The Early Release Guidelines on When to start antiretroviral therapy and on pre-exposure prophylaxis for HIV

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World Health Organization

HIV TREATMENT

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PEPFAR

CDC

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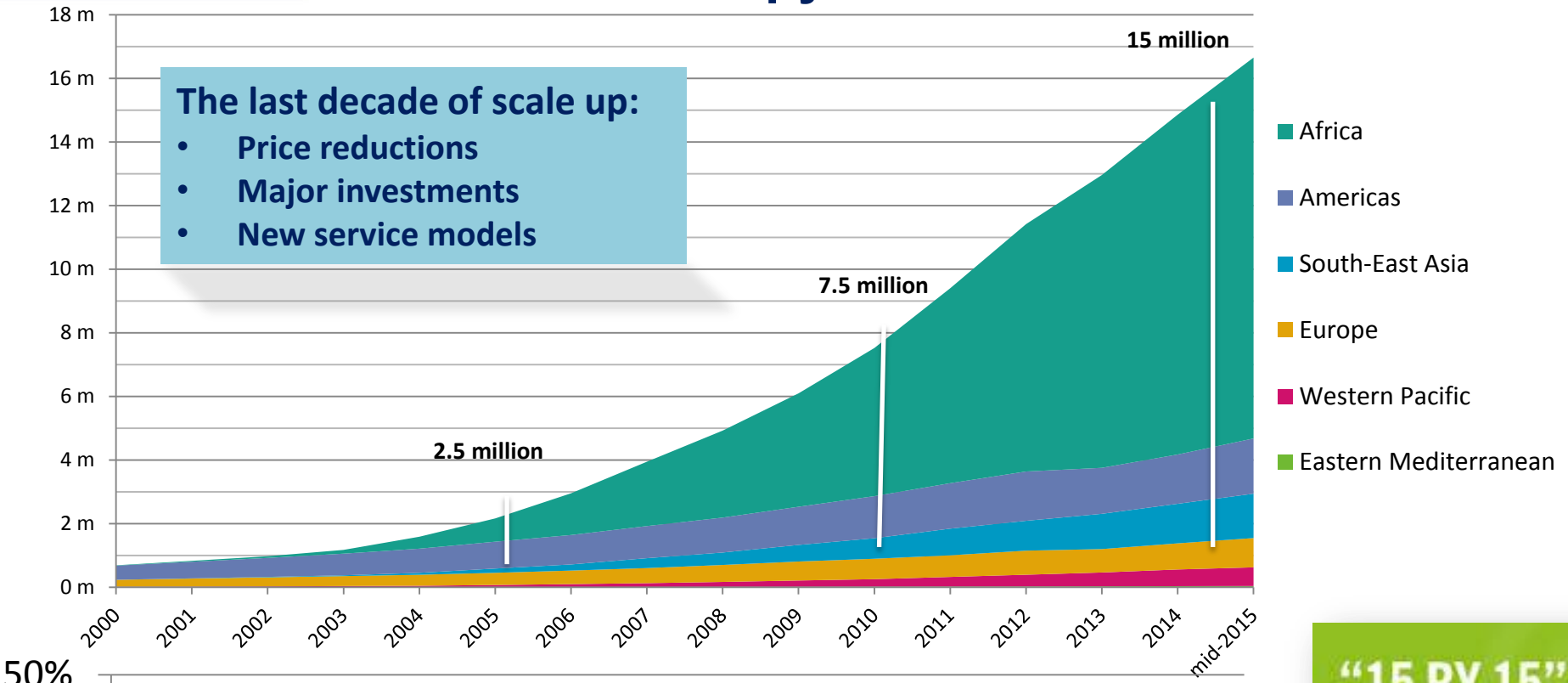
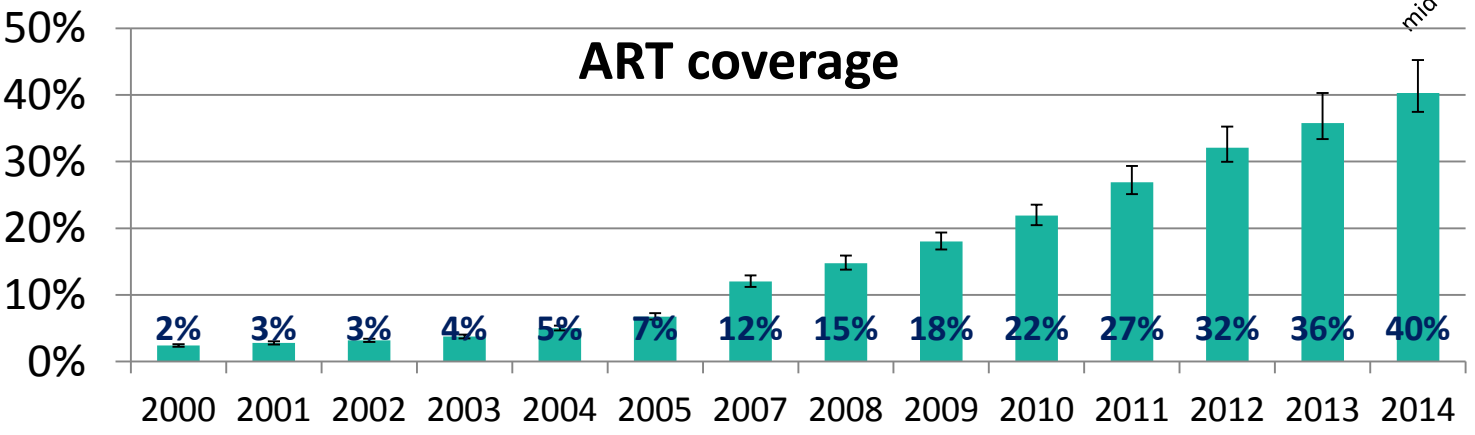
Progress in access to antiretroviral therapy: 2000–2015

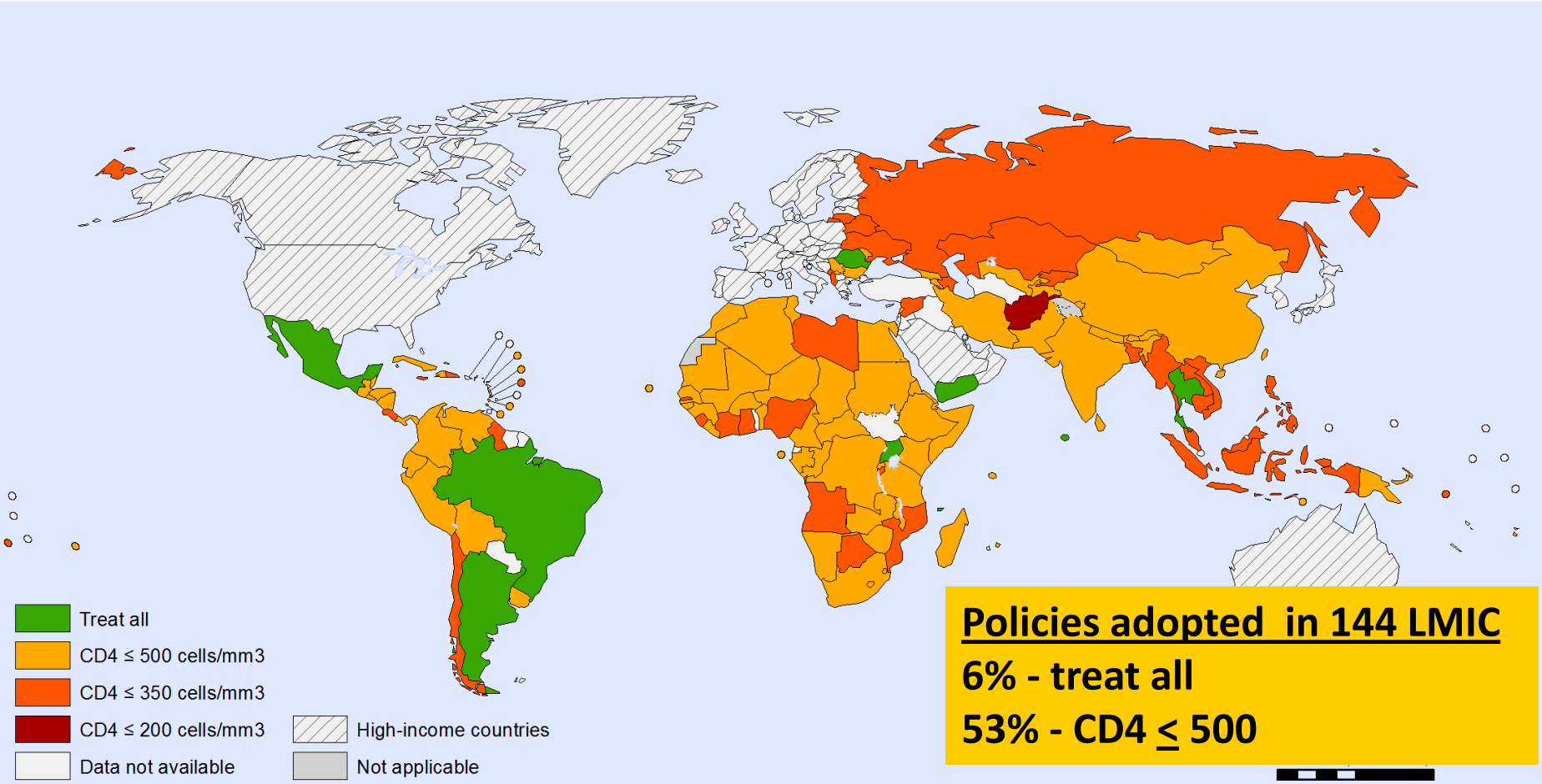


The last decade of scale up:

