



10 YEAR **PrEP** REPORT

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SUMMARY



Science has overwhelmingly demonstrated the effectiveness of Pre-Exposure Prophylaxis (PrEP) at preventing HIV yet the global rollout has been relatively slow. Countries have varied approval times and processes, resulting in many gay and bisexual men left without access to PrEP. Governments often fail to adequately fund and promote the medication, and doctors do not adhere to the proper protocol to prescribe. In turn, gay and bisexual men filled the gap and advocated and mobilized for PrEP, with some success. As a result, the agency of gay and bisexual men across the globe was augmented, and quality of life within the community, especially sexual satisfaction, greatly increased. There are a few strong models that exist for PrEP oriented community mobilization and advocacy from which much can be learned.

In summary, PrEP has helped to shift the narrative around gay male sexuality, highlighting the power of community and elevated quality of life; the power and promise of PrEP extends past medical opportunities and benefits. It has and will continue to allow gay and bisexual men to have increased body autonomy, sexual satisfaction, and improved quality of life.

KEY FINDINGS

Interviews with key stakeholders from various countries were conducted to complete this report, but due to the importance of confidentiality and anonymity, some interviewee names, their countries, and current roles are omitted. Key findings from the report are summarized in Table 1 below. Each section of the table is explored in more detail throughout the report.

TABLE 1: KEY FINDINGS

WHAT IS PREVENTING LARGER UPTAKE OF PREP? WHO LACKS ACCESS TO PREP? WHERE CAN PREP BE FOUND/PRESCRIBED? OPPORTUNITIES: WHAT TO LOOK FORWARD TO?	• Legal and Political hurdles • Moralism • Systemic Homophobia • Lack of accurate awareness and knowledge • Migrant men • Racial & ethnic minorities • People who inject drugs • Sex workers • Trans Individuals • Rural/Urban Divide • Government-run clinics are beyond capacity; backlog exists • Increased access to telemedicine • Uplift lived experience leadership • Scale up government funding and/or provide private alternatives • Ensure generic PrEP is available globally • Translate PrEP materials into multiple languages • Fight stigma and normalize same-sex sexual behavior
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INTRODUCTION

Pre-exposure prophylaxis, known as PrEP, is an effective pill-based HIV prevention strategy. In 2012, the World Health Organization (WHO) produced the first PrEP guidance for public health stakeholders, recommending daily oral PrEP in the context of demonstration projects for gay, bisexual men and other men who have sex with men (MSM), transgender women, and serodiscordant heterosexual couples. In the same year, the United States Food and Drug Administration (FDA) officially approved the antiretroviral medication Truvada to be used as PrEP to prevent HIV.

Evidence of effectiveness from clinical trials of the “new promising” HIV prevention approach was already strong, but how PrEP would be implemented and scaled up in the real world was yet unclear. The results of demonstration projects and the continuing high rates of HIV incidence led WHO to issue new guidelines in 2014 recommending oral PrEP “as an additional HIV prevention choice within a comprehensive HIV prevention package” for MSM.

In the last 10 years, the status of PrEP and how it is administered has constantly evolved. For example, PrEP first started as a daily pill regimen, but for some, this was an overwhelming and unsustainable daily task. Therefore, the implementation of on-demand PrEP was also approved in some places; instead of a daily regimen, individuals can adopt the “2-1-1” plan. When adhering to the 2-1-1 protocol, it is suggested that one takes 2 pills 2-24 hours before sex, 1 pill 24 hours after the first dose, and 1 pill 24 hours after the second dose.

It is important to note that in addition to dosage, what medications are considered as PrEP have expanded. Truvada was virtually the only option until 2019 when the FDA formally approved Descovy for PrEP, too. In December 2021, the FDA added to the list and announced the first injectable form of PrEP is now approved and available.

1. 2012 WHO Guidance on oral pre-exposure prophylaxis (PrEP) for serodiscordant couples, men and transgender women who have sex with men at high risk of HIV: recommendations for use in the context of demonstration projects.

