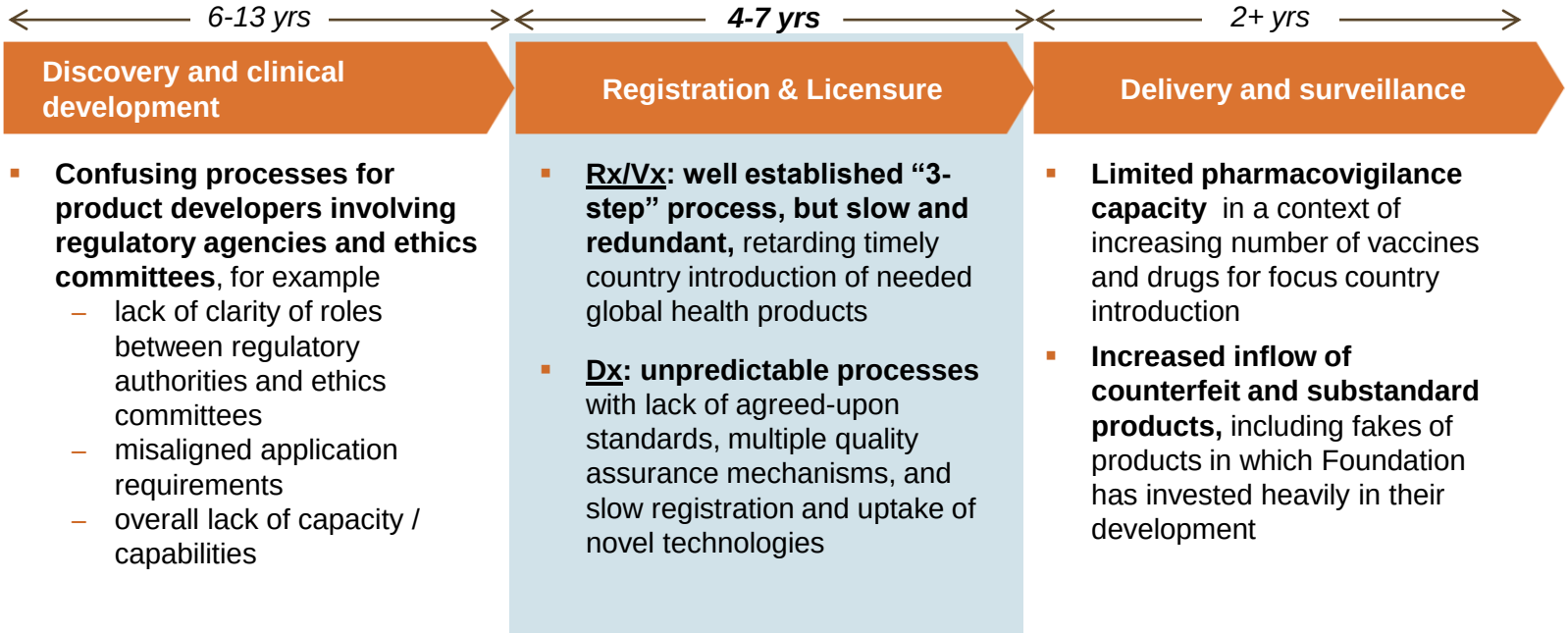
AFRICA REGULATORY SYSTEMS UPDATE

ACCELERATE ACCESS TO QUALITY PRODUCTS

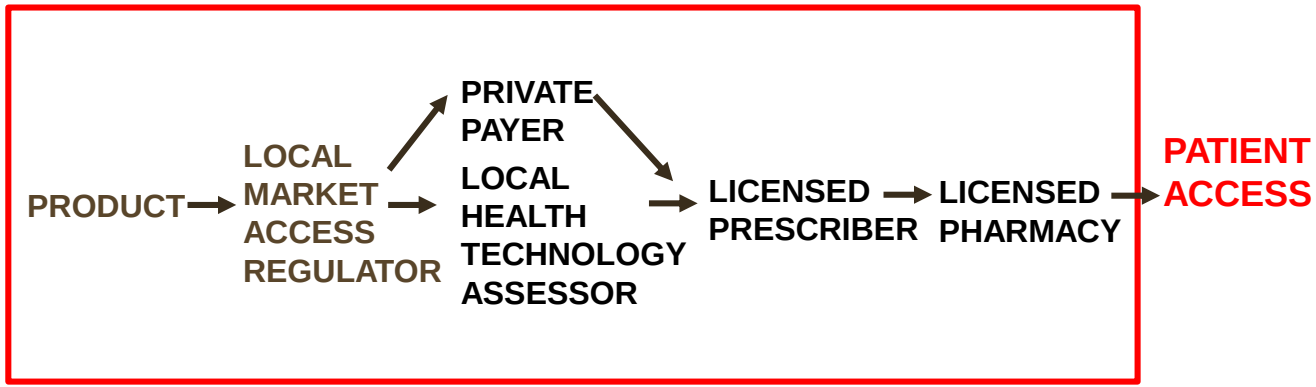
Regulatory Systems | Integrated Development | Global Health

