Pediatric HIV/AIDS: Philippine Perspective

The number of adults and children estimated to be living with HIV/AIDS in 2014, according to the 2016 UNAIDS Report on the Global AIDS Epidemic.
**HIV/AIDS estimates, end of 2007**

UNAIDS/WHO, November 2007

<table>
<thead>
<tr>
<th></th>
<th>Estimate In million</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>People living with HIV/AIDS in 2007</td>
<td>33.3</td>
<td>30.6-36.1</td>
</tr>
<tr>
<td>Adults living with HIV/AIDS in 2007</td>
<td>30.8</td>
<td>28.2-33.6</td>
</tr>
<tr>
<td>Women living with HIV/AIDS in 2007</td>
<td>15.4</td>
<td>13.9-16.6</td>
</tr>
<tr>
<td>Adults newly infected with HIV</td>
<td>2.1</td>
<td>1.4-3.6</td>
</tr>
<tr>
<td><strong>AIDS death in 2007</strong></td>
<td>2.1</td>
<td>1.9-2.4</td>
</tr>
<tr>
<td><strong>Children living with HIV/AIDS in 2007</strong></td>
<td>2.5</td>
<td>2.2-2.5</td>
</tr>
<tr>
<td><strong>Children newly infected with HIV in 2007</strong></td>
<td>0.42</td>
<td>0.35-0.54</td>
</tr>
<tr>
<td><strong>Child AIDS death in 2007</strong></td>
<td>0.33</td>
<td>0.31-0.38</td>
</tr>
</tbody>
</table>

**HIV Ab Seropositive Cases by Year HIV/AIDS Registry, January 1984-September 2007 (N=2,965)**

The registry logs the western blot -confirmed cases

<table>
<thead>
<tr>
<th>Year</th>
<th>AIDS</th>
<th>Asymptomatic</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>84</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>85</td>
<td>10</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>86</td>
<td>29</td>
<td>8</td>
<td>37</td>
</tr>
<tr>
<td>87</td>
<td>32</td>
<td>11</td>
<td>43</td>
</tr>
<tr>
<td>88</td>
<td>39</td>
<td>15</td>
<td>54</td>
</tr>
<tr>
<td>89</td>
<td>66</td>
<td>21</td>
<td>87</td>
</tr>
<tr>
<td>90</td>
<td>65</td>
<td>26</td>
<td>91</td>
</tr>
<tr>
<td>91</td>
<td>51</td>
<td>18</td>
<td>69</td>
</tr>
<tr>
<td>92</td>
<td>64</td>
<td>21</td>
<td>85</td>
</tr>
<tr>
<td>93</td>
<td>61</td>
<td>19</td>
<td>80</td>
</tr>
<tr>
<td>94</td>
<td>51</td>
<td>17</td>
<td>68</td>
</tr>
<tr>
<td>95</td>
<td>58</td>
<td>17</td>
<td>75</td>
</tr>
<tr>
<td>96</td>
<td>45</td>
<td>19</td>
<td>64</td>
</tr>
<tr>
<td>97</td>
<td>42</td>
<td>18</td>
<td>60</td>
</tr>
<tr>
<td>98</td>
<td>44</td>
<td>17</td>
<td>61</td>
</tr>
<tr>
<td>99</td>
<td>44</td>
<td>18</td>
<td>62</td>
</tr>
<tr>
<td>00</td>
<td>37</td>
<td>15</td>
<td>52</td>
</tr>
<tr>
<td>01</td>
<td>37</td>
<td>15</td>
<td>52</td>
</tr>
<tr>
<td>02</td>
<td>37</td>
<td>15</td>
<td>52</td>
</tr>
<tr>
<td>03</td>
<td>37</td>
<td>15</td>
<td>52</td>
</tr>
<tr>
<td>04</td>
<td>37</td>
<td>15</td>
<td>52</td>
</tr>
<tr>
<td>05</td>
<td>37</td>
<td>15</td>
<td>52</td>
</tr>
<tr>
<td>06</td>
<td>37</td>
<td>15</td>
<td>52</td>
</tr>
<tr>
<td>07</td>
<td>37</td>
<td>15</td>
<td>52</td>
</tr>
</tbody>
</table>

