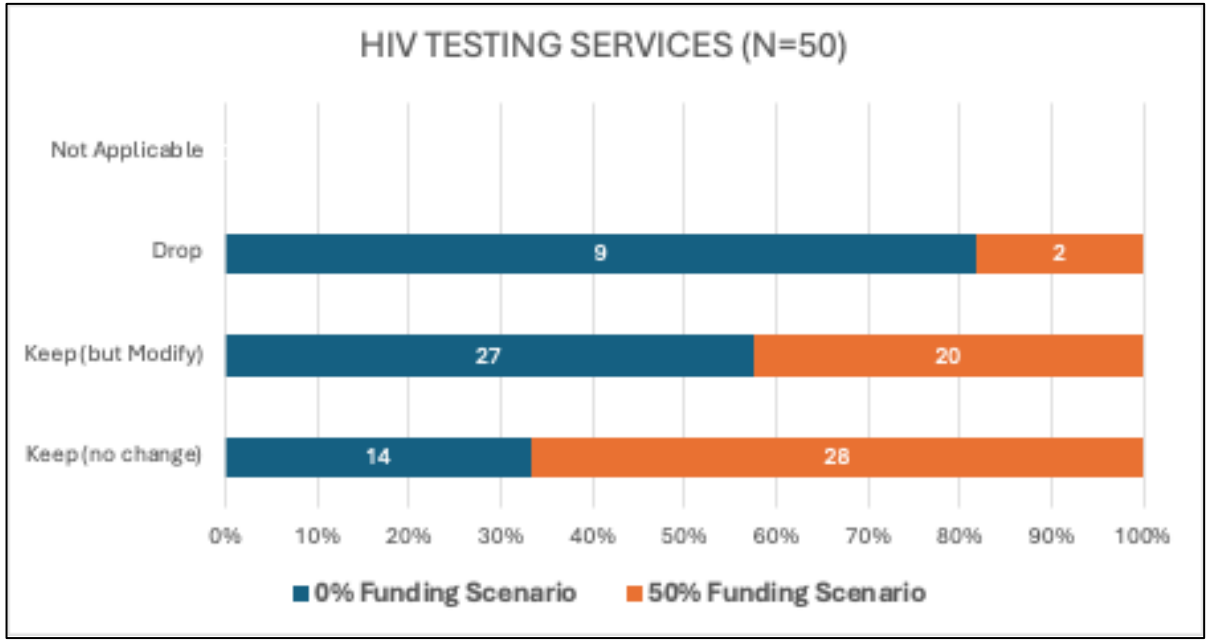
- Recency testing

Deprioritized services <u>at the 50% funding</u> scenario:

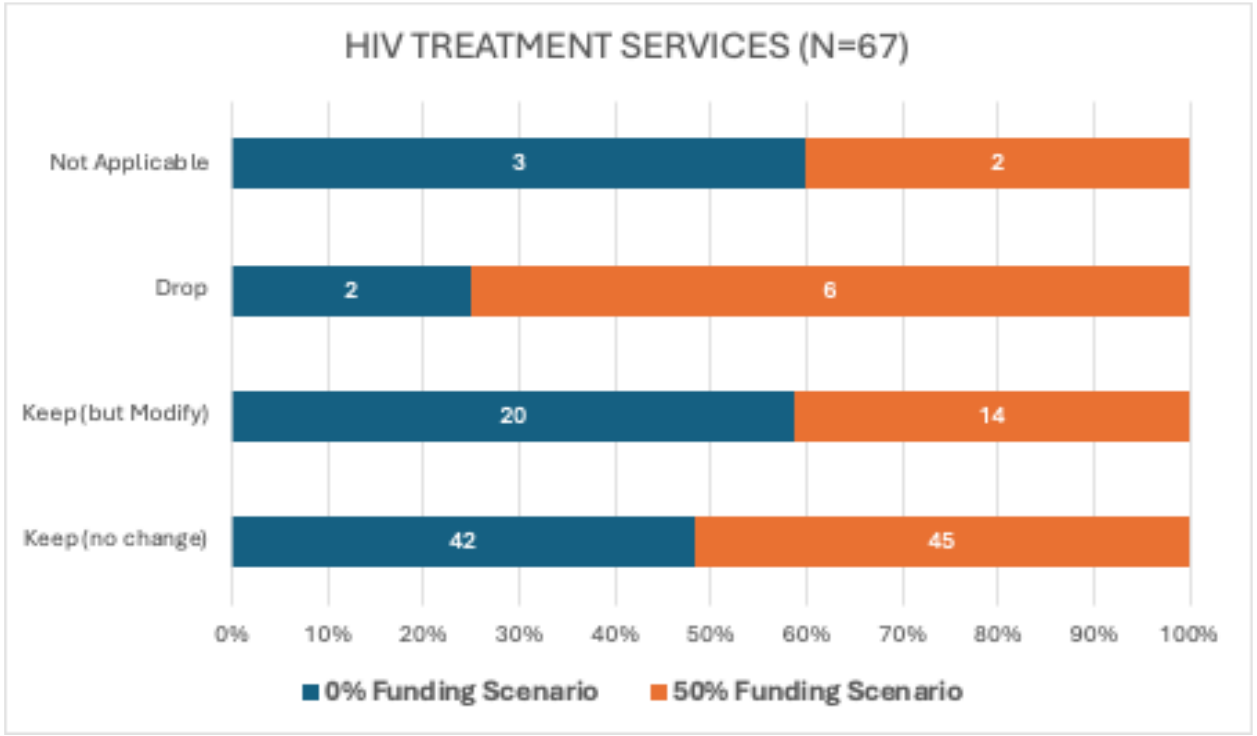
- Newly diagnosed female client: Biological children in the community

