the CHURCHILL fellowship

PrEP in the community in the UK

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Contents

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Executive Summary

Background

Pre-exposure prophlaxis (PrEP) is a medication that is taken before an exposure to prevent the acquisition of HIV. Reaching the populations that need PrEP the most is an ongoing challenge as the UK pursues the goals of the HIV Action Plan to achieve zero HIV transmission by 2030.

New strategies for delivering PrEP outside of the traditional hospital and specialist clinic setting in the UK need to be developed. The pathways adopted by other countries can be used to broaden the UK's delivery of PrEP especially in the community. This project explores how the experiences of PrEP provision abroad can be utilised to enhance the UK's delivery through a Churchill Fellowship.

Methods

Various stakeholders involved in the delivery of PrEP in the UK were interviewed around the challenges of PrEP in the community and this information was then used to focus the research phase of the Fellowship which took place in the United States of America, France and online with organisations in Thailand and New Zealand.

Themes

The barriers and facilitators of providing PrEP in the community were established throughout the interviews of the research phase. Themes were extracted from the data gathered on barriers and facilitators and used to inform what might be the critical areas to focus on to optimise the use of PrEP in the community

Case Studies

A select number of organisations visited are presented in detail, demonstrating the real-life challenges of PrEP delivery and how these have been overcome.

Recommendations

The information drawn from the themes and case studies inspires specific recommendations which are listed in reference to the barrier or facilitator that they relate to. The recommendations are categorised to the organisation or relevant stakeholder within the UK that the recommendation is most relevant to.

1. Project Background

1.1 What is PrEP?

PrEP (pre exposure prophylaxis) against HIV is a medication that is taken to prevent the acquisition of HIV prior to an exposure to HIV. The two drugs used in PrEP have been extensively used in the treatment of HIV for many years and there is evidence for their effectiveness as prophylaxis to prevent HIV from as far back as 2011.

PrEP is freely available in the NHS from specialised sexual health and genitourinary medicine clinics with Scotland pioneering the process from 2017. England followed suit in 2020 after the Impact trial in 2017-2020 which demonstrated the suitability for delivering PrEP in the UK.

People living in the UK were accessing PrEP from other sources and other countries before it was available on the NHS. It is freely available in all of the devolved nations of the UK although access can be variable across England, Scotland, Wales and Northern Ireland.

In England, PrEP is considered a key preventative measure of the government's HIV action plan which outlines a strategy to end new HIV transmission by 2030.

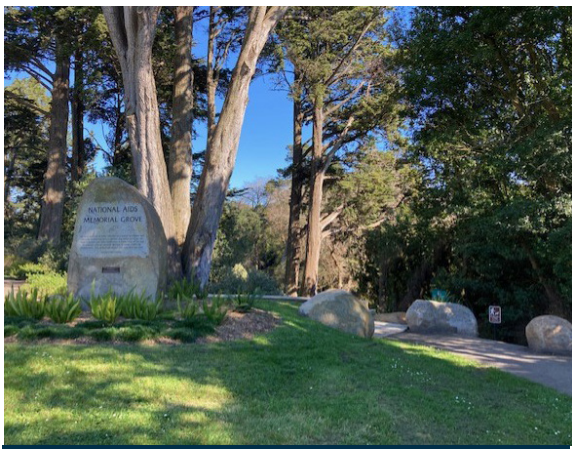
A 6% decline in the UK HIV incidence from 2014 until 2020 can be attributed to increased awareness and education, improvements in testing along with the advances in HIV prevention including PrEP.

1.2 The current status of PrEP Delivery in the UK

While there has been excellent uptake of PrEP throughout the UK the National AIDS Trust produced the 2022 document 'Not Prepared' which highlighted the difficulties in accessing PrEP in the UK.[1]

Many of the barriers presented when accessing PrEP will be faced by all populations who are at risk of acquiring HIV but there are more vulnerable groups of people which will be more severely impacted. The challenge in optimising PrEP as a most effective tool in reducing HIV transmission is in developing strategies to make PrEP accessible to all.

One approach to widening access to PrEP is to push its availability beyond the confines of city centre hospital settings and into the communities where people at risk of HIV might live. There is already extensive work being carried out in the UK to explore alternative pathways for providing access to PrEP to those that need it most. Some of this work involves the creation of clinics for specific populations or analysing the possibility of hosting PrEP clinics in entirely different environments for example in pharmacies.



National AIDS Memorial Grove, Golden Gate Park, San Francisco

1.3 My Fellowship

The way sexual health is addressed and resourced varies significantly across the globe. There is a great opportunity for us here in the UK to learn from the flexibility of other governments, public health departments and healthcare organisations in how they deliver PrEP.

As a senior specialist registrar training in genitourinary medicine I prescribe PrEP daily but also do several clinics per week giving treatment and monitoring to those patients living with HIV. Although excellent treatment now exists for those living with HIV, it is lifelong treatment which requires regular follow-up and is therefore different to preventative measures which can be episodic, adjusted or stopped.

For all of us working on the front line in the NHS the challenge for patients accessing care, especially those navigating the system for the first time, appears very stark.

I worked in the Royal Liverpool University Hospital sexual health department when the PrEP Impact trial rolled out PrEP medication to those at risk in 2017. It was eagerly anticipated by many patients and indeed many of them had already been purchasing PrEP privately. However, as PrEP became more widely available it was obvious that uptake was high in white gay, bisexual and other men who have sex with men (GBMSM) populations but less so in other populations that are at risk of HIV.

1.4 Locations

I had already thought about tapping into the use of PrEP in different environments but I wanted to ensure that the projects I explored covered the following areas given that my research time was limited:

- Places with similar populations to the UK
- Places with a similar healthcare infrastructure to the UK
- Representation of places with less resources or lower socio-economic growth
- Representation of places most impacted by HIV

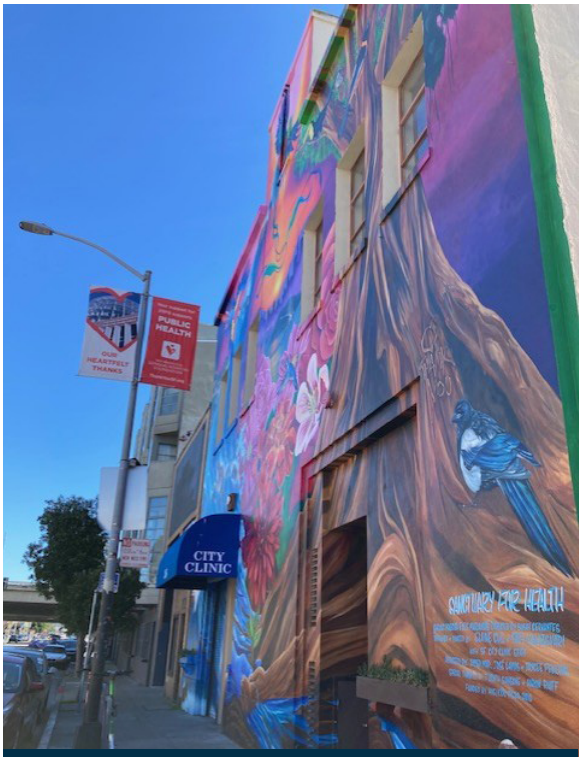
Clearly it is not possible to cover every project in every country and get a deeper appreciation of PrEP delivery in the community in all countries. I did some extensive online researching of Google, aidsmap, HIV i-base, the World Health Organisation website, X (formerly Twitter) and Instagram to create the foundations of where to start when looking for projects.

The vast majority of community projects that delivered PrEP were based in the USA, so this was an obvious choice for a visit. Some of the organisations I found in the USA involved research on PrEP in Kenya and other areas disproportionately affected by HIV.

I was really intrigued by a Covid-19 pandemic project I read about in Thailand where lay people delivered PrEP to people attending sex on premises venues like saunas during the pandemic. I was interested to see if Thailand tailored their PrEP provision to local HIV prevalence rates in a country with relatively high rates of HIV.

Having worked in Aotearoa/New Zealand in a rural area with the highest proportion of Māori in the country I was very aware of the cultural barriers facing Maori in accessing healthcare. I decided to include a New Zealand/Aotearoa organisation to learn more about the challenges with traversing cultural barriers in providing PrEP for other groups.

Finally, I was impressed by the breadth of prescribers writing scripts for PrEP in France and was interested in how healthcare workers provided PrEP in a country with high rates of immigration.



San Francisco City Clinic

2.Methodology/Research

2.1 Gaining insight and making contacts

In an attempt to garner a broader insight to the challenges of developing community PrEP in the UK, I decided to speak with as many stakeholders working in sexual health and HIV healthcare promotion, treatment and delivery as possible. I was keen to collate their thoughts on the current state of affairs for UK PrEP delivery.

Through NHS work connections and email I was able to arrange online meetings with the following individuals. The honesty, expertise and kindness of these individuals in giving up their time to focus my research cannot be underestimated.

- Dr John Saunders, UKHSA Lead for the National Institute of Health and Care Research (NIHR) Health Protection Research Unit (HPRU) in Blood Borne and Sexually Transmitted Infections (BBSTI) at University College London (UCL)
- Daniel Fluskey, Director of Policy, Research, and Influencing at National AIDS Trust
- Prof Jeremy Horwood, Professor of Social Science and Health at Bristol Medical School
- Adam Winter, Head of Sexual and Reproductive Health at Department of Health and Social Care
- Dr Will Nutland, Co-founder of PrEPster, a grass roots group that educates and advocates for access to PrEP
- Prof Matt Phillips, President of the British Association of Sexual Health and HIV.

