TIME TO STEP-UP: PRIORITIZE CHILDREN, ADOLESCENTS, FAMILIES AND CARERS AFFECTED BY AIDS IN EASTERN AND SOUTHERN AFRICA

RATT Eastern & Southern Africa Regional Inter Agency Task Team on Children & AIDS

The Coalition for Children Affected by AIDS

Ending the HIV pandemic is possible, but to do so, we must act quickly and recognize that the needs of children—the most vulnerable among us and unable to advocate on their own behalf—include but go beyond ending the spread of HIV and finding a cure. For children, urgent steps are required including: better integrating strategies to reach this population into regional and national plans; providing the care and support needed to ensure optimal development; and scaling up treatment, prevention and access to services—for children and their carers.

In eastern and southern Africa — the regions of the world with the highest levels of HIV prevalence — meeting the needs of children and adolescents, as well as their families and others who help to care for them, is a critical step we must take in order to defeat the disease. As discussions about national commitments to the Sustainable Development Goals continue, it is imperative that these populations receive greater attention.

Even if a child receives the necessary treatment, the long-term effects of the disease impact their quality of life. And the impact of HIV and AIDS is not limited only to those children who have contracted it themselves. Those whose parents have the disease, or who have lost a family member to it, also experience long-term effects. Studies show that children infected with — and affected by — HIV experience cognitive delays and school risks.[1] These children also face stigma, non-adherence, trauma, depression and behavioural problems from a combination of direct viral effects as well as indirect family and parenting effects.[2]

The Impact of HIV and AIDS on Children

Though great progress has been made in the fight against the disease globally, advancements for children are lagging behind:

As of 2013, an estimated 17.7 million children worldwide had lost one or both parents to AIDS.[3]

In Eastern and Southern Africa 40 – 60 percent of children orphaned by AIDS are cared for by older people, mainly older women.[4]

In 2013, only 42 percent of HIV-exposed infants received early diagnostic services within the first two months of life.[5]

Only 24 percent of all children living with HIV received antiretroviral treatment.[6]

Children with HIV have cognitive delays and their school attendance and performance is affected. HIV-exposed but uninfected children also perform less well than unaffected children on cognitive measures.[7]

An estimated 190,000 children aged 0–14 died of AIDS-related causes in 2013 due to lack of treatment.[8]

240,000 children globally became newly infected with HIV in 2013, equivalent to one new infection every two minutes.[9]

In 2013, 3.2 million children under the age of 15 were living with HIV, 210,000 in sub-Saharan Africa alone.[10]

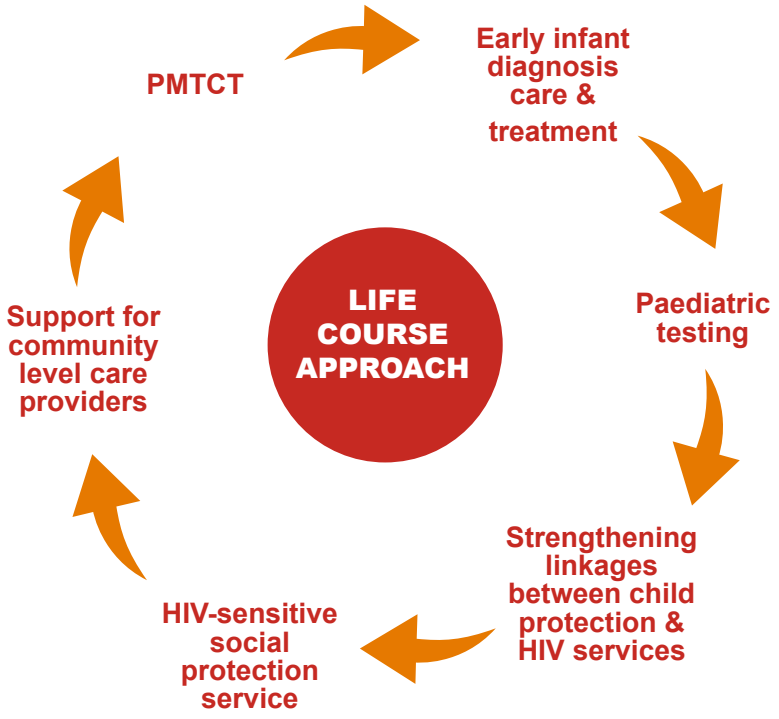
OPPORTUNITIES AND CHALLENGES

Declarations made at the global and regional levels provide a strong foundation for continued policy discussions related to children, adolescents, and those who care for them affected by HIV and AIDS. See Appendix A for detailed commitments.

Unfortunately, these global and regional commitments have rarely translated into national level action. Though efforts are underway to address this crucial missed step, the fact remains that governments must give greater priority to integrating — and, most importantly, implementing — commitments to alleviate the adverse effects of HIV and AIDS on children, adolescents, families and carers.

