HIV Prevention Webinar Transcript

Expanded HIV Prevention Options: Spotlight on HIV Prevention Technologies.
Aug 13, 2025

Lillian Mworeko: Good afternoon, good morning. Welcome, everybody. Today, we shall be discussing under the theme "Expanded HIV Prevention Options: Spotlight on HIV Prevention Technologies." We'll focus specifically on three new tools — the Dapivirine Vaginal Ring, Cabotegravir, and Lenacapavir (LEN). We are happy to have experts who will take us through these technologies in depth. This webinar is premised on the fact that HIV prevention is facing challenges, particularly in our region. However, through this conversation, we want to approach HIV prevention from both a feminist and a community-driven lens.

We shall hear from the World Health Organization (WHO), which has recently released exciting new recommendations on the use of injectable Lenacapavir. We will also hear from the Global Fund, which announced a new access agreement with Gilead Sciences for procuring Lenacapavir. Furthermore, in 2024, the Global Fund committed to procuring the Dapivirine Vaginal Ring.

We will explore these developments and hear perspectives from various stakeholders. This webinar also comes at a time when the UNAIDS Global Report has raised important questions — where do we stand in the global response, and where do we go next, especially amid limited and reduced funding? To help us get started, I will co-chair this session with Dr. Lillian Benjamin, the Executive Director of DARE Organization in Tanzania. She will help us set the scene as we move into the conversation.

We'll also hear from Michelle from WHO, who will help us understand the new guidance around LEN; from Leonard with Population Council (formerly IPM), who will discuss the Dapivirine Vaginal Ring; from Shannon on donor commitments; and from feminist advocate Yvette Raphael, who will bring in a feminist and community perspective.

Lastly, but not least, we'll hear from a young person, who will share her perspective on prevention — how she sees engagement with youth and how to move the agenda forward. We're happy that many of you are joining us today, and we appreciate the support of our funders, Aidsfonds and ViiV Healthcare, who made this webinar possible. Without taking much time, I now hand over to Dr. Lillian to help us set the scene and lead us into the conversation. Over to you, Dr. Lillian.

Dr. Lillian Benjamin: Thank you so much, Lillian, for getting us started, and thank you to everyone for making time to be part of this discussion. I'll be brief as we transition to hearing directly from our esteemed speakers for the day. A lot has been happening in the overall HIV response and global health at large.

On the positive side, we've seen many new HIV prevention technologies paving the way for expanded choice. More long-acting options are emerging at the country level, and some countries are leading in creating enabling environments to accept and accommodate these new prevention technologies — especially long-acting pre-exposure prophylaxis (PrEP) options — to ensure they are accessible to communities.

We acknowledge the approvals that have been made at country level, and the ongoing review of national guidelines to accommodate these tools. We've also seen continuing research to find more innovations that make HIV and SRHR prevention easier, more accessible, and more community-friendly. However, we cannot ignore that the past 7–8 months have been challenging. There has been uncertainty around resource mobilization and access for communities — particularly those most in need. Funding cuts have disrupted service delivery and affected community engagement.

Despite these setbacks, there's been significant reorganization happening — at country, community, and global levels — with ongoing conversations about sustainability and community ownership. Most importantly, we must discuss how to maintain access for communities, especially for long-acting prevention options, and how to preserve the gains we've made over the years in prevention and HIV control.

To help us unpack this, we'll begin with our first speaker, who will share the current WHO guidance on long-acting prevention technologies — particularly Lenacapavir (LEN) — and how WHO advises countries on integrating PrEP choice into programming, policies, and community involvement. With that, I'd like to invite our colleague from WHO, Michelle Rodolph, to enlighten us on what we need to know and how we can use this information to guide our next steps.

Michelle Rodolph: Now, this is not an optional loading dose — it's part of the regimen needed to reach protective levels within the first three to twenty-four hours. It requires two tablets on day one and two tablets on day two.

