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Preparing HIV services for long-acting injectable treatment and prevention in Uganda: a qualitative study of provider perspectives

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Research Article

Keywords: HIV, long-acting injectables, health services, organizational readiness, health workforce, financing, continuity of care, qualitative research, Uganda

Posted Date: October 29th, 2026

DOI: https://doi.org/10.21203/rs.3.rs-11331101/v1

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Additional Declarations: No competing interests reported.

Abstract

Background

Long-acting injectable HIV medicines depend on services able to administer doses and maintain continuing care. Positive provider attitudes suggest readiness only when the basis for their confidence is understood. We investigated how providers assessed readiness for long-acting injectable HIV treatment and prevention in Uganda.

Methods

A focused secondary qualitative analysis used available English-language provider interview files from a wider study associated with Mildmay Hospital and Kajjansi Health Centre IV. Framework analysis combined organizational domains with comparison of explanations, proposals and contradictory accounts. Interview summaries and case-by-domain matrices preserved the context of readiness judgments. Quotations were checked against source paragraphs. Interviewer prompts informed interpretation. The incomplete corpus precluded saturation claims and comparisons across facilities.

Results

Four themes explained readiness based on existing HIV services, redistribution of work through injectable delivery, continuing contact as a financed responsibility, and dependable supply. Providers relied on existing personnel, infrastructure and experience with HIV care. Optimism about simpler dispensing coexisted with expectations of additional technical work, larger patient volumes and staff fatigue. Proposed monitoring and outreach depended on financing, leaving uncertainty about responsibility for contact after dosing. Supply confidence rested on different assumptions about early shortage reporting, procurement funding and demand forecasting. Interviewer reassurance and hypothetical staffing arrangements formed part of several readiness exchanges. Providers suggested training, service integration and more accessible delivery, without describing implementation outcomes.

Conclusions

The interviews distinguish provider confidence in existing HIV services from preparation for the specific work of injectable delivery. Preparation requires assigned responsibilities for administration, appointments and adverse-event contact, financing for these tasks, and continuing supply. The findings capture provider expectations from an incomplete corpus rather than measured facility readiness.

Background

Long-acting injectable medicines for human immunodeficiency virus (HIV) offer alternatives to daily oral regimens, but every dose requires a service to administer it. The World Health Organization recommended injectable cabotegravir as an additional pre-exposure prophylaxis option in 2022 and lenacapavir as an additional prevention choice in 2025 [1, 2]. These recommendations cover specific medicines and indications. HIV treatment and prevention involve different eligibility criteria, monitoring and continuing care. Discussions of injectables need careful interpretation before informing a service plan.

Organizing injectable delivery involves more than administering medicine. Providers involved in trials of injectable antiretroviral therapy identified additional skilled personnel, appointment retention, workflow adaptation and storage as implementation concerns [3]. In Los Angeles County, stakeholders anticipating injectable HIV treatment described procurement, staffing, payment and organizational readiness alongside the expected reduction in daily treatment burden [4]. These accounts support examining positive attitudes toward a product separately from confidence in delivering it. Financing arrangements differ from Ugandan services, but the work of organizing repeated delivery remains relevant.

Ugandan research already documents both prospective and experienced use. Interviews with people with viraemia and health workers in south-central Uganda found enthusiasm alongside concerns about supply interruptions and monitoring [5]. At Fort Portal Regional Referral Hospital, people receiving injectable treatment and their providers described benefits, injection reactions, missed appointments and barriers to wider delivery [6]. The present study does not seek to establish the existence of these barriers again. It examines how providers explain readiness when confidence in established HIV services coexists with unresolved delivery requirements.

Experience with oral prevention and differentiated treatment provides context for these judgments. Training among health workers in Central Uganda improved preparedness to deliver oral prophylaxis, although knowledge gaps and concerns about staff capacity and infrastructure persisted [7]. Uganda's early adoption of differentiated HIV treatment drew on longstanding implementation experience, external support and adaptation of global guidance [8]. Established services bring resources to the introduction of new options while carrying existing constraints into a new delivery model. Readiness involves assessing which familiar systems will transfer and which tasks require different arrangements.

