Research Square

Preprints are preliminary reports that have not undergone peer review.
They should not be considered conclusive, used to inform clinical practice,
or referenced by the media as validated information.

The contingency of PrEP engagement: perspectives of underserved populations in the United Kingdom in the PrEP-Position mixed-methods study

Sara Paparini
SHARE Collaborative, Queen Mary University of London
Vian Rajabzadeh
v.rajabzadeh@qmul.ac.uk

SHARE Collaborative, Queen Mary University of London
Sophie Strachan
Wolfson Institute of Population Health, Queen Mary University of London
Carolina C. Camargo
Wolfson Institute of Population Health, Queen Mary University of London
Melanie Smuk
SHARE Collaborative, Queen Mary University of London
Nishat Halim
SHARE Collaborative, Queen Mary University of London
Chloé Pasin
SHARE Collaborative, Queen Mary University of London
Megan Devonald
SHARE Collaborative, Queen Mary University of London
Anqa Awan
Sophia Forum
Taranjit Chana
The PrEP-Position Steering Group
Kelsea Delatango
Bare Radicals
Vimbai Mandaza
Wolfson Institute of Population Health, Queen Mary University of London
Pamela Menzies-Banton
The PrEP-Position Steering Group
Uzochi Nwaosu
The PrEP-Position Steering Group
Juddy Otti

Sophia Forum

Kyle Ring

SHARE Collaborative, Queen Mary University of London

Taro Asimi

The PrEP-Position Steering Group

Vanessa Apea

SHARE Collaborative, Queen Mary University of London

Chloe Orkin

SHARE Collaborative, Queen Mary University of London

Research Article

Keywords: Pre-exposure prophylaxis, HIV prevention. Healthcare disparities, Intersectionality, Long-acting injectable PrEP, Candidacy, Sexual health services

Posted Date: August 20th, 2026

DOI: https://doi.org/10.21203/rs.3.rs-10498606/v1

License: This work is licensed under a Creative Commons Attribution 4.0 International License. Read Full License

Additional Declarations: Competing interest reported. SP has received research grants from Gilead Sciences and ViiV Healthcare. SS has received honoraria for advisory boards, consultancy and travel sponsorship from ViiV Healthcare and Gilead Sciences, and community grants from Gilead Sciences, ViiV Healthcare and MSD; she has been unremunerated Vice Chair of the BHIVA Women's Special Interest Group since late 2025. AA has received honoraria for community engagement from Gilead Sciences. JO sits on ViiV Healthcare and Gilead Sciences advisory boards for PrEP programmes. KR is a sub-investigator on the Gilead Sciences-sponsored PURPOSE-5 injectable PrEP trial, has received honoraria from ViiV Healthcare, and is Secretary of the BASHH Gender and Sexual Minorities Special Interest Group. CO has received honoraria for advisory boards, lectureships and travel sponsorship from Janssen, Gilead Sciences, ViiV Healthcare, MSD and AstraZeneca. VR's post is funded in part by the Gilead Sciences award that sponsored this study. All other authors declare that they have no competing interests.

Abstract

Background

PrEP remains poorly accessed by many of the UK populations who could most benefit from it. Access has been largely restricted to specialist sexual health services, with eligibility criteria derived from clinical trials conducted predominantly among gay and bisexual men who have sex with men (GBMSM). Little is known about how preferences vary across underserved groups, or about the processes shaping engagement.

Methods

We conducted a community co-produced, convergent parallel mixed-methods study, guided by the intersectionality-informed Contingency Framework, to describe PrEP awareness, use, and modality and delivery-setting preferences among underserved populations, and understand how identity, circumstances and practices shape engagement. Between August 2025 and February 2026 we recruited 264 survey respondents and 38 interview participants across the UK from underserved groups, collapsed into six overlapping subgroups for analysis. Current active PrEP users were excluded from interviews. Survey data were analysed descriptively; interview data were analysed thematically.

Results

Overall, 38.3% (n = 101) had never heard of PrEP before the study. Non-awareness was most frequent among racially minoritised cisgender women and heterosexual men, while all racially minoritised GBMSM had prior awareness. Among the 163 aware respondents, current use ranged from 22.9% (n = 8) among non-binary and transgender people to 64.1% (n = 25) among sex workers. Low preference for daily oral PrEP was reported by 47.0% (n = 63), while strong preference for injectable PrEP was reported by 87.3% (n = 138), rising to 97.3% (n = 36) among racially minoritised heterosexual men and 97.4% (n = 38) among sex workers. Over 70% of racially minoritised women and of sex workers preferred delivery through general practice, compared with 35.3% of racially minoritised GBMSM. Interviews showed that engagement depended on whether PrEP was recognised, reachable and usable, mediated by identity, circumstances and practices including religion, relationship power and the burden of daily dosing.

Conclusions

Underserved groups are broadly ready to use PrEP but are poorly served by existing provision. Equitable implementation will require long-acting options alongside delivery beyond specialist services, particularly through general practice and community settings, and promotion that makes PrEP recognisable to those currently outside its cultural framing.

Introduction

Oral pre-exposure prophylaxis (PrEP) for HIV prevention has been available through National Health Service (NHS) sexual health services in Scotland and Wales since July 2017 as part of the IMPACT trial (1). In England, PrEP has been commissioned since 2020 via specialist sexual health clinics (2).

When taken as directed, daily oral PrEP with tenofovir disoproxil fumarate and emtricitabine (TDF/FTC) reduces the likelihood of HIV acquisition by up to 99% (3, 4). However, in clinical practice efficacy is much lower due to non-adherence (5). Long-acting injectable PrEP with 2-monthly cabotegravir (CAB-LA), has demonstrated superiority to daily oral PrEP TDF/FTC in two phase III trial HPTN 083 and 084 (6, 7). CAB-LA was approved in the UK in 2024 and is now recommended in England and Wales for people unable to use oral PrEP; Scotland approved it earlier in 2025 (8, 9). Lenacapavir (LEN), a twice-yearly PrEP injection, has demonstrated superiority to oral PrEP in phase III trials but it is not yet approved for UK NHS use (10–13).

As of 2024, just over 111,000 people have received PrEP on the NHS in England (14). Around 70–75% of gay and bisexual men who have sex with men (GBMSM) with a PrEP need initiate PrEP compared with approximately 35–40% among heterosexual men and women. (15). This matches PrEP-to-need ratios (a measure of PrEP use relative to local HIV incidence) which are highest among White men and lowest among women of Black African heritage (16).

In 2022, the National AIDS Trust's 'Not PrEPared' report found that only 35% of people seeking PrEP were able to obtain it and no local authority in England reported more than five women using PrEP services (17). Recent modelling suggests that a substantial proportion of people in England who could benefit from PrEP are not receiving it (18). Furthermore, most individuals with unmet PrEP need did not attend sexual health service in the previous year, indicating that PrEP access must be extended beyond specialist settings (18).

Populations underserved by PrEP are neither small nor homogenous. Research suggests that non-binary and gender-diverse individuals, recent migrants (those residing in the UK for fewer than five years), sex workers, and people experiencing multiple intersecting disadvantages are amongst those systematically underserved by existing PrEP pathways (19), with the absence of reliable routinely collected PrEP surveillance data on these groups likely contributing to their marginalisation (19, 20).

Many individuals occupy multiple, intersectional social locations that are shaped by interlocking systems of marginalisation (21) impacting whether PrEP becomes visible, thinkable, and actionable in their lives at different timepoints (22, 23). Structural barriers to PrEP access include HIV-related and sexual stigma, institutional racism, homophobia, biphobia and transphobia, difficulties navigating clinical services and eligibility criteria historically derived largely from GBMSM trial populations. These barriers simultaneously contribute to persistent assumptions about who PrEP is form at three levels: at the system level, through guidelines and eligibility criteria; among clinicians, who may not identify suitable PrEP candidates beyond the established groups; among individuals, who may not perceive PrEP as relevant to them (19, 20, 24).