After almost one decade, there is much to celebrate about PrEP. It has demonstrated itself as a highly effective and powerful tool in the fight against HIV, like treatment and undetectable, ensuring zero transmissions. PrEP has contributed to steep reductions in HIV infections among gay men and other men who have sex with men in several cities in North America, Europe and Australia where PrEP is widely available, but the stark reality is that not everyone who wants or needs PrEP has access to it.

Globally, PrEP uptake has increased in the last years but vast inequalities still exist. Much of the PrEP scale-up is still highly concentrated in a fairly small number of countries, notably the United States of America, and in eastern and southern Africa. Despite being a key population with an elevated risk of HIV acquisition, gay and bisexual men, especially men of color and/or migrant men, have been deprioritized and under-invested in. In the absence of government support, gay and bisexual men across the globe have mobilized and advocated for better access to PrEP.

After 40 years of the HIV epidemic and 10 years of oral PrEP for gay men this is a strategic moment to review the global scenario of PrEP, analyzing critically what worked and what doesn't.

This report serves as a brief snapshot of the global state of HIV, PrEP, and gay and bisexual men. It should be used as a catalyst for conversations and action surrounding accountability, health justice, and more equitable access to PrEP.



2. 2014 WHO Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations.

THE CURRENT STATE OF HIV

Since the discovery of the virus in the early 1980s, HIV has remained a significant global public health challenge. The world has observed vast advancements in HIV care, ranging from more effective treatments that help sustain life to more accurate testing procedures. Despite significant advancements over the past 40 years, the global HIV pandemic continues to do immense harm, particularly to vulnerable populations. The latest figures from UNAIDS illuminate the state of HIV at the global level (see below).

- 28.2 million people were accessing antiretroviral therapy as of 30 June 2021.
- 37.7 million [30.2 million–45.1 million] people globally were living with HIV in 2020.
- 1.5 million [1.0 million–2.0 million] people became newly infected with HIV in 2020. It is estimated that 23% of these new infections occurred among gay, bisexual men and other men who have sex with men.

The scientific progress we have seen in HIV over the past 4 decades has been quite significant but not every population has benefited from this progress and persistent structural factors and inequalities prevent universal access. Stark discrepancies and disparities still exist. This is especially true for certain key populations, including gay and bisexual men.

Structural factors, such as stigma, discrimination and violence based on sexual orientation and gender identity, and the criminalization of same-sex sexual behavior create many barriers that prevent gay men from accessing HIV services. This disparity is exacerbated by race, social class, and one's geographic location. Gay men of color, those of migrant status, and those who live in the Global South maintain the highest rates of HIV acquisition, but also have the least amount of access to PrEP. The global fight against HIV requires substantial investment in gay and bisexual communities with a proactive, equity-centered approach that works to dismantle structural homophobia, racism, classism, and xenophobia.



EFFECTIVENESS OF PrEP

We have the tools available to push for equity and ensure adequate HIV care for all; PrEP is one prevention strategy that is currently underutilized. Opponents of oral PrEP exist, but its efficacy is well established. Despite PrEP's effectiveness and the potential to radically change the HIV pandemic, the uptake of PrEP was slow due to a myriad of attitudes, opinions, and beliefs. The prescription Truvada was the first method of medicalized PrEP approved. Pill-based PrEP, which now includes Descovy and generic options, combines tenofovir and emtricitabine, and when taken daily, PrEP reduces the risk of gay and bisexual men acquiring HIV from sex by 98%. The on-demand (2-1-1) strategy reduces risk by 86%.

PEP or post-exposure prophylaxis is another pill-based HIV prevention strategy. PEP is a series of pills one can take after potential exposure to HIV. PEP protocol requires an individual to take a series of medications (tenofovir/emtricitabine, and raltegravir or dolutegravir) within 72 hours of potential exposure and they must continue the regimen for 28 days.

Initial reports of PrEP's effectiveness were questioned by politicians and the medical community, and there were constant calls for more research before a large-scale rollout. In the early 2010s, two studies, in particular, were groundbreaking. A 2010 study (iPrEX) published in the *New England Journal of Medicine* was the first to document PrEP's effectiveness and opened the door for other studies. While PrEP was approved in the United States in 2012, other countries wanted to see more research. In 2015, Ipergay PrEP was officially published, reinforcing daily PrEP's efficacy while also revealing the promise of on-demand PrEP.

