Elizabeth Glaser Pediatric AIDS Foundation

Until no child has AIDS.

Submission by the Elizabeth Glaser Pediatric AIDS Foundation

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I. Introduction

1. The Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) was created in 1988, and is now the leading global nonprofit organization dedicated to eliminating pediatric HIV and AIDS. EGPAF has been supporting efforts to prevent, care for, and treat pediatric HIV and AIDS in Tanzania since 2003. Working with the Tanzania Ministry of Health and Social Welfare, EGPAF implements programmatic, research, and advocacy initiatives aimed at eliminating HIV infections in children and supporting HIV-positive children, mothers, and families.

2. Tanzania is one of the countries with the highest rates of HIV prevalence, and the epidemic disproportionately affects young women and children. Tanzania has made significant progress in preventing mother-to-child transmission of HIV, though increased efforts are needed to achieve virtual "elimination" of mother-to-child transmission.[1] Yet there remains significantly more work to be done to address the large gap in HIV treatment between children and adults.

3. Achieving and sustaining elimination of pediatric HIV in Tanzania will require changes at the political, financial, structural, and societal levels, including strengthened national health systems; strong and accountable leadership; effective and efficient service delivery models; timely and accurate health information; functional supply chains; sufficient and adequately trained health workers; and increased and transparently managed financial resources.[2] Stigma and discrimination are also recognized by the government of Tanzania and civil society actors as significant barriers to ensuring an adequate HIV/AIDS response for all people living with HIV.[3]

4. This report will consider progress and remaining challenges EGPAF has observed in Tanzania's protection of the rights of women and children affected by, or living, with HIV. The primary rights that will be examined are the right to health, including HIV/AIDS health services and sexual and reproductive health. It will also examine the right to non-discrimination and the right to gender equality as they relate to HIV prevention and treatment.

II. HIV and the Right to Health

5. The right to health is recognized by the Universal Declaration of Human Rights, Article 12 of the International Covenant on Economic, Social and Cultural Rights, Article 24 of the Convention on the Rights of the Child, and other international instruments. In the context of HIV/AIDS, these provisions entail a legal responsibility for each country to progressively ensure fully available, accessible, acceptable, and quality HIV prevention, testing, treatment, and care services for women, men, girls and boys of all ages. States must review all laws and policies and revise or repeal any elements that act as barriers to effective HIV diagnosis, treatment, care, and counseling.

6. Tanzania has demonstrated strong commitment to ending the HIV/AIDS epidemic through the development and implementation of a number of strategies and action plans. Yet Tanzania recognizes that its health system suffers from limited financial, human, and managerial resources for health, with significant consequences for its fight against HIV/AIDS.[4] The HIV/AIDS response, which is human resource intensive, puts an extra strain on the system. Tanzania has yet to establish a formal national policy permitting nurses

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[1] According to the WHO, elimination of mother to child HIV transmission requires a transmission rate of under 2% with no breastfeeding, and under 5% if a mother breastfeeds.
[2] EGPAF, *Tanzania Program Annual Report 2014*, http://b.3cdn.net/glaser/8f0a31c967ea4001fb_mlbrppa48.pdf, p. 28.
[3] United Republic of Tanzania National Composite Policy Index (NCPI) 2012: http://www.unaids.org/sites/default/files/en/dataanalysis/knowyourresponse/ncpi/2012countries/Tanzania%20NCPI%202012.pdf, p. 4.
[4] *Global AIDS Response Country Progress Report of Tanzania*, 31 March 2014, p.32.

to take on some tasks related to testing, initiation and maintenance on treatment, which could help boost its capacity to meet the needs of those living with HIV.[5]

7. In Tanzania, children are not benefiting from HIV prevention, treatment, and care in an equal manner with adults. The prevention of mother-to-child transmission (PMTCT) is an essential part of protecting children from HIV as 90% of HIV among children is from the mother. PMTCT involves several prongs of activity. The first step is to prevent HIV among women and adolescent girls through access to age-appropriate information about HIV and sexual and reproductive health (SRH) services. Yet such services are not sufficiently available in Tanzania, partly due to cultural sensitivities about these issues and to the low secondary school attendance level where such education may be provided to adolescents.[6]

8. One issue affecting HIV prevention among adolescents is the age of consent for HIV testing and counseling. The current legal age of consent for medical tests in Tanzania is 18, but many adolescents will not seek an HIV test if they need to ask permission from a parent or guardian. Yet knowing one's status is important to ensuring that proper measures are taken for the prevention of HIV transmission. With AIDS-related disease the number one cause of deaths in sub-Saharan Africa among adolescents, Tanzania may want to consider more permissive rules to increase testing by mature adolescents who are engaging in high-risk activities, such as sex or drug use.