So far, PrEP access in the UK has been largely restricted to specialist sexual health services (SHS), with eligibility criteria derived from clinical trials conducted predominantly among GBMSM and supported by cost-effectiveness models targeting populations with the highest diagnosed HIV incidence (19, 25). Recent policy and service developments (such as digital PrEP access) signal a shift towards more equitable provision (25). The 2025 British Association for Sexual Health and HIV/ British HIV Association (BASHH/BHIVA) guidelines included a dedicated equity chapter which broadens suitability criteria and recommends delivery through community pharmacies, primary care, and other community settings (25, 26). Similarly, the England HIV Action Plan 2025–2030 identifies improving PrEP access for heterosexual people, people of Black African heritage, and other underserved communities as a key priority (27). These changes will take time (19, 20). Meanwhile, long-acting injectable PrEP options can help mitigate challenges such the demands of daily pill-taking, concerns about privacy at home and difficulties with on-demand PrEP dosing (28, 29). For new modalities to transform equity outcomes, however, PrEP provision must be intentionally re-oriented towards those who are underserved by PrEP.

There is therefore an urgent need for community-grounded data on PrEP awareness, engagement, modality preferences and preferred delivery settings among underserved groups. The PrEP-Position study was designed to address this: in this article, we present our findings on PrEP awareness, use, modality and delivery priorities among key underserved UK populations as understood in relation to their identities, practices, and circumstances.

Methods

Study design and theoretical approach

PrEP-Position is a community co-produced study employing a convergent parallel mixed-methods design (30), conducted in partnership with the community organisation the Sophia Forum. Data collection took place between August 2025 and February 2026. A nine-person steering group with lived and professional experience relevant to the populations of interest was embedded across all stages of the research process (31). Involvement is reported using the GRIPP2 short-form checklist [see Additional file 1] (32). Co-production was operationalised as full partnership rather than consultation (31), through a tripartite model comprising academic researchers (QMUL), community lead (Sophia Forum), and independent external community research evaluator.

The study was guided by the specifically developed *Contingency Framework* (Fig. 1), an intersectionality-informed analytical framework. Intersectionality theory offers a way to shift our understanding of PrEP engagement from individual characteristics to a focus on how power relations shape differential access and engagement across changing social locations (26, 27). The Framework was further informed by the team's prior work on equitable responses to infectious disease (33) and advocacy principles that reframe HIV vulnerability away from stigmatising risk categories towards the lived reasons and structural circumstances shaping prevention choices (34).

The Contingency framework - tested and grounded in this study - proposes that identities, circumstances, and practices combine *contingently* rather than additively, such that their configuration at any given (time and place-specific) social location produces outcomes that cannot be explained by any single dimension alone. The framework sees each dimension itself as plural, fluid and situated, rather than fixed or inherent, and is aimed at understanding the salience of different intersectional configurations relevant to PrEP engagement, rather than the result of reified, static individual or group characteristics. Further, the framework is bidirectional: individuals perceive themselves, their circumstances and practices in relation to their experience and understanding of PrEP, including its modality and delivery.

Study population and eligibility

The study engaged adults (18+), based in the UK, who self-identified as belonging to at least one of the following national priority underserved groups: cisgender women from racially minoritised backgrounds; transgender women; non-binary individuals; transgender men; racially minoritised heterosexual men; racially minoritised GBMSM; sex workers; recent migrants; people who inject drugs; individuals living with chronic or mental health conditions; and neurodivergent individuals. For the survey, current, former, and never PrEP users were eligible. For qualitative interviews, current active PrEP users were excluded given our focus on barriers to PrEP access and persistence. Individuals living with HIV and those unable or unwilling to provide informed consent were not eligible.

Data collection procedures

Quantitative, online surveys

An anonymous cross-sectional online survey was administered via Qualtrics (35). Questions were branched according to prior PrEP awareness, with tailored question sets for those who had and had not heard of PrEP. The survey instrument [see Additional file 2] was structured around the Contingency framework to broadly capture factors influencing PrEP suitability. Items were informed by the 2025 BASHH/BHIVA suitability indicators, but not designed to replicate formal clinical assessment (25). Materials were reviewed for appropriateness by the study steering group and the SHARE Collaborative permanent Community Advisory Board (CAB) prior to launch. Electronic informed consent was obtained at the point of survey access. Participants received a £15 voucher on completion.

Qualitative interviews

Semi-structured, individual in-depth interviews were conducted with former and never users of PrEP users [see Additional file 3]. The topic guide explored PrEP awareness and knowledge, experiences of or barriers to access, discontinued use, HIV prevention context, and preferences for alternative modalities and delivery settings. Purposive sampling was guided by the study's research questions and an equity lens to ensure maximum variation in demographics and PrEP use history. Interviews were conducted by the lead

researcher. Online, in-person and interpreter options were offered. Written informed consent was obtained prior to each interview. All interviews were audio-recorded and transcribed verbatim; data were de-identified prior to analysis. Participants received a £40 voucher plus travel reimbursement where applicable.

Recruitment

Recruitment, for both the survey and the interviews, proceeded in three staged phases: direct community engagement through partnerships with community organisations and grassroots networks with distribution of materials via flyers, QR codes, and community event outreach; targeted social media outreach through partner organisations' platforms; advertisement through NHS sexual health clinics (activated following mid-point review with the steering group). Interview participants were recruited via the survey if they agreed to be contacted, and directly via community organisations.

Data Analysis and theory development

Participants self-identified against the eligibility categories listed above. For survey analysis, these were collapsed into six population subgroups, selected to reflect national PrEP priority populations and the sample sizes achieved: cisgender and transgender women from racially minoritised backgrounds; cisgender women from racially minoritised backgrounds; non-binary and transgender people; racially minoritised heterosexual men; sex workers; and racially minoritised GBMSM. Eligibility categories with too few participants to support subgroup reporting (recent migrants, people who inject drugs, people living with chronic or mental health conditions, and neurodivergent participants) were retained in the overall sample and qualitative analysis but not reported separately. Participants could belong to more than one subgroup, and totals therefore exceed the overall sample size.

Quantitative survey data were analysed descriptively in Stata v17 (39), with all variables presented as counts and percentages stratified by subgroup. Given the sample size and subgroup heterogeneity, inferential analyses were neither planned nor conducted, and subgroup differences are presented as exploratory.

Qualitative data were analysed thematically using a combined inductive–deductive approach (36), using the *Contingency Framework*, as a deductive organising structure while remaining open to inductively generated themes beyond it. Emerging concepts were tested and refined through iterative team and steering group discussions. Data were managed using Microsoft Excel with a structured coding spreadsheet.

Quantitative and qualitative data were integrated at the interpretive stage using a convergent approach (30), to produce a more comprehensive account than either strand alone could yield. We present both datasets in an integrated narrative throughout the article.

Results

Survey Sample Characteristics

A total of 264 participants completed the survey. Full sociodemographic characteristics stratified by the six population subgroups are presented in an additional table [see Additional file 4]. The sample was predominantly aged 25 to 44 (67.0%) and included cisgender and transgender women from racially minoritised backgrounds (n = 83), cisgender women from racially minoritised backgrounds (n = 78), racially minoritised heterosexual men (n = 56), sex workers (n = 53), non-binary and transgender individuals (n = 47), and racially minoritised GBMSM (n = 17). Notably, intimate partner violence in the preceding 12 months was reported by 34.5% of respondents overall, rising to 60.4% among sex workers (n = 32). Almost half of non-binary and transgender individuals were on gender-affirming hormone therapy (n = 20, 48.8%) (relevance of this is explored in the qualitative findings).

