

Rethinking ‘community’ in the implementation of long-acting injectable Cabotegravir and Rilpivirine: qualitative findings from the ILANA study

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Key Takeaways

- Delivery of CAB+RPV in community settings should be configured in a manner that promotes continuity of care and maintains access to HIV-specialist staff.
- People living with HIV should be consulted on their preferences for community delivery, and service providers should be aware that the offer of a single community setting may be insufficient to increase accessibility overall.
- Further research is needed on delivery of CAB+RPV in generic community health settings, with consideration given to strategies for reducing pressure on HIV-specialist staff capacity.

Background	Methods
<ul style="list-style-type: none">Delivery of long-acting injectable Cabotegravir and Rilpivirine (CAB+RPV) in community settings may increase acceptability and accessibility of treatment, where stigma is a concern. However, evaluation has so far been minimal.ILANA is the first mixed-methods implementation study examining the acceptability and feasibility of CAB+RPV in six clinics and community settings across Brighton, Liverpool and London in the United Kingdom (UK).This presentation focuses on the views of community healthcare providers (CHCPs) and people living with HIV regarding delivery of CAB+RPV in community settings.	<ul style="list-style-type: none">Study sites were six large urban clinics in the United Kingdom, in London (n=4), Brighton (n=1) and Liverpool (n=1). Each site chose a community setting feasible for them, which included home visits (n=3), community-based patient support organisations (CBOs) (n=2), and a community clinic (n=1).Longitudinal semi-structured interviews were conducted with patient participants (n=14) at baseline (Aug-Nov '22), with CHCPs (n=11) at month 8 (June-Aug '23) and with both participant groups at study end (Sept-Nov '23) and analysed thematically.Interviews were conducted over the phone or using videoconferencing software, depending on participant choice. Each interview was approximately 60 minutes.Three patient interview participants were community participants – two received home visits, one attended a CBO (Table 1).Community HCP participants (i.e. those who facilitated appointments in community settings) included CBO staff members (n=2), clinical nurses (n=2), community nurses (n=4), doctors (n=1), and research nurses (n=2). The majority (n=8) were from London-based study sites. (Table 2)

Table 1. Demographics of patient participants (N=14)

	n (%)
Age (years)	
<50	7 (50)
50+	7 (50)
Gender	
Cisgender male	6 (43)
Cisgender female	8 (57)
Ethnicity	
Black, Black British, African or Caribbean	5 (36)
Asian or Asian British	3 (21)
White British or European	6 (43)
Chosen treatment setting (M6-M12)	
Clinic	11 (79)
Home visits	2 (14)
Community-based patient support organisation	1 (7)

Table 2. Characteristics of community healthcare practitioner participants (N=11)

	n (%)
City	
Brighton	1 (9)
Liverpool	2 (18)
London	8 (73)
Occupation	
CBO staff member	2 (18)
Clinical nurse	2 (18)
Community nurse	4 (36)
Doctor	1 (9)
Research nurse	2 (18)

Results



Importance of trusted relationships

Most participants had attended their clinic for many years and had high levels of trust in the clinical staff – they wanted to maintain their access to and relationship with staff with HIV-specialist knowledge. They were also concerned about continuity of care and receiving their injections from staff skilled in administering these.

“ I’m quite happy where I am – I’ve been going there for the last twenty years. I’m used to the people, so I don’t really want to try form another relationship with new people. – Abimbola, Black African woman, aged 55, clinic arm, M12 interview ”

“ Some patients have said that their GP nurses aren’t very good, or they’re not very skilled or used to giving injections or taking blood, so they’re not very comfortable in having to hand over their HIV care to their GP. – Research nurse, London, M12 interview ”



Enduring challenge of stigma

Stigma played a nuanced role in influencing patient preferences for treatment setting. Rather than ‘clinic versus community’, participants discussed treatment settings as ‘HIV-specific versus generic’. Participants considered there to be greater risk of inadvertent disclosure from being seen attending HIV-specific settings, and while generic community healthcare settings (e.g. pharmacies) reduced this risk, they offered less guarantees about attitudes towards HIV among staff and about confidentiality.

“ If you go off somewhere different, there’s always that feeling that not everybody, even healthcare professionals, is sympathetic to HIV. – Michael, White British man, aged 62, community arm (CBO), M12 interview ”

“ It’s also that stigmatised, like when you go to [the clinic], it’s especially for [HIV]. So people know or they might know and then you worry if anyone sees you going in there. – Jackie, White British woman, aged 37, community arm (home visits), M12 interview ”



Added value of care beyond the clinic

Among those opting for community, many described receiving injections at home as more convenient and discreet, while CBOs offered a more relaxed setting and the opportunity to connect to other people living with HIV. Participants with HIV sero-concordant partners were interested in shared home appointments.

“ It was good that they came to me rather than me having to go over to ((city))... it just felt a little bit easier without having to worry about parking and things like that and like getting over there. –Emily, White British woman, aged 37, community arm (home visits), M12 interview ”

“ One patient enjoys staying [after their appointment] at the [CBO] for lunch... Of course, it’s socialising, because they don’t just stay for lunch. – Research nurse, London, M8 interview ”



Logistical challenges

The views of CHCP participants on delivery in community settings were mixed with many highlighting logistical and capacity challenges. Home visits were only offered by sites with existing community nursing teams, and this was only feasible due to the small numbers of ILANA participants. Delivery in community organisations required clinical staff to be off-site, meaning reduced capacity in clinic during these times.

“ ILANA was such small numbers... and that’s fine but [the community nursing team] don’t want to take on new long-acting injectable patients for our service cos it’s so time-consuming for us. – Community nurse, Brighton, M12 interview ”

“ At the moment, [the injectable clinic is] only run on Wednesday afternoons and Thursday all day, with one person. So, there’s not much capacity to have someone [to go to] the community, then maybe another person go in [to the clinic]. – Research nurse, London, M12 interview ”

Conclusion	Acknowledgments
<ul style="list-style-type: none">Our findings illustrate that the dichotomy of ‘clinic versus community’ does not reflect the diversity in community settings and the varying barriers or facilitators they present.Service providers should carefully consider how a particular community setting may help to address challenges for patients and be aware that the offer of a single community setting may be insufficient to increase accessibility overall.Consideration also needs to be given to the implications of expanded service delivery in the community for staff capacity.	<p>With thanks to the ILANA study group (Haviland J, Lam Wong Y, Ring K, Apea V, Kasadha B, Clarke E, Byrne R, Fox J, Barber TJ, Clarke A, Ullah S, Halim N, Hand J), Gill-Hilton Smith, Jenny Scherzer, Amber Haley and Maggie Czarnogorski (all of ViiV Healthcare), the SHARE Collaborative Community Advisory Board, and the Trial Steering Committee’s external members for their contributions to the wider study. Thanks also to the ILANA study participants who graciously consented to contribute data to improve our understanding around implementation of this new treatment modality.</p>