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Launch of the JIAS Supplement "Differentiated service delivery – beyond HIV treatment for integration and other health needs"

High acceptability, feasibility, and sustainability of a direct-to-pharmacy differentiated PrEP delivery model in public health HIV clinics in Kenya: Perspectives of PrEP clients and healthcare providers

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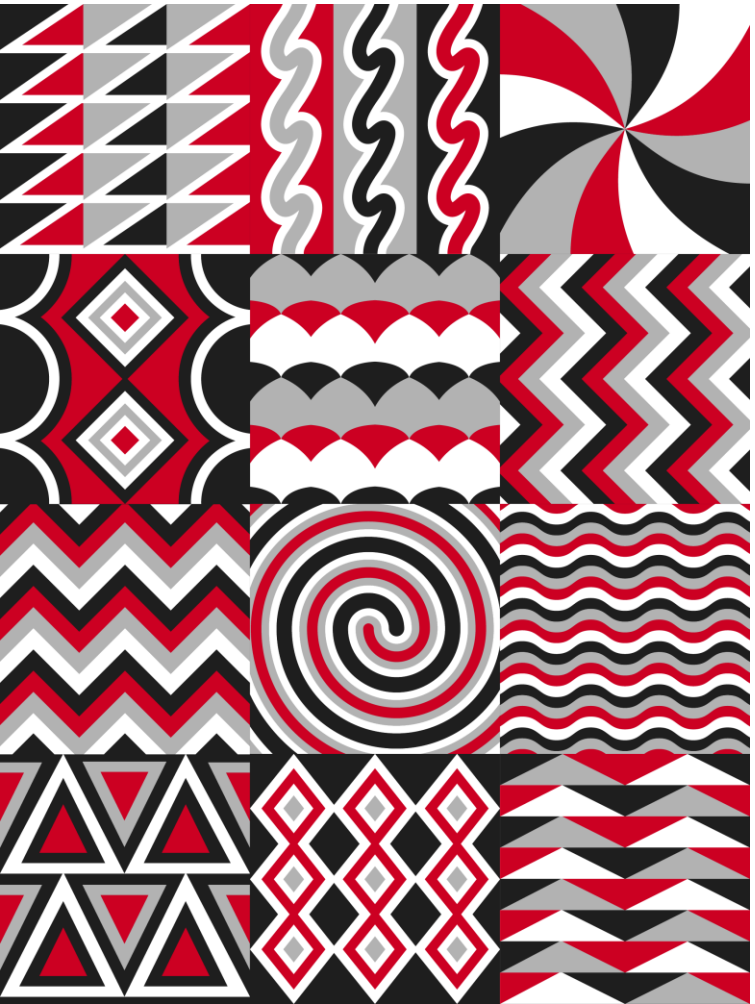
Background



- Health system barriers (e.g., long waiting times) hinder efficient oral PrEP delivery and access in public HIV clinics
- Differentiated service delivery (DSD) approaches could eliminate barriers to PrEP access and optimize delivery
- We sought to evaluate the **acceptability** and **feasibility** of a direct-to-pharmacy (DTP) PrEP refill visits with HIV self-testing (HIVST) model in real-world HIV clinics in Kenya

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Methods: Intervention

Study setting and population

- 4 HIV clinics with established PrEP services
- Nairobi and Central regions, Kenya
- Aged ≥18 years male and females

Design & implementation approach

- Quasi-experimental
- 2 clinics implemented the intervention (n=380)
- 2 comparable clinics served as controls (n=366)

Intervention package

1. Direct-to-pharmacy refill visits with pharmacist-led rapid risk assessment and dispensing
2. Client HIV self-testing while waiting for refills
3. PrEP client navigator

Standard client flow

1. HIV testing by clinic staff
2. Normal clinical consultation
3. Multiple stopovers (triage, HIV testing, counselling, clinical review, dispensing)

Methods: Qualitative

Qualitative study nested in 2 intervention clinics:

PrEP clients (n=20)	Healthcare providers (n=20)

Assessed client and provider perceptions of DTP:

Clients: Waiting time, experience, acceptability, and burden	Providers: Acceptability, feasibility, sustainability, willingness to implement

Guided by the **Consolidated Framework for Implementation Research** (CFIR)

Results: Time spent in clinic and services (minutes) by the intervention arm (Clinic visit records, PrEP refill records)

Characteristic[a]	N	Direct-to-pharmacy with client HIVST, $n = 58$[b]	Usual clinic flow, $n = 22$[c]	p-value[d]
Total clinic time	80	33.5 (29, 45)	50.5 (39, 104)	<0.001
Total time at the pharmacy	78	8 (6, 12)	8 (4, 15)	0.8
Direct contact time with pharmacy staff	78	7 (6, 8)	4 (3, 7)	0.001
Overall time for HIV testing	80	21 (18, 29)	25 (20, 42)	0.18
Direct time spent conducting HIV testing	80	20 (18, 27)	20 (18, 23)	0.46

[a]Overall time includes time for the activity/services plus wait time, while direct time excludes wait for the respective activity/service.
[b] and [c]Median (IQR).
[d]Wilcoxon rank sum test.

