PODCAST TRANSCRIPT

What Matters Right Now for Rolling Out the Ring and Injectable PrEP?

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March 30, 2022

Jeanne Baron [00:00:03] You're listening to Px Pulse, a regular podcast bringing you fresh voices on critical issues facing HIV prevention research today.

Jeanne Baron [00:00:25] The field of HIV prevention has two new approved products waiting in the wings. The dapivirine vaginal ring and injectable cabotegravir as PrEP. Until now, daily oral PrEP has been the only drug-based strategy for HIV prevention since it was approved in 2012. So here we are. Research has shown safety and efficacy for both the ring and injectable cabotegravir (CAB). Now it's time to take the next steps to deliver these options. At AVAC, we've been calling for plans to introduce and roll out new products, all new products, including the ring and injectable CAB, and to do it better than ever before. It's time to learn from the mistakes of the past, especially lessons from rolling out oral PrEP. And we're going to look at that more closely today. I'm Jeanne Baron. In this episode of PX Pulse AVAC's Executive Director Mitchell Warren is joining me in a conversation with Linda-Gail Bekker and Lillian Mworeko. Linda-Gale is a physician, scientist, and COO of South Africa's Desmond Tutu Health Foundation and a member of AVAC's board. Lillian is a Uganda-based advocate of HIV and women's health, and a leader in the International Community of Women Living with HIV East Africa. Thank you all for joining. As we speak, a lot of meetings, planning, key decisions hang in the balance for both of these new products. Let's talk about what matters right now for ring and CAB rollout to really reach all of the populations that need it. Linda-Gail, let's start with you.

Linda-Gail Bekker [00:02:03] Thanks, Jeanne. Right now, there are two important things that matter to me. The one is how much they will cost, because that really does have an impact on us being able to get it firmly into our public sector. But in the nitty gritty, we need to understand how we fold them into our health services. And that will vary from setting to setting, country to country, so much work to be done and urgently in order for us to be able to move this forward.

Jeanne Baron [00:02:39] Lillian, what are the most immediate priorities you see at this moment to get rollout right for each of these products?

Lillian Mworeko [00:02:48] I cannot say how excited I am that we have these two preventive tools coming up at a time when we are continuously struggling to have prevention tools that work for the vulnerable groups in our region, the adolescent girls and young women, the

female sex workers, and key populations. So what matters most right now is the urgency. There has to be immediate demand creation.

Jeanne Baron [00:03:27] Yeah, what's urgent about demand creation?

Lillian Mworeko [00:03:31] We are seeing countries not coming out very, very fast, [not as fast] as we would want them to do. And that means that they have to be pushed. So for me, demand creation, having the populations that are being impacted by the new HIV infections coming up strongly and pushing so that our countries are able to take this agenda forward is one important factor for me. And then there has to be a push on how we are going to bring down the costs. But also how we are going to make it real. We cannot continue talking about prevention that is not reaching the vulnerable groups. So I say again, to look at the question of cost, we must have voices. We are going to need to have activists stand up and speak loudly as to why it is important to bring these costs down. And for me, at this moment, there has to be a policy change and shift. We have Zimbabwe to learn from. Zimbabwe has approved the use of dapivirine vaginal ring, and also South Africa has given us a green light. Therefore there has to be a shift in policies and guidelines at the country level. So for me, it matters a lot that countries must adapt and change their policies and guidelines to make sure that they include these two preventive tools within their guidelines.

Jeanne Baron [00:05:07] Right. I hear you that governments have to not just approve but also integrate newly approved products into policies and practice. And hats off to Zimbabwe and South Africa for showing a commitment to making the ring available. We'll touch on this again in a moment. But first, let me ask you when you're talking about demand creation, who needs to push who?

Lillian Mworeko [00:05:33] So to me, what matters right now, and looking at where we've come from and where we are, most of the things that we have right now is because these communities stood up and said, 'we cannot wait any longer.' We have to mobilize adolescent girls and young women who are continuously, for example, getting infected in my region, sub-Saharan Africa. We have to mobilize communities of key populations. We have to mobilize civil society to make sure that they are pushing their governments, that they are pushing the donors, that they are pushing the pharmaceuticals to make sure that what needs to be done is done. But if we sit back and we are not showing them why it is important and how they have to do it, they may not move at the speed at which we need these processes to move.

