Feasibility of delivering long-acting cabotegravir as PrEP beyond sexual health services – a mixed methods study

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Background

Long-acting cabotegravir (CAB-LA) PrEP is approved for use across the United Kingdom (UK). CAB-LA offers benefits over oral PrEP but barriers to accessing sexual health services (SHS) remain. The 'Beyond the Clinic' study addresses evidence gaps about the implementation of non-SHS based CAB-LA provision to improve equitable PrEP access.

Methods

- Beyond the Clinic is a multi-phase, prospective feasibility study.
- Qualitative interviews were conducted with sexual health clinicians (April 2025), which informed a cross-sectional survey of sexual health services (SHS) (July – September 2025)
- Interviews were then conducted with non-SHS service providers in settings identified within the survey as feasible for CAB-LA provision (September 2025 – February 2026).
- Interview data were analysed thematically combining inductive and deductive codes informed by the Consolidated Framework for Implementation Research (CFIR).

Results

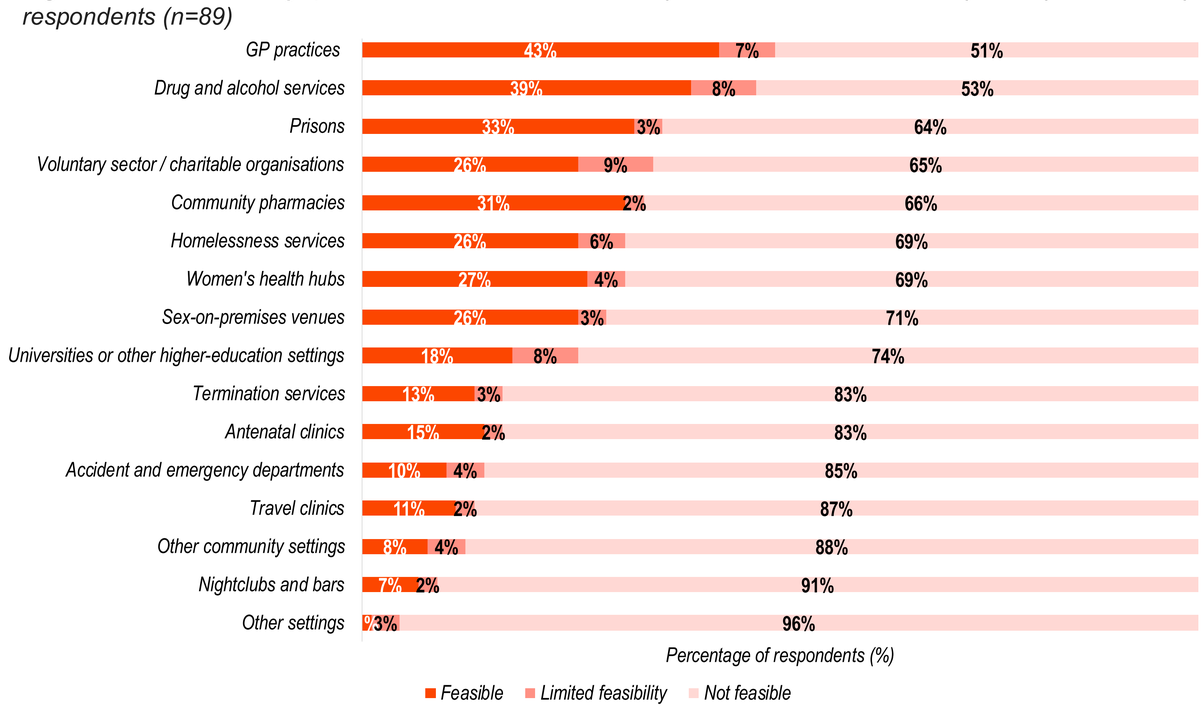
- Thirteen sexual health clinicians from 13 services participated in phase 1 in-depth interviews (further details published elsewhere [1]).
- 77% (89/116) of SHS in the UK participated in the survey. Characteristics of the services participating in the phase 2 survey are outline in **Table 1**.

Table 1. *Characteristics of sexual health services participating in survey (n=89)*

Characteristic	Category	Frequency (%)
Country (n=89)	*England*	**70 (79%)**
	Northern Ireland	**5 (6%)**
	Scotland	**10 (11%)**
	Wales	**4 (4%)**
NHS region (England only, n=70)	*East of England*	**7 (10%)**
	London	**16 (23%)**
	Midlands	**11 (16%)**
	North East and Yorkshire	**11 (16%)**
	North West	**9 (13%)**
	South East	**7 (10%)**
	South West	**8 (11%)**
HIV prevalence (England only, n=70)	*High*	**25 (36%)**
	Low	**45 (64%)**
*Offer **any** oral PrEP services outside the clinic?*	*No*	**39 (44%)**
	Yes	**50 (56%)**
Number of provider types delivering oral PrEP outside the clinic	*<3*	**71 (64%)**
	≥3	**18 (36%)**
Prescribing or dispensing oral PrEP outside the clinic?	*No*	**66 (74%)**
	Yes	**23 (26%)**
Number of current PrEP users (n=52)	*Median (IQR)*	**401 (229, 900)**
	Range	**0 - 30,000**

- Just over a quarter (28%) agreed out-of-clinic CAB-LA provision is feasible within the next 3-5 years.
- Figure 1 depicts the perceived feasibility among SHS survey participants for out-of-clinic CAB-LA provision in a range of non-SHS settings, including GP practices (43%), drug and alcohol services (39%), prisons (33%) and voluntary sector organisations (26%).
- Other services were mainly seen as feasible for promoting PrEP awareness and making referrals.

