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WORKING PAPER

Children and HIV: Using an evidence-based approach to identify legal strategies that protect and promote the rights of children infected and affected by HIV and AIDS

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"No child should be born with HIV; no child should be an orphan because of HIV; no child should die due to lack of access to treatment."

- Ebube Sylvia Taylor, an eleven year old born free of HIV, to world leaders gathered in New York to share progress made towards achieving the Millennium Development Goals by 2015[2]

1. Introduction

Around 2.5 million children across the world are living with HIV, according to the latest Joint United Nations Programme on HIV and AIDS (UNAIDS) *Report on the global AIDS epidemic 2010*.[3] These statistics demonstrate the ongoing need to increase access to HIV-related prevention, treatment, care and support services for children of all ages, targeted at the particular needs of individual children based on their age, capacity, gender as well as other characteristics or circumstances which may place individual children at increased risk of HIV exposure. These statistics also illustrate only one aspect of a larger burden borne by children and young people in the context of HIV and AIDS – children may be living with affected parents, caregivers, and siblings or in affected communities, and may be feeling the impact of HIV and AIDS on family resources and resilience.

Creating appropriate legal and policy responses to HIV for children requires a commitment to realising children's rights, an understanding of the impact of HIV on the rights of children of different ages, characteristics and circumstances, and finally an understanding of how current laws and policies, both positive and negative, impact on children's needs in the context of the HIV epidemic.

1 UNAIDS, (2010), UNAIDS report on the global AIDS epidemic 2010, Foreword, available from www.unaids.org [Accessed: 16 May 2011].

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3 UNAIDS, (2010), *UNAIDS report on the global AIDS epidemic 2010,* foreword, available from www.unaids.org [Accessed: 16 May 2011], p.23.

1.1 Background to children's rights in the context of HIV

The Convention on the Rights of the Child[4] (CRC) defines a child as a human being below the age of 18 years.[5] The CRC has served to create a clear normative framework for state responsibilities to realise children's rights.[6] The Convention has brought about a new international understanding of children's position in society and of the role of the law in providing a framework for the realisation of children's rights. Where previously, the law primarily viewed children as a vulnerable population in need of control and protection from harm, the CRC recognises children themselves as rights-holders who are entitled to participate in society to the extent that their evolving capacities allow. In this framework, the law should reflect the state's responsibility to realise children's right to freedom from discrimination, provide for their survival and development to the fullest extent possible, promote their best interests and allow for children's participation in all matters affecting their rights.[7]

State parties to the CRC are required to create national legal frameworks that are compatible with the CRC and that provide for the rights of the child. This requires the review and possible amendment of all national laws and policies that impact on aspects of children's lives and their relationships with others, including those relevant in the context of children and HIV, as well as measures to ensure the implementation of children's rights (such as the creation of relevant institutional structures, data collection, awareness raising and training, and the development of appropriate policies and programmes).[8] Regional human rights instruments and documents (for example, Article 1(1) of the African Charter on the Rights and Welfare of the Child) also exhort states to take active measures to review and reform law to give effect to the rights of the child.

In the context of HIV, rights-based law and policy has been seen to play a vital role in creating effective national responses to the epidemic, reinforcing the interdependence of all of a child's basic human rights in reducing, or increasing, his or her vulnerability to HIV. UNAIDS argues that rights violations and limited realisation of rights drive the HIV epidemic and create barriers to accessing HIV-related prevention, treatment and care services: 'HIV transmission is not a random event: the spread of the virus is profoundly influenced by the surrounding social, economic and political environment. Wherever people are struggling against adverse conditions such as poverty, oppression, discrimination and illiteracy, they are especially vulnerable to being infected by HIV.'[9] For example, it has argued that:

- Vulnerable populations such as girl children orphaned by HIV, with restrictive property rights and limited access to education and information, may become dependent upon male sexual partners for economic survival. This may place affected girl children in a position where they are unable to negotiate safer sex.
- Children living with HIV may fear HIV-related stigma and discrimination, discouraging them from disclosing their HIV status to carers and sexual partners, further limiting their access to prevention, treatment, care and support services.
- Children who are denied the right to access confidential sexual and reproductive health services independently of their parents may choose not to use health care services, thereby denying them the opportunity to access vital health care.[10]

Against this background the United Nations (UN) Committee on the Rights of the Child, General Comment No. 3[11] has identified the following broad-based legal strategies that ought to be used as part of a comprehensive response to dealing with the impact of HIV and AIDS on children:

- *Non-discrimination:* Laws, policies, strategies and practices should address all forms of discrimination that contribute to increasing the impact of HIV and AIDS. This includes HIV-related stigma and unfair discrimination, as well as inequality and human rights violations that increase the risk of HIV exposure amongst already vulnerable and marginalised populations.

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4 United Nations General Assembly, *Convention on the Rights of the* Child, 20 November 1989. available at www.unhcr.org [Accessed: 21 July 2011].

5 See further, Article 2 of the Organisation of African Unity (OAU), (1990), *African Charter on the Rights and Welfare of the Child*, CAB/LEG/24.9/49, available from www.unhcr.org [Accessed: 21 July 2011]. The CRC nevertheless recognises the evolving capacity of the child, and that children may have legal capacity to conduct certain legal acts at various ages before adulthood.

6 Sloth-Nielsen, J. & Mezmur, B.D., (2007), *Surveying the research landscape to promote children's legal rights in an African context*. African Human Rights Law Journal 2007(2). p.331.

7 UNICEF, (2008), *Assessing Compliance of National Legislation with International Human Rights Standards*. New York, USA.

8 United Nations Committee on the Rights of the Child, *General Comment No.5*, CRC/GC/2003/5, 27 November 2003.

9 UNAIDS, (2004), *2004 Report on the global AIDS epidemic*, Geneva, Switzerland.

10 See, for example, OHCHR and UNAIDS, (2006), *International Guidelines on HIV/AIDS and Human Rights, a*vailable at www.unaids.org [Accessed 18 May: 2011]. See also UNAIDS, (2004), *2004 Report on the global AIDS epidemic*, Geneva, Switzerland.

11 United Nations General Committee on the Rights of the Child, *General Comment No.3 (2003)*: *HIV/AIDS and the rights of the Child*, CRC/GC/2003/3, 17 March 2003.

- *Survival and Development*: Laws, policies and programmes should give children opportunities to survive to adulthood and to develop to the fullest extent possible. In the context of HIV, this requires laws and policies to realise children's rights and access to services to protect them from HIV, to provide for the needs of children and young people affected by HIV, as well as to prohibit harmful practices that increase a child's risk of HIV exposure.
- *Participation:* Laws and policies should provide for the rights of children and young people to participate, in accordance with their evolving capacities, in responses to HIV and AIDS. Mechanisms should be created to encourage children to express their views, and have their views considered in accordance with their age and maturity.
- *The Best Interests of the Child*: Finally, laws, policies and programmes should be adapted to ensure that responses to HIV and AIDS prioritise a child's best interests, rights and needs.

In addition to the CRC, the Office of the High Commission for Human Rights and UNAIDS *International Guidelines on HIV/AIDS and Human Rights*,[12] a number of states have subsequently made global and regional statements committing to rights-based responses to the HIV epidemic, including for affected children. The UN Political Declaration on HIV/AIDS of 2006 commits states to 'addressing the rising rates of HIV infection among young people to ensure an HIV-free future generation through the implementation of comprehensive, evidence-based prevention strategies, responsible sexual behaviour, including the use of condoms, evidence- and skills-based, youth-specific HIV education, mass media interventions and the provision of youth-friendly health services'. [13] It also commits states to 'addressing as a priority the vulnerabilities faced by children affected by and living with HIV; providing support and rehabilitation to these children and their families, women and the elderly, particularly in their role as caregivers; promoting child-oriented HIV/AIDS policies and programmes and increased protection for children orphaned and affected by HIV/AIDS; ensuring access to treatment and intensifying efforts to develop new treatments for children; and building, where needed, and supporting the social security systems that protect them'[14]

1.2 Complexities of using a rights-based approach in responding to children infected and affected by HIV

There are many complexities in using a rights-based approach in responding to children affected by HIV. Three of the most significant issues in this regard are, firstly, children are not a cohesive group. Laws and policies need to take into account the individual needs, circumstances and capacities of different children. Children evolve through distinct developmental stages, including infancy (0–6 years), middle childhood (6–10 years), early adolescence (10–14 years) and late adolescence (14–18 years).[15] These developmental stages require legislators to consider both the evolving capacity of children as they develop cognitively as well as their different vulnerabilities. This has implications for, amongst others, considerations of the point at which children have the capacity to consent independently to various medical interventions.

Secondly, the evolving capacity of the child is linked to the principle of child participation. The CRC recognises that children are the bearers of rights and, as such, ought to participate in decisions that affect them in accordance with their evolving capacity.[16] This requires a consideration of how children can be involved in decision-making both when they have capacity and in circumstances where they require assistance.

Thirdly, children are a vulnerable group that requires protection. Accordingly the CRC requires the best interests of the child to be a primary consideration in decisions that affect them.[17] It also obligates parents and families, in the first instance, to protect children and guide their decision-making.[18] This requires legislators to recognise the role played by third parties in the child's life. For example, protecting children from the harm caused by discrimination requires a recognition that discrimination may occur due to a parent or caregiver's HIV status and laws need to be broad enough to encompass this concern. Furthermore, protecting children from harm within a rights-based approach requires a careful balancing of a number of competing interests. Protection may conflict with access and vice versa. This requires a consideration by legislators of the most appropriate means of recognising a child's evolving capacity within an environment that nevertheless protects them from their youthfulness and lack of experience.

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12 OHCHR and UNAIDS, (2006), *International Guidelines on HIV/AIDS and Human Rights, a*vailable at www.unaids.org [Accessed 18 May: 2011]

13 United Nations General Assembly, *Political Declaration on HIV/AIDS*, Res 60/262, 15 June 2006.

14 *Ibid*, Article 32.

15 Zinner, S., (2004), *The role of cognitive development in paediatric medical decision-making*,Global Virtue Ethics Review Vol 5(1) pp.22–23.

16 United Nations General Assembly, *Convention on the Rights of the* Child, 20 November 1989. available at www.unhcr.org [Accessed: 21 July 2011], Article 12.

17 *Ibid*, Article 3

18 *Ibid, Article 5*.

1.3 Overview of the paper

In this paper, the impact of HIV and AIDS on children forms the backdrop for an examination of the role of human rights, law and policy in responding to HIV and AIDS for children and adolescents below the age of 18 years. While it cannot hope to deal with all child-related HIV law and policy issues, the paper examines a number of key issues that have been identified as posing potential barriers to effective responses for children in the context of HIV and AIDS. These have been clustered into three over-arching themes:

- Stigma and discrimination;
- Care, support and protection of children including; guardianship, birth registration, models of care, social protection for children, inheritance and property rights; and
- Access to sexual and reproductive health services including; age of consent to prevention, treatment, care and support services, access to treatment and care and access to harm reduction measures.

The issues selected reflect the areas in which legal complexities as well as law enforcement and implementation problems continue to exist, and in which many countries are still trying to grapple with, in establishing an appropriate legal and policy framework.

In this report an attempt has been made to reflect on the diversity of legal approaches to these issues across the globe and to describe the impact of these laws and policies on children in the context of HIV and AIDS. This has been done through an examination of relevant literature on impactto establish evidence of effective responses. An analysis of the law and its impact leads to recommended strategies for strengthening an enabling legal and regulatory framework that protects and promotes the rights of all children and young people in the context of the international guidance.

2. Children and HIV and AIDS

Most countries in the world define a child as a person below the age of 18 years,[19] although legal systems increasingly recognise the evolving capacity of children as they grow older, as well as the fact that children may reach legal adulthood due to factors other than age, such as marriage, the formation of a separate home or initiation.[20]

According to the *UNAIDS Report on the global AIDS epidemic 2010*, there were 33.3 million people living with HIV at the end of 2009. South Africa has the largest epidemic in the world, with an estimated 5.6 million people living with HIV in 2009. Of the global total of people living with HIV in 2009, 2.5 million are children, the large majority of which live in sub-Saharan Africa. The number of people living with HIV has increased in recent years with a reduction in AIDS-related deaths due to antiretroviral therapy (ART).[21]

However, there continues to be definite progress in reducing the HIV incidence and impact of HIV on adults and children. An estimated 370,000 children contracted HIV during the perinatal and breastfeeding period in 2009, down from 500,000 in 2001, due to increased access to services to prevent mother-to-child transmission (PMTCT) of HIV. A further 260,000 children below the age of 15 years died from AIDS in 2009 – 19% fewer than the estimated 320,000 children who died in 2004. In southern Africa there were 32% fewer children below the age of 15 years infected with HIV, and 26% fewer AIDS-related deaths in 2009 than in 2004. Recent research among young people provides further evidence of decreasing incidence and safer sexual behaviour, such as increased condom use, delayed sexual debut, and reductions in multiple partnerships. Seven countries showed a decrease of 25% or more in HIV prevalence among young pregnant women attending antenatal clinics in 2008. An additional 1.2 million people received ART in 2009 so that by the end of 2009 an estimated 36% of the 15 million people in need in low- and middle-income countries were receiving ART. The number of children younger than 15 years receiving ART increased by around 29% in the same year.[22]

Despite recent advances, there remain a number of ongoing challenges for managing the impact of HIV and AIDS on children and adolescents:

Number of orphaned children: The total number of children who have been orphaned (that is, have lost one or both parents[23]) as a result of HIV has increased from 14.6 million in 2005 to 16.6 million in 2009. Almost 90% of orphaned

19 South African Law Reform Commission, (2007), *Review of the Child Care Act*, Discussion Paper, 103, Project 110 available from www.justice.gov.za [Accessed: 30 May 2011].

20 *Ibid*.

21 UNAIDS, (2010), *UNAIDS report on the global AIDS epidemic 2010.*

22 *Ibid.*

23 UNICEF, (2004), *The Framework for the Protection, Care and Support of Orphaned and Vulnerable Children Living in a World with HIV and AIDS*, New York, USA.

children live in sub-Saharan Africa, and there are more than nine million orphans due to AIDS in six African countries – Kenya, Nigeria, South Africa, Uganda, United Republic of Tanzania, and Zimbabwe. More than 10% of all children have been orphaned by HIV in Zimbabwe (16%), Lesotho (13%), and Botswana and Swaziland (12%).[24] For these children, the loss of parental care when a parent is ill or dies from AIDS may result in loss of family income, increased medical expenses, poverty, diminished school attendance, children being required to care for a family member with AIDS or to work to support the family, as well as emotional distress, stigmatisation and marginalisation. This further heightens the children's vulnerability and their own risk of HIV exposure, especially for children who are forced into situations of increased vulnerability, such as living on the streets or survival sex. Young girls may be disproportionately affected due to the increased risk of additional care responsibilities, reduced access to educational opportunities, early marriages, or sexual relationships with older men, transactional sex and sexual violence.