- Price reductions
- Major investments
- New service models

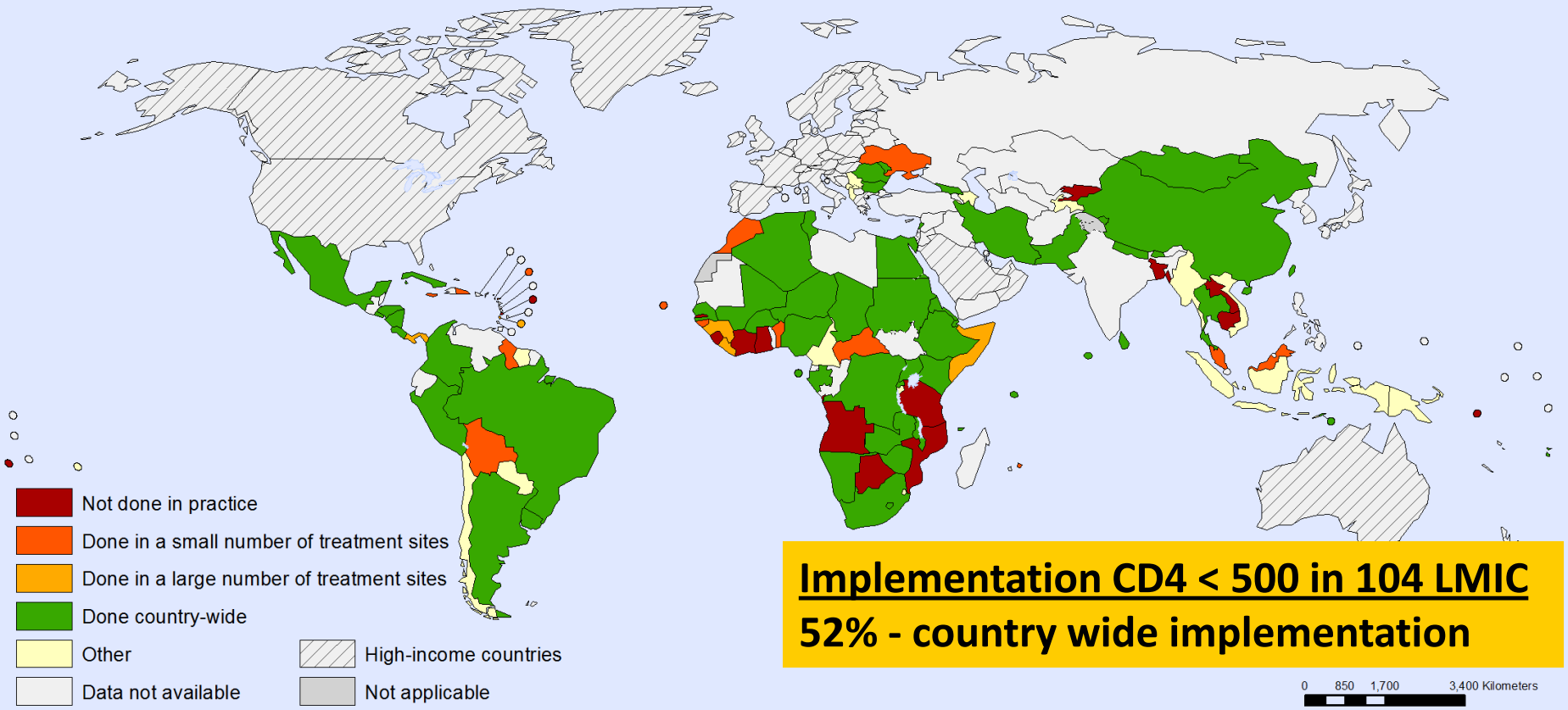


Uptake of WHO policy for initiation threshold among adults and adolescents living with HIV in low- and middle-income countries (situation as of end 2014)



Data Source: World Health Organization
Map Production: Health Statistics and Information Systems (HSI)
World Health Organization

Implementation and practice of initiating ART at a CD4 threshold of 500 among adults and adolescents living with HIV in low- and middle income countries (situation as of end 2014)

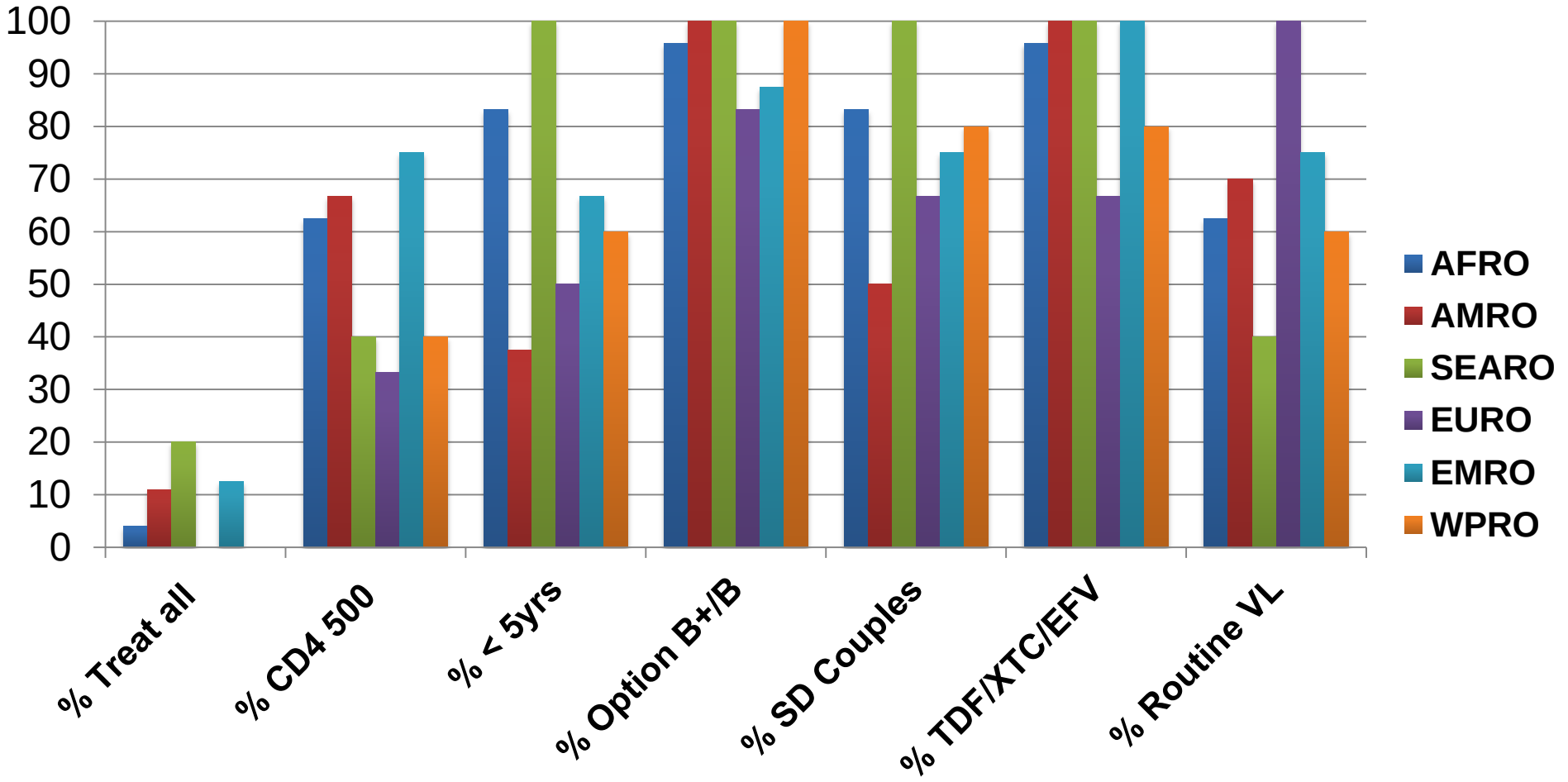


Implementation CD4 < 500 in 104 LMIC

52% - country wide implementation

Data Source: World Health Organization
Map Production: Health Statistics and Information Systems (HSI)
World Health Organization

WHO 2013 Consolidated ARV Guidelines
Policy uptake in 58 WHO focus Countries End 2014
(% responding yes, by region)



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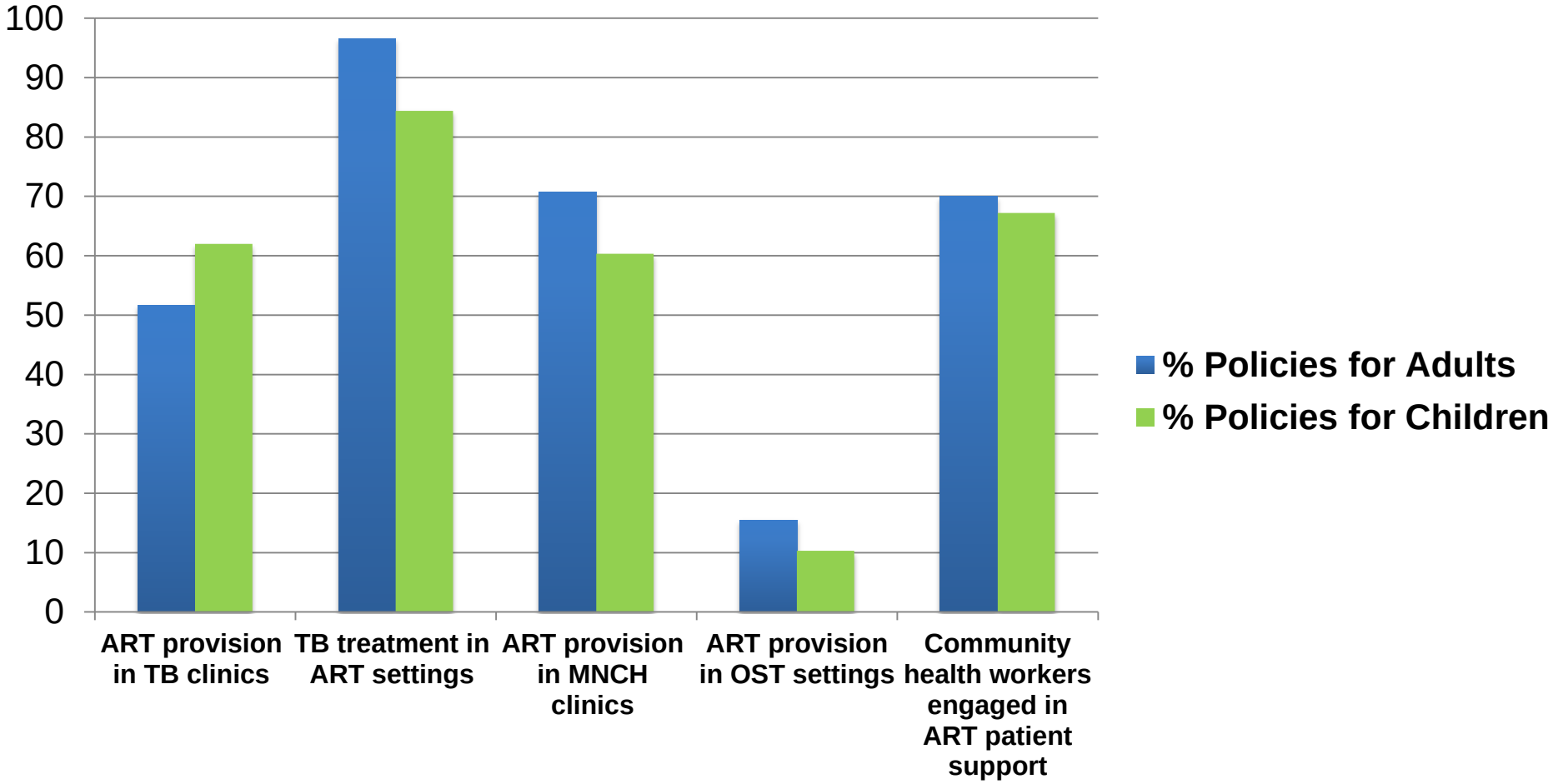
% Uptake of Service Delivery Integration Policies in the 58 WHO focus countries, end 2014



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2015 WHO Consolidated ARV Guidelines

WHAT TO DO?

- When to start
- What to use for children, adolescents, pregnant women
- How to monitor
- Co-infections
- HIV and MH & NCDs
- PrEP, PEP

Clinical

Operational & Service Delivery

Programmatic Prioritization

HOW TO DECIDE?

- Approaches to prioritization & sequencing
- Tool kits for country adaptation and implementation

HOW TO DO IT WELL?