ACTION STEPS

Following are the critical action steps needed to provide children, adolescents and carers affected by HIV and AIDS in eastern and southern Africa with the focused attention required to turn the tide on the disease.



2010

HIV and AIDS Strategic Framework

2011

Political Declaration on HIV and AIDS

2012

EAC HIV and AIDS Prevention and Management Act

2013

Abuja Actions Towards the Elimination of HIV & AIDS, TB & Malaria in Africa by 2030

2015

EAC AIDS/SYI & TB Multisectoral Strategic Plan and Implementation Framework

Scale-up Access to PMTCT Services

Though progress related to access of prevention-of-mother-to-child-transmission (PMTCT) services has been made in some countries, it has stalled and even declined in others. Between 2012 and 2013, the percentage of pregnant women living with HIV who received antiretroviral medicines rose only marginally from 64 percent to 68 percent.[11] At this rate, the PMTCT target put forth by *The Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping Their Mothers Alive (the Global Plan)* at the 2011 United Nations General Assembly High Level Meeting on AIDS — reducing new infections among children by 90 percent by 2015 — will not be reached. Renewed efforts will be needed to achieve the Plan's targets, especially in countries making the slowest progress.

KEY ACTIONS REQUIRED

- **Treatment must be provided to the 30 percent of pregnant women living with HIV who are not receiving ARV treatment to prevent vertical transmission.**
- **Governments and the international community must agree to extend the Global Plan and set ambitious targets for ending new HIV infections among children and keeping their mothers alive and healthy.**

Scale-up Paediatric Testing (Early Infant Diagnosis)

Studies indicate that up to 51 percent of infants who test positive for HIV in eastern and southern Africa never receive their results.[12] New diagnostic tools have the potential to overcome some of these challenges. Two early infant diagnosis point-of-care tests will shortly enter the market which could significantly reduce the need for remote testing at centralized labs and largely eliminate turnaround times, helping minimize early loss to follow-up (see Appendix B for additional details). Ultimately, a mix of centralized laboratories and point-of-care tools is needed to ensure timely diagnosis of children in diverse, resource-limited settings.

KEY ACTIONS REQUIRED

- **HIV testing must be prioritized as soon as possible after infants of women living with HIV are born, as peak mortality for infants living with HIV occurs at six to eight weeks. Testing should be repeated throughout the breastfeeding period when the risk of transmission is still substantial.**
- **Point-of-care should be included in national paediatric diagnostic scale-up plans and introduced as soon as possible, especially into remote facilities.**
- **Early infant diagnosis should use all possible child survival entry points — integrated community case management for sick children, immunization, and other child care point such as in-patient departments — as they appear to be more effective than only PMTCT platforms.**

Increasing Treatment Access and Reducing Loss to Follow-up

Research has shown that mortality in children diagnosed with HIV can be reduced by 67 percent by using cotrimoxazole – an antibiotic – as prophylaxis. However coverage in eastern and southern Africa is only 47 percent.[13]

Children with HIV early antiretroviral trial interim results[14] show that early antiretroviral therapy (ART) in HIV-infected infants aged 6–12 weeks reduces all-cause mortality by 76 percent and HIV disease progression by 75 percent. However, access to paediatric ART is still at low levels and treatment coverage is exceptionally low in Africa. In sub-Saharan Africa, and West and Central Africa only 22 percent and 10 percent of children living with HIV obtained antiretroviral treatment in 2013.

In addition, in a pooled analysis of results from 16 paediatric HIV treatment programmes in sub-Saharan Africa, substantial loss to follow-up was found. Fifty-one percent of children who were enrolled in HIV treatment before their first birthday were lost to follow-up within 24 months.[15]

0ver 90 percent and 76 percent of children with HIV in sub-Saharan Africa and globally respectively suffered from pain caused by symptoms related to HIV.

KEY ACTIONS REQUIRED

- **Ensure that clinical trials for new antiretroviral medicines focus on children and pregnant women.**
- **Make greater use of maternal and child health services as an entry point to paediatric HIV treatment and care and ensure that they partner effectively with local communities.**
- **Political leadership should commit to ensuring that all children living with HIV are initiated on treatment, including cotrimoxazole prophylaxis, within six weeks of birth.**
- **Use available technology — such as such as digital medical records and mobile phone communication — to track children on ART.**
- **Develop patient information systems where mothers and infants are followed through as a pair rather than separately.**
- **Palliative care should be given alongside treatment to ensure that pain and other distressing symptoms such as dyspnoea, adverse effects of drugs, wasting and other debilitating symptoms — including psychological issues — are adequately controlled.**