**Input to HRC Resolution 50/13 - challenges**

**Submission from the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF)**

1. *Major obstacles*

Children and pregnant and lactating women face high inequalities in accessing optimal medicines, vaccines, and other health products. This is because efforts to improve development and uptake of high-quality lifesaving commodities specifically designed to meet the needs of infants, children and pregnant women often do not exist, are sub-optimal or simply unavailable, especially in low-resource settings.

Lack of access to optimal treatment puts children’s lives at risk, hindering the achievement of the Sustainable Development Goals (SDGs). Disparities facing infants and children in the global HIV and TB responses are clear examples of this. In 2022, only 57% of children under age 15 living with HIV had access to treatment (compared with 77% among adults) – well short of the goal set by UNAIDS of 95% of children living with HIV who know their status initiated on treatment by 2025.[[1]](#footnote-2) While new technologies such as long-acting injectable formulations under consideration for preventing and treating HIV are nearly at hand for adults, children are at risk of once again being left out of the next generation of innovative medicines due to data gaps and lack of appropriate pediatric formulations. The availability of pediatric TB drug formulations has lagged approximately 7 years behind that of adult formulations for both bedaquiline and delamanid.[[2]](#footnote-3) The global 5-year target set by the UN high-level meeting in 2018 for number of people to be treated for drug-resistant TB was met by only 19% for children compared to 55% overall.[[3]](#footnote-4) Many drugs, even if available, are not palatable, or have no appropriate formulations or pediatric dosing determined.

Ensuring access to such drug treatments is an explicit component of the broad right to health enshrined in international human rights conventions. It is an integral component of the right to health, and the Convention of the Rights of the Child in its article 24 states that *Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health*.

Major obstacles include:

* **Lack of prioritization** on medicines for children to ensure targeted investments and coordination among stakeholders across the drug life cycle.
* **Complexities around clinical trials in children and pregnant and lactating women.**
* **Low public and private investments** on research and development for medicines for children and evaluating appropriate dosing and safety of drugs for pregnant and lactating women.
* Barriers related to the **low volume and fragmented market, pricing, supply, and** **regulatory processes**.
* **Country preparedness** for the introduction of and transition to optimal formulations takes time and investments to ensure accelerated and sustained access to optimal medicines for children in country.
* **Limited implementation of innovative models** of care to ensure children have access to the diagnostics and medications they need as well as support services for children and their caregivers to help promote adherence and long-term health outcomes.
* **Stigma and discrimination** in health care settings and within the community.
1. *Specific barriers affecting vulnerable populations*

Although progress has been made in reducing under-5 mortality, too many young lives are still being lost each year. Almost 5.2 million children under age five still die every year from preventable and treatable diseases, most of whom are in LMICs. Complexities around drug formulations, dosage guidelines, clinical trial enrollment and regulatory requirements combined with tough market economics all limit treatment availability.

Specific barriers for children and pregnant and lactating women in accessing medicines include:

* **Limited human rights-based** approach to the development and introduction of better medicines for children. A child born today could wait up to 10 years before a newly available drug for adults is tailored for their needs. An analysis done by Access to Medicine Foundation in 2021 shows that of the 1,073 R&D projects assessed, less than 7% (69) target children under the age of 12, revealing major gaps in the pediatric pipeline.[[4]](#footnote-5) A human rights-based approach changes the view that children are solely passive subjects of adult protection allowing for their specific needs to be met with entitlement to their own rights and proper investment in achieving universal healthcare for children.[[5]](#footnote-6)
* **Lack of pediatric drug optimization**. In many cases, appropriate pediatric formulations and doses do not exist. Identification of gaps and prioritization are necessary steps to enable a targeted approach to R&D, which needs to be undertaken in conjunction with developing and updating normative guidance on the use of medicine for treating and preventing communicable and noncommunicable diseases in children as well as in adults.
* **Clinical research in pediatric populations** is particularly challenging without adequate capacity on the ground and without enabling norms and standards. The lack of harmonized regulatory guidance for the development and introduction of paediatric medicines disincentivizes innovation.
* **Supply** **cannot meet demand when demand is neither forecasted nor pooled.** Pediatric populations often represent too small a market, with sometimes no epidemiological data on diseases for children, making traditional incentives for innovation and manufacturing insufficient. Pooled procurement, buyer collaboration encouraging competition between vendors, is critically important to ensure supply of optimal products recommended by the WHO, particularly for low market-volume products.
* **Country preparedness** for transition and introduction of optimal medicines takes time and investments. This includes development of policies, investments, capacities and accurate forecast data, and community engagement among others.
* **Limited implementation of innovative models** of care to ensure children have access to testing services and linkage to treatment. This includes decentralization of care and integration of services with differentiated and community-based service delivery models among others. Point of Care Early Infant Diagnosis (POC EID), for example, expedites infant testing at the local clinic level to ensure HIV-exposed infants have a virological test for HIV within 4-6 weeks after birth, ensuring those with a positive test are immediately started on antiretroviral treatment, which drastically reduces the high risk of early illness or death in infected infants. Likewise, integration of TB-case finding strategies into maternal and child health services promotes pediatric linkage to care, as young children with TB may often initially present in such settings.
* **Data on safety and appropriate dosing of medicines for pregnant and lactating women are very limited**. Due to safety concerns, pregnant and lactating women are usually excluded from enrollment into clinical trials, which results in limited data on appropriate dosing and safety of agents in pregnancy once a drug or vaccine is approved and inadequate pharmacovigilance once the drug is introduced. This trend was observed during the COVID-19 pandemic as pregnant women, a population at high risk of suffering from the severe symptoms of COVID-19, dealt with a lack of representation in many studies around the COVID-19 treatment and vaccines. The same trend is consistent for many drugs.