There have been important gains in decreasing the impact of orphanhood on affected children (with recent research showing that children orphaned by AIDS were *nearly as likely* to attend school as other children). Informal and formal systems and networks to support children orphaned by HIV have been important contributions to the response. However, most households caring for children affected by HIV are still not accessing any external care and support.[25]

Prevention: Knowledge and understanding of HIV has increased among young people (young people are generally categorised in reports on AIDS statistics as people aged 15–24 years), but is still far below United Nations Generally Assembly targets of 95%. Although young people in 25 of the countries with the highest HIV prevalence showed improved knowledge of HIV, less than half of young people living in 15 of those countries can correctly answer five basic questions about HIV and its transmission (these include Botswana, Burundi, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Guinea-Bissau, Kenya, Malawi, Nigeria, South Africa, Togo, United Republic of Tanzania and Zambia).[26] Adolescents still have inadequate access to the products and services they need to practice HIV risk-reduction strategies, and the special needs of adolescents at higher risk (for example from drug use, sex work, or unprotected sex between men) are not adequately addressed.[27] In Eastern Europe and Central Asia, one-third of all new HIV infections are amongst young people aged 15–24 years; a large proportion of these infections are linked to injecting drug use, sex work and sex between men, including between boys below the age of 18 years. Yet HIV programming focuses on 'mainstream' interventions, many of which fail to address the specific risk behaviours and environments of especially vulnerable populations.[28] For example, in Asia, 90% of resources for young people are spent on 'low-risk' youth, who represent just 5% of the people becoming infected with HIV.[29] Likewise, there are few programmes targeting boys to address HIV, sexual and reproductive health and gender-based violence.[30] Adolescents may be at higher risk of HIV exposure where they have limited independent access to HIV education, information and prevention technologies.[31] Despite gains in reducing mother-to-child transmission of HIV, PMTCT services are being held back by poor access to antenatal and postnatal services in many countries, and still need to be scaled up further.[32]

Access to treatment, care and support: Children living with HIV need a range of health-care and social services to manage the impact of HIV on their lives at different ages and at different stages of their illness. However, research shows that children and marginalised populations are less likely to receive treatment (specifically, ART) than the population at large.[33] In 2009, 28% of children in need received ART, compared with 37% of adults, and in sub-Saharan Africa (where an estimated 90% of the world's children live) access to ART is slightly below this global average, with a number of countries reporting far lower ART coverage for children than adults.[34] This requires responses that support parents and caregivers of infants and young children to access treatment, care and support services on their behalf, as well as to support adolescents to access HIV-related treatment, care and support services on their own.

Girls: Slightly more than half of all people living with HIV are women and girls. In nearly all countries in sub-Saharan

24 UNAIDS, (2010), *UNAIDS report on the global AIDS epidemic 2010.*

25 *Ibid*.

26 *Ibid*, p.68.

27 *Ibid*.

28 UNICEF, (2010), *Blame and Banishment*, New York, USA.

29 UNAIDS, (2010), *UNAIDS report on the global AIDS epidemic 2010.*

30 *Ibid.*

31 UNICEF, (2007),*Enhanced Protection for Children Affected by AIDS: A Companion Paper to the Framework for Protection, Care and Support of Orphaned and Vulnerable Children Living in a World with HIV and AIDS,* New York USA available from www.aidslex.org, [Accessed: 18 May 2011]; UNICEF, (2007), *Supporting the Realisation of Children's Rights through a Rights-Based Approach to Legislative Reform: Programming Guidance Paper Service: Working Paper,* New York, USA; Foster, G. & Williamson, J., (2000), *A review of current literature of the impact of HIV/AIDS on children in sub-Saharan Africa* AIDS 2000, 14 (suppl.3), p.S275-S284.

32 UNAIDS, (2010), *UNAIDS report on the global AIDS epidemic 2010.*

33 *Ibid*.

34 *Ibid*.

Africa and in certain Caribbean countries, the majority of people living with HIV are women, especially girls and women aged 15–24 years.[35] In sub-Saharan Africa, young women aged 15–24 years are as much as eight times more likely than men to be HIV positive.[36] A study by the World Health Organisation on women and health highlighted the role of gender inequalities in increasing women's risk of HIV exposure. It also found that many women have traumatic first experiences of sexual intercourse, with the prevalence of forced first sex among adolescent girls younger than 15 years ranging between 11% and 45% globally.[37] In Swaziland, which has one of the highest levels of HIV prevalence, a 2007 study showed that 33% of females 13–24 years old reported experiencing some form of sexual violence before reaching 18 years of age.[38] Adolescent girls face "double discrimination" on the basis of their age and gender where HIV-related law, policy and programmes fail to meet their particular needs as girls and as children.

3. Stigma and discrimination as barriers to the accessing of services

High levels of HIV-related stigma and discrimination continue to be experienced across the globe.[39] HIV-related discrimination often occurs within the context of multiple layers of other forms of discrimination. In particular, many children affected by HIV also face discrimination due to, amongst others, gender, sexual orientation and poverty. Stigma and discrimination affect children in a variety of different ways. Firstly, it may affect children of various ages differently, for example, homosexual adolescents may face discrimination due to their sexual orientation whilst with neonates discrimination is more likely to flow from their mother's HIV status. Secondly, children may face stigma and discrimination because of their own HIV status or because of the HIV status of a family member. In this context, HIV-related and other forms of discrimination may deny children benefits and opportunities or impose burdens and obligations on them.

Article 2 of the CRC provides that every child has the right to be free from discrimination in the enjoyment of any other rights. Although it doesn't list HIV status as a ground of non-discrimination the Committee on the Rights of the Child has interpreted the words 'other status' within the Article to include the HIV/AIDS status of the child or their parents.[40]

3.1 Diversity of legal approaches to stigma and discrimination

Initial legal responses to outlawing HIV discrimination used disability legislation. A number of cases in the US, Canada and Australia all established precedents that provided that persons infected with HIV were entitled to be protected by prohibitions outlawing discrimination against people with disabilities.[41] Subsequently, countries throughout the world have adopted legislation which expressly prohibits unfair discrimination against People Living with HIV or AIDS. Table 1 below shows that 123 countries out of 168 reviewed by UNAIDS reported that they had passed legislative measures to outlaw discrimination. In other words, 73.2% of countries have indicated that they have outlawed unfair discrimination based on a person's HIV status.

Table 1: Legislative measures to prohibit unfair discrimination[42]

Region / HIV Protection	East & Southern Africa	West & Central Africa	Middle East & North Africa	Caribbean	Latin America	Eastern Europe & Central Asia	N America and West/ Central Europe	Asia	Oceania	Total
Yes	14	17	10	6	18	18	21	10	9	**123**
No	6	6	5	7	2		3	12	4	**45**
Total	20	23	15	13	20	18	24	22	13	168

Source: UNAIDS Snapshots laws that support or block universal access to HIV prevention, treatment, care and support, 2010.

35 *Ibid.*

36 *Ibid.*

37 *Ibid.*

38 *Ibid.*

39 *Joint Action for Results: UNAIDS Outcome Framework 2009 -11* available from http://data.unaids.org/pub/Report/2010/jc1713_joint_action_en.pdf [Accessed: 3 June 2011].

40 Committee on the Rights of the Child (2003) General Comment No. 3, para 9 available from http://www1.umn.edu/humanrts/crc/comment3.htm [Accessed: 29 June 2011].

41 See for example, *Bragdon v Abbott* (1998) 524 US 624 and *Quebec (Commission des droits de la personne et des droits de la jeunesse) v Montreal (City)* 2000 SCC 27.

42 This table is based on information extracted from the *Making the Law Work for the HIV Response: A snapshot of selected laws that support or block universal access to HIV prevention, treatment, care and support*, UNAIDS, 2010, available from http://www.unaids.org/en/media/unaids/contentassets/documents/priorities/20100728_HR_Poster_en-1.pdf [Accessed: 3 June 2011].

With regard to children it appears that four legal strategies have been adopted. Firstly, some countries have general prohibitions of unfair discrimination which protect the right to equality of all persons. For example, the *Equality Act* in the United Kingdom which prohibits discrimination on various grounds such as disability and sexual orientation.[43] Secondly, a number of countries have HIV specific anti-discrimination measures which prohibit discrimination, for example, the Tanzanian *HIV/AIDS Prevention and Control Act* of 2008 provides that no person may discriminate against persons living with HIV or AIDS.[44] Thirdly, some countries have passed child-specific protections against unfair discrimination. For example, the South African *Children's Act* prohibits any discrimination based on a child's 'health status'.[45] Likewise in Haiti, Article 17 of the Statute on Non-Discrimination provides that all 'children are equal before the law, and have the right without any discrimination to exercise these rights recognised by this code, the Convention on the Rights of the Child and other international instruments ratified by the Republic of Haiti'.[46] Fourthly, a limited number of countries have HIV specific provisions which protect infected and affected children such as s. 32 of the Ugandan *HIV and AIDS Prevention and Control Bill*, which provides that no educational institution shall discriminate against any person on the grounds of their actual or perceived HIV status.[47]

3.2 Impact and enforcement of these legal approaches

Although most countries have legislation prohibiting discrimination due a person's real or perceived HIV status very little of this legislation is child specific. This is problematic as it has been argued that children may experience both stigma and discrimination differently to adults. [48] With regard to stigma Deacon and Stephney argue that this is because children are still 'developing cognitively, physically and socially and may interpret, express and react to stigma in different ways'.[49] This is borne out by a 2008 study of South African children which included AIDS orphans, non-AIDS orphans and non-orphans. Within the AIDS-orphan group a staggering 47% reported distress from incidents of bullying which appeared to be linked to their association with the epidemic.[50] Furthermore, a 2001 study by Strode and Barrett Grant found that discrimination impacted on children differently from adults. Within their cohort children reported discriminatory actions as resulting in a deep sense of rejection by both peers and role-models. Discrimination by role-models, which included teachers, was seen to being particularly undermining of their dignity and feelings of self-worth.[51]

Given the evidence of the differences in the way children experience stigma and discrimination it is possible to argue that the lack of a protective legal framework may have a greater impact on them as firstly, it may act as a barrier to the accessing of services. For example, if they engage in behaviours that are contrary to accepted cultural norms or that are illegal, such as underage sex or drug use, they may face higher levels of discrimination than adults and this will impede their access to services. It may also increase their risk of infection with HIV, for example, a 2011 United Nations Children's Fund (UNICEF) study showed that young men who have sex with men in Malawi would have a 20% risk of becoming HIV positive before the age of 24 whilst the risk of HIV infection in the general population was 3.1%.[52] Secondly, children because of their immaturity may allow teasing and isolation to result in them avoiding potential stigmatisation by not using services where their HIV status may become known.[53] Recent literature has confirmed this with studies showing that stigma can exacerbate the material and psychological problems faced by children affected by HIV.[54] In the longer term low self-esteem amongst children can also affect their ability and confidence to interact with, for example, health care workers in accessing services.

3.3 Legal and policy alternatives and recommendations

Guideline 5 of the *International Guidelines on HIV and Human Rights* requires states to enact or strengthen anti-discrimination laws to protect people infected and affected by HIV. If it is accepted that stigma and discrimination impacts on children differently this has a number of implications for law makers aiming to enact anti-discrimination laws. It requires states to consider the impact that HIV and other forms of discrimination have on children and to

43 S 4, *Equality Act* (2010) c.15 available from http://www.legislation.gov.uk/ukpga/2010/15/introduction [Accessed: 30 June 2011].

44 S 28, Act No. 28 of 2008, Tanzania.

45 S 6(2)(d), *Children's Act*, No. 38 of 2010, South Africa.

46 Duncan, B., (2008), *Global Perspectives on Consolidated Children's Statutes*, UNICEF, New York, USA, p.55.

47 *Bill No. 5*, 2010.

48 Deacon, H. & Stephney, I., (2007), *HIV/AIDS, stigma and children: A literature review*, Human Sciences Research Council, South Africa, p.2.

49 *Ibid*.

50 Cluver, L. & Orkin, M., (2009), Cumulative risk and AIDS-orphanhood: Intersections of stigma, bullying and poverty on child mental health in South Africa, *Social Science and Medicine* 69 p.1188.

51 Strode, A. & Barrett-Grant, C.J., (2001), *The role of stigma and discrimination in increasing the vulnerability of children and youth infected and affected by HIV/AIDS*, Save the Children (UK), South Africa, p.23.

52 UNICEF, (2011), *Opportunity in a crisis: Preventing HIV infection from early adolescence to young adulthood*, New York, USA, p.6.

53 Strode, A. & Barrett-Grant, C.J., (2001), *The role of stigma and discrimination in increasing the vulnerability of children and youth infected and affected by HIV/AIDS*, Save the Children (UK), South Africa, p.18.

54 Deacon, H. & Stephney, I., (2007), *HIV/AIDS, stigma and children: A literature review*, Human Sciences Research Council, South Africa, p.3.

develop protective laws that specifically address issues relevant to children such as outlaw discrimination in accessing education. Accordingly, it is recommended that countries enact child-specific laws to prohibit discrimination. Laws should recognise the diverse forms of discrimination that affect children of different ages. They should also address the possibility of the discrimination occurring not from the child's HIV status but from a family member. States should raise awareness about these laws among public officials and the public at large, enforce these laws, and monitor their implementation.

4. Care, support and protection of children

4.1 Guardianship of children

The law generally views children as a vulnerable population, lacking in decision-making capacity and in need of protection and care from their youthfulness and inexperience. As a result, most legal systems provide competent adults with responsibilities for children in their care and with legal capacity to act on behalf of these children until such time as children are legally recognised as capable of doing so themselves. The legal recognition of children's evolving capacity may provide children with the right to take various decisions independently of an adult as they grow older (e.g. such as consent to an HIV test); however, children remain under the general care of their guardian until such time as they reach legal majority.

'Guardianship' and related laws dealing with the status of children and the legal relationship between children and their parents or caregivers are thus vital to ensuring that a child has a person responsible for their care, is able to access basic services and is supported with decision-making where he or she lacks capacity. All children benefit from having a legally recognised guardian. In the context of HIV and AIDS, younger children living with HIV may require the consent of a guardian to access services such as HIV testing, prevention and treatment. Children affected by HIV may require the consent or support of a guardian to access social support services, such as social grants. Simultaneously, many children may have lost their parent/s and natural guardian/s and may be living in diverse family systems and households, such as being cared for by relatives, extended family members or members of the community, or in formal and informal 'foster care' arrangements. UNICEF has found that in 'nearly every sub-Saharan country, extended families have assumed responsibility for more than 90 percent of orphaned children' despite the great economic strain this has caused most households.[55] In the worst case scenario, children or their older siblings may themselves have taken on care-giving roles. This means that in many cases, children may be living with carers who are not formally appointed and recognised legal guardians with rights and responsibilities.