- Care Packages (Differentiated /Adaptive Care)
- Linkages, Retention, Adherence
- Quality of care
- Diagnostics
- Supply chain

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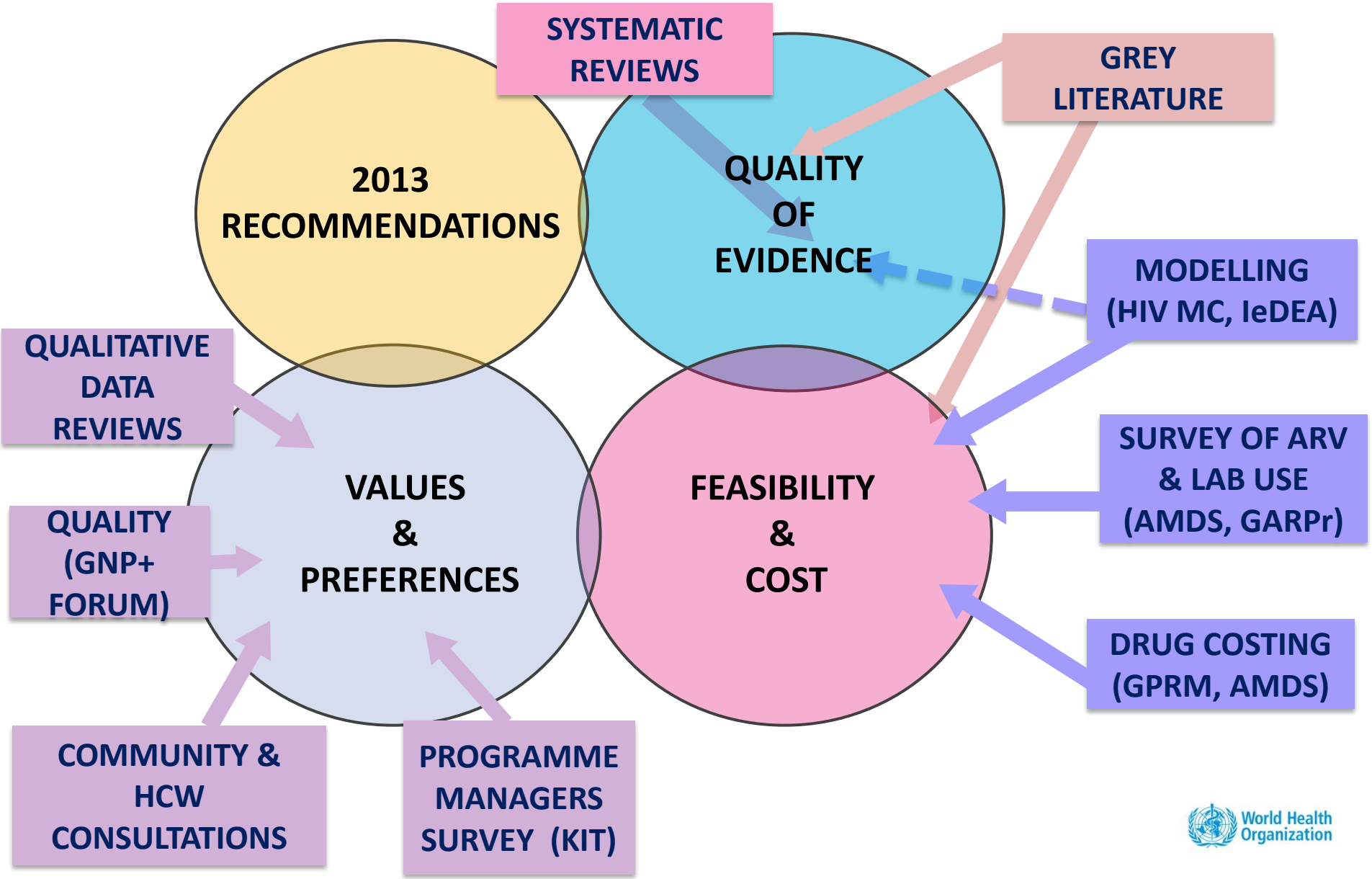
2015 ARV Guidelines Process

HIV/AIDS Department



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ART eligibility: 5 policy scenarios

Estimated millions of people eligible for ART (2014)

30 m. 36.9 m.

1	2	3	4	5
CD4 ≤ 200	CD4 ≤ 350	CD4 ≤ 350 + TasP	CD4 ≤ 500	All HIV+
Recommended since 2003	Recommended since 2010	Incremental approach 2012	+ indications for ART at any CD4	Treat ALL
			2013 guidelines	2015 guidelines

WHEN TO START - 2015 RECOMMENDATIONS

Target Population	Specific Recommendation	Recommendation Strength	Quality of Evidence
Adults	ART initiation at any CD4	Strong	Moderate NEW
	ART initiation if WHO clinical stage III/IV or CD4 ≤ 350 as priority	Strong	Moderate
Pregnant/BF women	ARV initiation at any CD4 and continued lifelong (Option B+)	Strong	Moderate REVISED
Adolescents	ART initiation if 10-19 years-old	Conditional	Low NEW
	ART initiation if WHO clinical stage III/IV or CD4 ≤ 350 as priority	Strong	Moderate
Children	ART initiation if 1-10 years-old	Conditional	Low NEW
	ART initiation if < 1 year-old	Strong	Moderate
	ART initiation if < 2 years-old or WHO clinical stage III/IV or CD4 < 25% (< 5 years) or ≤ 350 (>5 years) as priority	Strong	Moderate

Evidence Summary: When to Start in Adults

- **Systematic Review of 18 eligible studies** (1 RCT and 17 observational cohorts)
- Some observational studies reported **results from a single cohort** (6 studies)
- **Outcomes reported:**

✓ **Mortality**

✓ **Severe HIV disease**

✓ **HIV disease progression**

✓ **AIDS events**

✓ **Non-AIDS events**

✓ **Malignancy (AIDS and non AIDS)**

✓ **Tuberculosis**

✓ **HIV transmission**

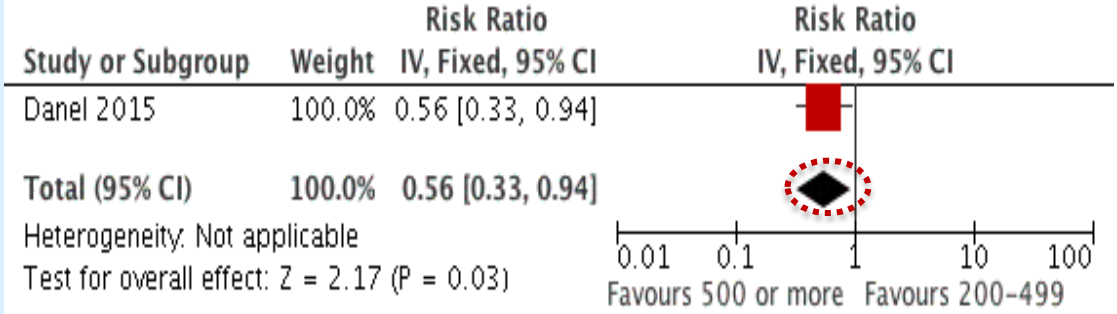
✓ **SAE and lab abnormalities**

✓ **Severe HIV disease or malignancy or mortality (combined outcome)**

Evidence Summary: Risk of death, severe HIV disease or HIV disease progression

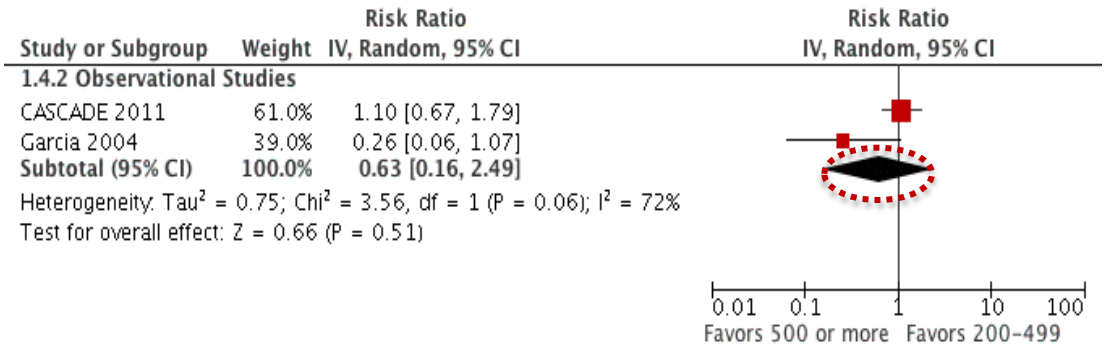
Clinical trials

Moderate quality evidence for lower risk **of death, severe HIV disease or malignancy** compared to those deferring treatment **(1 study)**



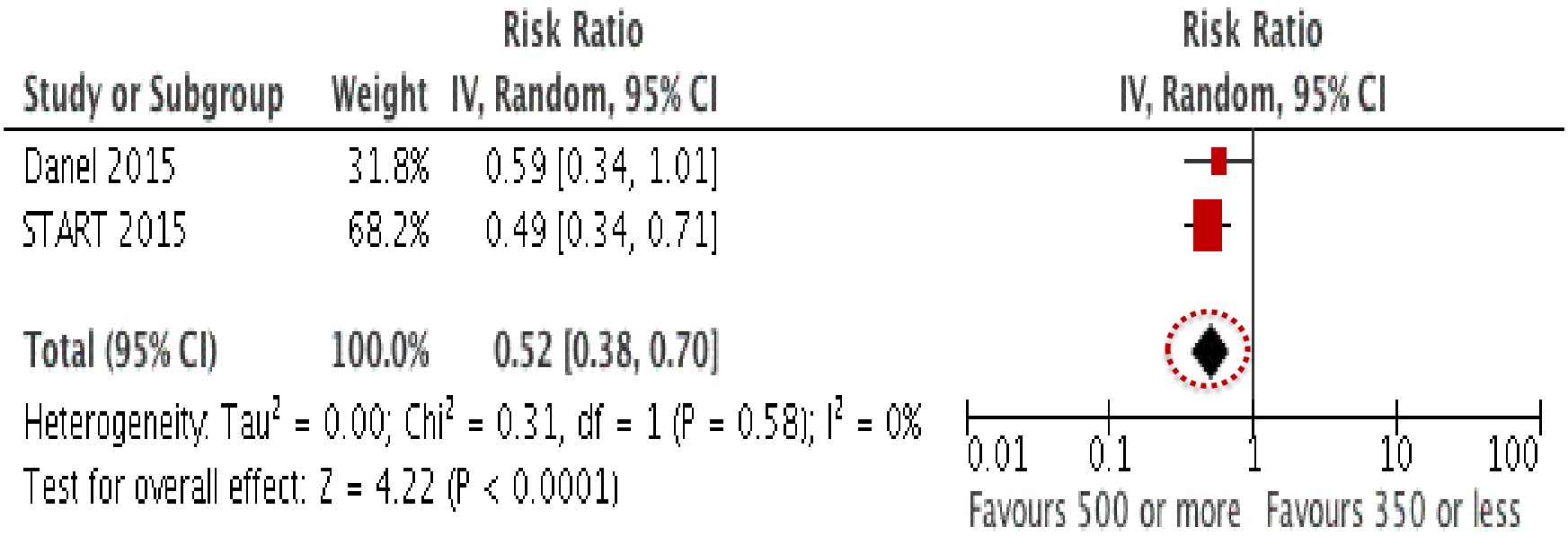
Observational studies

Very low quality evidence for lower risk of **death or progression to AIDS** compared to those deferring treatment (**2 studies**)



CI confidence interval; df, degrees of freedom; IV, inverse variance; RCT, randomised controlled trial

Severe HIV morbidity on TEMPRANO & START studies



CI confidence interval; IV, inverse variance; RCT, randomised controlled trial

Evidence Summary: Risk of Hepatic and Renal SAE

Clinical trial

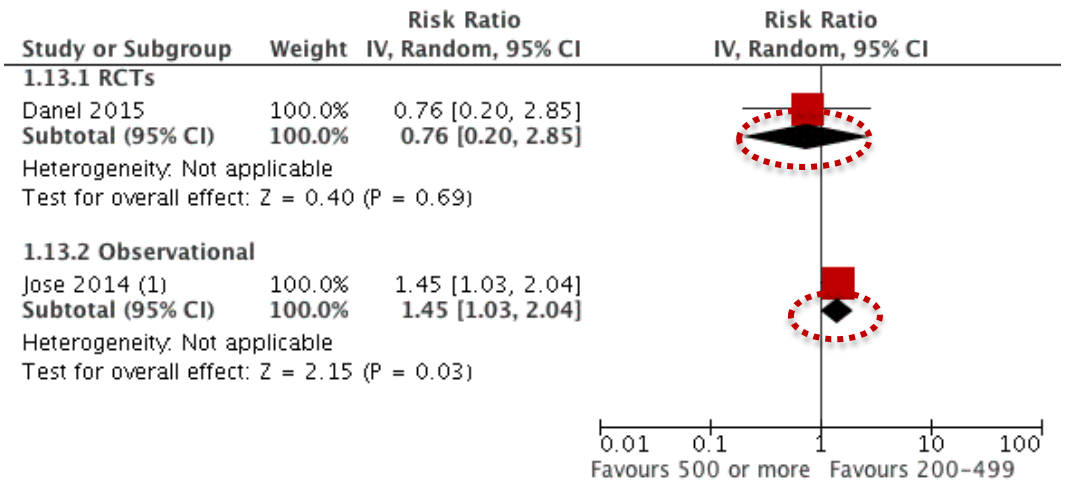
Low quality evidence for no increased risk of hepatic and renal SAE between early vs deferred treatment **(1 study)**