July 4, 2017

REGULATORY AFFAIRS – THE PROBLEMS WE FOCUS ON



GENERAL PROCESS IN HIGH INCOME COUNTRIES

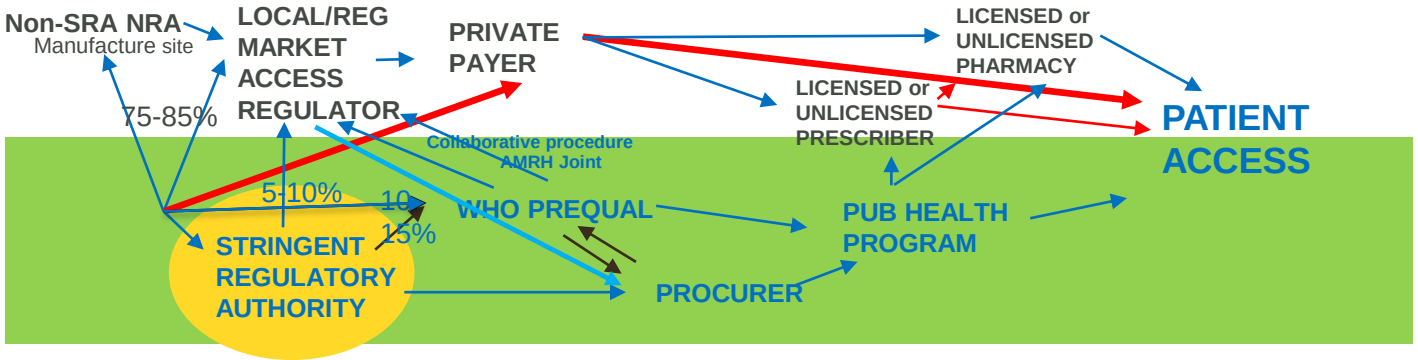


"Closed", highly regulated, proscribed system

