



## OPINION PIECE

*“Every Child Counts: Rethinking Access to Pediatric HIV Services”*

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**One Child At A Time!**

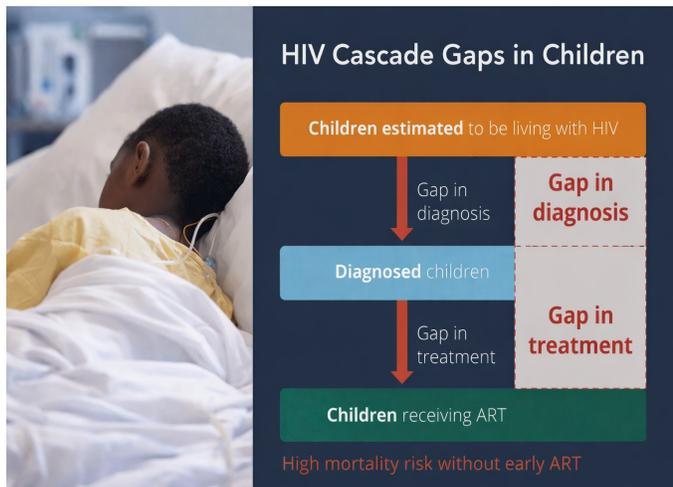


## Introduction



“I chose to adhere to treatment throughout my pregnancy, not only to protect my own health, but to ensure my children were born HIV-free. I never missed an appointment, kept a close eye on my viral load, and stayed fully engaged with my healthcare providers.” My experience reflects what is possible when women have consistent access to quality HIV services and support. However, this level of care is not the reality for many mothers and children. Persistent gaps in early diagnosis, treatment access, and continuity of care continue to place children at risk of HIV infection and poor health outcomes.

Even though data reports that new HIV infections among children have declined from 310,000 in 2010 to 120,000 in 2024, and the progress in reducing new HIV infections is greatest among children, the progress has stalled ever since(1). For instance, research shows that worldwide, children still have limited access to HIV testing services, with only 65% in 2024, and about 55% of children living with HIV were receiving ART in the same year(2). Additionally, approximately 120,000 children acquired HIV, and 12% of all AIDS-related deaths were among



children(3). Furthermore, children are more likely to present with advanced disease, leading to preventable morbidity and mortality(4). These disparities highlight persistent systemic challenges in the early identification of children living with HIV, timely linkage to care, and sustained treatment retention. Although prevention of mother-to-child transmission (PMTCT) programs have markedly reduced HIV transmission during pregnancy and delivery, critical gaps remain across the continuum of care. Notably, missed opportunities continue in early infant diagnosis

(EID), especially during the postnatal and breastfeeding periods, when the risk of HIV transmission remains elevated(5).

Every child born with HIV represents a missed opportunity for prevention. Despite the availability of effective treatment, the complicated challenges faced by pregnant and breastfeeding women living with HIV continue to hinder efforts to eliminate pediatric HIV. Addressing these gaps is not only a clinical priority but also a policy requirement, demanding urgent, equity-driven actions to guarantee that every child, regardless of birthplace, lives a healthy life with HIV, most importantly, an HIV-free life. This opinion piece reflects on both the progress made and the persistent barriers to vertical HIV elimination in sub-Saharan Africa (SSA) and South Africa, highlighting critical priorities to inform policy and practice.

## Gaps in pediatrics HIV prevention and treatment access in SA.

Research reports that HIV incidence among children aged 15 years experienced a 25% reduction between 2017 and 2022(6). Furthermore, the 2023 SABSSM VI showed an overall drop in HIV prevalence among children < 15 years old, from 2.8% in 2017 to 2.4% in 2022(7). This could be a real decline, or it could be due to children aging into an older age group, as well as the decreasing incidence.



Despite these positive outcomes, the high PMTCT coverage has not translated into the complete elimination of pediatric HIV. Broader social and structural factors such as poverty, stigma, population mobility, and health system constraints continue to disrupt continuity of care and weaken retention in treatment programs(8). This lack of integration weakens the overall impact of care platforms and misses opportunities to deliver holistic, child-centered services. These ongoing shortcomings highlight the importance of shifting focus from coverage alone to approaches grounded in equity, integration, and community engagement.

More importantly, South African infants who miss early testing, particularly during the postnatal and breastfeeding periods, are at increased risk of delayed diagnosis and poor health outcomes. For instance, data indicate gaps in mother-infant pair follow-ups, reflecting gaps in postnatal care and inconsistencies in service delivery across provinces, all of which contribute to ongoing transmission and unmet treatment needs (9). These losses to follow-up of mother-infant pairs remain a critical challenge, with many infants not receiving timely testing or being successfully linked to care immediately after diagnosis. Without targeted, equity-focused interventions, children will continue to be left behind in the global HIV response.