*(e) Main challenges in international cooperation*

* The **fragmented landscape of pediatric drug innovation** creates siloed approaches that tackle just one part of the product life cycle rather than a coordinated and sustainable approach. [The Global Accelerator for Pediatric Formulations (GAP-f)](https://iris.who.int/bitstream/handle/10665/352200/9789240044647-eng.pdf?sequence=1), was created to respond to the pediatric treatment gap by uniting siloed approaches and strengthening coordination across the drug life cycle, from prioritization to introduction of optimal formulations for children.
* **Global leadership is needed** to ensure access to medicines for children is on the top of the agenda of international stakeholders and donors and to secure proper support around coordination, alignment, and policy guidance.
* **Public and private investments in research and development** are essential to improve access to medicine in children through establishing targeted economic incentives to counterbalance the small market size, access planning that ensures availability and affordability, and leverage government funding, development assistance and philanthropic finances.
* **Funding to support innovations and accelerate access to affordable medicines in country,** including through multilateral actors such as Unitaid, Global Fund, GAVI and more. This will help to shape the local pediatric market, attract impact investors, and increase funding available for innovative approaches to expand access to pediatric products in LMICs.This includes investments in communities to ensure adequate demand creation, service delivery and advocacy.
* **Regional and global pooled procurement mechanisms** are critical to incentivize the market and ensure access to affordable and quality products. Pooled procurement has specifically been promoted to address several problems related to constrained access to affordable, quality assured medicines, such as small market size of the buyer, limited technical capacity and human resources, and insufficient incentives to manufacture or supply specific medicines or vaccines.
* **Stronger accountability systems towards agreed commitments** as part of international declarations, resolutions and policies should be strengthened and developed where they do not exist.

*(g) Main challenges ensuring quality, efficacy and safety*

Stemming from the broader regulatory, manufacturing, distribution and delivery systems in place, the main challenges that hinder secure, reliable development and dispersal of medicines for pediatric and maternal populations include:

* **Insufficient or nonexistent pediatric formulations or doses** adapted from already existing adult formulations.
* **Inadequate pharmaceutical research and development specifically among children**to keep up with emerging diseases, mutating and evolving pathogens, and changing patient needs.
* **Lack of policies that require new drugs that will be used widely by women of childbearing potential.** Conducting initial safety and pharmacokinetic studies in pregnancy during drug development to ensure that appropriate dosing for pregnancy will be known by the time of drug approval.
* **Need to address issues related to quality control during the manufacturing process**to ensure adherence to pre-established standards, regulations, and specifications, for example, the need for required rigorous testing and monitoring.
* **Insufficient pooled procurement to satisfy the demand for pediatric medications at affordable pricing,** no matter the size of the order.
* **Substandard or lack of proper storage**, transportation, and distribution practices to prevent temperature excursions, contamination, or tampering that can compromise product integrity.
* **Lack of robust pharmacovigilance systems** to facilitate prompt detection of adverse effects in children and pregnant women and their fetuses/children.
* **Insufficient measures to efficiently and effectively detect and prevent the circulation of readily available counterfeit or substandard medicines and vaccines**, which can be ineffective, unsafe, or harmful to patients.

