FACT SHEET
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New progress and guidance on HIV diagnosis and treatment for infants and children

Update on children with HIV

- Global efforts to provide access to HIV treatment to children living with HIV have reached a new milestone, with 355,000 children receiving life-saving antiretroviral treatment at the end of 2009 compared to 276,000 at the end of 2008.

- If tested and treated for HIV early, children born with HIV can survive and stay healthy.

- The most cost-effective way to tackle paediatric HIV globally is to both prevent young women from acquiring HIV and to use ARVs to reduce mother-to-child HIV transmission in HIV-positive pregnant women. However, every day, there are nearly 1,200 new HIV infections and more than 700 AIDS deaths among children.

2010 guidelines on HIV diagnosis and treatment in infants and children

- While there has been significant progress in the scale-up of HIV treatment in children, much remains to be done to sustain and improve prevention efforts and treatment services to reach all those in need.

- WHO is now launching new guidance on paediatric HIV. The new guidelines seek to address the ongoing paediatric treatment gap by making a series of bold recommendations that are focused on expanding access to testing, increasing the number of infants and children eligible for treatment, and improving the care of children with HIV.

Key recommendations

Testing children

- It is strongly recommended that all infants with unknown or uncertain HIV exposure being seen in health-care facilities at or around the time of birth or at the first postnatal visit (usually 4–6 weeks), or other child health visit, have their HIV exposure status ascertained. [This will help to ensure that infants whose mothers were not tested during pregnancy or delivery can still benefit from counselling and treatment to prevent breast-milk transmission. In addition, the identification of previously unrecognized exposed infants will also serve to identify women living with HIV, which, in turn, allows programs to provide treatment and care to women, and prevent transmission of HIV during future pregnancies]

- It is strongly recommended that all infants who are known to be exposed to HIV be tested at 4–6 weeks with virological assays to determine infection status. [This will promote the early identification of infected infants and enable those children to access life-saving treatment.]
**Treating children**

- It is strongly recommended to initiate ART in all HIV-infected infants diagnosed in the first year of life, irrespective of the CD4 count or whether the infant is sick. *[This recommendation has been in place since 2008 but has not been adequately implemented. The strength of the recommendation has been increased in light of recent findings that highlight the dramatic improvements in mortality seen when HIV-positive infants are initiated on treatment immediately at diagnosis.]*

- There is a conditional recommendation to initiate children between 12 and 24 months on ART irrespective of clinical and immunological stage. *[While there is lack of direct evidence to support this strategy, paediatric mortality is very high throughout the first year of life as long as children remain untreated.]*

- For all children above 2 years there are simplified criteria for treatment eligibility. *[Previous recommendations were often too complicated for providers in primary and secondary healthcare settings who lacked access to more sophisticated diagnostic capabilities. The simplified criteria offer a single threshold for CD4 eligibility and more straightforward clinical criteria to determine which children require treatment.]*

- It is strongly recommended that all HIV-positive children diagnosed with TB start ART as soon as possible after initiation of TB therapy. *[New clinical evidence shows that when TB and HIV occur together, survival is greatly improved when treatment for both diseases is administered concurrently rather than sequentially.]*

- It is strongly recommended that HIV-positive infants and young children who were exposed to nevirapine or efavirenz during pregnancy, delivery or breastfeeding start on treatment using a protease-inhibitor. *[Although protease inhibitor drugs are usually reserved for second-line treatment because of cost and availability, new evidence shows that in infants and young children who become infected despite the use of ARVs for prevention of mother-to-child transmission, treatment outcomes are much improved when the regimen contains protease-inhibitor drugs.]*

- Stavudine is no longer among the recommended ARVs except when there are no other options. *[Increasing evidence of the toxicity of stavudine has resulted in a global shift away from the use of stavudine as a primary option for treatment. Stavudine toxicity is not seen as often in children but as the range of options for paediatric treatment have improved it is preferable not to use this drug as a first-line choice. Almost all ARVs have some toxicity, but avoiding drugs which are known to cause irreversible toxicities such as stavudine is an important step to improving the quality of treatment.]*

- Further simplification of second-line regimens with a shift away from didanosine as a second-line drug. *[As increasing numbers of children initiate second-line treatment it is important to make second-line therapy as convenient and simple as first-line. The move away from didanosine (ddI) as a second-line drug for children allows second-line regimens to be delivered using simple, easy-to-use fixed-dose combination tablets.]*

**TB and HIV management in children**

- It is strongly recommended that isoniazid preventive therapy (IPT) be given to all HIV-positive children over 1 year of age without active TB disease as an element of comprehensive HIV care. *[IPT has not previously been recommended as a routine intervention for HIV-positive children in whom there is no known exposure to TB. This recommendation is based on new data showing that IPT is highly effective as a means of preventing TB in children living with HIV.]*

**Benefits and challenges**

- Early treatment will reduce HIV-associated mortality in children and in some high-burden settings will also significantly reduce overall infant and under-five mortality.
- Adoption of recommendations to screen infants for HIV exposure are adopted will result in more infants being identified as exposed while helping to identify other infected individuals.

- All exposed infants are born to infected mothers, and many of those women will have HIV-positive partners and/or other HIV-positive children. The infant is an index case that helps to identify a family living with HIV; this could be a critical route to expanding the reach of testing.

- Use of simpler first- and second-line regimens will enable countries to facilitate scale-up and lower costs by using paediatric FDCs.

- Paediatric HIV treatment programmes are weak and often not seen as a priority, even in high-burden settings, unlike treatment of adults, including pregnant women.

- Systems to perform early infant diagnosis are still nascent and require sending testing samples to a few large laboratories for diagnosis. Point-of-care virologic tests are necessary to scale up access to early infant diagnosis especially in rural communities.

- There is a degree of reluctance among health care providers to test and treat children, especially young children or healthy-looking children, due to a lack of understanding of the life-saving benefits of early treatment for children.

- The full 2010 guidelines on antiretroviral therapy for HIV infection in infants and children are on the web: www.who.int/hiv.

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