Interview sample characteristics

A total of 38 participants took part in qualitative interviews [see Additional file 5]. The sample was predominantly aged 25 to 44 (n = 27) (oldest 56, youngest 23). Gender identity included cisgender men (n = 14), cisgender women (n = 13), transgender men (n = 6), transgender women (n = 3), and non-binary or genderfluid individuals (n = 3). Ethnic groups included British Pakistani and Pakistani (n = 6), Latinx (n = 6), Black British, Black African, and Black Caribbean (n = 7), Arab (n = 3), White British and White other (n = 8), and mixed or other heritage (n = 8). Participants were recruited across England, Scotland, and Northern Ireland, with 14 based outside London. Religious identity included Muslim (n = 8), Christian (n = 10), atheist or no religion (n = 10), and agnostic or spiritual (n = 6). Educational attainment was high: 32 of the 38 participants held a degree-level qualification or above, of whom at least 16 held a postgraduate qualification. PrEP use history comprised never users (n = 20) former users (n = 16), and current ad hoc (rarely) or about-to-initiate users (n = 2).

PrEP Awareness and Use Patterns in the survey

Table 1 presents PrEP awareness and use, establishing who in the sample had been reached by existing PrEP promotion. Overall, 38.3% (n = 101) of participants had never heard of PrEP before taking part in the study. Non-awareness was most frequent among cisgender women from racially minoritised backgrounds (n = 26) and racially minoritised heterosexual men (n = 19), while all racially minoritised MSM had prior awareness (n = 17). Among the 163 participants with prior awareness (61.7%), current PrEP use ranged from 22.9% among non-binary and transgender individuals (n = 8) to 64.1% among sex workers (n = 25). Former PrEP use was most prevalent among racially minoritised heterosexual men (n = 18, 48.6%) and non-binary and transgender individuals (n = 14, 40.0%). Never having used PrEP whilst having prior awareness was reported by 39.3% (n = 64) of aware participants and was lowest among sex workers (n = 6, 15.4%) and highest in racially minoritised cisgender women (n = 24 = 1, 40.4%).

Table 1 presents PrEP awareness and use patterns among our population subgroups

Table 1: **PrEP Awareness and Use Patterns of Population Subgroups[1]**

Characteristic	Total n(%)	Cis/Trans Women (Racially Min.) n(%)	Cis-Women (Racially Min.) n(%)	Non-Binary/ Trans People n(%)	Racially Min. Het. Men n(%)	Sex Workers n(%)	Racially Min. MSM n(%)
PrEP awareness	**264 (100.0%)**	**83 (100.0%)**	**78 (100.0%)**	**47 (100.0%)**	**56 (100.0%)**	**53 (100.0%)**	**17 (100.0%)**
Heard of PrEP	163 (61.7%)	57 (68.7%)	52 (66.7%)	35 (74.5%)	37 (66.1%)	39 (73.6%)	17 (100.0%)
Never heard of PrEP	101 (38.3%)	26 (31.3%)	26 (33.3%)	12 (25.5%)	19 (33.9%)	14 (26.4%)	0 (0.0%)
PrEP Usage (among aware)[2]	**163 (61.7%)**	**57 (68.7%)**	**52 (66.7%)**	**35 (74.5%)**	**37 (66.1%)**	**39 (73.6%)**	**17 (100.0%)**
Currently using	53 (32.5%)	26 (45.6%)	25 (48.1%)	8 (22.9%)	9 (24.3%)	25 (64.1%)	8 (47.1%)
Never used	64 (39.3%)	21 (36.8%)	21 (40.4%)	13 (37.1%)	10 (27.0%)	6 (15.4%)	4 (23.5%)
Used previously	46 (28.2%)	10 (17.5%)	6 (11.5%)	14 (40.0%)	18 (48.6%)	8 (20.5%)	5 (29.4%)

[1]Participants could belong to more than one; subgroup percentages are calculated within each subgroup and do not sum to the column total.

[2] PrEP usage data are reported only among participants who indicated prior awareness of PrEP (n = 163, 61.7%).

PrEP Sexual health practices and indicators in the survey

Sexual health practices and indicators data stratified by subgroup are presented in an additional table [see Additional file 6]. Most participants reported two or more sexual partners in the past year (n = 132, 58.9%), inconsistent condom use (n = 126, 55.8%), and uncertainty regarding their most recent partner's HIV status (n = 73, 32.4%). Recreational drug use was reported by approximately one-quarter of participants (n = 57, 25.6%). In addition, one-quarter reported testing for STIs rarely or never (n = 59, 25.9%).

Qualitative findings based on the Contingency Framework

a) Identity and PrEP engagement

The gendered cultural coding of PrEP as a drug for cisgender GBMSM shaped relationships with PrEP in different ways for people at different social locations. Among cisgender men with undisclosed same-sex practices, non-initiation functioned as moral self-regulation rather than a knowledge or access problem:

"If you're taking PrEP, you're kind of actively thinking like, I'm going to be doing this. But from my ethnic background, my religious background, I shouldn't be doing that." (ID_02)

Cisgender women had the highest rates of lack of awareness, reflecting the structural absence of women from PrEP promotion. Transgender masculine/male participants encountered peer-circulated misinformation, and a clinical evidence gap initially excluding them from on-demand dosing (37). Transgender women described compounded barriers from NHS transgender healthcare precariousness and internal pressure to conform to heteronormativity leading to self-exclusion from PrEP.

Ethnicity shaped engagement through the fear of being seen accessing PrEP in community-proximate healthcare settings, distrust based on experience of discrimination in healthcare and absence of PrEP discussion in informal community networks. British Pakistani MSM described substantial privacy management labour, including changing GP, avoiding clinics near mosques, and surveying pharmacies in their local area before entering, to prevent disclosure of their sexual practices within their communities. Latina participants collectively had no prior PrEP awareness. Black British participants further described community-level HIV stigma operating alongside NHS distrust:

"In the Caribbean and the African communities, that's a 'them' problem. A lot of prejudice. They still think HIV is something from the 80s." (ID_35)

Religion shaped engagement via moral framings of PrEP as endorsing prohibited conduct, with structurally similar narratives expressed by Muslim and Christian participants. These identity-level patterns help explain the subgroup differences in survey results documented in Table 1 (presenting PrEP awareness and use), whereby racially minoritised cisgender women and heterosexual men were much less aware of PrEP than racially minoritised MSM.

b) Circumstances and PrEP engagement

Where identity shaped whether PrEP was perceived as relevant, circumstances shaped whether it was practically reachable. Relationship structure was the most consistently reported circumstantial reason for both PrEP initiation and discontinuation. Entering a monogamous relationship was the primary reason for stopping across at least nine former users, even among those who recognised this as an imperfect safeguard. Open and polyamorous relationships were associated with heightened perceived PrEP need, with one participant describing PrEP initiation as an act of relational care rather than individual protection:

"Being in an open relationship, we've been having loads of conversations about what it looks like for us to be safe with one another. Considering him is a big part of me going and getting prepped this week." (ID_29)

Service design functioned as a structural barrier independent of motivation. Multi-hour appointment waits deterred even highly engaged users, and appointment slots exhausted within moments of release systematically excluded those without flexible employment or immediate internet access. For sex workers, service design barriers intersected with occupational ones: the structural ambiguity around what to disclose in clinical settings, given the legal landscape and uncertainty about how clinicians would

respond to sex work disclosure, created a further layer of friction absent from mainstream PrEP access frameworks. Geographic location produced distinct access environments: participants outside London described reduced provision and, in some areas, a complete absence of PrEP promotion in sex education, contributing to a widespread misconception that PrEP was reserved for those with the greatest need.