National HIV/AIDS Registry, Sep 2007
Reported Mode of Transmission
HIV/AIDS Registry, January 1984-September 2007 *(N = 2,965)*

<table>
<thead>
<tr>
<th>Reported Mode of Transmission</th>
<th>Jan 1984- Sep 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual transmission</td>
<td></td>
</tr>
<tr>
<td>Heterosexual</td>
<td>1,798</td>
</tr>
<tr>
<td>Homosexual contact</td>
<td>586</td>
</tr>
<tr>
<td>Bisexual contact</td>
<td>211</td>
</tr>
<tr>
<td>Blood /blood products</td>
<td>19</td>
</tr>
<tr>
<td>Injecting Drug use</td>
<td>7</td>
</tr>
<tr>
<td>Needle prick injuries</td>
<td>3</td>
</tr>
<tr>
<td>Perinatal</td>
<td>44</td>
</tr>
<tr>
<td>No exposure reported</td>
<td>297</td>
</tr>
</tbody>
</table>
Pediatric HIV

“... nascent stage”

- The situation of Filipino Children Affected by HIV/AIDS: a rapid assessment
- September 2004-February 2005
- Lunduyan

“Children affected by HIV”
- <18 years old who have close family members living with HIV
- Those who have lost close family members to HIV/AIDS
- Those who are infected with HIV
• 22 of 33 initially-identified areas were covered
• 95 children were reached out of initial listings of 190

... The Findings

• Nationwide
• 3 children known HIV- infected
• 58% - both parents alive
  29% - orphan (one parent)
  15% - orphan (both parents)

Global Campaign on Children on HIV and AIDS

• 5-year campaign launched by UNICEF and UNAIDS
• October 2005
• AIMS:
  1. put children at the center of HIV agenda
  2. realize measurable progress for children in areas of prevention, preventing parent-to-child transmission, pediatric treatment, and protection and support of children affected by HIV.
Crossing Borders Project

• Main objectives
  – Integration of treatment, monitoring and care
  – To develop a standardized “stand-alone guidelines” for children affected with HIV/AIDS

Precious Jewels Ministry (NGO)
DOH -
San Lazaro Hospital
Philippine General Hospital
Research Institute for Tropical Medicine

Crossing Borders Project:

• Interim Guideline (Pioneering)
  A reference in applying multidisciplinary management of HIV & AIDS in children

• Developed for the health care provider (initially for the 3 hospitals) based on:
  → Review of literature
  → HEAVILY DEPENDED on the WHO manuscript
  → Result of agreements and consultations among stakeholders
  → Aligned with existing SOP’s of the participating hospitals and child advocate partners.

In 2007...The Interim Guideline on the Integrated Management of Pediatric HIV and AIDS was submitted to DOH for final review. (personal communication with Dr Melencia Velmonte – over all chair Crossing Borders Project)
Crossing Borders Project:

- 15 children HIV positive
- <10 years old
- 3 children on ARV
  - 5 candidates to start ARV in SLH
  - 1 in RITM
- Usual presentation:
  - Failure to thrive
  - Recurrent otitis media
  - Recurrent oral thrush
- All were perinatally acquired

Most babies born to HIV-positive mothers will not get HIV.

A baby can get HIV from its mother:

- During pregnancy (before birth);
- During delivery (the most common);
- Breast-feeding.
Accurate diagnosis of HIV infection in children at any age requires laboratory testing.

**Principles for the conduct of HIV testing:**

**3C’s**
- Confidential
- Counseling
- Consent

UNAIDS/WHO Policy Statement on HIV Testing
Pre-HIV test counseling

Informed consent

HIV testing

Post-HIV test counseling

RA 8504
Philippine AIDS Prevention and Control Law

INFORMED CONSENT TO HIV TESTING

(Before an HIV Test can be given, written informed consent is needed. If you have any questions, please feel free to ask your counselor.)

1. What is the HIV Antibody Test or “ABM” Test?
   The HIV Antibody Test is a blood test. The test shows if you have antibodies to HIV – the virus that causes AIDS. Test is not a diagnosis of AIDS.
   A positive test result means you have not infected with HIV. It is not a diagnosis of AIDS. A negative test means you are probably not infected. It takes the body a long time to produce antibodies against HIV. If you are infected, you need to be tested in several months to make sure you are not infected.