Countries vary on when PrEP was approved, who prescribes it and how it is paid for, but the evidence is abundantly clear- PrEP works and is an invaluable tool, but only to those who have access to it. In 2016, the UN General Assembly set a global target of 3 million oral PrEP users by 2020. There were about 940 000 people across 83 countries in the world who received oral PrEP at least once in 2020.

The importance of the engagement and mobilization of activists and community-led organizations and networks to expand access to information, generate demand, increase PrEP uptake was demonstrated in several studies. In summary, PrEP is most effective when deployed in a manner that engages, prioritizes, and empowers the community.

3. 2014 WHO Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations.

4. "A Timeline of Covid-19 Developments in 2020." AJMC. Accessed January 5, 2022. <https://www.ajmc.com/view/a-timeline-of-covid19-developments-in-2020>.

COVID 19'S IMPACT ON HIV & PrEP



As the world entered 2020, a new virus called COVID-19 was detected. Once discovered, the virus quickly spread and caused alarm in countries with confirmed cases. On January 31st, 2020, the World Health Organization (WHO) issued a global health emergency, making COVID-19 only the 6th instance of such a proclamation, but this declaration did not curb the impact of the virus. In March 2020, The WHO officially declared COVID-19 a global pandemic, making it the first pandemic since H1N1 over 10 years ago.

COVID-19 largely decreased the ability to secure PrEP and general access to medical care. COVID-19 restrictions like stay-at-home measures, created barriers to care as individuals were forced to cancel medical appointments, including PrEP follow-ups. In some cases, there also was a literal absence of physical space, capacity, and availability to see patients who did not have complications related to COVID-19.

The impact of COVID-19 led to some positive changes. For example, because of limited appointment availability, individuals were able to secure 3-6 month-long prescriptions for PrEP as opposed to the typical period. In addition to this, there was a large shift to telemedicine, which allowed patients to be assessed by a physician remotely, highlighting the promise of virtual care.

PrEP'S GAPS & CHALLENGES

The high cost of PrEP remains a significant challenge to increasing uptake in gay and bisexual men; this is especially true in countries without government-funded healthcare. Moreover, because of patent protections and other issues, generic PrEP is not available to all who need it. The cost has been a well-documented challenge, but this report would also like to highlight other barriers. Other gaps and challenges fall into three categories:

- 1) What is preventing the uptake of PrEP?
- 2) Who has been left out of PrEP?
- 3) Where can PrEP be prescribed?

#1: What is preventing a larger uptake of PrEP?

When asked about barriers to increasing PrEP, Teymur Noori (European Centre For Disease Prevention and Control-ECDC) stated, "I feel there definitely is still pressure to justify PrEP even though studies have been done. The reality of the issue is that it is about gay men. Gay men having sex." Another interviewee, Dr. Will Nutland of PrEPster (UK) echoed a similar sentiment- "We have grown to expect silence from the government. What sticks out most is the homophobia and silence from doctors and scientists. Even CBOs. Even if they are not silent, they are not advocating for PrEP like they should."

The two quotations above highlight a key finding- those who seek PrEP continue to face barriers rooted in sex-based stigma and homophobia. In order for PrEP to reach its maximum efficacy, the world would have to accept the sexual liberation of gay and bisexual men. However, this rarely emerges. For many, this stigma stems from being socialized in a world where condoms are the default and only approved HIV prevention measure, but this paradigm and language about protection have officially shifted.

The gay and bisexual community continues to face sex-based stigma from larger communities and institutions; in turn, there is a subtle yet constant dehumanization of gay men, their social worth, and sexual autonomy. This sex-based stigma is found both within the gay and bisexual community as well as outside of it. For example, the label "Truvada Whore" was a popular trope launched at gay men who took PrEP and were sexually active; this stereotype was heavily circulated by and within the gay community. One interviewee, Dr. Thiago Torres who is located in Brazil (INI-Fiocruz) noted, "I found that so many gay men, especially at the start were afraid of being open about taking PrEP. Afraid of the judgments. Afraid of the ridicule. They didn't want their friends to judge them for taking it. Sometimes doctors may hear you want PrEP and automatically assume you only want it to have more sex."