Helps assure product quality, safety, efficacy and supply chain security

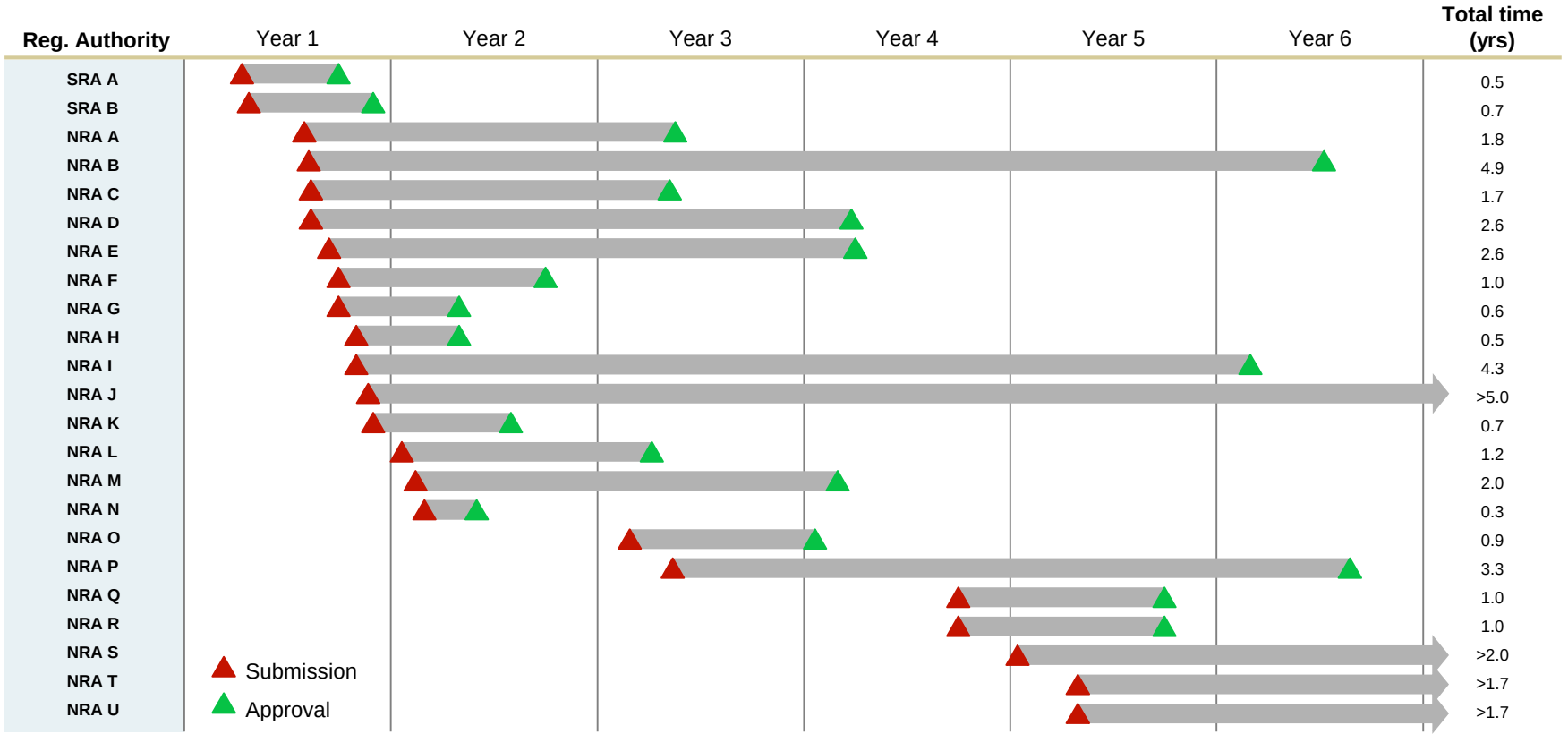
GENERAL PROCESS IN LOW INCOME COUNTRIES

PRODUCT