As a result, in the context of the HIV epidemic, it is vital that guardianship laws provide clear guidance to ensure that all children are provided with alternative family care, in the absence of a parent or legal guardian (this is dealt with in more detail in the social protection section below) and that the person providing such care has responsibilities that are recognised and set out in law. In particular:

- The responsibilities of a child's guardian are clearly defined and are in keeping with the need to recognise the evolving capacity of the child, so that children are able to access HIV-related prevention, treatment, care and support services with the support of a guardian (or able to participate in decision-making independently, where they have the capacity to do so);
- Legal provision for the transfer of guardianship to persons other than parents is clearly provided for, and respects the principle of the best interests of the child, so that where a child loses a guardian, an appropriate and legally recognised guardian may be appointed; and
- The rights of *de facto* caregivers of children are recognised in law, where appropriate, so that all children have a caregiver who is able to provide the requisite care, access services such as grants and provide legal decision-making on behalf of a child.

The United Nations General Assembly Resolution 64/142 Guidelines on the Alternative Care of Children[56] provide, amongst other things, that:

- All children should be provided with alternative care in the absence of parental care. Decisions regarding alternative care should take into account the views of the child, and should promote the best interests of the child;
- Where children without parental care are cared for informally by relatives or others, states should take steps to ensure their protection and welfare while in informal care arrangements including the legal recognition of such

55 UNICEF, (2003), *Africa's Orphaned Generations*. New York: United Nation's Children's Fund, available from www.unicef.org [Accessed: 15 May 2010].

56 UNICEF, (2010), *Guidelines on Alternative Care*, G.A. Res 64/142, 24 February 2010.

arrangements to facilitate access to grants and make decisions such as consent to medical treatment; and

- No child should be without the support and protection of a legal guardian or other recognised responsible adult or competent public body.

4.1.1 Diversity of legal approaches to guardianship

Common law, civil law as well as customary law approaches to guardianship generally view the biological parent/s of a child as the 'natural guardian' of the child. In some jurisdictions, the birth of the child in or out of wedlock has an impact on the natural guardian of the child. For example, in South Africa, earlier guardianship legislation vested guardianship of a child equally in both parents of a child born in wedlock, while only the mother of an extra-marital child automatically had these rights – the father could apply to court for guardianship, custody or access. In England and Scotland all mothers and all *married* fathers were natural guardians of a child.[57]

More recently, law reform initiatives in several countries have moved away from the concepts of parents as guardians, and refer to the concept of 'parental responsibilities' towards children in line with Article 5 of the CRC. This concept of parental responsibilities shifts the focus from the exercise of authority over a child, to the parent's duty to act in the interests of, and promote the realisation of, the rights of the child.

The term was first introduced into English law by the *Children Act*, 1989, and was subsequently adopted by the domestic laws of other English jurisdictions such as the Isle of Mann, Northern Ireland and Scotland. Similarly the Australian *Family Law Reform Act*, 1995 amended the *Family Law Act,* 1975 and also adopted the concept of parental responsibilities. This same trend towards talking of parental responsibilities can also be seen in recent child legislation in African countries such as the Uganda *Children Ac*t, 1996, [58] the Kenya *Children's Act* 8 of 2001 and the *Children's Act* 560 of 1998 in Ghana.[59] The South African *Children's Act* 5 of 2010, as with the recently enacted Lesotho *Children's Protection and Welfare Act*, 2011 refer to parental rights and responsibilities as the responsibility and the right to care for a child, maintain contact with a child, act as guardian of a child and maintain the child.[60]

A further shift in guardianship law has been the recognition of the rights, responsibilities and role of caregivers, other than guardians, in providing for a child's needs within a family environment. This shift recognises the fact that the exercise of responsibilities may be taken by *de facto* caregivers of children, and that vesting all responsibility in the child's legal guardian may not support children. These law reform initiatives are particularly useful in the context of HIV, where children (particularly younger children) may lack the assistance of a legal guardian when required to perform various acts, such as providing consent to medical treatment. These legal reforms are furthermore in keeping with the spirit of Article 5 of the CRC, recognising the importance of the family environment as the natural place for the development of children[61] and providing legal recognition for a diversity of family relationships within which children may live throughout the world.[62]

For example, the child law provisions of Azerbaijan, Bulgaria, Ecuador, Iceland, Mali and Uzbekistan provide that institutional care is a measure of final resort for children without family care. The provisions of child care law in Ecuador take account of both the nuclear and extended family system. [63] In New Zealand, the law defines family broadly, and allows for various people to be appointed as additional or substitute guardians for a child.[64] In the Caribbean, given that up to 50% of children may live in single-parent homes and others live in homes with unmarried parents, law reform initiatives have begun to recognise and give rights to domestic unions between men and women other than civil law marriages.[65] In Africa, the *Children's Act*, 1998 in Ghana defines a parent to include those who have taken on parental responsibilities[66] and the Lesotho *Children's Protection and Welfare Act*, 2011 defines a guardian as "any person who, in the opinion of the Children's Court having cognisance of any case in relation to the child or in which the child is involved, is for a time being in charge of and/or has control over the child".[67] The South African *Children's Act 5 of 2010* recognises a broad range of caregivers as capable of exercising parental responsibilities on behalf of a child. Section 1 of the Act defines a caregiver as any person other than a parent or guardian who factually cares for a child, and includes a

57 South African Law Reform Commission, 2002. *Review of the Child Care Act,* Report, Project 110, Pretoria, South Africa.

58 S 7(1), *Children Act*, 1996.

59 S 6(3) *Children's Act* No. 560 of 1998.

60 S 18, *Children's Act* No. 5 of 2010.

61 Duncan, B., (2008), *Global Perspectives on Consolidated Children's Statutes*, UNICEF, New York, USA.

62 South African Law Reform Commission, 2002. *Review of the Child Care Act,* Report, Project 110, Pretoria, South Africa.

63 Duncan, B., (2008), *Global Perspectives on Consolidated Children's Statutes*, UNICEF, New York, USA.

64 South African Law Reform Commission, 2002. *Review of the Child Care Act,* Report, Project 110, Pretoria, South Africa.

65 UNICEF,(2002), Family Law Reform in the Caribbean, *Children in Focus,* 15(1), available from www.unicef.org [Accessed: 19 May 2011].

66 S 124, *Children's Act*, 1998.

67 S 2, *Children's Protection and Welfare Act*, 2011.

foster parent, person caring for a child with the consent of the parent/guardian, person caring for a child in temporary safe care, person at the head of a child and youth care centre, person at the head of a shelter, child and youth care worker where a child is without alternative family care and even the child at the head of a child-headed household. The South African Law Reform Commission's *Review of the Child Care Act*[68] specifically cited the impact of HIV and AIDS on children as a factor considered in the review of the law relating to caregivers. The Act furthermore provides caregivers with the primary responsibility for caring for a child with the power to apply for child support grants, in terms of social assistance legislation.[69] Section 3(5) of the English *Children Act*, 1989 provides that a person who doesn't have parental responsibility, but who cares for a child, may do what is reasonable in the circumstances to protect and promote the child's welfare.

Legal systems provide that guardianship of a child can be transferred in a number of ways, including through the appointment of a guardian in a will, and by an order of court. For example, the English*Children Act, 1989*, the *Children (Scotland) Act, 1995* and the Australian *Family Law Act, 1975* (as amended) contain detailed provisions enabling people other than parents to acquire parental responsibilities, by court order.

Some countries have taken recent steps to simplify the transfer of guardianship, in an effort to recognise the role of adults other than legal guardians in protecting the interests of the child. The South African *Children's Act 5 of 2010* provides that where a parent appoints a guardian for a child in their will, the acceptance of the appointment transfers guardianship, without a court process being required.[70] Section 6 of the Uganda *Children Act*, 1998 provides that where the natural parents of a child die, parental responsibility may be passed on to relatives of either parent, or by way of a care order to a foster parent or the warden of an approved home.

4.1.2 Impact and enforcement of these legal approaches

Recent child law reform initiatives appear to have created increased legal certainty regarding parental responsibilities over children, and they certainly provide legal recognition for a wider range of alternative family relationships. However, there is limited data describing the impact of older or more recent guardianship laws on children living with and affected by HIV and AIDS.

A number of research reports detail the fact that children orphaned by AIDS generally live with extended family members or in informal care arrangements;[71] while this is not linked explicitly to guardianship laws, in many cases we may assume that such children often lack formally appointed legal guardians. Where the law fails to recognise the parental responsibilities of *de facto* caregivers, concerns arise over the lack of support for such children (particularly younger children with no real legal capacity) to exercise decision-making and to realise basic rights, such as access to health care and social protection.

Additionally, research on child-headed households (where children themselves care for younger children) describes the vulnerability faced by these households (including economic hardships, violence, abuse and limited access to health care),[72] although again, this is linked more to the lack of a caregiver in general than the lack of a legally appointed guardian. The South African Law Reform Commission, in its review of the child care legislation in South Africa in 2002, did consider the lack of legal recognition for child-headed households as a concern, in terms of the fact that child-headed households were unable to access social services such as child support grants.[73] Human Rights Watch found that the due to the lack of a supportive legal framework to facilitate legal guardians assuming responsibilities over orphaned children (as well as the lack of birth registration documents for children), orphans in Kenya were vulnerable to property-grabbing by relatives acting under the pretext of guardianship.[74]

4.1.3 Legal and policy alternatives and recommendations

It is vital that children have legally recognised caregivers. However, at present in many countries heavily affected by HIV (such as in sub-Saharan Africa), there is a discordance between cultural and legal concepts of guardianship, whereby children who are absorbed into the extended family are viewed by law as being without legal guardians, since legal

68 South African Law Reform Commission, 2002. *Review of the Child Care Act*, Report, Project 110, Pretoria, South Africa.

69 *Social Assistance Act* No. 59 of 1992 (as amended).

70 S 27(2), *Children's Act* No. 5 of 2010.

71 See, for example, UNICEF, (2003), *Africa's Orphaned Generations.* New York: United Nations Children's Fund, available from www.unicef.org [Accessed: 15 May 2011].

72 See for example, Foster, G., & Williamson, J., (2000), *A Review of Current Literature of the Impact of HIV/AIDS on children in sub-Saharan Africa*, *AIDS* 14 (suppl. 3) 275 – 284; Human Rights Watch, (2008), *A Question of Life or Death: Treatment Access for Children Living with HIV in Kenya*. New York, USA.

73 South African Law Reform Commission, 2002. *Review of the Child Care Act*, Report, Project 110, Pretoria, South Africa.

74 Human Rights Watch, (2001), *In The Shadow Of Death: HIV/AIDS and Children's Rights in Kenya.* New York, USA, available from www.hrw.org , cited in McPherson, D., 2005. *Property Grabbing and Africa's Orphaned Generation: A Legal Analysis of the Implications of the HIV/AIDS Pandemic for Inheritance by Orphaned Children in Uganda, Kenya, Zambia and Malawi.*

procedures for transfer of guardianship have not taken place.

Given the realities of care for children affected by HIV in heavily affected countries, such as in sub-Saharan Africa, it is important that the law recognises the roles and responsibilities of children's *de facto* caregivers, where necessary. This provides caregivers with legal responsibilities over children, and the legal capacity to access services and take decisions on behalf of children in their care.

However, there is limited research on whether recent law reform initiatives relating to parental responsibilities impact positively on children's rights. Laws that simplify transfer of guardianship clearly run the risk of providing legal recognition to inappropriate guardians. Yet formal court procedures for transferring guardianship fail to reflect the lived realities of children in Africa. Research is needed to determine whether more recent laws recognising the parental responsibilities of various caregivers of children, and simplified procedures in law for transferring guardianship over children, promote the best interests of children living with and affected by HIV. Ideally, the law should promote processes that allow for the participation of children themselves in appointing appropriate caregivers. Therefore it is recommended that child-related law and policy be reviewed to ensure that it respects 'the responsibilities, rights and duties of parents or, where applicable, the members of the extended family of community as provided for by local custom, legal guardians or other persons legally responsible for the child to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognised in the present Convention'[75]. In particular:

- Child care law recognises and clarifies the roles and responsibilities of parents (and other caregivers) in promoting the best interests of the child, rather than focusing on 'guardianship' of children;
- The roles and responsibilities of parents and other caregivers set out in law recognise the evolving capacity of the child him or herself;
- Research is conducted on law reform initiatives aimed at providing legal recognition for a broad range of caregivers and providing for transfer of guardianship through mechanisms other than court appointments, to determine whether such law reform initiatives protect and promote the best interests of the child in the context of HIV and AIDS.

4.2 Access to social protection

HIV and AIDS can propel individuals and families into poverty as they may face, amongst others, increased medical or burial costs, loss of income as breadwinners may need to stop work or work less, and increased household costs as orphans need to be absorbed into the family. [76] There is extensive evidence of this economic impact on families, for example, a study of orphans aged 7–14 in Ghana, Senegal, and South Africa found that they lived in poorer households than non-orphans.[77] In Botswana, household surveys have revealed that orphan households generally had fewer assets, poorer housing quality, smaller living spaces, and worse dependency ratios than non-orphan households.[78]

Article 27(1) of the CRC provides that every child has the right to 'a standard of living adequate for the child's physical, mental, spiritual, moral and social development'. An obligation is placed in the first instance on parents and others responsible for the child to 'secure, within their abilities and financial capacities, the conditions of living necessary for the child's development'.[79] However, where parents are unable to meet these responsibilities states 'in accordance with national conditions and within their means, shall take appropriate measures to assist parents and others responsible for the child to implement this right and shall in case of need provide material assistance and support programmes, particularly with regard to nutrition, clothing and housing'.[80]

Social protection aims at reducing poverty and marginalisation of families though the provision of resources when they are unable to provide sufficiently for their families.[81] Given the economic impact of HIV and AIDS on families, social

75 United Nations General Assembly, *Convention on the Rights of the* Child, 20 November 1989. available at www.unhcr.org [Accessed: 21 July 2011], Article 5.

76 Edstrom, J. & Kahn. N., (2009),*Protection and Care for Children Faced with HIV and AIDS in East Asia and the Pacific: Issues, priorities and responses in the region*, UNICEF, Bangkok, Thailand, p.12.

77 Miller, C., (2007), *Children affected by AIDS: A review of the Literature on Orphans and Vulnerable Children*, Centre for International Health and Development, Boston University, School of Public Health, USA, p.11.

78 *Ibid*.

79 United Nations General Assembly, *Convention on the Rights of the* Child, 20 November 1989. available at www.unhcr.org [Accessed: 21 July 2011], Article 27(2).

80 *Ibid,* Article 27(3).

