Narrow the Gulf Between HIV Prevention Research and Reality

The executive director of AVAC on the disparity between research and implementation.

March 14, 2014 By Mitchell Warren

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The 2014 Conference on Retroviruses and Opportunistic Infections in Boston generated more mainstream media attention that most scientific conferences in recent memory. From data in animals that suggest it may be possible to prevent HIV with quarterly antiretroviral drug injections to the announcement of a possible, though unconfirmed, cure in an HIV-positive newborn who received combination antiretroviral therapy directly after birth, it was a big week for HIV researchers and advocates alike.

But inside the conference venue, another narrative was playing out: Alongside the string of new research advances was the realization that we're failing to deliver what already works today to people in need.

This disparity between cutting-edge research and lagging implementation was underscored by new data from Atlanta, showing that one in 10 young gay or bisexual African-American men there become infected with HIV each year. It's hard to imagine a sharper sign of unmet HIV prevention needs. Addressing the epidemic in young gay men of color means tackling the multiple factors that impact HIV risk—stigma, health care access and more. Biomedical options also have a role to play -- and these sobering data from Atlanta come four years after clinical studies demonstrated that a daily antiretroviral pill could reduce the risk of HIV infection by as much as 90 percent.

This is a potentially powerful tool for men and women worldwide. Yet, still there is no consensus on how to deliver this option, known as oral pre-exposure prophylaxis, or PrEP, to people who can benefit. Even after positive trial results and FDA approval in 2012, we still do not have the robust set of "demonstration projects" that could help guide wider rollout to men and women worldwide. After a lot of advocacy and hard work, several projects are finally under way, while several more are still waiting to start. As the data from Atlanta show so clearly, we can't waste time figuring out what comes next.

Disconnects like this exist for many options. Women make up more than half of all people living with HIV worldwide. Despite efforts by many public health experts, scale-up of the female condom

-- a proven prevention tool that many women (and men) want -- has lagged far behind its full potential for decades.

In a AVAC's December 2013 report, "Research and Reality," we called for an aggressive effort to look beyond demonstration projects and into real-world implementation. As a first step, donors, researchers and national governments need to do a full and rapid review of progress on oral PrEP demonstration projects -- what questions they are answering, for what populations, and what we still won't know when the current studies are done. More projects that actually attempt to answer operational challenges and opportunities are needed to fill those gaps -- and prevent infections today.

But just as importantly, all of these projects -- and everything else we do to support oral PrEP rollout -- needs to be part of a plan. Put simply, the world needs to know what it's trying to accomplish with this, or any, new HIV prevention option. And we need a shared sense of how we will get to a clear understanding of strategic rollout of PrEP, including today's oral strategies and the future long-acting strategies that generated so much buzz at CROI. We've lived with this epidemic for too long to believe that the next big thing will be easier or simpler than what we've got today. It's time to solve current challenges and understand that this is the work that will prepare us for adding future options.

Even in cases where we've missed the opportunity for advance planning, we still can and must pick up the pace. Voluntary medical male circumcision (VMMC) is a great example of this. After clinical trials showed in 2006 that VMMC could reduce a man's chances of acquiring HIV from a female partner by nearly two-thirds, initial implementation was slow. Just two years ago, only a handful of countries had made significant progress in scaling up the intervention. But thanks to new investments and political commitments, more than four million circumcisions have occurred since then, preventing many thousands of new HIV infections in the long run.

Ultimately, though, if we want save as many lives a possible, then HIV prevention research and rollout need to be inseparable from the start. Research should proceed with a vision, and a plan, for eventual rollout. At the other end, HIV prevention programs should look deep into the research pipeline to anticipate tomorrow's life-saving options and the challenges they'll present.

There is every reason in the world to get excited about the scientific advances presented last week: long-acting injectable PrEP; new forms of user-controlled ring and film microbicides; vaccines and a cure are reasons to celebrate scientific investments and achievements. They are also reasons to commit to rolling out the options we have today, while the development of these new options moves forward.

People around the world have participated in clinical trials that have drastically changed the way we see HIV prevention. This has to be the year where we honor their commitment by following through on our promise to deliver proven options to the communities where they live.

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