PrEP-Position

Community Statements Report

2026

Sophia

SHARE
RESEARCH FOR HEALTH EQUITY

Queen Mary
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Forward

Despite great progress in HIV prevention modalities, the PrEP Position Study (1) has advanced the evidence base on the ways in which health inequalities prevent people from underserved communities from accessing and using PrEP, sexual health care and other HIV prevention methods in the UK.

For the vast majority of the communities we spoke to in our research, intersecting factors such as criminalisation of sex workers, systemic racism and sexism, lack of trust and safety accessing existing health services, significantly impact healthcare engagement.

For transgender and non-binary communities or for recent migrants, the added pressure to navigate our current political climate and exclusionary systems impacts their ability to consider their own health needs.

Everyone deserves access to the same rights and care, without the threats of violence and experiences of discrimination and prejudice we heard about in our study.

We have developed the Community Statements in this report based on our research and co-production with underserved communities to showcase what these communities believe needs to change in how we deliver HIV prevention and care.

Community members, researchers and academics have long advocated for what the community wants and needs: community-led services that foster trust, safety and equity of access to HIV prevention and care options in settings that meet their needs.

Centralised HIV prevention in NHS and statutory services is not sufficient to achieve PrEP equity and get to zero HIV transmissions by 2030. There is an urgent need to work together with communities and fund community-led initiatives in all areas of sexual health.

Our hope is that the Community Statements in this report and our ongoing wider advocacy materials and outputs will serve as changemaking tools that people use within their communities, places of employment, and personal lives, and to help influence decision makers at every level.

We have been intentional in calling out stakeholders that hold power, that are enablers in maintaining structural barriers, and that continue to contribute to health and gender inequity by not listening to the community's asks and needs.

It’s time to truly invest in communities: not only communities that need care, but also communities that want to play a key part in delivering this care, so that we can meaningfully change the course of people’s lives in HIV prevention.

INVEST at EVERY level.

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Jargon Buster

Key HIV terms:

Pre-exposure prophylaxis (PrEP)
Medication taken by people who do not have HIV to prevent them from getting HIV

HIV acquisition
The process of someone acquiring HIV

Oral PrEP
A pill that can be taken daily or event-based to prevent HIV

Long-acting injectable PrEP (Cabotegravir or Lenacapavir)
An injection given every 2-6 months that protects against HIV

Treatment modality
A type or way of delivering a treatment (ex: daily pill, injection)

Medically contraindicated
A situation in which a medicine or procedure should not be done because it could be harmful to the person

Adherence
How well someone follows their treatment plan (ex: taking their medication at the right time)

NICE
National Institute of Health and Care Excellence, an independent body that provides national guidance and advice for heatlh and social care

Social equity terms:

Underserved populations
Groups experiencing structural barriers and systemic inequalities to essential services like healthcare, education and safe spaces

Marginalised populations
Groups of people who are systematically excluded and discriminated against in society based on factors such as their race, sexuality, or socioeconomic status

Intersectionality
Overlapping social identities (such as race, gender, class, and sexuality) are not isolated phenomena but mutually construct and reinforce one another to produce unique experiences of discrimination and privilege

Institutional racism
Racism embedded in the structures, policies and practices of social and political institutions, reflected in professional practice and working methods that result in racialised disparities (2)

Equity
Treating people in ways that make sure they are not unfairly prevented from accessing resources and opportunities nor that others have an unfair advantage (3)

Jargon Buster

Research terms:

Methodology
The overall approach and methods used to carry out a study

Qualitative research
Research that explores people's experiences, views, and feelings, often using interviews or focus group discussions

Quantitative research
Research that focuses on information that can be measured numerically, often collected through surveys

Co-production
A partnership where people with lived experience and professionals work together on an equal footing to design, plan and deliver the desired project, service or product

Dissemination
Sharing research findings or information with others, such as communities, policymakers, or professionals

Narrative literature review
A summary of existing research that explains and discusses what is already known about a topic

Policy and systems terms:

Provision
The delivery or supply of a service, such as healthcare or medication

Commissioning
The process of planning, funding, and organising services to meet the needs of a population

Integrated care
Different health and care services working together in a coordinated way to meet a person's needs

Social determinants of health
The conditions in which people are born, grow, live, work and age, and people's access to power, money and resources (4)

Background

Pre-exposure prophylaxis (PrEP) to prevent HIV acquisition has been available in the UK since 2017 (5,6). Despite the availability of PrEP in the UK health service, inequalities remain. Uptake among various communities, including, for example, women (both cisgender and transgender women), transgender and non-binary individuals, racially minoritised men who have sex with men, recent migrants, sex workers and those with complex psychosocial needs has been low, with these groups being underserved and under-represented in both trials and early real-world data (7–12).