Domestic privacy was a barrier through the visibility of pill storage, particularly for LGBTQ+ individuals who needed to keep their identity or prevention choices private at home. Migration status highlighted two further structural gaps: the early period after NHS registration as a missed onboarding window for health promotion, and the absence of multilingual provision as a barrier to PrEP access that operated independently of English-language fluency. These circumstantial barriers help explain the subgroup differences in former use documented in Table 1 (PrEP awareness and Use)

, which was most prevalent among racially minoritised heterosexual men and non-binary and transgender individuals.

c) Practices and PrEP engagement

The third dimension of the framework, practices, addresses whether PrEP could be incorporated into everyday routines. The fit between PrEP regimen design and actual sexual practice patterns was a persistent theme. Daily oral PrEP assumed a consistency of sexual activity that did not characterise most participants' lives, while on-demand dosing, though well- suited to many, was the least known modality across the qualitative sample. The daily pill burden paradoxically reduced HIV anxiety yet generated a new anxiety about missing doses, leading one participant to choose sexual abstinence over continued use. Side effects including nausea and bloating drove rational switches to on-demand dosing; one transgender woman participant had a specific medical history making tablet-taking physically problematic and injectable PrEP her only viable option. Among transgender masculine participants managing testosterone injection regimens, existing injection infrastructures had divergent effects: some described batching PrEP with hormone appointments as enabling, while one preferred oral PrEP specifically to avoid adding another injection.

Three practice-level framings of PrEP emerged inductively: first, *PrEP integrated into a daily wellness* routine alongside supplements resolved adherence and identity-labelling burdens simultaneously; second, *PrEP as liberation* connected PrEP to freedom from both HIV anxiety and homophobic views about same-sex harms. Third, *an occupational harm reduction framing* positioned PrEP as protection under conditions of economic coercion:

"If you're selling sex and you can't afford to say no, and rent is due, this is just another kind of tool in the arsenal for someone to stay safe." (ID_21)

Finally, the research process was revealed to be an incidental PrEP literacy intervention for at least six participants who reported that they learned about PrEP for the first time through participation in the study. These practice-level findings illuminate the mechanisms behind the modality preferences presented later in an additional table [see Additional file 7], particularly the preference for injectable PrEP.

Bidirectionality

The three dimensions of the framework do not operate in one direction only. System-level framings of PrEP, produced through trial design, marketing, eligibility criteria and service delivery, feed back through all three framework dimensions before any individual decision is made. The cultural coding of PrEP as a drug for (mostly) white cisgender gay men generated self-exclusion among transgender participants, women and racially minoritised individuals, and influenced which peer networks transmitted PrEP information. Bidirectional dynamics help explain why increasing access to PrEP alone is insufficient: the conditions under which individuals encounter, recognise, and engage with PrEP are themselves structurally produced.

PrEP Modality and Delivery Preferences in the survey

Modality and delivery-setting preferences diverged across subgroups; full detail is presented in an additional table [see Additional file 7]. Preferences were reported separately for each modality rather than as a ranking. Low preference for daily oral PrEP was reported by 47.0% of respondents (n = 63), while a strong preference for injectable PrEP was reported by 87.3% (n = 138), rising to 97.3% (n = 36) among racially minoritised heterosexual men and 97.4% (n = 38) among sex workers. Delivery setting priorities diverged by subgroup. Preference for sexual health clinics was high overall (oral: n = 98, 65.8%; injectable: n = 97, 65.1%), but this aggregate masked substantial variation between subgroups. Over 70% of racially minoritised women and of sex workers expressed a preference for delivery through general practice, compared with 35.3% (n = 6) of racially minoritised GBMSM. These divergences map onto the patterns of institutional trust and access described in the qualitative findings.

Discussion

Interpretations and comparisons with the existing literature

Our findings extend existing literature on PrEP by showing how barriers and facilitators operate across intersecting identities, relational practices, and practical circumstances. Previous UK research has been focussed on studies with GBMSM and by on patient-level barriers or deficits (e.g., awareness, knowledge and access limitations), with comparatively little attention to structural or provider level factors (19). Our findings show that low awareness may reflect absence from mainstream PrEP promotion rather than a lack of interest in PrEP. The literature on cisgender and transgender women similarly highlights structural exclusion from PrEP promotion and eligibility frameworks, and the study data support this interpretation by showing that cisgender women's low awareness reflected exclusion from prevailing prevention narratives rather than an individual deficit (20).

Studies focusing on Black African heritage communities in England have consistently reported low levels of PrEP awareness and uptake, alongside misconceptions about who PrEP is for and how to access it (38). Our findings are consistent with this but suggest that several other racially minoritised, intersectional groups also showed limited awareness and engagement. This aligns with Grenfell et al., who showed that

peer led, community embedded PrEP education can reach cisgender women and non-binary people, including Black cisgender women, migrant people and those who are racially minoritised, not being reached through mainstream PrEP promotion (39). Our research process with its intentional and co-designed recruitment strategy itself functioned as an incidental PrEP literacy intervention for some participants, indicating that current information pathways remain insufficiently embedded in the communities in need.

For Black cisgender women in our study specifically, the findings are closely aligned with Coukan et al., who showed that Black African women remain the most underserved population in England in relation to PrEP access, with the lowest PrEP-to-need ratios despite national commissioning (16). Subsequent work by the same group has co-designed interventions with Black cisgender women, including tailored PrEP awareness campaigns, community-based peer outreach, and collaborations with Black-led voluntary sector organisations (40). Complementary public health work has similarly emphasised community-led approaches in which Black community organisations, faith leaders, and local residents shape HIV prevention messaging and delivery (41). Our study data add nuance by showing that inequity is not driven only by awareness gaps in specific groups, but also by relationship context, privacy concerns, migration, language and service configuration. Combined, this supports a shift away from deficit-based explanations of low uptake and towards a more structural interpretation of underuse among cisgender women from racially minoritised groups.

The transgender and gender diverse literature also maps closely onto the findings. Witney et al. describe sexual health services in the UK as poorly designed for transgender and gender diverse people, with services often experienced as cisnormative and difficult to navigate (42). Hibbert et al. similarly show that anticipated and experienced discrimination can drive avoidance of sexual health clinics among transgender people (43). Our qualitative findings echo these patterns but go further by showing that PrEP engagement is shaped by the interaction between gender-affirming hormone therapy, injection preferences, clinical evidence gaps and wider precariousness in access to transgender healthcare. These patterns imply that, for transgender and gender diverse people, injectable PrEP may be the most appropriately delivered within the context of wider gender-affirming care, rather than in isolation.

The findings on injectable PrEP are also consistent with international evidence and current UK policy developments. Wang et al. found high levels of interest in long-acting injectable PrEP across MSM, transgender individuals and cisgender heterosexual women globally, with injectables frequently preferred over daily oral tablets in stated-preference studies (44). A recent scoping review in Eastern and Southern Africa similarly reported that long-acting products, particularly injectables, were preferred over daily oral PrEP across a range of populations, with discretion, reduced dosing burden and perceived efficacy identified as key drivers of preference (45). Tolley et al. reported that preferences for injectable PrEP among African cisgender women taking part in HPTN 084 were shaped by reduced daily burden, greater privacy and the ability to integrate injections into existing healthcare routines (46). The present findings align with this literature but also indicate that interest in injectable PrEP is not solely related to oral intolerance, as many participants appeared to value injectables because they better fitted their lives,

identities and prevention routines. This is relevant to current NICE guidance on CAB-LA, which has so far framed eligibility more narrowly around an 'inability to use or adhere to oral PrEP' (47). The relationship pattern findings are also consistent with prior work. Ongolly et al. and subsequent programme evaluations in Kenya have shown that perceptions of reduced vulnerability to HIV following changes in relationships are a common reason for PrEP discontinuation, with many users stopping during periods they understand as having limited HIV exposure (48, 49). The present findings support this pattern but also indicate that relationship structure can shape decisions in both directions. Entering a monogamous relationship often led participants to stop PrEP as an expression of commitment or trust, whereas moving into open or non-monogamous relationships could motivate initiation as an expression of shared responsibility between partners, echoing studies of gay and bisexual men in open or 'monogamish' relationships who frame PrEP as a couple-level strategy (50, 51). These decisions were not made on equal terms. Participants' capacity to initiate, disclose, or sustain PrEP use was shaped by relationship power dynamics, including partner control over disclosure, and for those experiencing IPV, by the risks attached to negotiating prevention at all (52). We develop existing literature by highlighting relationship context not simply as a proxy for shifting patterns of HIV exposure, but as a dynamic social frame through which prevention decisions are negotiated (48, 50, 51, 53).

