are still overlooked, particularly for the youngest children who are unable to take tablet formulations. Unlike for adults where fixed-dose combinations of ARVs are available, children younger than 5 years have to use liquid formulations and caregivers have to measure before administering each dose twice a day.9 Drugs produced by different companies vary in bottle size and special storage needs. Some carry unpleasant tastes and risks of toxicity.10 Dosage adjustments depending on weight are needed up to 3 times in the first year of life alone. Procurement of pediatric drugs is complex and forecasting of demand is difficult with a market only a fraction of the size of the adult market. This also leads to prices twice as expensive as the adult equivalents.11

We propose that unless more child-friendly formulations are developed, late cART initiation of children is likely to continue. It is also likely that the situation will be even worse in busy nonresearch health settings in LMICs.

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Authors’ Reply: Early Initiation of Antiretroviral Therapy Among Young Children: A Long Way to Go

To the Editors:

We thank Doherty and co-workers, for their thoughtful and pertinent response to our article describing trends in immunodeficiency at antiretroviral therapy (ART) initiation in children in low, middle, and high income countries.1 We agree that it is important to know more about the International Epidemiologic Databases to Evaluate AIDS (IeDEA) sites included in the analysis to assess the extent to which they are representative of general public health facilities, and hence whether the finding of improvement in proportion of children with immunosuppression at ART initiation (albeit modest) is generalizable across these countries.

The IeDEA collaboration and the participating sites have therefore been described in dedicated profiles,2,3 and a survey of the IeDEA sites providing HIV care for children has been published.4 The survey included 63 sites in Asia (10), Central Africa (4), East Africa (29), Southern Africa (10), and West Africa (10). Nearly 75% of sites were public government-run clinics, 65% were in urban settings, and 57% provided pediatric care in combined adult–pediatric clinics.4 As pointed out by Doherty and co-workers, many sites received additional financial support from research grants (57%), the US PEPFAR programme (54%) or the Global Fund (24%).5 We cannot exclude that access to timely pediatric ART at non-IeDEA facilities may be even worse. However, all IeDEA sites followed the relevant national ART guidelines, and the strength of IeDEA data is that it is collected as part of routine care and not from dedicated research cohorts. We believe that the availability of individualized data through the IeDEA collaboration allowed a more nuanced picture of pediatric ART than analyses of program-level aggregate data, while preventing the ecological bias that may affect aggregate data analyses.5

We concur with Doherty and co-workers regarding the importance of advocacy for pediatric HIV as a neglected disease with an urgent need for better access to diagnostic tests and effective and safe pediatric-friendly drug formulations.6 The first barrier to early ART initiation is poor access to early infant diagnosis for which coverage remains low in many settings due to lack of virological diagnostic capacity, delivery services, and low social acceptability.7,8 Even in IeDEA sites, early infant diagnosis for infants was not universally available throughout the period of data collection, with the diagnosis of HIV being dependent on the presence of clinical symptoms. In the IeDEA site survey, access to certain drugs especially as part of fixed dose combinations was limited in certain regions.4 Interestingly, Asian sites had poorer access to tenofovir and abacavir, which may reflect more frequent
We have also previously found limited access to second-line options for children, which may result in delays or lack of switching to second-line therapy. Although the dramatically increased coverage and effectiveness of prevention of mother to child transmission programs are to be welcomed, there is a risk of even further neglect of treatment options for children as the market diminishes in size. In addition, the low priority and complexity of conducting research in children mean that there is limited high-quality data from randomized clinical trials to inform optimal pediatric treatment guidelines and drug choices. We strongly endorse the call for better drug options for children, especially for very young infants where treatment options are extremely limited, and we know that there is substantial mortality and morbidity benefit in starting ART before 3 months of age.

**for the IeDEA, NISDI, PHACS and IMPACT 219C Studies**

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**ERRATUM**

High HIV, HPV, and STI Prevalence Among Young Western Cape, South African Women: EVRI HIV Prevention Preparedness Trial: Erratum

In the article by Giuliano et al, appearing in *JAIDS: Journal of Acquired Immune Deficiency Syndromes*, Vol. 68, No. 2, pp. 277-35 entitled “High HIV, HPV, and STI prevalence among young Western Cape, South African women: EVRI HIV prevention preparedness trial”, there is an error in the conflicts of interest and the following statement needs to be added: “M.F. SvdL. received research funding from Sanofi-Pasteur MSD not related to this trial and was a co-investigator on the Merck 9-valent vaccine.”

**REFERENCE**