

# The State of Children and HIV

Despite the amazing progress science treatment and care programs have made in HIV/AIDS over the past 30-some years, some issues remain that we have yet to effectively address.

**To us the most tragic is children.**

*Just one-third of the 3.2 million children living with HIV currently have access to treatment compared to half of adults.*

*Children with HIV are dying at an alarming rate. Without treatment one-third (33%) of children will die before their first birthday; 50% will die by their age of two, and 80% will die before age five.*

Even now, with treatment programs scaled up around the world and experts heralding the dawn of an HIV-free generation, today, and every day, more than 700 children will be infected with HIV and 500 children will die.

“Children are being left behind in the fight against HIV and AIDS. Unless countries take action to make treatment services more available, hundreds of thousands of children will continue to die each year from HIV-related causes.” –[Increasing Children's Access to Treatment](#)



**Understanding the Challenge**

Among HIV positive people globally, estimates are that one person in every five does not know they have the disease (Health and Human Services, 2012, p 2.). That number is most likely higher for children since their access to testing is more limited than adults. No one truly knows the number of undiagnosed cases of HIV in children. Testing is generally available at medical facilities to which mothers may or may not have ready access. Some mothers are not aware of their own status let alone their child's. Often they do not go to the clinic until there are signs of illness in themselves or their child. If testing is available there is a fear of testing positive due to stigma or superstition associated with the disease. If these are not the barriers, sometimes distance is.

Traveling long distances to equipped facilities can be expensive, time consuming and out of reach to many. Also, testing for HIV in infants and young children requires a more complicated and expensive process necessitating more lab work with longer wait times for the results.

Once a child is tested, a second hurdle must be conquered: *Child-friendly and accessible treatments.*

Some barriers to treatment access are the same as the barriers to testing, but there are further challenges when it comes to treatment. Shortages and inconsistency in the supply of antiretroviral (ARV) drugs (particularly pediatric dosages and formulations) are common, especially in rural settings where many of these children live. This can delay a child from starting treatment, or interfere with the consistent treatment required for effectiveness.



Additionally, dosing of pediatric drugs can be complicated since appropriate dosages are determined by the ever-changing growth and weight of the child. Many medical practitioners shy away from starting children on drugs for fear of incorrectly prescribing appropriate treatment or simply because consistent supplies are not guaranteed for prolonged treatment.

Like adults, HIV treatment for children requires a daily “cocktail” of 3 distinct drugs that work together to keep the immune system strong, accompanied by a prophylactic drug to ward off other illnesses. That can add up to a lot of pills or a complicated combination of tablets and liquids. It is not uncommon for children to be taking 5 to 12 tablets, or tablets and liquids in combination, every day, that they cannot readily swallow and taste bad.

With the current lack of fixed dose combinations (FDCs, or multiple drugs in one formulation) in appropriate pediatric dosages, many children are still taking drugs that must either be cut (if tablet doses are too high), or multiplied (if tablets doses are too small). Either way, these regimes are complicated and lead to poor or non-adherence, which in turn leads to high morbidity (illness) and mortality (death) rates of these children.

According to the Drugs for Neglected Diseases initiative,

*There is still a great need for continued simplification of treatment by means of developing fixed-dose combinations, in formulations that are child and caregiver friendly, well taste masked, storable at room temperature, and with a long shelf-life and non-conspicuous packaging (2013, p. 4).*

In 2014 we have seen a new, energized focus on child HIV testing and closing the treatment gap between children and adults. It is a primary focus of the President's Emergency Plan for AIDS Relief (PEPFAR), the newly launched Pediatric HIV Treatment Initiative, and is included in the UNAIDS slate of priorities.

Yet more needs to be done by many on a worldwide scale to find the children in this epidemic who so desperately need life-saving medicine.

**Please join CAFI in this fight.**