I learned a vast amount from speaking with this group of individuals who have had pivotal roles in the delivery of PrEP in the UK. I was able to get first-hand accounts of the challenges that lie ahead with developing PrEP delivery in the community.

Many of these connections were made through opportunistic emailing, finding emails online in medical journals and on organisational websites. There were connections made through word-of-mouth or through colleagues who were very generous with their time among the sexual health, genitourinary medicine and HIV community.

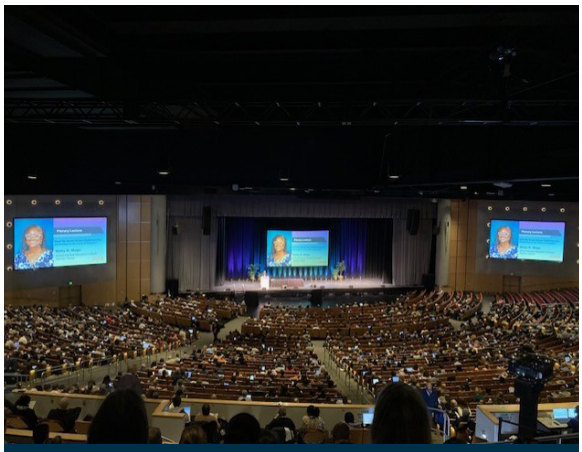
The majority of these meetings were done on Microsoft Teams making notes with the idea scrambled together then forming the basis for a questionnaire, utilised to collect information from the organisations I would speak with abroad.

2.2 Reaching out internationally and CROI 2024

I took a similar approach when organising meetings with the chosen countries to link-in with. As far back as 2022 I started emailing contacts in the USA and Thailand to arrange visits. I established connections with partners through email or Teams meetings and later when visit dates were created touched base again. An initial Teams meeting often opened many doors and they would lead to a plethora of new contacts. If I was unable to get through by email I rang up clinics and tried to make contacts that way.

This was time consuming, especially when trying to organise meetings in between night shifts, revising for exams and long commutes with full-time work. Time-consuming but rewarding and night shifts certainly helped with Teams calls on a time difference!

I set off on my travels having gathered significantly fewer contacts than I would have liked. I had learned from one of my contacts that the Conference for Retroviruses and Opportunistic Infections (CROI) 2024 would be taking place at the start of the trip. I thought this would be an exciting and educational event to attend but was naïve to how useful it would be in generating a significant number of contacts in San Francisco. The power of meeting people face-to-face rather than through emails was demonstrated…as an old colleague once said, 'most of medicine is just showing up.'



CROI Conference, Colorado Convention Center, Denver 3rd-6th March 2024

CROI was an amazing conference and really showed the breadth of HIV research being done across the world. It was particularly interesting to learn about a wide range of PrEP projects from motorcycle delivery of PrEP in Kenya to persistence on contraception and PrEP in hair salons in South Africa along with how countries like Australia and France are delivering PrEP. The conference gave a platform to the countries most impacted by HIV and it was amazing to hear Frank Mugisha speak. Mr Mugisha is a Ugandan LGBT advocate and Executive Director of Sexual Minorities Uganda, who has won the Robert F. Kennedy Human Rights Award and Thorolf Rafto Memorial Prize 2011 for his activism.

CROI Conference, Colorado Convention Center, Denver 3rd-6th March 2024

2.3 Interviews and data collection

Initially I had endeavoured to carry out formalised, structured interviews but as time went on the interviews would appear organically depending on the role of the interviewee and how much time they had and whether the meeting was opportunistic e.g. a chance meeting at the CROI conference or if I walked into the clinic or pharmacy hoping to meet them.

People were extremely generous with their time and I would always have some structured questioning around barriers and facilitators. I always tried to get an idea of what interventions interviewees thought might change PrEP provision in their community.

Meeting Dr Oliver Bacon, Medical Director, San Francisco City Clinic, a contact made at CROI

When I returned I transcribed all of the recorded interviews (about 30 hours in total) and later I manually highlighted the facilitators and barriers to PrEP while making note of any recommendations the interviewees had made. I manually coded these and later looked at the frequencies of the data gathered, arranging them into different groups.

2.4 Knowledge to action Framework of Implementation Science

In order to bridge the Know-Do gap I adapted the conceptual framework of Knowledge to Action by Graham et al during my project.[2] This allowed me to apply the theory of what I was learning and collecting in interviews to enhance the implementation and dissemination of my findings into UK healthcare policy and guidelines. The framework concentrates on knowledge creation and an action cycle and throughout my work I attempted to answer the following questions:

- Why have we undertaken this work?
- What is the key message we need to communicate?
- Who is our key audience for this communication?
- How are we going get the message across?

3 Findings

3.1 Global locations of organisations and visits

3.2 Visits

17 organisations engaged

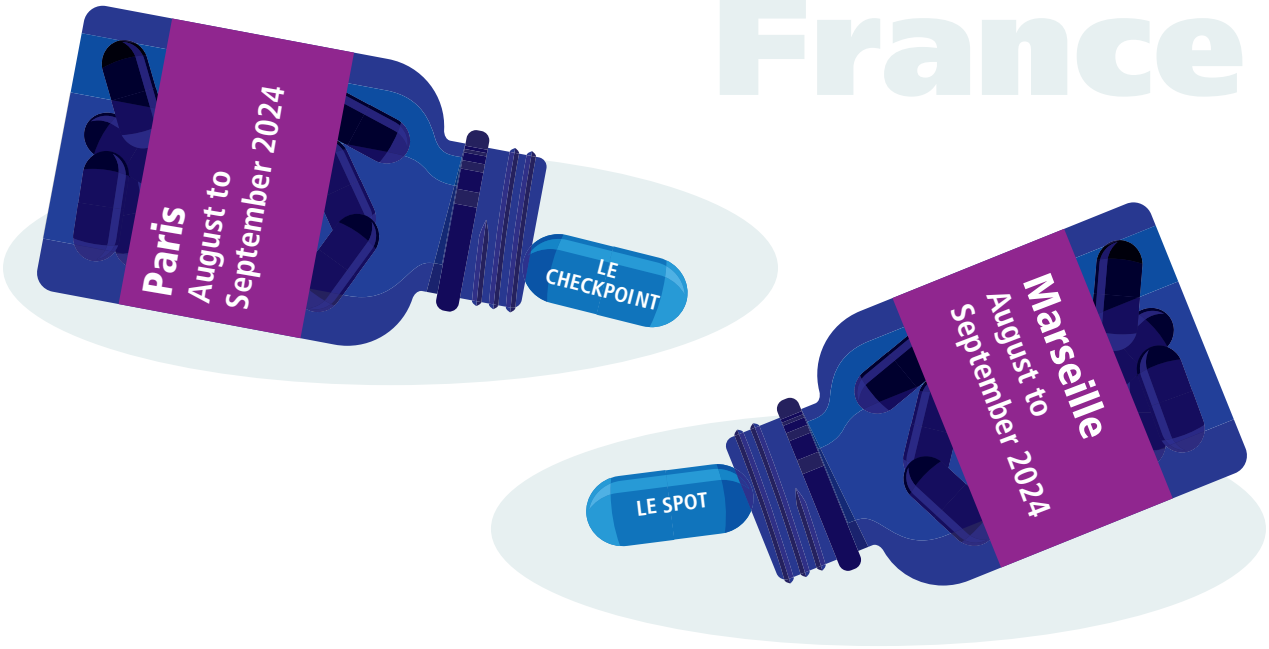
35 individuals interviewed

17 face-to-face interviews

5 online meetings

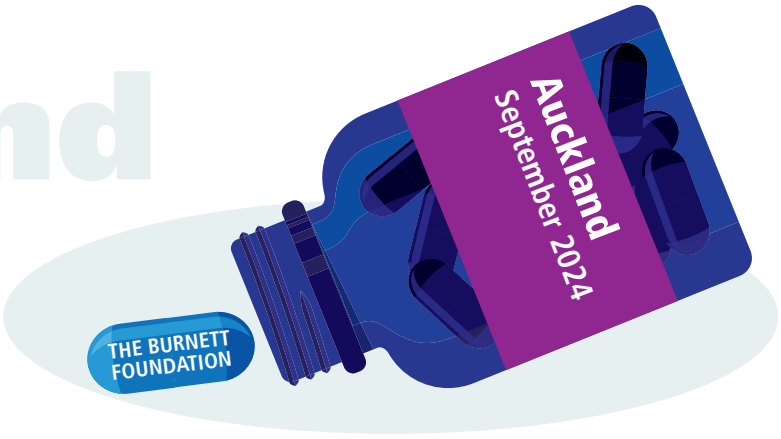
31 meetings (9 in the UK; 22 overseas)