 *(i) Recommendations*

At the global level:

* Adopting a **human rights-based approach** to improve access to medicines among children is necessary and must be supported by robust international assistance and cooperation. This means prioritizing children’s needs across the drug cycle life.
* **Mobilize leadership** to ensure that access to better medicines for children remains high on the global and regional health and development agendas, increase international cooperation for and provide appropriate support to existing platforms that coordinate access to better medicines for children, such as GAP-f and maximize existing funding mechanisms for innovations and introduction, including Unitaid, the Global Fund and GAVI.
* **Strengthen coordination across the drug life cycle to improve the pediatric drug market,** from drug optimization process **(e.g.** [**WHO Antiretroviral Drug Optimization [PADO] Working Group**](https://iris.who.int/bitstream/handle/10665/349315/9789240039520-eng.pdf?sequence=1)**)** to research, development, regulatory issues, introduction and roll-out. Building on existing mechanisms such as GAP-f to strengthen coordination and advocacy will help simplify and incentivize the pediatric research and development process through overcoming inefficiencies in the regulatory procedures and more.
* **Increase public and private investments in clinical research,** strengthencapacity and accelerate the development of guidelines, norms, and standards for clinical research in children and pregnant/lactating women and ensure feasibility as well as implementation of results once drugs are approved.
* **Leverage pooled procurement** (global and regional) to address small market challenges through strong coordination mechanisms among domestic and international procurement agencies. This includes joint price negotiations and efforts to reduce transaction and operational costs, using long term multiyear agreements, accurate forecasting and demand creation, and strong advocacy to find solutions to stock outs and supply disruptions.
* **Strengthen engagement of civil society, communities, and patient groups** to ensure accountability, advocacy and information gathering and sharing to accelerate access to better medicines for children.

At the national level:

* **Strengthening country preparedness is essential to ensure access to affordable and quality medicines as quickly as possible.** EGPAF and the Drug for Neglected Diseases Initiative (DNDI), with support from Unitaid, conducted a study across eight sub-Saharan African countries with the objective of learning how to accelerate access to optimal child-friendly antiretroviral drug formulations for children living with HIV. This study identifies nine barriers and proposes recommendations to overcome them to ensure quick introduction, and sustainability, of optimal formulations for children. More on this study can be found [here](https://pedaids.org/wp-content/uploads/2021/02/ARV-Lessons-Learned-Brief-v5.pdf).
* **Strong coordination and leadership from Ministries of Health (MOH) through existing technical working groups** are critical in ensuring a smooth transition from legacy regimens to optimal pediatric antiretroviral formulations.
* **Strong collaboration and investments in communities by member states** to ensure demand, accountability, advocacy, and the provision of an effective response to stigma and discrimination in health and community settings and psychosocial support.
* **Ensuring the consistent and continual availability of optimal pediatric drug formulations and preparation for effective transition** is critical. This requires strengthening stock management and reporting, working closely with key stakeholders, and strengthening national capacity for quantification for pediatric medicines. Greater emphasis on pharmacovigilance and active monitoring as part of transition planning is essential in promoting better reporting and data use.
* **Training health care workers, especially on the administration of newer formulations, should be prioritized and well timed with transition plans.** Caregiver education on drug administration can be given before transition to a new drug and reinforced during the transition. This will help increase treatment literacy, promote demand, provide structured follow-up caregiver literacy sessions, and allow caregivers to address any questions or challenges.
* **Ensuring public insurance coverage includes essential medicines for children.** Pediatric formulations need to be invested in and adequately funded to prevent children from continuing to lag behind in many disease areas.
* **Investing in community and civil society engagement by member states** to increase demand and strengthen accountability in country.
1. The path that end AIDS. 2023 UNAIDS Global AIDS Update. 2023. [2023\_report.pdf (unaids.org)](https://thepath.unaids.org/wp-content/themes/unaids2023/assets/files/2023_report.pdf) [↑](#footnote-ref-2)
2. Garcia-Prats A.J et al. (2021) New drugs and regimens for tuberculosis disease treatment in children and adolescents. Journal of Pediatric Infectious Diseases. 11 (Suppl 3): S101. [↑](#footnote-ref-3)
3. Global Tuberculosis Report. WHO, 2023. [9789240083851-eng.pdf (who.int)](https://iris.who.int/bitstream/handle/10665/373828/9789240083851-eng.pdf?sequence=1) [↑](#footnote-ref-4)
4. Closing gaps in access to medicine for children: how R&D and delivery efforts can be ramped up. Pediatric Analysis. Access to Medicine Foundation. March 2021. [Closing gaps in access to medicine for children: how R&D and delivery efforts can be ramped up | Access to Medicine Foundation](https://accesstomedicinefoundation.org/resource/closing-gaps-in-access-to-medicine-for-children-how-r-d-and-delivery-efforts-can-be-ramped-up) [↑](#footnote-ref-5)
5. Promoting children’s rights to health and well-being in the United States. The Lancet. August 2023. [Promoting children's rights to health and well-being in the United States (thelancet.com)](https://www.thelancet.com/action/showPdf?pii=S2667-193X%2823%2900151-5) [↑](#footnote-ref-6)