The belief that gay men should not possess bodily autonomy and the right to engage in pleasurable, consensual sex is embedded in homophobia and sexual stigma. This idea is still prevalent.

Most progress related to PrEP has relied on the work of the community in the absence of government. Often, especially toward the beginning of PrEP's global rollout in the mid-2010s, government officials were slow to invest in PrEP. Dr. Nutland explains, "PrEP served as a rallying cry for the HIV sector. It gave us a common purpose and target. We saw the government was not doing anything and decided we had to do something." Initially, the idea of funding PrEP and advocating for the drug on a large scale was unfathomable; leaders, including politicians and health officials, across the world contended condoms were enough and more research must be conducted to ensure PrEP is safe and does not lead to increased "reckless and risky sexual encounters." Teymur of ECDC, expressed a turning point with research- "We kept hearing we need more research. We don't know enough. We need more research. We don't know enough. I feel a lot of that changed in 2016. The 2016 meeting at Ipergay after was influential. We had evidence we didn't have before. And we were finally all together to discuss."

After having access to more research, governments started to slowly invest in PrEP, but the majority of the work was still driven by the gay and bisexual community. The community continues to face various attitudinal barriers; it is impossible to cover the depth, breadth, and scope of these issues in one report, but 4 large attitudinal barriers (political/legal hurdles, sex-based stigma, homophobia, and awareness/-knowledge) are preventing a larger scale-up of PrEP.

Barriers:

1) First, in many regions, there are still massive legal and political hurdles to securing PrEP. If engaging in any same-sex sexual encounter is illegal, it is unrealistic to expect one would accept the substantial legal and social risks associated with asking for PrEP. One interviewee explicitly expressed this idea- "If my doctor can report that I am gay for asking for PrEP, and I know that being gay can lead to greater issues in my country, I probably would not ask. I may not even know who or where is safe to ask. I would not risk it to find out." The criminalization of same-sex sexual behavior appears to be an insurmountable barrier for PrEP in countries like Uganda where homophobia is codified in the law. It is important to note that political hurdles have existed regardless of political affiliation, but interviewees noted that growing conservatism often comes with moral judgments, revealing a second belief contributing to the larger problem.

2) Second, there is still a large cloud of moralism that looms over conversations surrounding PrEP. Its efficacy is rarely in dispute, instead, individuals decide they are morally opposed to PrEP. This could be for many reasons; on one hand, a doctor may be homophobic and does not approve of the “lifestyle.” Even if a doctor serves gay and bisexual men, they could still refuse to provide PrEP because they fear it encourages more condomless sexual encounters. Based on interviews, in a Latin American nation with government-sponsored PrEP, there are instances of doctors rejecting prescribing PrEP even though the prescription is already covered by the government. One interviewee explained, “Even if it is technically illegal to reject patients who want it, doctors have the power. They prescribe it. I know stories of doctors lying and saying they don’t have PrEP when the clinic is government-funded and must have PrEP. If this happens, what do the guys do? Who can they tell?” This quotation highlights a clear power difference at play- doctors are an essential piece in advancing PrEP, but beliefs are preventing patients from accessing it.

3) Third, as previously highlighted, stigma & systemic homophobia still remain strong barriers to adequate PrEP uptake. This is especially true in nations like Russia where same-sex encounters may not be illegal but are heavily policed and stigmatized. An act does not have to be illegal to put one at risk.

Even if direct physical or psychological violence is not a concern, the constant strain and stress of homophobic based stigma is enough to lead to significant mental health concerns, distrust in medical/government, and a lack of self-efficacy. Systemic homophobia pressures one to defend their existence. This homophobia extends into every aspect of society. For instance, as outlined above, a doctor may simply refuse to prescribe PrEP to an out gay man because they do not want to approve of the “promiscuous lifestyle,” even if there is no evidence that their gay patient is ‘promiscuous.’ This notion, which is still prevalent, is rooted in homophobia. As a response to this homophobia, gay men proved to be creative and resilient in their responses to secure PrEP. For instance, some men report lying about their sexuality and sexual history as a means to secure PrEP. Provider hesitation is a perfect example of how homophobia can be subtle yet embedded in our structures. The idea of provider resistance is discussed in more detail below.

