PDiBA

PrEP DESIRABILITY IN BLACK AMERICA

September 2026

THE BLACK PREVENTION

HEALTH AGENDA:

Understanding Black Prevention and PrEP Desirability

A National HIV Prevention Plan for Black America

PrEP Desirability in Black America (PDiBA)
2026 Briefing Report

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EXECUTIVE SUMMARY

THE RATIONALE FOR PDiBA

Black communities continue to experience a disproportionate share of the HIV epidemic while receiving an inequitable share of the benefits made possible by pre-exposure prophylaxis, or PrEP. This gap cannot be explained by awareness, individual behavior, or medication availability alone. It reflects a prevention system that too often fails to make PrEP relevant, trusted, accessible, navigable, and sustainable in Black people's lives.

PrEP Desirability in Black America—PDiBA, publicly known as "The Desirability Project"—was created to understand these failures and organize a coordinated response. Conceived, funded, and led by Black advocates, researchers, and organizations PDiBA brings together community experience, implementation evidence, policy strategy, workforce development, and accountable investment.

During spring and summer 2026, PDiBA conducted 12 listening sessions across 10 engagement locations. These discussions included community members and people working within or alongside HIV prevention, navigation, care delivery, policy, and community engagement. PDiBA then launched a national survey of Black adults to examine whether the patterns identified through these listening activities were evident across a broader population. By August 31, 2026, (n=311) people had enrolled, exceeding the initial goal of 250.

Preliminary Phase 1 findings identified **four observable breakdowns** and **one evidence priority across the PrEP journey**:

1. **Awareness and Relevance:** PrEP messages do not consistently reflect the diversity of Black identities, ages, relationships, and life experiences.
2. **Motivation and Trust:** Concerns about cost, stigma, safety, and institutional trust can discourage people from considering PrEP.
3. **Navigation and Access:** The transition from wanting PrEP to finding, financing, and receiving it emerged as a critical system failure.
4. **Initiation and Early Engagement:** Early experiences with providers, medication options, and follow-up can shape continued engagement.
5. **Sustained prevention**: More evidence is needed to understand how prevention can remain responsive as people's lives, preferences, and needs change.

PDiBA organized these insights into a five-stage conceptual model informed by the Transtheoretical Model and COM-B. The model examines both where people are in the PrEP journey and what individual, community, organizational, and structural conditions influence their movement.

These findings are being translated into five coordinated strategic tracks: **demonstration projects and sites; funding and sustainability; a Black-centric prevention campaign; workforce development; and advocacy and policy action**. Together, these tracks constitute the Black Prevention Agenda a framework for moving from community evidence to implementation, investment, and accountability.

The intended result is not another description of disparities. It is a prevention system designed to help Black people recognize PrEP as relevant, reach it without unnecessary barriers, choose the option that fits their lives, and use it for as long as it is wanted or needed.

Data identifies the need. Community defines the response. Action delivers the change.

WHY PDIBA AND HOW WE WORKED

PDiBA began with a defining question: **Why has PrEP not produced its intended benefit for Black communities?**

We did not want to produce another list of familiar barriers. We wanted to understand how barriers are experienced, where they accumulate across the PrEP journey, and what institutions must change to make prevention more relevant, accessible, trusted, and sustainable.

PrEP Desirability in Black America, PDiBA, publicly known as "The Desirability Project", is a Black-led national initiative. National Black Gay Men's Advocacy Coalition (NBGMAC) serves as the lead organization, partnering with Morgan State University's Center for Urban Health Equity, and Black-led organizations: Us Helping Us People into Living, the National Black Women's HIV/AIDS Network, NMAC, and Black AIDS Institute.

PDiBA's approach is direct: listen to community members and system enablers; examine the emerging patterns through a national survey; identify where the PrEP journey breaks down; and translate the evidence into five coordinated areas of action.

The Black Prevention Health Agenda translates these findings into a coordinated national response. This report explains why PDiBA was created, what Phase 1 revealed, how those insights informed the PDiBA conceptual model, and what partners can now help build, fund, implement, and evaluate.

Figure 1. The map reflects PDiBA's broader engagement footprint, including city-based listening sessions, the Detroit pilot, and discussions conducted during national convenings. Not every location shown contributed the same type or volume of data. The Phase 1 registration profile presented later in this report includes only selected city-based sessions for which registration records were available.

We listened to community members and system enablers and examined the individual, organizational, and systems conditions shaping PrEP desirability.

By moving from evidence to culturally grounded implementation, PDiBA aims to strengthen the prevention system and help change the trajectory of HIV in Black America.

