Elizabeth Glaser Pediatric AIDS Foundation | *Until no child has AIDS.*

Parallel Report by the Elizabeth Glaser Pediatric AIDS Foundation on the Report by Kenya under Article 44 of the Committee on the Rights of the Child

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Introduction

1. The Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) was created in 1988, and is now the leading global non-profit organization dedicated to eliminating pediatric HIV and AIDS. EGPAF has been working in Kenya since 2000 to increase women's access to high-quality services to prevent mother-to-child HIV transmission, as well as to expand access to HIV prevention, care, and treatment for women, children, and their families. In close partnership with Kenya's Ministry of Health and other governmental and non-governmental actors, EGPAF supports mother-to-child HIV transmission prevention and other HIV prevention, care, and treatment services in Kenya.

2. As detailed below, the HIV epidemic in Kenya has a particularly heavy impact on children, with significantly higher rates of new infections and mortality among children than adults and lower rates of treatment. While significant progress has been made in recent years in Kenya to prevent mother-to-child transmission of HIV, increased efforts are needed to meet the goal of eliminating such transmission. In addition, there remains significantly more work to be done to address the large gap in access to antiretroviral treatment (ART) between children and adults and to keep children on treatment over time. Beyond public health challenges, there remain legal, economic, societal, and cultural barriers to an effective HIV/AIDS response that are hindering HIV prevention and treatment among children in Kenya.

3. The Convention on the Rights of the Child contains several provisions with a bearing on the prevention and treatment of HIV among children, as described in General Comment No. 3 (2003): HIV/AIDS and the rights of the child. Accordingly, EGPAF would like to encourage the Committee on the Rights of the Child to include in its concluding observations to Kenya several issues that were not adequately addressed by Kenya in its report submitted to the Committee or in its response to the List of Issues developed by the Committee. Our suggestions and brief background on each element are presented below.

The Right to Health (Article 24)

4. Article 24 of the Convention on the Rights of the Child entails a legal responsibility for each State Party to ensure that quality HIV prevention, testing, treatment, and care services are available and accessible to all children, including HIV prevention among girls and women, family planning for those living with HIV, and appropriate pre-natal and post-natal health care for mothers. However, data points to a need for Kenya to make a more determined effort to improve pediatric HIV prevention and treatment in order to meet these obligations. For example, while children make up around 13% of the estimated 1.2 million people living with HIV in Kenya, they counted for 23% of total new HIV infections in 2014, and 25% of deaths from AIDS-related causes.[1]

5. Despite significant progress made by Kenya over the past five years in preventing new HIV infections among children through the scale-up of PMTCT, it still has the second highest number of annual new HIV infections in children in Africa.[2] The final mother-to-child HIV transmission rate in 2014 was 17%, whereas the WHO defines "elimination" of mother-to-child transmission (eMTCT) after breastfeeding as a rate of under five percent.[3] Numerous factors contribute to relatively high levels of new HIV infections among children, including challenges with primary HIV prevention of girls and women, family planning among girls and women living with HIV, and ensuring long-term treatment for pregnant girls and women living with HIV.

6. Concerning HIV prevention and sexual and reproductive health education, Kenya reports low rates of comprehensive knowledge about HIV prevention among young people and a "great need to raise awareness of HIV prevention among the youth."[4] A recent report shows lower rates of modern

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[1] See UNAIDS AIDSinfo database: http://aidsinfo.unaids.org/.
[2] UNAIDS, *How AIDS changed everything: MDG 6, 15 years, 15 lessons of hope from the AIDS response*, July 2015, p. 457-58.
[3] UNAIDS, *2015 Progress report on the Global Plan towards the elimination of new HIV infections among children and keeping their mothers alive*, http://www.unaids.org/sites/default/files/media_asset/JC2774_2015ProgressReport_GlobalPlan_en.pdf, November 2015, p.16.
[4] UNAIDS, Kenya AIDS response progress report 2014: progress towards zero, March 2014, p.12.

contraception use in women living with HIV than non-HIV positive women, as well as a higher rate of unintended pregnancies.[5] Accordingly, Kenya announced in September 2015 a plan to scale up implementation of the HIV curriculum and age-appropriate sexual and reproductive health education in all secondary schools.[6] Kenya also reported to the Committee that it has increased the availability of sexual reproductive health information to adolescents in youth friendly centers and via social media.[7]