4) Finally, there is a dearth of PrEP knowledge and awareness. Initially, there are large portions of men who have sex with men (MSM) who may have never heard of PrEP. This is especially true for individuals who do not identify as “gay,” “queer,” or “bisexual.”

Dr. Nikolay Lunchenkov, LGBTQI+ health coordinator at the Eurasian Coalition on Health, Rights, Gender and Sexual Diversity, explained, “the further you get from cities, the less is known. There is still a lack of awareness in the larger community. But people don’t trust government. So, there is a ton of community work that needs to be done in the region to make sure people know about it.”

Adding to this, accurate knowledge surrounding insurance coverage, and other medical reimbursements, etc complicate the issue. On one hand, patients often fail to seek help because they do not know PrEP is free under state health centers. On the other hand, many medical establishments, both private and public, neglect to carry PrEP because of the risk, stigma, and fears of minimal reimbursement. In a Latin American nation, one interviewee outlined how government-funded clinics may still reject PrEP- “Some centers don’t want to deal with PrEP because they do not want to learn all of the steps and tests needed. They believe it is a lot more work, but not more money. They don’t believe there is any additional compensation for PrEP. A lot of clinics don’t want to be known as the PrEP clinic” In countries without government-funded healthcare, some private clinics, especially in the United States, fear not being able to sustain PrEP long term without additional resources, funding, and/or faster reimbursement time.



#2: Who has been left out of PrEP?

Migrant Populations:

Across the globe, queer migrant men have been largely left out of access to PrEP; this is true even when a country's rates of HIV acquisition are highest amongst this demographic. In the UK, especially Britain, South-Asian migrant gay and bisexual men (namely: Pakistani, Indian, and Bangladeshi) have the highest rate of new HIV infections, but also the smallest amount of new PrEP prescriptions. In Eastern European countries, the same problem persists- migrant MSM are not treated equally, and simply do not have adequate access to PrEP. It is important to note even if PrEP is available, this does not always yield increased uptake and adherence.

Many migrant men fear government-run clinics because they fear being flagged (stigmatized) in the government's system, or worse, deported. In some instances, if one is undocumented, one believes they may not even have access to state programs. Dr. Nutland, alluded to this dilemma, "We know about 50% of new infections are in migrant men. Many migrant men don't know that PrEP is covered even if they are not a citizen so they don't even come into clinics. When they do, they are afraid they will be flagged and reported. But sexual health has an added layer of protection. It is not reported the same way. We just need a name-can be a fake one even. A number to reach you and postal code for transmission data."

Racial & Ethnic Minorities:

In addition to disparities in migrant communities, extensive inequalities also exist across racial barriers. Globally, racial and ethnic minorities continue to lack adequate access to PrEP. This is especially true for more racially diverse nations such as the United States and Brazil. In the United States, figures from 2019 reveal Black gay and bisexual men made up around 38% of HIV diagnoses amongst MSM whereas Latino gay and bisexual men account for nearly 35% of diagnoses. Together, the demographics represent over 70% of HIV cases, but do not account for 70% of the gay and bisexual community.

In Brazil, both the fatality rate and rate of new infections disproportionately impact the Black men in the country. In the United States, Black MSM have not observed the same progress as other populations. According to the latest CDC reports, while some other demographic groups are observing decreases in HIV incidence rates, Black MSM are experiencing the opposite- the last decade has ushered in elevated rates of HIV diagnoses. Figures released by the 2016 Conference on Retrovirus and Opportunistic Infections (CROI) unveiled a stark reality. If current trends persist, approximately 1 in 2 (50%) Black MSM will be diagnosed in their lifetime. Such figures highlight a somber, but important truth- Black MSM continue to bear the biggest burden in combating HIV and have had less access to PrEP.

People Who Inject Drugs:

Because of their marginalized social position, people who inject drugs rarely have access to PrEP. Again, this is true despite research indicating the demographic possesses elevated levels of risk. Often, this lack of access is tied to moralism and/or judgment; doctors may neglect to prescribe PrEP because they believe it “justifies” the patient’s behavior. Doctors may also fail to prescribe the medication because they assume one who injects drugs will not adhere to the treatment protocol.