Jeanne Baron [00:06:27] So it's the communities who need these products who must demand that decision-makers such as governments, funders and drug makers do what it takes, do their part to speed these products, which we know work, onto the shelf and into people's hands. And there is momentum right now behind both these products. As we mentioned earlier, South Africa's regulatory body has just joined Zimbabwe in giving a green light to the ring. And as we speak, the WHO is developing guidelines for injectable cabotegravir. Mitchell, one of the big lessons from oral PrEP is that it took too long before it was delivered at scale. It was approved in 2012, but approval in many countries took years, including in the African countries where HIV

continues to be a really heavy burden. The number of people using it all over the world remained really low until 2020 or so. And it's still too low, approaching two million users when there's tens of millions who might benefit from it. What does the field need to do differently?

Mitchell Warren [00:07:37] Well, I do think, and I'd love to hear both Lillian and Linda-Gail's reflections, you know, there's so much time and effort put into the clinical trials. And yet we don't commit similar urgency and resources to what comes after efficacy. A lot of emphasis in funding for research and development, but less so for delivery. Oral PrEP really demonstrated that, as you just said, Jeanne, and we need to flip the script. Not only for these new products, but for future products. How do we get people to understand that the investments in delivery are actually even more important than the ones in R&D? Because if we don't invest in the delivery, then the fruits of great science, whether it's PrEP in any form or COVID vaccines, don't have impact. And I'm wondering, given the current environment both with HIV prevention and with COVID vaccines, if there is a new way to think about what needs to happen.

Linda-Gail Bekker [00:08:35] Yes, Mitchell, Jeanne, if I could just chime in here, I think the best model of late has been how we've really tackled COVID vaccines, right? Yes, there was urgency in clinical trial development of COVID vaccines, but thereafter there has been an unprecedented push to get these vaccines into arms really across the world.

Jeanne Baron [00:08:58] And what has it taken? What are some of those models?

Linda-Gail Bekker [00:09:02] It's been extraordinary. We've differentiated care. We've said you can drive through. We've had pop-ups. We've had vaxi- taxis. I mean, you name it, we've had innovation around getting these vaccines out. Now, even in the face of that, we know there has been some reluctance on the part of individuals. I think there's even lessons there, that if you don't go out with good information to people, and I think Lillian's right, we need to create that demand. But before we create demand, we've got to make sure that every woman you know, every young MSM person, every person who could benefit from PrEP is fully aware, That's number one, that there is such a thing as pre-exposure prophylaxis in the world today. Secondly, that they now have choice that choice includes taking a daily pill, an event-driven pill, an injectable PrEP, or indeed for women, a vaginal ring. And this is just revolutionary. We then have to make this accessible to every single person who could benefit.

Jeanne Baron [00:10:10] And let me just quickly add here, you referred to MSM, that's men who have sex with men and gay men. And Linda-Gail, let me press you, actually all three of you. What lessons from oral PrEP are you focused on at this stage of planning for these two new products?

Linda-Gail Bekker [00:10:26] Yeah. So maybe I'll jump in with the one that I tend to be most involved in, and that is the dreaded word 'pilot'. So I do hear quite a lot of chat about how we need to do the health service research or the implementation science to understand: where are we going to do this? Who is going to administer it? How is it going to be administered? How do we distribute it? Et cetera. And indeed, we do need to do that learning. But I think what we

did with oral PrEP, which was a mistake, was that it was a bit of a free for all in terms of the implementation science. And we tended to do it in serial and wait for results before we move to the next step. Certainly, that was my impression from where I was sitting. This time around, that urgency that Lillian was speaking about is something that needs to drive the engines. That we really figure out by when we want to have these products in the hands of women, outside of pilots, outside of implementation, by when do we want to scale up? And then we kind of work backwards in terms of what can we do between this time and that time and hold ourselves accountable to meet those goals? And with the vaginal ring now in South Africa, we have no excuse. We have regulatory approval. What are we going to do immediately to enable that move towards scale up? There needs to be consensus about that. Less talk, more do, within the next months, not years.

Jeanne Baron [00:12:11] So working in parallel, scale up in the real world, while pursuing questions about what will make programs most effective. Lillian, is this kind of approach on track?