Organizational readiness theory separates commitment to introducing a change from confidence in the collective ability to implement it [9]. This distinction informed our interpretation without treating individual statements as validated organizational measures. A provider describing a hospital as ready might mean professional competence, available space, client demand or expected future support. Each reason points to different preparation needs. Confidence based on staff experience raises a different planning question from confidence in future donor support.

We asked how providers assessed readiness for long-acting injectable HIV services and which organizational tasks and resources shaped these assessments. The focus is on preparation for

administration, continuing contact and supply. Companion manuscripts from the parent study address formulation preferences and information needs. The parent preprint also reports implementation requirements [10]. This secondary analysis compares explanations and contradictions within provider interviews. Its contribution rests on this comparison rather than a different participant label or an additional list of barriers.

Methods

Study design and analytic orientation

We conducted a focused secondary qualitative analysis of the available provider interview texts. A framework approach supported comparisons within and across accounts addressing organizational service questions [11]. The orientation was contextual and interpretive. We treated readiness statements as accounts shaped by professional experience, the product under discussion and the interview exchange. They served as neither measurements of facility preparedness nor predictions of implementation success.

The broader parent report describes a qualitative study using client group discussions and provider interviews at Mildmay Hospital and Kajjansi Health Centre IV in Wakiso District [10]. Its reported sample comprised 46 participants across six client discussions and ten provider interviews.

Setting and source corpus

Mildmay is a specialized HIV referral and teaching service and Kajjansi is a public primary referral facility providing HIV care and prevention [10].

All the available interview files were included because they contained discussion of provider attitudes, service readiness or anticipated delivery requirements. We assigned analytic identifiers I1 to I5 and preserved source paragraph numbers. Two respondents identify themselves as medical officers. Another describes working as a doctor in inpatient and outpatient care. Table 1 presents the verified corpus characteristics without names.

Table 1
Characteristics established from the five available interview files.

Identifier	Role documented	Setting information
I1	Medical officer	Respondent identifies Mildmay; inpatient and outpatient work.
I2	Doctor	Respondent describes inpatient and outpatient work at Mildmay.
I3	Medical officer	Respondent identifies Mildmay.
I4	Nurse	Introduction names both parent-study facilities; respondent workplace not established.
I5	Nurse	Introduction refers to Mildmay; respondent cadre not established.

Interview material and data management

The texts contain semi-structured exchanges about anticipated benefits, facility readiness, clinic flow, training, staffing, supply, monitoring and integration into existing care. The parent report describes audio recording, transcription and translation where necessary [10]. The current analysis used the supplied English texts and did not independently inspect recordings, original-language material or translation records.

The supplied texts provided the basis for examining how questions and explanations entered the discussion. We reviewed the documents in full and preserved interviewer and respondent turns. The original codebook supported navigation and comparison without replacing transcript-level interpretation. We checked extracts against surrounding turns and retained contradictory statements. Personal names were omitted from quotations and public analytic summaries. Text searches and document-processing scripts supported passage retrieval, paragraph indexing and quotation checks. We calculated neither statistical tests nor thematic frequencies.

Framework analysis

Familiarization first examined each interview as a whole, noting the initial readiness judgment and the reasons supplied. Preliminary domains covered existing service capacity, administration work, staffing, occupational safety, training, continuing contact, financing, supply and proposed delivery arrangements. These domains reflected the research question and recurring interview topics. Inductive comparison then examined explanations not captured by a simple barrier label, including expectations of future support, different assumptions about workload and negotiation of readiness during probing.

We summarized each interview in a case-by-domain matrix. Summaries distinguished existing practices reported by respondents, expected problems, suggested responses and interviewer assertions. Each entry retained paragraph locators. Within-interview comparisons examined initial confidence alongside

specific tasks or constraints introduced during discussion. Across interviews, we compared conflicting explanations, including reduced pill dispensing versus increased injection work and early shortage reporting versus procurement dependence.

