

HAART: When to Start? What to Start? A View from Namibia

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NAMIBIA

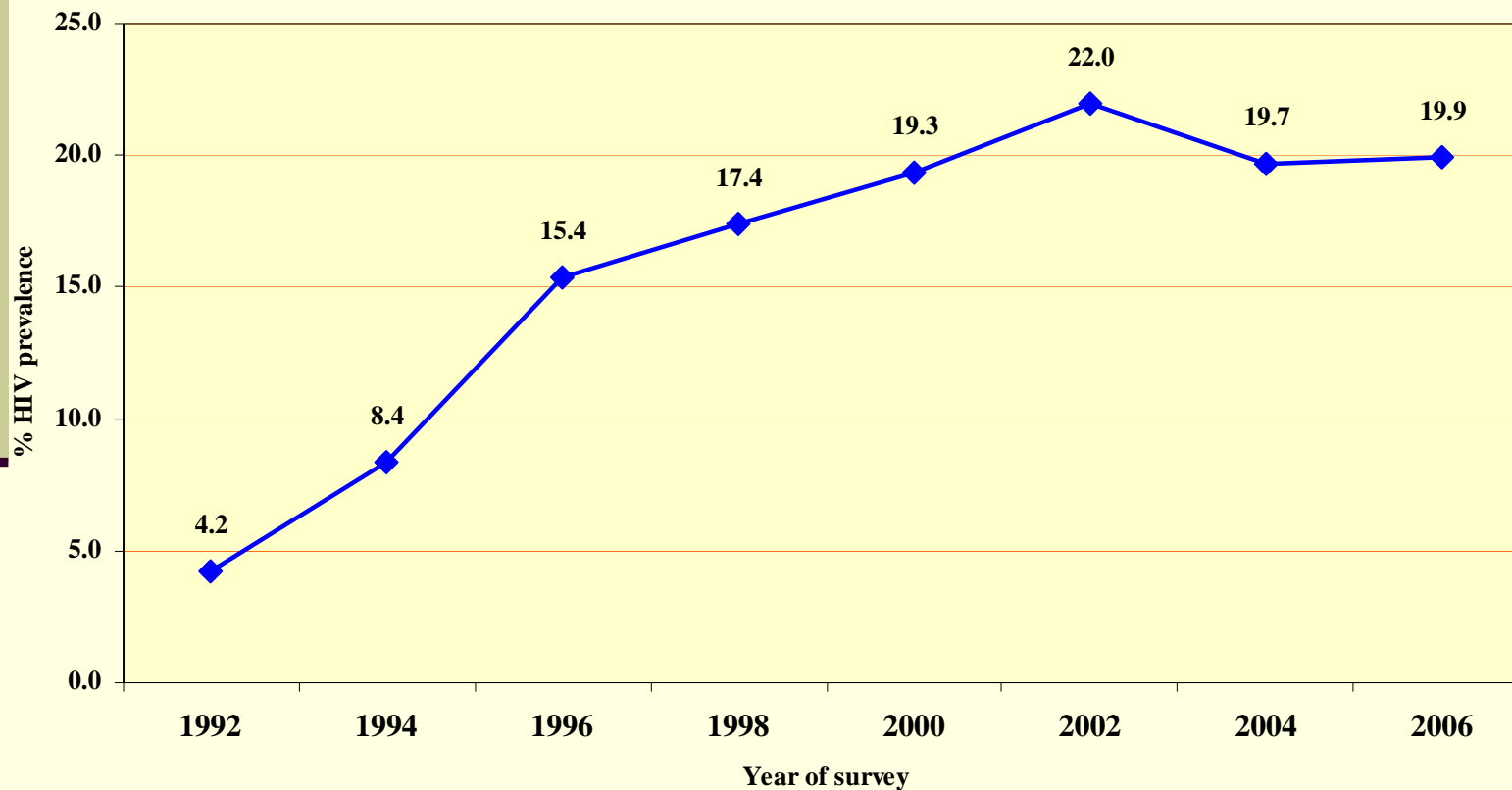


