

# HATiP

HIV & AIDS Treatment in Practice

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## Revised WHO Treatment Guidelines - deadline for comments 14 November

The World Health Organisation has published new draft treatment guidelines for use in resource-limited settings, with an emphasis on the use of fixed dose drug combinations wherever possible. The guidelines are designed to encourage the scale-up of antiretroviral therapy in the absence of comprehensive laboratory monitoring. WHO is inviting comments from interested parties to be submitted by November 14.

The guidelines recommend that drug combinations should use either efavirenz or nevirapine as cornerstones, with either AZT/3TC or d4T/3TC as the nucleoside analogue backbone. The guidelines are intended to help countries choose which drugs to use as the lead regimen in national programmes, but in practical terms it is likely that countries will need to maintain a formulary of the five drugs in order to allow switching between nevirapine and efavirenz, and between AZT and d4T, and to accommodate patients with tuberculosis and pregnant women.

In practical terms, it is likely that the WHO guidelines will encourage very wide use of generic antiretrovirals manufactured in India and South Africa. Two weeks ago the Clinton Foundation announced that it had reached agreement with Indian and South African manufacturers to sell a fixed dose combination of d4T, 3TC and nevirapine for \$132 a year to Mozambique, Tanzania, Rwanda and South Africa and nine Caribbean states.

WHO also recommends a three tier approach to monitoring. At community health centre level, rapid HIV antibody testing, haemoglobin testing and pregnancy testing are the only tests recommended. Haemoglobin testing is only necessary if AZT is included in the regimen, and it can be done using a haemoglobin colour scale published by WHO. Haemoglobin testing for anaemia is necessary because the condition can worsen when AZT treatment begins. Pregnancy testing is only needed if efavirenz is included in the regimen.

At district hospital level, rapid HIV antibody testing and confirmatory testing using a second method are recommended, together with CD4 counting. WHO says it is committed to working with member states to make CD4 counting as widely available as possible. Full blood counts and liver enzyme measurements are also encouraged, as is sputum smear testing for tuberculosis. A full blood count and differentials is preferred to haemoglobin in this setting for measuring anaemia and neutropenia, and for calculating total lymphocyte counts where CD4 cell counting is not possible. Total lymphocyte count is judged to be a useful measure of immune system damage in symptomatic patients, but cannot be used for monitoring responses to treatment.

Treatment failure can be judged by the appearance of new symptoms (not to be confused with immune reconstitution syndrome), or the recurrence of a previous opportunistic infection. If CD4 counting is available, the guidelines recommend that treatment should be switched if the CD4 cell count falls below the pre-treatment baseline, or falls at least 50% below its peak level. In either case, clinicians should rule out the effects of tuberculosis. Reinfection with TB could occur without treatment failure.

Second line treatment should be based on ddI plus tenofovir or abacavir and either lopinavir/saquinavir or saquinavir/ritonavir. However, both require a secure cold chain for storage of the ritonavir element. Atazanavir, a new protease inhibitor which can be taken once daily and which does not require cold storage, is judged to be too new for use in resource-limited settings.

To download the draft guidelines, click on the link below:

[WHO Draft guidelines for a public health approach to scaling up antiretroviral therapy in resource limited settings](#)

## about HATiP

A regular electronic newsletter for health care workers and community-based organisations on HIV treatment in resource-limited settings.

The newsletter is edited by Theo Smart (Cape Town) and Keith Alcorn, NAM's Senior Editor (London).

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