81 Edstrom, J. & Kahn. N., (2009),*Protection and Care for Children Faced with HIV and AIDS in East Asia and the Pacific: Issues, priorities and responses in the region*, UNICEF, Bangkok, Thailand, p15.

protection is increasingly recognised as an essential part of a comprehensive response to HIV and AIDS.[82] There are many links between guardianship, models of care and social protection. In particular access to social protection may be difficult if the adults providing alternative care are not recognised as guardians or care-givers of the child.

Laws and policies form the pillars underpinning social protection.[83] It has been argued that social protection laws and policies can contribute to both the prevention and care of persons infected and affected by HIV. However, evidence on the impact of social protection laws is limited making it difficult to draw conclusions on effectiveness.[84]

4.2.1 Diversity of legal approaches to social protection

A number of countries have legislation which provides for a range of social protection measures such as social services and grants. For example, in Latin America and Eastern Europe, a number of countries have a general government policy to support vulnerable populations.[85]

Many countries also have child-specific forms of social protection, for example, in Africa some countries have legislated broad socio-economic rights within children's statutes, for example, s 10(1) of the Lesotho *Children's Protection and Welfare Act* of 2011 provides that a 'child has a right to access education, preventive health services, adequate diet, clothing, shelter, medical attention, social services or any other service required for the child's development'. Other countries have legislation providing specific services to children, for example, in China the social protection scheme includes the abolition of school fees, medical aid, and minimal living guarantee scheme.[86] Likewise in a number of African countries, primary health care is free or available at low cost to certain sectors of the population, for example, Zimbabwe offers free health care to children under five.[87] Likewise, in Malawi there is free primary school education and grants for books and clothing.[88]Finally, some countries provide cash grants to support children in need such as the Child Support Grant in South Africa which is paid to the primary caregivers of children. Although all these legislative examples result in support being provided to children infected and affected by HIV no examples were found of HIV-specific social protection.

4.2.2 Impact and enforcement of these legal approaches

The evidence relating to social security frequently focuses on the implications or a lack of such measures. There is therefore evidence that when social security does not exist and children do not have food security this impacts on their health. This has a disparate impact on children living with HIV as there is evidence showing good nutrition slows the progression of AIDS and promotes the effectiveness of ART.[89]

There is also a large body of evidence showing that without external support older children may need to leave school to reduce household expenditure, work to supplement the household income or stay at home to care for their sick parents or younger siblings.[90] Research in Asia found that paternal orphans and double orphans were less likely than non-orphans to attend school.[91] Similar studies in Africa estimate that in Sub-Saharan African orphans are 13% less likely to attend school than non-orphans.[92] The loss of educational opportunities has a greater impact on older orphans, with research showing that until the age 11, there is no difference in school attendance between orphans and non-orphans. However, from 11 to 14, orphans have a slightly lower attendance rate than non-orphans.[93] Where states have created rights of universal access to primary school education there is some evidence that the cost of uniforms,

82 Adato, M. & Bassett, L., (2009), *Social protection to support vulnerable children and families: the potential of cash transfers to protect education, health and nutrition*, AIDS Care, S1, p.72.

83 Temin, M., (2010), *HIV-sensitive Social Protection: What does the evidence say?*, UNICEF, Geneva, Switzerland, p.25.

84 *Ibid*.

85 Duncan, B., (2008), *Global Perspectives on Consolidated Children's Statutes*, UNICEF, New York, USA, p.72.

86 Edstrom, J. & Kahn. N., (2009),*Protection and Care for Children Faced with HIV and AIDS in East Asia and the Pacific: Issues, priorities and responses in the region*, UNICEF, Bangkok, Thailand, p.17.

87 SAfAIDS and the Commercial Farmers Union, (1996), *Orphans on Farms: Who Cares? An Exploratory Study into Foster Care for Orphaned Children on Commercial Farms in Zimbabwe,* Harare, Zimbabwe.

88 UNICEF, (1998),*Children in Need of Special Protection Measures: The Growing Needs of Children who have lost Caregivers due to HIV/AIDS: Draft Strategy Paper*, Geneva, Switzerland.

89 Adato, M. & Bassett, L., (2009), *Social protection to support vulnerable children and families: the potential of cash transfers to protect education, health and nutrition*, AIDS Care, S1,p.60.

90 Hunter, S., (1998), *Rethinking Development Paradigms in the Context of Extremely High Mortality in Sub-Saharan Africa*, Report prepared for UNICEF, Geneva, Switzerland.

91 Edstrom, J. & Kahn. N., (2009),*Protection and Care for Children Faced with HIV and AIDS in East Asia and the Pacific: Issues, priorities and responses in the region*, UNICEF, Bangkok, Thailand, p.16.

92 Miller, C., (2007), *Children affected by AIDS: A review of the Literature on Orphans and Vulnerable Children*, Centre for International Health and Development, Boston University, School of Public Health, USA, p.20.

93 *Ibid*.

books, stationery, building funds and levies that have to be met by parents or caregivers remain an obstacle to children affected by HIV attending school.[94]

There is also some evidence of the lack of social support having a disparate impact on girl children.[95]

Even where a social protection system exists, it frequently fails the most vulnerable who are unable to access the support it offers. For example, research in South Africa showed that although social grants were available to the study participants only about 30% of households received such grants.[96] With regard to the foster care grant which was available to persons formally fostering children, the study found that very few households accessed these grants. Reasons for their failure to obtain the grants included a lack of knowledge and assistance with respect to the application process, concern over the length of time involved in applying for the grant, and doubts about the potential success of the application.[97]

4.2.3 Legal and policy alternatives and recommendations

State grants have been identified as a key means to reducing this economic impact on families and supporting orphans and vulnerable children. Adato *et al* find in a study of orphans and vulnerable children in three South African provinces that 'state grants provide a crucial social safety net for orphans, particularly the Old Age Pension and the Child Support Grant'.[98] Recently there has been considerable research into cash transfers as a form of social protection. Studies have shown that where transfers are conditional on, for example, children enrolling in school and achieving an attendance rate of approximately 85% they significantly affected secondary school attendance rates. For example, a study in Mexico found that although the cash transfer system had a minimal impact on primary school enrolment (this was already high) it had up to a 9.3% increase in secondary school enrolment rates.[99]

Accordingly, a number of social protection recommendations are made:

i. Develop legislation which creates a range of social protection grants for families in need. Support should be targeted at the areas in which families require the most assistance, for example, providing cash grants to meet basic household nutrition needs;

ii. Undertake further research into the type of law reform that would be needed to ensure that cash transfers which are currently occurring through social protection grants are linked to key health, education and welfare outcomes such as school attendance and childhood immunisations;

iii. Ensure that education policies provide for free or subsidised education for vulnerable children and that such policies address the barriers created by, amongst other, school uniform policies; and

iv. Reform health legislation so as to provide free health care services to children under five.

4.3 Property rights

Despite constitutional guarantees to the right to property, customary and religious laws and practices on intestate succession in many communities perpetuate gender inequality, and restrict women's rights to own and inherit property.[100] Parents who die of AIDS often die intestate, particularly in African communities. Children are left without rights to their family property specified in a will and as a result their inheritance rights are governed by either statutory or customary laws of intestate succession. This means that children orphaned by AIDS (in particular, younger children who lose a father or both parents to AIDS) are at risk of losing their homes, land and property, where law and policy fail to protect their rights, or the rights of their remaining parent. Widows and their children (and in particular, girl children) may struggle to claim family property due to statutory or customary laws which favour sons and male relatives, or due to 'property grabbing' (defined as the "dispossession of orphans and widowed parents (predominantly women) by relatives and others"[101]), exacerbated by HIV-related stigma towards affected families and weak law enforcement of inheritance

94 SAfAIDS and the Commercial Farmers Union, (1996), *Orphans on Farms: Who Cares? An Exploratory Study into Foster Care for Orphaned Children on Commercial Farms in Zimbabwe,* Harare, Zimbabwe.

95 Akhtur, S., (1996), *Do Girls Have a Higher School Drop-out Rate than Boys? A Hazard Rate Analysis of Evidence from a Third World City*, Urban Studies, Vol 33(1), p.55 and Lloyd, C.B., et al., (2000), *The Effects of Primary School Quality on School Dropout among Kenyan Girls and Boys*, Comparative Education Review, Vol. 44 (2), p.127–128.

96 Adato. M., et al., (2005), *Children in the shadow of AIDS: Studies of vulnerable children and orphans in three provinces in South Africa,* International Food Policy Research Institute, Centre for Latin America Studies and the University of Calgary, p.54.

97 *Ibid.*

98 Ibid. *p.62*.

99 *Ibid.*

100 International HIV/AIDS Alliance, (2010), *Enabling Legal Environments for Effective HIV Responses*, available from www.aidsalliance.org [Accessed: 16 May 2011].

101 McPherson, D., (2005), *Property Grabbing and Africa's Orphaned Generation: A Legal Analysis of the Implications of the HIV/AIDS Pandemic for*

rights.[102] Loss of inheritance serves to increase the social and economic vulnerability of all children, exacerbating the impact of HIV on the lives of children living with HIV and placing affected children at further risk of HIV exposure.[103]

International recommendations on children's rights, as well as those on women's rights, require states to take all appropriate measures to protect the rights of women and children to own and to inherit property.[104] Article 33 of the United Nations Committee on the Rights of the Child General Comment No. 3 (2003) obliges states parties to ensure that both law and practice support the inheritance and property rights of orphans, with particular attention to the underlying gender-based discrimination which may interfere with the fulfillment of these rights. Articles 2 and 5 of the Convention on the Elimination of all forms of Discrimination Against Women require states to take all appropriate measures, including legislation, to abolish customs and practices that constitute discrimination against women.

4.3.1 Diversity of legal approaches to property rights

The law of succession ('inheritance law') sets out the rules regarding the distribution of property on a person's death. Succession can be testate – that is, in terms of a valid will recognised by the law of a country and drawn up by a person before his or her death – or it can be intestate. A person dies intestate where he or she dies without leaving a valid will. The common laws of many countries favour testate succession, allowing a person to choose how to distribute his or her property upon death. However, common law and statutory rules of intestate succession have developed to ensure that a deceased person's male or female spouse, as well as his or her children, receives a fair portion of the deceased estate on a person's death.

However, many people throughout the world are governed by customary laws of inheritance. Customary laws of succession are generally intestate. They provide fixed rules for the distribution of land and livestock, tending to favour group over individual interests, men and male children over women and girl children, and other adults (such as relatives) over children of the deceased. Customary laws relating to succession do not generally provide for consideration of the best interests of the individual child in each circumstance or the impact of the HIV epidemic on children living with and affected by HIV.

Despite constitutional guarantees of the right to equality and non-discrimination, and protection from discrimination on the grounds of sex, gender and age, the constitutions of many countries nevertheless make such protections subject to existing customary laws, such as laws on inheritance. A review of nine Pacific island countries (Marshall Islands, Federated States of Micronesia, Fiji, Papua New Guinea, Solomon Islands, Samoa, Vanuatu, Kiribati and Tuvalu) found that these countries give constitutional status to customary law in relation to land, resulting in women having limited rights to own and to inherit property in many cases.[105] Similar situations apply in many African countries. For instance section 31(2) of the Ugandan Constitution requires Parliament to enact legislation to protect the rights of widows and widowers to inherit the property of their deceased spouse and to have parental rights over their children; however, in terms of section 237(3), land tenure may be regulated by customary law. As a result, the Ugandan *Succession Act* of 1972 protects only usufructary rights to land for widows and their children.[106] Zambia's *Marriage Act* provides non-discriminatory rules for property division between husband and wife for civil law marriages, but the majority of Zambians are married in terms of customary laws.[107]

African customary laws of inheritance may follow matrilineal or patrilineal lines of descent; however, in many areas patrilineal systems prevail. Although the systems of inheritance are more complex than discussed here, patrilineal systems tend to pass land to the eldest son, granting limited usufructary rights to surviving widows.[108] Female children, as well as extra-marital children (born outside of a recognised customary union) are denied the right to inheritance in

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Inheritance by Orphaned Children in Uganda, Kenya, Zambia and Malawi.

102 UNICEF, UNAIDS, (2004), *The Framework for the Protection, Care and Support of Orphaned and Vulnerable Children Living in a World with HIV and AIDS, a*vailable from http://www.aidslex.org/site_documents/CY-0031E.pdf. [Accessed: 19 May 2011); UNICEF, (2007), *Supporting the Realisation of Children's Rights through a Rights-Based Approach to Legislative Reform: Programming Guidance Paper Service: Working Paper,* New York, USA

103 See, for example, Duncan, B., & Brants, C., (2004), *Access to and Control Over Land from a Gender Perspective: A Study Conducted in the Volta Region of Ghana*. Ghana: McPherson, D., (2005), *Property Grabbing and Africa's Orphaned Generation: A Legal Analysis of the Implications of the HIV/AIDS Pandemic for Inheritance by Orphaned Children in Uganda, Kenya, Zambia and Malawi*.

104 United Nations General Committee on the Rights of the Child, *General Comment No.3 (2003)*: *HIV/AIDS and the rights of the Child*, CRC/GC/2003/3, 17 March 2003.

105 International HIV/AIDS Alliance, (2010), *Enabling Legal Environments for Effective HIV Responses*, available from www.aidsalliance.org [Accessed: 16 May 2011].

106 McPherson, D., (2005), *Property Grabbing and Africa's Orphaned Generation: A Legal Analysis of the Implications of the HIV/AIDS Pandemic for Inheritance by Orphaned Children in Uganda, Kenya, Zambia and Malawi*.

107 *Ibid*.

108 *Ibid*. See also Duncan, B., & Brants, C., (2004), *Access to and Control Over Land from a Gender Perspective: A Study Conducted in the Volta Region of Ghana*. Ghana, Human Rights Watch, 2003. *Double Standards: Women's Property Rights Violations in Kenya*. New York, USA, available from www.hrw.org [Accessed: 17 May 2011].

patrilineal systems, on the understanding that they will be provided for by a future husband.[109] Matrilineal systems of customary law suggest a potentially more beneficial system of inheritance for women and children who lose a father due to AIDS, since inheritance passes through the female line; however, in reality the situation is far less straightforward and may still result in tenuous rights for surviving widows against their own male relatives or the female relatives of their deceased husbands.[110] In many parts of sub-Saharan Africa, the only way for a widow to retain household property is if she has no sons,[111] or if she is 'inherited' by one of her husband's male relatives.[112] In addition, other customary laws treat women as minors, limiting their ability to enter into binding legal contracts or to bring matters to court without the consent of a husband.[113] This means that where children lose a father (or both parents) to AIDS, their rights to family property are dependent upon the rights of an eldest son, or on a male relative. Widows, younger children and girl children may have no legal right to inherit property.

