Regional Issues Brief:

CHILDREN, HIV AND THE LAW

For the Africa Regional Dialogue of the Global Commission on HIV and the Law

4 August 2011
Pretoria, South Africa
Acknowledgements

The members of the Global Commission on HIV and the Law wish to express their deep appreciation to all those who made submissions to and participated in the Africa Regional Dialogue, and those who supported the Regional Dialogue process, and contributed to this Issue Brief.

The Africa Regional Dialogue was hosted by UNDP Regional Service Centre for Eastern and Southern Africa and was jointly organised with the Secretariat of the Global Commission on HIV and the Law, based at the UNDP HIV/AIDS Group in New York. Thanks to the Office of the Commissioner for Social Affairs at the African Union Commission, the UNDP Regional Centre for West & Central Africa and the UNAIDS Regional Support Teams for help and support in organising the dialogue.

Special thanks to Minister Jeffrey Thamsanqa Radebe MP, Minister of Justice and Constitutional Development, Republic of South Africa; H.E. Bience Gawanas, Commissioner for Social Affairs, African Union Commission; Sheila Tlou, Regional Director, UNAIDS Regional Support Team for Eastern and Southern Africa; Agostinho Zacarias, UN Resident Representative/Resident Coordinator, Republic of South Africa; and Jeffrey O’Malley, Director HIV/AIDS Group, UNDP for opening the Africa Regional Dialogue;

To Commissioners Ms. Ana Helena Chacon-Echeverría, Mr. Charles Chauvel, Dr. Shereen El Feki, H.E. Bience Gawanas, Dame Carol Kidu, Hon. Michael Kirby, Mr. Stephen Lewis, Mr. JVR Prasada Rao, Mr. Jon Ungphakorn, and Professor Miriam K. Were for actively participating in the Regional Dialogue.

The Regional Dialogue greatly benefited from the creative and engaging moderation by Zeinab Badawi.

The Commission would like to acknowledge the support and commitment from Jonathan Berger who attended on behalf of the Technical Advisory Group and members of the Regional Advisory Group (listed below) who provided advice and assessed submissions.

In particular, the Global Commission on HIV and the Law would like to recognise the UNDP HIV/AIDS Group in New York for providing unwavering support and the staff members of the Secretariat of the Global Commission on HIV and the Law for their overall guidance, planning and support: Mandeep Dhaliwal, Vivek Divan and Emilie Pradichit. Tilly Sellers, Amitrajit Saha, Catherine Grant, Margaret Sakatsie; Lerato Mahlaole and Godfrey Maringa from the UNDP Regional Service Centre for Eastern and Southern Africa were instrumental in organising the Regional Dialogue.

Many thanks to the following individuals who offered invaluable assistance and support: Natalie Amar, Dominic Bocci, Meagan Burrows, Megan Cribbs, Reeti Desai, Amy Edwards, Laura Goldsmith, Brianna Harrison, David Levy, Rumbidzai Maweni, Kathleen Meara, David Ragoneatti, Rohan Sajnani, Aaron Scheinwald, Ji-Eun Seong, Dimitri Teresh, and Nadeah Vali.