Observational studies

Low quality evidence for increased risk of hepatic SAE compared to those deferring treatment but no increased risk for renal SAE

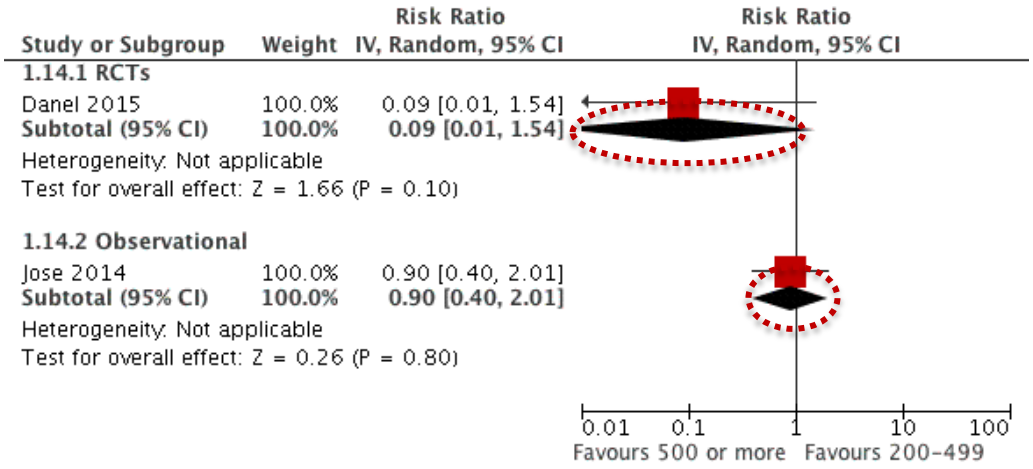
(1 study)

Hepatic SAE



(1) 500+ vs <350

Renal SAE

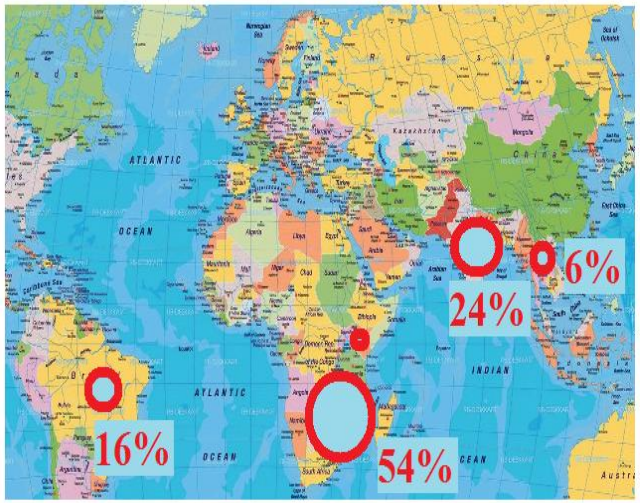


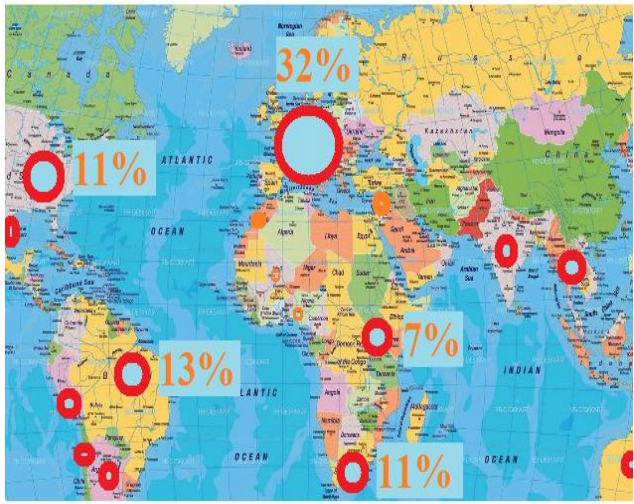
CI confidence interval; IV, inverse variance; RCT, randomised controlled trial

When to Start in Adults: Evidence Summary

- Evidence **show clinical benefits of ART initiation over 500 CD4 to all PLHIV compared with < 500 CD4 initiation**, with reduction of severe HIV morbidity, HIV disease progression and HIV transmission, without increase in grade III/IV adverse events.
  - Quality of evidence for the combined outcome of death, severe HIV disease or malignancy was of **moderate quality**
  - Quality of evidence for any Grade 3 or 4 laboratory abnormalities was also of **moderate quality**
  - Quality evidence for HIV disease progression and HIV transmission was **very low**
  - All other outcomes showed evidence of **low to very low** quality, including mortality, incident malignancies , tuberculosis, non-AIDS events, and specific SAEs

Number of participants and location





HPTN052

- Total: 1761
  - Africa 54%

TEMPRANO

- Total: 2056
  - Africa 100%

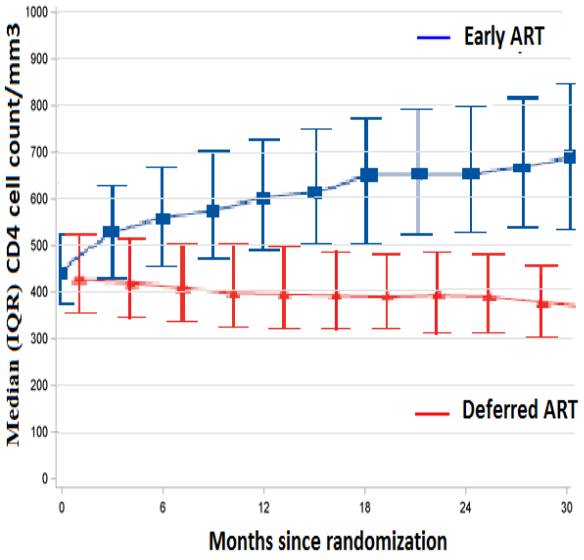
START

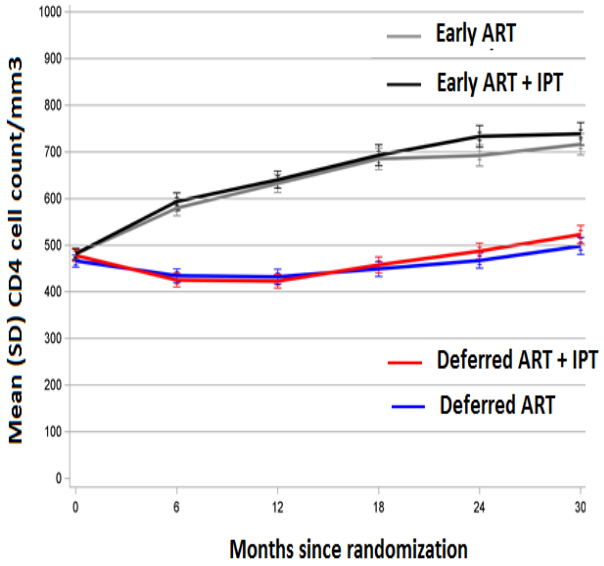
- Total: 4651
  - Africa 21%

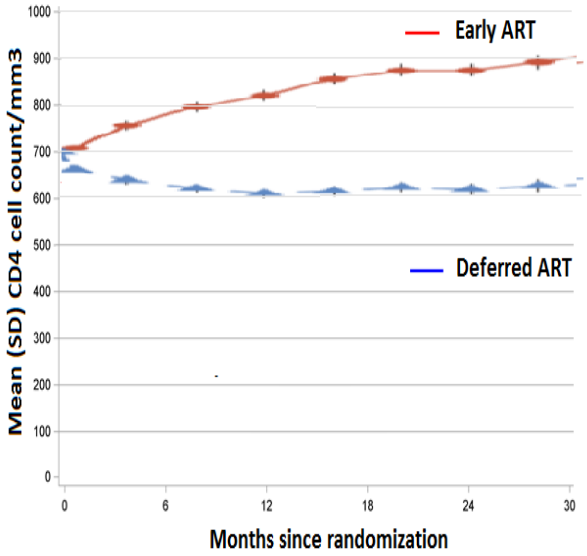
HPTN052: Grinsztejn, *Lancet Infect Dis* 2014; 14:281-90
Temprano: Temprano study group, *NEJM* 2015; 373:808-22
START: INSIGHT START study group, *NEJM* 2015; 373:795-807

Angalret ANRS Sept 2015

CD4 Inclusion Criteria







HPTN052

- Inclusion : 350-550
- Initiate ARV: < 250

TEMPRANO

- Inclusion : 250-800
- Initiate ARV: < 250
  < 350
  < 500

START

- Inclusion : >500
- Initate ARV: < 350

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Primary outcomes

HPTN052

- Death
- WHO Stage 4
- Tuberculosis
- Cancers non-AIDS
- Severe bacterial infections
- CVD
- Diabetes

TEMPRANO

- Death
- WHO Stage 4
- Tuberculosis
- Cancers non-AIDS
- Severe bacterial infections

START

- Death
- AIDS (except oral candida and invasive HSV)
- Tuberculosis
- Cancers non-AIDS
- CVD
- Renal insufficiency
- Severe hepatic insufficiency

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Hazard ratio of primary outcome by study

	Early treatment (n=886)	Delayed treatment (n=875)	Hazard ratio (95% CI)	p value
Any serious clinical event	57 (6%)	77 (9%)	0·73 (0·52–1·03)	0·074
Any AIDS event	40 (5%)	61 (7%)	0·64 (0·43–0·96)	0·031
Tuberculosis	17 (2%)	34 (4%)	0·49 (0·28–0·89)	0·018
Severe bacterial infection*	20 (2%)	13 (1%)	..	..
Any WHO stage 4 event (excluding tuberculosis)	9 (1%)	19 (2%)	..	..
Non-AIDS event	12 (1%)	9 (1%)	1·35 (0·57–3·19)‡	0·50
All deaths	11 (1%)	15 (2%)	0·73 (0·34–1·59)‡	0·43

	Early ART			Deferred ART			Adjusted Hazard Ratio (95% CI)
	no. of patients	*person-yr*	*rate*	*no. of patients*	*person-yr*	*rate*	
Death or severe HIV-related illness (primary outcome)	64	2313	2.8	111	2248	4.9	0.56 (0.41–0.76)
Death	21	2520	0.8	26	2502	1.0	0.80 (0.45–1.40)
Death or AIDS	50	2333	2.1	84	2288	3.7	0.58 (0.41–0.83)
AIDS	33	2333	1.4	65	2288	2.8	0.50 (0.33–0.76)
Tuberculosis	28	2337	1.2	55	2298	2.4	0.50 (0.32–0.79)
Invasive bacterial diseases	14	2358	0.6	36	2332	1.5	0.39 (0.21–0.71)