Theme development examined relationships between explanations. Discussion of similar service topics did not automatically indicate agreement. A statement about sufficient space differed from an expectation of future financial support, even when both supported an affirmative readiness judgment. We retained negative and qualified accounts alongside optimistic ones. Four themes concerned the basis of confidence, redistribution of work, financed continuing contact and dependable supply. Additional file 1 presents the analytic domains, interview summaries and selected source locators.

Reflexivity and trustworthiness

The interviews concern an innovation which providers and interviewers often discussed favourably. We examined whether questions assumed demand, reduced workload or funding availability. In I4, interviewer challenges explicitly disputed staffing and financing concerns. In I5, a hypothetical two-monthly schedule introduced a different workload scenario. These passages informed interpretation, rather than being removed from the evidence supporting readiness judgments.

The audit trail links quotations to source paragraphs and analytic summaries. The reporting review used the Consolidated Criteria for Reporting Qualitative Research (COREQ) as a guide to identify documented procedures and unresolved reporting items [12]. The checklist in Additional file 1 distinguishes information visible in the current files from procedures described only in the parent report.

Ethics and relationship to companion reports

The parent study received ethical approval from the Mildmay Uganda Research Ethics Committee (MUREC-2026-1828) and was conducted in accordance with the Declaration of Helsinki. All participants provided written informed consent, including permission to disseminate de-identified quotations. The present analysis used existing interview texts and involved no new recruitment or participant contact.

Results

Provider accounts and thematic structure

The five available interviews included both favourable views of injectable options and qualified accounts of delivery. Providers generally expected clients to gain relief from daily medication. Service judgments depended on the work providers considered and the support they expected. Table 2 summarizes the four themes. These describe meanings and contrasts within the available corpus without estimating how commonly providers hold each position.

Table 2
Themes and contrasts in provider accounts.

Theme	Central contrast	Supporting files
Established services as the basis of readiness	Confidence in familiar staff and infrastructure, qualified by training needs and expected future support.	I1, I2, I3, I5
Redistribution of work	Simpler dispensing versus technical administration, attendance volumes, staff fatigue and safety requirements.	I1, I2, I4, I5
Continuing contact as a financed responsibility	Proposed monitoring and outreach versus limited funds for contact between doses.	I1, I2, I3
Dependable supply as a condition	Early shortage reporting versus procurement funding, demand planning and proposed accessible delivery.	I1, I3, I4, I5

Readiness grounded in established HIV services

Providers based confidence on the staff, infrastructure and experience supporting oral HIV treatment and prevention. I1 described a facility experienced in managing large patient volumes and providing treatment despite queues. The ability to deliver existing services supported an affirmative readiness judgment:

"So, I think the facility generally is well prepared in managing." (I1)

I3 likewise linked readiness to professional experience, existing equipment and clients asking about injections. This account located the remaining requirement principally in product availability:

"Only we need the drug to be available at the hospital and we can be able to provide this drug to the patients." (I3)

These statements did not describe an assessment of a complete injectable service pathway. They drew on familiar strengths and anticipated transferring them to a new option. I2 regarded professional knowledge as largely sufficient, but acknowledged uncertainty about storage and welcomed further training. I5 referred to an existing framework for oral prevention and reported continuing medical education on updated guidance. These accounts combined confidence with particular areas still requiring preparation.

Readiness also depended on expected assistance. I3 anticipated funding and equipment support if the facility received authorization to provide injectables. Later in the same interview, the provider described dependence on external funds for procurement and outreach. Expected future support entered the readiness judgment alongside existing resources. Confidence based on future assistance leaves implementation dependent on decisions outside the immediate service team.

Provider observations of client interest helped build the case for introduction. Respondents recalled questions from clients about availability. These were reported encounters rather than systematic estimates of demand. Enthusiasm for an option did not establish how many clients would meet eligibility criteria, attend repeatedly or prefer it after receiving product-specific information.