PHASE 1: LISTENING AND ENGAGEMENT

During spring and summer 2026, **PDiBA conducted 12 listening sessions across 10 engagement geographies. See Figure 1.** Site selection was intentional and reflected both epidemiologic need and local implementation readiness.

PDiBA prioritized geographies where three conditions converged:

1. A disproportionate HIV burden;
2. Federal investment through the Ending the HIV Epidemic initiative; and
3. Persistent evidence of unmet PrEP need, including a low PrEP-to-Need Ratio.

These were geographies where the need was clear and resources had been committed, but PrEP use remained below its potential and HIV prevention was suboptimal, and is a public health failure.

Other geographies also met these criteria. Available funding, geographic reach, and the readiness of local engagement coordinators to support recruitment and facilitation informed the final selection.

The sessions explored five domains:

- Awareness and meaning-making: How people understand PrEP and determine whether it is relevant to their lives.
- Motivation and structural triggers: What encourages, delays, or prevents movement toward PrEP.
- Navigation and system experience: How people enter and move through prevention services.
- Communication and messaging: How PrEP is discussed and how communication could become more relevant and trustworthy.
- Implementation and policy: What organizational, financial, and policy conditions enable or restrict equitable PrEP access.

Editorial Note:
Findings were not uniform across engagement locations. In one Philadelphia cohort, participants described access as less salient than stigma associated with condom practices and broader cultural and social norms. This variation reinforces the need for locally responsive strategies rather than a single intervention applied uniformly across Black communities.

Following the Detroit pilot, PDiBA developed a semi-structured discussion guide for system enablers. System enablers were defined as people working directly within—or adjacent to—PrEP communication, navigation, financing, policymaking, and delivery. This definition intentionally extended beyond clinical providers to reflect the broader system through which people encounter and access prevention.

Each session lasted up to 90 minutes. Local partners supported recruitment and helped create settings in which participants could discuss their experiences openly. The PDIBA team utilized Interpretative Phenomenological Analysis (IPA) to deeply immerse themselves in the lived experiences of system enablers. Through rigorous initial noting of descriptive, linguistic, and conceptual nuances, they developed seventeen emergent themes. They then clustered these into five superordinate themes that captured patterns of convergence and divergence across all individual cases. Ultimately, these master themes form the foundation of the PDIBA model. These gaps serve as the guiding model for PDiBA.

Gap 1 - Awareness: - "I Don't see Myself"

Participants described PrEP marketing that did not consistently reflect their age, gender, relationship, or stage of life. When people could not recognize themselves in the imagery or narrative, PrEP was less likely to be personally relevant. These concerns were compounded by persistent mistrust of healthcare institutions and prevention messaging.

"I don't see myself at 37 in [the] commercials."
—Richmond, VA Listening Session

Why it matters: Representation influences more than whether a campaign attracts attention. It helps determine whether people interpret PrEP as relevant, credible, and intended for them.

Gap 2 - Motivation and Trust: The Cost-Confidence Gap

Participants described both actual and perceived financial barriers. Insurance complexity, billing concerns, and uncertainty about medication and service costs could discourage people from pursuing PrEP. Although assistance programs may reduce some expenses, the availability of such programs does not automatically create confidence that care will be affordable.

Closing this gap requires more than communications. It requires transparent cost information, accessible financial navigation, and delivery systems that people trust.

"If we go to an integrated model, then we focus more on the patient's journey through wellness… We're in a sick-and-disease model in this space."
—Focus-group participant, Indianapolis

"I" Black women come to the providers more than Black men, and they want it, but can't get it." —Provider, Charlotte

Gap 3 - Navigation and Access: The Moment of Truth

Across engagement geographies, navigation emerged as a critical failure point. Even after someone decided to pursue PrEP, identifying a provider, securing an appointment, understanding costs, completing required steps, and receiving a prescription could interrupt progress.

PDiBA therefore identifies the transition from intention to access as the "moment of truth" in the PrEP journey. Motivation alone cannot overcome a service that is unavailable, difficult to locate, or burdensome to navigate.

"We only have one place that's designated that's the only place where we're also technically offering PrEP services." — Houston, PrEP provider

Gap 4 - Initiation & Early Engagement: Choice and Early Experience Matter

Long-acting injectable PrEP emerged positively and without prompting in several listening sessions, particularly among participants concerned about daily pill burden. This suggests that greater method choice may support initiation and early engagement. However, additional formulations will not, by themselves, eliminate provider, cost, scheduling, or navigation barriers.

The community listening session in Indianapolis demonstrated the value of rapid local coordination. Following an identified navigation problem, community partners mobilized within 24 hours to begin developing a response. This experience offers an early example of the locally led implementation capacity that PDiBA seeks to strengthen, evaluate, and replicate where appropriate.