Many interviewees expressed the need for increased access for people who inject drugs. One stated, “Progress has been made for many groups, but injection drug users are not talked about enough because of stigma and criminalization. I know we have talked about homophobia and structural issues already and we have to acknowledge that many people use drugs as a way to cope with these issues. Drug use is a response to a problem, not the problem itself.” Another interviewee located in Eastern Europe acknowledged the growing rates of injection drug use and HIV in the region. He explained, “Injection drug use is huge here. Casual and as a sex drug. Party drugs. Being a drug user is a different kind of stigma than being gay or bisexual. We have come a long way with understanding sexuality. I don’t think we have come that far with drug use. People can look at an injection drug user and believe they are not worthy of help. Or sympathy. To them, they are not worthy of PrEP.”

It is important to note that as highlighted above, in many nations, injection drug use is a criminal offense and a patient could risk punishment if proper protocols and protections are not put in place.

Sex Workers:

People who participate in sex work are also at an elevated risk of acquiring HIV, but have been systemically pushed out of access to PrEP. Dr. Nutland highlighted one issue when he stated, “many, not all, do sex work because they have to. And sometimes unprotected sex will bring in more money. Sex workers can be very vulnerable and exploited. They really depend on each other for community and protection.” The quotation above explains how sex workers can be pressured to engage in condomless intercourse, a well-known HIV risk factor. Sex workers must see a physician to get PrEP, but seeking medical treatment and paying for PrEP is not easy, especially if one is transient. One interviewee briefly discussed a systemic barrier. He explained that getting PrEP and staying on PrEP is easier if one has a predictable schedule, consistent income, and stable housing, but a large portion of sex workers must be flexible to meet the needs of clients.

Trans Individuals:

It is important to note that none of these barriers or challenges exist in a vacuum, and accounting for intersections is of the utmost importance. For example, certain demographics are more prone to engage in injection drug use as a coping mechanism and/or sex work out of economic necessity. Even though they are at an elevated risk of acquiring HIV, individuals of the trans experience, both trans men and trans women, largely lack access to PrEP. Structural factors, such as lack of long-term employment opportunities and stable housing, remain significant barriers that exacerbate known risk factors. Moreover, in various countries, sexuality may be protected under the law, but rarely is one's trans identity explicitly protected. Most troubling, trans individuals are constantly at risk of violence. In the United States, at least 47 trans people were killed in 2021, and this is the highest figure ever recorded for this type of violence. Trans individuals continue to face overt and covert discrimination that impact their ability to access PrEP. For example, even if one has the resources to secure a PrEP appointment, a doctor may disregard their request as they disagree with one's gender "choice"; this eliminates the sexual agency of trans individuals and leaves them more at risk of acquiring HIV.



#3: Where can PrEP be found/prescribed?

Adding to who has been largely left out of PrEP, attention toward where PrEP can be prescribed is also worthy of discussion.

Urban/Rural divide:

As PrEP advances, gay and bisexual men in rural and more isolated communities are not receiving adequate care. Essentially, most PrEP advocacy, PrEP providers, and testing can be found in the larger metropolitan areas. Both access to PrEP and awareness of PrEP drastically decrease as one moves away from city centers. More troubling, for many MSM in rural areas, access to solid, consistent internet is also not available; therefore, any hope for telemedicine or online access to PrEP is virtually nonexistent. One's geographic location should not prevent them from accessing a potentially life-saving drug.

Government Clinics:

By far, one of the most significant barriers to PrEP is accessing a physician willing to prescribe it. Various macro and micro level attitudinal barriers were discussed above, but it is important to note that a patient's desire and strong demand for PrEP, even with adequate coverage, does not mean they can actually receive a prescription. Intense moral objections may prompt physicians to claim they do not have PrEP, even when there is a legal mandate.

Most nations with state-run health-care, require PrEP can only be prescribed and monitored through official government offices/channels. However, for many countries, especially those in the UK, EU, and Latin America, demand for PrEP far exceeds government capacity, creating a massive backlog of cases. Interviews revealed that in a Latin American nation, individuals did not even have the ability to request PrEP appointments because all of the clinics "were fully booked." This backlog extends past access to appointments. For example, in many countries, the actual processing of HIV and other STI tests are also delayed. Thus, gay and bisexual men across the globe are: struggling to find doctors to prescribe PrEP, diligently waiting for their test results, and concerned about how to pay for the medication.