PrEP has traditionally been thought of, promoted to and taken up by a limited group of users (namely men who have sex with men), which is not inclusive of all who might need and benefit from it, and thus is not an equitable offer.

As of Summer 2026, the current delivery setting in the UK (i.e. through sexual health clinics only (12)) results in barriers to PrEP for different populations who might otherwise benefit. This is due to: i) multiple access issues related to sexual health clinics (e.g. stigma, opening hours, institutional racism, fear of deportation); and ii) barriers feared and/or experienced by individuals currently willing/seeking to access PrEP and previous PrEP users due to the sexual behaviour risk assessment done in clinic (11,12). In the last six years, since PrEP became available on the NHS, eligibility criteria have been based on narrow sexual risk assessment and clinical trial eligibility criteria, in some ways following this limited understanding of who PrEP is for and having the anecdotal effect of creating misunderstanding and a gender bias as to who is offered PrEP and who sees themselves as a candidate, disproportionately targeting GBMSM (13). Guidelines on the use of PrEP have recently changed in July 2025; they highlight equity and access for underserved populations. The updated guidelines move away from clinical trial-based eligibility criteria for PrEP and towards a more individualised person approach, seeking to expand suitability for PrEP and emphasise need (13).

To achieve equitable PrEP outcomes, we must innovate beyond our current treatment modality (i.e. oral PrEP) and introduce new, longer-acting modalities (14,15) which have been shown to be more effective. Daily oral dosing of PrEP is difficult for many individuals and populations to adhere to, such as, for example, those experiencing homelessness, unstable housing, or intimate partner violence.

This has recently been recognised in the NICE approval of CAB LA (long-acting injectable cabotegravir, administered every two months) for PrEP for those who cannot use oral PrEP. This includes people for whom oral PrEP is medically contraindicated, people who cannot take tablets, and people for whom oral PrEP is unsuitable because of social or personal circumstances, such as the conditions described above. We must also innovate our delivery models and make different forms of PrEP available beyond the clinic, in alternative settings, to increase choice, which is being addressed by current pilots and interventions in different parts of the UK (e.g. digital PrEP; outreach clinics).

Our PrEP-Position study seeks to contribute to creating the evidence needed to support widening access for more equitable PrEP provision to underserved populations through innovation and community-based solutions. Based on the evidence gathered from our study, this report introduces community co-produced statements that serve as recommendations for a variety of stakeholders to improve the state of PrEP provision in the UK, with the aim of achieving equity in HIV prevention with PrEP. Drawing on participatory, community-based research, it outlines the process by which survey and interview data, coupled with lived experiences, were transformed into recommendations for change. This report centres community voices and highlights how co-production led to creating key priorities for equitable PrEP.[1]

[1] A complementary advocacy toolkit is under development to support communities and stakeholders in the use of these recommendations

Methodology

In order to engage populations commonly underserved, the study was designed intentionally to include groups with lower PrEP uptake such as; women (cisgender or transgender) from a racially minoritised backgrounds, non-binary and transgender individuals, racially minoritised men who have sex with men (MSM), racially minoritised men who identify as heterosexual, recent migrants, people experiencing insecure housing or homelessness, people who inject drugs, and sex workers.

The study adopted a participatory, mixed-methods, community-based, and co-production approach. The study was conducted entirely in collaboration with our community lead partner, the Sophia Forum, who led, chaired, and facilitated our study Steering Group (SG). The SHARE collaborative and Sophia Forum worked towards an institutional co-leadership model approach through iterative dialogue processes that embedded community expertise across all methodological stages, ensuring research remained anchored in lived experiences throughout the project lifecycle.

Ethics approval for Phases 1-3 (co-production activities) was obtained from the Queen Mary University of London Global Public Health Devolved Ethics Committee (ref: GHDE_2425_02, 12th December 2024). Ethics approval for survey and interview primary data collection (Phases 4-8) was obtained from the Queen Mary University of London Ethics of Research Committee (QMREC) (ref: QME25.0655, 3rd July 2025).