2. What are the benefits of taking the test?
   If you test negative:
   You can be sure you are not infected and can go about your daily life.
   You can help protect others from getting the virus, too, i.e., you are not infected.
   You can learn how to take care of your health, and your doctor can take care of you better.

3. Voluntary Testing
   Taking an HIV antibody test is voluntary. You do not have to take the test. You can have the test without your name.

4. Confidentiality of Test Results
   Your test results are confidential. It will only be given to you or to people you authorize.

5. Make informed with disclosure.
   If you test positive, you should be careful about telling others what your test showed.

My questions about the HIV test have been answered. I agree to take the HIV antibody test.

Date: ___________________________

Signature: ________________________

I have explained the HIV antibody test, how it is done, the meaning of the results and the possible consequences of disclosure.

Name: __________________________

(Signature over printed name)
Laboratory Diagnosis of HIV among children

Depends on the age of the child

*In adults and children more than 18 months*  
**antibody** testing → ELISA  
→ Western Blot

*In children less than 18 months*  
**Virologic** testing HIV DNA PCR – available at SACCL in SLH

HIV DNA PCR :

*preferred virologic method in infant < 18 months*

- HIV DNA PCR - detects pieces of the viral gene that are incorporated in the human blood cell

**HIV Antibody** testing detects the antibody that the body makes in response to the HIV virus
Establishing presence of HIV infection in infants <18 months of age with confirmed HIV exposure: **HIV DNA-PCR**

40% can be detected within 48 hours of life

28D - 96% Sensitivity
99% specificity

Non-breastfeeding infants

HIV –DNA PCR from 6-8 weeks or older

Positive test

Negative test

Repeat PCR test anytime

Infant assumed to be HIV uninfected

Positive

Negative

Infant is HIV infected

Available in SACCL
Establishing presence of HIV infection in a breastfed infants <18 months of age with confirmed HIV exposure:

**Antibody test**

- **Non-breastfeeding/Breastfeeding infants**
  - Antibody testing at 6-9-12 months
    - 8 wks or more after cessation
      - ▲ Breastfeeding
  - **negative test**
    - Infant is likely to be HIV uninfected
  - **positive test**
    - Western blot Reactive
      - yes
      - **Confirmed HIV infection**

**If HIV DNA PCR NOT AVAILABLE**

- HIV antibody fades during first 6-18 months of life
  - Most uninfected infants test negative by 12 mo of age
  - All uninfected infants test negative by 18 months of age
Establishing presence of HIV infection in a breastfed infants <18 months of age with confirmed HIV exposure:

**Antibody test**

- Non-breastfeeding/Breastfeeding infants
- Antibody testing at 6-9-12 months
- 8 wks or more after cessation
- ▲Breastfeeding

**If HIV DNA PCR NOT AVAILABLE**

- **negative test**
  - Infant is likely to be HIV uninfected
- **positive test**
  - Western blot Reactive
  - Yes
  - **Confirmed HIV infection**
  - Western blot available in SACCL RITM

Chemoprophylactic Regimens for Infants Exposed to HIV-positive mothers

- Start AZT within 8-12 hours after delivery
- Dose: 2mg/kg/dose every 6 hours for **6 weeks**

- Start Cotrimoxazole on the 4-6th week:
- Dose: 6-8 mg once daily
Cotrimoxazole-prophylaxis

<table>
<thead>
<tr>
<th>Age</th>
<th>Status</th>
<th>Start</th>
<th>Discontinue</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 18 mo</td>
<td>HIV exposed</td>
<td>4-6 weeks or when 1st seen</td>
<td>Only if HIV excluded by negative virologic test and mother not breastfeeding &gt;6 months</td>
</tr>
<tr>
<td>≥18 mo</td>
<td>HIV infected</td>
<td>with any clinical signs or symptoms suggestive of HIV, regardless of age or CD4 count.</td>
<td>Indefinitely where ARV treatment is not yet available. If ARV treatment is being given- stopped once clinical or immunological indicators confirm restoration of the immune system for 6 months or more</td>
</tr>
</tbody>
</table>

Joint WHO/UNAIDS/UNICEF statement

WHEN TO START Antiretroviral Therapy?