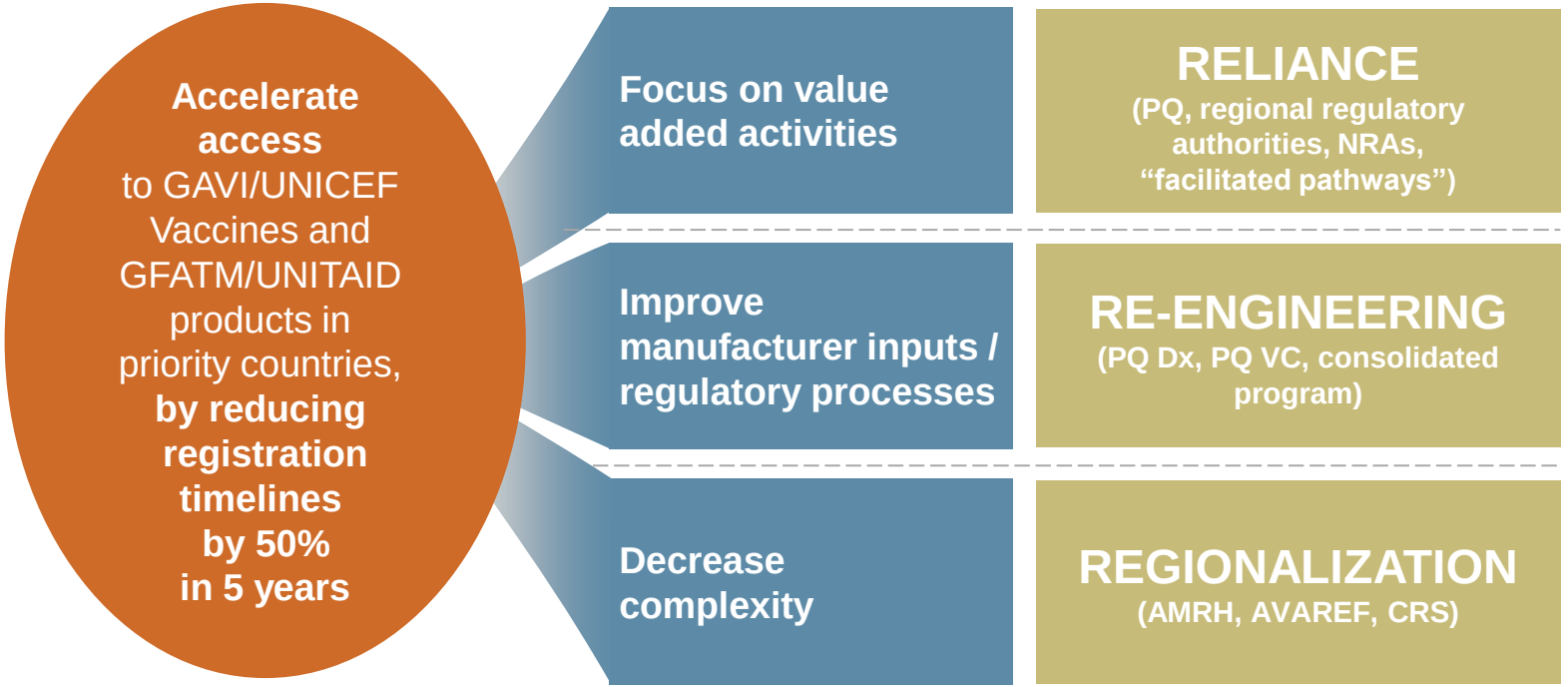
"Open", loosely (if at all) regulated, multifaceted, complex system
Helps assure products of uncertain quality, safety, efficacy and supply chains that are insecure