- DTP refill visits **improved service efficiency, quality, and satisfaction** derived from**:**
  - **Improved waiting times:** Seeing fewer providers, less movement, and use of HIVST.
  - **Improved client flow:** Less queuing, fewer steps, less congestion.
  - **Reduced workload:** Less provider interaction with PrEP clients, and client-conducted HIVST.

Results: Acceptability

- **Clients**: Reduced delays, improved privacy, reduced stigma, and opportunity costs, motivated continuation.

*[DTP] has really given me the morale [motivation] of taking the drugs because **you spend less time** in the hospital. Also, you are dispensed drugs for three months, not like before when it used to be for one month only. (Female Client, Age 33, Facility A).*

- **Providers**: Smoother clinic flow, reduced congestion, reduced workload, and improved knowledge.

*[DTP] has **improved the workflow**, you can see more patients, we have more time for other things, you are spending less time on one client…Before, they [clients] used to go to the clinician, the social worker…So, they are free to attend to other more needy clients. (Male Pharmacist, Facility B).*

Results: Feasibility

- **Low complexity** and easy implementation.
- **Adaptability:** Enabled **task-sharing** and workflow optimization.
- **Challenges**: Potential missed counselling, loss of roles among HIV counsellors, increased pharmacy staffing burden.

*"[DTP] is **easy** because you are empowered, you understand all the process. So, when the client comes, you are able to serve them as it should be and refer them where it's appropriate." (Female HIV Counsellor, Facility B).*

*[DTP] has **improved the workflow**, you can see more patients, we have more time for other things, you are spending less time on one client…Before, they [clients] used to go to the clinician, the social worker…So, they are free to attend to other more needy clients. (Male Pharmacist, Facility B).*

Results: Potential for sustainability

- High client and provider **motivation**, **confidence**, and **willingness** to continue participating in DTP.
- Alignment with clinic goals and capacity.
- Beliefs DTP would improve PrEP uptake and continuation.
- **Challenges**: Supply chain interruptions (HIVST kits), documentation, staffing, and space.

"We believe [PrEP] uptake will be a bit higher because most of the clients were defaulting because they were coming here, they line up, they go through the process over again, and again they come here. Now that it is direct-to pharmacy, I think the uptake will be a bit higher." (Male HIV Counsellor, Facility A).

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Discussion

DTP PrEP refill visits with HIVST were a highly **acceptable** and **feasible** DSD approach among PrEP clients and providers

Concerns of pharmacy provider burden and client missed counselling opportunities highlight need for continuous **monitoring** and innovative clinic-level **adaptations**

Future implementation and scalability depend on consistent **resource availability**, continuous provider **training**, leadership **support**, and integration in PrEP service **guidelines**

Next steps

- Simplified **client-centred** delivery models have the potential to improve the efficiency of PrEP delivery

- Context-specific **adaptations** and **scale-up** are needed in other delivery settings

- **Tailored DSD strategies** are needed among other **priority sub-populations** of PrEP users.

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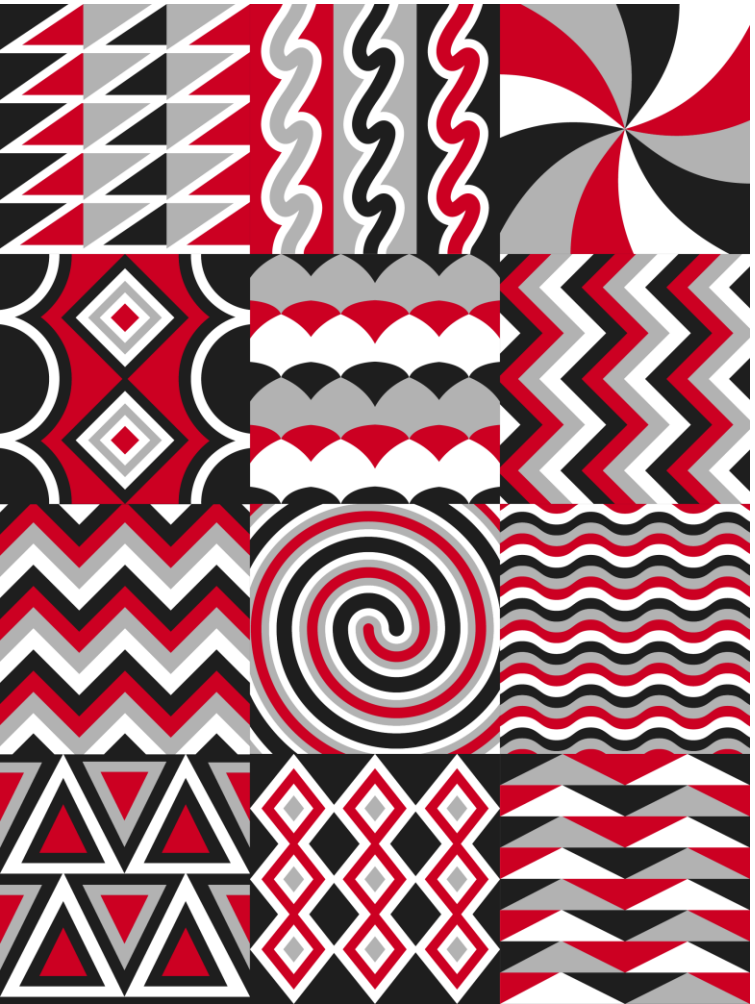

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