The Issue Brief was prepared by Ann Strode, consultant. The content, analysis, opinions and recommendations in the document do not necessarily reflect the views of the Global Commission on HIV and the Law, UNDP or UNAIDS. Thanks to Ian Mungall and Rodrigo Domingues for design of this publication.
<table>
<thead>
<tr>
<th>Organization</th>
<th>Contact Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa Regional Advisory Group, Global Commission on HIV and the Law</td>
<td></td>
</tr>
<tr>
<td>United Nation Development Programme (UNDP)</td>
<td>Béchir N’Daw</td>
</tr>
<tr>
<td>African Council of AIDS Service Organisations (AFRICASO)</td>
<td>Innocent Laison</td>
</tr>
<tr>
<td>Enda-Santé</td>
<td>Daouda Diouf</td>
</tr>
<tr>
<td>HIV/AIDS Alliance</td>
<td>Baba Goumbala</td>
</tr>
<tr>
<td>National Empowerment Network of People Living with HIV/AIDS in Kenya (NEPHAK)</td>
<td>Nelson Otwoma</td>
</tr>
<tr>
<td>AIDS and Rights Alliance of Southern Africa (ARASA)</td>
<td>Michaela Clayton</td>
</tr>
<tr>
<td>Swaziland National Network of People Living with HIV and AIDS (SWANNEPHA)</td>
<td>Thembi Nkambule</td>
</tr>
<tr>
<td>Eastern Africa National Networks of AIDS Service Organisations (EANNASO)</td>
<td>Olive Mumba</td>
</tr>
<tr>
<td>Centre for Health, Human Rights and Development (CEHRUD)</td>
<td>Moses Mulumba</td>
</tr>
<tr>
<td>African Union Commission (AUC)</td>
<td>Dr. Benjamin Djoudalbaye</td>
</tr>
<tr>
<td>African Sex Workers Alliance (ASWA)</td>
<td>Kyomya Macklean</td>
</tr>
<tr>
<td>Joint United Nations Programme on HIV/AIDS (UNAIDS)</td>
<td>Wayne Gill</td>
</tr>
<tr>
<td>United Nations Development Programme (UNDP)</td>
<td>Catherine (Kitty) Grant</td>
</tr>
<tr>
<td>Southern African Litigation Centre (SALC)</td>
<td>Priti Patel</td>
</tr>
<tr>
<td>African Men for Sexual Health and Rights (AMSHeR)</td>
<td>Joel Nana</td>
</tr>
<tr>
<td>Regional Psychosocial Support Initiative (REPSSI)</td>
<td>Lynette Mudekunye</td>
</tr>
<tr>
<td>United Nations Office on Drugs and Crime (UNODC)</td>
<td>Brian Tkachuk</td>
</tr>
<tr>
<td>Researcher: Ghent &amp; Wits University</td>
<td>Marlise Richter</td>
</tr>
</tbody>
</table>
Abbreviations

AIDS  Acquired Immune Deficiency Syndrome
CRC  Convention on the Rights of the Child
ESA  East and Southern Africa
IDU  Injecting Drug Use
HIV  Human Immunodeficiency Virus
PMTCT  Prevention of mother-to-child transmission of HIV
SADC  Southern African Development Community
UN  United Nations
UNAIDS  Joint United Nations Programme on HIV and AIDS
Introduction

A significant number of children are infected with the Human Immunodeficiency Virus (HIV). At the end of 2009, there were 2.5 million children living with HIV around the world. Furthermore, an estimated 400,000 children became newly infected with HIV during 2009. One seventh of the 1.8 million people who died of the Acquired Immune Deficiency Syndrome (AIDS) during 2009 were children. Many more children are affected by HIV with more than 16 million children under the age of 18 having lost one or both parents to AIDS. HIV is depleting economically active populations who are both parents and providers of services (education, health, social services etc.) to children. The impact of HIV and AIDS on a child begins as soon as their parent contracts HIV and includes stigma and discrimination, physical care for the ill parent, loss of family income and use of resources for medical care, uncertainty and fear. African children are the most affected by the epidemic with twenty countries in sub-Saharan Africa accounting for an estimated 69% of all new HIV infections globally in 2009. Furthermore, most children living with HIV/AIDS – almost nine out of ten – live in sub-Saharan Africa with one out of every three young people newly infected with HIV in 2009 being from South Africa or Nigeria.

2 Ibid.
3 Ibid.
4 Ibid.
Legal responses to children infected and affected by HIV

The Convention on the Rights of the Child (CRC) has been acceded to by most countries indicating a high level of normative consensus on the idea and content of children’s rights. The Convention reflects an international understanding of children’s position in society and of the role of the law in providing a framework for the realisation of their rights. Previously, the law viewed children as a vulnerable population in need of protection while the CRC recognises children as bearers of rights who are entitled to participate in society according to their evolving capacities.

Against this background the United Nations (UN) Committee on the Rights of the Child General Comment No. 3 has identified the following 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;

- **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 facilitate access to appropriate rights and services and 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; and

- **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.