7. In order to prevent mother-to-child HIV transmission among pregnant women living with HIV, such women must start ART as early as possible in the pregnancy and adhere properly to treatment through the breastfeeding period, which is an equally high-risk period for HIV transmission. The latest WHO guidelines now recommend all persons with HIV begin treatment immediately and stay on treatment for life. Yet in Kenya, only 67% of pregnant women living with HIV received antiretroviral medicines in 2014, compared with an average of 75% in sub-Saharan Africa and rates of over 90% in eight other African countries.[8] A recent study shows very low retention of women on ART within a year of initiation in Kenya, though poor record-keeping could also explain some of the low numbers.[9]

8. Achieving eMTCT will require improving deficiencies in human resources, supply chain management, and laboratory equipment. Greater efforts are also needed to increase ante-natal care visits, which enable health-care workers to initiate women on treatment, monitor their adherence, check whether the ART is effectively suppressing the virus, and conduct further testing of HIV-negative women to determine if they have become newly infected with HIV. Moreover, many women, especially poor women in rural areas, are not delivering in health institutions or with the care of skilled birth attendants.[10] Increasing institutional birth deliveries would also help ensure the baby is immediately started on preventative treatment and would enable health care workers to better track mother-infant pair after delivery. Some of the factors that discourage HIV-positive women from ANC visits, institutional births, and remaining on ART are long distances to health clinics, the costs associated with travel, disrespectful treatment by health care workers, and stigma and discrimination.[11]

9. For those infants exposed to HIV during pregnancy or breastfeeding, it is critical to quickly test them for HIV and initiate them on medication. Yet progress on diagnosing children with HIV and putting them on treatment has been much slower in Kenya than for adults. HIV tests suitable for infants are usually only available in centralized laboratories. So while Kenya has made good progress in the number of infants being tested within two months of birth, EGPAF has observed that long turn-around-times on such test results continue to be a problem. [12] As it can take weeks or even months to deliver results, it may be too late to save the baby's life by the time results are received. As well, poor follow-up of mother-baby pairs mean that many mothers or caregivers never receive test results or linkage to treatment for the baby.

10. Kenya has increased the rate of children living with HIV on treatment from 16% in 2008 to 41% in 2014, but this number is still far too low, and represents a significant gap with the adult treatment

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[5] Kimani et al, "Family planning use and fertility desires among women living with HIV in Kenya," *BMC Public Health*, 15:909 (2015), p.2.
[6] Daniel Psirmoi, "New online tool launched to boost war against HIV," *Standard Digital*, 17 September 2015 and Moses Nyamori, "Ministry gives nod on sex education in Kenya schools to reduce teenage pregnancies," *Standard Digital*, 3 Sept. 2015.
[7] Republic of Kenya. Responses to the issues raised on the 3RD, 4TH AND 5TH UNCRC periodic state party report, http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRC%2fC%2fKEN%2fQ%2f3-5%2fAdd.1&Lang=en, October 2015, p. 15.
[8] UNAIDS, *2015 Progress Report on the Global Plan* , p.15.
[9] PEPFAR, USAID, HIVCore, "Secondary Analysis of Retention Across the PMTCT Cascade in Selected Countries: Rwanda, Malawi, Kenya, and Swaziland," January 2015.
[10] Committee on the Rights of the Child, Consideration of reports submitted by states parties under article 44 of the convention: combined third, fourth and fifth periodic reports of states parties due in 2012, Kenya, http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRC%2fC%2fKEN%2f3-5&Lang=en, 30 March 2015, p.29.
[11] Miriam Gathigah, "Divided Opinions on Feasibility of Kenya's Option B+ Roll Out," Inter Press Service, 26 May 2014, http://www.ipsnews.net/2014/05/divided-opinions-feasibility-kenyas-option-b-roll/.
[12] UNAIDS, *2015 Progress Report on the Global Plan*, p.21.

rate of 57%.[13] Without treatment, 50% of children with HIV will die by their second birthday, and 80% will die before they turn five. Keeping children on treatment over time is also a major challenge.[14] Kenya has recognized and pledged to do more to close the treatment gap for children. This will require scaling up early infant diagnosis in decentralized clinics to reduce turnaround times for test results; improving tracking and servicing of mother-infant pairs; increasing community outreach programs to find undiagnosed children with HIV and to retain children of all ages on treatment; and training of health care workers on identifying, testing, treating and caring for children with HIV.