Injection delivery as a redistribution of work

Providers differed on whether injectables would simplify service delivery or add work. I1 expected less effort in dispensing tablets and viewed administration as comparatively straightforward:

“it's easier for a nurse to just give an injectable than to count the pills the patient is taking.” (I1)

I2 expected fewer clinic contacts because of a long interval between doses. I5 initially expected little disruption because injectable prevention would fit existing testing and counselling routines. When the interviewer introduced two-monthly injections and larger numbers returning, I5 described technical demands, slower turnaround and staff fatigue:

“That means there will be a bit of physical drain on the available medical staff.” (I5)

The same respondent therefore supplied different expectations under different scheduling assumptions. Reduced visit frequency for a client did not necessarily mean less staff work at an injection encounter. The interviews considered pill counting, technical administration, patient volumes and return intervals unevenly. Their differing expectations reveal the need to specify the tasks and product schedule behind a workload judgment.

I4 questioned an interviewer scenario in which five staff would share injections among 50 clients. The respondent disputed whether those staff were available:

“There's no five staff to be injecting people in the current situation. You only have probably one person available who will get tired at the end of the day.” (I4)

The concern extended beyond the time needed to give an injection. It involved procurement, education, client prioritization and administration. After further questioning, I4 supported implementation while retaining challenges. This qualified endorsement preserved concern about the staff needed to perform the work.

Occupational safety was another aspect of preparation. I1 raised concerns about needle exposure and reluctance among some staff to administer injections, proposing further safety education:

“Safety measures have to be increased in that some health workers may recklessly or without knowing be exposed to those needles.” (I1)

This was an anticipated concern and a reported view of staff attitudes. The corpus contains no measured occupational exposure associated with long-acting HIV medicines. The account nevertheless

broadens readiness beyond the number of available personnel to include their willingness and confidence to perform administration tasks.

Continuing contact as a financed responsibility

Providers proposed monitoring and appointment support after initiation, but described different assumptions about the resources supporting these tasks. I3 proposed contact during early use, recording reactions and arranging review. The same interview described reminders as an extension of existing oral-treatment practice. Continuity relied on an organization able to maintain contact, rather than on an injection removing the need for adherence support.

I2 described monitoring options when outreach resources were limited. The interviewer first raised the loss of community screening activities. The respondent then described reliance on telephone calls or clients returning after a reaction. Telephone contact itself carried a cost:

“you are only left with relying either on just make a phone call to a patient, but also that comes with the cost anyway.” (I2)

The issue concerned who would maintain contact, how the work would be financed and what would happen when outreach was unavailable. Clinical knowledge alone did not resolve these responsibilities. Asking clients to return after a problem shifted part of the monitoring work to them, including arranging travel and recognizing when to seek care.

I3 described community tracking as feasible under a funded plan and difficult without external resources:

“Now the challenge might be the funds are not availed since it all depends on funds from outside.” (I3)

This account connected an existing model of outreach with an anticipated monitoring arrangement. It did not establish a funded injectable follow-up programme. I1 also worried about reduced opportunities to monitor when visits became less frequent. Across the interviews, longer intervals offered relief from repeated medication tasks while raising questions about contact between doses.

The distinction between appointment reminders and adverse-event response remained important. A reminder prompts the next planned visit. Contact after an unexpected reaction requires a route for reporting, someone able to assess the concern and a response arrangement. Providers sometimes discussed these together, but their accounts identify different responsibilities. The corpus establishes proposed approaches and resource concerns, rather than their effectiveness in retaining clients or managing reactions.

Dependable supply as a condition of implementation

Providers supported introduction while expecting different levels of supply reliability. I1 described early reporting of shortages as a way to prevent interruption:

“So I don't think we'll have any problem with stock-out.” (I1)

I3 described dependence on procurement funding and expected interruptions if funds were delayed:

“Some facilities may run short of the drugs because of that and they may have to wait until the funds are availed so that they can get the drugs.” (I3)

The contrast reflects different assumptions about the reach of facility action. Early reporting addresses recognition and communication of a shortage. A delayed source of purchasing funds requires a response beyond the individual prescriber. Neither account establishes actual injectable stock-outs, but each identifies the basis of a service expectation.