France



Thailand

New Zealand



3.3 Data

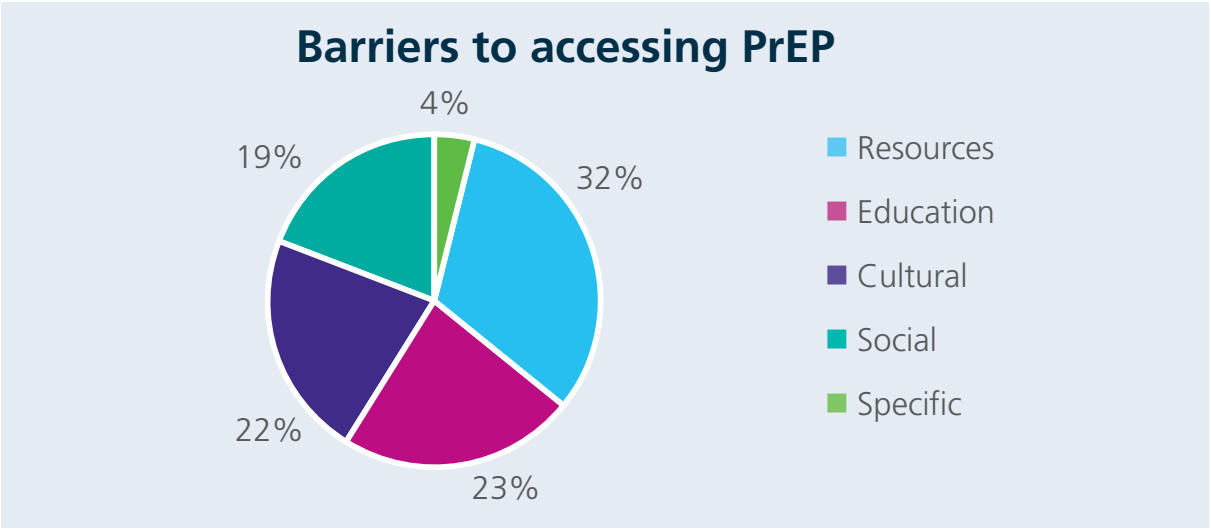
During the analysis of the interviews, comments, discussions and responses to questions were labelled accordingly as barriers and facilitators to PrEP access.

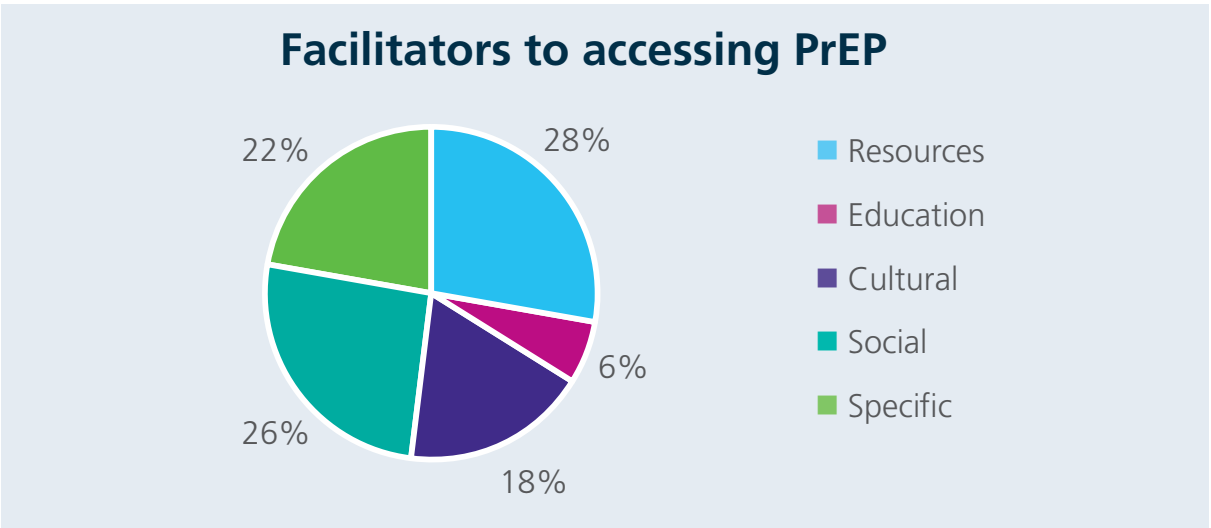
It is useful to break down the data into themes as this helps focus the areas that are to be addressed in the recommendations for improving services.

Barriers and facilitators identified in the 22 interviews fell into 5 main domains (resources, education, cultural, social and specific) and individual barriers were mentioned 247 times (barriers) while facilitators were mentioned 271 times.

Resources was the most common barrier theme, mentioned in 32% (79/247) of responses but also formed 28% of facilitators suggested by interviewees. Cultural barriers appeared to be a bigger problem in France (36%) compared to the USA (18%) while the majority of barriers in New Zealand were social (33%).

Along with the themes, the frequency of individual barriers and facilitators are highlighted here. Given this data reflects common factors reported by all organisations it suggests that the particular barrier/facilitator could be more relevant and this is discussed in more detail in Section 4. Themes.





3.4 Significant barriers and facilitators to PrEP provision

Most frequently identified barriers to PrEP provision of 247 responses

Resources Education Cultural Social

Resources Phlebotomy, 12	Financial, 10	**Social** PrEP deserts, 11	**Education** Workforce/ medical school education, 9	Medical Colleague Resistance/ Demedicalise prep, 9
Staffing, 10	Clinic space, 9	Transportation/ Geography, 10	**Cultural** Stigma, 10	

Most frequently identified facilitators to PrEP provision of 271 responses

Resources Education Cultural Social

Resources Demedicalise PrEP, 12	Integrated healthcare provision, 10	**Social** Community Champion, 16	**Cultural** Partner Organisations, 10	Workforce reflecting the community/ LGBTQ friendly, 9
Safe location/ space, 10	Retention tool/App, 10	Opportunistic/ Walk-in, 10	**Education** Staff, 8	

4. Themes

4.1 Resources

Castro district, San Francisco

Clinic resources play a dual role as both a barrier and a facilitator in developing PrEP delivery within the community. Limited access to point-of-care testing and blood monitoring can hinder timely PrEP initiation and follow-up, especially in resource-constrained settings. Additionally, a shortage of **skilled staff or high turnover rates** may impact continuity of care, making it difficult for patients to receive consistent PrEP services. Insufficient **public health financial support** further restricts clinics from expanding their services or investing in necessary infrastructure.

However, well-resourced clinics with strong retention and follow-up plans can enhance PrEP accessibility by ensuring patients receive ongoing care and **adherence support. Demedicalising PrEP** by shifting delivery from doctors to trained pharmacists, nurses, and lay providers can alleviate pressure on the healthcare system while expanding access to a broader population. This approach enables more flexible, **community-based service models that integrate PrEP into pharmacies** and outreach programmes, ultimately improving uptake and **retention** in care. Professor Orlando Harris from University of California San Francisco suggested 'Our way of thinking about healthcare delivery, we need a paradigm shift around that. If we're trying to reach the most vulnerable.'

He lamented the uncertainly around the rollout of long-acting injectables that resulted in only the most privileged accessing it. He used the example of doctors initially only giving 30 days of PrEP medication to demonstrate how slow the demedicalisation process can be and how it could be much more seamless.

Public Health Seattle and King Country Sexual Health Clinic, Harborview, Seattle

4.2 Social

Social issues are embedded in the shaping of the delivery of PrEP outside hospitals, often creating disparities in access for those most at risk of acquiring HIV.

The **digital divide** can be a major barrier, as reliance on online appointment systems, telehealth consultations, and digital reminders may exclude individuals with **limited internet access or digital literacy**. This isolation not only affects PrEP uptake but also hinders access to essential services such as **STI testing and renal blood monitoring**.

Many projects have highlighted how technological advancements, while streamlining care for some, have **deepened disparities** for those in greatest need.

The **Covid-19 pandemic** made these inequities even more apparent, as testing and vaccination programmes often failed to reach the most disadvantaged populations, particularly **people of colour**, due to structural and logistical barriers. As Prof Harris from UCSF stated 'We've learned nothing from COVID and it's not lost on me that with every new advancement in terms of biomedical HIV prevention and treatment, we always seem to create new disparities for communities of colour.'

Addressing these social barriers requires targeted, inclusive strategies, such as **in-person outreach, non-digital appointment options, and culturally sensitive community engagement**, to ensure equitable access to PrEP and related healthcare services.

Beyond digital access, physical accessibility to PrEP remains a significant challenge. **Transport** and **clinic locations** can make the difference between whether a person is able to get PrEP or not. In both urban and rural areas, "**PrEP deserts**" exist-regions where there is little to no PrEP access, leaving at-risk populations underserved. Dr. Chase Cannon of University of Washington Harborview Clinic found this troubling. 'There's no real national system for PrEP access. It just depends which state you live in...so it deepens health inequities.'

Dr. Cannon acknowledged that although community based organisations did admirable work at filling in the gaps , it can be challenging for states to dedicate public funding when 'it's hard to identify if there are metrics, targets or clear accountability.'

The importance of bringing PrEP into the community has been demonstrated by projects like Magnet clinic at Strut in the Castro, San Francisco, which used **mobile clinics** to reach populations that otherwise wouldn't access PrEP. Similarly, the International Community Health Services (ICHS) in Seattle, set up PrEP services 45 minutes outside the city centre in North Seattle (see 5.4), highlighting the **geographic barriers** to access.