11. Kenya has shown strong political commitment at the national and international level to ending AIDS, including among children and young women. Such commitment needs to be matched with increased domestic financing for health. Kenya currently covers 16% of its AIDS response, though it has pledged to raise the amount to 50%.[15] Under the Abuja Declaration of 2001, African Union heads of state pledged to allocate at least 15% of their domestic spending to the improvement of the health sector, with an emphasis on the fight against HIV/AIDS, tuberculosis and other infectious diseases. Kenya appears far from meeting this goal, however, with only 4.5% of spending allocated to health care in 2013,[16] though it did note in its report to the Committee that it is "committed to scale up its financial budget in order to meet the Abuja commitment as well as increase pediatric services to children infected by HIV and AIDS."[17] In addition, the recent devolution of primary healthcare to the county level has put an additional strain on an already under-resourced healthcare system, with a risk of insufficient local prioritization of funding and health care worker capacity to implement HIV programs.

Suggested recommendations to the Government of Kenya:

- Take all necessary measures to achieve, by 2020, elimination of mother-to-child HIV transmission, including by encouraging greater frequency and quality of ante-natal care and institutional birth deliveries and strengthening the health care system's capacity for testing and treating all pregnant and breastfeeding women living with HIV;
- Improve access to age-appropriate and adolescent-friendly health services and education for sexual and reproductive health and HIV/AIDS, including confidential services;
- Expand early HIV testing and ART initiation and long-term retention among children;
- Increase domestic spending on healthcare, particularly on endemic diseases such as HIV/AIDS, and ensure sufficient allocation of financial, human, and material resources at the county level to HIV/AIDS testing, treatment, and care.

The Right to Non-Discrimination (Article 2)

12. Stigma and discrimination seriously impact the lives of children living with or affected by HIV, including by interfering with effective HIV prevention; impeding adequate care, treatment, and psychological support; deterring children's access to education and social services; and leading to exclusion by their family, community, or society.[18] Stigma and discrimination are recognized by the government of Kenya and civil society actors as significant barriers to access to testing, treatment,

[13] UNAIDS, *Kenya AIDS response progress report 2014: progress towards zero*, published March 2014, p. 24 and
[14] PEPFAR, USAID, HIVCore, "Secondary Analysis of Retention Across the PMTCT Cascade in Selected Countries: Rwanda, Malawi, Kenya, and Swaziland," p.2.
[15] UNAIDS, *How AIDS Changed Everything*, p. 212 & 375.
[16] WHO Global Health Observatory Data Repository: http://apps.who.int/gho/data/node.main.75?lang=en
[17] Committee on the Rights of the Child, *Consideration of reports submitted by states parties, Kenya*, p.13.
[18] Convention on the Rights of the Child General Comment No. 3, *HIV/AIDS and the rights of the child*, CRC/GC/2003/1, http://www.unhchr.ch/tbs/doc.nsf/898586b1dc7b4043c1256a450044f331/309e8c3807aa8cb7c1256d2d0038caaa/$FILE/G0340816.pdf, p.3.

and care among persons living with HIV despite a clear legal prohibition on discrimination against persons with HIV and the establishment in 2009 of an HIV and AIDS Equity Tribunal.[19]

13. Children living with HIV in particular suffer from the impact of stigma as they are more sensitive than adults to negative feedback from others, especially from peers or authority figures. Children are also impacted by stigma and discrimination targeted against adults as they are dependent on parents or healthcare workers for their treatment and psychosocial support. [20] Stigma against children in education settings and discrimination in the form of dismissal, suspension or prevention from attending an education institution is still far too common.[21]

14. On 17 September 2015, President Kenyatta announced a new presidential campaign against stigma and discrimination, especially against children and young people. President Kenyatta had announced in February 2015 another initiative to reduce stigma against children in schools and improve access to treatment, which included a directive to collect data on the HIV status of children in school and their guardians.[22] As the names and HIV status of these individuals were to be stored in centralized records, the directive could have endangered the right to privacy of children with HIV and increase the stigma and discrimination they face, prompting human rights groups to challenge the directive in court.[23]

Suggested recommendations to the Government of Kenya:

- In consultation with people living with HIV, take additional steps to combat and prevent stigma and discrimination against children living with and affected by HIV/AIDS.
- Ensure that actions being taken to reduce stigma and discrimination against children in schools are carried out in a manner that also protects their right to privacy.