By taking these tablets as prescribed, an individual reaches the target levels for protection rapidly. However, if the tablets are not taken, it would take approximately three to four weeks for the injection alone to provide full protection against HIV. I emphasize this to highlight the importance of the loading dose. As part of the WHO guidelines, we identified several implementation considerations and research gaps. Among the key considerations are: Pregnancy (which I will address shortly), Provider training, Community engagement, and Demand generation.

Research gaps include the need for more data on product switching and key populations. Providers play a crucial role in reaching people with these products. They must be trained not only in how the products work, but also in how to encourage and support people who can benefit from Lenacapavir. Training must emphasize non-stigmatizing and non-discriminatory service delivery. WHO also stresses that Lenacapavir should be introduced as an additional prevention choice, alongside other HIV prevention tools such as oral PrEP, the ring, and CAB-LA.

Data from South Africa shows clearly that providing multiple PrEP options increases overall uptake. Countries should continue implementing differentiated service delivery models — some are already offering LEN in community settings, while others use health facilities. Both approaches work. Simplified testing strategies, such as rapid diagnostic tests (RDTs), can facilitate easier access and higher acceptability while linking people living with HIV to care. Importantly, the successful introduction of LEN depends on full community participation in design, implementation, and monitoring.

Regarding pregnancy, the PURPOSE 1 trial included pregnant women, providing valuable safety data. The study found no increase in adverse pregnancy or birth outcomes among 184 pregnancies reported. Additional, though unpublished, data has shown similar results. Based on this, no dose adjustment is expected during pregnancy. WHO reviewed all available data on LEN, oral PrEP, the Dapivirine Ring, and Cabotegravir during pregnancy. The conclusion is clear: PrEP should not be discontinued during pregnancy or breastfeeding based on current safety data.

However, the decision to start, continue, or stop PrEP during pregnancy should be made jointly by the woman and her healthcare provider, taking into account her circumstances and preferences. Women must be empowered to make informed choices about their prevention methods. In summary, women can safely continue using oral PrEP, the Dapivirine Ring, or CAB-LA during pregnancy and breastfeeding.

Finally, I want to conclude with a point on choice: Offering multiple HIV prevention options increases uptake, effective use, satisfaction, and protection. People's choices

are dynamic — they may prefer one product today and another tomorrow — and that's okay. The best PrEP product is the one that a person wants and will use consistently.

Dr. Lillian Benjamin: Thank you so much, Michelle, for these valuable insights — and for the reminder that options must coexist.

I loved your example from South Africa, showing that choice increases overall uptake. This is a strong call to all of us — whether we are designing programs, developing policies, or conducting research — to ensure that choice remains central in our HIV response and prevention strategies.

With that, I'll now hand back to Lillian Mworeko to introduce our next speaker.

Lillian Mworeko: Thank you very much, Dr. Lillian and Michelle. I'm truly encouraged by the emphasis on choice.

We now move to our next speaker — Leonard Solai, from South Africa. As you've heard, we now have a growing pool of HIV prevention tools to choose from. But of course, choice remains critical. Leonard, please speak to us about one of my favorite products — the Dapivirine Vaginal Ring — and how it fits among other existing and emerging prevention tools.

Leonard Solai: Thank you, Lillian, my sister, and thank you to ICWEA for inviting me to this important webinar. I'll be discussing where the Dapivirine Vaginal Ring fits within our comprehensive — yet still evolving — HIV prevention toolkit. I'm especially excited that this webinar is happening during South Africa's Women's Month, which we celebrate not just nationally but across the continent. It's fitting that we're examining HIV prevention through a community-driven and feminist lens.