	Immediate-Initiation		Deferred-Initiation		Hazard Ratio
	no.	*no./100 person-yr*	*no.*	*no./100 person-yr*	
Composite primary end point	42	0.60	96	1.38	0.43 (0.30–0.62)
Serious AIDS-related event	14	0.20	50	0.72	0.28 (0.15–0.50)
Serious non–AIDS	29	0.42	47	0.67	0.61 (0.38–0.97)
Death from any cause	12	0.17	21	0.30	0.58 (0.28–1.17)
Tuberculosis	6	0.09	20	0.28	0.29 (0.12–0.73)
Kaposi's sarcoma	1	0.01	11	0.16	0.09 (0.01–0.71)
Malignant lymphoma	3	0.04	10	0.14	0.30 (0.08–1.10)
Cancer not related to AIDS	9	0.13	18	0.26	0.50 (0.22–1.11)
Cardiovascular disease	12	0.17	14	0.20	0.84 (0.39–1.81)

Hazard Ratio pour le critère de jugement principal

HPTN052

- 0.73 (0.52-1.03)

TEMPRANO

- 0.56 (0.41-0.76)

START

- 0.43 (0.30-0.62)

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When to Start Children and Adolescents

- ART should be initiated in all adolescents with HIV regardless of WHO clinical stage and at any CD4 cell count ***(conditional recommendation, low-quality evidence).***

- ART should be initiated in all children infected with HIV, regardless of WHO clinical stage or CD4 cell count
  - Infants diagnosed in the first year of life ***(strong recommendation, moderate-quality evidence)***
  - Children infected with HIV one year to less than 10 years of age ***(conditional recommendation, low-quality evidence).***

Age	When you start
10 years to less than 19 years	**Treat all adolescents** Individuals with WHO clinical stage 3 or 4 and with CD4 count ≤ 350 cells/mm3 as a priority
1 year to less than 10 years	**Treat all children** (children ≤2 years or with WHO stage 3 or 4 or CD4 count ≤750 cells/mm³ or <25% in younger than 5 years and CD4 count ≤350 cells/mm³ in 5 years and older as a priority)
Infants (<1 year)	**Treat all infants**

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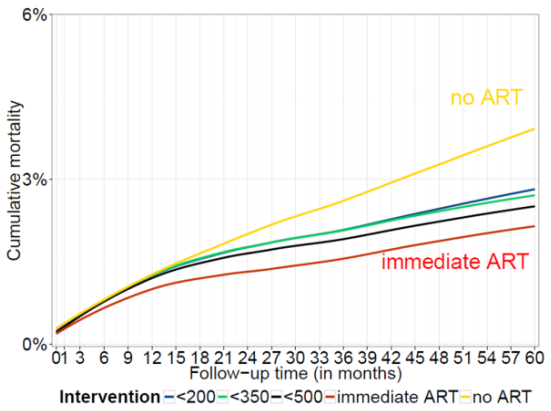
Evidence for Children & Adolescents

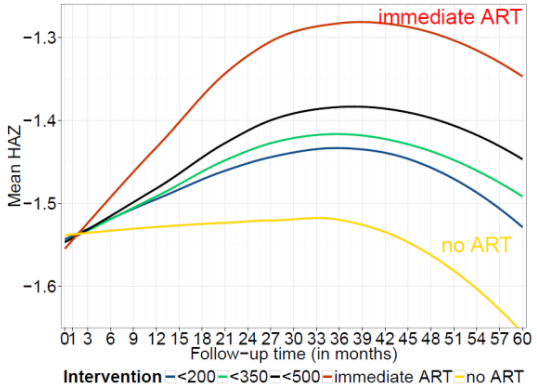
- **Lack of direct evidence** in support of earlier initiation (particularly for horizontally infected adolescents)[1]
- Indirect evidence suggests **reduction in mortality and improvement in growth** (particularly in children 5-10 years with CD4 >500)[2]
- A growing body of evidence demonstrates the **positive impact of ART** on growth[3], neurodevelopment[4], immunological recovery[5] and in preventing pubertal delays[6]
- Gains appear to be limited for vertically infected **adolescents**[2,5]

Mortality – age 5-10 – present with CD4> 500



Difference 'immediate ART' to '< 500':
0.4% (0.02%; 0.6%)

Growth - age 5-10 – present with CD4> 500



Difference 'immediate ART' to '< 500':
0.10 (0.07; 0.12)

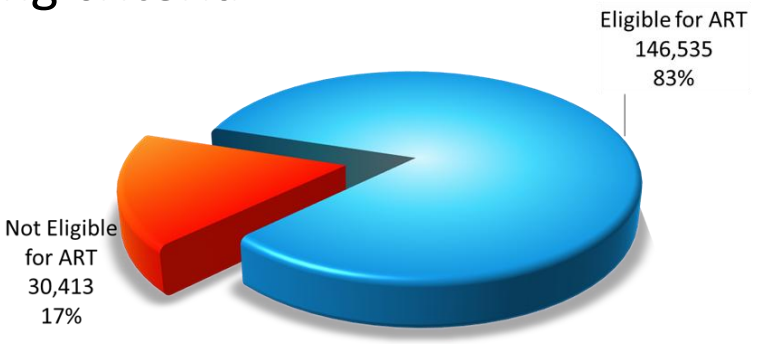
References:
1. Sigfried et al 2014
2. IeDea network 2015
3. McGrath et al 2011
4. Laughton et al 2012
5. Picat et al 2013
6. Szubert et al 2015

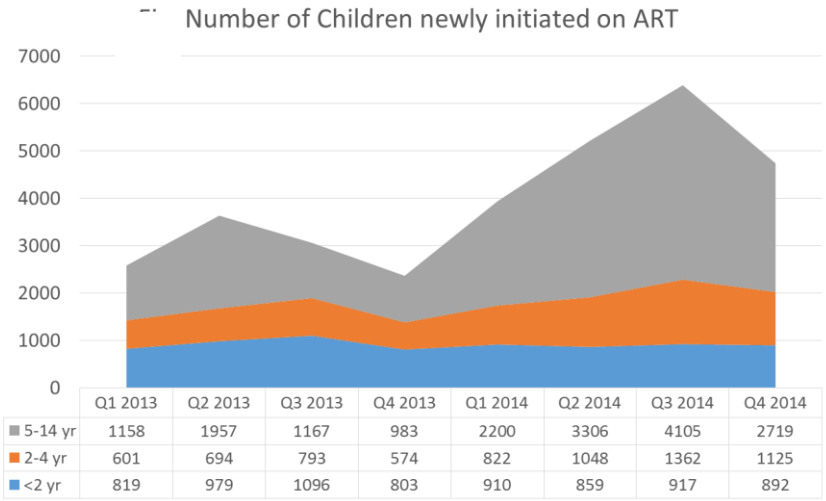
HIV TREATMENT

Programmatic Rationale Children and Adolescents

Only ~20% are not eligible based on existing criteria

- **Eliminates the need** for determining CD4 count to initiate ART
- **Avoids delaying** ART in settings without access to CD4 testing.
- **Simplifies** paediatric treatment and facilitate expansion of paediatric ART (task-shifting and decentralization)
- Improves **retention** in care compared to pre-ART





	Q1 2013	Q2 2013	Q3 2013	Q4 2013	Q1 2014	Q2 2014	Q3 2014	Q4 2014
5-14 yr	1158	1957	1167	983	2200	3306	4105	2719
2-4 yr	601	694	793	574	822	1048	1362	1125
<2 yr	819	979	1096	803	910	859	917	892

However…need adherence support (particularly in adolescents), careful planning, strengthening laboratory services and improvement of procurements and supply of key commodities

Source: Uganda National programme - Rapid assessment May 2015

World Health Organization

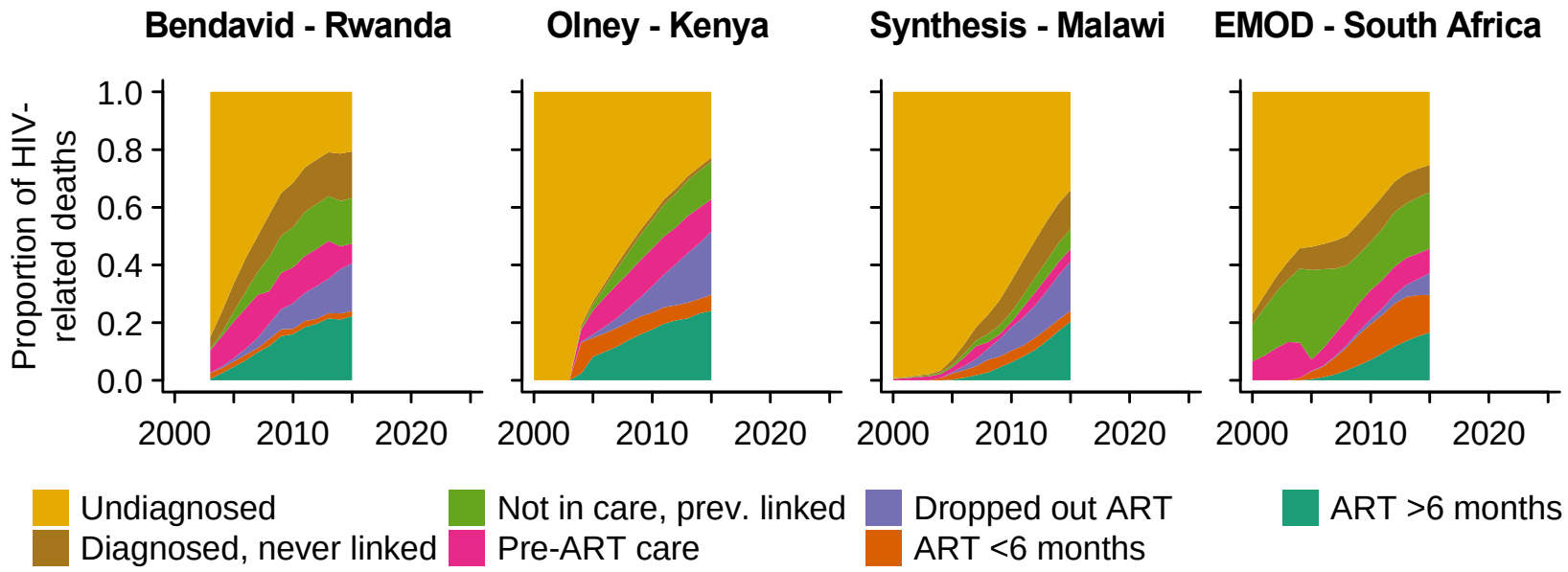
Community – led Global Consultation:

AFROCAB ICW VIA LIBRE Pangaea APN PLUS POSITIVE CHANGE EATG European AIDS Treatment Group AHF UKRAINE

Acceptability of Earlier Initiation of ART

- 24 workshops, 8 countries, 8 sub populations, 206 people living with HIV, 74 service providers.
- Earlier initiation was deemed **acceptable**, specific considerations were highlighted
- **Collaborative decision-making** with the ultimate decision to initiate ART being client-driven
- The requirement for **comprehensive and accurate information** to ensure an informed decision as well as readiness
- Initiating ART is relatively easy however **maintaining adherence is challenging**
- **Stigma and discrimination** were uniformly raised as fundamental concerns by all and seen to constrain treatment access and adherence

Model Estimates and Projections



- More HIV-related deaths are among people on ART, but projections indicate that there will still be **25-40% of HIV deaths** among persons never initiated ART.
- Deaths among persons **disengaged from ART** care will **increase** to be a substantial proportion of HIV deaths (purple).
- Only **10-30%** of HIV deaths will be among adults stable on ART.