In addition to the existence of discriminatory customary laws, courts of African countries show a reluctance to overturn customary law even where it contradicts constitutional guarantees of protection from sex discrimination, particularly in relation to inheritance matters.[114] For instance, in South Africa the Constitution states that customary law is recognised to the extent that it is consistent with the *Bill of Rights*,[115] which includes the right to gender equality.[116] However, in a 2000 case the South African High Court of Appeal case of *Mthembu v Letsela and Another* 2000 (3) SA 867 (SCA), the court rejected the claim of a daughter born out of wedlock to her father's estate, finding against the claim that the rule of primogeniture in intestate succession was unfair discrimination on the grounds of sex or gender. The court also chose not to enquire into the constitutionality of the customary law rule prohibiting inheritance to all children born out of wedlock as a form of discrimination on the basis of birth.

There are a number of more recent, positive examples of constitutional guarantees of children's and women's rights to inheritance (including in South African case law), as well as statutory reforms of laws of succession. These law reforms and judicial responses, while not specifically targeting children living with or affected by HIV, clearly benefit all orphaned and vulnerable children.

For example, Article 22 of the Constitution in Ghana guarantees all spouses a reasonable portion of each other's estate, and requires parliament to enact legislation to regulate the property rights of spouses on death or dissolution of a marriage. The *Intestate Succession Act*, 1985 thus provides equal rights of inheritance between spouses and increased rights for children, irrespective of a person's class, marriage type or lineage system and contrary to the provisions of customary law.[117] The recently enacted Lesotho *Children's Protection and Welfare Act*, 2011 provides that "a child has a right to reasonable provisions out of the estate of a parent, whether or not born in wedlock or orphaned."[118] The Constitution of Malawi, 1996 provides that "any law that discriminates against women on the basis of gender or marital status shall be invalid and legislation shall be passed to eliminate customs and practices that discriminate against women, particularly practices such as… deprivation of property, including property obtained by inheritance."[119] The Wills and Inheritances Act provides that where a husband dies intestate, widows and children must be given a share of the property of the estate, to the exclusion of heirs at customary law. These law reforms provide greater protection for the inheritance rights of all children, irrespective of their gender, who lose a father, or both parents to AIDS.

4.3.2 Impact and enforcement of these legal approaches

Research shows that access to land and property, and by extension laws that facilitate such access, has an important and positive impact on families affected by HIV; it increases food security, household income and family welfare.[120] Widows and child heads of households face severe economic hardships where they lose family property, since resources that

109 McPherson, D., (2005), *Property Grabbing and Africa's Orphaned Generation: A Legal Analysis of the Implications of the HIV/AIDS Pandemic for Inheritance by Orphaned Children in Uganda, Kenya, Zambia and Malawi*.

110 *Ibid*.

111 *Ibid*. See also International HIV/AIDS Alliance, (2010), *Enabling Legal Environments for Effective HIV Responses*, available from www.aidsalliance.org [Accessed: 16 May 2011].

112 McPherson, D., (2005), *Property Grabbing and Africa's Orphaned Generation: A Legal Analysis of the Implications of the HIV/AIDS Pandemic for Inheritance by Orphaned Children in Uganda, Kenya, Zambia and Malawi*.

113 *Ibid*.

114 International HIV/AIDS Alliance, (2010), *Enabling Legal Environments for Effective HIV Responses*, available from www.aidsalliance.org [Accessed: 16 May 2011].

115 S 39(3), Constitution of the Republic of South Africa, 1996.

116 *Ibid*. S 9(3).

117 Duncan, B., & Brants, C., (2004), *Access to and Control Over Land from a Gender Perspective: A Study Conducted in the Volta Region of Ghana*. Ghana:

118 Article 18, Child Protection and Welfare Act, 2011.

119 S 24(2)(c), Constitution of Malawi, 1996.

120 For example, see

would have been available for education, food and health care for family members are diverted to securing shelter, pushing families into extreme poverty. In addition, affected children and families deal with the emotional impact of rejection and abandonment. These impacts further heighten their vulnerability to HIV and AIDS.[121]

It appears that children orphaned by AIDS are extremely vulnerable to losing their rights to family property for various reasons, including the following:

- Discriminatory customary laws of succession, and the strong influence of customary laws and practices even where protective statutory rights exist;
- HIV-related stigma and discrimination against families affected by HIV and AIDS;
- Poor access to justice for children already made vulnerable by their orphaned status; and
- Weak law enforcement mechanisms which fail to adequately protect and enforce the rights of children to inherit property.

McPherson reports that property grabbing from orphans and widows is a serious problem; in Kenya, neither formal laws nor customary laws provide adequate protection once the male head of a household dies, leading to widespread disinheritance and destitution for women and their (especially girl) children.[122]

In Zambia, the ongoing challenge of property grabbing is said to reflect a number of issues, including weaknesses within the statutory Intestate *Succession Act* itself and its incongruence with Zambian customary law.[123] Customary law principles can be reviewed either by the state, or by traditional leaders. For instance, Duncan's study on the current state of matrilineal and patrilineal forms of inheritance in Ghana showed how the nephew inheritance system practiced among the matrilineal Akan communities was adapted due to its detrimental impact on a man's children.[124]

HIV and AIDS has been reported to increase the likelihood of 'property grabbing' for affected widows and children in a number of African countries due to HIV-related stigma and discrimination, the underutilisation of land when family members are ill, and the reduced ability of orphaned children to protect their rights. The practice of 'widow inheritance' is also falling out of use in some communities where a husband dies of AIDS; while the loss of the discriminatory practice may benefit women in various ways, there is no provision for alternative mechanisms to secure their inheritance rights to family property.[125]

Access to justice issues impacting on children's abilities to enforce their inheritance rights are raised in a number of reports. For instance, a 2001 Human Rights Watch report found that children orphaned by HIV in Kenya lost their rights to family property primarily as a result of gaps in the judicial system, which limited consideration of children's property cases.[126] Relatives and caregivers of children orphaned by AIDS struggled to claim children's rights to property due to administrative issues, such as lack of proof of identity of children in their care and due to weak administrative, judicial and traditional systems.[127]

A further problem arises in the application of law by customary systems. Despite the existence of constitutional guarantees and statutory laws of succession in some countries in Africa, many communities continue to regulate land according to traditional systems. In Kenya, the Kenya Legal and Ethical Issues Network (KELIN) worked within traditional legal systems to reinstate disinherited women and children, providing a good example of how customary law can evolve to incorporate human rights principles of gender equality. In terms of Luo customary law in Kenya, the discriminatory practice of 'widow inheritance' provides for a woman to be inherited by a deceased husband's brother or other male relative, in order to ensure that the widow and her children (as well as the deceased's property) remain within the care of the clan. However, particularly where a husband is known to have died from AIDS, a widow and her children may be rejected by the husband's clan. This means that the widow loses her (already limited) rights to her family property as well

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Duncan, B., & Brants, C., (2004), *Access to and Control Over Land from a Gender Perspective: A Study Conducted in the Volta Region of Ghana*. Ghana:

121 McPherson, D., (2005), *Property Grabbing and Africa's Orphaned Generation: A Legal Analysis of the Implications of the HIV/AIDS Pandemic for Inheritance by Orphaned Children in Uganda, Kenya, Zambia and Malawi*.

122 *Ibid* and Human Rights Watch, 2003. *Double Standards: Women's Property Rights Violations in Kenya*. New York, USA, available from www.hrw.org [Accessed: 17 May 2011].

123 *Ibid,* Human Rights Watch, 2002. *Suffering In Silence: The Links between Human Rights Abuses and HIV Transmission to Girls in Zambia,* New York, USA, available from www.hrw.org [Accessed: 19 May 2011].

124 Duncan, B., & Brants, C., (2004), *Access to and Control Over Land from a Gender Perspective: A Study Conducted in the Volta Region of Ghana*. Ghana:

125 McPherson, D., (2005), *Property Grabbing and Africa's Orphaned Generation: A Legal Analysis of the Implications of the HIV/AIDS Pandemic for Inheritance by Orphaned Children in Uganda, Kenya, Zambia and Malawi*.

126 UNICEF, (2007), *Supporting the Realization of Children's Rights Through a Rights-Based Approach to Legislative Reform. Supra.*

127 Human Rights Watch, *In The Shadow Of Death: HIV/AIDS and Children's Rights in Kenya, supra.*

as the support of her deceased husband's clan. Although a Kenyan woman's right to inherit property from her husband is protected by legislation, KELIN found that rural women preferred disputes to be handled by traditional elders. They provided support to elders to mediate inheritance disputes based on a balance of customary law rules and human rights norms.[128]

Finally, law enforcement of inheritance rights is weak. In Zambia, the non-governmental organization (NGO), Women and Law in Southern Africa, argue that statutory protections of inheritance rights are "weakened first and foremost by the lack of conviction among women themselves that they have a legal right to their deceased's husband's property, and secondly, by their fear of reprisals should they invoke the law. Furthermore, even the lawyers and the law enforcement agencies such as the police and Local Courts may have failed to give the new law the respect it deserves and encourage its use."[129] Widows also report police indifference to property grabbing complaints.[130] A 2004 study by Duncan in the Volta region of Ghana showed that knowledge of statutory inheritance law amongst the communities in the study was extremely limited, and that land disputes were generally resolved by means of customary methods of conflict resolution. State court systems were considered a measure of last resort.[131]

4.3.3 Legal and policy alternatives and recommendations

An overwhelming number of children lose one or both parents due to AIDS. An overview of the existing laws, as well as ongoing problems facing all children (especially younger and girl children) orphaned by AIDS suggests the need for strengthening the legal and regulatory framework, as well as taking steps to promote access to justice and law enforcement of inheritance rights. In particular:

- Statutory and constitutional law should clearly regulate the relationship between constitutional rights to equality (and statutory laws on inheritance based on guarantees of equality and non-discrimination) and customary laws and practices. Where customary laws discriminate on the basis of sex, gender and age, and negatively impact on children affected by HIV, rights to equality and non-discriminatory statutory laws should prevail; and[132]
- Statutory and customary inheritance laws should be reviewed and reformed to provide for non-discriminatory and fair inheritance rights for women and children, including girl children. Laws should pay attention to the underlying gender-based discrimination which impacts on the ability of girl children, as well as children whose fathers have died, to claim their rights.[133]

In addition to law review and reform, the following additional measures are recommended:

- Judicial activism should be used to reconcile conflicts between discriminatory customary laws and human rights norms, while continuing to preserve the operation of non-discriminatory aspects of customary law;[134]
- Traditional leaders and customary court systems should be encouraged to adapt customary law to respond to human rights principles, and to promote the best interests of children affected by HIV;
- Child-friendly mechanisms should be developed to allow for the participation of children in resolving land disputes;[135]
- Law enforcement needs to be strengthened to improve access to justice and enforcement of property rights for children affected by HIV and AIDS; and[136]
- The state needs to address underlying factors contributing towards property grabbing as a matter of urgency, such as HIV-related stigma and discrimination, as well as poverty within communities.

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128 *Ibid.*

129 McPherson, D., (2005), *Property Grabbing and Africa's Orphaned Generation: A Legal Analysis of the Implications of the HIV/AIDS Pandemic for Inheritance by Orphaned Children in Uganda, Kenya, Zambia and Malawi*.

130 *Ibid*.

131 Duncan, B., & Brants, C., (2004), *Access to and Control Over Land from a Gender Perspective: A Study Conducted in the Volta Region of Ghana*. Ghana:

132 International HIV/AIDS Alliance, (2010), *Enabling Legal Environments for Effective HIV Responses*, available from www.aidsalliance.org [Accessed: 16 May 2011].

133 *Ibid*.

134 *Ibid*.

135 McPherson, D., (2005), *Property Grabbing and Africa's Orphaned Generation: A Legal Analysis of the Implications of the HIV/AIDS Pandemic for Inheritance by Orphaned Children in Uganda, Kenya, Zambia and Malawi*.

136 *Ibid.*

4.4 Birth registration

The CRC provides all children with a right to a name and nationality. However, in many parts of the world, children's births go unregistered. In 2000, statistics showed that in sub-Saharan Africa, 70% of births went unregistered; 63% of children born in South Asia were not registered and in the Middle East and North Africa one third of all children born were unregistered.[137]

Birth registration not only establishes a child's legal identity, it is also vital to accessing services, such as health services, social welfare services and education. Where a child is not registered, it may be difficult to enforce rights relating to, for example, property, inheritance and social support.[138]

In the context of HIV and AIDS, children require access to a range of services in order to promote their continued health and well-being, such as HIV-related health care and social support. In particular, children who lose a parent or parents as a result of HIV are frequently absorbed into the care of extended family members or community members. In this context, birth certificates may be vital to facilitate these children's access to rights such as family property and inheritance. The United Nations Committee on the Rights of the Child's General Comment No. 3 specifically states as follows: "The Committee wishes to emphasise the critical implications of proof of identity for children affected by HIV/AIDS, as it relates to securing recognition as a person before the law, safeguarding the protection of rights, in particular to inheritance, education, health and other social services, as well as to making children less vulnerable to abuse and exploitation, particularly if separated from their families due to illness or death. In this respect, birth registration is critical to ensuring the rights of the child and is also necessary to minimise the impact of HIV/AIDS on the lives of affected children. States parties are, therefore, reminded of their obligation under article 7 of the Convention to ensure that systems are in place for the registration of every child at or immediately after birth."[139]

4.4.1 Diversity of legal approaches to birth registration

Most countries have a legal provision that recognise a child's right to an identity (that is, a name, nationality and birth registration)[140], and provide for the registering of children's births within a prescribed period.[141] For example, in Sierra Leone and Ghana, the law places a responsibility on every parent to register the birth of their child, and further provides that the names of both parents must appear on the birth certificate (except when the father of the child is unknown to the mother).[142] In some countries, the law provides for social workers to be employed in medical institutions to ensure that newly-born and abandoned children are not deprived of the right to be registered, and that certificates are issued within 24 hours of birth. [143] Other countries have taken steps to support birth registration for populations that may give birth to children with traditional birth attendants rather than within health facilities. In Haiti, the law recognises that children may be born outside of health institutions, and so requires a record of birth to be made before actual registration. In Ecuador, children of indigenous populations are given the right to register their births in the language of their choice.[144]

4.4.2 Impact and enforcement of these legal approaches

UNICEF argues that in many countries, laws on birth registration are not comprehensive enough;[145] (for instance, law may not provide for universal and free birth registration). However, the major issue relating to birth registration appears to be its lack of implementation and enforcement. UNICEF reports that 'in many developing countries, birth registration systems have fallen into disuse. In some cases this may be due to bureaucratic lethargy and a lack of oversight. It may also be linked to a lack of resources, given the costs attached to providing birth registration. There are also practical problems, for example where births occur away from registration locations. This includes births in isolated rural areas, or births away from medical facilities where registration normally takes place.'[146]

In the context of HIV and AIDS, research shows a particularly negative impact of the lack of birth certification and proof of identity on children orphaned by HIV. For instance, relatives and guardians of children orphaned by AIDS struggle to

137 UNICEF *Fact Sheet: Birth Registration, a*vailable from www.unicef.org [Accessed: 21 July 2011].

138 UNICEF, (2007), *Enhanced Protection for Children Affected by AIDS: A companion paper to the Framework for the Protection, Care and Support of Orphans and Vulnerable children Living in a World with HIV and AIDS.* New York, USA.