Looking at the Dapivirine Ring through a feminist lens, we must acknowledge the persistent gender disparities that fuel HIV infections, particularly among adolescent girls and young women. Our trials and prevention strategies all aim to reduce infections within this demographic. Three major factors continue to drive HIV among women and girls: Many young women face barriers such as distance to clinics, stigma, and unwelcoming healthcare providers — even with differentiated service delivery and mobile outreach models. Sadly, GBV remains widespread across the region. Every day's news reminds us of the epidemic of violence that continues despite government and NGO interventions. Limited ability to negotiate safer sex. This remains unchanged and continues to expose women to HIV risk.

The Dapivirine Ring therefore goes beyond a biomedical intervention — it's also a feminist tool that addresses structural barriers women face in controlling their sexual

health. Since COVID-19, and in the wake of weakened health systems, many countries have adopted multi-month dispensing models for treatment and prevention. Similarly, with the ring, women can now receive three rings at once for three months of protection. Encouragingly, trials for the three-month Dapivirine Ring have also shown positive results, and we hope to see its rollout soon. We have good results from the bioavailability trial for the three-month ring as well. This means women will make fewer trips to healthcare facilities. Before insertion, only a rapid HIV test is required.

The product also has no special storage requirements, which makes it ideal for rollout in community settings — it remains stable even in warmer climates where most people live. Furthermore, it can be distributed in more convenient and accessible community-based settings. Currently, the ring is a scheduled product, meaning regulators in all countries where it's approved require it to be dispensed by a medical practitioner or a healthcare provider trained to prescribe ARVs. However, we are working to make it available over the counter — accessible at the community level and even dispensed by trained community health workers since it only requires an HIV test.

Regarding gender-based violence and the inability to negotiate safer sex, the ring provides a discreet solution. It can be inserted by the woman herself or by a healthcare provider, and it can be used with or without the partner's knowledge — giving women greater bodily autonomy. Now, let's look at some data from the CATALYST study, an implementation study run in five countries by FHI 360, funded by USAID. Unfortunately, CATALYST came to a grinding halt due to a change in U.S. policy, which was extremely disappointing — access to the product stopped instantly. Participants weren't formally exited from the study, and many didn't know where to access the product afterward.

There was even discussion of destroying the remaining products, but thanks to collaboration with ministries of health and ethics committees, these were instead integrated into public health systems. The study was conducted in Kenya, Lesotho, South Africa, Uganda, and Zimbabwe. From Stage 1 of CATALYST (before CAB-LA was introduced), data showed that the Dapivirine Ring was chosen for its ease of use.57% of participants selected the ring, with 53% citing that they preferred it because they didn't have to swallow pills. After one month, 32% of oral PrEP users returned to clinics, while 55% of ring users came back for refills. Ring users also reported higher adherence compared to oral PrEP users.

These results reinforce what Michelle mentioned — we must continue messaging around choice. People choose products for reasons beyond efficacy. In Eswatini, which became the first country to roll out the ring in all public health facilities (with support from the Global Fund), findings were similar. 72% of participants initially chose the ring, often because it was new and user-friendly. After one month, 51% returned for follow-up (49% were lost to follow-up). Among those who continued, 75% stayed on the ring, 17% switched to oral PrEP, and 8% stopped using PrEP altogether.

Even with modest efficacy, the ring clearly has a valuable role — it's non-systemic and woman-controlled.

Some key takeaways: The Dapivirine Ring is a feminist intervention. When IPM developed it, we were mandated by donors to create HIV prevention for women — and we've succeeded in developing a female-controlled, long-acting product. We've also completed the three-month ring bioavailability study and are working with the European Medicines Agency (EMA) for its approval as a line extension. We hope for introduction by early next year. The combination ring (Dapivirine + Levonorgestrel for contraception) is also progressing well in clinical trials.

Regarding efficacy, the EMA has approved use of the ring for breastfeeding women based on safety data and is now reviewing its safety during pregnancy. Excitingly, the EMA has also lowered the approved age from 18 years to 16 years and older — a major step forward.

