



3rd Long-Acting HIV Treatment and Prevention Conference

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MEETING PEOPLE WHERE THEY ARE:

Integrating long-acting HIV care into differentiated service delivery

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The injection is only half the intervention



PRODUCT

Efficacy • duration • tolerability

DELIVERY

Access • convenience • continuity



Principals of Differentiated Service Delivery

Definition: A client-centred approach that simplifies and adapts HIV prevention services to reflect the needs of diverse populations, reduce unnecessary burdens, and ensure quality of care.

WHO delivers

- Task-shifted to NIMART-qualified nurses
- Pharmacists (oral PrEP, growing role)
- Trained lay counsellors and CHWs
- Community health workers — demand creation
- Doctors: complex cases, supervision, protocol design

WHERE it's delivered

- Mobile clinics — in the community
- Pharmacies — extended hours, no appointment
- Schools and universities
- Courier / home delivery
- Workplaces and community venues

WHAT is delivered

- Right product for the right person (choice)
- Up to 6 months' supply (MMD for oral/DVR)
- HIVST kits at every dispensing visit
- Adherence counselling adapted to lifestyle
- Integrated SRH services

WHEN / HOW OFTEN

- Flexible scheduling — not fixed clinic hours
- Reduced visit frequency via MMD
- Asynchronous follow-up using HIVST
- Telehealth check-ins between visits
- CAB-LA: built-in 8-weekly clinic touchpoint

Integration is the first redesign



SILOED

HIV clinic

Family planning

STI service

ANC / postnatal



ONE INTEGRATED TOUCHPOINT

HIV test + PrEP/ART

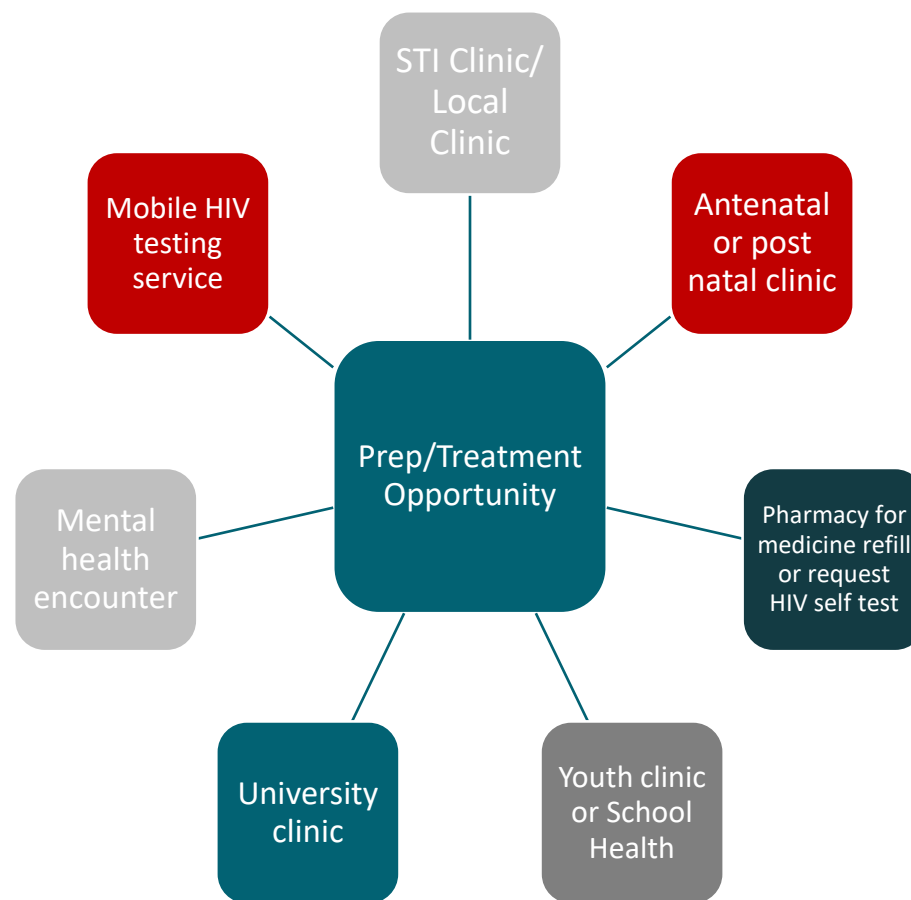
STI screening

Contraception / pregnancy
care

Adherence + mental
health support

Long-acting delivery should be embedded, not bolted on.