9. The second prong in the PMTCT cascade is sexual and reproductive health services to support HIV-positive women in their decision on whether to have children, and at what intervals. But many women desiring to limit or space the birth of their children are not able to access family planning services in Tanzania, and stock ruptures in contraceptive commodities remains a frequent problem despite the government's recent efforts to increase availability.[7] The problem is particularly difficult for adolescent girls due to the lack of youth friendly family planning services.

10. Next, pregnant women living with HIV need to be tested and initiated on ART as early as possible during the pregnancy and through at least the end of the breastfeeding period in order to maximize protection for the baby and keep themselves healthy. In Tanzania, testing and treatment of pregnant women has been greatly facilitated by the integration of PMTCT services into virtually all health facilities with reproductive and child health services. A significant proportion (85%) of pregnant women is tested for HIV during ANC visits.[8] And in 2014, approximately 90% of HIV-infected pregnant women received ARVs to prevent transmission of HIV to their infant.[9]

11. Yet several challenges remain to making further progress toward elimination of mother-to-child transmission, which remains at a 15% transmission rate and accounts for 18% of new infections.[10] Some of the reasons identified by Tanzania are: continued use of "inefficient (drug) regimens, drug stock outs or poor adherence to treatment, or simply lack of access to PMTCT services during pregnancy."[11] EGPAF has also noted shortages of key

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[5] Task-shifting for pediatric HIV treatment is a goal of the US Presidential Emergency Plan for AIDS Relief (PEPFAR), which aims to double the number of HIV-positive children ART by 2016. See PEPFAR/MOHSW, *Tanzania: Strategic Plan for Pediatric ART Acceleration 2014 — 2016*, p. 8.
[6] UNICEF Statistics, United Republic of Tanzania: http://www.unicef.org/infobycountry/tanzania_statistics.html .
[7] United Nations Population Fund Tanzania. http://countryoffice.unfpa.org/tanzania/2013/09/13/7939/overview/. Published September 2013. Tanzania's reported efforts to increase availability of contraception in its 2014 report to CEDAW, CEDAW/C/TZA/7-8, 25 November 2014, p. 37.
[8] *Global AIDS Response Country Progress Report*, p. 22.
[9] UNAIDS, AIDSInfo: http://aidsinfo.unaids.org.
[10] *Global AIDS Response Country Progress Report*, p. 11 and UNAIDS, *2013 Progress Report On The Global Plan*, p. 49.
[11] *Global AIDS Response Country Progress Report*, p. 16.

commodities like ARVs and diagnostic kits, resulting in missed opportunities for identifying, counseling, and treating pregnant women living with HIV.[12]

12. Negative attitudes of health workers may prevent women from accessing pre-natal and ante-natal care, which are critical for ensuring women living with HIV start and adhere to ART through breastfeeding. Women in Tanzania report high levels of disrespectful treatment from health care workers during childbirth.[13] Such treatment may contribute to the fact that only around 50% of women deliver at a health facility in Tanzania, another impediment to PMTCT.[14]

13. It is critical to initiate infants exposed to HIV on prophylactic drugs at birth and test them for HIV by six weeks. Infants diagnosed with HIV must begin ART as quickly as possible. Due to their immature immune systems, infants with HIV are at much higher risk of developing AIDS. Without treatment, 50% of children with HIV will die by their second birthday, and 80% will die before they turn five. Yet only 27% of eligible children living with HIV were on ART in 2014, compared to 68% of HIV-infected adults in need of treatment.[15] Such data signifies a need for Tanzania to make a more determined effort to improve pediatric HIV treatment, thereby assuring adequate protection of children's right to health.

