Global issues in the prevention and treatment of childhood AIDS

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In 2005, global paediatric HIV treatment seemed an impossible dream

**The past**

- <30,000 children on treatment worldwide (<5% of children in need of ART)
- Very few women were accessing services to prevent vertical transmission
- Syrups were the only option for children, the cost was around $500/child/year and dosing was very complex
- Infant diagnosis using PCR testing was impossible to access
- Very few clinicians had the knowledge and skills to care for children with HIV and paediatric treatment was only available at select tertiary clinics
Five years later, we have made significant progress

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The present

- >275,000 children on treatment worldwide (40% of children in need of ART)
- Overall about 200,000 pediatric infections have been prevented
- 5 new paediatric fixed dose combination tablets are now available, cost $60/child/year with very simple dosing
- Infant diagnosis is more readily available ~150,000 tests per year performed
- Thousands of nurses and doctors have been trained, and paediatric treatment is now available at most ART centers
Each year, over 100,000 newly diagnosed children start ART

Combined paediatric treatment numbers from 20 countries with highest burden of disease

Source: UNICEF stocktaking report 2009
But...global progress masks individual country performance: some lag far behind

Many countries have achieved >50% of need met. BUT....many are far from there
And although we start 100,000 children per year on ART, there are 430,000 new infections.
As prevention efforts improve, we must look beyond PMTCT to find infected children.

**Known Cases**

**Unknown Cases**

All pregnant women

*PMTCT Testing*

HIV+ pregnant women

HIV exposed infants

HIV infected children

Positive women not tested in ANC are not identified and get no PMTCT services

A significant number of infected infants never receive their PCR results and are lost to follow-up

**Strategies to identify unknown infected children**

**First tier**

- Routine offer of testing in inpatient wards, TB clinics and malnutrition units
- Proactive testing of children of adult patients enrolled in HIV care programs

**Second tier**

- Testing children in HIV+ social networks and families
- Testing infants and children of unknown status at vaccine or U5 clinics
- Door-to-door testing focused on children

Source: Kellerman & Essajee, PLOS, 2010
“Need” is relative. In reality almost all children would benefit from ART

2006 WHO guidelines: “Treat the sickest”

2010 WHO guidelines: “Treatment saves lives”

2010 US guidelines: “Treat almost all”
And today, Universal Access faces the most serious global economic crisis since 1930's...

Available resources

- Resources Available for HIV services
- Resource needs for country defined UA
So what can we do together, as advocates, policy makers and clinicians to turn the wheel?

**WHO**
Must develop the policy guidance to encourage suppliers to make cheaper child friendly products as a priority.

**Clinicians**
Must document experience and engage in operational research to drive policy based on best practice.

**National Programs and partners**
Must adopt testing & treatment policies set ambitious targets and encourage USE of priority products.