The African Charter on the Rights and Welfare of the Child is the most significant regional charter on children. Its implementation is monitored by the African Committee of Experts on the Rights and Welfare of the Child. The Committee has begun to respond to HIV through the development of a Plan of Action on Orphans and Vulnerable Children. The Plan of Action emphasises resource allocation for implementing children’s programmes; enhancing the life chances of children; overcoming HIV and AIDS to ensure child survival, developing the potential of children by realising their right to education, protecting children to ensure their development and survival and ensuring the participation of children. This Action Plan also highlights the importance of:

- Developing national strategies to enable orphans and vulnerable children attain their physical, mental, spiritual, moral and social development;

- Meeting the special needs of orphans and vulnerable children by strengthening the capacity of caregivers, providing orphans and vulnerable children with essential services, providing social protection and facilitating a supportive environment through child centered community development;

- Poverty elimination; and

- Developing broad partnerships.

---

9 Ibid. See Articles 32 – 46.
10 In the report of the 5th meeting of the African Committee of Experts on the Rights and Welfare of the Child held at the Nairobi Safari Club in Nairobi, Kenya, 8-12 November 2004.
The first significant regional statement on HIV and children was the Tunis Declaration on HIV/AIDS and the Child in Africa. It was adopted in June 1994 by the Assembly of Heads of State and Government. The Declaration obligated governments to create a national policy framework to guide and support appropriate responses to the needs of affected children covering social, legal, ethical, medical and human rights issues.

Other significant regional declarations include the Abuja Declaration which was adopted in Nigeria on 27 April 2001 by the Heads of State and Governments of the Organisation of African Unity (OAU). This Declaration has a number of child-specific provisions including:

“4. We recognise the role played by poverty, poor nutritional conditions and underdevelopment in increasing vulnerability. We are concerned about the millions of African children who have died from AIDS and other preventable infectious diseases. We are equally concerned about the particular and severe impact that these diseases have on children and youth who represent the future of our continent, the plight of millions of children orphaned by AIDS and the impact on the social system in our countries.

We are particularly concerned about the high incidence of mother to child transmission, especially given the challenges of infant breastfeeding in the context of HIV infection on the continent.

6. We recognise that special efforts are required to ensure that Africa’s children are protected from these pandemics and their consequences and that the full and effective participation of young people in prevention and control programmes is essential to the success of these interventions.”

The Maputo Declaration on HIV/AIDS, Tuberculosis, Malaria and Other Related Diseases (2003), although it does not deal with the impact of HIV on children in any great detail, noted:

“The majority of those infected with and affected by HIV/AIDS in our continent are women, children and young people; especially the poor who have limited access to effective care and support. This reflects their vulnerability particularly in societies marked by gender inequality, where the burden of care for the sick and for the children orphaned by AIDS falls overwhelmingly on women. In this connection, we recognise the need to redouble efforts in giving particular attention to women and young people’s participation and access to information, life skills and services. Recognise the urgent need to alleviate the impact of the HIV/AIDS on the lives of orphans and their long-term development prospects. In this regard, appropriate policies including legal and programmatic frameworks, as well as essential services for the most vulnerable children, should be adopted and applied at all levels. The challenge is to keep parents alive through effective treatment and prevention as a first vital step.”

---

12 Ibid.
3. Legal responses to children and HIV in Africa

Since the adoption of the CRC in 1989 an estimated 69 countries or 35.7% of the 193 State Parties to the CRC have enacted children’s statutes. A number of African countries have been part of this international move towards reforming children’s laws including for example, Botswana, Kenya, Lesotho, Madagascar, Malawi, Mozambique, South Africa and Uganda. There are also draft laws being prepared in Namibia, Swaziland and Zambia.

Similarly there has been a flurry of legislative activity regarding HIV and AIDS in the last decade. For example, in the report on HIV/AIDS and Human Rights in Southern Africa (2009) it was noted that all countries in the region had taken some form of law or policy reform with regard to HIV and human rights. In a number of these acts there are provisions which protect children. For example, the report found 42.8% of countries had HIV laws which protected children.

3.1 Prohibiting discrimination

High levels of HIV-related stigma and discrimination continue to be experienced within Africa. 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. Laws are required which prohibit discrimination against children or their caregivers.

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 does not 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 HIV status of the child or their parents.

A Joint United Nations Programme on HIV and AIDS (UNAIDS) review of 58 African countries found that 41.4% of African countries had laws outlawing discrimination (see Table 1 below).