We were inspired by the **James Lind Alliance (JLA) Priority Setting Partnership (PSP)**, a method for conducting health research equitably and inclusively that involves patients, carers, and healthcare professionals in setting the research agenda, and used some of their principles to approach our priority setting co-production partnership (16).

The co-production methodology began with joint workshops mapping community-identified PrEP access gaps against existing data in the literature (phase 3, Figure 1), followed by co-design of recruitment strategies leveraging community trust networks. Questionnaire items were iteratively improved through Steering Group testing to ensure cultural appropriateness, while continuous feedback during data collection allowed adjustments to participant recruitment. Interview topic guides were also reviewed, discussed and finalised with the steering group. Community members co-interpreted analysis findings during validation workshops, maintaining methodological rigour while anchoring research priorities in situated community experiences throughout design, implementation, analysis, and dissemination.

From the survey and interview data, we determined preliminary key themes and findings, which we presented to the Steering Group. The Steering Group then assessed their alignment to these findings with their lived realities and refined them into priority areas. The Steering group was asked:

- Which findings surprised you the most?
- What is one immediate change you would prioritise based on these results?
- In your opinion, what is the single biggest challenge we face moving forward?

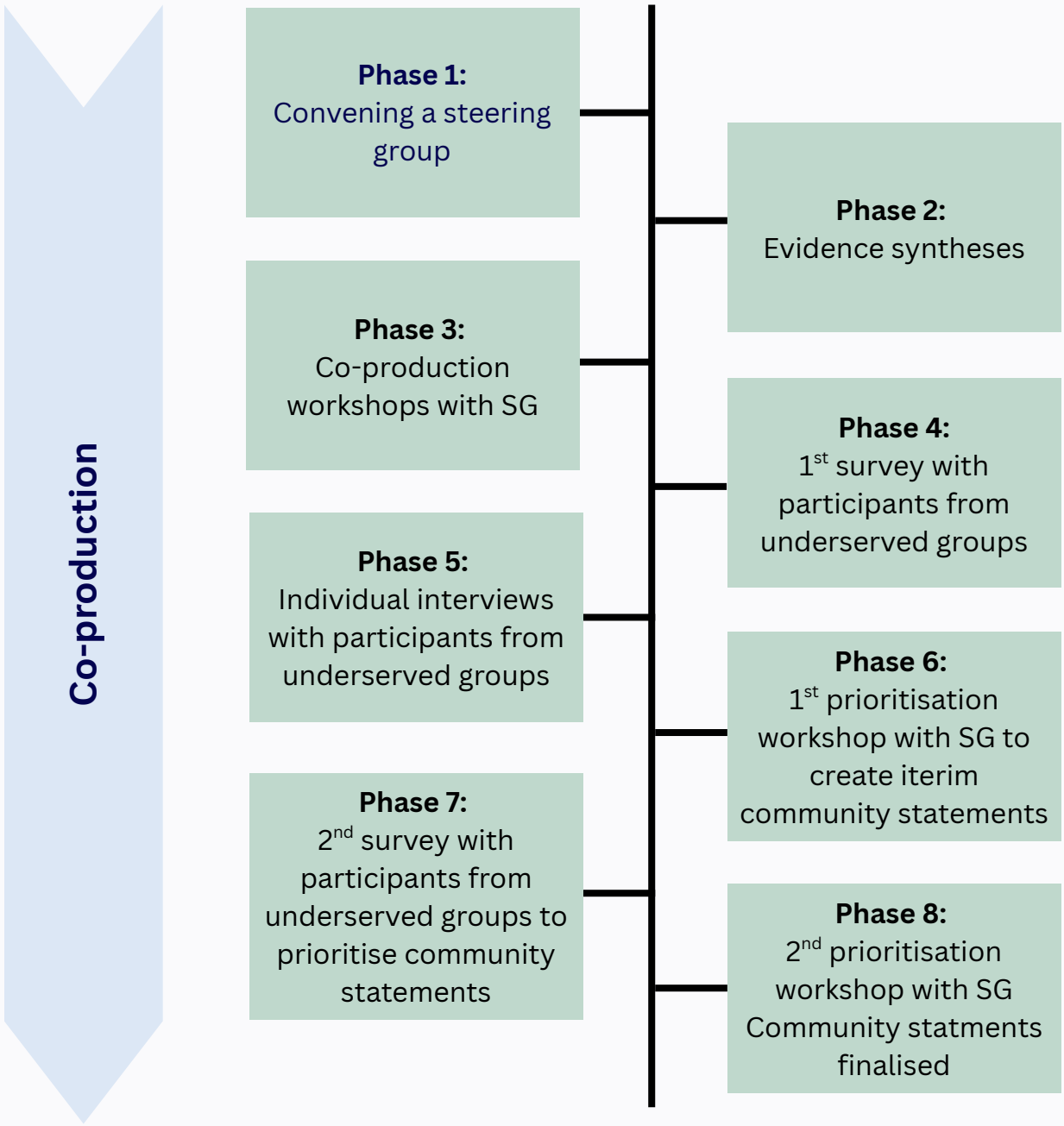
The priorities were returned to the research team for reworking and were then presented to survey respondents via a second survey, which respondents then ranked in order of perceived importance. Following this survey, Steering Group members further refined the statements, resulting in **14 'Community Statements' that express what underserved communities believe needs to change to make PrEP provision more accessible, inclusive and effective**, presented in this report. The Steering Group was critical in reformulating language that sounded academic or medical to establish priority statements that carried the most weight among their communities for real-world change.