Combining an integrated service with Differentiated service delivery



A long-acting DSD lens



WHO

NIMART nurses
Pharmacists
Peer navigators



WHERE

Clinics
Mobile services
Pharmacies
workplaces



WHAT

Choice of modality
Integrated SRH
Testing + follow-up



WHEN

Dosing windows
Flexible booking
Digital support

DSD is not fewer services. It is the right intensity, location and team for each person.

Adapted from WHO DSD framing and SAHCS PrEP implementation materials.

Treatment DSD is the foundation

South Africa already delivers ART through multiple differentiated models.



FACILITY ADHERENCE CLUB

**Group-based care
On-site**

Peer support
Health education

COMMUNITY ADHERENCE CLUB

**Group-based care
Closer to home**

Peer support
Community access

QUICK PICK-UP

**Fast medication
collection
Minimal contact**

Speed
After-hours flexibility

EXTERNAL PICK-UP

**Pharmacy
community venue
Medication locker**

Decentralised access
Reduced facility burden

The lesson: different people value different combinations of speed, support and location.

- Mukumbang FC, Ndlovu S, van Wyk B. Comparing Patients' Experiences in Three Differentiated Service Delivery Models for HIV Treatment in South Africa. Qualitative Health Research. 2022;32(2):238–254. doi:10.1177/10497323211050371.

- Huber AN, Jamieson L, Fox MP, Manganye M, Malala L, Chidarikire T, et al. Evaluating the impact of differentiated service delivery (DSD) on retention in care and HIV viral suppression in South Africa: A target trial emulation using routine healthcare data. PLOS Medicine. 2025;22(8):e1004489. doi:10.1371/journal.pmed.1004489.

What people value in treatment DSD

Convenience is essential, but convenience alone is not person-centred care.



PATIENT EXPERIENCE ATTRIBUTE	Facility club	Community club	Quick pick-up
Quick service + shorter waits	●	●	●
Easy ART access + flexibility	●	●	●
Health education	●	●	
Peer / psychosocial support	●	●	
Group empowerment	●	●	

Preserve the support people value when redesigning care around long-acting treatment.

IMPALA: long-acting treatment for people conventional care misses

African evidence makes the DSD question impossible to ignore.



540

participants across 7 sites
Uganda • Kenya • South Africa

48-WEEK VIRAL SUPPRESSION

91%

CAB/RPV LA

89%

oral ART

Non-inferior: RD +2.3% (95% CI -2.7 to 7.2)

THE DSD IMPLICATION

- Participants had recent viraemia, delayed visits or disengagement from care
- Two-monthly injectable ART reduced daily pill burden
- DSD must actively support appointment keeping and rapid re-engagement
- Viral-load surveillance and prompt oral fallback remain essential

DSD should target support by need, not simply reduce clinic contact.

Real World Case study of successful DSD and Integrated services



FastPrEP

FastPrEP Aim: implement and evaluate a district wide PrEP intervention that will lead to Increased coverage of at risk, sexually active population (AGYW, incl. pregnant women), male partners and MSM through provision of sexual reproductive health service and PrEP engagement (uptake and effective use) in a peri-urban setting in Cape Town, South Africa

HUB-and-SPOKES MODEL



The primary objectives are to distinguish **PrEP persistence patterns across different PrEP modalities** (vaginal, oral, and injectable) and from **multiple PrEP delivery platforms** that will aid the provision of PrEP choice to adolescents and young people in South Africa

Geographic coverage: South Africa,, Western Cape –
Klipfontein/Mitchells Plain health sub-district

PrEPared to CHOOSE



Adolescent & Youth Friendly PrEP Platform
AGYW, Het Men, Gender and Sexually Diverse Populations
Current and Naive PrEP Users