Deprioritized services <u>at the 0% funding</u> scenario:

- *Men*: Targeted outreach HTS (congregant settings - transport hubs, bars)
- *ABYM:* Targeted outreach HTS (educational facilities, youth centres)
- *Key populations:* All previous outreach points and drop-in centres run by community-based organizations
- *STI clients from 95s gap populations with HIV negative result*: Sexual partner testing utilizing enhanced passive notification with HIVST kit/s provision
- *VCT/HIVST collection available* (any frequency)
- *STI clients with HIV negative result:* Sexual partner testing utilizing enhanced passive notification with HIVST kit/s provision
- *Key populations:* High volume outreach points and drop-in centres run by community-based organizations
- *STI clients with HIV negative result:* Sexual partner testing utilizing provider-assisted notification for facility-based testing (consider centralized/virtual)



HIV *Treatment* Prioritization



Deprioritized services in <u>both</u> funding scenarios include:

- Sustain individual DSD models for key populations not based at facilities.
- Sustain individual DSD models not based at facilities.

Deprioritized services <u>at the 50%</u> funding scenario include:

- Sustain group DSD models managed by healthcare workers.
- Conduct home tracing if there is no response to calls for clients with abnormal lab results.
- Conduct home tracing if there is no response to phone calls: for those with active OIs, (re)started ART, stage 4, CD4 <200, children and adolescents, pregnant and breastfeeding women.
- Conduct home tracing if there is no response to phone calls for all who have missed their scheduled appointment by more than 28 days.

M&E Indicator Prioritization

Program Area	External Funding Scenario			
	0%		50%	
	Indicator Status	Notes	Indicator Status	
VTP	7/7 indicators: Keep [No change]		7/7 indicators: Keep [No change]	
HTS	4/4/ indicators: Keep [No change]		4/4/ indicators: Keep [No change]	
ART	4/5 indicators: Keep [No change]	Mortality to be kept but modified	4/5 indicators: Keep [No change]	Mortality to be kept but modified
VL	3/3 indicators: Keep [No change]		3/3 indicators: Keep [No change]	
TB	4/4 indicators: Keep [No change]		4/4 indicators: Keep [No change]	
HIV prevention	3/4 indicators: Keep [No change]	Condom distribution is N/A	3/4 indicators: Keep [No change]	Condom distribution is N/A

25/27 [93%] proposed indicators will be kept [with no change] in both funding scenarios

Lessons Learnt (1)

Impact on Planning and Budgeting

- Integration into national health strategy and investment case
- Informing Global Fund and PEPFAR planning
- Better alignment between service delivery and available resources

Emerging TA Needs

- Support for cost data analysis
- Capacity building on prioritization frameworks
- Continued guidance on aligning prioritization with M&E and budgeting processes

Lessons Learnt (2)

Challenges Faced

- Gaps in cost or outcome data
- Balancing national priorities with partner interests
- Making the tough decision to deprioritized services
- Time constraints for robust deliberation

Emerging TA Needs

- Support for cost-effectiveness analysis of integrated service models
- Facilitation of multi-stakeholder dialogue platforms to align priorities.
- Technical guidance on national strategic planning and donor coordination
- TA to build real-time dashboards integrating HIV, SRHR, and NCD data

Way Forward

Align Global Fund planning with HIV program priorities to guide resource allocation and implementation timelines.

Share prioritization results with key stakeholders and civil society for technical and strategic alignment.

Advocate for the absorption of laid-off program staff into the government system to retain capacity and ensure service continuity.

Reallocate resources to high-impact interventions to maximize impact and sustainability.

Implement training, supervision, and demand creation strategies aligned with national priorities and target population needs.

Repeat the prioritization exercise as needed to stay responsive to evolving data and funding landscapes.

Thank you!

Q&A Discussion

Moderators

Onyekachi Ukaejiofo
Regional Clinical and QI Advisor ICAP in Nigeria

Rachel Mudekereza
Senior Clinical Advisor, WCA
ICAP in Côte d'Ivoire

Anna Grimsrud
Senior Technical Advisor
IAS

Discussants

Isidoro Nobre
DSD Coordinator
STI/HIV/AIDS Control Program
MOH, Mozambique

Sindy Matse
Program Manager
MOH, Eswatini

Lindiwe Simelane
Director
Dream Alive, Eswatini

Papa Oumar
M&E Focal
MOH, Senegal

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Next CQUIN webinar in September TBA!

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Thank You!