Professor Julie. Dombrowski of Public Health Seattle/University of Washington noted, that poorly planned PrEP delivery can create additional barriers. **Private pharmacies** were set up in Seattle malls, but these clinics struggled due to **lack of confidentiality for PrEP counselling** and their **inappropriate location** in areas of the city that already had ample PrEP services. The commercial failure of PrEP in these locations demonstrated that simply making PrEP available isn't enough—it must be **accessible in the right locations** with the **right support structures.**

An example of a private pharmacy in a shopping mall downtown Seattle

To successfully establish and **sustain PrEP services** in the community, nearly all projects highlighted the need for a **community champion** - a passionate individual who takes on the challenge of building new services. This can be someone from the community itself or an ally who understands the barriers and is committed to working from within.

A strong community champion plays a crucial role in **bridging gaps between the community, healthcare providers, public health agencies, and government entities**. They help **navigate bureaucratic obstacles**, form essential partnerships, and ensure that PrEP services are **both culturally appropriate and effectively integrated** into the community. Without this leadership, many initiatives struggle to gain momentum.

Addressing social issues such as the digital divide, physical access, and strategic service placement requires not just policy changes but also grassroots leadership and community-driven solutions to ensure equitable PrEP access for all.

'There's no real national system for PrEP access. It just depends which state you live in so it deepens inequities but with community organisations it can be hard to identify if there are metrics, targets or clear accountability.'

Dr. Chase Cannon, University of Washington Harborview Clinic

4.3 Educational

Many organisations have highlighted how the **presence, or absence of sexual health education in schools** directly influences awareness of HIV and PrEP.

Dr Chase Cannon at the Public Health Seattle/University of Washington Harborview Clinic emphasised that while there have been attempts to introduce education in schools, such as linking with school nurses to provide information on HIV and syphilis, **making changes at the state level** remains challenging. In King County, the level of sexual health education varies significantly depending on individual schools and municipal boards, meaning that many students may never receive information about HIV prevention or PrEP. Without this foundational knowledge, individuals are less **likely to recognise their own risk or seek out PrEP** when they need it. The lack of early education creates a **knowledge gap that persists into adulthood**, limiting PrEP uptake in communities that might benefit from it the most.

Meeting Dr Chase Cannon, Public Health Seattle clinic/University of Washington

Educational barriers also exist within the medical community itself. Many professionals I spoke with described experiences of **resistance from colleagues**-both within and outside of their specialties-toward the rollout of PrEP. In the early days of PrEP in the USA, scepticism surrounded its feasibility and impact on HIV prevention, despite strong supporting evidence. As PrEP became more established, new barriers emerged, particularly around **expanding PrEP delivery beyond specialist units**.

Dr Elyse Tung of the Kelley-Ross Pharmacy recounted the initial reluctance to allow non-medical professionals, such as pharmacists and nurses, to take on PrEP prescribing. Concerns over renal monitoring, prescriptions, side effects, and STI testing were frequently cited, but over time, solutions have been developed to **safely integrate PrEP into a broader range of healthcare settings**. However, lingering misunderstandings about PrEP continue to restrict its delivery to specialist sexual health clinics, reinforcing the **misconception that it is too complex for primary care or pharmacy-based models**.

The persistence of PrEP as a specialist-only service highlights the need for ongoing education within healthcare systems. Dr Budek of the Madison Clinic at Harborview/ University of Washington clinic in Seattle, questioned **why general practitioners can prescribe specialised psychiatric medications but often cannot prescribe PrEP**.

This resistance is not purely clinical but reflects a deeper **lack of awareness and institutional reluctance to adapt**. To address this, Dr Budek has worked on developing **educational templates to train non-specialist and non-medical providers** on how to prescribe and manage PrEP. These resources **help bridge the knowledge gap** among healthcare workers while ensuring that PrEP is **delivered in a way that resonates with diverse communities**. This approach represents an important non-formal educational pathway, equipping providers with the tools to communicate effectively with patients and integrate PrEP into routine care outside of traditional specialist clinics.

Omar Ramos-Gutierrez from International Community Health Services (ICHS) also pointed out that 'Care providers need to understand the options available to patients- daily, 211 or event based dosing and the availability of injectables. If their knowledge is not up to date-it's an immediate barrier.'

Overall, education (or the lack of it), remains a major factor in PrEP delivery. By **integrating PrEP awareness into early education, addressing resistance among medical professionals, and providing structured training for non-specialist providers, communities can work toward more equitable and widespread access to PrEP**, ensuring that those most at risk are given the knowledge and resources to protect themselves.

'Care providers need to understand the options available to patients- daily, 211 or event based dosing and the availability of injectables. If their knowledge is not up to date-it's an immediate barrier.'

Omar Ramos-Gutierrez from International Community Health Services (ICHS)

4.4 Cultural

Public Health Syphilis Poster en espanol, Downtown Seattle

Probably some of the most emotive and potent factors to influence PrEP delivery when I spoke with the partners abroad were cultural themes. This is likely to reflect PrEP delivery globally and can often be the most challenging aspect to induce change in.

Many of the partners highlighted **language** as a barrier - whether this was a **lack of community or colloquial language** or the **loss of direct communication** often driven by the **stigma of healthcare providers**.

Professor Orlando Harris, a nurse and researcher from UCSF, discussed the difficulties that gay black men had in accessing PrEP- providers were declining prescribing black men PrEP because they felt PrEP would encourage further sexual risk and this would lead to harm. The **paternalism** and **racism** were compounded by the **stigma from their own communities** around accessing HIV medication or attending clinics or locations that may reveal their sexuality. Professor Harris explained 'It's not as easy as getting a van together, get staff and go into the community. It's a layered onion.'

Meeting Prof Orlando Harris, Researcher, University of California San Francisco (UCSF)

> **'It's not as easy as getting a van together, get staff and go into the community. It's a layered onion.'**
>
> **Prof Orlando Harris,Researcher UCSF**

Stigma around PrEP is a huge issue and is found in organisations, staff and fellow members of the community. The ability to maintain **confidentiality** around medication appears to be a significant barrier especially in the context of immigrants. The International Community Health Services (ICHS) in Seattle, and Checkpoint Paris had seen the **fear experienced by immigrants** on PrEP

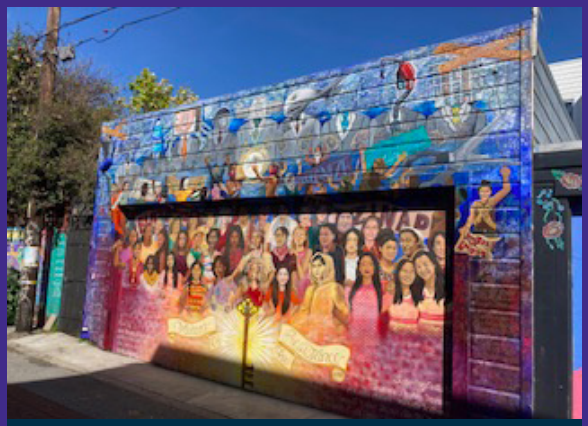
that the medication may be found by friends who might presume a diagnosis of HIV. Immigrants also **delayed the opportunity to access PrEP** for fear that staff would r**eport them to authorities**.

This also taps into how **PrEP was marketed** when it first became available. Whether it was pamphlets, advertisement billboards, on buses or on TV the target audience appeared to be white GBMSM over any other population including black men and heterosexual women.

Professor Orlando Harris speaks of how black men became aware of PrEP when seeing it on the profile of other men on **social media dating apps like Grindr** (another example of new technology creating new disparities).

Legislation and the bureaucracy that comes with it were seen as a barrier by several organisations. Maria Lopez of the Mission Wellness Pharmacy in San Francisco had a personal experience of dealing with **resistance among the medical community** on several issues when it came to pharmacists expanding their scope of practice. Maria was a terrific **community champion** knowing that the **location of the Mission Wellness Pharmacy** in the Mission district of San Francisco **accessible to a large Latinx community**, was in a prime position to reach out to those at risk of HIV. Maria adopted a role as a community champion when she approached other **allies and partner organisations** including a senator who was HIV advocate to produce legislation. This allowed pharmacies to **overcome the barriers** placed by medical colleagues over what was a territorial issue. Ultimately the right thing was done for patients and the community.

Mission Wellness Pharmacy, Mission District, San Francisco



Balmy Alley murals addressing Latin American human rights, Mission District, San Francisco

Workforce not reflecting the community is a theme that strands into a lot of complex issues around access to healthcare, and the layers of barriers that prevent accessibility to people that need it most. There is a striking picture in the foyer of the International Community Health Services Clinic (ICHS) in Seattle of the protests by Asian communities in the 1970s.

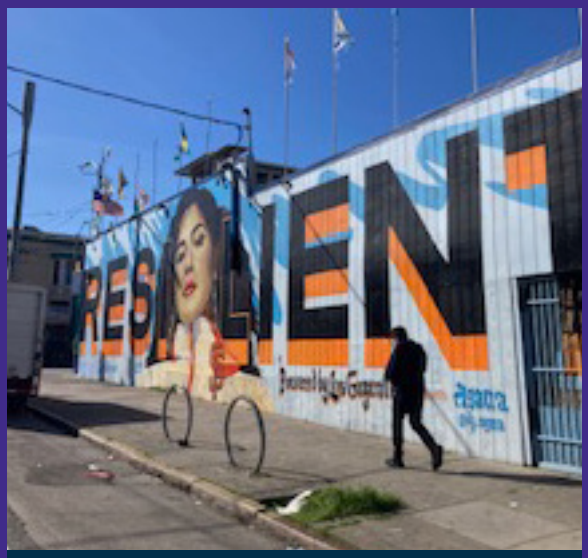
A woman holds a placard with '**Chinatown is not only a place to eat-people live there too**.' The ICHS was formed in the 1970s by a small group of student activists who set out to bring affordable health care to Filipino, Chinese and Japanese immigrants in the Chinatown-International district of Seattle (see 5.4). Many of the elderly residents were living in squalid conditions and

had not seen a doctor in years. Today there are multiple clinic sites, and the clinic operates in the outskirts of Seattle particularly in areas where there are high numbers of immigrants including Vietnamese and Latinx populations. The ICHS is **staffed with members of the community, which is essential for language and communication but also for developing a trust and empathy around situations** and an understanding through lived experience.