1. Age of the child
2. WHO Pediatric Clinical Guidelines
3. Immunologic MARKERS
   • CD4
   • Total Lymphocytes count
4. Psychosocial assessment
5. Co-morbidity
WHO Pediatric Clinical Staging

- For use in those 12 years or under with confirmed laboratory evidence of HIV infection

<table>
<thead>
<tr>
<th>Clinical Stage</th>
<th>HIV-Associated Clinical Disease Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Asymptomatic</td>
</tr>
<tr>
<td>II</td>
<td>Mild</td>
</tr>
<tr>
<td>III</td>
<td>Advanced</td>
</tr>
<tr>
<td>IV</td>
<td>Severe</td>
</tr>
</tbody>
</table>

WHO clinical Staging of HIV/AIDS for Children

- Clinical staging 1:
  - Asymptomatic
  - Persistent generalized lymphadenopathy

- Clinical Staging 2: **MILD**
  - Unexplained persistent hepatosplenomegaly
  - Papular pruritic eruptions
  - Extensive warts
  - Extensive molluscum contagiosum
  - Fungal nail infections
  - Recurrent oral ulcerations
  - Unexplained persistent parotid enlargement
  - Linear gingival erythema
  - Herpes zoster
  - Recurrent or chronic upper respiratory tract infection
WHO clinical Staging of HIV/AIDS for Children

• Clinical Staging 3: **ADVANCED**
  - unexplained moderate malnutrition not adequately responding to standard treatment
  - Unexplained persistent diarrhea (>14 days)
  - Unexplained persistent fever (>37.5 >1 month)
  - Persistent oral candidiasis
  - Oral hairy leukoplakia
  - Acute necrotizing ulcerative gingivits or periodontitis
  - Pulmonary tuberculosis
  - Severe recurrent bacterial pneumonia
  - Symptomatic lymphoid interstitial pneumonitis
  - Chronic HIV- associated disease including bronchiectasis
  - Unexplained anemia (<8g/dL), neutropenia (<500/cmm) and thrombocytopenia (<50000/cmm)

WHO clinical Staging of HIV/AIDS for Children

• Clinical Staging 4:
  - unexplained severe wasting, stunting or severe malnutrition not adequately responding to treatment
  - Pneumocystis pneumonia
  - Recurrent severe bacterial infections
  - Chronic herpes simplex infection
  - Extrapulmonary tuberculosis
  - Kaposi sarcoma
  - Esophageal candididasis
  - Central nervous system toxoplasmosis
  - HIV encephalopathy
WHO clinical Staging of HIV/AIDS for Children

• Clinical Staging 4:
  – CMV infection
  – Extrapulmonary cryptococcosis
  – Disseminated non-tuberculous mycobacterial infection
  – B-cell non-hodgkins lymphoma
  – Progressive multifocal leukoencephalopathy
  – Symptomatic HIV associated nephropathy or HIV associated cardiomyopathy

1994 Revised Human Immunodeficiency Virus Pediatric Classification System:
Immune Categories Based on Age-Specific CD4+ T Cell Count and Percentage

<table>
<thead>
<tr>
<th>Immune category</th>
<th>&lt;12 months</th>
<th>1-5 months</th>
<th>6-12 yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>(CD4)</td>
<td>No/mm³</td>
<td>CD4 (%)</td>
<td>No/mm³</td>
</tr>
<tr>
<td>Category 1: No Clinical suppression</td>
<td>≥1,500</td>
<td>(&gt;25%)</td>
<td>≥1,000</td>
</tr>
<tr>
<td>Category 2: Moderate suppression</td>
<td>750-1,499</td>
<td>(15%-24%)</td>
<td>500-999</td>
</tr>
<tr>
<td>Category 3: Severe suppression</td>
<td>&lt;750</td>
<td>(&lt;15%)</td>
<td>&lt;500</td>
</tr>
</tbody>
</table>

- Consider AGE as variable when interpreting CD4 count
- CD4 absolute count changes with age while the CD4% does not
- CD4% is a better marker of disease progression up to the 6 years of age
## Immunological Criteria in Initiating ART

