About ending HIV among children

Uganda has made commendable progress in the fight against HIV over the last two decades.

Yet one painful reality remains: Babies are still being born with HIV. HIV infection in children, mainly those below five years is not just a medical condition. It reflects gaps in prevention, access to services, stigma, and social vulnerability.

In our planned strategies to ending AIDS as a public health threat by 2030, paediatric HIV will be at the centre of our national conversation.

Paediatric HIV refers to HIV infection in infants and children. Unlike adults, who primarily acquire HIV through unprotected sex or unsafe blood exposure, children usually acquire the virus from their mothers. This is known as mother-to-child transmission (MTCT) and it can occur during pregnancy, labour and delivery, or breastfeeding.

Without treatment, there is a significant risk of transmission from an HIV-positive mother to her baby. However, with proper medical care - including antiretroviral therapy (ART) for the mother, the risk can be reduced to zero.

The science is clear and available in Uganda, but the tragedy is that babies continue to be born with HIV, 4,700 babies in 2024 alone.

First, late HIV testing among pregnant women remains a challenge. Some women attend antenatal care late in pregnancy, while others never attend at all. Without early testing, HIV-positive mothers are not started on treatment in time to protect their babies.

Second, stigma continues to undermine progress. Fear of discrimination discourages some women from testing, disclosing their status, or consistently taking medication. In certain communities, myths and misinformation about HIV still thrive.

Third, treatment interruptions remain common. Poverty, long distances to health facilities, stock-outs of medicines and weak follow-up systems contribute to mothers defaulting on treatment.

When a mother's viral load rises because she has stopped medication, the risk of transmitting HIV to her baby increases significantly.

Fourth, gaps in early infant diagnosis persist.

DR NELSON MUSOBA

Babies born to HIV-positive mothers require early testing usually within the first six weeks and follow-up testing during breastfeeding.

When testing is delayed, infected infants may not start treatment early enough, increasing the risk of severe illness or death.

Lastly, structural inequalities including teenage pregnancies, gender-based violence, and limited male partner involvement fuel vulnerability. When young girls become pregnant before they are empowered with sexual and reproductive health knowledge, the cycle continues. Paediatric HIV, therefore, is not just about medicine. It is about community systems, culture and equity. What must be done to keep babies safe?

The good news is that we already have the tools to prevent nearly every case of paediatric HIV. What we need is consistent implementation and community ownership.

1. Early and Routine HIV Testing in Pregnancy

Every pregnant woman should test for HIV as early as possible during antenatal care. Repeat testing later in pregnancy and during breastfeeding is equally important, especially in high-prevalence settings like Uganda. Knowing one's status is the first step in protecting a child.

2. Immediate and lifelong treatment

If a woman tests positive, she should begin antiretroviral therapy immediately and remain on it for life. Effective treatment suppresses the virus in her body to undetectable levels. When the viral load is undetectable, the risk of transmitting HIV to the baby becomes extremely low.

3. Safe delivery and infant prophylaxis

Health facilities must ensure safe delivery practices. Babies born to HIV-positive mothers should receive preventive antiretroviral medication after birth as recommended by national guidelines.

4. Exclusive and guided breastfeeding

Breastfeeding remains vital for infant survival in Uganda. HIV-positive mothers who are on effective treatment can breastfeed safely. Mixed feeding (combining breast milk with other foods too early) increases transmission risk and should be avoided in the first six months.

5. Early infant diagnosis and follow-up

All HIV-exposed babies must be tested within six weeks of birth and monitored throughout breastfeeding. If a child tests positive, immediate initiation of treatment dramatically improves survival and quality of life.

6. Addressing stigma and male involvement

Every child deserves a healthy start to life. Paediatric HIV is preventable. If we commit to early testing, lifelong treatment and compassionate community support, Uganda must raise a generation free from HIV.

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