Figure 1. *External settings perceived as feasible[1] for delivery of CAB-LA in the next 3-5 years by clinic survey respondents (n=89)*



1. 'Limited feasibility' captures responses where respondents considered these settings feasible ONLY for 'Promoting CAB-LA awareness' AND/OR 'Identifying CAB-LA candidates'. 'Feasible' settings captures responses where respondents considered these settings as feasible for 'Promoting CAB-LA awareness' AND/OR 'Identifying CAB-LA candidates' AND 'Conducting baseline testing', 'Prescribing CAB-LA', 'Administering CAB-LA', 'Conducting follow-up testing' AND/OR 'CAB-LA adherence support'.

- Thirty non-SHS providers participated in phase 3 in-depth interviews and included a range of:
  - Countries: England (n=25), Northern Ireland, Scotland and Wales (n=5).
  - NHS regions (England only): London (n=11), Midlands (n=1), North East and Yorkshire (n=5), North West (n=2), South East (n=3), South West (n=3).
  - HIV Prevalence[1]: High (n=18), Low (n=10), Data unavailable (n=2)
  - Provider type: routine primary care (community pharmacy, n=3; GP practice, n=4), specialist primary care (drug and alcohol support, n=4; homelessness services, n=3; women's health hubs, n=2, community gynaecology, n=1), third sector / charitable organisations (n=11) and online sexual health providers (n=2)
  - Role type: Clinical role, e.g. specialist nurse (n=14), Non-clinical role, e.g. service manager (n=16)

1. High/Very High diagnosed HIV prevalence in England defined as >2 per 1000 (2), High in Scotland defined as >1 per 500 (3).

- Overall, phase 3 participants were **more positive about the prospective feasibility** of delivering CAB-LA of non-SHS based CAB-LA provision than their SHS counterparts.
- **Services catering to specific underserved groups**, including people who inject drugs, sex workers, homeless populations and prisoners, **were particularly supportive**.
- **More generalist settings**, such as routine primary care services, **felt it would be important to understand ways of appropriately triaging** those who could benefit from CAB-LA

- Phase 3 participants referred to a range of other interventions they had experience of which helped them to 'make sense' of the idea of implementing CAB-LA in their setting, including, amongst other things:
  - Injectable opioid substitution therapy
  - Injectable contraception
  - Weight loss injections
  - Vaccinations

Based on the interview data, determinants of effective and equitable implementation of non-SHS CAB-LA provision included:

- **Challenges around prescribing and procuring CAB-LA in non-SHS settings**

Challenges included national PrEP prescribing policy, procurement processes, NHS workforce capacity, and the readiness of external providers to provide CAB-LA.

> *"Just changing the policy that allowed NHS staff to prescribe within a community isn't the answer, if there isn't NHS workforce capacity to do that. So, [it] makes sense that you have community organisations that have people who are skilled and trained – that have the ability – through some kind of NHS subcontracting relationship – so that they can prescribe PrEP and use the same clinical governance protocols that that clinic or that primary care provider would do.*
>
> *Interview Participant, Voluntary Sector Organisation, Non-clinical role, London, High HIV Prevalence*

- **Concerns around being adequately involved in, and remunerated for, non-SHS clinic service delivery**

Participants emphasised the importance of collaborative, co-produced approaches to promote buy-in – particularly in terms of equitable and transparent remuneration.

> *"I think a commissioned shared care clinic would be a really good idea. What would happen is you'd then attract GPs or professionals in primary care who are interested in it, and it would be a specialist interest role, and I think it also then gives the validation and recognition… That actually, you know what, we are gonna put it into primary care (...) it's a joint understanding rather than well you know what, we're dumping this onto primary care, you need to deal with that."*
>
> *Interview participant, GP practice, Clinical role, London, High HIV Prevalence*

- **Perceived low levels of PrEP awareness and demand among underserved groups**

The effectiveness of community-based delivery models was seen as contingent on improving baseline knowledge and awareness.

> *"I think there would be a big educational piece around it. It's the classic, "It won't happen to me, it won't happen to me, it won't happen to me."*
>
> *Interview participant, Drug and alcohol support service, Non-clinical role, London, High HIV Prevalence*

Conclusion

- Although perceived feasibility of CAB-LA delivery outside of SHS was relatively low among sexual health clinicians, a range of non-SHS settings were identified as potentially feasible.
- External providers within these settings often expressed confidence in their ability to deliver injectable interventions with appropriate support.
- To improve feasibility of CAB-LA delivery outside of SHS, key strategies should include:
  1. addressing legal and regulatory barriers to integrated service provision;
  2. involving non-SHS service providers as equal partners to promote buy-in, and;
  3. generating demand for CAB-LA and addressing inequitable uptake through education, awareness-raising and removal of structural barriers.

References

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