Outline of Presentation

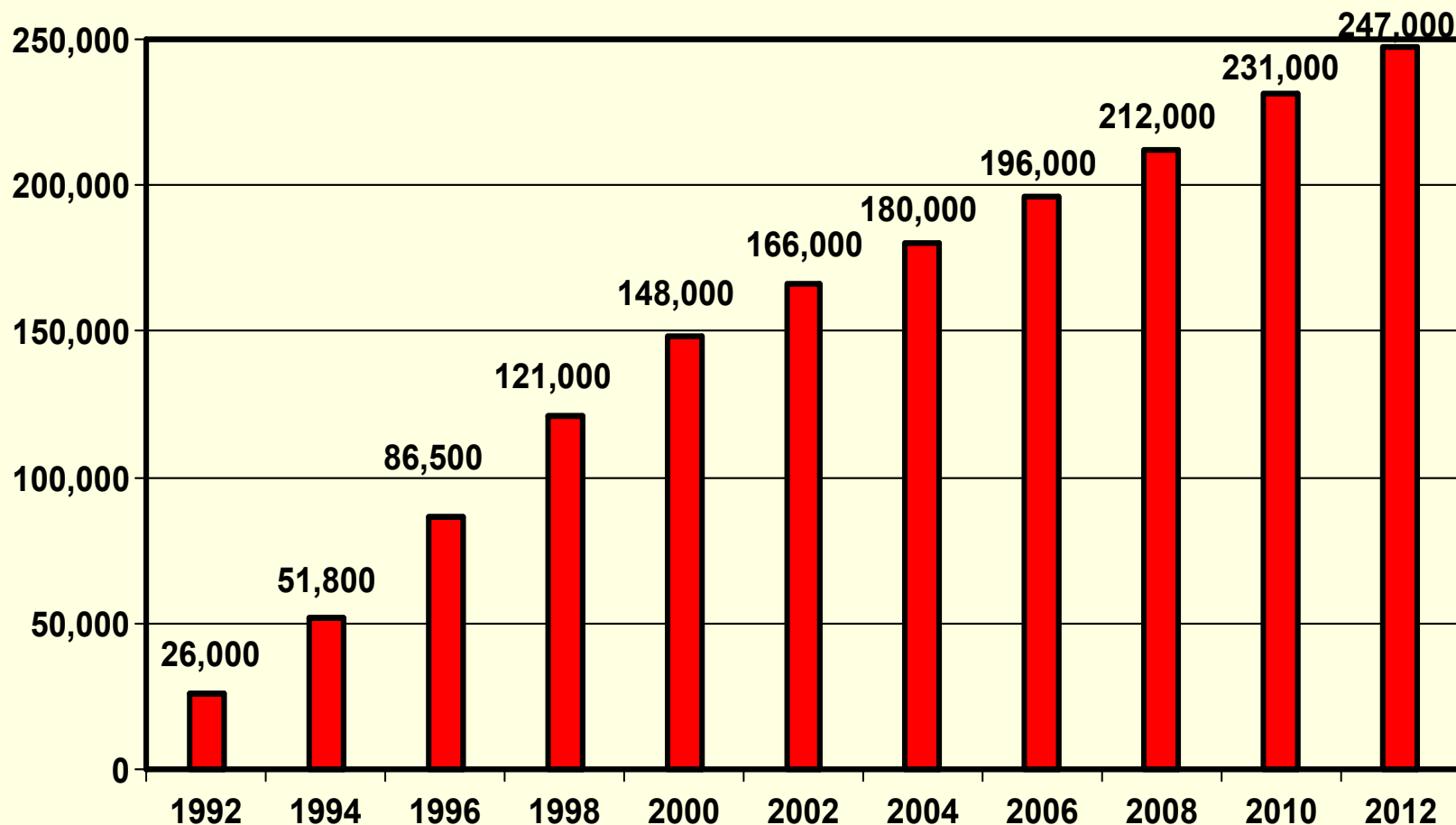
- Namibia's Current HIV/AIDS Epidemic
- First line regimen
- Challenges
- Way forward