SUCCESS

Despite all of the barriers and issues outlined above, progress on PrEP has been made. In 10 years, PrEP has gone from research to approval to global rollout. PrEP advocacy has been achieved in spite of large-scale support, not because of it. The nearly 1.5 million individuals currently taking PrEP can attest to its effectiveness. After 10 years, we are in a strategic moment to learn from gay activism and community engagement in PrEP implementation—what works and what is needed to expand access to this prevention option and invest in the lives of gay men. Mobilization and advocacy of the community have been the crux of advancing PrEP globally.

Going forward, government investment needs to match the passion of community mobilization. It is crucial to highlight the power of the community and augment its power. Over the past 10 years, community mobilization has achieved a multitude of successes.

The next section will highlight two takeaways as well as present an exemplar case study of PrEP advocacy within the gay and bisexual community.

Success #1: Increased Agency, Self-Advocacy & Sense of Community

As discussed in this report, PrEP dramatically increased sexual agency, even in the face of intense stigma. Similar to the ACT UP advocacy at the beginning of the HIV epidemic, gay and bisexual men were forced to consolidate power and advocate for themselves.

In the absence of government assistance and support, MSM had to lean on each other. This sparked organic, grassroots movements in various countries. These movements were incredibly important for various reasons. First, in addition to ample social support within these networks, individuals were able to pass along information about securing PrEP that would have otherwise been unknown. Word of mouth and social support are often the antidotes to homophobia and stigma. Sharing information on doctors, affordability, etc. is an invaluable tool for accessing PrEP. Secondly, the lack of access to PrEP provided the community with a clear, tangible target. Individuals were able to turn individual rage into collective action and push for PrEP.

Third and perhaps most importantly, gay and bisexual men were able to achieve an elevated rate of self-advocacy and agency. Through the process, the community recognized their brilliance and ability to influence policy. These experiences, ones that honor and uplift community and lived experience need to be at the forefront of global PrEP advocacy. Dr. Nutland, who is a co-founder of PrEPster expressed the following, “*lived experience is expertise and should be treated as such. We need to call out the HIV establishment and medical industry. PrEP still needs more education and advocacy.*”

Success #2: Better Understanding of Overall Sexual Health

Analysis from the stakeholder interviews reveals that in addition to increased self-advocacy, PrEPster has been successful in ushering in more productive conversations surrounding sexual health amongst gay and bisexual men. Dr. Nutland explained that after the advent of PrEP, “even if the language and conversations were not perfect, the community started to have convos about sexual health. It drew gay and bisexual men together to discuss their health and well-being.” Simply, PrEPster has pushed HIV and sexual health back into the public sphere. An example of how this was done can be best understood by analyzing the work of PrEPster (UK).

Exemplar Case Study: PrEPster (UK)

This report could not be complete without highlighting the prevalence, promise, and power of PrEPster (UK). What started as an informal meeting at a kitchen table has blossomed into a large-scale PrEP advocacy movement with huge success. As a response to fatal moralism (“we won’t approve PrEP”) by England and other nations in the UK, PrEPster started because there was a lack of PrEP availability. While it started in England, its impact has spilled over to the larger UK and EU. PrEPster has influenced PrEP in various ways. (1) At the political level, it allowed for men to harness their collective power and mobilize for PrEP in the UK. Scotland approved PrEP in 2017, but England did not approve PrEP for the general public until 2020. (2) PrEPster did an impeccable job of carving out a space for digital advocacy.

For example, PrEPster was able to test and verify the safety and efficacy of PrEP found online as well as generic options; both of these tasks were ignored or rejected by official government entities. PrEPster single-handedly was able to secure PrEP for hundreds, if not thousands of gay and bisexual men in the region. Adding to their direct action, PrEPster also established multiple websites that can help one navigate the complex process of securing PrEP. Working with another organization, PrEPster helped establish <https://www.iwantprepnnow.co.uk/>, a website that gives information about PrEP, including insights about coverage under the National Health Service.