Integrated PrEP and SRH service
offered from two sites



Site 1:
Mobile
Clinic



Site 2:
Government
Clinic



Structured HIV PrEP Choice Counselling

CAB-LA



DapiRing



Oral PrEP



Final PrEP choice with
same day administration

Primary Objective: Describe Patterns
of PrEP Use Over Time

Total Time on PrEP Product



Frequency of Discontinuations & Restarts



Frequency of Product Switching



PrEP Start

7 Months
Short-term

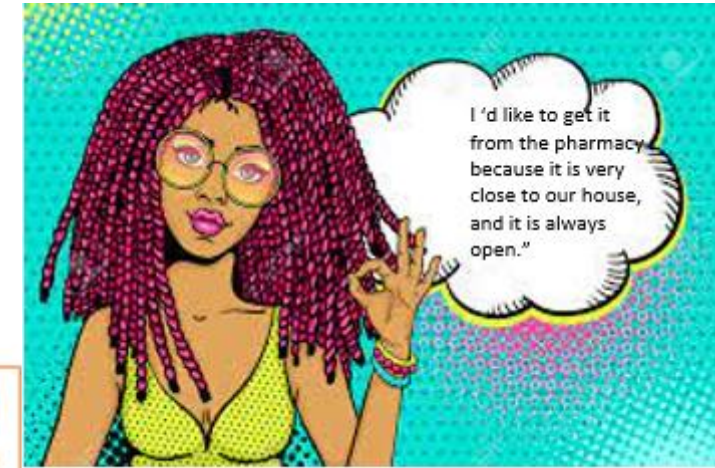
18 Months
Long-term

PASSIVE FOLLOW UP

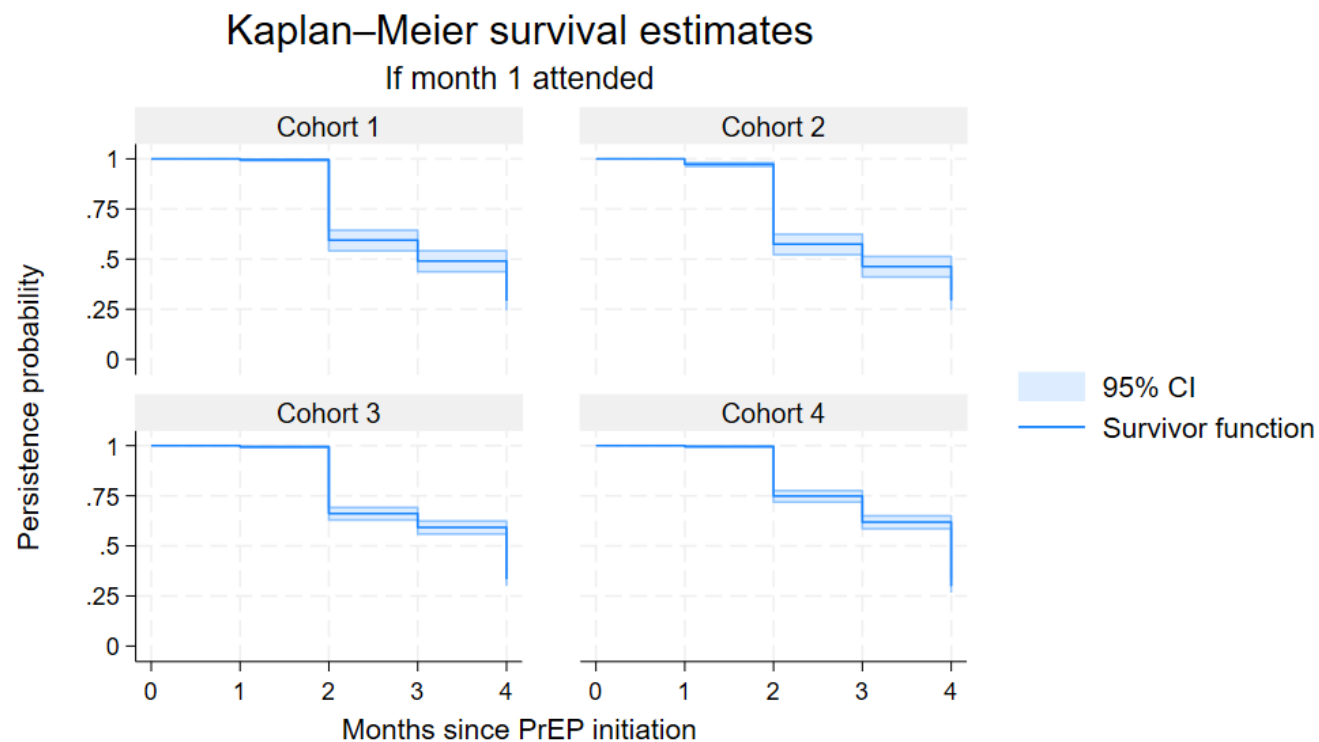
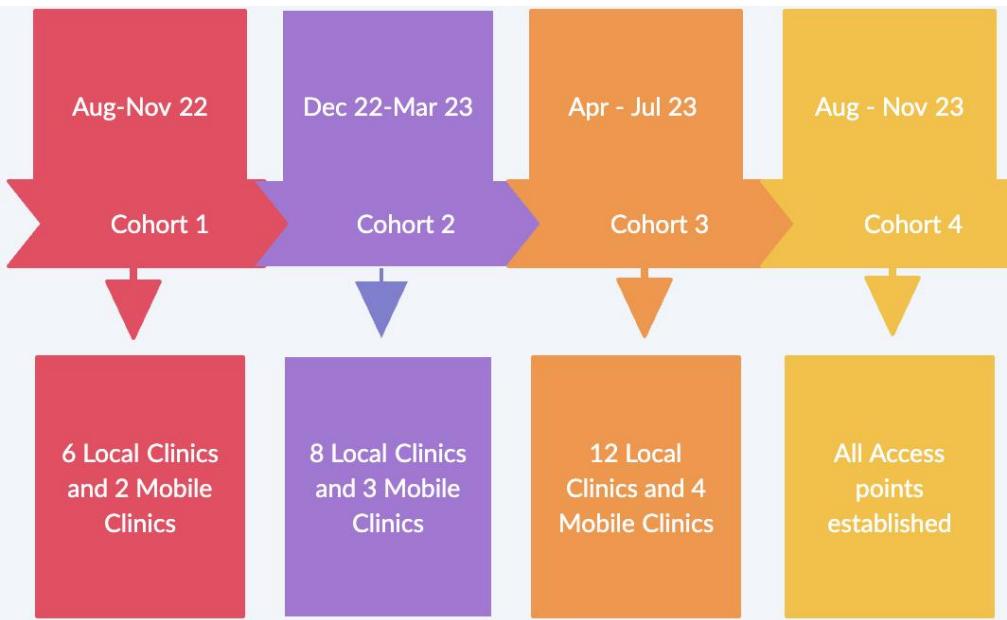
Minimal Retention Efforts; No Reimbursement for PrEP Visits