Source: HIV Modeling Consortium June 2015

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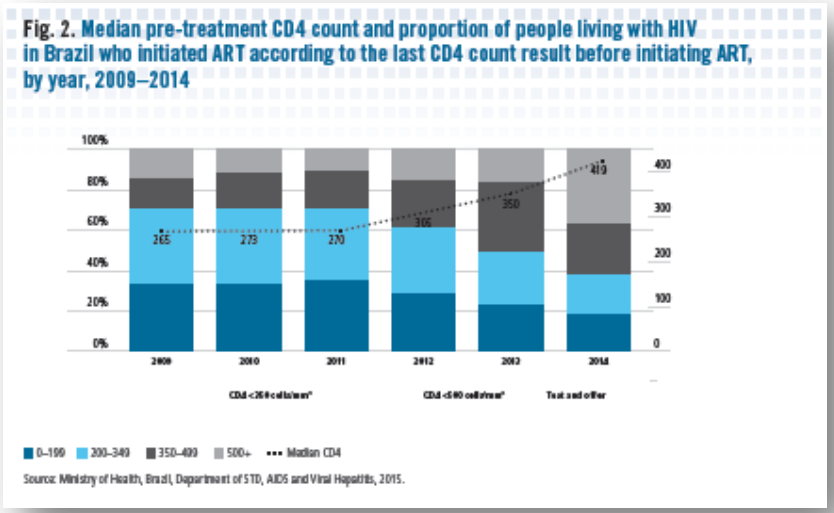
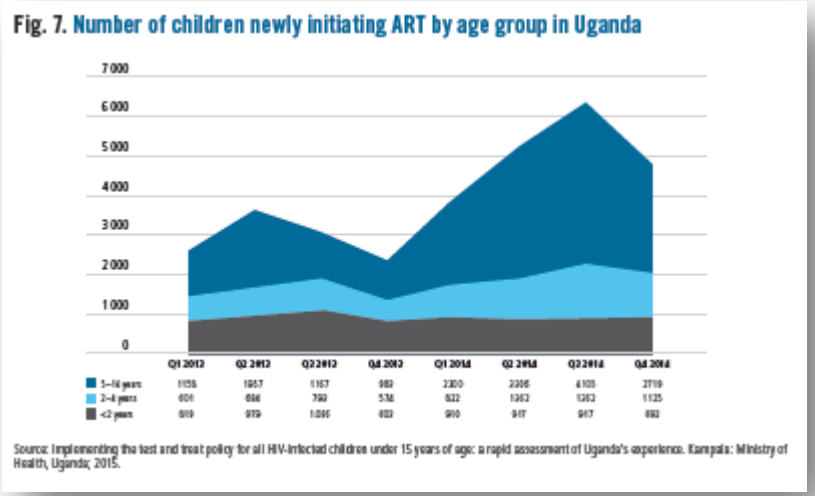
Countries are leading the way

Examples from five countries implementing Treat All or Treating All in specific populations:



- **Uganda started to treat all children < 15 years in 2014**
- Seen increase in overall number children on ART
- Retention at 12 m similar; VLS = 84%



- **Brazil has been treating all for one year**
- Leading to increase in median CD4 at ART initiation (265 to 419)
- Similar retention and VLS at 12 months (81% for CD4 > 500)

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Why consider PrEP

2.1 million people infected with HIV in 2013

Among key populations:

- Burden of HIV infection is 19 fold higher among MSM and 49 fold higher among transgender women compared with the general population.
- High rates of HIV incidence among MSM across all regions.
- High HIV prevalence among sex workers in Africa >20% in Nigeria;>50% in South Africa and Zimbabwe.
- Estimates from South Africa show a 5.6% HIV prevalence among girls aged 15–19 years, increasing to 17.4% for young women aged 20–24 years.

Demonstrated need for more prevention options

HIV incidence in 18-35 year women in this community:

9.1%

9.1 per 100 women-yrs
(95% CI: 7 - 12)

Source: Abdool Karim Q et al, Science 2010

HIV in pregnant women in rural South Africa (2001-2013)

Age Group (Years)	HIV Prevalence (N=4818)
≤16	11.5%
17-18	21.3%
19-20	30.4%
21-22	39.4%
23-24	49.5%
>25	51.9%

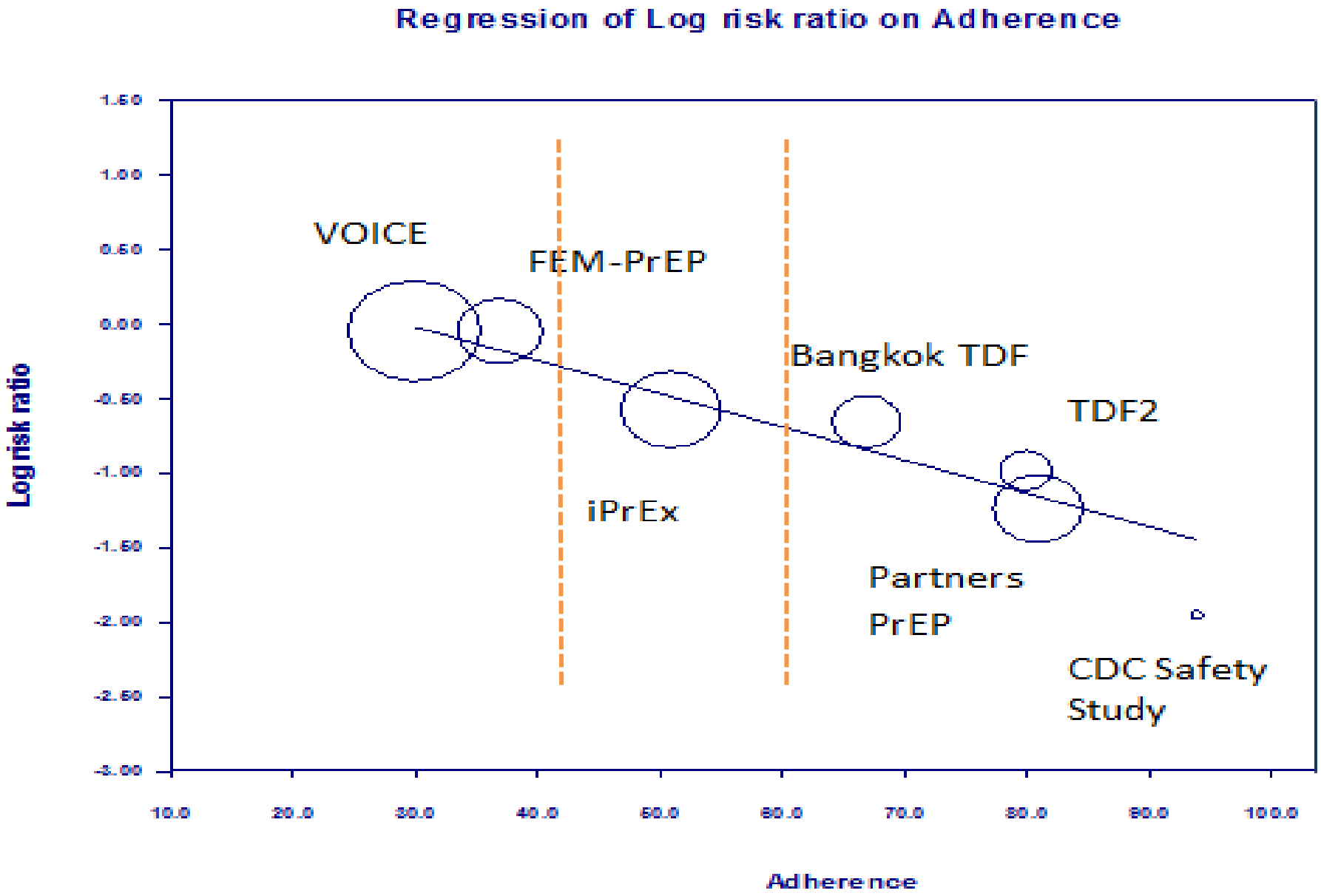
***Source**: Abdool Karim Q, Int J Epi, 2014*

PrEP Systematic review results

Analysis	No. of studies	Sample Size (N)	Risk Ratio (95% CI)	p-value	I^2	P-value (meta-regression)
RCTs comparing PrEP to placebo						
Overall	10	17424	0.49 (0.33-0.73)	0.001	70.9	--
Adherence						
High (>70%)	3	6150	0.30 (0.21-0.45)	<0.0001	0.0	<0.0001
Moderate (41-70%)	2	4912	0.55 (0.39-0.76)	<0.0001	0.0	0.009
Low (≤40%)	2	5033	0.95 (0.74-1.23)	0.70	0.0	*ref*
Mode of Acquisition						
Rectal	4	3167	0.34 (0.15-0.80)	0.01	29.1	0.36
Vaginal/penile	6	14252	0.54 (0.32-0.90)	0.02	80.1	
Biological sex[1]						
Male	7	8706	0.38 (0.25-0.60)	<0.0001	34.5	0.19
Female	6	8716	0.57 (0.34-0.94)	0.03	68.3	
Age[2]						
18 to 24 years	3	2997	0.71 (0.47-1.06)	0.09	20.5	0.29
≥25 years	3	5129	0.45 (0.22-0.91)	0.03	72.4	
Drug Regimen						
TDF	5	4303 active	0.49 (0.28-0.86)	0.001	63.9	0.88
FTC/TDF	7	5693 active	0.51 (0.31-0.83)	0.007	77.2	
Drug Dosing						
Daily	8	17024	0.54 (0.36-0.81)	0.003	73.6	0.14
Intermittent	1	400	0.14 (0.03-0.63)	0.01	0.0	
RCTs comparing PrEP to no PrEP						
Overall	2	720	0.15 (0.05-0.46)	0.001	0.0	NA

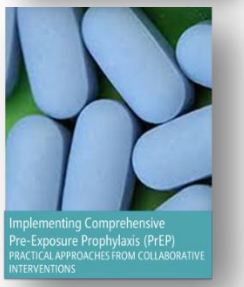
[1] The iPrEx trial included 313 (13%) transgender women. [2] Includes only studies that stratified age by <25 and ≥25.

PrEP Adherence and effectiveness



GRADE table: HIV infection

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Oral PrEP (containing tenofovir)	Control	Relative (95% CI)	Absolute		
HIV Infection--PrEP vs. Placebo--Adherence >70%												
3	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	39/3866 (1%)	79/2284 (3.5%)	RR 0.30 (0.21 to 0.45)	24 fewer per 1000 (from 19 fewer to 27 fewer)	⊕⊕⊕⊕ HIGH	CRITICAL
HIV Infection--PrEP vs. Placebo--Adherence 40-70%												
2	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	53/2455 (2.2%)	97/2457 (3.9%)	RR 0.55 (0.39 to 0.76)	18 fewer per 1000 (from 9 fewer to 24 fewer)	⊕⊕⊕⊕ HIGH	CRITICAL
HIV Infection--PrEP vs. Placebo--Adherence <40%												
2	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	146/3002 (4.9%)	95/2031 (4.7%)	RR 0.95 (0.74 to 1.23)	2 fewer per 1000 (from 12 fewer to 11 more)	⊕⊕⊕⊕ HIGH	CRITICAL
HIV infection--PrEP vs. no PrEP												
2	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	3/367 (0.82%)	22/353 (6.2%)	RR 0.15 (0.05 to 0.46)	53 fewer per 1000 (from 34 fewer to 59 fewer)	⊕⊕⊕⊕ HIGH	CRITICAL



WHO guidance on PrEP *(2012, 2014, 2015, 2016)*

2012. Guidance for MSM & Serodiscordant Couples in the context of demonstration projects *to encourage countries to conduct such demonstration projects*

201. Consolidated KP Guidelines

Recommendation for MSM

Among men who have sex with men, PrEP is recommended as **an additional HIV prevention choice** within a **comprehensive HIV prevention package** *(strong recommendation, high quality of evidence)*.