"I went 90 days without PrEP… I've been living with HIV for five years now." —Advocate and former PrEP user, Indianapolis

Gap 5 - Sustainability & Systems: An Evidence Priority

Our findings did not produce sufficient evidence to characterize long-term persistence, discontinuation, or re-engagement. Rather than obscure this limitation, PDiBA prioritizes sustained prevention for Phase 2 analysis and future implementation work.

PHASE 1 OUTCOMES

PDiBA organized its preliminary findings around five stages in the PrEP journey. Phase 1 provided evidence of breakdowns involving awareness, motivation, navigation, and early engagement. It did not produce sufficient evidence to characterize long-term persistence, discontinuation, or re-engagement. Rather than obscure this limitation, PDiBA identifies sustained prevention as a priority for Phase 2 analysis and future implementation work.

PHASE 2: NATIONAL SURVEY AND INTEGRATED ANALYSIS

WHO PARTICIPATED IN PHASE 1?

Available registration records (N=101)

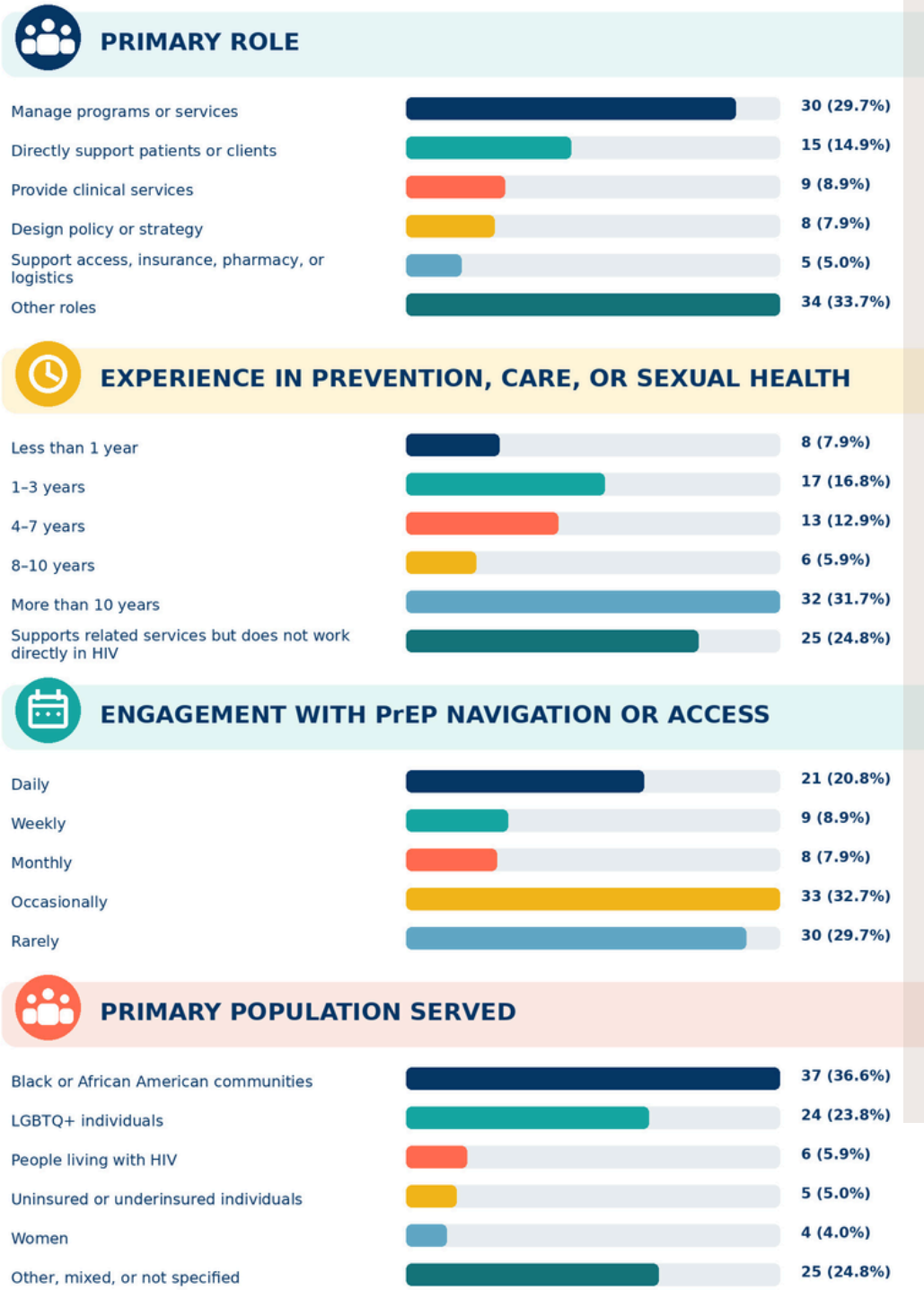


Figure 2. summarizes 101 available registration records from selected city-based PDiBA listening sessions conducted between April and July 2026. The records primarily represent Indianapolis, Richmond, Norfolk/Hampton Roads, Columbia, Charlotte, and Houston. They exclude some session participants, the Detroit pilot, and discussions held during national convenings, including Montgomery. These data therefore describe available registrants—not everyone engaged during Phase 1. Percentages may not total 100% because of rounding. Categories reflect participants' primary selected response and may not capture the full range of their roles or communities served.

Phase 2 extends the project's inquiry beyond the Phase 1 engagement geographies. The national survey examined the reach and relevance of the patterns identified through listening sessions among a broader sample of Black adults.

Following review and approval (IRB #266/06-0197) by the Morgan State University Institutional Review Board, PDiBA recruited participants through its national network of community partners. Eligible participants self-identified as Black, were at least 18 years old, and reported sexual activity during the previous 12 months. Any additional eligibility requirements and the Board's formal determination are described in the Methods and Limitations section.

As of August 31, 2026, PDiBA exceeded its initial recruitment goal of 250 (n=311). PDiBA will analyze these data alongside Phase 1 findings to identify patterns, examine differences across communities, and refine strategies for improving PrEP relevance, access, initiation, and sustained engagement.

THE PDiBA CONCEPTUAL MODEL FROM FINDINGS TO ACTION

HOW WE ORGANIZED THE EVIDENCE

PDiBA does not treat its findings as a list of disconnected barriers. Instead, the initiative organized them into a dynamic conceptual model showing how people may move toward, pause, discontinue, restart, or sustain PrEP use.