Differentiated PrEP delivery:

Evolving landscape with the introduction of long-acting modalities



Early lessons from FASTPrEP: Greater access options increased PrEP persistence in young people accessing community - based sexual and reproductive services in CapeTown, South Africa



PrEP persistence at 3 months was 49.9% (95% CI: 44.5%-55.1%), 48.1% (95% CI:42.6%-53.3%), 59.7% (95% CI:56.3%-62.9%) and 62.5% (95% CI:59.1%-65.6%) for cohorts 1-4, respectively.

Lessons from FastPrEP



- Meet people where they are
 - >70% uptake in FastPrEP occurred in mobile clinics
- More access points = Better Persistence
 - In FastPrEP, the persistence improved per cohort
 - DSD adds to better uptake and persistence
- Choice drives uptake
- SRH Integration is essential
 - Every PrEP encounter is a good STI screening opportunity. Every STI Symptoms encounter is a good PrEP opportunity
- Task shifting works
 - Majority of FastPrEP staff included lay counsellors and nursing staff



Real-world Expanded Access
and Choice for HIV Prevention

REACH: Taking twice-yearly lenacapavir from efficacy to real-world impact

A pragmatic implementation study supporting South Africa's public-sector introduction of long-acting lenacapavir for HIV prevention in the Western Cape.



Bringing PrEP choice closer to where people live, study and work



18,000 people

Adolescents and adults seeking HIV prevention, with a focus on populations with greatest prevention need.

Hub-and-spoke delivery

Public-sector clinics + mobile/community platforms + TVET colleges across Cape Town Metro and George.

Clinics | Mobile clinics | Community spaces | Colleges & universities

Choice + continuity

Twice-yearly lenacapavir or oral PrEP, supported by choice counselling, peer navigation and PrEP Companion digital platform.

What REACH will tell us

Can we translate >96% clinical-trial efficacy into sustained, equitable protection in routine care?

Primary: protected at 12 months | Co-primary: LEN continuation at 26 weeks.

WHAT ARE WE EVALUATING?