2015

Oral PrEP (containing TDF) should be offered as an additional prevention choice for people at substantial risk of HIV infection as part of combination prevention approaches (Strong/High Quality)

2016

Implementation guidance, package of implementation tools for a variety of implementers and populations forthcoming

Implementation tool / guidance, *forthcoming*

Who might benefit from PrEP – people at 'substantial' HIV risk

Step 1. consider an incidence in a community/population of ≈ 3 per 100 person–years

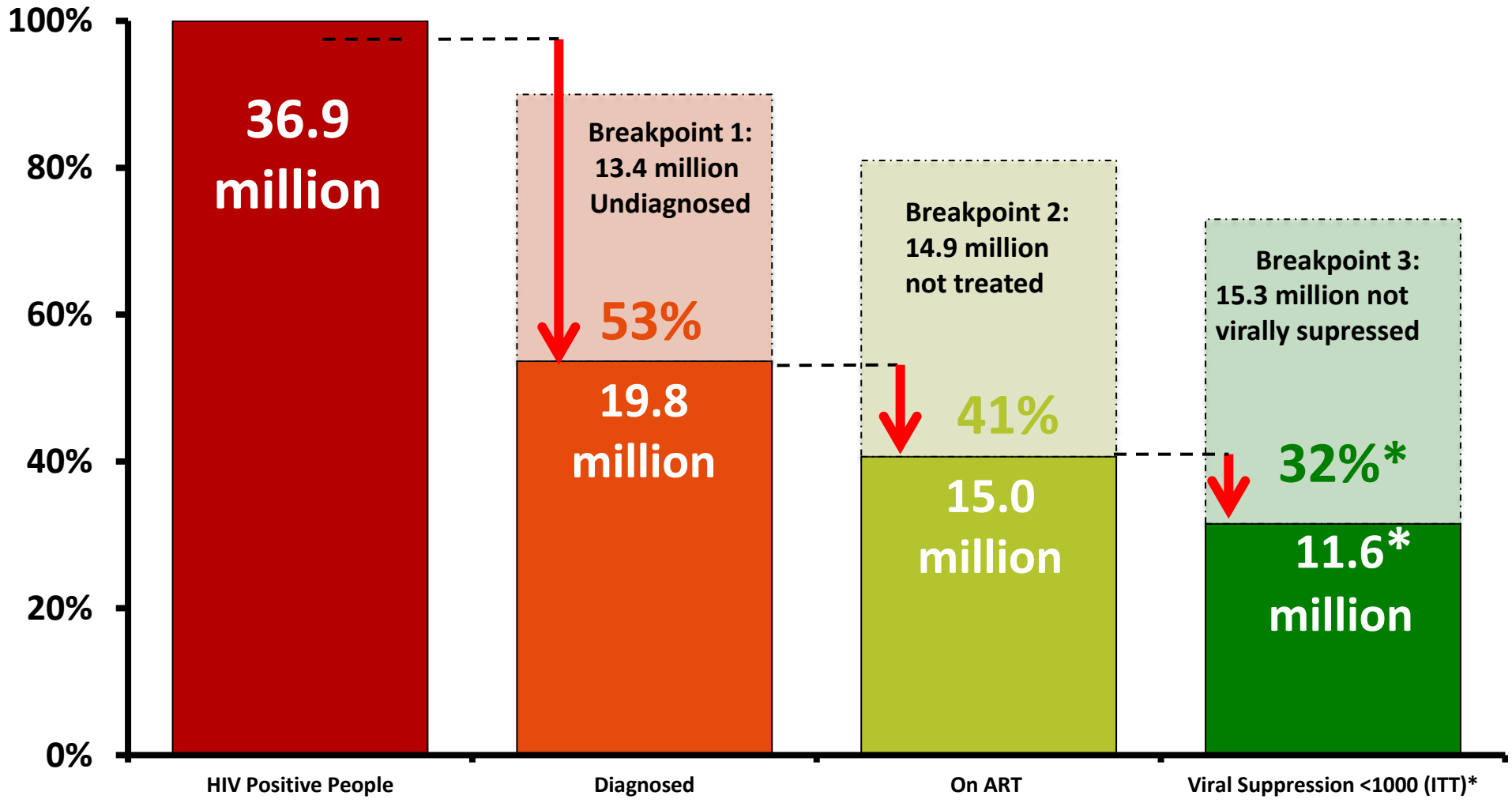
Step 2. Within a population with incidence ≈ 3% there will be significant heterogeneity. Not all people will have high HIV risk. Simple screening questions will help identify those at most risk within this population or community and those who are ***not*** using other effective HIV prevention methods

Step 3 . Those who are identified at highest HIV risk and a would welcome and want to take an additional prevention option

HIV TREATMENT

HIV/AIDS Department

Global estimates (2014-2015) vs the gap to reach 90-90-90 targets in 2020



Ref: On ART = March 2015. How Aids Changed Everything. Fact Sheet. UNAIDS 2015. MDG 6: 15 YEARS, 15 LESSONS OF HOPE FROM THE AIDS RESPONSE July 2015. * Average viral suppression% Intention to Treat LMIC rate from a Systematic Review by McMahon J. et al. Viral suppression after 12 months of antiretroviral therapy in low-and middle-income countries: a systematic review." *Bulletin of the World Health Organization* 91.5 (2013): 377-385.

World Health Organization

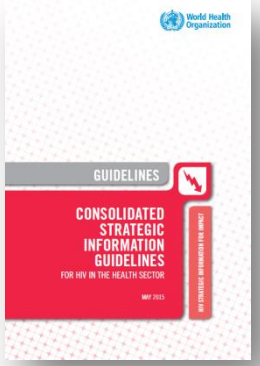
Critical issues addressed in New HTS Guidelines

- **New approaches**
  - Trained lay providers testing (*new recommendation*)
  - Test for Triage (*new testing strategy*)
  - HIV self-testing (*push for implementation and monitoring*)

- **Better linkage**
- **Preventing misdiagnosis**
  - Focus on QA
  - Re-emphasise re-testing all +ve before ART initiation
- **Strategic choices**

HIV TREATMENT

Consolidated Strategic Information Guidance



Know your epidemic

Epidemic pattern by key population, age, sex and geography

Inputs

Health system inputs and financing

Outputs & Outcomes

HIV care cascade

Prevention → Testing & counselling → Linkage to care → ART → Viral suppression

Evaluate impact

Reduced incidence and deaths, equity
Assess outcomes at all stages of the cascade

(1) People with HIV
Number and % of people living with HIV (PLHIV)

(2) Domestic finance
% of HIV response financed domestically

(3) Prevention by key populations
% condom use among key populations or needles per PWID

(4) Knowing HIV status
% of PLHIV who have been diagnosed

(5) Linkage to care
Number and % in HIV care (including ART)

(6) Currently on ART
% on ART

(7) ART retention
% retained and surviving on ART

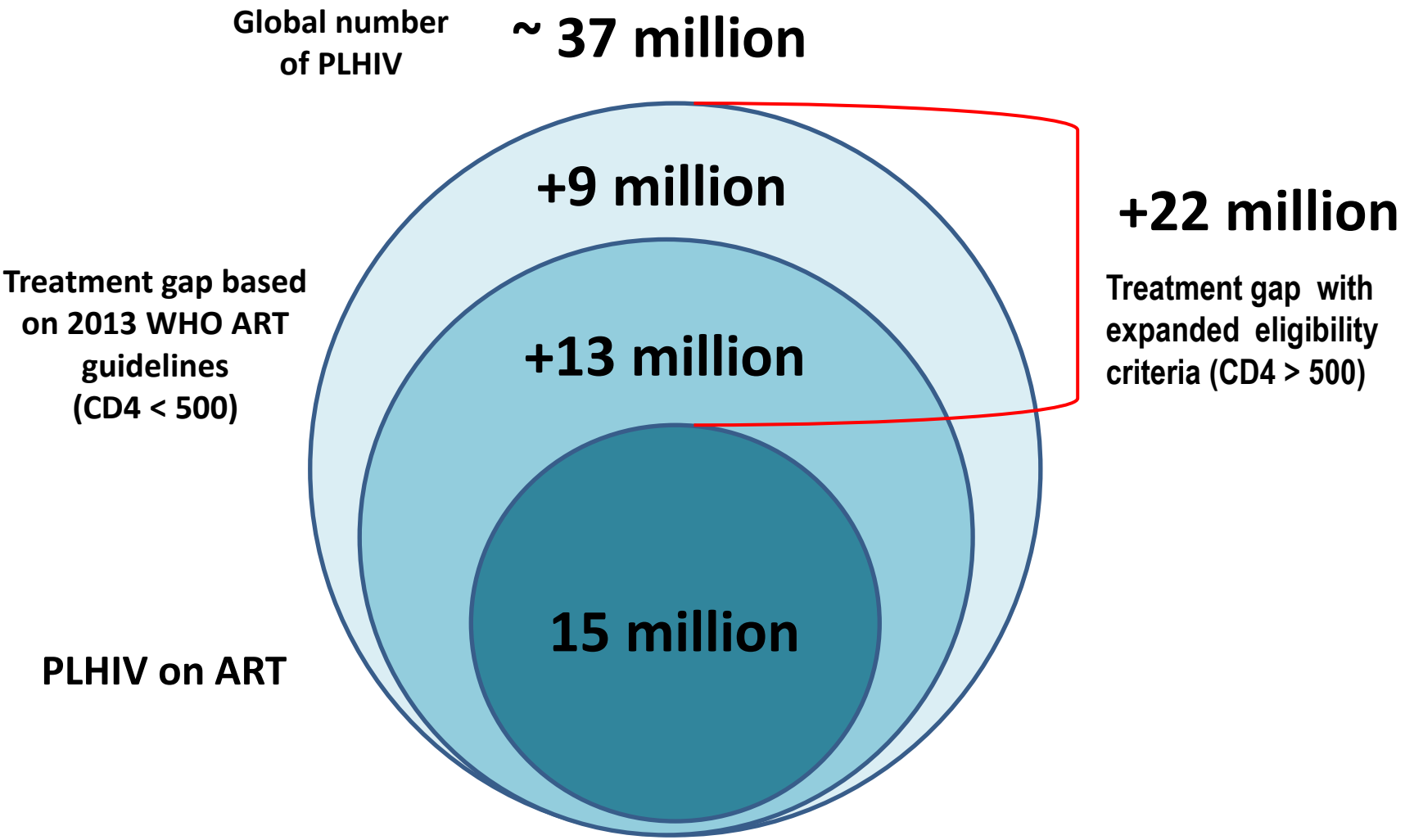
(8) Viral suppression
% on ART virally suppressed