139 Article 32.

140 Duncan, B., (2008), *Global Perspectives on Consolidated Children's Statutes*, UNICEF, New York, USA.

141 UNICEF *Fact Sheet: Birth Registration, a*vailable from www.unicef.org [Accessed: 21 July 2011].

142 Duncan, B., (2008), *Global Perspectives on Consolidated Children's Statutes*, UNICEF, New York, USA.

143 For example, this is the case in Mali and Romania; *Ibid*.

144 *Ibid.*

145 UNICEF *Fact Sheet: Birth Registration, a*vailable from www.unicef.org [Accessed: 21 July 2011].

146 *Ibid.*

support children to protect their property rights, in the absence of legal proof of identity, leaving children vulnerable to property grabbing.[147]

4.4.3 Legal and policy alternatives and recommendations

The following recommendations are made:

- Ensure law and policy provides for universal and free birth registration for all children born inside and outside of health facilities;
- Ensure law and policy removes barriers to birth registration (for example, where births take place outside of hospitals or where parents lack identity documents), based on country-specific research findings.

Beyond law review, provide for programmes to promote awareness and education on the importance of birth registration, as well as to provide services (for example, training of health care workers and traditional birth attendants).

5. Access to sexual and reproductive health services

5.1 Age of legal capacity to consent to sexual and reproductive health services including, medical treatment, HIV testing and contraceptives

Adolescents are at high risk of HIV infection. In 2009 41% of all new HIV infections were in persons between 15–24. Furthermore it has been estimated that approximately five million young people aged 15–24 and 2 million adolescents aged 10–19 were living with HIV in 2009.[148] In this context, HIV prevention and treatment services need to be made accessible to adolescents. This requires legal recognition of the evolving capacity of children and laws enabling mature adolescents to access health care services independently of parents and caregivers. This approach embodies the principle of child participation as it enables children, according to the evolving capacities to be involved in making decisions and exercising their rights regarding sexual and reproductive health matters.

Article 5 of the CRC recognises that as children grow older they have evolving decision-making capacity. This should influence the weight given to the opinion of the child in matters affecting him/her and his/her ability to give legal consent. Committee on the Rights of the Child in *General Comment No. 4 (2003) on Adolescent health and development in the context of the Convention on the Rights of the Child* provides more detailed guidance on how this concept should be understood within the context of adolescent health. In its general principles it provides firstly that states parties must pass legislation to implement the rights in the CRC. Such legislation should deal specifically with:

> setting a minimum age for sexual consent, marriage and the possibility of medical treatment without parental consent. These minimum ages should be non-discriminatory between boys and girls (article 2 of the Convention) and closely reflect the recognition of the status of human beings under 18 years of age as rights holders, in accordance with their evolving capacity, age and maturity (articles 5 and 12 to 17).[149]

Secondly, in order to ensure access to sexual and reproductive services the General Comment requires states parties to:

> ensure that appropriate goods, services and information for the prevention and treatment of STIs (Sexually transmitted infections), including HIV/AIDS, are available and accessible. To ensure this, States Parties are urged to (a) develop effective prevention programmes, including measures to change cultural views about adolescents' need for contraception and STI prevention, and to address cultural and other taboos surrounding adolescent sexuality; (b) adopt legislation to combat practices that either increase adolescents' risk of infection or contribute to the marginalisation of adolescents who are already infected with STIs or HIV; (c) take measures to remove all barriers hindering the access of adolescents to information, preventive measures such as condoms, and care.[150]

5.1.1 Diversity of legal approaches sexual and reproductive health services including, medical treatment, HIV testing and contraceptives

The age at which children can consent to medical treatment varies between jurisdictions. Generally where jurisdictions allow children to consent to medical treatment at a certain age this allows them to access a wide range of health-related procedures, such as contraceptives, HIV testing and treatment for sexually transmitted infections. Medical treatment does not extend to consent to medical operations. There are some jurisdictions which distinguish between consent to

147 Human Rights Watch, *In The Shadow Of Death: HIV/AIDS and Children's Rights in Kenya, supra.*

148 UNICEF, (2011), *Opportunity in a crisis: Preventing HIV infection from early adolescence to young adulthood*, New York, USA, p.4.

149 Point 6(d).

150 Point 23.

medical treatment and other specific health interventions such as accessing contraceptives.

There appear to be three distinct approaches. Firstly, some countries have passed legislation dealing directly with the age at which children may consent to medical treatment. This could be in child-specific, family law or health-related laws. For example, in England the *Family Law Reform Act* of 1969 provides that from the age of 16 minors can give independent consent to surgical, medical and dental treatment.[151] These laws set an age requirement and on reaching that age it is presumed that the child has the capacity to consent to medical treatment.

Similar provisions exist in many other countries, see Table 2 below, which sets out the position in 24 countries across the globe. This shows that in most countries that have legislation dealing with an age of consent to medical treatment, the age is set lower than the age of majority with the average age of consent to medical treatment being 16. However, in 25% of countries there is no recognition of the evolving capacity of children as the age of consent to medical treatment is the same as the age of majority. Only, Mauritius and South Africa have specific provisions regarding the age of consent to HIV testing.

Table 2: Age of independent consent to medical treatment[152]

COUNTRY	Minimum age of consent for medical consent and other interventions, if provided[1]	Age of majority
Burundi	21	21
Denmark	15	18
Ghana	No age in set in law	18
Ireland	16	18
Israel	14	18
Jamaica	16	18
Kazakhstan	16	18
Maldives	No age of consent to medical treatment, medical counselling: 18	18
Mauritius	18, HIV testing permissible independently if the minor has understanding	18
Namibia	18	21
Nigeria	16	18
Poland	16	18
Sao Tome and Principe	No age of consent for medical treatment. Medical counselling: 16	18
Saudi Arabia	Medical counselling: 15	18/20
Seychelles	18	18
Slovenia	15	18
South Africa	12, contraceptives 12 and HIV testing 12	18
St. Lucia	16	18
St. Vincent and the Grenadines	16	18
Swaziland	21	21
Tajikistan	16	18
Thailand	21	Not defined
Tunisia	13	20
Zambia	21	Not defined

Source: UNICEF (2011)

In some countries children younger than the age set in legislation or the age of majority consent to medical treatment. These principles were established in the English case of *Gillick v West Norfolk and Wisbeck Area Health Authority and the DHSS*.[153] Here the House of Lords held that children under the age of 16 did not lack the legal capacity to make their

151 S 8(1), Family Law Reform Act, 1969 (Chapter 46) available at http://www.legislation.gov.uk/ukpga/1969/46?view=plain.

152 This table is based on data obtained from a UNICEF data base of countries who have reported to the Committee on the Rights of the Child regarding legislation that protects or promotes the rights of children as required by the Convention.

153 [1985] 3 All ER 402. In this case a local authority issued a notice to doctors informing them that they could issue contraceptive advice or treatment to girls under the age of 16 without parental knowledge or consent. Doctors were in terms of the notice required to use their clinical

own decisions by age alone.[154] They had capacity to make such decisions when they had sufficient understanding and intelligence to fully understand what was proposed.[155]

Secondly, some countries have legislated an age and a capacity requirement which enables children of a certain age who demonstrate maturity to consent independently to medical treatment. See for example s 240(2) of the Lesotho *Child Protection and Welfare Act* of 2011 which provides that a 'child may consent, to medical treatment provided the child is– (a) at least 12 years of age; and (b) of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the treatment or operation'.[156] This is an inversion of the *Gillick* principle as the age at which children can consent to medical treatment is low and the maturity requirement is used to ensure that children of this age and above have capacity.

Thirdly, some countries do not have legislation or common law principles enabling children to consent independently to medical treatment whilst they are children or legal minors. In the *Regional Issues Paper for Eastern Europe and Central* issued by the Global Commission on HIV and the Law it was noted that in most East European and Central Asian countries the age of consent to medical treatment is not specified.[157] Likewise, in a review of the age of consent to medical treatment in eight Southern African countries researchers established that only two countries had passed legislation creating an age at which children may consent independently to medical treatment during childhood.[158] It is assumed that in such situations children will require parental consent for medical treatment until the age of majority

Some countries separate access to contraceptives and HIV testing from the general rules regarding consent to medical treatment. With regard to access to contraceptives there appear again to be three legislative approaches. One, some countries make no specific legal reference to access to contraceptives but adolescents may access such services by virtue of being able to consent to medical treatment. Two, some countries have created a specific right of access to contraceptives for children, for example, in South Africa the *Children's Act* (2010) provides that from the age of 12 children can confidentially consent to contraceptives and contraceptive advice.[159]Three, in some legal systems, there is no reference to either an age of consent to medical treatment or contraceptives.[160]

Overall there appears to be less legislation which deals specifically with HIV testing of children. There are isolated examples of providing for consent to HIV testing in dedicated children's legislation such as has happened in Lesotho and South Africa.[161] There are also some countries which have testing norms for children in HIV laws, for example, in s 7(5) of the Mauritian *HIV and AIDS Act 31 of 2006* which allows a child to be tested for HIV without parental consent provided they understand the nature of the test.[162]

The age of consent to medical treatment, contraceptives and HIV testing must also be seen in the context of the age of consent to sexual intercourse. Children who are sexually active require access to sexual and reproductive health services in order to protect themselves from HIV infection or to treat HIV and other sexually transmitted infections. If the age of consent to sex is different from the age at which children may access such services it can act as a barrier to children using such services. Again, there have been a range of legal approaches to whether children have the capacity to consent to sex. Some countries have legislated an age of consent to sex before adulthood. Others only allow children to consent to sex if they are married. Table 3 below shows the limited recognition of the emerging autonomy and right to sexual and reproductive health services of children in 12 countries in South America. In this instance, none of the 12 countries surveyed had laws specifying the age at which children can consent independently to medical treatment or HIV testing. It is presumed that this implies that children do not have the capacity to consent independently to such health services until the age of majority. Five of the countries did not specify an age of consent to sex. Again it is

judgment and to act in good faith in ensuring that they protected young girls against harm. A Roman Catholic mother of 5 daughters (all under the age of 16) objected to this notice and applied for an order declaring the advice in the notice to be unlawful at 404I–405b.

154 *Ibid,* 409g–h.

155 *Ibid*.

156 A copy of the Act is available at http://www.aclr.info/images/stories/uploader/Publication_files/Bills/Lesotho_childrens_protection_bill_2004.pdf [Accessed: 25 May 2011].

157 *Regional Issues Paper for Eastern Europe and Central Asia,* (2011), Global Commission on HIV and the Law, United Nations Development Programme, New York, USA.

158 Centre for Human Rights, Faculty of Law, (2010), *Legal and policy issues related to HIV and young people in selected African countries,* Pretoria, South Africa.

159 S 134, Act No. 38 of 2010.

160 Centre for Human Rights, Faculty of Law, (2010), *Legal and policy issues related to HIV and young people in selected African countries,* Pretoria, South Africa. This report found that children of 15 and above could access condoms in Lesotho and children of 12 and above could access condoms in South Africa.

161 S 241(2), *Children's Protection and Welfare Act*, (2011), Lesotho and s. 130, *Children's Act*, South Africa. See for example a critique of this approach in Strode, A., Slack, C., & Essack, Z., (2010), *Child consent in South African law: Implications for researchers, service providers and policy makers*, Vol 100 *SAMJ,* 247–249.

162 *HIV/AIDS and Human Rights in Southern Africa,* (2009), AIDS and Rights Alliance of Southern Africa, Windhoek, Namibia.

presumed that this implies that children do not have the capacity to consent to sex below the age of majority. However in Argentina, Chili, Costa Rica, Guyana, Grenada, Mexico and Panama, children can consent to sex before they can consent to medical treatment independently (as this is not specified in law). This means that although they can lawfully have sex they will require the assistance of their parents in accessing contraceptives, HIV testing and treatment for sexually transmitted infections.

Table 3: Ages of consent to sexual and reproductive health services in South America

Country	Age of majority	Age of consent to medical treatment (if specified in law)	Age of consent to sex (if specified in law)
Argentina	21	-	15
Brazil	21	-	-
Chili	18	-	12 (females)
Costa Rica	-	-	13
Cuba	18	-	-
Ecuador	18	-	-
El Salvador	18	-	-
Grenada	21	-	16
Guyana	18	-	13
Mexico	18	-	12
Panama	18	-	18
Peru	18	-	-

Source: UNICEF (2011) The state of the age of the child, New York, USA

Two further issues which relate to ages of consent to medical treatment are: the rights of children to confidentiality regarding their health status; and their right to information on their health status if they are unable to consent independently. With regard to the first issue it appears that in the jurisdictions that allow independent consent to medical treatment children would also have the right to privacy regarding any health information. Some countries have child-related legislation on the right to privacy, for example in South Africa the *Children's Act* in a very broad provision provides that children have the right to privacy regarding their 'health status', and it is argued that this would include a child's HIV status.[163] A limited number of countries have passed HIV-specific privacy provisions; for example, s 244(1) of the *Children's Protection and Welfare Act* in Lesotho provides that children have the right to confidentiality regarding their HIV status.[164] With regard to the second issue, some examples were found of provisions which promoted child participation which could be used to argue that children have a right to information on their HIV status, for example, s. 10 of the *Children's Act* in South Africa states 'every child that is of such an age, maturity and stage of development as to be able to participate in any matter concerning that child has the right to participate in an appropriate way and views expressed by the child must be given due consideration'. No examples were found of laws which required disclosure of a child's HIV status to them.

5.1.2 Impact and enforcement of these legal approaches

Laws requiring parental consent to access sexual and reproductive health services can act as a barrier to adolescents accessing such services. There is evidence showing that less than 20% of American adolescents wished to involve their parents when accessing sexual and reproductive health services.[165] Furthermore, several studies on access to abortions and contraceptives have shown that potential negative reactions from parents deter adolescents from using such services.[166] With the most common reasons for non-disclosure to parents being a concern for parent's feelings including a fear of disappointment or embarrassment and expected negative results such as physical punishments or other forms of retaliation.[167]

163 S 13(1)(d), *Children's Act*, South Africa.

164 *Children's Protection and Welfare Act*, (2011), Lesotho..

165 Reddy, D.M., et al., (2007), *Effect of mandatory parental notification on adolescent girls' use of sexual health care services*, *JAMA, 288,* p.711.

166 Jackson, S., & Hafemeister, T.I., (2001), *Impact of parental consent and notification policies on the decisions of adolescents to be tested for HIV*. Journal of Adolescent Health, *Vol 29,* p.85.

167 *Ibid,* p.86.