National HIV Prevalence in Pregnant Women 1992-2006

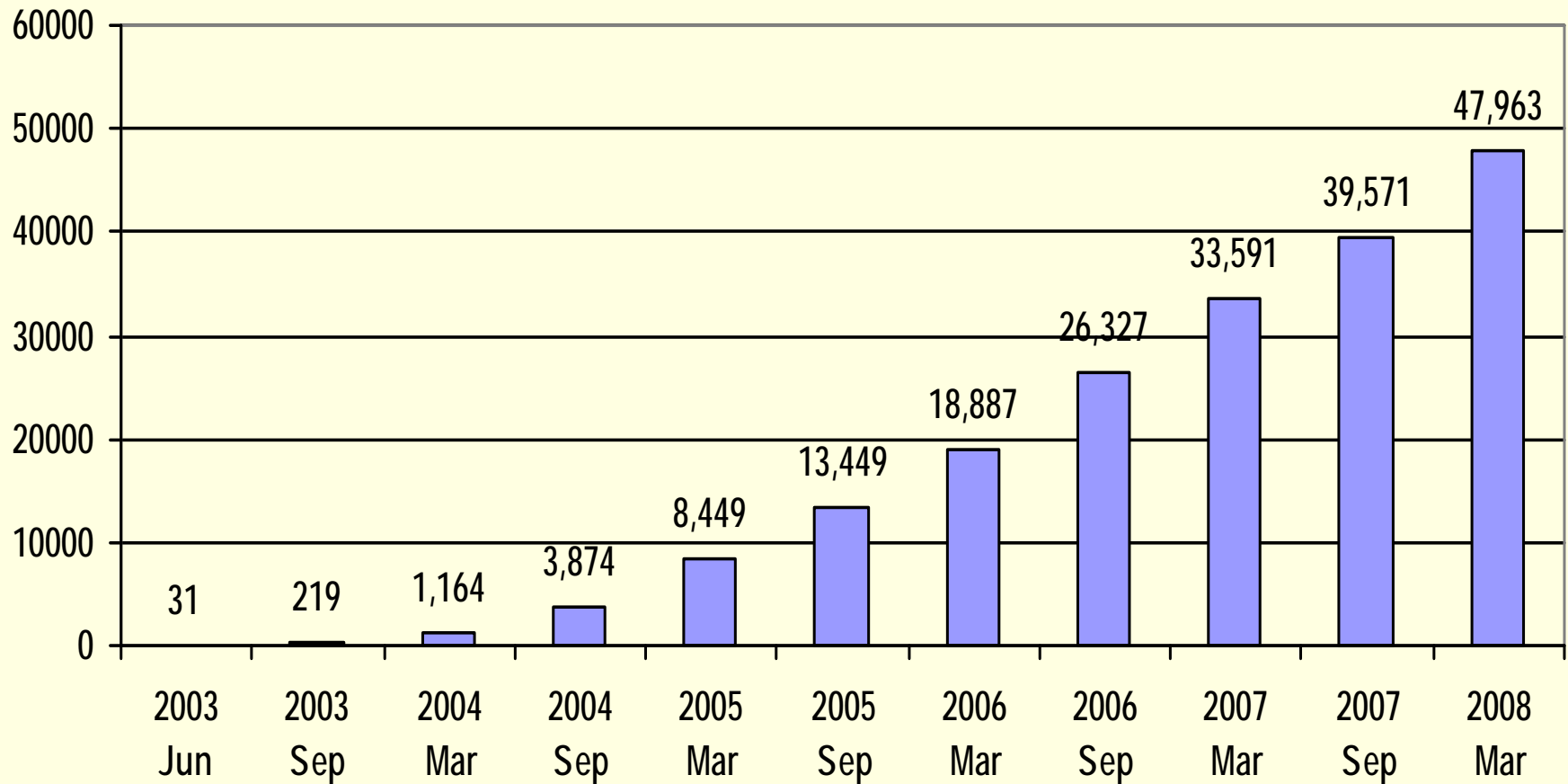
HIV prevalence rate in pregnant women, biannual surveys
1992-2006, Namibia



Estimated Number of HIV+ People in Namibia, 1992-2008



Number of Patients on HAART in the Public Sector, June 2003 - March 2008



Namibian Criteria For Starting HAART In Adults

2003

- WHO Stage 4 or CD4 count <200

2007

- WHO Stage 3 or 4
- CD4<200 for the general population
- CD4<250 for pregnant women

Namibian Criteria For Starting HAART In Infants & Children

WHO Pediatric Stages	Age specific recommendations		
	<18 months		≥18 months
4	Treat All		
3	Treat all		Treat all, but CD4 guided with TB, LIP, OHL, thrombocytopenia
2	25%	CD4 guided	20%
1	25%	CD4 guided	20%

Adult First-line Regimen

- AZT/3TC/NVP

alternatives if cannot use preferred first line:

- AZT/3TC/EFV

- D4T/3TC/NVP

- D4T/3TC/EFV

N.B. Patients starting d4T-containing regimens will be on 30mg bd, regardless of weight

First-line with Co-morbidities

- TB co-morbidity: AZT/3TC/EFV
 - TB co-morbidity in pregnancy: AZT/3TC/EFV if beyond first trimester
 - Consider triple 'nuc' regimen: AZT/3TC/ABC if in first trimester
- HBV co-morbidity:
 - TDF/3TC/NVP if asymptomatic and ALT<3xULN, otherwise
 - TDF/3TC/EFV

First-Line Paediatric HAART In Namibia

- The first-line regimen for children is:
Stavudine + Lamivudine + Nevirapine
(d4T + 3TC + NVP)

Alternatives

AZT/3TC/NVP

Challenges and Way Forward

- CD4 count of <200 at initiation too low;
- Technical Advisory Committee considering CD4 <350 at initiation for better outcomes on treatment.
- This brings own challenges:
 - Putting those with advanced disease first on treatment 'sickest first'
 - Increasing cost of ART program
 - Need for more personnel and bigger infrastructure to accommodate increased numbers of eligible patients for ART
 - Addressing adherence concerns as patients start on treatment when they are still fairly asymptomatic and may not be as motivated to adhere to treatment

Challenges and Way Forward

- AZT induced anemia and need for multiple blood transfusion, even use of expensive recombinant erythropoietin. This is not sustainable

Action: Reconsider choice of first line regimen

- Consider TDF in first line
 - TDF/FTC cheaper than AZT/3TC and available in private sector
 - TDF/FTC/EFV a good option; convenient once a day dosing
 - Using TDF in first line preserves AZT and D4T for use in second line; if TDF resistant, only K65R mutation and so can move to AZT or D4T. Failure on AZT or d4T leads to development of multiple TAMs and limited treatment options for NRTI class
- ABC in first line: not an option now as it is expensive