This process created iterative cycles where community judgment continuously shaped analytic outputs until consensus emerged on wording and priorities, constituting the practical work of co-production. Co-production ensured each statement accurately reflected what communities actually need and experience with PrEP. The process enabled participants' voices to be transformed into concrete, legitimate recommendations, where the knowledge of those living these realities is fully integrated with the research team's analysis.

To protect the integrity of the prioritisation approach, an independent facilitator with relevant lived and sector experience worked alongside the research team, the Sophia Forum, and the Steering Group to ensure adherence to JLA principles, foster trust, and enhance contextual sensitivity.

Methodology

Figure 1: Study Phases



*Further details of the study phases can be found in Appendix 1

Community statements

The community statements are situated and co-produced recommendations that express a range of voices. They are derived from:

1. The perspectives and experiences of PrEP-Position participants (survey and interview respondents, demographics available in Appendix 2)

2. Our community engagement outreach to support study recruitment, which was extensive and included a period of stakeholder mapping in which we identified a range of (over 200) community organisations that could support truly inclusive recruitment, which was UK-wide and as balanced as possible.

3. The statements were then further prioritised by the Steering Group. The Steering Group consisted of members representing a range of intersectional identities who work with and for a variety of communities.

Taken together, participants, steering group members, outreach organisations and the multidisciplinary study team as a whole brought experience across community engagement, advocacy, social justice, sexual health, healthcare and work with women, racially minoritised communities, transgender communities, migrants and asylum seekers, people who have experienced intimate partner violence, people with neurodiverse needs, people experiencing homelessness and people who use drugs. The list is not exhaustive as groups, needs, and issues overlap and change over time. As a result, **these statements convey a synthesis of diverse voices and communities with heterogeneous experiences and opinions and should be seen as such, rather than as an attempt to be representative of all demographics and populations.**

How this report works:

The 14 statements have been grouped into four priority areas:

A – Changing the conversation

B – Improving how you access care

C – Community leadership and peer support

D – Understanding and improving health systems

We offer, for each priority area, evidence from our study, the interpretation and reflections from the steering group, and the relevant statements. We also highlight many community organisations that have done extensive work in the sector. The interpretations and reflections from the steering group synthesise the main points and themes of discussion in the first prioritisation workshop, attempting to highlight how they interacted with the findings from the study and how they translated those into the community statements.

Community statements

Priority area A: Changing the conversation

- Change how we talk about HIV prevention, shifting the focus from risk to supporting individual needs and choices.
- Use respectful, judgement-free language that avoids stigmatising specific groups or making assumptions based on relationship status and sexual activity, ensuring everyone who needs PrEP feels welcome to access it.
- Shift the focus to prevention as a part of holistic, personal health decision-making and away from sexual behaviour share messages that PrEP is a standard, proactive health choice.
- HIV prevention messaging should be designed to normalise prevention decisions as a routine part of overall well-being, empowering individuals to make informed and proactive health choices.