The model emerged from Phase 1 findings, was refined during a June 2026 working session, and will guide the integrated analysis of qualitative and quantitative data. It enables PDiBA to identify where barriers emerge, what supports movement, and which individual, community, organizational, or policy interventions may be most likely to produce change.

WHY THIS MODEL

The PrEP journey is not a one-way funnel. People may enter at different points, move forward, pause, change methods, discontinue, or return to an earlier stage as their relationships, health needs, insurance coverage, treatment preferences, and life circumstances change.

People with **sustained prevention** experience may also become peer leaders and trusted messengers, helping others see PrEP as relevant and attainable. The model is therefore best understood as a dynamic loop rather than a fixed sequence.

THE FIVE-STAGE FRAMEWORK

A — AWARENESS & RELEVANCE

PrEP has limited visibility or is not yet understood as a personally relevant prevention option. Stigma, misinformation, limited representation, and prevailing cultural narratives may shape meaning.

Intervention Lever: *Exposure, normalization, trusted messengers and community-based messaging.*

B — CONTEMPLATION & MOTIVATION

The individual is aware of PrEP and beginning to consider it, weighing potential benefits against concerns involving cost, stigma, side effects, trust, and provider access.

Intervention Lever: Navigation, care coordination, financial assistance, community health workers, and simplified access.

C — PREPARATION & NAVIGATION: "THE MOMENT OF TRUTH"

The individual has begun PrEP. Early experiences with the medication, provider, service setting, and follow-up can shape continued engagement.

Intervention Lever: Responsive follow-up, method choice, peer support, and person-centered care.

D — INITIATION & EARLY ENGAGEMENT

The individual has begun PrEP. Early experiences with the medication, provider, service setting, and follow-up can shape continued engagement.

Intervention Lever: *Responsive follow-up, method choice, peer support, and person-centered care.*

E — SUSTAINED PREVENTION & PEER INFLUENCE

PrEP or another chosen prevention strategy can be used as long as desired or needed. Individuals may continue, pause, switch methods, restart, or become trusted messengers for others.

Intervention Lever: Flexible care, re-engagement support, peer leadership, and durable prevention infrastructure.

THE PDiBA CONCEPTUAL MODEL

WHY WE SELECTED THIS APPROACH

The PDiBA conceptual model integrates two complementary behavioral frameworks: the Transtheoretical Model of Behavior Change, or TTM, and the Capability, Opportunity, Motivation–Behavior framework, or COM-B. TTM helps explain where a person may be in a process of change. COM-B helps explain what conditions may support or impede movement.