THE PROBLEM: EXAMPLE OF LONG SUBMISSION SPREADS



Source: BMGF Regulatory Strategy study

VISION AND KEY STRATEGIC AXES



IMPACT IN EAST AFRICA

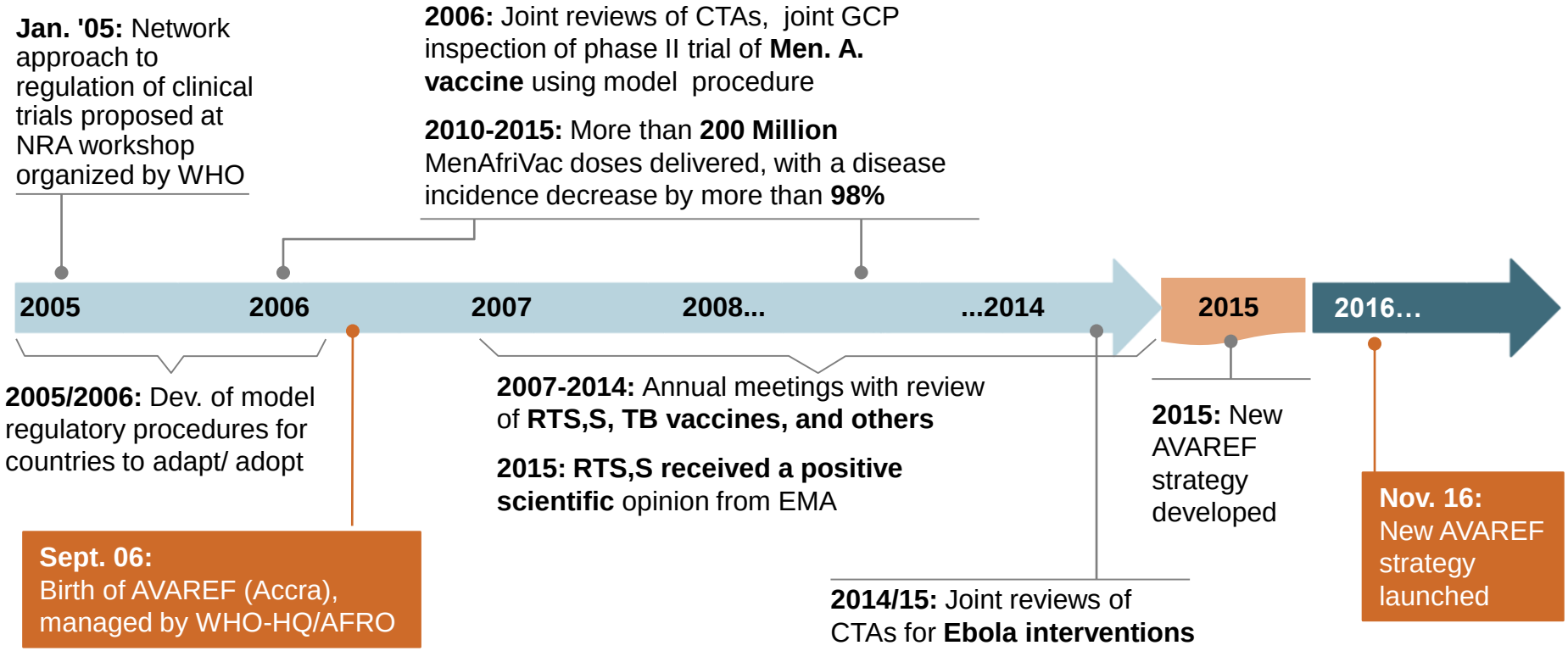
- **Harmonized standards** (technical guidelines and requirements) **developed and approved at the EAC ministerial level in 2014**

- **Implementation started with two pilots** (7 products) of regional review and registration with
  - **40-60% reduction in timelines**
  - **Eliminated spread in time** of manufacturer submissions to NRA

- **Full implementation on track**
  - Launched regional EAC product registration in Jan. 2015 - Expression of Interest approach
  - To-date **4** joint review sessions, **32** products reviewed (non previously PQed) - 4 positive opinion, 2 provisional approval, 26 awaiting manufacturer responses
  - Manufacturers: Sandoz (13), Mylan (5), Roche (4), Hetero (3), Bayer/Janssen/Merck (1 each), EAC-based (4)
  - Disease Category: HIV (2), TB (1 Bedaquiline), NCDs (17), Cancer (7), Antibiotic (2), others (3)
  - GMP assessments – **desk reviews, or <u>single</u> joint inspections**; big 3 paying for their staff travel

- **Expanding to other product streams** (Vaccines) **and regulatory functions** (Pharmacovigilance)

AVAREF HISTORY



KEY ELEMENTS OF NEW AVAREF STRATEGY

Goal

To strengthen clinical trials regulatory authorization and oversight in Africa by increasing system's efficiency and building an optimal clinical trial regulatory infrastructure

Key objectives

- Develop harmonized clinical trial application (CTA) requirements
- Develop guidelines for joint review of CTAs for vaccine and drug candidates
- Develop a formal accelerated regulatory pathway for CTAs in emergencies

PHARMACOVIGILANCE LANDSCAPE IN LMICS

Overview of PV landscape in LMICs

Main strengths

- Most LMICs with **established national PV center** for data collection and upload to WHO Safety Database
- **Strong willingness** to improve PV systems