I4 anticipated high demand and proposed using initial attendance to inform later planning. The interviewer challenged a proposed pilot on fairness grounds. The respondent clarified the intention as learning from the first month rather than restricting access to a small group:

“So that whole month, you try to see how many people are actually coming for the drug. And then the next month, you'll be able to plan ahead of time.” (I4)

This exchange shows how a planning proposal changed in its explanation under probing. It should not be reported as evidence of an approved pilot or implemented forecasting system. I3 likewise discussed prioritizing clients if doses were insufficient. Those suggestions concerned perceived need and distance from the facility. We treated them as allocation reasoning, rather than endorsed clinical eligibility criteria.

I5 raised availability at lower-level facilities and proposed community or pharmacy delivery for prevention. The suggestion linked accessibility with training and equipment needs:

“if we can further integrate it into community referral models, pharmacy and train people at the existing community pharmacy levels and there's the equipment how to maybe administer the drug” (I5)

Decentralization was therefore a proposed way to extend access, with responsibilities transferred to additional service points. It did not establish a functioning delivery network or authorization for the proposed model. I1 instead proposed integrating injections into an existing consultation room to protect privacy. I2 described daily access to existing services as helpful for attendance. These accounts proposed building on familiar arrangements while adapting where and when clients received care.

Readiness judgments within the interview exchange

The interviews did not provide a single stable judgment of readiness. I4 initially described difficulties with implementation in the context of funding and service changes. The interviewer offered reassurance and challenged the staffing concern. The respondent rejected the suggestion of a brief transition:

“No, man. It's more than a transition. Yeah, to me, it's more than a transition. There's a lot that has to be adopted.” (I4)

Later, I4 affirmed readiness while retaining challenges. The exchange included both caution and endorsement, without demonstrating persuasion or an individual attitude change caused by the interview. I5's workload account also followed the introduction of a particular dosing scenario. These examples help explain why a final affirmative answer needs interpretation alongside the practical assumptions discussed earlier.

Discussion

What providers meant by readiness

Providers considered services ready for different reasons. Familiarity with HIV care, existing staff and perceived client interest supported confidence. Discussion of delivery tasks raised uncertainty about personnel, financing for contact and dependable supply. Readiness therefore referred to several judgments within the interviews. Some concerned confidence in professional competence, while others assumed support still to arrive.

Weiner's distinction between commitment and collective capability helps interpret this pattern [9]. The respondents expressed support for introduction, but the interviews supplied incomplete evidence of shared capacity across a service team. We therefore interpret the findings as individual accounts of perceived readiness. We do not infer organizational consensus or classify a facility as ready or unready. The useful planning question is which responsibilities and resources substantiate a provider's confidence.

This interpretation extends earlier Ugandan findings while preserving overlap. Kennedy and colleagues described interest and perceived feasibility alongside stock and monitoring concerns [5]. Zakumumpa and colleagues examined actual injectable treatment and identified workforce, space and appointment challenges [6]. Our available interviews examine how optimism persists alongside anticipated constraints and how particular assumptions support it. The contribution is an explanation of readiness judgments, rather than evidence of a new national pattern.

Preparing the workforce around a specified delivery pathway

The workload findings support examining the entire service encounter. One account emphasized fewer pill-dispensing tasks. Others emphasized technical administration, education, prioritization and staff fatigue. These are different units of work. Assessing capacity through injection time alone would overlook tasks respondents associated with offering the service.

Mantsios and colleagues likewise identified staff, workflow and appointment retention as linked requirements [3]. Cocohoba and colleagues found favourable attitudes toward pharmacy administration alongside concerns about staff, training, space and reimbursement [13]. Their models differ from the setting of our interviews, but both studies support specifying responsibilities rather than assuming

positive attitudes establish operational capacity. Training adds skills, while staffing and work allocation determine whether someone is available to apply them.

Ugandan evidence on oral prophylaxis also shows why continuing education deserves attention. Muwonge and colleagues found gains after training together with remaining knowledge gaps and uneven preparedness [7]. Our corpus includes reported education and requests for further training, without independent verification of competence. Product-specific preparation should address administration and the service processes surrounding it. A short practical assessment of the complete pathway would clarify whether staff knowledge, time, equipment and supervision align.