Together, the frameworks allow PDiBA to move beyond asking whether a person uses PrEP. The combined model asks:

- Where is the person in the PrEP journey?
- What capability, opportunity, or motivation is shaping that position?
- What must change within the individual, community, organization, or broader system to support the next step?

TRANSTHEORETICAL MODEL

The Transtheoretical Model recognizes that behavior change occurs through **stages—including precontemplation, contemplation, preparation, action, and maintenance—**and that people may advance, pause, discontinue a behavior, or return to an earlier stage (Prochaska & DiClemente, 1983; Prochaska & Velicer, 1997). TTM has been applied in HIV prevention to assess readiness for consistent condom use and related protective behaviors among different populations, including women and people at increased risk of HIV (Schnell et al., 1996; Evers et al., 1998; Horowitz, 2003). For PDiBA, TTM provides a foundation for understanding movement from limited PrEP awareness to sustained and normalized use without assuming that the journey is linear.

CAPABILITY, OPPORTUNITY, MOTIVATION-BEHAVIORS FRAMEWORK

COM-B complements TTM by examining whether people have the capability, opportunity, and motivation required to act (Michie et al., 2011). Research applying COM-B to PrEP uptake among men who have sex with men found that knowledge, service access, social influences, stigma, perceived need, medication concerns, and confidence interact to shape PrEP decisions (Madhani & Finlay, 2022). Together, TTM and COM-B help PDiBA identify both where a person is in the PrEP journey and what individual, community, organizational, or systems conditions must change to support the next step. The figure below shows how these behavioral frameworks come together in our work. The model operates as a loop rather than a one-way funnel. This means people may move forward, pause, change methods, discontinue, restart, or re-enter Stage A as trusted community messengers and peer leaders.

ORGANIZATION + SYSTEM

What institutions, services, financing, and policies make PrEP possible?

- Cost & insurance coverage
- Provider practices and trust
- Clinic access and navigation
- HIV workforce, service delivery models
- Policy, behavioral economics

A **AWARENESS**
PrEP becomes visible and personally relevant

B **MOTIVATION**
Benefits, concerns, and readiness are weighed

C **NAVIGATION**
Intent meets the realities of accessing care

D **INITIATION**
Early experiences shape continued engagement

E **SUSTAINABILITY**
Use is supported for as long as it is wanted or needed

INDIVIDUAL + COMMUNITY

What people know, feel, trust, & experience about PrEP to be visible and personally relevant.

- Knowledge and relevance
- Identity and lived experience
- Peer stories and trusted messengers
- Stigma, confidence, and motivation

THE FIVE-TRACK STRATEGIC FRAMEWORK: FROM EVIDENCE TO ACTION

The Five-Track Strategic Framework connects what Black communities told us about what must be done now. It defines what PDiBA will build, outlines where resources must be directed, how partners can contribute, and what results stakeholders should expect.

The tracks do not correspond to the five journey stages one at a time. Each track addresses multiple failure points, and all five are intended to operate as a coordinated portfolio.

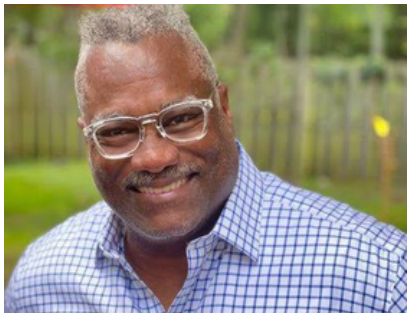
We know where the PrEP pathway breaksdown. Now we know where to build.

Data identifies the need. Community defines the response. Action delivers the change.

INVESTEMENT PATHWAYS	WHAT SUPPORT ACTIVATES	WHAT STAKEHOLDERS CAN EXPECT
Demonstration Projects and Sites **Fund and evaluate locally designed models that address identified breakdowns in the PrEP journey.**	Community-designed interventions tested in prioritized locations.	Evidence about what works, for whom, in which settings, and under what conditions.
Funding and Sustainability **Develop durable financing strategies for prevention infrastructure, implementation, evaluation, and scale.**	Long-term infrastructure and aligned investment across the PDiBA portfolio.	Defined investment priorities, coordinated funding, measurable deliverables, and greater accountability.
Black-Centric Prevention Campaign **Develop national and locally adaptable communication grounded in Black identities, lives, language, and experiences.**	Messaging designed to strengthen relevance, visibility, trust, and normalization.	A community-informed prevention narrative and adaptable campaign resources.
Workforce Development **Strengthen the capacity and leadership of Black navigators, peer educators, providers, program leaders, and prevention professionals.**	Training, leadership development, and stronger pathways into the HIV-prevention workforce.	A culturally responsive workforce better equipped to support access, choice, and continued engagement.
Advocacy and Policy Action **Advance federal, state, and local reforms that reduce financial, regulatory, geographic, and administrative barriers to PrEP.**	Coordinated advocacy informed by community findings.	Clear policy priorities, advocacy tools, and mechanisms for public accountability.