Poster in ICHS clinic, Seattle

The **historical legacy of medical discrimination** also continues to shape community attitudes toward PrEP and healthcare in general. Dr Joanne Stekler of the University of Washington pointed to the Tuskegee syphilis study and other medical experiments on black communities as a **source of ongoing distrust in the healthcare system**, which can discourage engagement with PrEP and other preventative care. This pattern is echoed in New Zealand/Aotearoa, where **Māori and Pasifika communities are underrepresented in the medical workforce**, leading to **lower healthcare engagement and PrEP uptake**. Entry requirements into medical school in Aotearoa had been adjusted for Māori students in the hope that this would trigger a seismic cultural change in healthcare. These examples highlight the **far-reaching impact of cultural history on current healthcare access**-without providers who reflect and understand the communities they serve, barriers to care persist.

Ultimately, addressing cultural influences on PrEP delivery requires more than just policy changes-it demands deep, community-driven engagement. From tackling **stigma and language barriers** to **ensuring diverse representation in the healthcare workforce**, PrEP programmes must be designed **in partnership with the communities they aim to serve**. Community champions, culturally competent providers, and trust-building initiatives are all essential in making PrEP more accessible and equitable across different cultural contexts.



Resilient. Street art in the Mission District, San Francisco

4.5 Specific

Several key aspects of clinic operations significantly enhance the accessibility of PrEP delivery in the community. One of the facilitators most frequently mentioned by interviewees was the availability of **walk-in and opportunistic PrEP services**. With busy lifestyles and the need for frequent STI testing and medication refills, requiring scheduled appointments can create unnecessary barriers. The ability to easily access PrEP refills before running out ensures **continuity of prevention** and reduces the risk of individuals **unintentionally transitioning from PrEP to HIV treatment**. Similarly, providing flexible PrEP access points, including pharmacies and community clinics, helps **remove logistical barriers and supports adherence**.

Patient autonomy in choosing between oral PrEP and long-acting injectables allows individuals to select the method that best suits their lifestyle and needs. While injectable PrEP presents additional logistical challenges, having alternative options can improve overall **uptake and retention**.

A more holistic approach to healthcare further enhances PrEP accessibility. Several clinics have successfully **integrated PrEP services with general healthcare visits**, allowing patients to access PrEP while seeking care for other medical concerns. This approach benefits both patients and healthcare providers-it minimises the need for multiple visits and ensures that providers have a full understanding of a patient's medical history. For example, initiating PrEP counselling during visits for long - acting contraception in obstetrics and gynaecology clinics or community sexual health services provides a **natural opportunity to introduce PrEP to individuals at higher risk of HIV**.

Expanding the workforce capable of prescribing PrEP is another critical factor in improving community accessibility. In the outskirts of Paris, community sexual health centres have adapted to train staff who can prescribe PrEP in areas of high prevalence of HIV, making PrEP more widely available outside traditional specialist clinics. **Demedicalising PrEP** and enabling lay staff, pharmacists, and non-specialist providers to take on prescribing roles ensures that **PrEP reaches populations who might not otherwise engage** with the healthcare system for prevention services. This approach was particularly emphasized in discussions with the University of Washington Harborview Clinic in Seattle and the Thai Ministry of Health, both of which highlighted the importance of adapting specialist models and training non-specialist providers using standardised protocols. Ensuring that staff are equipped with clear **templates and community-appropriate language** allows for consistent, high-quality care across different service settings.

5. PrEP in the community case studies

5.1 Case study 1: Kelley-Ross Pharmacy

Kelley-Ross Pharmacy at Seattle LGBTQ Center, Capitol Hill

Clinic background:

- Location: Seattle City Centre at two locations
- 1200 patients on PrEP
- 9 pharmacists, 4 FTE clinics per week

PrEP delivery

Dr Elyse Tung, is the clinical director of Kelley-Ross Pharmacy and she initiated the pharmacist-led PrEP clinic with the organisation back in 2015. The clinic is based at two locations, one a speciality medical clinic and the other in the Seattle LGBTQ Center in Capitol Hill, Seattle.

Elyse faced a great challenge in setting up one of the first pharmacy led PrEP clinics in the whole of the USA, in the early days of PrEP when Public Health had some doubts around the viability of prep as HIV prevention. Elyse also faced resistance from some of the medical community over the abilities of a pharmacist to counsel, prescribe and monitor patients around PrEP.

'There is always a work around, no matter what is presented, no matter how bad you think the problem is.'

Community Champion and Pharmacy Medical Director Dr Elyse Tung

Meeting Dr Elyse Tung, Clinical Director of Kelley-Ross Pharmacy, Seattle

Inspired by what she saw presented at a conference in 2014 Elyse knew that PrEP was a gamechanger in preventing HIV and reducing the amount of HIV treatment her team would be managing especially in the centre of Seattle. She was aware how much time and effort were required to convince the relevant stakeholders. The key to maximising it's use early on was to push PrEP beyond the confines of speciality medical clinics. Initially the idea began with casual conversations with colleagues.

Organising a pitch meeting to the relevant stakeholders was the catalyst to driving the idea of the clinic forwards. A PowerPoint presentation with a SWOT (strength weakness opportunity and threats) analysis was key to facilitating an open table conversation about whether the project was something the company wanted to be involved in. This was then voted for and introduced. As she says 'There is always a work around, no matter what is presented, no matter how bad you think the problem is.'

Having overcome colleague resistance Elyse noticed that another long-term barrier in accessing HIV treatment was when the workforce didn't reflect the community. As a result, it was important to ensure people accessing PrEP felt they were in a safe environment. Kelley Ross therefore provides PrEP in its original clinic but also in a further clinic at the LGBTQ centre in the gay district of Seattle.

She acknowledged the difficulty in cultivating a clinic that was truly reflective of the community but indicated that while there wasn't a quick fix for this it was important for a clinic to make an effort to build relationships and involve communities to provide a shared learning and building environment. She found that AFAB (assigned female at birth) patients were much more likely to respond positively to having female members of staff deal with their 'specific care challenges.'

Elyse is keen to highlight 'Language is key, meet them on their level.' Using the language of the community reduces stigma and trauma and lessens the barriers even if the healthcare worker doesn't come from the community they are helping.

The location of the clinic was also a factor in maintaining a high PrEP retention rate. Elyse also stressed that at the core of this was the pharmacy providing everything from testing, counselling, dispensing meds to facilitating links to colleagues if further treatment was required (for example STI treatment).

Pharmacies have an incentive to diversify their revenue streams particularly in the US and although this wasn't Elyse's primary motivation it did give an opportunity to use her skills as a community champion to improve PrEP access for the citizens of Seattle, a city with a diverse population on the west coast of USA.

Key themes

- Community champion role
- Is the workforce reflective of community?
- Safe spaces for community
- Resistance from medical colleagues
- Pharmacy-led PrEP

Key recommendations

- Communication with stakeholders e.g. pitch meetings
- Pharmacy diversification
- Ensuring clinic is in a relevant location to community
- Cohesion of services, dynamic workflow, STI testing

5.2 Case study 2: Checkpoint

Le Checkpoint Clinic, Paris

Clinic background:

- Location: 2nd Arrondissement, Paris city centre, France with associated peripheral clinics in the outskirts of Paris

Clinic development

Checkpoint is part of the association group SOS which is a European-led social entrepreneurship and has benefited people in vulnerable situations since the initial HIV epidemic in 1984.

Checkpoint clinic was created in 2010 as part of biomedical research into rapid HIV testing. The clinic provided valuable information beyond its initial objectives and therefore a follow up to this study was developed in 2016 and Checkpoint Paris became a CeGIPP (a centre for free information, screening and diagnosis).

This enabled the checkpoint to expand its free sexual health service as a community-based approach by combining STI screening, PrEP and a rapid referrals service to specialised care services. The clinic also offers sexual health counselling, specialised consultations in gynaecology for women having sex with women, GBMSM, trans women and addiction services.

Checkpoint has tried to widen community access to PrEP on two fronts: through the establishment of CeGIPP clinics and a partnership project between Sexual Health Departments and Community Health Centres.

CeGIPP/Community Sexual Health Clinics

Becoming a CeGIPP in May 2021 allowed Checkpoint to increase the number of its PrEP initiations from 81 in 2020 to 743 in 2022 which was 19% of the total PrEP initiations in Paris.

Thus the key objective of community sexual health clinics was to increase the number of initiations and this required collaboration with community medicine and the promotion of nursing-led prescriptions.

A big challenge was accommodating clinic capacity for the increased number off follow-up appointments that new initiations would create.

Creativity was needed to re-think the fee for the service bill for consultations with a sexual health model and allow other professionals (especially women) including district nurses, mediators and midwives to collaborate.