Also, <https://www.shl.uk/> is a website that men in London can use to get screened for STIs at home. Last, PrEPster has remained steadfast in its advocacy related to queer migrant men. PrEPster’s sponsored website, <https://www.queerhealth.info/projects/qmm> is one of the only global resources dedicated to migrant men who have sex with men and their sexual health. PrEPster is a textbook example of what a community can do when they have to, but to be clear, the onus of advancing PrEP should not rest solely on the shoulders of the community.

OPPORTUNITIES

The global state of PrEP and MSM is marked by barriers, challenges and accomplishments. Although the problems are well warranted and documented, progress can happen. In fact, the gaps and challenges outlined above should be perceived as opportunities for growth going forward. PrEP has the ability to usher in a new norm for gay and bisexual men across the globe; a norm where stigma and homophobia are not paramount, but agency, advocacy, and activism are. How can we ensure the next 10 years of PrEP is more productive and equitable than the first 10 years? This report outlines 6 different opportunities:

OPPORTUNITY

#1: INCREASED FUNDING FOR AND ACCESS TO TELEMEDICINE.

#2: INCREASE COMMUNITY ENGAGEMENT, SHIFT FUNDING TO LOCAL ORGANIZATIONS, AND UPLIFT LIVED EXPERIENCE LEADERSHIP.

#3: IN ORDER TO MEET GROWING DEMAND, GOVERNMENT-FUNDED CENTERS MUST:
(1) INCREASE CAPACITY AT LOCATIONS OR
(2) PROVIDE ADEQUATE PRIVATE ALTERNATIVES

RATIONALE

If issues of isolation, region, and geography continue to present barriers, telemedicine could mitigate some concerns, but the expansion requires increased internet access. The use of telemedicine for PrEP exploded during PrEP, highlighting testing and delivery of medication can be accomplished virtually if necessary.

PrEPster revealed the promise of community action and lived experience. Advancing PrEP will require a different framework and the men who were originally left behind must be included going forward.

The report showed one of the major barriers to services was the ability to be seen by a doctor. If demand is repeatedly overwhelming the supply, the pattern should be acknowledged and resources shifted.

**#4: PUSH FOR GENERIC OPTIONS
TO BE AVAILABLE GLOBALLY**

**#5: ENSURE PREP CENTERED
MATERIALS ARE AVAILABLE IN
MULTIPLE LANGUAGES**

**#6: COMBAT STIGMA BY
NORMALIZING SAME-SEX SEXUAL
ENCOUNTERS AND
DECRIMINALIZING GAY SEX**

Rates of acquisition are highest in marginalized groups, and these demographics often have less disposable income to pay for brand name PrEP. If the next 10 years are to be more equitable, generic must be offered.

Our world, and the networks of gay/bisexual men will become increasingly more diverse. Linguistic differences must be respected and acknowledged. Migrant men should have access to PrEP in their native language

In some countries, decriminalizing gay sex is the first step to increasing PrEP access because the elimination of large-scale legal/political hurdles is critical. In addition to actual policy changes, a large cultural shift where gay sex is no longer stigmatized is needed.



CONCLUSION

Overall, PrEP's medical efficacy is unmatched. In addition to the clear medical benefits of the drug, PrEP revolutionized health within the gay and bisexual community. PrEP is undoubtedly a pill that centered sexual power and placed the power back within the hands of the community. As one interviewee boldly proclaimed:

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I have worked in HIV prevention and health promotion for 25 years. PrEP is the most impactful health promotion tool that we have to bring people into sexual health services. In one nation, 1/3 of new PrEP recipients had never received any sexual screening or sexual health services in the past two years. I have never seen a more powerful tool for anything related to sexual health.

– Dr. Will Nutland,
PrEPster UK

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The studies recently published about the efficacy of a long-acting injectable medicines to prevent HIV among gay men have once again demonstrated the innovative and promising nature of PrEP as a tool that can contribute to end the HIV epidemic by 2030. How long it will take for this new technology to effectively reach the people that most need it and the impact it will have on advancing prevention is still unpredictable. The accumulated experience and lessons from the implementation of oral PrEP give us an opportunity to avoid the mistakes of the recent past.