GOVERNANCE AND ACCOUNTABILITY

FOUNDATIONAL PARTNERS



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PDiBA is made possible through the leadership and contributions of Black-led organizations, researchers, community partners, advocates, providers, and individuals committed to strengthening HIV prevention in Black America.

- **National Black Gay Men's Advocacy Coalition.** Lead organization.
- **NMAC.** Workforce mobilization partners
- **Black AIDS Institute.** Community mobilization partner
- **Us Helping Us, People into Living.** Community implementation partner
- **National Black Women's HIV/AIDS Network.** Data interpretation partner
- **Morgan State University, Center for Urban Health Equity.** Academic partner

GOVERNANCE AND ACCOUNTABILITY

Community organizations and individuals dedicated to bringing people together around the project's aims and supporting locally responsive action.

Governing Principle:

PDiBA uses a community-centered governance model designed to connect national strategy with local experience. NBGMAC serves as the lead organization. The Executive Committee provides strategic and operational stewardship. The National Steering Committee broadens representation and strengthens accountability. The Partnership Council connects community organizations and individuals committed to advancing the project's aims. Five workgroups translate the Agenda's priorities into coordinated action.
Community insight is not a single activity within this structure. It informs strategy, investment, implementation, and accountability at every level

FROM LISTENING TO ACTION:

2026-2027 IMPLEMENTATION TIMELINE

For the specific federal and state policy asks this Agenda's findings support, see the standalone **Advocacy Plan,** by visiting www.nbgmac.com

OUR CALL TO ACTION:

Every finding in this Agenda points toward the same conclusion: data alone will not close the gap between PrEP need and use in Black America. Progress requires coordinated action from the people and institutions that shape awareness, trust, access, financing, delivery, and policy.

The following asks identify how each group can contribute to a prevention system that works more effectively for Black communities.

FOR PEOPLE LIVING WITH HIV (PLW HIV)

The experiences of people living with HIV offer essential insight into how treatment, prevention, navigation, and peer-support systems differ—and where those systems should be better connected.

- Help shape status-neutral prevention strategies and peer-messenger programs.
- Share observations about PrEP-access barriers affecting partners, families, and communities through PDiBA's protected engagement channels.
- Consider serving as a peer leader, advisor, or trusted messenger where appropriate and adequately supported.

FOR PEOPLE WHO CAN BENEFIT FROM PrEP

If you've been told you don't need PrEP or have quietly wondered whether it's for someone like you, this Agenda exists because many people in the Listening Sessions said the same thing.

- Ask your provider about PrEP directly; focus on the method that works best for your life (e.g., injectable or oral).
- If cost or insurance status has ever stopped you from asking, say so publicly or to PDiBA. Perceived cost is documented as a barrier even where PrEP is free, and that gap only closes with more voices behind it.

FOR POLICY MAKERS

Unequal PrEP outcomes reflect addressable failures involving coverage, navigation, workforce capacity, and service delivery.

- Advance the federal and state priorities detailed in the companion **Advocacy Plan**.
- Reduce cost sharing, administrative burden, and geographic barriers to clinically appropriate PrEP.
- Support equitable telehealth, pharmacist-prescribing, and community-based delivery policies.
- Establish sustained funding for Black-led community organizations and prevention infrastructure.
- Use PDiBA findings and future dashboard measures to strengthen public accountability.

OUR CALL TO ACTION:

FOR FUNDERS, PAYERS, AND PHARMACY BENEFIT MANAGERS (PBM)

Financing, formulary, reimbursement, and prior-authorization decisions directly shape whether people can obtain the PrEP option that is clinically appropriate and workable for their lives.

- Audit coverage, formulary, and prior-authorization policies across all FDA-approved PrEP options.
- Identify policies that create inequitable access across populations or delivery settings.
- Invest in navigation, community delivery, workforce capacity, and implementation infrastructure—not medication access alone.
- Fund the five strategic tracks through coordinated, multiyear commitments with defined measures of accountability.

FOR COMMUNITY MEMBERS

Community insight created this Agenda and must continue to shape its implementation.

- Join the Partnership Council, a workgroup, or a local engagement activity.
- Tell PDiBA what is working, what remains inaccessible, and what should be built differently.
- Help assess whether PDiBA's actions remain relevant, respectful, and accountable to Black communities.
- Serve as a trusted messenger if and when that role is safe, appropriate, and supported.