**Recommendations According to Age-related Immunological Makers**

<table>
<thead>
<tr>
<th>Immunological Marker</th>
<th>Age-specific recommendation to initiate ART</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>≤ 11 months</td>
</tr>
<tr>
<td>CD4 %</td>
<td>25%</td>
</tr>
<tr>
<td>CD4 count</td>
<td>1500 cells/mm³</td>
</tr>
<tr>
<td>TLC</td>
<td>4000 cells/mm³</td>
</tr>
</tbody>
</table>

*To be used only in absence of CD4 assays:*

Notes:
- Immunological markers supplement clinical staging
- ART should be initiated by these cut-off levels, regardless of clinical stage; a drop of CD4/TLC below these levels significantly increases the risk of mortality

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## Recommendations for initiating ART in infants and children according to clinical stage and availability of immunological markers

<table>
<thead>
<tr>
<th>WHO Pediatric Stage</th>
<th>Availability of CD4 cell measurement</th>
<th>Age specific treatment recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 (a)</td>
<td>CD4</td>
<td>Treat All</td>
</tr>
<tr>
<td></td>
<td>No CD4</td>
<td></td>
</tr>
<tr>
<td>3 (a)</td>
<td>CD4</td>
<td>Treat all</td>
</tr>
<tr>
<td></td>
<td>Treat all</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Treat all in those with TB, LIP, OHL, thrombocytopenia</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Treat all</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>CD4</td>
<td>Close to or below CD4 threshold*</td>
</tr>
<tr>
<td></td>
<td>No CD4</td>
<td>At or below TLC threshold*</td>
</tr>
<tr>
<td>1</td>
<td>CD4</td>
<td>Only where at or below CD4 threshold*</td>
</tr>
<tr>
<td></td>
<td>No CD4</td>
<td>Do not treat</td>
</tr>
</tbody>
</table>

*For CD4 and TLC values refer to table
(a) Stabilize any opportunistic infection prior to initiation of ARV therapy
(b) In children with pulmonary tuberculosis, the CD4 level and clinical status should be used to determine the need for and timing of initiation of ART in relation to TB treatment*
### What to start with

**Summary antiretroviral drugs**

<table>
<thead>
<tr>
<th>NRTI</th>
<th>NNRTI</th>
<th>PI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zidovudine (AZT)</td>
<td>Nevirapine (NVP)</td>
<td>Nelfinavir (NFV)</td>
</tr>
<tr>
<td>Stavudine (d4T)</td>
<td>Efavirenz (EFV)</td>
<td>Saquinavir (SQV)</td>
</tr>
<tr>
<td>Lamivudine (3TC)</td>
<td>Delavirdine (DLV)</td>
<td>Lopinavir (LPV)</td>
</tr>
<tr>
<td>Abacavir (ABC)</td>
<td></td>
<td>Indinavir (IDV)</td>
</tr>
<tr>
<td>Didanosine (ddI)</td>
<td></td>
<td>Ritonavir (RTV)</td>
</tr>
<tr>
<td>Emtricitabine (FTC)</td>
<td></td>
<td>Amprenavir (APV)</td>
</tr>
<tr>
<td>Tenofovir * (TDF)</td>
<td></td>
<td>Atazanavir (ATV)</td>
</tr>
</tbody>
</table>

### Backbone of management

2 NRTI + 1 NNRTI (or 1 PI)

- **ZIDOVUDINE (AZT)**
  - syrup: 10 mg/ml
  - 8-15 mg/kg dose BID
  - or (180-300 mg/m²) BID

- **LAMIVUDINE (3TC)**
  - Syrup: 10 mg/ml
  - 4 mg/kg/dose BID

- **NVP (syrup: 10 mg/ml)**
  - Induction dose (14 days): 4 mg/kg/day
  - or (200 mg/m²)
  - Maintenance dose <8 years: 7 mg/kg 2x/day
  - ≥8 years: 4 mg/kg 2x/day
**Backbone of management**

2 NRTI + 1 NNRTI (or PI)

- **ZIDOVUDINE (AZT)**
  - Syrup: 10 mg/ml
  - 8-15 mg/kg/dose BID
  - Or (180-300 mg/m²) BID