Le Checkpoint team were mindful that although one third of new HIV diagnoses in Paris are women from Sub-Saharan Africa, 97% of PrEP users are MSM born in France with favourable socioeconomic status and living in an urban environment.

One of the biggest barriers is freeing up time to do PrEP counselling and the clinics use peer health mediators to make this more efficient. Counselling can be done both before and after a patient's PrEP consultation.

In 2023 there were 'Hors les murs' or 'off-site' clinics taking place in four areas with social housing (HLMs).

Community Health Centres

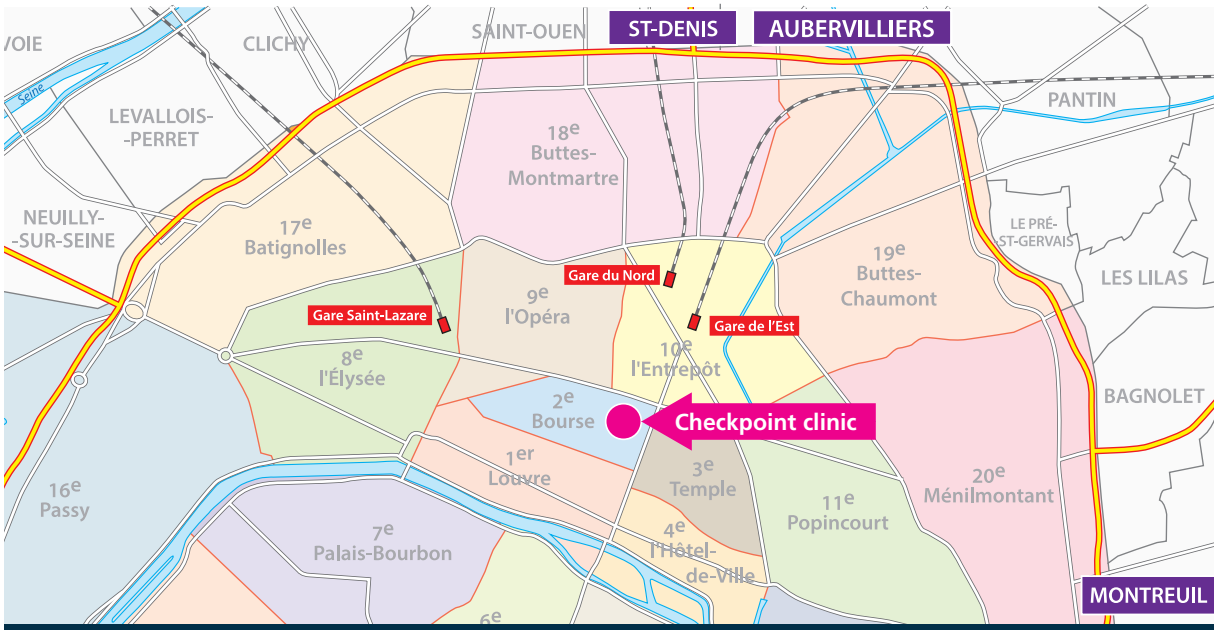
Checkpoint realised that although PrEP is an effective HIV prevention tool it was unevenly distributed in populations exposed to HIV risk in Paris.

The PARLOUS survey in 2012-2013 highlighted that a large proportion of HIV infections take place after people arrive in France and that it is essential that clinics took place in the areas where these people live.

In 2021 as a reaction to PrEP inequalities Checkpoint was a central player in the development of a project with community health centres (family health centres, different to community sexual health clinics) where primary care professionals could disseminate PrEP in the under-resourced district of Aubervilliers. In 2023, two further districts were covered by the project, including Seine-Saint-Denis and Montreuil. The choice of Seine-Saint-Denis was obvious in terms of public health. The district was considered to be a 'medical desert' and had the highest number of new HIV diagnoses in Paris at 17% of all cases.

Partnerships

Checkpoint has highlighted the need for community champions and community organisations to target specific populations particularly outside of Paris city centre. There are partnerships with Africa Rainbow, women's buses and LGBTQ+ groups. The Asia Project links in with Chinese speaking sex workers with the focus on using condom provision as a means to STI testing along with interpreter services and HPV vaccine provision.



Map of Paris showing Checkpoint in central Paris and the locations of community health centres in the 'medical deserts' of Saint-Denis, Aubervilliers and Montreuil

Holistic approach concentrated on initiations with supported maintenance

Checkpoint has developed a uniquely holistic approach to its vulnerable populations. With the extensive use of rapid point-of-care testing, patients can receive results within 90 minutes and this tightens PrEP retention. As many of the doctors in the clinic work part time they come from a range of specialities. Checkpoint has well-defined pathways to access psychological support or manage a referral to gynaecology that can save a patient time and offer them broader healthcare options in a safe space.

However, the focus of Checkpoint is really on achieving as many new initiations as possible. When someone has been supported through the system and their barriers lowered, the Checkpoint team discusses referring them on to a community doctor for PrEP maintenance when they feel support levels can be safely lowered. Thus, staff resources are effectively used to manage the most vulnerable and given the breadth of the PrEP prescribing ecosystem, the maintenance workload can be moved on to less pressurised zones.

Meeting Annabelle Pringault and Anais Gautier at Le Checkpoint

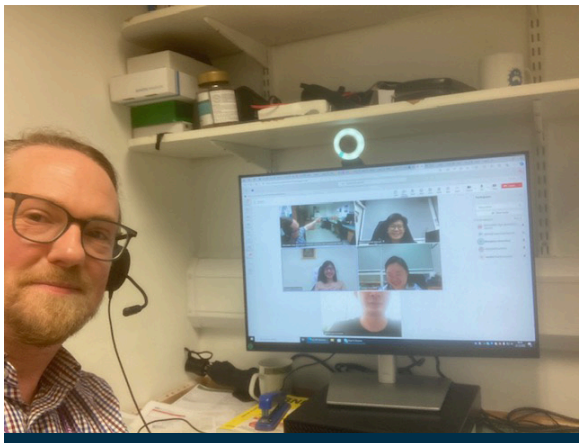
Key Themes

- Location-development of PrEP clinics close to the most vulnerable people at risk of HIV infection
- PrEP deserts
- Partner organisations (with community medicine/voluntary organisations)
- Language-importance of counselling and the use of mediators
- Rapid point of care STI testing
- Integrated healthcare (with other specialities)
- Specific support for vulnerable patients
- Fear of immigration services

Key recommendations

- Epidemiology on HIV incidence/ prevalence should act as a landmark for who needs PrEP the most
- Rapid point-of-care testing in clinics

5.3 Case 3: Ministry of Public Health Thailand and Rainbow Sky Association Thailand (RSAT)



Online meeting with Thailand Ministry of Health/ Institute of HIV Research and Innovation and Rainbow Sky Association Thailand, Bangkok

Background of HIV and PrEP in Thailand

In Thailand the HIV prevalence in sex workers is 1% and for GBMSM it is 12%. An appreciation of the provision of PrEP in Thailand was sought through an online interview with Dr Nittaya Phanuphak, Executive Director of the Institute of HIV Research and Innovation (IHRI) in Bangkok, Dr Rena Janamnuaysook, Program Manager for Implementation Science at IHRI and Dr Suchada Jiamsiri, Deputy Director, Division of AIDS and STIs Department of Disease Control, Ministry of Public Health Thailand.

Thailand became the first country in the world to pilot same-day PrEP through key population-led health services (KPLHS) in 2016. In 2017, these services integrated with gender-affirming care. The funding of these services was sourced from the US President's Emergency Plan for AIDS relief (PEPFAR), the Global Fund and other partner organisations.

In 2019 regulation changes allowed key population-led PrEP that progressed these projects beyond pilots. Funding was still an issue until 2021 when the services became eligible for direct reimbursement for services under Thailand's' Universal Coverage Scheme. This is an insurance programme providing free access to a comprehensive health benefits package for all Thai citizens. Community-based PrEP services now make up most National Health Security Office-funded PrEP users.

Key population-led services are now supporting 82% of Thailand's 32,000 HIV pre-exposure prophylaxis (PrEP) users, just three years after the country legalised key provider-led PrEP. [3]

Key-population led PrEP care

Dr Janamnuaysook explained that using lay providers trained to national standards can offer a more comprehensive, gender-sensitive service free, from stigma and discrimination. This can streamline with care in more traditional settings. She highlighted that these key population-led services are identified by the key population themselves, therefore the workforce reflects the community, and this enables a patient-centred and tailored approach to care.

Shifting PrEP services out of hospitals wasn't without its challenges. Thailand had only achieved about 10% of its 2021 PrEP target, according to the Ministry of Public Health. Although staff at 276 hospitals across the country had been trained to provide PrEP, 40% of these sites had been unable to implement PrEP by June 2022.

Ministry of Public Health officials continue to coach staff and conduct monitoring and evaluation through a centralised national PrEP database, PrEPThai.net. Education of staff, especially lay staff, is critical. Thailand is trying to scale-up best practice models of key population-led PrEP.

2023 challenge

The Ministry of Public Health's 2023 guideline on pre-exposure prophylaxis (PrEP) service delivery at community-led facilities outlined significant changes including 'only government doctors can prescribe PrEP' and 'key-population-led clinics cannot stock PrEP medicine.'