FOR RESEARCHERS

Phase 1 identified emerging patterns. Phase 2 will examine those patterns across a broader national sample. The next evidence priority is understanding which implementation strategies improve PrEP relevance, access, initiation, and sustained prevention in Black communities.

- Partner with Black-led organizations as equitable research and implementation partners.
- Evaluate promising models across the five stages of the PDiBA conceptual model.
- Strengthen evidence concerning program continuity, workforce capacity, financing, implementation, and sustainability.
- Return findings to participating communities in timely, accessible, and actionable formats.

FOR COMMUNITY-BASED ORGANIZATIONS

Community organizations translate national strategy into trusted local action.

- Join a PDiBA workgroup or the Partnership Council.
- Identify local breakdowns in awareness, navigation, financing, or service delivery.
- Partner in designing, implementing, or evaluating demonstration projects.
- Use community feedback to hold institutions and PDiBA accountable for results.

CONCLUSION:

PDiBA began with a question about why PrEP has not worked as intended for Black communities. What we heard points to a larger truth: PrEP cannot deliver on its promise when people are asked to navigate prevention systems not designed around their identities, realities, choices, or trust.

The barriers identified through this work do not occur at one point. They accumulate across the journey, from whether someone sees PrEP as relevant, to whether they trust the offer, can find a provider, afford care, begin the method they prefer, and remain connected to prevention for as long as it is useful to them. No single campaign, clinic, policy, or funding stream can address these conditions alone.

That is why the Black Prevention Agenda advances five coordinated tracks: demonstration projects and sites, sustainable investment, a Black-centric prevention campaign, workforce development, and advocacy and policy action. Together, they provide a structure for converting community knowledge into measurable systems change.

This report is both a direction and a commitment. PDiBA will integrate Phase 1 listening evidence with Phase 2 national survey findings, test and refine the five-stage conceptual model, examine meaningful differences across communities, and use what it learns to guide investment and implementation. The initiative will report its findings, identify where evidence remains incomplete, and maintain community accountability as the work advances.

The opportunity before us is not simply to increase PrEP uptake. It is to build a prevention system in which Black people can recognize themselves, make informed choices, reach care without unnecessary barriers, and stay connected to prevention on their own terms.

The data has identified the need. Community has defined the direction..

The next responsibility is collective action.

DATA. COMMUNITY. ACTION.

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APPENDICES

SEE FOLLOWING PAGES

THE PDIBA CONCEPTUAL MODEL

INTEGRATING THE TRANSTHEORETICAL MODEL(TMM) AND COM-B

A State-Based, Person- and System-Centered Framework to Advance PrEP Equity in Black America

From Awareness to Sustainable Prevention:Aligning Individual Readiness and System Responsiveness

PDiBA + TTM STAGE	A. Awareness & Pre-Contemplation **TTM: Pre-Contemplation** Increasing knowledge, relevance, and accurate information about PrEP	B. Contemplation & Motivation **TTM: Contemplation** Weighing PrEP, addressing stigma, self-assessing life fit, and building intention	C. Preparation & Navigation **TTM: Preparation** Turning intention into access by overcoming practical and structural barriers	D. Initiation & Early Engagement **TTM: Action** Starting PrEP and establishing a supportive care relationship	E. Retention, Sustainability & Prevention Alignment **TTM: Maintenance** Staying on PrEP, switching appropriately, and sustaining prevention support
COM-B MODEL Capability Opportunity Motivation	• Knowledge about PrEP • Trusted, relevant information • Personal relevance and perceived risk	• Decision-making and individual self-assessment • Supportive social/clinical dialogue • Perceived benefit, reduced stigma, and life fit	• Navigation skills and insurance literacy • Provider access, status-neutral coverage, and navigation • Confidence and perceived ability to take next steps	• Side-effect management and care self-efficacy • Low-friction clinical and pharmacy access • Trust in providers and the health system	• Adherence skills and prevention planning • Ongoing care, flexible services, and community support • Sustained benefit and positive experience
COMMON BARRIERS (EXAMPLES)	• Low awareness or misinformation • Community stigma • Few trusted messengers • Limited visibility in Black communities	• Stigma and fear of judgment • Distrust of the healthcare system • Uncertainty about need or benefit • Competing priorities and relationship dynamics	• Insurance status, literacy, and coverage barriers • Fear of bills; co-pays, deductibles, labs, and visits • Difficulty finding affirming providers • Complex systems, limited navigation, transportation, and time	• Negative provider experiences • Side effects and concerns • Lack of follow-up • Feeling unwelcome; fragmented services	• Adherence challenges • Loss to follow-up • Changing prevention needs • Ongoing stigma or discrimination • Limited sustained community infrastructure
EVIDENCE-INFORMED MODELS (2 PER STAGE)	• PrEP Chicago peer change-agent model • Kelly social-network, opinion-leader, and diffusion model	• PrEP Counseling Center tailored counseling • Mobile IMB-informed intervention	• PrEP patient-navigation model • Social-networking strategies for linkage and navigation	• Brief navigation + follow-up model • Integrated clinical-pharmacy-navigation model	• PrEPmate text-messaging support • LifeSteps for PrEP structured adherence support
KEY OUTCOMES & MEASURES (EXAMPLES)	• PrEP awareness • Accurate knowledge • Movement from A to B	• Increased intention/desirability • Reduced stigma • Self-assessed applicability and life fit • Movement from B to C	• Completed appointment • Coverage or assistance approval • Medication in hand • Movement from C to D	• PrEP initiation • 30- and 90-day engagement • Provider trust and satisfaction • Movement from D to E	• Adherence and retention at 3, 6, and 12 months • Continued prevention engagement • Re-initiation when needed • Alignment with broader sexual-health goals