Needle exposure deserves inclusion in workforce preparation without being presented as a widespread finding. I1's concern connects safety procedures with willingness to administer injections. The corpus does not establish the frequency of exposure or staff refusal. Services should nevertheless incorporate sharps handling and occupational incident response within ordinary administration preparation, alongside product-specific instruction. This is a proposed service implication, rather than an intervention evaluated here.

Funding the work between injections

The continuing-contact theme identifies organizational work behind expectations of monitoring. One account proposed routine contact and documentation of reactions. Another described a limited response when outreach lacked funds. The difference concerned responsibility and resources as well as clinical intent. A service offering fewer medication encounters still needs arrangements for questions, missed visits and unexpected reactions.

Doherty and colleagues' analysis of Uganda's Option B+ programme connected external support with both resource strengthening and uncertainty about sustainability [14]. Mukose and colleagues described training, supervision, supplies, follow-up and patient support as interdependent aspects of preparedness in Central Uganda [15]. These studies concern different HIV interventions. Their relevance lies in the organizational relationship between a delivery model and the resources supporting continuing care. Our interviews identify telephone and outreach costs as specific examples of this relationship.

Budgeting should include the work between doses. Programmes need to assign responsibility for checking appointments, making agreed contact, documenting concerns and arranging review. Clients need a stated contact route and clear response expectations. Follow-up promises become difficult to sustain when staff personally absorb costs or rely on outreach resources assumed to exist. The interviews identify this planning issue without quantifying costs or comparing follow-up models.

Appointment support also needs to fit clients' circumstances. Qualitative SEARCH research among people receiving injectable cabotegravir in Uganda and Kenya described reminders as helpful, with work and travel still affecting appointments [16]. These accounts come from experienced users, unlike our mainly anticipatory provider discussions. Together they support considering how staff contact and client

availability interact, while leaving comparative effectiveness and programme costs for prospective evaluation.

Supply continuity and accessible delivery

Providers differed on whether early shortage reporting would be sufficient or procurement depended on external funds. The accounts identify useful tasks at different levels of authority. Facility staff recognize and communicate demand. Procurement and financing arrangements determine whether products reach the service. Implementation plans should connect these responsibilities and specify escalation procedures when supply threatens continuing care.

Uganda's differentiated treatment experience shows how longstanding HIV implementation capacity and external assistance have supported policy uptake [8]. Our interviews suggest both confidence in this history and concern about reliance on future resources. The findings do not establish national funding changes or diversion of procurement funds. Such assertions remain respondents' accounts. The service implication is to verify the funding and supply commitments on which local readiness judgments depend.

Decentralized delivery offers another organizational question. Henderson and colleagues' global consultation found provider support for differentiated prevention alongside concerns about testing, costs and staff able to administer injections [17]. Formative research in Kenyan pharmacies identified accessibility advantages alongside policy, information-system, staffing and compensation barriers [18]. These findings support examining proposed community and pharmacy models as service arrangements requiring explicit support. They do not establish their appropriateness or authorization for every product or Ugandan setting.

The World Health Organization's provider module addresses oral and long-acting prevention within specified service requirements [19]. Current lenacapavir guidance also emphasizes flexible testing approaches and identifies unresolved implementation questions [2]. Plans derived from our interviews should therefore begin with a named medicine and indication. Statements about twice-yearly attendance, storage or self-testing should not be generalized across injectable treatment and prevention. The respondents discussed different schedules and products, sometimes within the same interview.

Implications for assessing readiness

The findings suggest assessing readiness around the client pathway. Before initiation, the service needs an assigned person for eligibility assessment, product-specific explanation and administration. Continuing care requires a documented appointment process, contact arrangements and a response to concerns. For each task, planners should establish who performs it, which resources support it and who responds if the arrangement fails. A willingness question alone leaves these arrangements unspecified.

Research on implemented services gives practical examples. Agovi and colleagues described staff training, pharmacist involvement and flexible appointments in a safety-net injectable treatment

programme, alongside understaffing and medication-access barriers [20]. Our corpus provides an earlier-stage view of expectations. It identifies questions to test during preparation, rather than evidence of achieved readiness. Observation of clinic processes, stock records, staffing schedules and follow-up logs would assess whether the expected arrangements operate in practice.