Priority area B: Improving how you access care

- Offer a range of ways and places for people to access HIV prevention (both for modality and for settings) to ensure fair access to accommodate various life circumstances.
- Design flexible, person-centred HIV prevention services that function as safe, welcoming, and judgment-free spaces, regularly re-evaluating individual needs and goals as life circumstances evolve to actively counteract the stigma and hostility faced by marginalised groups.
- Design HIV prevention service models that prioritise equity and flexible access, implementing diverse culturally sensitive options (including digital pathways) to account for social determinants of health and the unique circumstances of people with high mobility, housing insecurity, or unstable socioeconomic backgrounds.
- Use discreet, confidential access points to avoid compromising an individual's security or status when they are seeking help with their health.

Priority area C: Community leadership and peer support

- Sustain funding for community-led initiatives over service-led models, increasing resources to deliver culturally competent information and access in informal, de-medicalised settings where individuals feel comfortable.
- Sustainably fund dedicated, paid community outreach and peer support roles, prioritising hiring from key populations (e.g., sex workers, trans people) to ensure high-quality, representative work.
- Invest in community-led awareness campaigns to innovate and deliver culturally appropriate PrEP and HIV prevention information. Communications strategies must prioritise these flexible, tailored initiatives over models constrained by institutional regulations to reach diverse populations effectively.

Priority area D: Understanding and improving health systems

- Integrated Care Boards/local authorities must conduct local needs assessments to accurately identify their population, informing targeted service provision for all groups, and conducting focused research on the cultural, social, and economic factors driving HIV transmission.
- Deliver HIV prevention through a health service model that properly integrates specialised HIV prevention, sexual health, mental health, and primary care services, and meets the complex and interconnected needs of marginalised people.
- Direct advocacy efforts immediately towards securing policy direction and funding alignment for new prevention technologies, such as long-acting PrEP options, to ensure the prevention landscape remains effective and equitable.

Changing the conversation

Priority area A

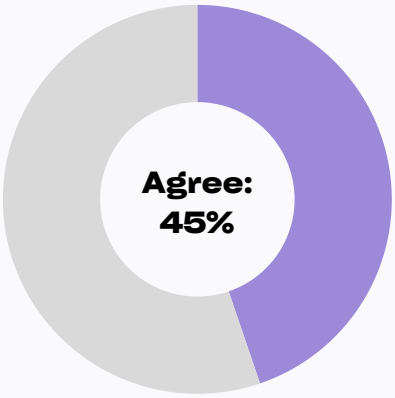
29% **think their HIV risk is too low to be taking PrEP**

30% **don't think PrEP is for people like them**

Findings from PrEP-Position highlight how existing HIV prevention messaging centred around 'risk' and 'behaviour' did not resonate with participants. Many participants who took part in qualitative interviews were not taking PrEP or did not feel the need, as they did not perceive they could benefit from it, or that they may be 'at risk'. Their decisions were commonly based on 1) their relationship status or 2) perceived low sexual activity. Participants also did not view themselves as suitable for PrEP due to common misconceptions that it is intended for specific groups, such as gay, bisexual, and other men who have sex with men (GBMSM) and/or for those who are frequently sexually active with multiple partners.

The Steering Group reflected on both the study findings and their own lived and working experience to build on the voices of the community of people who were interviewed and completed the survey to develop recommendations for improving how PrEP is discussed and framed. They identified perceptions of "risk" as a central issue, noting that one of the key challenges is making PrEP feel relevant and accessible to everyone, rather than to a narrowly defined set of groups. They emphasised that using language associated with risk not only causes people to disengage but also fail to connect the dots from their own behaviours, relationships, and needs. For example, people in perceived monogamous relationships often assume that they're not at risk of an STI and may interpret the suggestion of PrEP as implying infidelity.

'I am concerned about how others might percieve me for taking PrEP'



Risk-based messaging focused on sexual behaviour was viewed as exclusionary and discriminatory, reinforcing stigma among communities. Reframing PrEP away from risk and towards personal care or responsibility was viewed as key to addressing stigma and increasing relevance. By providing the tools for people to consider their needs in relation to PrEP, it provides them with ownership over their health.