These changes could pose a real threat to Thailand's cost-effective, key-population-led, same-day PrEP service. EpiC Thailand data revealed a 21% decrease in the number of new clients receiving PrEP after 3 months of guideline implementation in contrast to the 11–12% upward trend in previous quarters.[4]

This resulted in a concerted effort to engage non-government doctors in the key-population-led PrEP service delivery. Finding enough government doctors who feel comfortable prescribing PrEP over the previous 8 years had proved difficult.

'We need a paradigm shift from community engagement to community leadership in the fight to reduce HIV transmission: key populations can't only be service recipients'

Dr Rena Janamnuaysook, Program Manager for Implementation Science at IHRI in Bangkok, Thailand

5.3.1 Rainbow Sky Association Thailand (RSAT)

'We are driven to improve the lives of LGBTQINA+ through change in order to realize their rights, appreciate their contributions and ensure their ability to participate fully in developing and sustaining a more inclusive and equitable society.'

RSAT objectives, https://www.rsat.info/

Background

In Thailand the need for stigma-free services led to the establishment of the Rainbow Sky Association in 1998 and its primary aims were to improve healthcare and reduce inequalities for MSM. In the early days the organisation was involved in collecting data on HIV prevalence in Bangkok which helped increase awareness of HIV and the need for diagnosis and treatment in Thailand.

RSAT offers sexual healthcare for MSM, migrants, people who inject drugs (PWID) sex workers and transgender people. It acts as an advocacy group for the full rights and equity of healthcare of the LGBTQINA+ communities.

Location

RSAT is situated in the Bang Kapi district of Bangkok due to it being an area of HIV prevalence (relative to other areas of Bangkok) and because large populations of sex workers were resident in the area. It is also developed, with good transport links, which helps lower further barriers to accessing PrEP, by bringing PrEP outside of the inner city to what were essentially PrEP deserts with a high at-risk population. The Thai Ministry of Health aim was to have at least one PrEP clinic in every province of Thailand.

Key Population-Led Healthcare Clinic (KPLHC) 2019

When KPLHCs were introduced in 2019 RSAT was able to develop trained counsellors to collect finger-prick blood samples and specimens for sexually transmitted infection (STI) screening. These healthcare workers could also perform point-of-care HIV and STI testing and report results. Workers were also permitted to dispense physician-prescribed PrEP, post-exposure prophylaxis (PEP) and oral STI treatment, trained through special templates. Most importantly the workers mostly came from the community accessing the clinic's care.

RSAT, like many other KPLHCs, operate outside of traditional working hours to ensure services are convenient for key

populations e.g. sex workers who work at night. The fluidity of the service was highlighted during the Covid pandemic when PrEP was given to people in sex on premises venues, like saunas by RSAT.

For the future, Dr Janamnuaysook is hopeful that the success of community-led services can be applied to new PrEP advances for example using injectables like cabotegravir. Furthermore, the success could be replicated to other models covering different healthcare streams.

'We need a paradigm shift from community engagement to community leadership in the fight to reduce HIV transmission: key populations can't only be service recipients.'

Key Themes

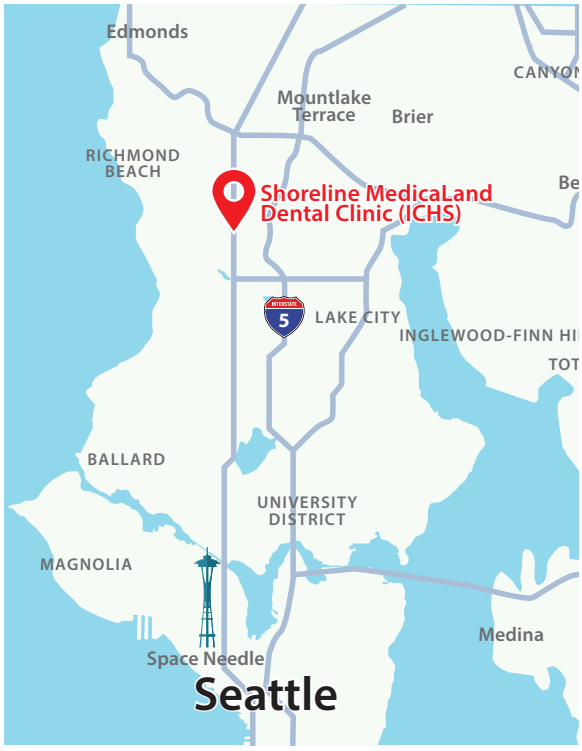
- Location-bringing PrEP to the community
- Workforce reflecting the community
- Safe location/safe space
- Education and staff training
- Diversification of PrEP delivery model
- Public health financing
- Medical resistance/demedicalise PrEP
- Using HIV prevalence as a marker for PrEP delivery

Key recommendations

- Opportunistic/walk-in PrEP suitable for the community
- Location of PrEP delivery close to community

5.4 International Center for Health Services (ICHS), Seattle

International Center for Health Services (ICHS) in Shoreline, Seattle



- Location: Chinatown-International District and Shoreline District

Background

The International Community Health Services (ICHS) was born out of a social justice campaign for Asian communities living in Seattle's Chinatown International District in the 1970s. Originally the protests were fuelled by the construction of a nearby stadium (Kingdome) rather than regenerating the dying Chinatown-International District. On a wider scale, the protesters were able to negotiate stadium construction jobs for Asians, 1000 units of low-income housing and a stadium user tax to support community projects and a health clinic.

This also led to the birth of a major social service agency that serves as the bedrock of support for immigrants in need and refugees and people of colour throughout the region.

The ICHS provide everything from dental care to primary care services and mental health services. There remains a clinic in the Chinatown-International District in Seattle city centre but the organisation recognised the importance of bringing healthcare services to where their patients live and now has three other clinics as well as school and mobile clinics.

The Shoreline ICHS clinic is 11 miles outside of Seattle city centre and situated in an area where there are high proportions of immigrants, refugees and people of colour.

The location alone puts this Federally Qualified Health Centre (FQHC), like other primary care settings, in a 'unique position to serve patients disproportionately impacted by HIV including people of colour, immigrants, and the LGBTQI+ community' according to Antonio Foles, Omar Ramos-Gutierrez and John Marrin. They are members of the team dedicated to providing nurse-led PrEP counselling and initiation.

Aurora Avenue leading from Seattle city centre into Shoreline District

The Shoreline FQHC is in the outskirts of Seattle and the main route from the city was lined with residential areas, motels and petrol garages. The centre serves more than 30,000 patients across King County, Washington and more than 70 languages are spoken by the clinic's patients.

Multimodal approach

In 2022 the clinic felt it could expand its reach with regards to HIV testing and PrEP provision. The baseline universal HIV screening rate was 37.7% and it had only 40 patients on PrEP. The intervention process began with a HIV screening and PrEP information email series for those involved in the programme. A pilot of nurse-led PrEP counselling and initiation of PrEP was held before the gradual addition over the next year of a range of further interventions. What may seem like relatively small but numerous interventions resulted in a 66% increase in PrEP prescribing and an 87% increase in the number of HIV tests done. Care co-ordination was carried out for three patients living with HIV.

Facilitators

There are lots of barriers that prevent people in the Shoreline area from readily accessing PrEP. English proficiency is lower among patients here (57%) and 78% of patients are people of colour so having a workforce that reflects the community really helps in lowering language, cultural and religious barriers.

Public health funding has a played a vital role in sustaining the project. The project received a US Department of Health, Health Resources and Services Administration (HRSA) grant to support the creation of a HIV prevention team. Furthermore, 69% of those attending clinic have Medicare/ Medicaid or are uninsured, and more than 80% are considered low income. Without governmental support to access HIV prevention care this develops into treatment care.

Partnerships adherence strategies

ICHS identified that managing PrEP on an individual case basis was an effective way of PrEP delivery for those who are socially and geographically isolated. Transportation costs would be a consistent barrier for rural patients, but this was overcome by arranging for mail delivery from speciality pharmacies.

A deliberate adherence strategy is adopted by the clinic team to engage more vulnerable patients with follow-up phone calls addressing issues like side-effects or running short on pills. This targeted approach is adopted by team members who use a diary to look up patients who haven't attended for bloods or haven't picked up scripts, in the words of Omar Ramos-Gutierrez 'we remove all the barriers for them.'

For patients that are struggling to afford access, ICHS can enrol them on the Directly Observed Therapy (DOT)

programme and can assist with the necessary paperwork before contact with community partner organisations to get the financial support to obtain PREP.

Working with partner organisations in the community also enables ICHS to target specific populations, such as people who inject drugs, to access prep by using already established links and trust to increase the availability of medication.

ICHS credits its ability to link in with other organisations as part of the reason its impact has such depth in the community. It accepts referrals from the local Shoreline Community College, Entre Hermanos, (a Latino organisation) and People of Color Against AIDs Network (POCAAN, an organisation for people of colour living with HIV). It also accepts referrals from the local public health department.

At ICHS Seattle with John Marrin, Advanced Practice Provider

Ongoing barriers

In spite of the many positive paths ICHS has taken, there are ongoing barriers to how it delivers PrEP in the community.

The team at times find it difficult to challenge the stigma that persists around HIV in some parts of the community, especially in some isolated areas where people may hold conservative views. This is compounded by healthcare provider stigma and lack of knowledge around PrEP. If a provider is unable to offer basic information on PrEP then the possibility of opportunistic PrEP to those who need it is extremely low.