Interview design also affects the evidence used for planning. Hypothetical staffing scenarios and reassurance about funding entered our interviews. These exchanges helped expose assumptions, but their final affirmative responses should not be treated as independent evidence of preparedness. Future assessments should first elicit providers' own account, then use consistent product descriptions and clearly labelled scenarios. Recording disagreement preserves information about constraints which a final yes-or-no readiness answer obscures.

Strengths and limitations

The focused provider corpus supported comparison of statements within complete interview exchanges. We preserved qualified positions, separated proposed arrangements from reported practice and checked quotations against source paragraphs. The matrix links central interpretations to accounts across interviews, providing traceability beyond thematic labels in the original codebook.

Accounts chiefly concern anticipated introduction. They do not establish injection-related workload, programme costs, actual supply interruption, monitoring effectiveness or patient outcomes. Variations in product terminology and schedules also complicate comparison. Interviewer explanations formed part of the context and limit interpretation of final readiness statements as unprompted views.

Conclusions

Provider confidence in established HIV services coexisted with unresolved questions about the work and resources required for injectable delivery. The available interviews distinguish simpler pill dispensing from increased administration work, proposed monitoring from funded contact, and early shortage reporting from dependable procurement. Preparation requires a specified product, assigned responsibilities across the full care pathway and confirmed resources for continuing delivery. These findings describe situated expectations from five available interview files rather than measured facility or national readiness.

Abbreviations

ART: antiretroviral therapy. COREQ: Consolidated Criteria for Reporting Qualitative Research. HIV: human immunodeficiency virus. KII: key informant interview. MUREC: Mildmay Uganda Research Ethics Committee. NIHR: National Institute for Health and Care Research. PrEP: pre-exposure prophylaxis. WHO: World Health Organization.

Declarations

Ethics approval and consent to participate

The parent study received ethical approval from the Mildmay Uganda Research Ethics Committee (MUREC-2026-1828). The parent study report documents written informed consent and conduct in accordance with the Declaration of Helsinki [10]. This secondary analysis used existing provider interview texts and involved no new recruitment or participant contact.

Consent for publication

The parent study report states participants consented to publication of de-identified quotations [10]. This manuscript omits personal names from quotations and uses coded provider identifiers. Individual consent records were unavailable for independent verification.

Competing interests

The authors declare no competing interests.

Funding

The parent study was funded by a Royal Society of Tropical Medicine and Hygiene Early Career Research Grant in partnership with the UK National Institute for Health and Care Research (grant NIHR25125). The funder had no role in study design, data collection, analysis, interpretation or the decision to publish [10]. No separate funding was reported for this secondary analysis.

Author Contribution

SCO conceptualized the secondary analysis, developed the analytic approach and drafted the manuscript. WUM and DMU led the parent study, secured funding and contributed to the secondary analysis methodology, interpretation of findings and critical manuscript revision. AIS, SO, MH, NIS and AMJ contributed to interpretation and critically revised the manuscript. CDS provided methodological guidance and critically revised the manuscript. All authors reviewed and approved the final manuscript and agreed to accountability for the work.SCO: Stephen Charles Olet.WUM: Wandera Uthmaan Muluga.DMU: Drake Musoki.AIS: Abdirahman Ibrahim Said.SO: Sam Ongom.MH: Mustafe Hussein.NIS: Nasra Ibrahim Said.AMJ: Abdirahman Mohamed Jama.CDS: Chad D. Stecher.

Acknowledgement

We thank the providers who shared their perspectives and the parent-study investigators who made the interview texts and supporting documents available for this secondary analysis.

Data Availability

The manuscript and Additional file 1 contain the quotations, analytic summaries and source paragraph locators supporting the reported interpretation. Full transcripts contain potentially identifying contextual information and are not publicly available. Requests for access to the underlying data should be directed to the corresponding author, Dr Stephen Charles Olet, at solet@musph.ac.ug. Access is subject to applicable ethical approvals, institutional requirements and participant confidentiality protections.

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