These reflections were resolved into **four statements:**

- Change how we talk about HIV prevention, shifting the focus from risk to supporting individual needs and choices.
- Use respectful, judgement-free language that avoids stigmatising specific groups or making assumptions based on relationship status and sexual activity, ensuring everyone who needs PrEP feels welcome to access it.
- Shift the focus to prevention as a part of holistic, personal health decision-making and away from sexual behaviour share messages that PrEP is a standard, proactive health choice.
- HIV prevention messaging should be designed to normalise prevention decisions as a routine part of overall well-being, empowering individuals to make informed and proactive health choices.

Improving how you access care

Priority area B

56% reported experiencing racism in healthcare

82% want safe and welcoming spaces to discuss PrEP

49% have experienced prejudice based on their gender identiy in healthcare

PrEP-Position examined participants' preferences regarding the setting and modality of PrEP delivery. Preferences were based on concerns of stigma, discretion, convenience, accessibility (geographical / travel) and comfort. Discrimination and prejudice in healthcare were evident among groups such as transgender people, sex workers, and racially minoritised populations, leading to a resistance to seeking care out of fear of judgment or medical mistrust. Furthermore, current service models that require patients to travel to clinics and navigate booking appointments were described as exclusionary, particularly for people with disabilities or neurodivergence. Participants emphasised their need for discretion and privacy, particularly with family and community members.

The Steering Group discussed ways in which PrEP could be made more accessible to suitable populations, including expanding service settings, modalities and emphasising the importance of judgement free care experiences. They highlighted that the current provision of PrEP exclusively at sexual health clinics reinforces stigma and limits reach. They expressed a strong preference for increasing both access points and modalities of PrEP (e.g., long-acting injectables) to allow for choice and to increase uptake. Central to this discussion was the belief that choice is essential for equity in care, not just an added benefit. **Given the complexity of people's lives, the absence of choice results in exclusion from care.** Steering Group members also emphasised that individuals' needs and preferences are not static; they may change over time depending on factors such as relationship status, occupation, and housing stability. Mobile populations can experience disruptions in care due to unstable and insecure housing, leading to poor adherence. The group emphasises that services need to reflect these needs and barriers. The group also underscored the importance of local services, considering the hostile political climate and the rise in hate crimes among marginalised populations such as transgender people and migrants. They stressed the need to recognise how the rise in hate crimes is affecting people's access to health services and their willingness to engage with care.

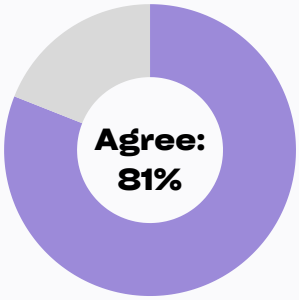
These considerations led to **four statements:**

- Offer a range of ways and places for people to access HIV prevention (both for modality and for settings) to ensure fair access to accommodate various life circumstances.
- Design flexible, person-centred HIV prevention services that function as safe, welcoming, and judgment-free spaces, regularly re-evaluating individual needs and goals as life circumstances evolve to actively counteract the stigma and hostility faced by marginalised groups.
- Design HIV prevention service models that prioritise equity and flexible access, implementing diverse culturally sensitive options (including digital pathways) to account for social determinants of health and the unique circumstances of people with high mobility, housing insecurity, or unstable socioeconomic backgrounds.
- Use discreet, confidential access points to avoid compromising an individual's security or status when they are seeking help with their health.

Community leadership and peer support

Priority area C

‘I would like support networks with people who share similar experiences’



Interviews highlighted a strong preference for community-led, informal approaches to accessing PrEP, particularly within queer and LGBTQ+ spaces such as gyms, clubs, events, and online platforms. These findings suggest the value of delivering services in de-medicalised settings where individuals feel more comfortable, especially given experiences of stigma in GP and sexual health clinic environments. Participants emphasised that community-based delivery led by peers, individuals with lived experience, or queer and trans people could also help destigmatise PrEP and increase awareness. Across groups, participants identified barriers related to health literacy, noting that medical terminology can be inaccessible and that information is often not available in preferred languages, especially for migrant communities. Some participants also suggested expanding outreach through schools, colleges, social media, and festivals, using more accessible, “down-to-earth” approaches.