The findings also resonate with literature on PrEP stigma and social meaning. Calabrese and Underhill argued that stigma surrounding PrEP use can undermine both prevention and sexual wellbeing (54, 55). The present findings develop this argument by showing that moral framings of PrEP as a marker of promiscuity were not confined to MSM contexts, but were also articulated by Muslim and Christian participants, for whom religious framings shaped whether PrEP could be imagined as socially legitimate. Similarly, Witzel et al. showed that stereotypical understandings of PrEP can limit self-identification as a potential PrEP user among Black MSM in London (56). The present findings extend this argument by showing that across multiple subgroups, self-identification as a PrEP candidate was shaped by identity, cultural meaning, and network membership before any individual assessment of HIV acquisition likelihood was made.

Finally, the findings support the growing evidence base for non-traditional delivery models. Harrison et al. showed that community pharmacy PrEP provision is acceptable and feasible for underserved populations (57), while the 2025 BASHH/BHIVA guidelines (25), marked an important move towards equity oriented delivery across community pharmacies, primary care and community settings. The guideline also includes a dedicated equity chapter and moves away from using clinical trial inclusion criteria as a basis for eligibility (26). The findings support this direction, particularly because service preferences were mixed rather than uniform. Sexual health clinics remained important, but many participants also viewed GP and pharmacy delivery as more accessible or less stigmatising. This suggests that an equitable PrEP system requires multiple entry points rather than a single service model. To accompany this research, we have developed a set of co-produced community-led recommendations to inform these changes further (58).

Strengths and limitations

To our knowledge, this is the largest UK study of PrEP engagement recruited entirely from populations underserved by existing provision, comprising 264 survey respondents and 38 interviewees. It reached groups consistently absent from both PrEP research and routine surveillance, including recent migrants, sex workers, transgender and non-binary people, and racially minoritised cisgender heterosexual men and women, and it therefore allows engagement to be examined across, rather than within, the categories through which PrEP has conventionally been studied.

A second strength is the use of a purpose-built theoretical framework to guide data collection, which was then refined through the analysis. This moves the account beyond narrow behavioural explanations of uptake and non-use, showing how apparent 'decisions' are shaped by social location and by what services make available. It adds to a growing qualitative literature demonstrating that PrEP access is mediated not only by knowledge and exposure, but by social meanings, anticipated judgement, and the extent to which people recognise themselves, and are recognised by others, as legitimate PrEP candidates (59). A third strength is the attention paid to variation in preferred delivery models. Recent UK evidence suggests that pharmacy-based delivery may be both acceptable and feasible for underserved groups, while the 2025 BASHH/BHIVA guidance explicitly prioritises equity, broader suitability assessment, and delivery beyond specialist settings (57). By examining preferences across sexual health clinics, general practice, and pharmacy settings, the study speaks directly to this policy shift and shows why a single delivery model is unlikely to meet the needs of all potential users.

There are, however, important limitations. The study was not designed to produce statistically representative estimates. Both the survey and interview samples were purposively recruited from populations underserved by PrEP, and the interview sample was drawn largely from survey participants who consented to further contact and is therefore self-selected. Participants in both strands were also more highly educated than the general population. Because education is associated with health literacy and with the capacity to navigate and advocate within services, the awareness and access barriers reported here are likely to understate those faced by less educated members of the same communities. The study was also cross-sectional, capturing views and intentions at a single point in time rather than the changing circumstances of participants' everyday lives. It therefore cannot fully reflect the dynamic ways in which PrEP preferences, perceived need and service choices shift in response to relationships, health, mobility, stigma or access, which are some of the very processes the Contingency Framework is hoping to address in further research. These findings should therefore be read as an account shaped by the policy, service and discursive landscape at the time of data collection. As PrEP, including long-acting options, becomes more widely available across community, digital, primary care and pharmacy settings, perceptions of eligibility, stigma and service preferences may continue to evolve, requiring ongoing monitoring and evaluation of equitable implementation.

Implications

The findings suggest that improving PrEP coverage and equity requires interventions at several levels. Our community-led recommendations offer more details that can inform future planning and advocacy (58).

At the individual and interpersonal level, both quantitative patterns and qualitative accounts indicate that PrEP stigma and narrow ideas about who PrEP is “for” continue to shape interest, candidacy and comfort discussing PrEP with providers. Addressing these issues will require communication and training that actively challenge promiscuity-based stereotypes and support clinicians to adopt more inclusive, person-centred approaches to initiating conversations around PrEP, while assessing PrEP suitability.

At the service level, the evidence that preferences for delivery models are mixed rather than uniform supports current policy moves towards multiple PrEP entry points. Sexual health clinics remain central for some, but they cannot be the sole route: most people in England with an unmet PrEP need do not attend a sexual health service (18), and many participants here viewed GP and community pharmacies as more accessible, less stigmatising, or better aligned with their everyday healthcare use, including through discreet access points that avoid compromising an individual's security or status. This suggests that embedding PrEP across different parts of the health system, rather than concentrating it in specialist clinics, is likely to be critical for reaching people who currently experience structural and symbolic barriers to access.

High-stated preference for long-acting options should not be assumed to translate into uptake. Our findings indicate that current non-use is not primarily a matter of low interest, and the structural conditions that have limited the reach of oral PrEP, including eligibility framing, service configuration, and the cultural location of PrEP, will also determine whether injectable PrEP reaches those who want it. Without deliberate attention to equitable implementation, long-acting PrEP risks reproducing the inequities of the oral era.

The qualitative findings reinforce the importance of sustaining funding for community-led initiatives and dedicated peer support roles filled by people with lived experience of the populations being served. For populations with legitimate reasons to distrust statutory services, community-embedded delivery is not an optional supplement to NHS provision but the primary condition under which prevention becomes credible and reachable.

At the policy and systems level, the study reinforces the importance of equity-focused guidance that moves away from using clinical trial inclusion criteria as the primary basis for eligibility. Integrated Care Boards and local authorities should conduct local needs assessments to accurately identify underserved populations and target provision accordingly. The findings also support directing advocacy towards securing policy and funding alignment for new prevention technologies, particularly long-acting injectable PrEP, and highlight the need for ongoing evaluation of whether new delivery models reduce or inadvertently reproduce existing inequities.

Conclusion

The study shows that PrEP engagement is shaped by changing and contingent configurations. Across the findings, decisions about PrEP were shaped by how participants understood themselves and were recognised by others, by the changing circumstances of their relationships, lives and service access, and

by the practical ways PrEP could or could not be incorporated into everyday routines. Taken together, the mixed-methods findings suggest that PrEP candidacy and access are socially structured through processes of recognition, belonging and legitimacy, rather than determined by biomedical criteria alone. For policymakers and practitioners, this means that expanding eligibility and supply is necessary but not sufficient: PrEP also needs to be made socially imaginable, morally legitimate and practically reachable for those who are currently least well served.