Main challenges / limitations

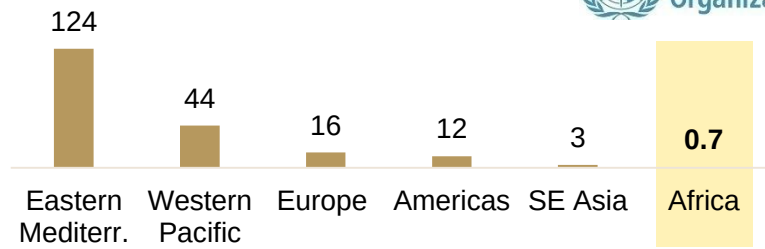
A. Limited reporting: Spontaneous reporting methodology used in developed countries not helpful / appropriate in LMICs

B. Low local capacity / capability to analyze data collected

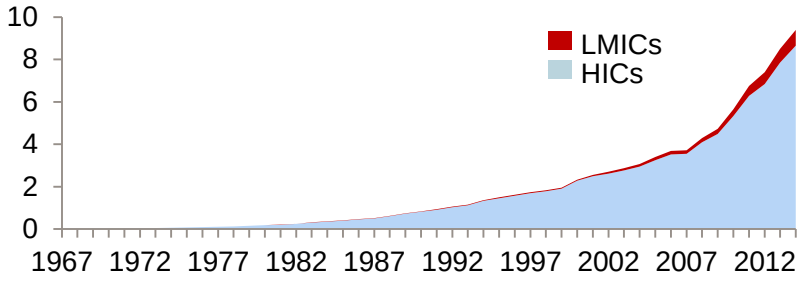
C. Low NRA capacity / capability to take action from alert signals received: Only a small fraction (3 in 55 according to 2008 survey by WHO) of the NRAs regularly take specific actions from signals received and most of these decisions are a replication of what was done by the SRAs

Very limited safety reporting from LMICs

AEFI[1] reports by 10,000 births



Millions of Safety Reports in WHO database (VigiBase)



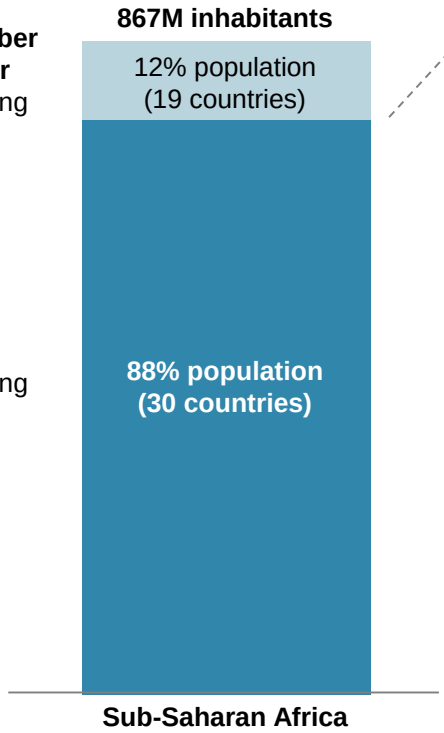
1 AEFI – Adverse Events Following Immunization
SOURCE: Safety Surveillance Working Group report, WHO, Uppsala Monitoring Centre

OVERVIEW OF REPORTING FROM SUB-SAHARAN AFRICA

WHO monitoring program in Sub-Saharan Africa

Associate member or not a member of WHO monitoring program

Full member of WHO monitoring program



	Number of #ICSRs[1] submitted to UMC[2]	# ICSRs / M inhabitants	Average completion
South Africa	27,159	62	42%
Nigeria	10,148	11	78%
Kenya	8,134	37	64%
DR Congo	4,757	14	87%
Ghana	2,333	13	86%
Zimbabwe	1,698	25	87%
Uganda	1,664	9	65%
Namibia	1,547	116	59%
Eritrea	1,349	42	93%
Sierra Leone	1,218	31	79%
Madagascar	1,062	7	66%
Tanzania	925	8	54%
Ethiopia	737	1	41%
Mozambique	661	5	59%
Togo	312	8	77%
Angola	239	2	44%
Zambia	218	2	42%
Cape Verde	180	72	79%
Other	679	2	70%

1 Individual Case Safety Report; 2 Uppsala Monitoring Centre
Source: WHO, Uppsala Monitoring Centre