The Steering Group emphasised that marginalised populations often express relational mistrust of institutions (i.e., the NHS, academic institutions) and healthcare providers due to prior experience and thus advocated for more community-led initiatives. Mistrust is not something people ‘have or do not have’, but rather a product of historical and systematic racism, medical exploitation, and discrimination in healthcare and is caused by institutions themselves. The SG highlighted the demand for informal settings and for embedding outreach into existing spaces and events, emphasising the need for and importance of advocacy and outreach led by peer workers or community representatives. They emphasised that it is crucial to go beyond outreach, and work to give power to the communities to lead

80% reported they would like more community led-iniatives

initiatives, rather than solely advise or consult. The group also stressed the importance that outreach roles be valued and paid adequately, as uncompensated community engagement is unrealistic and inequitable. Even if individuals are willing to participate, the role requires time and energy and may be impossible to undertake without financial compensation, especially for marginalised populations. Much of HIV prevention literature and resources use biomedical or academic language, which can be particularly challenging for people for whom English is not the first language or people with low health literacy levels to understand. Institutions are often bound by certain policies around language and what they can share, hence enabling community organisations to take control would improve engagement and effectiveness.

The steering group translated these considerations into **three statements**:

- Sustain funding for community-led initiatives over service-led models, increasing resources to deliver culturally competent information and access in informal, de-medicalised settings where individuals feel comfortable.
- Sustainably fund dedicated, paid community outreach and peer support roles, prioritising hiring from key populations (e.g., sex workers, trans people) to ensure high-quality, representative work.
- Invest in community-led awareness campaigns to innovate and deliver culturally appropriate PrEP and HIV prevention information. Communications strategies must prioritise these flexible, tailored initiatives over models constrained by institutional regulations to reach diverse populations effectively.

Understanding and improving health systems

Priority area D

93% reported they like the idea of longer acting protection

Findings from PrEP-Position highlight the fact that different populations have different needs, awareness, preferences, and barriers regarding HIV prevention care that change. Individuals' reasons for low awareness or uptake of PrEP differ due to various cultural, social, and economic factors. For some, they don't want to take PrEP as they associate it with stigmatising beliefs about certain populations or behaviours. Some may not feel comfortable going to sexual health clinics. Others may lack knowledge or awareness about PrEP, as sexual health is not a topic for conversation in their communities. These findings emphasise that a substantial proportion of PrEP suitable individuals require more coordinated and integrated care.

The Steering Group emphasised that a 'one-size-fits-all' approach doesn't work, and that needs vary by geography, population, circumstances, and social context. Needs also change over time, and assessments and research should be conducted continuously to understand communities. They called for local authorities and commissioners to consider these factors when identifying health barriers and designing services, recognising that current models are frequently failing to reflect the complexity of people's lives. The group emphasised that when designing and implementing new models of service delivery, it is important to consider moving beyond clinical and hospital-based models of delivery and creating more community-based options for accessing PrEP, such as through GPs, pharmacies, and other trusted spaces. Digital and remote models of service delivery were seen as particularly important for reaching communities and individuals who may face challenges or not have the time to access traditional clinic-based services. These were a

18% **reported that they cannot access PrEP easily**

all seen as essential for equity and meeting the needs of underserved populations. There was also a clear emphasis on the need for investing in long-acting new technologies to ensure equitable care. These new methods also need to be implemented and marketed equitably, so that they are reaching all populations who may be suitable.

These were resolved into **three statements**:

- Integrated Care Boards/local authorities must conduct local needs assessments to accurately identify their population, informing targeted service provision for all groups, and conducting focused research on the cultural, social, and economic factors driving HIV transmission.
- Deliver HIV prevention through a health service model that properly integrates specialised HIV prevention, sexual health, mental health, and primary care services, and meets the complex and interconnected needs of marginalised people.
- Direct advocacy efforts immediately towards securing policy direction and funding alignment for new prevention technologies, such as long-acting PrEP options, to ensure the prevention landscape remains effective and equitable.

Further resources

Community resources

We would like to highlight and amplify the valuable work being carried out by organisations and community groups across the sector to address barriers to PrEP access and HIV prevention. Thank you to all the community researchers and research academics who work to improve community experiences through lived experience voices.