Although there have been very few empirical studies on the rates of HIV testing if parental consent is required, one study in Connecticut, USA found a significantly higher proportion of adolescents volunteered for HIV testing once the parental consent requirement was abolished.[168]

Furthermore, laws which do not recognise the evolving capacity of children to consent to sexual and reproductive health services can have a disparate impact on orphans and vulnerable children (OVC). Research into the sexual practices of children affected by AIDS in Zimbabwe showed that they are at higher risk of HIV infection. OVC (aged 15–18) had a higher HIV prevalence rate (3.2% versus 0% among non-OVC).[169] Furthermore OVC were 75% more likely to have symptoms of STIs, the teenage pregnancy rate was higher with 8.3% female OVC falling pregnant as opposed to 1.9% amongst other girl children and OVCs were more likely to have initiated sexual relations or married at an earlier age.[170] Similarly, Foster and Williamson suggest that the social, economic and psychological impacts of HIV/AIDS on orphans increase their vulnerability to HIV infection through early onset of sexual activity, commercial sex and exposure to sexual abuse. They refer to research in Uganda with similar findings, including that 30% of orphan girls were sexually active by the age of 12. The girls reported economic needs, peer pressure, experimentation, the lack of parental supervision and rape as the most common reasons for engaging in sexual activity.[171] Creating legal barriers to accessing sexual and reproductive health services could heighten their vulnerability.

Poor drafting or inappropriate legal protections also create access barriers, for example, in Mauritius, children wishing to test for HIV without parental consent must submit a request in writing for such a test.[172] This makes accessing HIV testing difficult for adolescents who may not want a record of their request kept in their file. In South Africa and Lesotho HIV testing can only be done if it is in the 'best interests' of the child. It has been argued that this exceptionalises HIV testing from other diagnostic interventions and undermines the autonomy of children. Given that many health care workers are unfamiliar with applying this principle it may also result in children being denied access to HIV testing. Gaps also remain within many legal frameworks on key issues, such as the age of independent consent, and there are limited guidelines on the persons who can provide proxy consent.[173] Furthermore, in a number of regions, adolescent sexual and reproductive rights are only provided for in policies rather than laws.[174]

A further impact of some of the current legal strategies is the confusion that has arisen from contradictory approaches to the evolving capacity of children. This results in for example, children being able to access contraceptives before the age of consent to sex but health care workers who provide such services being compelled to report underage sex to authorities.[175] Laws regulating the age at which children can consent to sex must balance a range of competing factors so as to ensure that they do not undermine other public health initiatives. A World Bank report on *Legal Aspects of HIV/AIDS: A Guide for Policy and Law Reform* suggests that 'while it is imperative to protect vulnerable children from the advances of manipulative older partners (who are more likely to have had previous sexual partners), criminalising consensual relationships between adolescents who are close in age may have a negative impact on them. Also, enforcement actions may act as a pretext for violating the privacy of adolescents with regard to their sexual relationships'.[176]

Many countries have failed to ensure that such a balance is achieved. Accordingly, there have been disparate legislative approaches between different branches of government regarding ages of consent to sex and ages of consent to medical treatment. Thus some countries allow children to consent to sex before adulthood but do not allow independent access to HIV testing before 18.[177]This increases the vulnerability of older adolescents who may be lawfully sexually active. Others allow access to medical treatment at a younger age than the age of consent and this may have the unintended consequence of indirectly criminalising access of sexual and health reproductive services as health care workers may be required to report underage sex.[178] For example, in Indonesia, the *Law on Population Development and*

168 *Ibid,* p.85.

169 Gregson, S., et al., (2005), *HIV infection and reproductive health in teenage women orphaned and made vulnerable by AIDS in Zimbabwe*. AIDS Care*, 17*(7), p.788.

170 *Ibid*.

171 Foster, G., & Williamson, J., (2000), *A review of literature of the impact of HIV/AIDS on children in Sub-Saharan Africa*. AIDS Vol 14, p.281.

172 *HIV/AIDS and Human Rights in Southern Africa, (2009),Southern Africa and HIV/AIDS dissemination Service, Available from http://www.safaids.net/content/hivaids-human-rights-southern-africa-2009-aids-rights-alliance-southern-africa-arasa.*

173 Goyena, M., (2007), *Multi-Country Review of Laws and Policies on HIV Testing and Counseling in Select Countries in East Asia and the Pacific: Scaling up HIV Testing and Counselling in Asia and the Pacific Report of a Technical Consultation Phnom Penh, Cambodia 4–6 June 2007*.

174 Centre for Human Rights, Faculty of Law, (2010), *Legal and policy issues related to HIV and young people in selected African countries,* Pretoria, South Africa.

175 Strode, A., & Slack, C., (2009), Sex, lies and disclosures: Researchers and the reporting of underage sex. *Southern African Journal of HIV Medicine*, p.8.

176 *Legal Aspects of HIV/AIDS: A Guide for Policy and Law Reform,* World Bank, Washington, USA, p. 160.

177 *Regional Issues Paper for Eastern Europe and Central Asia 2*011, Global Commission on HIV and the Law, United Nations Development Programme, New York, USA.

178 See for example, Strode, A., & Slack, C., 2009. Sex, lies and disclosures: Researchers and the reporting of underage sex. *Southern African Journal*

Development of Family states that every citizen has the right to obtain information and receive education related to reproductive rights.[179] Furthermore, the government is responsible for providing information, services, and technology for family planning for adolescents.[180] However, the *Criminal Code* criminalises the supplying of information relating to the prevention and interruption of pregnancy.[181] See Table 5 below which reflects this disparity in six other countries. The country in grey allows access to medical treatment below the age of consent to sex. Whilst the countries in white allow children to consent to sex at a lower age than that at which they can consent to medical treatment.

Table 5: Disparate approaches to the evolving capacity of children regarding sexual and reproductive health

Country	Age of Majority	Age of consent to sex	Age of consent to medical treatment
Bosnia	18	16	No age set in law
Chile	18	14	No age set in law
Namibia	21	16	18
Poland	18	15	16
South Africa	18	16	12
Thailand	Not defined	18	21

Likewise laws which criminalise same-sex relationships or set higher ages of consent for such relationships act as barriers to sexual minorities accessing sexual and reproductive health services.[182]

Finally, despite recent information on the health benefits of informing children of their HIV status[183] there have been very few legislative steps towards creating a right of access to health information for children.

5.1.3 Legal and policy alternatives and recommendations

Countries need to create a coherent approach to legislating on a child's capacity to make decisions before adulthood. This approach should be premised on the principle articulated in Article 5 of the CRC that children have evolving capacity. Accordingly, laws should make provision for older adolescents to consent independently to medical treatment, contraceptives and HIV testing. Legislation in this respect should be based on evidence and a review of international standards and best practices.[184] This approach would enhance their right to child participation in decision-making and could be done in a number of different ways, for example:

- Setting an age of consent in law; or
- Enabling children to consent when they demonstrate the individual capacity to make the decision.

Furthermore the term 'medical treatment' ought to be defined broadly so as to include access to contraceptives and HIV testing. Alternatively, legislation should set out when children have the capacity to consent independently to a range of sexual and reproductive health services.

Finally, guidance is needed on the principles that could be used to effectively balance the need to protect children from engaging in under-age sex whilst nevertheless facilitating access to sexual and reproductive health services for this group.

5.2 Access to HIV prevention education and information

Sexual transmission of HIV accounts for more than 80% of new HIV infections worldwide.[185] In this context HIV-related education is important not only to empower individuals to protect themselves against infection but also to reduce

of HIV Medicine, p.8, which describes the conflicts that are posed to South African health care workers providing services to children between the ages of 12 and 16.

179 Article 5 of Law No. 52/2009.

180 Articles 20 to 29, (2010), *Education sector response to HIV, drugs and sexuality in Indonesia* Jakarta, UNESCO, p.27.

181 *Left without a choice: Barriers to reproductive health in Indonesia,* (2010), Amnesty International, London, UK.

182 *Regional Issues Paper for Eastern Europe and Central Asia* 2011, Global Commission on HIV and the Law, United Nations Development Programme, New York, USA.

183 Draft *Guidance on HIV Disclosure Counselling for Children aged up to 12 years: A review of the Evidence*, (2011), UNICEF, Geneva, Switzerland, p.19.

184 Centre for Human Rights, Faculty of Law, (2010), *Legal and policy issues related to HIV and young people in selected African countries,* Pretoria, South Africa.

185 *Joint Action for Results: UNAIDS Outcome Framework 2009–2011.*

stigma and discrimination through dealing with misunderstanding and misinformation on HIV transmission.

The Committee on the Rights of the Child has stated in its *General Comment No. 3 on HIV/AIDS and the rights of the child* that children and adolescents have the right to access adequate information related to HIV prevention:

> Effective HIV/AIDS prevention requires States to refrain from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information, and that, consistent with their obligations to ensure the right to life, survival and development of the child (art. 6). States parties must ensure that children have the ability to acquire the knowledge and skills to protect themselves and others as they begin to express their sexuality.[186]

The right to access to effective and age-appropriate HIV prevention, treatment care and support services is also affirmed under *International Guidelines on HIV/AIDS and Human Rights:*

> States should ensure that children and adolescents have adequate access to confidential sexual and reproductive health services, including HIV information, counselling, testing and prevention measures such as condoms, and to social support services if affected by HIV.[187]

Despite the importance of HIV prevention and sexuality education for children very few states have passed laws creating the right to such education.

5.2.1 Diversity of legal approaches to prevention education and information

There appear to be three legislative approaches to legislating on HIV and sexuality education for children. Firstly, some countries have created broad rights to information on health-related issues. For example, the *Children's Act* in South Africa provides that every child has the right to access to information on 'health promotion and the prevention and treatment of ill-health and disease, sexuality and reproduction'.[188]

Secondly, increasingly countries have been creating rights to HIV education. Often these provisions are in new HIV laws. For example, in Kenya the *HIV/AIDS Prevention and Control Act 14 of 2006* refers to the right to access education on HIV for young people in and out of schools.[189] Likewise, a review of laws in Asia Pacific found that most countries in the region had laws requiring education on HIV, see Table 6 below:

Table 6: Review of laws providing for HIV and AIDS education in the Asia Pacific Region[190]

Country	Law	Requires HIV/AIDS Education
Cambodia	Law on Prevention and Control of HIV/AIDS 2002, Article 3	Yes
China	Regulation on AIDS Prevention and Control (2006)	Yes
The Philippines	Regulation on AIDS Prevention and Control (2006)	Yes
Lao PDR	Law on the Protection of Rights and Interests of Children (2007),	Yes
Indonesia	The Law on Population Development and Development of Family (2009)	Yes

Source: The Rights of Children and Young People to Access HIV-Related Services: Regional Issues Brief for Asia Pacific (2011)

Thirdly, some states have no laws or policies on HIV and sexuality education. For example, in Eastern Europe and Central Asia it has been reported that there is limited HIV and sexuality education and no national strategies dealing with this issue.[191]

186 United Nations General Committee on the Rights of the Child, *General Comment No.3 (2003): HIV/AIDS and the rights of the Child*, CRC/GC/2003/3, 17 March 2003, para.16.

187 OHCHR and UNAIDS, (2006), *International Guidelines on HIV/AIDS and Human Rights, a*vailable at www.unaids.org [Accessed 18 May: 2011]

188 S 13(1)(a) *Children's Act*, South Africa.

189 Ss 4, 5, 6 and 8 HIV/AIDS Prevention and Control Act No. 14 of 2006.

190 This table was developed using information provided in the *The Rights of Children and Young People to Access HIV-Related Services: Regional Issues Brief for Asia Pacific*.

191 *Regional Issues Paper for Eastern Europe and Central Asia* 2011, Global Commission on HIV and the Law, United Nations Development Programme, New York, USA.

5.2.2 Impact and enforcement of these legal approaches

There have been numerous reviews of the impact of sexuality education. These studies demonstrate the positive impact that rights to such education can have on sexual behaviour. For example, in a review of 33 studies on the impact of in- and out-of-school sex education programmes on adolescent sexual behaviour in North America it was found that such programmes (a) do not encourage early sexual debut or increase the frequency of sexual behaviour, and (b) some programmes resulted in delays in sexual debut and the frequency of sexual activity.[192] Similar studies undertaken in the United Kingdom confirmed these results. One English study found that having the school as the primary source of sex education may well have increased the use of condoms during the first sexual encounter.[193]

A more recent review of 83 studies from both developed and developing countries found that in:

- 34 studies measuring the number of sexual partners as an outcome of the programme, 12 (35%) noted a decrease in the number of sexual partners;
- 54 studies measuring the impact on condom use, almost half (48%) showed an increase in condom use following the intervention; and
- 28 studies which developed measures of monitoring the frequency of sex without a condom half the studies found that the programmes significantly reduced sexual risk-taking. None of them found increased sexual risk-taking.[194]

A key limitation of many legislative approaches is that they focus on providing HIV education to children in schools. However, many of the children that belong to high risk populations do not attend school, for example, street children, drug users and girls in early marriages. States must assure that laws require information and prevention education to be provided to children not in school. Furthermore, the rights of children to information on how to protect themselves from HIV infection via illegal behaviours such as drug use are missing from laws and national policies.

5.2.3 Legal and policy alternatives and recommendations

The right to HIV and sexuality information needs to be provided for in dedicated children's statutes or laws relating to HIV. Furthermore, this right needs to be more fully described in national policies which ensure that such programmes are based on appropriate material, that they facilitate access to prevention services and that at-risk populations or behaviours are targeted by programmes.

5.3 Access to treatment and care

Globally, an estimated five million young people aged 15–24 were living with HIV in 2009.[195] Young women bear the burden of the epidemic. They make up more than 60% of all people living with HIV worldwide whilst in sub-Saharan Africa 72% of all those infected are young women.[196] In other words most children living with HIV are African and female with the highest numbers of adolescent boys and girls living with HIV in South Africa, Nigeria, India, Kenya, Malawi, Mozambique, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe.[197]

The CRC provides in Article 24 that states should 'recognise the right of the child to the enjoyment of the highest attainable standard of health'. This article places very specific obligations on states including: (1) ensuring every child has the right to access to health services, (2) a duty to diminish infant and child mortality, (3) a duty to provide medical assistance and health care to all children, (4) a duty to ensure the provision of adequate nutritious foods and clean drinking water, (5) a duty to provide pre-and post-natal care for mothers, (6) a duty to ensure that parents and children have information and are supported in the use of basic knowledge relating to child health and nutrition, breastfeeding, hygiene and environmental sanitation and accident prevention, and (7) an obligation to develop preventive health care guidance and family planning education/services.

Furthermore Guideline 6 of the *International Guidelines on HIV and Human Rights* states that governments should enact legislation to provide for the regulation of HIV-related goods, services and information, so as to ensure widespread availability of quality prevention measures and services, adequate HIV prevention and care information and safe and effective medication at an affordable price. Furthermore, states should take any measures necessary to ensure on a

192 Kirkby, D., (1995), Sex and HIV/AIDS education, *BMJ,* Vol 311, p.403.

193 *Ibid*.