14. Specific barriers to initiating and maintaining children on ART in Tanzania include difficulty identifying and testing HIV-exposed infants, especially over the long breastfeeding period when transmission can still occur. [16] The result is missed opportunities to conduct early infant diagnosis (EID) and start infants on treatment during the critical early stage of disease progression. Indeed, only 30% of health facilities in Tanzania provide EID, and only 26% of HIV exposed infants accessed EID in 2013.[17] Linkage to care and treatment in clinical care services also remains a challenge, especially for children and adolescents, as does the lack of youth-friendly testing and counselling services and health care workers properly trained in addressing pediatric HIV.[18] Finally, there needs to be a better tracking and outreach system in all facilities caring for infants, children and adolescents to improve retention.[19]

III. The Right to Non-Discrimination and Equality of Rights

15. Stigma and discrimination due to a person's actual or perceived HIV/AIDS status violates their rights under international law to freedom from discrimination and to equality before the law, and undermines the "inherent dignity" of all persons enshrined in the Universal Declaration of Human Rights. Yet stigma and discrimination remain key barriers to an effective HIV/AIDS response, standing in the way of people seeking a diagnosis, disclosing their status to others, and keeping up with treatment for fear of the impact this might have on personal, societal, or professional relations.[20] Children living with HIV in particular suffer from the impact of stigma and discrimination, and poor treatment by teachers and schoolmates often discourages children from staying in school or taking their medicine.[21]

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[12] EGPAF, *Tanzania Program Annual Report 2014*, p.18.
[13] See, for example, Margaret Kruk et al, "Disrespectful and abusive treatment during facility delivery in Tanzania: a facility and community survey," *Health Policy and Planning*, 26 June 2014.
[14] UNICEF, Tanzania: Maternal and Child Health at http://www.unicef.org/tanzania/maternal_child_health.html.
[15] PEPFAR/MOHSW, *Tanzania: Strategic Plan for Pediatric ART Acceleration 2014-2016*.
[16] EGPAF, *Tanzania Program Annual Report 2014*, p. 4.
[17] *Global AIDS Response Country Progress Report* , p.16.
[18] PEPFAR/MOHSW, *Tanzania: Strategic Plan for Pediatric ART Acceleration 2014-2016*, p.17.
[19] PEPFAR/MOHSW, *Tanzania: Strategic Plan for Pediatric ART Acceleration 2014-2016*, p. 22.
[20] UNAIDS, *How AIDS Changed Everything*, 2015, p. 109.
[21] Angel Navuri, "Children`s right to information on HIV prevention, treatment and care vital," IPPMedia, 17 July 2015, http://www.ippmedia.com/?l=82336.

16. Tanzania has solid legislation against discrimination under "The HIV/AIDS (Prevention and Control) Act of 2008." The Act states that no one may "formulate a policy, enact any law or act in a manner that discriminates directly or by its implication persons living with HIV and AIDS, orphans or their families" and bars any person from stigmatizing or discriminating against another based on actual or suspected HIV/AIDS status. It also specifically requires health workers to provide health services "without any kind of stigma or discrimination" and prohibits discrimination in a wide range of circumstances, such as employment, travel, and residence. On the other hand, Tanzania recognizes that "enforcement of such provisions has not always being successful due to cultural and religious beliefs among members of the societies,"[22] and that that there is a "high level of stigma in various sectors and even more in health facilities, hindering access to prevention and treatment for People Living with HIV."[23]

17. The government of Tanzania has a duty to continue to work against such discriminatory attitudes through education and awareness-raising campaigns, as well as by full enforcement of the HIV and AIDS Act provisions against discrimination. It should also review its laws and policies to ensure they do not contribute to discrimination and societal stigma. For example, the HIV/AIDS Act criminalizes the transmission of HIV, with a punishment of life imprisonment.[24] The law contributes to the stigmatization of persons living with HIV and encourages persons living with HIV to hide their status, or to refrain from testing in the first place, for fear of the legal ramifications of unintentional transmission.

