LONG-ACTING HIV TREATMENT

“The future of antiretrovirals in Africa: Long-acting agents and beyond’

From evidence to choice
A 24-year view from the ground

Speaking on behalf of PLHIV who have been waiting beyond the research

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Mandisa Dukashe | 24 years living with HIV | Clinician • Public health expert • Advocate

I have watched HIV treatment change & I have lived that change.

"For 25 years, I have worked in public health and watched the ARV landscape evolve."

"For 24 years, HIV has been part of my life. For 18 years, I have taken ARVs"
Mandisa Dukashe

THE SCIENCE

From complicated regimens to highly effective treatment that allows people to live long and healthy lives.

THE EXPERIENCE

For me, ART is not only a prescription. It is something I carry through work, relationships, stigma and at times with fatigue

THE QUESTION IS..

If long-acting options can reduce some of our burdens, why should we wait for years after the science has advanced?

"I am not asking whether innovation is possible.
I am asking when it will become a meaningful option for the person sitting in the clinic"?

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Let me tell you our secrets!

We sometimes feel tired of HIV; we feel tired of taking ARVs

Some of us wait in long queues; some of us worry about being seen.

So when we hear “long-acting”, we ask:

"Could this make life with HIV a little easier” If yes, WHEN?

What people living with HIV really want!

Yes, we want our medicine to work, so that we can live longer.

But most importantly, we want:

- Less daily reminders that we have HIV
- Convenience
- Fewer clinic visits when possible
- Options that fit our lives
- Privacy
- Respect

How long do we have to wait?

We imagine....

Waking up in the morning and not having to think about HIV tablet.

Travelling without worrying about carrying our medicine.

Not having to explain our tablets to someone we live with.

Going to the clinic and knowing: “We have options.”

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THE SCIENCE HAS MOVED

What the evidence now tells us

Cabotegravir + rilpivirine (CAB/RPV) is a long-acting injectable HIV treatment regimen that can be given every 4 or 8 weeks.

CARES - AFRICA

512 adults
96 weeks: 97% in both LA and oral groups maintained HIV RNA <50 copies/mL.

The trial supports feasibility in African context

SOUTH AFRICAN DATA

Pooled South African participants from FLAIR/ATLAS-2M: 92% receiving CAB/RPV LA maintained HIV RNA <50 copies/mL at week 96.

PREFERENCE

Across trials, many participants reported high satisfaction and preferred injections because of convenience and discretion. In ATLAS-2M, 94% preferred 8-week dosing over oral or 4-week dosing.

The implementation question is becoming more important: how do we translate evidence into equitable, routine, person-centered care?

The message is “not inject everyone” But “expand meaningful options”

Source
1. Flaxman L, Ogbuagu O, Achhra AC. Progress toward longer-acting antiretroviral regimens for adult HIV treatment. Expert Review of Clinical Pharmacology. Published online 27 Aug 2026
2. Kityo C, et al. CARES: CAB/RPV in virologically suppressed adults in Africa; week 96 results. Nature Medicine. 2026;32:168–177

FROM THE GROUND

An injection may not automatically be easier or generally acceptable

For one person, an injection may feel like freedom. For another, it can create a different set of burdens.

LESS DAILY BURDEN

No daily pill reminder; potentially less visible medication.

MORE PRIVACY

Fewer visible routines can reduce unwanted disclosure.

BUT...

Another clinic trip, transport costs, queues, cold chain, needle anxiety or worry about side effects.

A DIFFERENT ADHERENCE TASK

The responsibility shifts to attending appointments.

Long-acting is not only a product intervention, it is a service-delivery intervention.

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What PLHIV want

We shouldn't hear about long-acting ART after decisions are already made.

DON'T DESIGN SERVICES FOR US WITHOUT US.

Bring us into the conversation. Ask us:

- What is your preferred choice?
- What would make you choose it?
- Where would you want to receive it?
- What would make you trust it?
- What support would you need?

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SAFETY + TRUST

If life happens, will the system help me understand these....

DISCONTINUATION

CAB/RPV has a prolonged pharmacologic tail. Residual drug can persist for up to 12 months after discontinuation, potentially creating subtherapeutic exposure and resistance risk if alternative ART is not started.

RESISTANCE

The review estimates a small but meaningful 1–2% risk of virologic failure in clinical trials, with resistance implications when failure occurs.

HBV + PREGNANCY

CAB/RPV does not treat hepatitis B. Pregnancy safety data remain limited. Address these issues before problems arise, not after.

People do not need complicated words. We need simple answers, reliable pathways and a health system that does not punish us for being human.

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South Africa is moving: But prevention and treatment are not moving at the same speed.

LENACAPAVIR PREVENTION

55,123
people initiated

360 public facilities
24 districts | 6 provinces
as of 7 September 2026

71% of recipients were female, with many pregnant and breastfeeding mothers.

THE TREATMENT QUESTION

If long-acting treatment is the future, when does that future become an ordinary option?

South Africa has strong African evidence for CAB/RPV LA treatment and a rapidly advancing prevention program. The remaining challenge is to translate treatment evidence into equitable, routine, person-centered access.

We should not confuse "not yet in routine care" with "not yet possible."

Source: Bhekisisa Centre for Health Journalism. July 2026

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Our Ask!

1. MAKE CHOICE REAL

Long-acting should expand options, not replace oral ART

2. BUILD THE SERVICE BEFORE THE PRODUCT

Stock, injection capacity, and pharmacovigilance systems alongside rollout.

3. INVEST IN COMMUNITY CAPACITY

Position and resource communities as implementation partners , not only mobilisers.

4. MEASURE WHAT MATTERS

Track uptake and suppression, but also satisfaction, privacy, travel burden, missed appointments, and reasons.

5. DEMAND EQUITY

Rural communities, adolescents, men, women, key populations, people with disabilities and people facing poverty must not receive different futures.

6. KEEP THE DOOR OPEN

People must be able to move between formulations without stigma or bureaucratic punishment.

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When implementation plans are developed, the voice of the person living with HIV must find the seat at the table.

NOT AFTER THE ROLLOUT

Community engagement cannot mean:

“Here is the new product. Please help us promote it.”

BEFORE & DURING

Communities should shape:

- service models
- eligibility
- visit pathways
- privacy safeguards
- demand generation
- monitoring indicators
- accountability mechanisms

BECAUSE TRUST IS DATA

If people do not trust the service, uptake data will tell only part of the story.

Experience is not “soft data”. It is implementation evidence.

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My message to decision makers

Remember, we are the clinical trials, and the clinical trials are us!

Don't let long-acting ART become another innovation we hear about but cannot access.

And when long-acting ART becomes available…
Please don’t make us wait years to benefit from the future that we worked hard to build.

We are not asking for a miracle. We are asking for the future to arrive where we are!

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We are not waiting for the future to happen to us.
We are asking to help build it.

Thank you.

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