194 Kirkby, D., et al., (2007), *Sex and HIV education programs: Their impact on sexual behaviour of young people throughout the world*. Journal of Adolescent Health, *Vol 40 p.*209.

195 UNICEF, (2011), *Opportunity in a crisis: Preventing HIV infection from early adolescence to young adulthood*, New York, USA, p.1.

196 *Ibid,* p.5.

197 *Ibid*, p.24.

sustained and equal basis the availability and accessibility of quality goods, services for and information about HIV/AIDS prevention, treatment, care and support including antiretroviral and other safe and effective medicines, diagnostics and related technologies for prevention, curative, palliative care of HIV/AIDS and related opportunistic infections and conditions.

Children living with HIV have differing health needs relating to, amongst others; their age, stage of development and health status. Paediatric disease is very different from HIV in adults and without treatment children rapidly progress to a terminal stage.[198] Nevertheless, all children living with HIV require both medical treatment and psycho-social support.[199] However, in many parts of the world children are not receiving adequate care and treatment.[200] UNICEF reports that progress on PMTCT and paediatric AIDS care has been uneven.[201] By the end of 2009 only 28% of children in need of antiretrovirals (ARVs) were receiving them whilst 37% of adults in need were in ARV treatment programmes.[202] Laws and policies on the rights of children to access treatment and care are also uneven with many countries having not legislated on a child's right to health or created policies specifically providing for paediatric ARV access.

5.3.1 Diversity of legal approaches to access to treatment and care

There have been a number of different legal strategies used in responding to the international law obligations in the CRC. Firstly, in some parts of the world there are broad rights to health care. Whilst these are not child specific they ensure that all sectors of society have access to basic health care services. For example, in Eastern Europe and Central Asia most countries have laws which guarantee free health care at state facilities. This usually includes primary health care, accident and emergency medical care and secondary health care if referred by a primary health care practitioner.[203]

Secondly, some countries have created child-specific rights to health care. This has been done in a number of different ways. In South America a number of countries have broad legal provisions which guarantee the right to health for children. For example, in Ecuador health laws provide that children and adolescents have the right to enjoy the highest level of physical, mental, psychological and sexual health. Under the Code of Brazil there are also broad provisions on health for children and adolescents which enable them to access the Universal Single Health System.[204] In some instances these broad health laws locate the right to health amongst other socio-economic rights thus ensuring that children have access to health and the conditions which facilitate health such as adequate shelter and nutrition. For example, in Lesotho the *Children's Protection and Welfare Act* provides that a child 'has a right to access education, preventive health services, adequate diet, clothing, shelter, medical attention, social services or any other service required for the child's development'.[205] Other countries have passed child specific provisions which aim at meeting the duties established under Article 24 of the CRC. For example, in New Zealand in an effort to reduce infant and child mortality and provide medical assistance to children health care is provided free to those under the age of 6.[206] Not all of these interventions are in children's laws, for example, the International Labour Organization has reported that over 80 countries have passed employment legislation which promotes breastfeeding by enabling working women with some flexibility regarding breaks at work and working hours.[207]

Finally, a number of countries have created HIV-specific HIV treatment policies which promote access to health care for children living with HIV. For example, in South Africa the ARV guidelines were revised in 2010 to provide specifically for infants, children, adolescents and adults.[208] Furthermore the *HIV/AIDS and Human Rights in Southern Africa* (2009) report found that all 14 SADC countries had PMTCT policies.[209]

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198 Children's Institute and Save the Children (Sweden), (2004), *What about the children? Anti-retroviral roll out in South Africa: where do children feature?* University of Cape Town, South Africa, p.20.

199 *Ibid*, pp.15–16.

200 World Health Organisation, (2006), *Antiretroviral treatment of HIV infection in infants and children in resource limited settings: towards universal access*, Geneva, Switzerland, p.1.

201 UNICEF, (2010), *Children and AIDS: Fifth Stock taking Report,* Geneva, Switzerland, p 2.

202 *Ibid*, p.11.

203 *Regional Issues Paper for Eastern Europe and Central Asia* 2011, Global Commission on HIV and the Law, United Nations Development Programme, New York, USA.

204 Duncan, B., (2008), *Global Perspectives on Consolidated Children's Statutes*, UNICEF, New York, USA, p.68.

205 S 10(1), *Children's Protection and Welfare Act*, (2011), Lesotho.

206 http://www.moh.govt.nz/moh.nsf/indexmh/phcs-funding-lowcost-under6s [Accessed: 13 July 2011].

207 International Labour Organisation, (1997), *Report V(1) Maternity protection at Work*, Geneva, Switzerland, p.62, available at http://www.ilo.org/public/english/standards/relm/ilc/ilc87/rep-v-1.htm [Accessed: 13 July 2011].

208 Department of Health, (2010), *South African Antiretroviral Treatment Guidelines.* Pretoria, South Africa.

209 OHCHR and UNAIDS, (2006), *International Guidelines on HIV/AIDS and Human Rights, a*vailable at www.unaids.org [Accessed 18 May: 2011], p.78.

5.3.2 Impact and enforcement of these legal approaches

Limited protection of a child's right to health has resulted in child mortality rates rising in the last two decades throughout sub-Saharan Africa. Much of this increase has been attributed to the impact of AIDS on child health. In Botswana, Namibia, Swaziland and Lesotho AIDS has nearly or more than doubled child mortality rates.[210] The gap between the rate at which children are accessing ARVs compared to adults starkly shows the failure of governments to legislate on and enforce a child's rights to health.

In many instances, even where children have rights to health these are narrowly construed and do not address a child's broader socio-economic rights. There is extensive evidence for example, of the impact of poor nutrition on a child's health, particularly children living with HIV,[211] yet some legislative reform continues to address the right to health in isolation without linking it to social protection.

Finally, whilst there has been some use of litigation and advocacy to hold governments to account regarding their obligations under the CRC or national law this needs to be intensified. For example, the *Minister of Health v Treatment Action Campaign* case in South Africa is a good example of strategic litigation which compelled the state to change its PMTCT policy. In this matter an NGO, the Treatment Action Campaign, challenged a restrictive PMTCT policy which limited access to this programme to two research sites per province using s. 27 of the South African Constitution, the right to access to health care services.[212] The Constitutional Court held that the Department of Health acted unreasonably in failing to roll out its PMTCT programme across the country. They were ordered to end all prohibitions on the provision of PMTCT outside of research sites and to extend the programme.[213]

5.3.3 Legal and policy alternatives and recommendations

It is recommended that governments review legislation promoting a child's right to health with a view to reforming and strengthening such provision. Such reviews should recognise the following key issues:

i. Young people living with HIV contract the virus either through mother-to-child transmission, unprotected sex or the sharing of injecting drug equipment with an infected person.[214] This requires a recognition by legislatures to address a child's right to health in a holistic manner which does not treat children as a homogenous group;

ii. Health laws should link with social protection measures to ensure that children live in conditions which promote their health; and

iii. Consideration should be given to the broader legislative steps that are required to implement the goals set out in Article 24 of the CRC.

5.4 Access to harm reduction services for young people who use illicit drugs

Injecting drug use is a major factor fuelling the HIV epidemic amongst adolescents in Asia. Recent data shows that in some countries in this region, injecting drug use is occurring at younger ages. For example, a multi-country study of injecting drug users (IDU) aged 15–24 showed that up to 30% reported being younger than 15 when they first became users.[215] Of concern is research showing that a significant proportion of children who inject drugs become infected with HIV within the first 12 months of drug use.[216] It is also increasingly being recognised that HIV transmission through injecting drug use is an emerging issue in Africa and the Caribbean.[217]

The *International Guidelines on HIV and Human Rights* in Guideline 4 provide that 'the criminal law should not be an impediment to measures taken by States to reduce the risk of HIV transmission among IDU and to provide HIV-related care and treatment for IDU. Criminal law should be reviewed to consider: the authorisation or legalisation and promotion of needle and syringe exchange programmes; the repeal of laws criminalising the possession, distribution and dispensing of needles and syringes'.[218]

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210 Miller, C., (2007), *Children affected by AIDS: A review of the Literature on Orphans and Vulnerable Children*, Centre for International Health and Development, Boston University, School of Public Health, USA,pp.16–17.

211 UNICEF, (2008), *Realising Children's Rights to Adequate Nutrition through National Legislative Reform*, Geneva, Switzerland, p.1.

212 *Constitution of the Republic of South Africa*, 1996.

213 2002 (4) BCLR 356 (CC).

214 UNICEF, (2011), *Opportunity in a crisis: Preventing HIV infection from early adolescence to young adulthood*, New York, USA, p.24.

215 *Ibid.* p.6.

216 *Ibid*.

217 Beyrer, C. *et al.*, (2010), *Time to act: a call for comprehensive responses to HIV in people who use drugs*, *Lancet*, p. 111.

218 OHCHR and UNAIDS, (2006), *International Guidelines on HIV/AIDS and Human Rights, a*vailable at www.unaids.org [Accessed 18 May: 2011].

Despite the high risks of infection with HIV faced by young drug users legal systems have in most instances failed to provide rights to access harm reduction services.

5.4.1 Diversity of legal approaches to access harm reduction services for Injecting Drug Users

There appear to be only two legal approaches regarding providing access to harm reduction services. Firstly, most countries are silent on this issue, for example, in the Caribbean all countries criminalise the supply, possession and use of illicit drugs and there have been no reports of any laws facilitating harm reduction services.[219] Secondly, some countries allow lawful access to harm reduction services even though drug use remains criminalised. For example, a 2009 review of laws and policies in the Southern African Development Community found that Mauritius had laws which enabled clean needles to be supplied to any person dependent on a dangerous drug.[220] Furthermore, used needles could be disposed of in a safe manner[221]and a person in possession of a needle in compliance with the Act would not be considered to have committed an offence in terms of the Dangerous Drugs Act.[222]

5.4.2 Impact and enforcement of these legal approaches

It has been argued that the continued criminalisation of people who use drugs is fuelling the HIV epidemic.[223] Reasons given for this include: legal prohibitions on the provision of sterile needles and opioid substitution therapy prevent persons at risk from protecting themselves against infection with HIV as they are often compelled to continue using unclean needles, which directly impede HIV prevention efforts.[224] Some state responses to controlling drug use result in human rights abuses, the denial of essential medicines and health services.[225] When drug use is illegal people who inject drugs may not carry sterile syringes or other injecting equipment due to fear of arrest.[226] Likewise, the criminal nature of the activity makes the provision of harm reduction services difficult as health care workers may be prosecuted for aiding and abetting a crime through offering clean needles to users.[227]Accordingly, harm reduction generally remains absent from frameworks which use a criminal justice response to drug use rather than a public health approach.

Furthermore, in Eastern Europe and Central Asia although harm reduction programmes are available youth appear reluctant to use them, and this enhances their vulnerability.[228] There are distinct gender issues relating to the risks faced by female users however laws and policies fail to address them.[229]

5.4.3 Legal and policy alternatives and recommendations

A UN document the *Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users* recommends that IDUs be offered a range of health care services such as ARV treatment and condom distribution. They also suggest that users should have access to needle and syringe programmes and other drug-dependence treatment. These services can only be offered in an environment where accessing such services will not result in legal sanctions.[230] Similar recommendations have been made regarding decriminalising the possession of drug use equipment and the use or possession of drugs for personal use.[231] This approach was re-iterated in the 2010 Vienna Declaration which recommends the decriminalisation of drug use and a shift towards a public health response.[232]

It is recommended that states should be encouraged to decriminalise drug use. Furthermore, rights to harm reduction

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219 Cenac, V., & Day, M., (2011), *Caribbean Regional Dialogue,* Global Commission on HIV and the Law, United Nations Development Programme, New York, USA.

220 S 14(1)–(3) HIV and AIDS Act of 2006.

221 *Ibid,* S 15.

222 *Ibid,* S 16.

223 Cohen, J., (2004), *Not enough graves: the war on drugs, HIV/AIDS*, and violations of human rights, Human Rights Watch, p.42.

224 *Enabling legal environments for effective HIV responses: A leadership challenge for the commonwealth,*(2010), International HIV/AIDS Alliance and Commonwealth HIV/AIDS Action Group p.38.

225 *Ibid,* p.39.

226 *Ibid.*

227 *Ibid.*

228 *Regional Issues Paper for Eastern Europe and Central Asia* 2011, Global Commission on HIV and the Law, United Nations Development Programme, New York, USA.

229 International Harm Reduction Association, (2008), *Harm Reduction and Human Rights: The Global response to Injection Driven HIV Epidemics*, Submission to the Office of the High Commissioner for Human Rights for the biannual report on HIV/AIDS requested by Commission on Human Rights Resolution E/CN.4/RES/2005/84, p.16.

230 WHO, UNODC, UNAIDS, (2009),*Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users*, Geneva, Switzerland.

231 Commonwealth manual, *supra*, p.42.

232 The Vienna Declaration, issued by the 2010 International AIDS Conference, available from http://www.viennadeclaration.com/about/backgrounder/ [Accessed: 10 July 2010].

measures should be enshrined in law. Age should not be a barrier to accessing such services. To off-set the vulnerability of child drug-users policies are required detailing the additional support and services that should be provided to children. Hard to reach groups, such as street children, should be given special attention in such policies.

6. Conclusion

All States Parties to the CRC have taken efforts to domesticate and implement the rights enshrined therein. It is clear that the CRC and the Committee on the Rights of the Child can provide a very useful general framework for states on how to tailor their legal responses to children infected and affected by HIV. However, despite this, many law reform programmes are to a large extent not assisting in reducing the vulnerability of children to HIV and protecting those infected with HIV. There are a number of reasons for this including: law reform is not always informed by evidence, the links between human rights and public health are not fully operationalised, and the evolving capacity of children is not fully recognised.

Although specific recommendations have been made with regard to each substantive issue the following are over-arching recommendations which ought to inform all actions which aim at protecting and promoting the rights of children affected by HIV:

i. Law reform is required in almost all of the areas addressed by this paper. Such reform must address the specific needs of children affected by HIV, including their evolving capacity, their lack of (in many instances) parental protection and their vulnerability to discrimination;

ii. Further guidance is required from the Committee on the Rights of the Child on how countries can implement the principle of the evolving capacity of the child with regard to children accessing sexual and reproductive health services. In particular guidance is needed on balancing protection with autonomy with regard to children engaging in illegal activities;

iii. Comprehensive legal strategies are required to respond to the complexities created by dualistic legal systems which discriminate against women and children; and

iv. More work is needed on collecting evidence on appropriate law reform responses in order to provide countries with informed legal reform strategies. Guidance should be provided to states on the type of evidence that is needed and how the data could be collected.