Abbreviations

BASHH/BHIVA
British Association for Sexual Health and HIV / British HIV Association
CAB-LA
Cabotegravir long-acting
GBMSM
Gay and bisexual men who have sex with men
HIV
Human immunodeficiency virus
LEN
Lenacapavir
NHS
National Health Service
PrEP
Pre-exposure prophylaxis
SHS
Sexual health services
TDF/FTC
Tenofovir disoproxil fumarate / emtricitabine
CAB
Community Advisory Board
GDPR
General Data Protection Regulation
GP
General practice / general practitioner
GRIPP2
Guidance for Reporting Involvement of Patients and the Public, version 2
HPTN
HIV Prevention Trials Network
IPV
Intimate partner violence
LGBTQ+
Lesbian, gay, bisexual, transgender and queer

MSM
Men who have sex with men
NICE
National Institute for Health and Care Excellence
QMUL
Queen Mary University of London
STI
Sexually transmitted infection
UK
United Kingdom

Declarations

Ethics approval and consent to participate

This study was conducted in accordance with the Declaration of Helsinki. Informed consent to participate was obtained from all participants, all of whom were aged 18 years or over, before any data were collected; survey participants consented electronically at the point of survey access and interview participants provided written consent prior to interview. Ethics approval was granted by two Queen Mary University of London committees: the Global Public Health Devolved Ethics Committee for early co-production activities (GHDE_2425_02, December 2024) and the Ethics of Research Committee for primary data collection (QME25.0655, July 2025), the latter including three subsequent minor amendments. Data were stored on secure encrypted servers in accordance with the UK General Data Protection Regulation, and full details of consent procedures and data anonymisation are reported in the published protocol (60).

Consent for publication

Participants consented at the point of recruitment to the use of anonymised verbatim quotations in publications arising from the study. All quotations are reported under study identifiers only and contain no information that could identify an individual. No images, videos or other individual-level personal data are included.

Competing Interests

SP has received research grants from Gilead Sciences and ViiV Healthcare. SS has received honoraria for advisory boards, consultancy and travel sponsorship from ViiV Healthcare and Gilead Sciences, and community grants from Gilead Sciences, ViiV Healthcare and MSD; she has been unremunerated Vice Chair of the BHIVA Women's Special Interest Group since late 2025. AA has received honoraria for community engagement from Gilead Sciences. JO sits on ViiV Healthcare and Gilead Sciences advisory boards for PrEP programmes. KR is a sub-investigator on the Gilead Sciences-sponsored PURPOSE-5 injectable PrEP trial, has received honoraria from ViiV Healthcare, and is Secretary of the BASHH Gender

and Sexual Minorities Special Interest Group. CO has received honoraria for advisory boards, lectureships and travel sponsorship from Janssen, Gilead Sciences, ViiV Healthcare, MSD and AstraZeneca. VR's post is funded in part by the Gilead Sciences award that sponsored this study. All other authors declare that they have no competing interests.

Funding

This study was sponsored by Gilead Sciences Inc. The funder had no role in study design, data collection, analysis, interpretation of data, or the decision to submit the article for publication.

Author Contribution

SP conceived the study. SP and CO acquired the funding and supervised the study. CO designed the methodology. VR collected the data. VR and NH administered the project. MS conducted the quantitative analysis, and VR conducted the qualitative analysis. VR drafted the original manuscript. SS and CC coordinated the Steering Group. Members of the PrEP-Position Steering Group (AA, TC, KD, VM, PMB, UN, JO, KR and TA) contributed to study design, instrument co-design, recruitment and interpretation of findings. All authors reviewed and edited the manuscript and approved the final version for submission.

Acknowledgement

We would like to express our sincere gratitude to all the study participants for their invaluable contributions, and to the community organisations that supported recruitment. We also gratefully acknowledge the PrEP-Position Steering Group, Sophia Forum, and wider SHARE Collaborative team for their support.

Data Availability

The study protocol is publicly available on the Open Science Framework (https://doi.org/10.17605/OSF.IO/VXD5T) (60). The full survey instrument and interview topic guide are provided as Additional files 2 and 3. The datasets generated and analysed during the current study are held securely at Queen Mary University of London and are not publicly available. De-identified quantitative survey data are available from the corresponding author on reasonable request, subject to institutional data-sharing approval. Qualitative interview transcripts are not available, as participants did not consent to the sharing of full transcripts and the risk of deductive disclosure cannot be excluded given the small size and identifiability of several participant groups.

Clinical trial number

not applicable.

References

1. Sullivan AK, Saunders J, Desai M, Cartier A, Mitchell HD, Jaffer S et al. HIV pre-exposure prophylaxis and its implementation in the PrEP Impact Trial in England: a pragmatic health technology assessment. Lancet HIV [Internet]. 2023;10(12):e790–806. Available from: http://dx.doi.org/10.1016/S2352-3018(23)00256-4
2. UK Health Security Agency. Routine commissioning of HIV pre- exposure prophylaxis (PrEP) in England. 2022;(March). Available from: https://assets.publishing.service.gov.uk/media/62272619e90e0710be035556/UKHSA-PrEP-monitoring-and-evaluation-framework-for-England-2022.pdf
3. GR M, LJ R, AP L, Vanessa M, LA Y, Lorena V et al. Preexposure Chemoprophylaxis for HIV Prevention in Men Who Have Sex with Men. N Engl J Med [Internet]. 2026;363(27):2587–99. Available from: https://doi.org/10.1056/NEJMoa1011205
4. McCormack S, Dunn DT, Desai M, Dolling DI, Gafos M, Gilson R et al. Pre-exposure prophylaxis to prevent the acquisition of HIV-1 infection (PROUD): Effectiveness results from the pilot phase of a pragmatic open-label randomised trial. Lancet [Internet]. 2016;387(10013):53–60. Available from: http://dx.doi.org/10.1016/S0140-6736(15)00056-2
5. Zhang J, Li C, Xu J, Hu Z, Rutstein SE, Tucker JD et al. Discontinuation, suboptimal adherence, and reinitiation of oral HIV pre-exposure prophylaxis : a global systematic review and meta-analysis. Lancet HIV [Internet]. 2022;9(4):e254–68. Available from: http://dx.doi.org/10.1016/S2352-3018(22)00030-3
6. Landovitz RJ, Donnell D, Clement ME, Hanscom B, Cottle L, Coelho L, et al. Cabotegravir for HIV Prevention in Cisgender Men and Transgender Women. N Engl J Med. 2021;385(7):595–608.
7. Delany-Moretlwe S, Hughes JP, Bock P, Ouma SG, Hunidzarira P, Kalonji D, et al. Cabotegravir for the prevention of HIV-1 in women: results from HPTN 084, a phase 3, randomised clinical trial. Lancet (London England). 2022;399(10337):1779–89.
8. Public Health Scotland. Cabotegravir (page within the PrEP therapeutics protocol section) [Internet]. Right Decision Service, Healthcare Improvement Scotland / NHS Scotland. 2025. Available from: https://www.rightdecisions.scot.nhs.uk/hiv-transmission-elimination/prep-therapeutics-protocol/cabotegravir/
9. Collins S. NICE approves limited access to injectable cabotegravir PrEP in England and Wales + BHIVA notes on prescribing. HIV Treat Bull [Internet]. 2025; Available from: https://i-base.info/htb/52527
10. Bekker L-G, Das M, Abdool Karim Q, Ahmed K, Batting J, Brumskine W, et al. Twice-Yearly Lenacapavir or Daily F/TAF for HIV Prevention in Cisgender Women. N Engl J Med. 2024;391(13):1179–92.
11. Kelley CF, Acevedo-Quiñones M, Agwu AL, Avihingsanon A, Benson P, Blumenthal J, et al. Twice-Yearly Lenacapavir for HIV Prevention in Men and Gender-Diverse Persons. N Engl J Med. 2025;392(13):1261–76.