IV. The Rights of Women and girls

18. In addition to the biomedical prevention elements discussed above, protection of the equality of rights of women and girls is an important part of reducing the risk of HIV transmission. Gender inequality greatly increases the risk of acquiring HIV by women and girls and interferes with the ability of those living with HIV to seek treatment.[25] Women in Tanzania have a higher HIV prevalence estimate than men for each age group, with an overall national HIV prevalence of 6% for women as opposed to 4% for men. [26] The prevalence rate was twice as high among females aged 15-24 than males, and women aged 20-29 were over 2.5 times more like to be seropositive than men in the same age group.[27] Among 15-49 year olds, a statistically significant decline in the HIV rate of 6.3% to 3.9% was observed among men, but not among women.[28]

19. Tanzania cites "Social, economic and political gender inequalities including violence against women" as one of the six key factors shaping the epidemic in the country.[29] Tanzania has previously reported to the Human Rights Council that its laws provide for equal property rights, and its penal code criminalizes various forms of gender-based violence, while national and local plans and policies, including the National Plan of Action for the Prevention and Eradication of Violence against Women, "provided important opportunities to address gender-based violence."[30] Yet traditional practices that place women at a higher risk of HIV continue, including "wife inheritance" by a male relative of

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[22] United Republic of Tanzania Report NCPI 2012, p. 6.
[23] *Global AIDS Response Country Progress Report*, p.17.
[24] Global Criminalisation Scan: Tanzania at http://criminalisation.gnpplus.net/country/tanzania-united-republic.
[25] Eliane Drakopoulos, "UN Committee on Women's Rights Takes Strong Stand on Gender and HIV," 29 July 2013, http://www.pedaids.org/blog/entry/un-committee-on-womens-rights-takes-strong-stand-on-gender-and-hiv. See also: http://www.treatybodywebcast.org/cedaw-55-session-hiv/.
[26] "Tanzania HIV and Malaria Indicator Survey 2011 – 2012 (THMIS III)," March 2013, p. 109.
[27] Ibid, and http://www.unicef.org/infobycountry/tanzania_statistics.html.
[28] *Global AIDS Response Country Progress Report*, p. 4.
[29] See: Tanzania Commission for AIDS, "Tanzania HIV/AIDS and Malaria Indicator Survey 2011-2012," at: http://www.tacaids.go.tz/index.php?option=com_content&view=article&catid=31:hiv-and-aids-information-&id=140:drivers-of-the-epidemic&Itemid=160
[30] United Republic of Tanzania 2011 Report under the Universal Periodic Review.

the deceased husband, female genital mutilation, early or child marriages, and limited property rights for widows.[31]

20. More needs to be done to protect women and girls in Tanzania from physical and sexual violence, a key risk factor for HIV. Intimate partner violence is seen as a "serious public health problem" in Tanzania, with between 41% and 56% of women affected by physical and/or sexual violence by a husband or partner.[32] According to a 2012 UNICEF survey on violence against children in Tanzania, almost one out of three females has experienced some form of sexual violence prior to the age of eighteen.[33]

21. Many women living with HIV are abused psychologically or physically after disclosing their HIV status to their partner due to a societal tendency to blame women for bringing HIV into the family. Findings from studies done in Tanzania and other sub-Saharan countries showed that women living with HIV had consistently higher rates of intimate partner violence.[34] Anticipation of such a reaction leads many women to refrain from testing themselves or their children, and may discourage them from adhering to a treatment regime that will give their status away. Even if they have disclosed their status, "approximately 40% of women do not have the final say in decisions regarding their own health, their children's health or their own daily household expenditure," and may not feel empowered to seek or stay on treatment.[35]

22. Tanzania considers intergenerational sex to be one of the five key drivers of the HIV/AIDS epidemic in Tanzania.[36] Such relationships are more prevalent when girls drop out of school early or are forced into transactional sex for economic reasons. While girls' attendance of primary school in Tanzania is high (98%), attendance rates dropped to 24% for secondary education in 2008-12.[37] A lack of economic opportunities for such girls, especially those who have lost one or more parents to AIDS-related illness, may push them into transactional sex, prostitution, or other relationships with older men.

