

**MEETING REPORT ON**  
FRAMEWORK FOR METRICS TO SUPPORT  
EFFECTIVE TREATMENT AS PREVENTION

**2–3 APRIL 2012** GENEVA, SWITZERLAND





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## ACRONYMS AND ABBREVIATIONS

<b>ARI</b>	annual risk of infection
<b>ART</b>	antiretroviral therapy
<b>ARV</b>	antiretroviral
<b>EWI</b>	early warning indicator
<b>FSW</b>	female sex worker
<b>GARP</b>	Global AIDS Response and Progress
<b>HIV-DR</b>	HIV drug resistance
<b>HPTN</b>	HIV Prevention Trials Network
<b>HTC</b>	HIV testing and counseling
<b>LQAS</b>	lot–quality assurance sampling
<b>M&amp;E</b>	monitoring and evaluation
<b>MMC</b>	medical male circumcision
<b>MSM</b>	men who have sex with men
<b>PEP</b>	postexposure prophylaxis
<b>PITC</b>	provider-initiated testing and counselling
<b>PLHIV</b>	people living with HIV
<b>PMTCT</b>	prevention of mother-to-child transmission
<b>PrEP</b>	pre-exposure prophylaxis
<b>PWID</b>	people who inject drugs
<b>STI</b>	sexually transmitted infection
<b>TasP</b>	treatment as prevention
<b>TB</b>	tuberculosis
<b>UTT</b>	universal testing and treating
<b>WHO</b>	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.<sup>1</sup> 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.

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