- **LAMIVUDINE (3TC)**
  - Syrup: 10 mg/ml
  - 4 mg/kg/dose BID

- **EFAVIRENZ (EFV)**
  - Capsule: 200 mg
  - Tablet: 600 mg
  - ~15 (10-20) mg/kg/day OD

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**Currently Available Drugs in the Crossing Borders Project**

**First line Regimens**

- **Normal Hemoglobin**
  - AZT + 3TC + EFV for child more than 3 years old
  - AZT + 3TC + NVP for a child 3 years old and below

- **Hemoglobin Below 12 gm/dl**
  - AZT → Stavudine
## Baseline and Monitoring Pediatric ARV

<table>
<thead>
<tr>
<th>Baseline</th>
<th>On ARV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confirm dx</td>
<td>-</td>
</tr>
<tr>
<td>Clinical stage</td>
<td>Clinical stage</td>
</tr>
<tr>
<td>Readiness</td>
<td>Adherence</td>
</tr>
<tr>
<td>Concom conditions/meds</td>
<td>Concom conditions/meds</td>
</tr>
<tr>
<td>Wt, ht, develop</td>
<td>Wt, Ht, growth, development</td>
</tr>
<tr>
<td>Nutritional status</td>
<td>Nutritional status</td>
</tr>
<tr>
<td>CD4 (desirable not required)</td>
<td>CD4 q 6-12 mos (or clinical indic)</td>
</tr>
<tr>
<td>Hb (esp if on AZT)</td>
<td>Hb (WBC) 1-3 mos post start ARV,</td>
</tr>
<tr>
<td>Other lab</td>
<td>Then Sx-directed, eg ALT, lipid, glucose</td>
</tr>
<tr>
<td>VL if available</td>
<td>VL if indicated (to confirm CD4 drop?)</td>
</tr>
</tbody>
</table>

## Referral

- If facilities are not available in your hospital, consider referring a child suspected to have HIV infection:

1. For pre and post test counseling
2. For HIV testing
3. To access free antiretroviral drugs and free medicines for opportunistic infections
4. For community based social support program
5. For further counseling and continuing psychosocial support

... coordination through HIV/AIDS Core Team (HACT)
Treatment hubs in the Philippines

• Metro Manila
  Research Institute for Tropical Medicine
  San Lazaro Hospital
  Philippine General Hospital

• La Union (Ilocos Training and Regional Medical Center)

• Cebu (Vicente Sotto Memorial Medical Center)

• Davao (Davao Medical Center)

* Needs coordination with the HACT Team
NASPCP Role in Health Sector: HIV and Children
National AIDS/STD Prevention and Control Program

• Governance
  – Technical leadership
  – Policy development on Pediatric HIV Guideline and PMTCT in 2008
  – Operations of Pilot Implementation of PMTCT (on-going)
  – Trainings for Service Providers
  – Operational Research on the Vulnerability of Children
  – Engagement of Private Sectors

• Regulation
  – Coordination with Reference Labs for HIV testing laboratories

NASPCP Role in Health Sector: HIV and Children

• Financing
  – PhilHealth OPD Package for HIV

• Service Delivery
  – Free ARV and drugs for OI (adult and pedia)
  – Fund allocation for PCR at the NRL-SACCL
  – Diagnostic Services
  – Care and Support Services for PLWH and significant others
Challenges and opportunities

- **Challenges**
  1. Sustaining the interest
  2. Reaching the children

- **Opportunities**
  1. Access to treatments
  2. Network and advocates
  3. Valuing family

---

The Child’s name is ....

We are guilty of many errors and faults,
But the worst crime is abandoning the children.
   Neglecting the fountain of life
Many of the things we need can wait....
   The children cannot.
Right now is the time their bones are being formed,
   Their blood is being made and
   Their senses are being developed.
To them, we cannot answer “Tomorrow”
   The child’d name is “TODAY”

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Lundayan, The situation of Filipino Children affected by HIV and AIDS: a Preliminary Assessment, 2005

Adapted in the Interim Guideline on the management of Pediatric HIV and AIDS
Acknowledgements

- Drs Dizon and Tactacan – SLH
- Drs. Velmonte, Gonzales, - PGH
- Dr. Ditanco - RITM
- Dr. Gerard Belimac – NASPCP, DOH

... And to all the children, who are our best teachers