UPTAKE



CONTINUATION



EQUITY



DELIVERY & COST



SCALE-UP

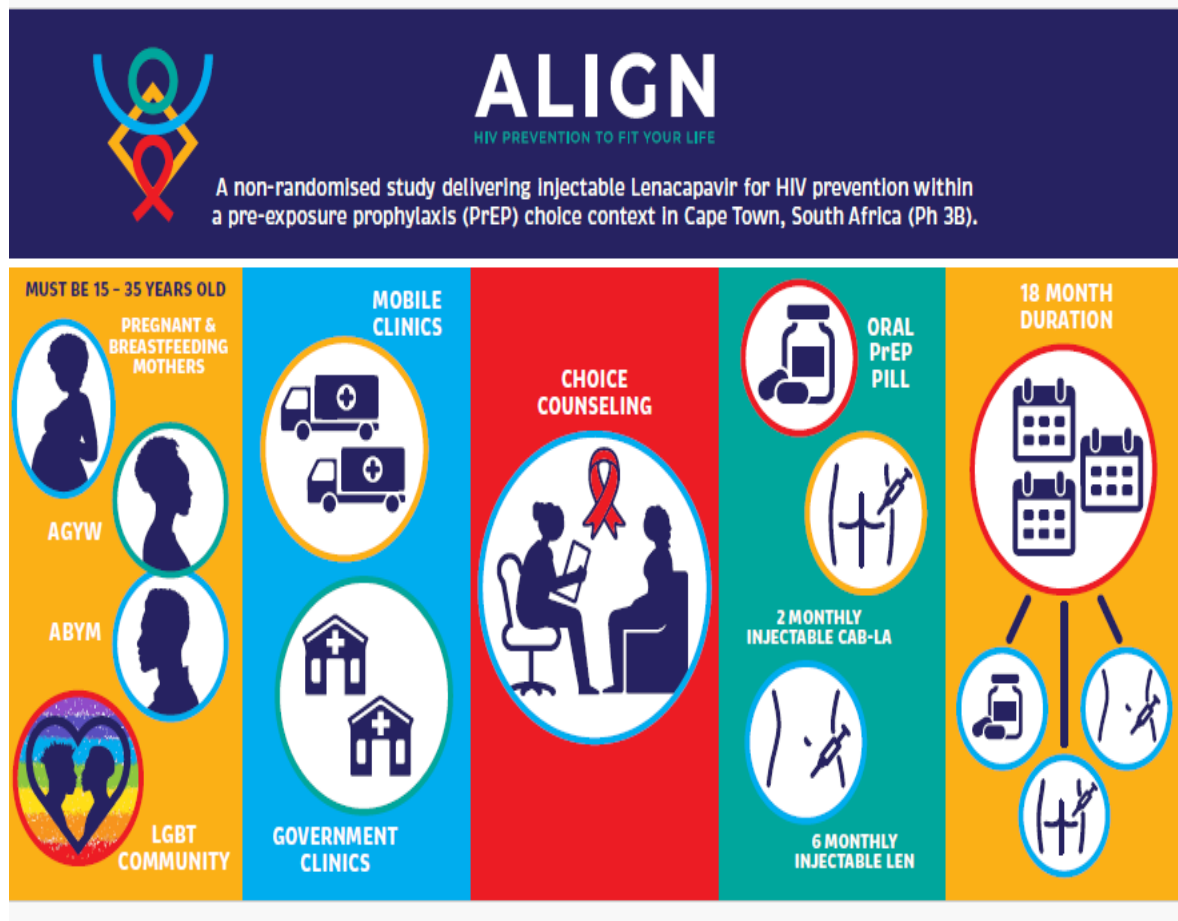


DESMOND TUTU
HEALTH FOUNDATION

3rd LA ART Conference

ALIGN: choice in the long-acting era

A DTHF platform comparing how young people use prevention options in routine delivery.



ALIGN

NON-RANDOMISED PrEP CHOICE STUDY

UP TO 3,700

young people

AGES 15–35

Cape Town

6 MONTHS

follow-up

CHOICE OFFERED

Oral PrEP • CAB-LA • Lenacapavir

Implementation learning: preference, uptake and continuation within a choice context.

Implementation challenges we must solve



CLINICAL

- Missed or delayed injections
- HIV testing and viral monitoring
- Oral bridging and tail management
- Resistance and escalation pathways

OPERATIONAL

- Appointment and recall systems
- Stock continuity and cold-chain needs
- Injection capacity and trained teams
- Data linkage across delivery points

EQUITY

- Rural and mobile populations
- Youth-friendly and key population access
- Transport, work and school constraints
- Avoiding selective offer or digital exclusion