We'll soon engage national regulatory authorities across countries to update local guidelines accordingly. In terms of efficacy data: Phase III trials showed around 30% efficacy, which we know was affected by low adherence — the same challenge seen in early oral PrEP studies. In open-label studies, efficacy rose to over 55%, as women were more adherent. Sub-analyses excluding non-adherent users show efficacy between 75–91%. Another MTN analysis found that during periods of sexual activity when the ring was used, efficacy was 63–65%. The conclusion is clear: efficacy improves with adherence.

Lillian Mworeko: Thank you very much, Leonard — and thank you for reminding us that it's Women's Month. You've also highlighted the importance of access, and I'm thrilled that the age threshold has now expanded to include 16-year-olds. This means younger women can access the ring. I'll now hand over to Dr. Lillian to take us through the next presentation.

Dr. Lillian Benjamin: Thank you, Lillian. Now moving on to our next speaker — Shannon Kowalski, Senior Technical Advisor on Gender at the Global Fund. Shannon Kowalski, I have a question for you: How is the Global Fund currently positioning choice in the context of HIV prevention within ongoing and upcoming implementation cycles? You are welcome.

Shannon Kowalski (Global Fund): Thank you so much, Lillian, and thank you to ICWEA and the DARE Organization in Tanzania for bringing us together. It's truly exciting to discuss how PrEP contributes to women's and adolescent girls' bodily autonomy and agency — by giving them a range of options to prevent HIV and protect their health and well-being. A few years ago, Dr. Connie Celum and Dr. Jared Baeten wrote an article describing PrEP as analogous to contraception — a self-controlled method that can be started or stopped as needed and is highly effective with adherence. The goal,

therefore, should be to ensure a range of choices that meet people's needs and preferences at different times in their lives. Today, with oral PrEP, CAB-LA, the Dapivirine Ring, and Lenacapavir, we now have that range of effective products. Our collective goal is to support women, adolescent girls, and key populations in choosing the methods that work best for them.

The Global Fund plays a critical role in this: We're a major donor supporting access to all WHO-recommended PrEP products. Our HIV prevention investments are nearing $1 billion for Grant Cycle 7 (GC7). We also fund community-led organizations, especially women- and youth-led groups, to take leadership in design, delivery, monitoring, and accountability of HIV prevention services. We're committed to ensuring HIV prevention is gender-responsive and rights-based.

For GC7, countries have already procured oral PrEP, the Dapivirine Ring, and CAB-LA with our support. Through collaboration with the Children's Investment Fund Foundation (CIFF), we established a PrEP Matching Fund to expand access to oral PrEP and plan for future product introductions. We also developed the PrEP Ring Early Market Access Vehicle, making 150,000 Dapivirine Rings available at no cost to high-impact countries. Last month, we signed an agreement with Gilead Sciences to make Lenacapavir PrEP available to low- and middle-income countries, aiming to reach 2 million people between 2026 and 2028.

Our next step is to ensure rapid country introduction of LEN, with women, girls, and key populations at the center. However, availability alone is not enough. Success depends on ensuring that people know PrEP exists, understand their options, and feel supported in choosing what works best for them. That's why we're encouraging countries to: Integrate PrEP into SRHR and GBV services; Deliver PrEP through community-led models; and Engage women and young people in design and delivery.

We're also tackling policy barriers such as age-of-consent laws and restrictions that limit women's decision-making autonomy. Looking ahead to Grant Cycle 8, we will continue scaling up all WHO-endorsed PrEP options, provided adequate funding is secured through the Eighth Replenishment. In short: our mission is to ensure everyone who chooses PrEP can act on that choice. Thank you so much for this important conversation.

Dr. Lillian Benjamin: Thank you so much, Shannon. I'd like to echo some of your key points — particularly that we must make a range of HIV prevention options available for communities and allow people to choose what works best for them. I also want to emphasize the importance of collaborative investments that are gender-responsive, uphold bodily autonomy, and ensure equitable access.