(9) HIV deaths
Number and ratio of HIV-related deaths

(10) New infections
Number and % of new HIV infections

10 Global Indicators

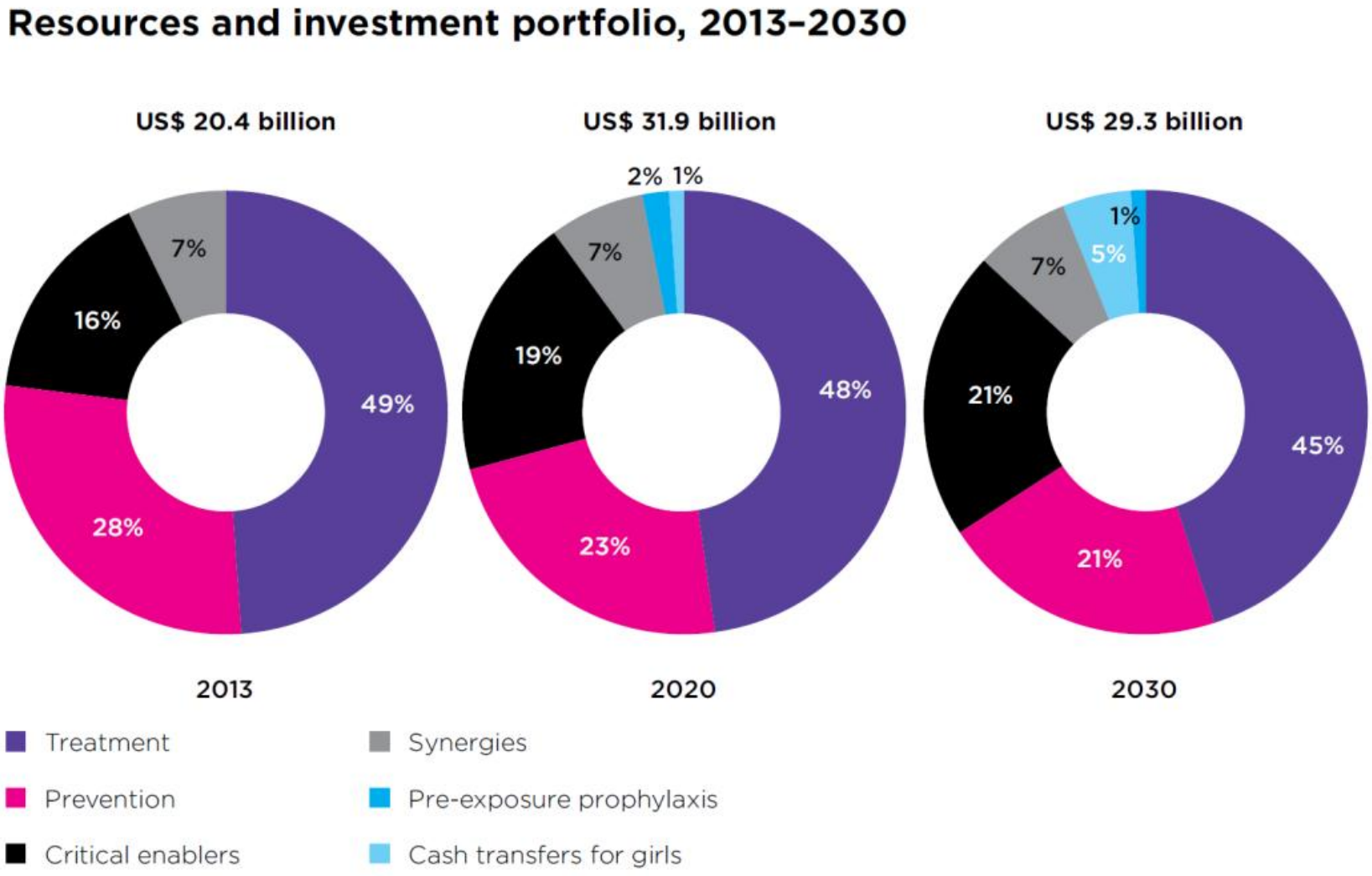
The estimated gap between treatment targets & actual numbers of PLHIV on ART according to eligibility criteria



Concerns from countries/donors on how to address immediate increased cost and service demand

RESOURCE USE - COSTS

From UNAIDS Fast Track Modeling



Source: Based on GARPR reports through 2015 and on Fast-Track: ending the AIDS epidemic by 2030. Geneva: UNAIDS; 2014.

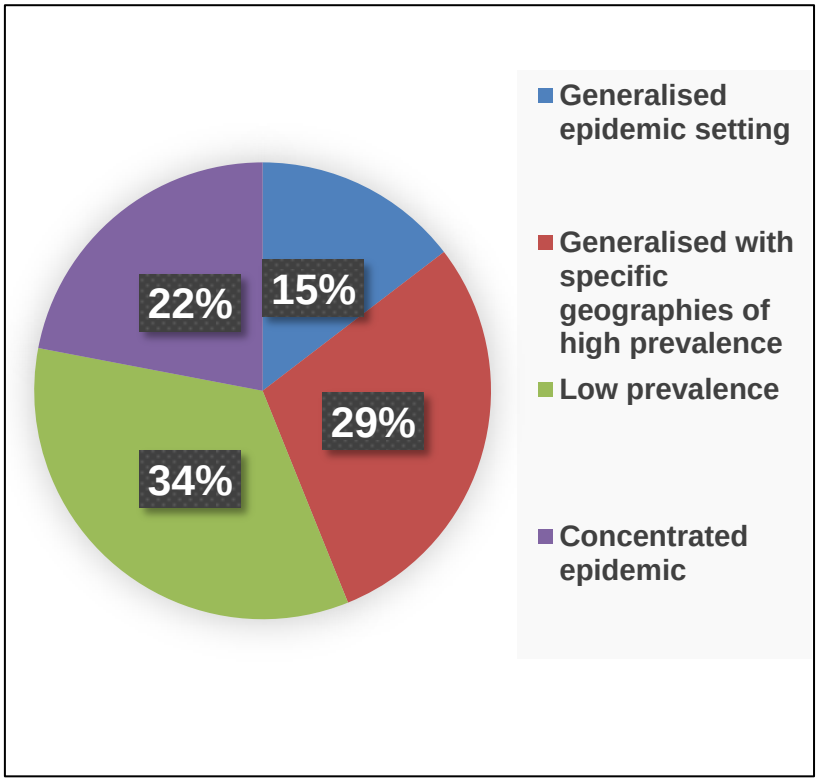
MDG results & new targets…

Key parameters	2005	2015	2020	2030
New HIV infections	3 million	2 million [↓ 35%]	500,000	200,000
AIDS-associated deaths	2.4 million	1.2 million [↓ 50%]	400,000	200,000
PLHIV accessing ART	1.5 million	15 million [↑ 10x]	30 million	ALL
Investments for global HIV response (US$)	7 billion	20 billion [↑ 3x]	32 billion	29 billion

WHO & UNAIDS reports , 2015

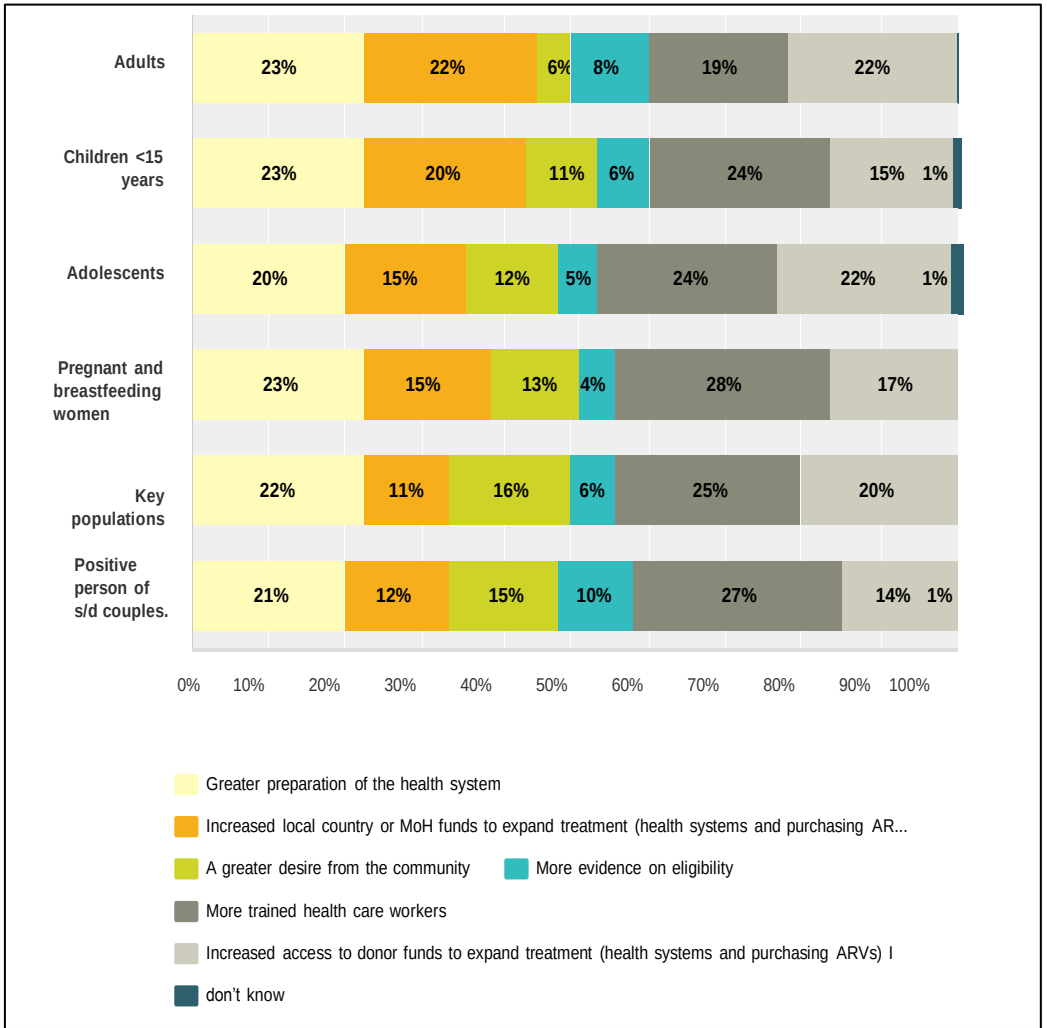
Results: Programme Managers Survey

Figure 1: Country HIV epidemic settings of survey respondents (N=41)



Source: National ART Programme managers perspectives' on implementing HIV interventions, KIT 2015

Figure 2: Top 3 requirements to enable your country to expand ARV treatment initiation criteria for each of the groups stated (N=33)



Michel Sidibé, Executive Director, UNAIDS

"Everybody living with HIV has the right to life-saving treatment. The new guidelines are a very important step towards ensuring that all people living with HIV have immediate access to antiretroviral treatment."

Deborah L. Birx, U.S. Global AIDS Coordinator & U.S. Special Representative for Global Health Diplomacy

" These are transformative to epidemic control. Short of an HIV vaccine or cure, this gives us the critical tools we need to create an AIDS-free generation utilizing the FAST TRACK strategy. We have no excuses - it is up to us to seize this moment…"

Mark Dybul, Executive Director, The Global Fund

"The two recommendations are critically important to moving us towards the fast-track treatment and prevention goals…. We must embrace ambition if we are going to end HIV as a public health threat."

What is new in the Early release guideline?

- Treat all (at any CD4) - people living with HIV across all ages
- The sickest remain a priority (symptomatic disease and CD4< 350)
- New age band for Adolescents (age 10-19)
- Option B not taken forward; Option B+ as the new standard
- PrEP recommended as an additional prevention choice for all people at substantial risk of HIV infection (> 3% incidence)

HIV TREATMENT

2015 ARV : Timeline

Evidence retrieval:
Systematic reviews
Values and preferences
Community consultations
Modelling
Dec 2014 – May 2015

Key recommendations preview
July 19 2015

Launch Full Updated 2015 Consolidated ARV Guidelines
Dec 1 2015

Core group
July 23-24 2015

Supplement launch WAD
Dec 1 2014

Core group
Oct 20-21 2014

GDG Clinical/ Operational
June 1-5 2015
June 16-19 2015

Launch Interim Guidelines on when to start and pre-exposure prophylaxis
Sept -Oct 2015

Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan

World Health Organization

HIV TREATMENT

Acknowledgements

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IeDEA Collaboration

The Global Network of People living with HIV/AIDS

PEPFAR

CDC

USAID

Bill and Melinda Gates Foundation

World Health Organization