23. Another HIV risk factor for girls is the continued practice of early and forced marriage. Under the Marriage Act of 1971, in Tanzania girls may marry at the age of 15, whereas the minimum age of marriage for boys is 18.[38] Research shows a strong correlation between rates of HIV/AIDS and rates of early school dropout, teenage marriage and pregnancy. In recognition of the discriminatory nature of this provision, the impact of early marriage on girls' development, and the increased risk from early marriage of acquiring HIV/AIDS, the government is reportedly reviewing the law with a view to increasing the minimum age of marriage for all to 18.[39] Yet the government has observed that "Reviewing the age of marriage has been a challenge for years due to some traditional and religious stands."[40]

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[31] Tanzania Third National Multi-Sectoral Strategic Framework for HIV and AIDS (2013/14 – 2017/18), p. 11.
[32] USAID, "Intimate Partner Violence and Empowerment among Women in Tanzania: Prevalence and Effect on Utilization of Reproductive and Maternal Health Services," 2014 Demographic and Health Surveys No. 106, p. 2.
[33] Tanzania Third National Multi-Sectoral Strategic Framework for HIV and AIDS (2013/14 – 2017/18), p. 10.
[34] Maman S, Mbwambo JK, Hogan NM, et al. "HIV-positive women report more lifetime partner violence: findings from a voluntary counseling and testing clinic in Dar es Salaam, Tanzania," *Am J Public Health* 2002; 92: 1331–37.
[35] Tanzania Third National Multi-Sectoral Strategic Framework for HIV and AIDS (2013/14 – 2017/18), p. 9.
[36] See Tanzania Commission for AIDS, "Tanzania HIV/AIDS and Malaria Indicator Survey 2011-2012," at: http://www.tacaids.go.tz/index.php?option=com_content&view=article&catid=31:hiv-and-aids-information-&id=140:drivers-of-the-epidemic&Itemid=160
[37]UNICEF Statistics, United Republic of Tanzania: http://www.unicef.org/infobycountry/tanzania_statistics.html
[38] Equality Now, "The Law of Marriage Act, 1971, as amended by Act 23/73, Act 15/80 and Act 9/96" at http://www.equalitynow.org/law/the_law_of_marriage_act_1971_as_amended_by_act_2373_act_1580_and_act_996
[39] IRIN, "Tanzania govt to amend girls' age consent for marriage," http://www.afrol.com/articles/22560.
[40] Tanzania Report to CEDAW, December 2014, p.11.

V. Proposed Recommendations

Based on the analysis above, the Elizabeth Glaser Pediatric AIDS Foundation would like to propose the following recommendations for consideration by Human Rights Council members:

1. Ensure adequate domestic and international support for the national HIV/AIDS response, with particular attention to preventing mother-to-child HIV transmission throughout the pregnancy and breastfeeding period and to providing adequate diagnostics, treatment, and care for children exposed to or living with HIV.
2. Take further steps to improve access to high-quality, age-appropriate sexual and reproductive health care services, including increased availability of commodities to prevent pregnancy and sexually transmitted diseases such as HIV and higher rates of deliveries at health facilities, especially for women with HIV.
3. Ensure the full implementation of Part VII "Stigma and Discrimination" of the 2008 HIV and AIDS (Prevention and Control) Act and otherwise take steps to improve awareness and sensitivity about HIV/AIDS among all segments of the population, including health care workers.
4. Review all laws and policies and revise or repeal any elements that act as barriers to effective HIV diagnosis, treatment, care, and counseling, such as Section 47 of the 2008 HIV and AIDS (Prevention and Control) Act that criminalizes transmission of HIV/AIDS and the policy establishing 18 as the age of consent for HIV testing and counseling.
5. Take all appropriate measures to end discriminatory laws, policies, and traditional practices against women and girls, including "wife inheritance" and discrimination against rural women with respect to inheritance or ownership of land, and to increase girls' attendance of secondary school.
6. Amend the Marriage Act 1971 to establish a minimum age of marriage of 18 for both girls and boys.
7. Ensure full enforcement of the law prohibiting gender-based violence and the National Plan of Action for the Prevention and Eradication of Violence against Women.