However, as you mentioned, resources remain a major issue when it comes to how far we can go in scaling up in the coming funding cycles. Now, I'd like to turn back to Lillian Mworeko to introduce our next speaker. Thank you so much, Shannon.

Lillian Mworeko: Thank you very much, Dr. Lillian. We are now going to listen to our own Yvette Raphael — a recent award winner and passionate advocate for choice. One of the things I deeply admire about Yvette is that she strongly believes that science and community must meet in order for progress to happen. This belief has guided her advocacy and earned her recognition, including the American Association for the Advancement of Science Award. We are proud of you, Yvette — congratulations, and welcome! Please speak to us about what you see as the current global advocacy messages around HIV prevention, especially in light of changing funding priorities and emerging prevention tools. Also, help us understand this from a feminist and women-centered perspective.

Yvette Raphael: Thank you so much, Lillian, and good afternoon, everyone. Thank you to ICWEA and the DARE Organization for inviting me to speak on the role of feminism in HIV prevention — and yes, it absolutely has a place in today's conversation. Feminism plays a crucial role in addressing the disproportionate impact of HIV on women and girls. Gender inequality, including gender-based violence, unequal power dynamics, and limited access to resources, continues to increase women's vulnerability to HIV.

Feminist approaches focus on empowering women, promoting gender equality, and addressing the root causes of inequality — which are essential to preventing HIV effectively. By challenging harmful gender norms, promoting women's rights, and advocating for equal access to opportunities, feminism directly reduces women's vulnerability to HIV. Feminism also addresses gender-based violence (GBV) — recognizing its clear link to HIV transmission. Feminist interventions aim to prevent and respond to violence, including sexual violence, which increases the risk of infection.

As Leonard mentioned earlier about how the Dapivirine Ring was conceptualized, we can see why feminist organizations and women's movements across the world advocate for it: because it promotes bodily autonomy and gives women control over their sexual health. Feminism also promotes sexual and reproductive health and rights (SRHR), which are increasingly under threat globally. It emphasizes the importance of women's autonomy over their bodies and their right to make informed decisions about their sexual and reproductive health. This includes access to comprehensive sexuality education, HIV testing and counseling, and a range of prevention methods — such as condoms, PrEP, PEP, and others. Empowering women and girls enables them to negotiate safer sex, access prevention services without fear, and participate in decision-making processes that affect their lives.

We, as advocates, often talk about engaging men — and yes, this remains essential. But it must be done in ways that support women's leadership in HIV prevention and ensure

their meaningful participation in policy and programming. Feminism also works to dismantle stigma and discrimination associated with HIV. By challenging negative attitudes and promoting inclusion, it creates more supportive environments for women living with HIV.

There's always pressure to include men and boys in HIV programs — and that's good — but we must also strengthen cross-border collaboration among women's movements to ensure equity and equality in prevention choices. There's no shortage of women-led movements working on HIV prevention, GBV, and stigma. What we need now is greater unity and collaboration.

A good example is the African Women's Accountability Board, which connects women across seven countries to strengthen leadership and collective action. An intersectional feminist approach is also vital — recognizing how multiple forms of discrimination overlap. A woman's experiences of violence or exclusion may be compounded by her race, class, sexual orientation, or disability. We must acknowledge these overlapping inequalities and understand how they affect women's ability to access care and justice.

Feminist, intersectional approaches challenge harmful norms and power imbalances that perpetuate violence — and promote gender-transformative programs that don't just respond to survivors' needs, but also change the systems and structures that enable violence. Engaging boys and men in these efforts is equally essential — to challenge toxic masculinities and promote equality.

Practical examples include: Training judges and legal professionals to understand GBV dynamics, working with community leaders, developing targeted interventions for at-risk groups, and creating specific programs and resources for women, LGBTQ+ people, and others facing discrimination. I'll end there — thank you so much for inviting me to be part of this important conversation.