Lillian Mworeko [00:12:22] Speaking where I'm sitting here in my country in Uganda, it is so disheartening that the National Drug Authority, for example, has given an approval that indeed we should be moving forward with the ring. But we are still waiting for the ministry to make the announcement. But as I sit here and speak, young people, female sex workers, key populations are getting infected. And then you get in meetings, and you're getting statistics, statistics. So the accountability for me comes in that the international community may need to really stand up and speak to this. There's a question around who makes decisions for people because some of the countries are waiting for this announcement from America. But the FDA is not saying anything.

Jeanne Baron [00:13:18] Right. The ring's developer withdrew it from FDA review, and this has troubled advocates for women and HIV prevention around the world, who know regulators in other countries often prefer to follow an FDA approval. I hear you saying governments have to step up with or without the FDA. At the time of this recording, Zimbabwe and South Africa have announced approval of the ring, but Uganda is one of several countries who've only quietly approved it. You're saying it's time for governments to get out there and really lead on scaling up access to these lifesaving interventions?

Lillian Mworeko [00:13:55] Yes. So I think America and its decision-making powers must also be held accountable because it impacted the vulnerable groups in our region. But if it works for Africa, why not give it? We should be making decisions because every human being matters. So that is for me number one. I think the second point here is that what we have learned in the past, in so many years, it is going to be critical that communities are at the center of decision-making, at the center of our implementation, that they are not just left out there as beneficiaries, but that they are part and parcel of every stage. This is one thing that we have learned for over forty years. I think that it raises an important point around integration. I hear you, Linda-Gail, and I agree with you. But from where I come from, as a community person, I think one of the key things that needs to be done faster is that we are not going to continue

learning and learning and learning when people are waiting for services. So for me, my call is that we need to implementation actions happening and we learn from what we are doing.

Linda-Gail Bekker [00:15:26] Here, here. That needs a resounding applause.

Mitchell Warren [00:15:30] What Lillian, you said, is so very important and it reminded me, one of the most exciting opportunities we have in front of us right now is to break the mold of thinking about products. Rather, [the field should be thinking about] how to engage in a different conversation about the individual, about the young woman, about making those options actual choices. And that actually is both incredibly exciting, but also it's a new challenge for us. And picking up a bit on something you said, Linda-Gail, about how we stop the incremental...'Let's do oral PrEP now, let's add the ring, now let's add injectable.' Rather, how do we imagine an entirely new approach that can say to people, 'let's talk about your life. Let's talk about relationships and sexuality and what you might want and need. Oh, and we have a bunch of options that you may be interested in hearing more about.' And we haven't had that opportunity, and we certainly haven't taken advantage of that opportunity in HIV prevention. I get excited by that prospect and I wonder if that provides opportunities, Linda-Gail and Lillian, for us to really think in completely different ways.

Lillian Mworeko [00:16:40] I agree with you, Mitchell. If we place people at the center, if we use person-centered approaches, I think we get there. But sometimes I feel like that is more on paper than in reality. But also, I feel that it comes at the end. How I see it happen is small, small bits. [People say,] 'Let's continue learning.' And then the question is, you are learning on people's lives. Studies have been done, [the products] have shown they actually work. But then the next conversation that I'm predicting that is going to happen is, 'OK, let's get into pilots to see whether it is going to work. And by the time we finish pilots, the momentum is gone, but lives are lost that cannot be gotten back. For me, it is more about: do we care about the human beings that we want to serve? And you can place that in every situation. For example, if you talk about the country, they are going to be negotiating around 'Shall we have resources to sustain it.' Then. 'We need to have a conversation around policies or guidelines. What does it mean?' If you go to funders, it is the same. 'Do we have enough resources? How would we place this into the context?' But meanwhile, the person, that human being, is at the mercy of all these processes.

Linda-Gail Bekker [00:18:23] I agree. And I think maybe two things I want to say on the paradigm shift. The one is, we can learn as we do. Lillian said it and I'm going to underscore it. We can learn as we go, rather than the small pilots that we learn little bits of work from. Let's think big. That would be the first, let's think urgently. And then, I also want to say, we have paid lip service to the fact that prevention is different from anti-retroviral therapy. Although they use somewhat of the same product, in terms of antiviral-based preventions, it is a very different paradigm, and I don't know that we've come at it from that viewpoint. People seeking prevention are healthy and well. We've said this many times, but then we don't treat them like that. We insist they have to come into health service facilities. They have to be seen by accredited healthcare workers. They have to often fill out forms. Then they are judged on a sort

