HIV/AIDS Programme

MEETING REPORT ON

FRAMEWORK FOR METRICS TO SUPPORT EFFECTIVE TREATMENT AS PREVENTION

2–3 APRIL 2012 GENEVA, SWITZERLAND

World Health Organization

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ACRONYMS AND ABBREVIATIONS

ARI	annual risk of infection
ART	antiretroviral therapy
ARV	antiretroviral
EWI	early warning indicator
FSW	female sex worker
GARP	Global AIDS Response and Progress
HIV-DR	HIV drug resistance
HPTN	HIV Prevention Trials Network
HTC	HIV testing and counseling
LQAS	lot–quality assurance sampling
M&E	monitoring and evaluation
MMC	medical male circumcision
MSM	men who have sex with men
PEP	postexposure prophylaxis
PITC	provider-initiated testing and counselling
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
PrEP	pre-exposure prophylaxis
PWID	people who inject drugs
STI	sexually transmitted infection
TasP	treatment as prevention
TB	tuberculosis
UTT	universal testing and treating
WHO	World Health Organization

I. BACKGROUND OF TREATMENT AS PREVENTION (TasP) AND THE DEVELOPMENT OF RELEVANT METRICS

A. WHAT IS TasP?

In this document, the term TasP refers to the use of antiretrovirals (ARVs) for treating people living with HIV (PLHIV). When ARVs are effective in reducing viral load, they also reduce a person's likelihood of transmitting HIV to others, independent of CD4 cell count.[1] TasP should not be perceived as being separate from the use of antiretroviral therapy (ART) for therapeutic benefits. It includes the use of ARVs for the prevention of HIV and tuberculosis (TB) *(1)* regardless of CD4 count but it does not include the use of ARVs for postexposure prophylaxis (PEP), pre-exposure prophylaxis (PrEP) and the use of ARV-based microbicides.

The factors that are critical for ART to reduce AIDS-related morbidity and mortality are consistent with those necessary for effective TasP, i.e. high coverage and quality across the cascade of services – from testing, linkage to care, initiation on ART, adherence to the regimen, monitoring viral suppression and early detection of drug resistance.

Assuming constant levels of risk behaviour and cofactors, such as the prevalence of sexually transmitted infections (STIs) and coverage of male circumcision, the potential number of HIV infections averted through the use of ARVs by PLHIV depends upon the number of individuals and unprotected contacts a person on ARVs is likely to have over a period of time, and the duration of time the infected person maintains viral suppression while on ARVs. Similarly, for vertical transmission, the number of infections averted among HIV-exposed infants is related to the proportion of infected pregnant women using ARVs during pregnancy and the period of breastfeeding. Optimizing the use of TasP at a programmatic level requires evidence-based decisions about which groups of PLHIV are prioritized for receiving ART, how early ART is initiated among PLHIV, and service delivery models to achieve and maintain viral load suppression through good adherence and clinical/laboratory monitoring of different types of patients on ART.