Dr. Lillian Benjamin: Thank you so much, Yvette, for sharing the importance of bringing a feminist lens into HIV prevention. We truly can't end HIV without feminist approaches. Feminism helps us address not just HIV, but the broader issues that make women vulnerable — such as gender-based violence and inequality. Now, from global advocacy, we'll move to community voices. I'd like to welcome a young woman to share her perspective.

Lillian Mworeko: This is no other than Beryl Abade, a PEP champion and youth advocate from Kenya. Beryl, if you can hear me, kindly unmute.

Beryl Abade: Yes, thank you so much for having me, Lillian**.**

Lillian Mworeko: Great — thank you for joining us, Beryl. I have two questions for you. Let's start with the first: Why **do young people need to have a choice when it comes to HIV prevention tools?**

Beryl Abade: Thank you, Lillian, and thank you ICWEA for this opportunity. As a young person, I believe we need to feel supported in choosing and accessing HIV prevention tools.

First, we need more information and educational materials. Right now, most facilities only have oral PrEP IEC materials, yet we also have new prevention choices — like the Dapivirine Ring and Lenacapavir. When you visit a facility, all you'll find are materials on oral PrEP. There's nothing about the ring or LEN. We need updated materials that help young people learn about all available options.

Second, we need continuous sensitization for service providers — both on existing and new prevention tools. Usually, providers are trained once when a product is introduced, but there's no follow-up. This leaves many unaware of newer or diverse client needs.

Third, prevention choices must be available and accessible. For example, here in Kenya, we're advocating for the ring, but we can't yet access it — and that needs to change. Fourth, we need safe spaces within communities — led by informed champions — where young people can meet, share experiences, and learn about prevention. These spaces make it easier to link to facilities for services.

Fifth, facilities should be one-stop shops — where young people can access HIV testing, PrEP, condoms, and family planning all in one place, instead of being referred elsewhere. And finally, services must reach diverse and marginalized groups — sex workers, LGBTQ+ people, people with disabilities, and adolescent girls and young women (AGYW). We also need more youth champions. They do incredible work at the grassroots, spreading awareness and linking peers to services — but they need support and recognition.

Lillian Mworeko: Thank you so much, Beryl.

You've shared so many actionable insights — from safe spaces to youth engagement and demand creation. I especially appreciate your point about the information gap. Most young people only know about oral PrEP, while there's little to no awareness about the Dapivirine Ring, Lenacapavir, or other emerging prevention tools. Your message is clear: information is power, and choice must start with awareness. So, one last question, Beryl — in just one sentence, why do you think choice is important to young people when it comes to HIV prevention?

Beryl Abade: I feel that we, young people, are the next generation. If we don't adopt or access new HIV prevention choices that can stop reinfection and transmission, we risk losing progress. We must be equipped with both information and tools — and ensure that these are available and accessible to everyone who needs them.

Lillian Mworeko: Thank you so much, Beryl. Indeed, information is power — and that's exactly what young people need to make informed choices and access HIV prevention options. Now, I'll hand over to Dr. Lillian to guide us through the next part of the discussion.

Dr. Lillian Benjamin: Thank you very much, everyone. We have a few remaining questions in the chat. I'd like to invite our panelists to respond if they can. We'll now move into a short guided Q&A. As a reminder, this discussion aims to help us generate collective asks, shared strategies, and a joint communiqué to guide our advocacy and coordination around HIV prevention. Let's begin with a question for Leonard: from everything you've heard on this call, what do you think are the broad actions needed right now?

Leonard: Well, from where I sit, there are a few urgent things we need to focus on.

First, we desperately need demand creation and awareness raising. Young women, young men, older people, and those who don't identify within that binary — everyone who could benefit from these prevention tools — must first know that these products exist. Second, we must help people understand that these products are for them. Too often, young people feel invincible — they think nothing bad can happen to them. I was once a young woman, and I know that mindset well.