There can also be issues with providing care in PrEP deserts. The team highlighted the importance of good communication from the state public health department with local organisations representing indigenous communities in areas like Snohomish City. There is a flexibility required to ensure indigenous populations aren't left behind or left exposed.

Key Themes

- Partner organisations
- Language and location
- Workforce reflecting the community
- HIV stigma
- Fixed retention strategies/follow-up
- Public health funding and communication
- PrEP deserts

Key recommendations

- Importance of having resources and team-members communicating in language of community
- Standardised and tailored retention strategies
- Importance of Public Health addressing PrEP deserts and mapping out gaps in provision

6. Recommendations

I have stratified the key recommendations I have assimilated from my thematic analysis according to their broad themes and I have then grouped these relevant to the key stakeholder that the recommendations apply to. I endeavour to meet with each of the stakeholders as part of my post-Fellowship research, reviewing the knowledge gained from the Fellowship and my specific recommendations to them. Multiple themes and recommendations will overlap and of course apply to multiple stakeholders. The recommendations are highlighted to denote recommendations which address barriers (red) and facilitators (green) of PrEP access in the community.

Theme key:

- PRACTICAL
- TECHNOLOGY
- IDENTIFYING AND SUPPORTING COMMUNITY CHAMPIONS
- EDUCATION/ AWARENESS
- DEMEDICALISING PREP
- TARGETING SPECIFIC POPULATIONS
- DELIVERY IN PARTNERSHIP
- ACADEMIC/PUBLIC HEALTH

	6.1 PUBLIC
	1. Give autonomy of PrEP initiations back to patients
	2. Give community champions and organisations the freedom and autonomy to disseminate PrEP information to communities
	3. Appreciate that community champions will come from different areas within the community and workforce.
	4. Develop a network of community champions to enable shared learning

Theme key:

- PRACTICAL
- EDUCATION/ AWARENESS
- TARGETING SPECIFIC POPULATIONS
- TECHNOLOGY
- DEMEDICALISING PREP
- DELIVERY IN PARTNERSHIP
- IDENTIFYING AND SUPPORTING COMMUNITY CHAMPIONS
- ACADEMIC/PUBLIC HEALTH

	6.2 VOLUNTARY SECTOR/ CHARITABLE SECTOR/SUPPORT ORGANISATIONS/NATIONAL AIDS TRUST
	1. Deliver PrEP in places where people feel safe. (LGBTQ centres, churches, confidential environments)
	2. Partner with Student and Trainee Association for Sexual Health and HIV (STASHH) to promote the knowledge of PrEP through student communication
	3. Implement POCT testing for creatinine, RPR and HIV to allow PrEP to be delivered outside specialist centres
	4. Consider a paradigm shift in how PrEP is monitored and delivered and the demand for demedicalised models
	5. Give community champions and organisations the freedom and autonomy to disseminate PrEP information to communities
	6. Ensure that partner organisations have pathways to refer for PrEP
	7. Appreciate that community champions will come from different areas within the community and workforce.
	8. Support community champions to achieve delivery and uptake of PrEP in the community even if that is unlikely to be replicated in other parts of the UK
	9. Develop a network of community champions to enable shared learning
	10. Ensure that community champions willing to deliver PrEP have streamlined access to HIV and STI testing and referral processes to specialist care

Theme key:

- PRACTICAL
- TECHNOLOGY
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- DELIVERY IN PARTNERSHIP
- ACADEMIC/PUBLIC HEALTH

	6.3 WORKFORCE: Sexual health clinics/Genitourinary medicine
	1. Develop local strategies/guidelines to develop PrEP equity
	2. Consider use of PrEP counsellors to help with clinics (free up time for pharmacists/doctors/nurses)
	3. Deliver PrEP in places where people feel safe. (LGBTQ centres, churches, confidential environments)
	4. Be mindful of how organisations delivering PrEP provision are marketed - PrEP is for everyone at risk of HIV
	5. Consider the use of injectable PrEP for people who face increased barriers in accessing oral PrEP i.e. PWID, minority populations who face stigma
	6. Amplify the use of telemedicine to increase the capacity to deliver PrEP
	7. PrEP telemedicine provision for rural patients or where transport to traditional centres is complex. Provide telemedicine counselling before collection of medication
	8. Implement POCT testing for creatinine, RPR and HIV to allow PrEP to be delivered outside specialist centres
	9. Consider a paradigm shift in how PrEP is monitored and delivered and the demand for demedicalised models
	10. Give Community Champions and organisations the freedom and autonomy to disseminate PrEP information to communities
	11. Ensure that partner organisations have pathways to refer for PrEP
	12. Support community champions to achieve delivery and uptake of PrEP in the community even if that is unlikely to be replicated in other parts of the UK
	13. Develop a network of community champions to enable shared learning
	14. Identify pharmacists and general practitioners in areas of high PrEP demand who would be interested in developing PrEP services. Use the templates from other projects and adapt to their local environment
	15. Ensure that community champions willing to deliver PrEP have streamlined access to HIV and STI testing and referral processes to specialist care
	16. Use testing to deliver interventions-identifying those living with HIV and engaging their close contacts/friends with PrEP information. Move interventions upstream.

Theme key:

- PRACTICAL
- EDUCATION/ AWARENESS
- TARGETING SPECIFIC POPULATIONS
- TECHNOLOGY
- DEMEDICALISING PREP
- DELIVERY IN PARTNERSHIP
- IDENTIFYING AND SUPPORTING COMMUNITY CHAMPIONS
- ACADEMIC/PUBLIC HEALTH

	6.4 WORKFORCE: Primary Care/Secondary Care
	1. Be mindful of how organisations delivering PrEP provision is marketed - PrEP is for everyone at risk of HIV
	2. Engage with other specialities (O+G, General Practice, A+E, Ophthalmology) to increase awareness of PrEP and enable signposting
	3. Engage with other specialities including O+G, Community Sexual Health and General Practice to consider PrEP information and counselling at opportunistic moments when accessing other services
	4. Give community champions and organisations the freedom and autonomy to disseminate PrEP information to communities
	5. Appreciate that community champions will come from different areas within the community and workforce.
	6. Identify pharmacists and general practitioners in areas of high PrEP demand who would be interested in developing PrEP services. Use the templates from other projects and adapt to their local environment
	7. Ensure that community champions willing to deliver PrEP have streamlined access to HIV and STI testing and referral processes to specialist care

	6.5 LOCAL GOVERNMENT/COUNCIL
	1. PrEP telemedicine provision for rural patients or where transport to traditional centres is complex. Provide telemedicine counselling before collection of medication
	2. Work with local authorities to outline the cost-effectiveness of HIV prevention with PrEP
	3. Support community champions to achieve delivery and uptake of PrEP community even if that is unlikely to be replicated in other parts of the UK

Theme key:

- PRACTICAL
- EDUCATION/ AWARENESS
- TARGETING SPECIFIC POPULATIONS
- TECHNOLOGY
- DEMEDICALISING PREP
- DELIVERY IN PARTNERSHIP
- IDENTIFYING AND SUPPORTING COMMUNITY CHAMPIONS
- ACADEMIC/PUBLIC HEALTH

	6.6 NHS ORGANISATIONS/NHS TRUSTS
	1. Opportunistic and walk-in PrEP should be available in all GUM services in the UK
	2. Be mindful of how organisations delivering PrEP provision are marketed - PrEP is for everyone at risk of HIV
	3. Amplify the use of telemedicine to increase the capacity to deliver PrEP
	4. Organise an electronic record template available in different languages to be used for PrEP counselling that is standardised
	5. Work with local authorities to outline the cost-effectiveness of HIV prevention with PrEP
	6. Identify pharmacists and general practitioners in areas of high PrEP demand who would be interested in developing PrEP services. Use the templates from other projects and adapt to their local environment

	6.7 DEPARTMENT OF HEALTH/NATIONAL GOVERNMENT
	1. Address 'PrEP deserts' and consideration of alternative clinics in areas where PrEP is not easily accessible. Develop a PrEP map that is easily accessible online
	2. Include PrEP in the curriculum of all UK medical schools
	3. Consider including PrEP in sex education for schools - moving the intervention upstream
	4. Be mindful of how organisations delivering PrEP provision are marketed - PrEP is for everyone at risk of HIV
	5. Widen PrEP prescribing-statins, anti-depressants are specialist drugs prescribed in primary care so why can't PrEP be the same?
	6. Organise an electronic record template available in different languages to be used for PrEP counselling that is standardised

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	6.8 GENERAL MEDICAL COUNCIL
	1. Include PrEP in the curriculum of all UK medical schools

	6.9 UKHSA
	1. Use other indicators to identify PrEP needs of a population e.g. the rates of emergency contraception prescribed
	2. Use testing to deliver interventions - identify those living with HIV and engage their close contacts/friends with PrEP information. Move interventions upstream.

7. References

1. Not Prepared - Barriers to accessing HIV prevention drugs in England. National AIDS Trust 03/11/2022. Not PrEPared - National AIDS Trust
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3. Barmania S. Successes and challenges in Thailand's HIV response. https://www.thelancet.com/journals/lanhiv/article/PIIS2352-3018(24)00013-4/fulltext
4. Ministry of Thailand PrEP guideline March 2023 https://ddc.moph.go.th/uploads/ckeditor2//files/Guideline.pdf
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An evening with the Public Health Seattle/University of Washington team