

Pediatric HIV

How U.S. policymakers can improve HIV prevention, diagnosis, and treatment efforts for children and adolescents.

Eric Bond/EGPAF, 2024

Children are disproportionately affected by the HIV epidemic yet are consistently deprioritized and underserved compared to other affected populations.

UNAIDS' global treatment targets call for 95% of people living with HIV to know their status; 95% of people who know their status to be on treatment; and 95% of people on treatment to sustain viral suppression by 2030, referred to as 95-95-95. Globally, children have progressed more slowly than adults across all targets, at 63%-87%-86% compared to 87%-89%-94%.ⁱ And while just 3% of all HIV cases are children, they are 11% of all HIV related deaths—demonstrating a clear unmet need.ⁱⁱ While gains have been made in prevention strategies and treatment options, further efforts are needed to ensure an HIV-free generation—an outcome that will save lives, protect families, and strengthen communities and economies.

In 2024, an estimated 2.4 million of the 40.8 million people living with HIV were children and adolescents.ⁱⁱⁱ Each day, approximately 712 children and adolescents were newly infected with HIV and 250 died from HIV-related causes.^{iv,v} With less developed immune systems, children and adolescents living with HIV experience more severe sickness than adults.^{vi} Eighty-four percent of children with HIV live in sub-Saharan Africa.^{vii}

How Children Acquire HIV

The primary way newborns and children under five contract HIV is through vertical transmission, which can occur during pregnancy, labor, delivery, or breastfeeding. Globally, 1.3 million women with HIV become pregnant each year, and without intervention, there is a 15-45% chance of vertical transmission.^{viii} Adolescents, aged 10-19, most commonly acquire HIV through sexual transmission.^{ix}

Preventing Pediatric HIV

Preventing HIV in children starts with halting vertical transmission.^x When a mother is on antiretroviral therapy and remains virally suppressed, the risk of transmission is less than 2%.^{xi} As children get older, their risk of HIV exposure changes, as does effective prevention. Testing is a necessary component of prevention efforts. The World Health Organization (WHO) recommends that infants born to mothers living with HIV are tested by two months of age, during breastfeeding, and when breastfeeding ends; as well as regular testing for older children living in high-prevalence regions.^{xii}

Point-of-care (POC) early infant diagnosis uses innovative technology to deliver HIV test results during a single clinic visit, unlike conventional laboratory testing that could take more than a month for results. Studies show that the health status of a caregiver living with HIV directly impacts the ability of a child with HIV to maintain viral suppression.

Importance of Treatment

Once diagnosed, it is critical that children and adolescents remain on medical treatment to stay healthy through adolescence and adulthood. HIV is treated through a prescribed regimen of antiretroviral medicines. In recent years, advances in ART and PrEP have made HIV a manageable chronic condition.^{xiii} New treatment options have made HIV care more effective and easier to access for both children and adults.



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Recommendations

1. Expand funding for early infant HIV diagnosis technologies.

Funding should be directed toward greater point-of-care testing capacity, which often provides same day results to caregivers. Where point-of-care technology is not available, prioritize digital follow-up programs, including text message outreach, which reduces stigma and improves continued engagement with the health system.

2. Invest in the development and distribution of child-friendly ART formulations.

Increase research into, and procurement of, pediatric-specific medications, including the WHO-recommended pALD, which combines three drugs into one kid-friendly flavored tablet, that can be dissolved in water for easy administration and is taken just once daily. Child-friendly medications are more convenient for both caregivers and children, linked to improved treatment adherence, viral suppression rates, and health outcomes.

3. Fund integrated maternal and child health service delivery models in high-prevalence regions.

Prioritize funding for combined maternal and child health service models that keep mother-baby pairs together at every stage of care, helping to ensure that a child's HIV diagnosis, treatment, and follow-up are anchored to an existing relationship with the health system enabled by the mother.



4. Increase investment in, and distribution of, long-acting injectable PrEP for pregnant and breastfeeding women, and for adolescents at risk of acquiring HIV.

Dedicate funding for the 2026 U.S.-Global Fund commitment to expand access to lenacapavir in high-burden countries. Support should include better distribution, provider training, and community outreach. Prioritize adolescents and pregnant and breastfeeding women who are not being reached by existing PrEP programs.

5. Address additional barriers to adolescent HIV prevention through targeted research and programming.

Recognize prevention barriers particular to adolescents, including stigma and lack of adolescent health education and services; fund adolescent-specific prevention strategies as integral to, not separate from, broader pediatric HIV policy.

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