of therapeutic basis. Whereasm when we think about offering anything else to people that we want them to freely take up for their own good, their own value, we, in a way, flood the market, if I could use that terminology. We go out and we make it very accessible. We put it at their disposal with largesse and generosity. And then people say, 'Well, I can use this. I can make this work for me.' Think of any marketing strategy. Yet we constantly, I don't know, go down the rabbit hole of turning this into a medical intervention. As long as we do that, that is going to be problematic. I use the COVID vaccine strategy as an example, because I think we did quite well. Certainly, in my country, you know, we differentiated delivery and service quite extraordinarily, and people did take them up in the millions. You know, we reached millions and millions of people around the world.

Jeanne Baron [00:20:37] Such powerful lessons about what not to do from oral PrEP and powerful models of innovation from distributing COVID-19 vaccines. Are there early signs that we've learned the lessons, that we're preparing to flood the market, as you put it, and make it super easy to get these tools, instead of expecting people to go to the clinic, for example?

Linda-Gail Bekker [00:20:59] No. So Jeanne, on the contrary. I'm very worried that I'm already getting a sense of rationing, of choosing particular populations [to get these products]. Some of that might be anxiety about how much it's going to cost, the availability. But that immediately pushes us into stigmatizing the products and moving them into a more exclusive kind of framework. And that we need to fight against with all of our power. It does come somewhat down to logistics. You know, these are products that have to be made in the factory. Of course, they cost money to make and then they have to be licensed, and then they have to be brought to countries and rolled out. So we understand all the logistics. But I think at every turn, we need to keep saying, 'how do we distribute this like we would our favorite bottled water? How do we get this out?' Very important that we don't think about a particular population. The word I coined during tenofovir and emtricitabine rollout was offering hesitancy.

Jeanne Baron [00:22:11] Tenofovir and emtricitabine are the active ingredients in oral PrEP.

Linda-Gail Bekker [00:22:16] Yes. And by that, I mean that we ourselves, as the providers, regulated and drip-fed the tenofovir emtricitabine prevention miracle. We didn't treat it like something we wanted to flood the market with. And that, I think, really harmed the tool itself. Because people, one, became suspicious of it. Two, it became stigmatized. Three, it was just hard to find and hard to access. So we have to fight that at all cost.

Jeanne Baron [00:22:53] Mitchell, is there any lesson that is getting learned, that you want to call out? And if you've got a different warning light flashing than Linda-Gail, what is it?

Mitchell Warren [00:23:01] I actually agree with a lot of what Linda-Gail described, and I worry that we are still in that too small, too slow approach to implementation science rather than thinking about how to get more urgently to scale. But I do think we are learning, and I think there are few examples. When the dapivirine vaginal ring got its original positive scientific opinion from the European Medicines Agency last year, the World Health Organization almost

immediately developed guidelines and recommended the ring. When you think about oral PrEP, we saw the U.S. FDA approve it. But we saw a recommendation from World Health Organization three years after that initial regulatory approval. With the dapivirine vaginal ring, we saw it in a matter of months. And we're seeing something similar for injectable cabotegravir for PrEP, which was approved just two months ago, in the United States at least. And we will see guidelines I think middle of this year, so we are seeing a [time] compression. In addition, you know, ViiV, the developer of injectable cabotegravir, filed in a number of African countries even before the FDA approved the product. And again, we saw a three-year delay between U.S. approval of oral PrEP and the first approvals in Africa. So there are some lessons, there aren't as many positive moves as I would like, but we are in a better place. I think we now not only have these additional options, but we do have faster regulatory approvals, faster regulatory guidance. I think it's on all of us, as Lilian described, as advocates, to make sure that we do not squander this opportunity.

Jeanne Baron [00:24:45] AVAC is working across our programs and our partnerships to ensure these new prevention options become a reality in people's lives. For a deeper dive into the lessons learned from rolling out oral PrEP, search "lessons" on PrEPWatch.org. And join AVAC's Advocates Network to connect with upcoming webinars and materials that will be covering critical issues related to turning these new options into real choices. You've been listening to Px Pulse, recorded in the New York City studios of the Relic Room. Our theme music was composed by Alexi Stevens. Our engineer is Sam Bair. I'm Jeanne Baron.