← FEEDBACK LOOPS: People may move forward, backward, or re-enter at any stage as circumstances and prevention needs change. →

CROSS-CUTTING SYSTEM & CONTEXTUAL FACTORS	Racism and structural inequities	Healthcare-system responsiveness	Policy and payer environment	Black-led community infrastructure	Cultural humility and trust	Data, evaluation, and continuous improvement

WHEN INDIVIDUAL READINESS MEETS SYSTEM RESPONSIVENESS, PREVENTION BECOMES POSSIBLE.

Data. Community. Action

About, Methods, and Limitations

PrEP Desirability in Black America (PDiBA) is a Black-led, community-centered national evaluation and action initiative led by the National Black Gay Men's Advocacy Coalition in collaboration with academic, advocacy, community, and public health partners. It examines the individual, community, organizational, and structural conditions influencing PrEP awareness, consideration, access, initiation, and sustained use.

This report draws on PDiBA evaluation findings, community and system-enabler listening sessions, coalition deliberations, and publicly available HIV surveillance and PrEP-use data. Participation was voluntary and did not use probability sampling. Registration records exclude some participants and do not represent every PDiBA engagement, pilot, or national convening. Findings from participating locations are not citywide or nationally representative estimates. Self-reported experiences were not independently verified, qualitative frequency does not establish population prevalence, and observed associations should not be interpreted as causal. National surveillance and PrEP-use measures may reflect different reporting years and data sources. AIDSVu PrEP data are weighted prescription-based estimates rather than a complete census. The PrEP-to-Need Ratio is a population-level indicator of relative prevention need, not an individual clinical-risk or eligibility measure.

Ethics, Privacy, and Data Use

The Morgan State University Institutional Review Board reviewed PDiBA and determined it exempt under an exemption category in July, 2026 (Protocol No. 26/06-0197). Activities were conducted within the scope of that determination. Material changes or future analyses outside the approved scope will undergo additional institutional review when applicable.

PDiBA limits access to nonpublic information, removes direct identifiers, reports findings in aggregate or thematic form, and reviews quotations and small demographic groups for re-identification risk. Quotations may be lightly edited for readability or confidentiality without changing their intended meaning. They represent individual perspectives and are not statistically representative.

Future research, data linkage, external data sharing, commercial use, or other materially different uses require appropriate PDiBA governance review, community consultation when warranted, institutional determination, and written authorization or data-use agreements when applicable.

Medical Disclaimer

This report supports public health planning, policy, education, implementation, and advocacy; it does not provide individualized medical advice. Clinical decisions regarding HIV testing, PrEP, medication selection, monitoring, or treatment should be made with a qualified healthcare professional using current clinical guidance.

PrEP is intended for people without HIV who may benefit from protection against HIV acquisition. People living with HIV who achieve and maintain an undetectable viral load through treatment have zero risk of sexually transmitting HIV, also known as Undetectable = Untransmittable, or U=U.

Funding, Independence, and Disclosures

PDiBA was supported through private, non-industry funding. Funders did not control participant responses, data analysis, interpretation, or publication decisions. Findings and recommendations reflect the authors' and PDiBA leadership's interpretation and do not necessarily represent every partner, funder, institution, organization, or contributor.

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THANK YOU

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US HELPING US PEOPLE INTO LIVING

NATIONAL BLACK WOMEN'S HIV/AIDS NETWORK

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