12. Patel RR, Hoover KW, Lale A, Cabrales J, Byrd KM, Kourtis AP. Clinical Recommendation for the Use of Injectable Lenacapavir as HIV Preexposure Prophylaxis — United States, 2025. 2025;74(35):2018–23.
13. Gilead. Yeztugo® (Lenacapavir) Is Now the First and Only FDA-Approved HIV Prevention Option Offering 6 Months of Protection [Internet]. 2025 [cited 2026 Jun 15]. Available from: https://www.gilead.com/news/news-details/2025/yeztugo-lenacapavir-is-now-the-first-and-only-fda-approved-hiv-prevention-option-offering-6-months-of-protection
14. UK Health Security Agency. HIV diagnoses fall in England [Internet]. GOV.UK. 2025 [cited 2025 Mar 12]. Available from: https://www.gov.uk/government/news/hiv-diagnoses-fall-in-england
15. UK Health Security Agency. HIV testing, PrEP, new HIV diagnoses and care outcomes for people accessing HIV services: 2025 report [Internet]. 2025. Available from: https://www.gov.uk/government/statistics/hiv-annual-data-tables/hiv-testing-prep-new-hiv-diagnoses-and-care-outcomes-for-people-accessing-hiv-services-2025-report
16. Coukan F, Sullivan A, Mitchell H, Jaffer S, Williams A, Saunders J, et al. Impact of national commissioning of pre-exposure prophylaxis (PrEP) on equity of access in England: a PrEP-to-need ratio investigation. Sex Transm Infect. 2024;100(3):166–72.
17. National AIDS. Trust. Not PrEPared: Barriers to accessing HIV prevention drugs in England. London: England; 2022.
18. Huntington SE, Bates L, Coukan F, Adams EJ. Estimating the number of people who could benefit from HIV pre-exposure prophylaxis (PrEP) in England and the unmet need. Sex Transm Infect. 2025;101(8):506–12.
19. Coukan F, Murray KK, Papageorgiou V, Lound A, Saunders J, Atchison C, et al. Barriers and facilitators to HIV Pre-Exposure Prophylaxis (PrEP) in Specialist Sexual Health Services in the United Kingdom: A systematic review using the PrEP Care Continuum. HIV Med. 2023;24(8):893–913.
20. Whelan I, Strachan S, Apea V, Orkin C, Paparini S. Barriers and facilitators to HIV pre-exposure prophylaxis for cisgender and transgender women in the UK. Lancet HIV [Internet]. 2023;10(7):e472–81. Available from: https://doi.org/10.1016/S2352-3018(23)00080-2
21. Bowleg L. The problem with the phrase women and minorities: Intersectionality-an important theoretical framework for public health. Am J Public Health. 2012;102(7):1267–73.
22. Sievwright KM, Stangl AL, Nyblade L, Lippman SA, Logie CH, De Sousa Mascena Veras MA, et al. An Expanded Definition of Intersectional Stigma for Public Health Research and Praxis. Am J Public Health. 2022;112:S356–61.
23. Logie CH, James LI, Tharao W, Loutfy MR. HIV, gender, race, sexual orientation, and sex work: A qualitative study of intersectional stigma experienced by HIV-positive women in Ontario, Canada. PLoS Med. 2011;8(11).
24. Nakasone SE, Young I, Estcourt CS, Calliste J, Flowers P, Ridgway J, et al. Risk perception, safer sex practices and PrEP enthusiasm: Barriers and facilitators to oral HIV pre-exposure prophylaxis in Black African and Black Caribbean women in the UK. Sex Transm Infect. 2020;96(5):349–54.

25. British Association of Sexual Health and HIV and the BHA. Guidelines on the use of HIV pre-exposure prophylaxis (PrEP) 2025. 2025; Available from: https://bhiva.org/clinical-guideline/PrEP-guidelines/
26. Clutterbuck D, Brady M, Rodger A. Driving progress towards PrEP equity: Key changes in the 2025 BASHH/BHIVA UK PrEP guidelines. HIV Med. 2025;26(7):1125–41.
27. GOV.UK. HIV Action Plan for England, 2025 to 2030 [Internet]. 2025. Available from: https://www.gov.uk/government/publications/hiv-action-plan-for-england-2025-to-2030/hiv-action-plan-for-england-2025-to-2030
28. Lorenzetti L, Dinh N, van der Straten A, Fonner V, Ridgeway K, Rodolph M, et al. Systematic review of the values and preferences regarding the use of injectable pre-exposure prophylaxis to prevent HIV acquisition. J Int AIDS Soc. 2023;26(Suppl 2):e26107.
29. Tolley EE, Zangeneh SZ, Chau G, Eron J, Grinsztejn B, Humphries H et al. Acceptability of Long-Acting Injectable Cabotegravir (CAB LA) in HIV-Uninfected Individuals: HPTN 077. AIDS Behav [Internet]. 2020;24(9):2520–31. Available from: https://doi.org/10.1007/s10461-020-02808-2
30. Fetters MD, Curry LA, Creswell JW. Achieving integration in mixed methods designs - Principles and practices. Health Serv Res. 2013;48(6 PART2):2134–56.
31. Beresford P. Public Participation in Health and Social Care : Exploring the Co-production of Knowledge. 2019;3(January).
32. Staniszewska S, Brett J, Simera I, Seers K, Mockford C, Goodlad S et al. GRIPP2 reporting checklists : tools to improve reporting of patient and public involvement in research practice is based on the best evidence. 2017.
33. Pasin C, Weil B, Hayes R, Siddiqui Q, Whelan I, Nutland W et al. 'It was something that I let slip by the wayside': a qualitative study of challenges to equitable mpox vaccination in the UK outbreak response. 2025.
34. ViiV Healthcare. ViiV HEALTHCARE LAUNCHES. 'RISK TO REASONS' INITIATIVE IN THE UK TO EMPOWER WOMEN TO TAKE CONTROL OF THEIR HIV PREVENTION CHOICES [Internet]. 2025 [cited 2026 Jun 8]. Available from: https://viivhealthcare.com/hiv-news-and-media/news/press-releases/2025/october/viiv-healthcare-launches-risk-to-reasons-initiative/
35. Qualtrics LLC. Qualtrics [software] [Internet]. Provo, UT. 2025. Available from: https://www.qualtrics.com
36. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol [Internet]. 2006;3(2):77–101. Available from: https://www.tandfonline.com/doi/abs/10.1191/1478088706qp063oa
37. Dang M, Scheim AI, Teti M, Quinn KG, Zarwell M, Petroll AE, et al. Barriers and Facilitators to HIV Pre-Exposure Prophylaxis Uptake, Adherence, and Persistence Among Transgender Populations in the United States: A Systematic Review. AIDS Patient Care STDS. 2022;36(6):236–48.
38. Giuseppe K, Di, Kasoka K, Dunkley Y. Investigating Preexposure Prophylaxis (PrEP) Uptake Among Black African Communities in East London and Hertfordshire : A Brief Report of a Mixed Methods Study Investigating Preexposure Prophylaxis (PrEP) Uptake Among Black African. Int J Sex Heal [Internet]. 2019;0(0):1–6. Available from: https://doi.org/10.1080/19317611.2019.1634174