Furthermore, data reports that the absolute risk for HIV transmission through breast milk in the absence of antiretroviral therapy (ART) is as high as 16% to 20%(10). Breast milk transmission of HIV occurs when high maternal viral load levels are present in both plasma and breast milk. To lower this risk, all pregnant women should receive antiretroviral therapy early in their pregnancy, and throughout, including during breastfeeding. Failing to provide these services, followed by delays in pediatric diagnosis and treatment initiation, puts these children at risk of developing AIDS and dying, as HIV progresses faster in them than in adults. Early infant diagnosis (EID) and rapid initiation of ART are therefore critical to improving survival outcomes. These gaps are further worsened by missed follow-up opportunities, which continue to undermine PMTCT efforts, particularly in resource-constrained settings (11).

Beyond programmatic gaps, inconsistent implementation of guidelines across provinces and facilities is also reported to contribute to unequal access to services (12).

Notably, research indicates that multifaceted interventions, such as improving early infant diagnosis, enhancing linkage to and retention in care, and promoting community-led monitoring and advocacy, are crucial steps to close the remaining gaps in pediatric HIV outcomes(13). Along with these, reducing a mother's viral load before or shortly after birth, since a higher viral load increases the risk of HIV transmission to the baby during breastfeeding, should be prioritized by providing comprehensive support throughout pregnancy and postpartum. This includes addressing social and healthcare needs for both mothers and infants, and exploring new approaches, such as long-acting ART or broadly neutralizing antibodies, to achieve earlier viral suppression in this vulnerable population (14).

Beyond access to services, limitations in knowledge and understanding of PMTCT services further weaken



program effectiveness. For instance, a Gauteng study found that a large proportion of respondents were aware of PMTCT services; however, 41% indicated a poor understanding of these services. This suggests that while general awareness is relatively high, comprehensive knowledge and understanding remain limited.

Other barriers to the effective utilization of PMTCT services include transportation costs to health facilities, negative staff attitudes, and long waiting times. These challenges, particularly high transport costs, extended waiting periods, and limited understanding of PMTCT benefits, continue to hinder optimal uptake of services (15).

Additionally, limited access to point-of-care (POC) diagnostic technologies continues to delay diagnosis and treatment initiation. For instance, Sub-Saharan Africa accounts for 90% of all new pediatric HIV infections globally, of which up to 50% remain undiagnosed largely due to challenges with early infant diagnosis (EID) of HIV, resulting in a widening pediatric HIV treatment gap(16). New point-of-care (POC) diagnostic technologies could result in increased rates of EID of HIV among infants with perinatal HIV exposure, with guaranteed shorter result turnaround times, and timely access to antiretroviral therapy.

Regrettably, there are limited studies that have evaluated the deployment of this technology in community settings to reach mother-infant pairs (MIPs) missed by traditional prevention of vertical transmission of HIV programming in South Africa. While POC testing has the potential to provide same-day results and improve linkage to care, its scale-up remains uneven or scarce in SSA and S.A, particularly in primary healthcare and community settings. Addressing these gaps requires a shift from policy availability to effective implementation, with a focus on strengthening community health systems, improving service integration, and reducing structural and social barriers to care. Critically, community-led demand creation, literacy, and accountability mechanisms must be prioritized to ensure caregivers are informed, empowered, and supported in accessing services. Without addressing both system-level and community-level barriers, progress towards eliminating pediatric HIV will remain uneven and inequitable.

## Implications for HIV investments

Failure to prioritize pediatric HIV undermines global investments in HIV programs. While ART has improved survival, untreated pediatric HIV leads to increased morbidity, mortality, and long-term healthcare costs. Persistent gaps in pediatric services highlight inequities in the HIV response and threaten progress toward epidemic control, particularly in high-burden countries such as South Africa.

### Call to Action

**Strengthen Early Infant Diagnosis and Decentralize Services:** Scale up point-of-care (POC) early infant diagnosis to ensure same-day testing and rapid initiation of ART

👉 No child should die waiting for a test result.

**Close the Pediatrics Treatment Gap:** Expand access to child-friendly ART formulations *and* implement differentiated service delivery models tailored to children and caregivers

👉 Children must receive the same urgency and priority in access to treatment as adults.

**Strengthen Postnatal and Breastfeeding Care:** Address ongoing transmission risks during breastfeeding through continuous support and monitoring

👉 The postnatal period remains one of the weakest links in prevention.

**Address Structural and Social Barriers:** Facilitate multi-sectoral collaboration, support community-led demand creation, and invest in community-based education, stigma reduction, and family-centered care.

👉 Biomedical tools alone cannot close the gap

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