Sophia Forum

Positive East

National AIDS Trust

PrEPster

Terrance Higgins Trust

AIDSMAP

The Love Tank

BHIVA

BASHH

NAZ Project

I-Base

Do It London

Africa Advocacy Foundation

Appendix

Appendix 1: Study Phases

Phase 1: Convening a steering group
To ensure the integrity of this adapted JLA process, we relied on the guidance and oversight of an SG comprising 12 members. The SG was chaired and convened by our Lead community partner, The Sophia Forum, in collaboration with the research team to ensure a diversity of perspectives and intersectionality with regards to identities and to represent a variety of underserved communities: non-binary individuals, cisgender and transgender racially minoritised men and women (and of different age groups including young adults), sex workers, LGBQ and heterosexual individuals, and people with varied experiences of migration to the UK (incl. refugees).

Phase 2: Evidence Syntheses
Both a targeted narrative literature review and a structured academic review were conducted for this study. The literature review was conducted by the research team and reviewed with the SG to inform the attributes, preferences, domains of experience, and recommendations for the following phases. The academic review explored different scenarios for developing cost-effective PrEP models in the UK, helping identify gaps in the evidence.

Phase 3: Co-production workshops with SG
Co-production workshops were held with the Steering Group (SG) to ensure that the design of the quantitative survey (Phase 4) and the qualitative interviews (Phase 5) was grounded in community priorities and lived experiences. These sessions provided a structured space for the SG to review and refine research questions, survey items, and interview guides, ensuring that the survey and interview questions were culturally relevant, accessible, and sensitive to the needs of the communities involved. The SG's feedback directly informed adaptations to language, question order, and the inclusion of topics they considered essential, thereby strengthening the validity and ethical quality of the subsequent data collection phases.

Phase 4: Quantitative Research
The study surveyed participants from three groups: current PrEP users, former PrEP users (those who have used but are not currently using PrEP), and people who have never used PrEP. The study aims to include people from underserved groups, such as:

- Women (cisgender or transgender) from a racially minoritised background
- Transgender men
- Racially minoritised men who have sex with men
- Racially minoritised men who identify as heterosexual
- Non-binary individuals
- Individual with recent migrant status (< 5 years in the UK)
- Someone experiencing insecure housing or homelessness
- People who inject drugs
- Sex workers

The survey asked participants about their knowledge/awareness of PrEP, modality preferences (i.e., interest in Long-Acting injectables), and their identity, sexual practices, and circumstances.

Phase 5: Qualitative Research
Qualitative interviews were also conducted with a subsample of survey participants to further understand the experiences of non-PrEP users or those who have stopped using PrEP.

Phase 6: Prioritisation Workshop with SG
The initial results and analysis from the survey and interviews were presented by the research team to the SG. During the workshop, the SG created an interim list of preferences and priority areas for the prioritisation survey.

Phase 7: Prioritisation survey
This survey was sent to all the participants from the original questionnaire (Phase 3) who agreed to take part in a follow-up survey. This survey asked participants to rank their most important preferences or influences regarding PrEP access and modality.

Phase 8: Second Prioritisation workshop with SG
The SG convened a final workshop to review the results of Phase 7 and continue discussion until sufficient consensus is reached on the final prioritised areas. The insights from this final phase have been and will be collated to co-design and implementation and advocacy toolkit to achieve maximum impact.

Appendix

Appendix 2: Study demographics

A) Qualitative interviews:

Sample Characteristic	N=38
Age	Median 34 years (range 23–56)
Gender	Cisgender men 13 (34%) | Cisgender women 13 (34%) | Transgender men/masc 6 (16%) | Transgender women 3 (8%) | Non-binary/Gender diverse people 3 (8%)
Ethnicity	White 13 (34%) | S/ME Asian 9 (24%) | Black African/British 3 (8%) |Black Caribbean 1 (3%) | Black British (heritage not disclosed) 3 (8%) | Latin American/Mixed 7 (18%) | Other 2 (5%)
PrEP experience	Never used 23 (61%) | Former user 14 (37%) | Recent user (on-demand) 1 (3%)

B) Survey

Population group* (n=264)	N	%
Racially minoritised cis/transgender women	83	31.40%
Sex workers	53	20.10%
Non-binary/transgender people	47	17.80%
Other racially minoritised heterosexual men	28	10.60%
Black heterosexual men	28	10.60%
Recent migrant (< 5 years)	29	11.00%
People who inject drugs	9	3.40%
Racially minoritised MSM	17	6.40%
Individuals experiencing insecure housing	10	3.80%

***Participants may belong to more than one group**

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