We need to make HIV prevention desirable, something people actually want to use. Providers should bring it up in every conversation. And when people express interest, they should know there are multiple options available to choose from. Those are the first critical steps. Of course, financial support is also a huge part of this, but without demand creation and awareness, even the best-funded programs won't succeed.

Dr. Lillian Benjamin: Thank you so much, Leonard, for being so clear and direct about that.Yvette, are you still with us?

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Yvette Raphael: Yes, I am, Lillian. For me, one of the most important things we must emphasize is the programming of HIV prevention itself. Some call it the demedicalization of prevention — and I think that's the direction we must take. We can't treat HIV prevention as a program for the sick; it's for healthy people who want to remain healthy. It must become part of everyday life. Young people should be able to talk about HIV prevention the same way they talk about fashion, school, or music —

something normal and cool. We shouldn't make prevention feel like a burden or a surveillance exercise. As one young person told me, "This thing you're asking me to use shouldn't disturb my life." And that's true.

So, our challenge is to make prevention fit naturally into young people's lives, not disrupt them. We must also recommit to community engagement. Too often, we speak only to ourselves — to the same circles, to the same advocates. We need to go out, meet new people, new audiences, and make prevention real for them. Until we do that, we'll keep missing the people who need it most. Thank you so much.

Dr. Lillian Benjamin: Thank you, Yvette. That's a powerful reminder. Prevention must be a lifestyle, not a one-time intervention. I see Kevin and Connie have raised their hands. Please go ahead.

Kevin: Thank you so much. I had raised my hand by mistake, but since you've called on me, I just want to congratulate all the speakers. I really liked the point about making HIV prevention a lifestyle. It shouldn't be treated as something separate — it should be part of daily living. And I also agree that messaging is key. As a former young person myself, I know we once felt invincible, but life humbles you. Emotions and realities come in. So, yes — communication and continuous messaging are critical, not just for oral PrEP but for all prevention methods, including the newer long-acting ones. Thank you.

Dr. Lillian Benjamin: Thank you so much, Kevin. That was a thoughtful contribution. Let's hear next from Natasha, then John Bosco.

Natasha Nakayuka: Thank you so much, everyone. My name is Natasha Nakayuka, from Zambia, working with the Youth Platform. First, I want to thank all the presenters — the insights shared today have been incredibly inspiring. As someone working with adolescents and young people, I've noticed that while we are advocating for new options, availability remains a challenge. For example, CAB-LA isn't available in every district in Zambia. So even when young people hear about it and want to access it, they can't. That creates a risk: we might demarket existing options like oral PrEP in the process of promoting newer ones. I've seen this happen — once young people hear about the injectables, they lose interest in oral PrEP, even though the injectables aren't available yet. So my question is: how do we make sure that, in promoting new HIV prevention tools, we don't undermine the ones that are already available and effective? Thank you.

Dr. Lillian Benjamin: Thank you so much, Natasha. That's an excellent question. Shannon, can you help us address that from the Global Fund's perspective?

Shannon Kowalski: Sure. I think a lot of this comes down to advocacy and inclusion in decision-making.

It's critical that women's organizations and adolescent girl-led groups are part of national planning and rollout discussions. They can ensure that all prevention products — oral PrEP, the ring, CAB-LA, and LEN — are introduced and scaled responsibly. From the Global Fund's side, we aim to make sure that a range of products is available to everyone, not just a select few. Of course, this depends on resources — which is why we need countries to not only rely on donor funding but also invest domestic resources to support sustained rollout. And as Natasha mentioned, the goal is not to prioritize one method over another but to ensure multiple options coexist. In the short term, countries need to design funding requests that support diverse product mixes and expand access for as many people as possible.

Dr. Lillian Benjamin: Thank you, Shannon. I love that — the focus on diversity of options. As I often say, HIV prevention should be like a buffet — everyone gets to choose what works for them. Now, Leonard, could you share your final thoughts before we wrap up this section?