39. Grenfell P, Rafael S, Calliste J, Nutland W. ‘ We go where we know ’: Reflections from Mobilizing for PrEP and Sexual Health (MobPrESH) – A peer-led PrEP education programme across England, for and by women and non-binary people. 2022;15–7.
40. Coukan F, Thamm W, Afolabi F, Murray KK, Rathbone AP. Co – designing interventions with multiple stakeholders to address barriers and promote equitable access to HIV Pre – Exposure Prophylaxis (PrEP) in Black women in England. BMC Public Health [Internet]. 2025; Available from: https://doi.org/10.1186/s12889-025-23023-5
41. London Local Authorities. Towards Equity : Reimagining HIV Prevention for London ’ s Black Communities.
42. Witney T, Rait G, Saunders J, Hobbs L, Mitchell L, Stewart J et al. One way or another, you are not going to fit: trans and gender diverse people ’ s perspectives on sexual health services in the United Kingdom. 2025;287–93.
43. Hibbert MP, Wolton A, Weeks H, Ross M, Brett CE, Porcellato LA et al. Psychosocial and sexual factors associated with recent sexual health clinic attendance and HIV testing among trans people in the UK. 2019;1–10.
44. Wang H, Kolstee J, Gaetani M, Aphami L, Lozano AA, Zimmermann HML et al. Interest in and Preference for Long-Acting Injectable Pre-exposure Prophylaxis Among Men Who Have Sex With Men, Trans * Individuals, and Cisgender Heterosexual Women : A Global Systematic Review and Meta-Analysis. 2025;100(5):377–90.
45. Pfau B, Saravis A, Cox SN, Wu L, Wittenauer R, Callen E, et al. User preferences on long-acting pre-exposure prophylaxis for HIV prevention in Eastern and Southern Africa: a scoping review. BMC Public Health. 2025;25(1):2361.
46. Tolley EE, Bula A, Chitukuta M, Ndimande-Khoza N, Etima J, Namey E et al. Preferences for oral and injectable PrEP among qualitative sub-study participants in HPTN 084. PLoS One [Internet]. 2024;19(10 October):1–18. Available from: http://dx.doi.org/10.1371/journal.pone.0309811
47. National Institute for Health and Care Excellence (NICE). Cabotegravir for preventing HIV–1 in adults and young people [Internet]. 2025 [cited 2026 Jun 10]. Available from: https://www.nice.org.uk/guidance/ta1106/chapter/1-Recommendations
48. Ongolly FK, Dolla A, Ngure K, Elizabeth M, Odoyo J, Wamoni E et al. I just decided to stop: Understanding PrEP discontinuation among individuals initiating PrEP in HIV care centers in Kenya. 2022;87(1):1–17.
49. Wairimu N, Ngure K, Ogello V, Owidi E, Mwangi P, Etyang L et al. Low HIV-risk aligned discontinuation among HIV pre-exposure prophylaxis users within public HIV clinics in Kenya : A mixed method study. 2025;1–16. Available from: https://doi.org/10.1371/journal.pgph.0004493
50. Kahle EM, Sharma A, Sullivan S, Stephenson R. The Influence of Relationship Dynamics and Sexual Agreements on Perceived Partner Support and Benefit of PrEP Use Among Same-Sex Male Couples in the U.S. AIDS Behav. 2020;24(7):2169–77.

51. John SA, Starks TJ, Rendina HJ, Grov C, Parsons JT. Should I Convince My Partner to Go on Pre-Exposure Prophylaxis (PrEP)? The Role of Personal and Relationship Factors on PrEP-Related Social Control among Gay and Bisexual Men. AIDS Behav. 2018;22(4):1239–52.
52. Jeffers NK, Zemlak JL, Celius L, Willie TC, Kershaw T, Alexander KA. 'If the partner finds out, then there's trouble': Provider perspectives on safety planning and partner interference when offering HIV Pre-Exposure Prophylaxis (PrEP) to women experiencing intimate partner violence (IPV). 2022;26(7):2266–78.
53. Ngure K, Thuo N, Ogello V, Kiptinness C, Kamolloh K, Frances B et al. Dynamic Perceived HIV Risk and Sexual Behaviors Among Young Women Enrolled in a PrEP Trial in Kenya : A Qualitative Study. 2021;3(August):1–9.
54. Calabrese SK, Underhill K. How Stigma Surrounding the Use of HIV Preexposure Prophylaxis Undermines Prevention and Pleasure: A Call to Destigmatize Truvada Whores. Am J Public Health. 2015;105(10):1960–4.
55. Goymann H, Berner- A, Mavuso M. If I wasn ' t a pastor, I would be telling them about condoms, contraceptives and PrEP — conflicts, dilemmas and credibility : qualitative insights from religious leaders and the promotion of exposure prophylaxis (PrEP). Eswatini. 2025;1–12.
56. Witzel TC, Nutland W, Bourne A. What are the motivations and barriers to pre- exposure prophylaxis (PrEP) use among black men who have sex with men aged 18–45 in London ? Results from a qualitative study. 2019;2017(October 2017):262–6.
57. Harryman L, Stockwell S, Family H, Kesten JM, Denford S, Scott J et al. Development and implementation of a pharmacy PrEP awareness- raising and referral pathway : acceptability and feasibility of a UK pilot. 2026;1–7.
58. Sophia Forum S, Collaborative, Queen Mary University of London. PrEP-Position Community Statements Report [Internet]. 2026 [cited 2026 Jul 21]. Available from: https://shareresearch.org.uk/resources/
59. Kerr J, Ayangeakaa S, Ama N, Bullock A, Burton K, Combs R et al. A Qualitative Exploration of Various Stigmas Impacting HIV Pre-exposure Prophylaxis (PrEP) Uptake among African American Young Adults. 2023;45(4):218–27.
60. Paparini S, Orkin C, Strachan S, Rajabzadeh V, PrEP-Position. UK LA PrEP Preference Study. [Internet]. OSF. 2026. Available from: https://doi.org/10.17605/OSF.IO/VXD5T

Figures

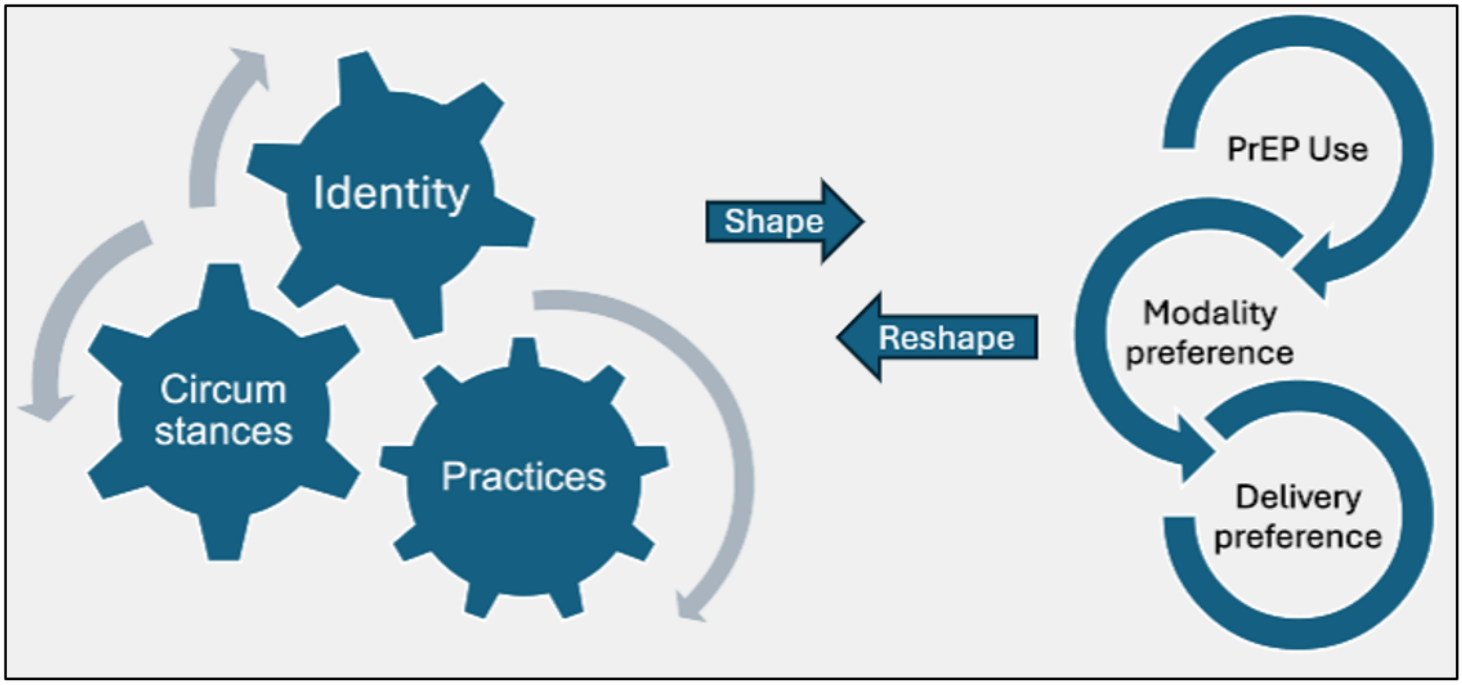


Figure 1

The Contingency Framework (33)

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- PrEPPositionAdditionalfiles27Jul.docx