The Right to Survival, Life, and Development (Article 6)

15. The Marriage Act of 2014 bans underage marriage, but approximately 25% of girls are married before their 18th birthday in Kenya.[24] Child marriage creates a heightened risk of HIV acquisition among girls, with ramifications for their right to survival, life, and development. Typically, such marriages occur between young girls and older men, who have already had several sexual partners and thus a higher exposure to HIV. For example, in a study in Kisumu, 33% of married girls surveyed were infected with HIV as opposed to 22% for their sexually active, unmarried counterparts.[25] These marriages are also associated with higher levels of intimate partner violence and an unequal power balance that can prevent girls from exercising decisions about using protection as well as seeking HIV testing or treatment. [26] Early marriage usually halts girls' education, associated with a higher risk of HIV and a lower likelihood of seeking help in cases of intimate partner violence.[27]

Suggested recommendation to the Government of Kenya:

- Ensure full implementation and enforcement of the ban on child marriage in collaboration with community and traditional leaders.

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[19] See "Punitive Laws and Practices Affecting HIV Responses in Kenya," 2014; "The National Symposium on HIV Law and Human Rights, October 2012; and "NEPHAK, GNP+The People Living with HIV Stigma Index: Kenya, November 2011," http://www.stigmaindex.org/sites/default/files/reports/Kenya%20People%20Living%20with%20HIV%20Stigma%20Index%20Report%202009.pdf
[20] Deacon H, Stephney I, "HIV/AIDS, Stigma and children: a literature review," *Human Sciences Research Council*. 2007, p.2.
[21] NEPHAK, GNP+, *PLHIV Stigma Index Kenyan Country Assessment*.
[22] UNAIDS, *How AIDS Changed Everything*, p. 158.
[23] Notice of Motion Anand Grover, 8 July 2015 at http://kelinkenya.org/wp-content/uploads/2010/10/NOTICE-OF-MOTION-Anand-Grover-copy.pdf
[24] GirlsnotBrides: Kenya at http://www.girlsnotbrides.org/child-marriage/kenya/. Accessed 23 November 2015.
[25] "GirlsnotBrides: Kenya" at http://www.girlsnotbrides.org/child-marriage/kenya/. Accessed 23 November 2015.
[26] Peter Piot et al, *A UNAIDS–Lancet Commission on Defeating AIDS—Advancing Global Health*, p. 7.
[27] "Goal: promote gender equality and empower women," at http://www.unicef.org/mdg/index_genderequality.htm.

The Right to Education (Article 28)

16. In order to prevent HIV among girls, it is particularly important to protect their equal access to education, including secondary education. Studies have shown that the longer girls stay in school, the later they are likely to begin sexual relations, get married, or get pregnant; the more likely they are to engage in safe practices when they do become sexually active; and the greater the chance of achieving economic independence – all of which will help protect them from HIV infection.[28] Primary education is free in Kenya, and Kenya has taken steps to make secondary education affordable to more children of poor families. Yet in 2013, only around 44% of girls attended secondary school, and in 2014, 25% of girls 18 and under had begun childbearing.[29] Kenya reports that "retention and transition rates of girls [in school] has remained low compared to boys" due to factors such as early pregnancies and a societal preference for boys' education over girls'. Various hidden fees for schooling also make education unaffordable to many families.[30] Further steps to keep girls in secondary school as long as possible will maximize HIV prevention benefits.

Suggested recommendation to the Government of Kenya:

- Take further steps to ensure access to education by all girls and boys through secondary school, including by eliminating all direct and indirect fees.

[28]Karen Ann Grépin and Prashant Bharadwaj, "Secondary education and HIV infection in Botswana," The Lancet, Vol.3, Number 8, August 2015.
[29] "UNICEF Country Statistics: Kenya," http://www.unicef.org/infobycountry/kenya_statistics.html and Kenya Demographic and Health Survey, 2014.
[30] Committee on the Rights of the Child. *Consideration of reports submitted by states parties, Kenya*. p.30.