Leonard: Thanks, Lillian. What's most important to me — and to many advocates right now — is how we move forward in the face of donor defunding, especially from USAID.

Many Ministries of Health seem hesitant to advance choice, partly because they fear they won't have the capacity or resources to implement and operationalize these products. For instance, Shannon mentioned the ring donations through SIF and the Global Fund. In theory, those products are freely available to countries — but in practice, there are bottlenecks everywhere: tax issues, understaffing, logistics gaps, and so on.

It's ironic — years ago, we struggled because products weren't available. Now, products are available, but delivery systems are failing. We, as advocates, must put pressure on governments to act. Choice means nothing if it doesn't translate into access. And yes, I agree with what's been said about community engagement. We must get back to grassroots work. We can't keep advocating from behind our laptops or talking only to each other — the choir. We're missing too many people who need these tools most.

Dr. Lillian Benjamin: Thank you, Leonard — that's such a strong note to end on. You're absolutely right — advocacy and delivery must go hand in hand. I hope that as an advocacy community—despite the funding cuts, changes, and even organizations closing—we remain a strong ground force. I hope we maintain the will and passion among advocates to continue joining forces, keeping up the fight, and doing the work. The saddest thing would be losing the power and progress we've built over the years. So, I appeal to everyone on this call to continue being the strong family we've always been.Thank you so much.

Michelle: I'll be brief. I just want to emphasize that we must promote choice.The speakers before me have covered many important points, but having the last word gives me the privilege to echo one key message: the best prevention option is the one a person will use. That's all I want to leave you with — we must continue to promote choice. Thank you so much, Lillian.

Dr. Lillian Benjamin (Closing Summary): Thank you so much, Lillian, to all our panelists, and to every participant who joined today's session.

It has truly been an engaging and insightful discussion, with excellent questions and reflections shared throughout. Allow me to highlight a few key takeaways from today's conversation: We heard from WHO about new guidance on long-acting prevention technologies, emphasizing that multiple options must coexist if we are to sustain gains in HIV prevention. Choice drives uptake of HIV prevention services. It was encouraging to hear how Lenacapavir studies included safety data for pregnant and breastfeeding individuals early on—ensuring that no group is left behind once these services are available.

We also explored how long-acting options like the Dapivirine Vaginal Ring (DVR) go beyond the biomedical aspect of prevention by addressing behavioral and societal barriers that increase women's vulnerability, such as gender-based violence and power imbalances in relationships. Many of these methods have shown higher adherence compared to other prevention tools, reaffirming that when people have choice, they choose what works best for them.

We discussed the importance of integrating HIV and SRHR services, and we learned about ongoing clinical research exploring combination long-acting options that address both HIV prevention and contraception. The discussion also underscored the crucial role of feminism in HIV prevention—reminding us to view women holistically and address the broader structural factors affecting their lives. ***As highlighted in the HIV Prevention Choice Manifesto, "When it comes to HIV prevention, choice is not a luxury—it's a right."***

We must uphold this right. As countries prepare for the introduction of Lenacapavir and other long-acting prevention technologies, key considerations must include: Population-specific needs, differentiated service delivery models, demand generation activities, provider training, and most importantly, community engagement—because we cannot move forward without communities.

We also discussed the need for collaborative investments in scaling up PrEP and prevention options. Resources and donors cannot work in silos. Domestic investment at the country level is equally important for sustainability, especially as donor funding

fluctuates. Young people must remain at the heart of this work. As Beryl reminded us, information is power. We need to involve young people in demand creation, make long-acting options available and accessible, and ensure HIV prevention is seen as a lifestyle—something empowering and even cool.

Finally, to all our panelists—thank you for sharing your expertise and passion. To our organizers, well done for making this possible. And to all participants, thank you for showing up and engaging so meaningfully.

Until next time, this marks the end of today's webinar.

Thank you, everyone—and goodbye.