Table 1: Legislative measures to prohibit unfair discrimination

<table>
<thead>
<tr>
<th>AFRICAN REGION</th>
<th>No. of Countries with Protective Laws</th>
<th>No. of Countries without Protective Laws</th>
</tr>
</thead>
<tbody>
<tr>
<td>Middle East &amp; North Africa</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>West and Central Africa</td>
<td>17</td>
<td>6</td>
</tr>
<tr>
<td>East and Southern Africa</td>
<td>14</td>
<td>6</td>
</tr>
<tr>
<td>Totals</td>
<td>41</td>
<td>17</td>
</tr>
</tbody>
</table>

Source: UNAIDS: 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, 2010.

Examples of good practice:

• Child specific non-discrimination provisions in HIV laws. Article 32 of Law 1/018 on the Legal Protection of People Infected with HIV and of People Suffering from AIDS (2005) in Burundi provides that “children of infected persons, whether they themselves are infected or not, may not be denied admission or stay in public or private education...”

15 Duncan, B (2008), Global Perspectives on Consolidated Children’s Statutes, UNICEF.
centres, nor be the object of discrimination on any given pretext”. Likewise Article 36 of Law 2005-040 on the Fight against HIV/AIDS and the Protection of Rights of People Living with HIV (2005) states that “when exercising his rights, the child shall not be subjected to any discrimination or stigmatisation on the account of his real or presumed HIV status, the status of his partners, parents or legal guardians or close relatives”. In some countries there are also child-specific provisions, which protect children from discrimination in certain instances, such as in accessing education. For example, section 24 of the Prevention and Control of HIV and AIDS Act 2007 in Sierra Leone provides “no educational institution may deny admission to any person due to their actual, perceived or suspected HIV status”. These types of provisions are important as they ensure that children who may be discriminated against because of their own or a care-giver’s HIV status are protected; and

- **Child specific provisions protecting children from discrimination based on their health status.** In both Lesotho and South Africa dedicated children’s legislation protects children from being discriminated against because of their “health status”. The breadth of such provisions ensures that HIV is not exceptionalised and aims to ensure that discrimination on the grounds of a child’s health status does not occur.

**Areas of concern:**

- **The lack of child-specific protection in some countries.** In some countries, although discrimination is outlawed, legislation does not deal with child-specific issues. For example, the 2007 HIV and AIDS (Prevention and Control) Act in the United Republic of Tanzania does not specifically refer to children’s issues.

- **The lack of broad equality provisions.** Although almost all constitutions have broad equality provisions, only South Africa has dedicated equality laws. This means that if children face a range of discrimination because of, for example, their gender or sexual orientation coupled with inequality due to HIV, it may be difficult to obtain legal redress on issues other than their HIV status.21

- **In a number of countries there is only policy protection against unfair discrimination.** For example, a review of legislation and policy in 14 Southern African Development Community (SADC) countries in January 2009 confirmed that although many countries had laws outlawing discrimination, in 50% of the SADC countries’ protection against discrimination was only found in policy documents as opposed to formal legislation.22

### 3.2 Access to treatment

The highest numbers of adolescent boys and girls living with HIV are found in Africa with the most affected countries being South Africa, Nigeria, Kenya, Malawi, Mozambique, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe.23

Article 24 of the CRC provides 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.

**Examples of good practices:**

- **Legislations that describe a child’s right to health.** Examples exist of laws that recognise a child’s right to health. For example, the Children’s Act in Kenya provides that every child “shall have a right to health and medical care the provision of which shall be the responsibility of the parents and the Government”.24

**Areas of concern:**

- **In some countries litigation has had to be used to compel governments to provide treatment.** For example, in the case of Minister of Health v Treatment Action Campaign, in South Africa, the Treatment Action Campaign, challenged a restrictive prevention of mother-to-child transmission (PMTCT) policy, which limited access to

---

20 Children’s Protection and Welfare Act (2011, Lesotho) and section 6(2)(d) of Children’s Act (2010, South Africa).
22 Ibid at p. 33.
23 Ibid at p.24.
24 Section 9, Children’s Act (2001, Kenya).
the PMTCT programme to two research sites per province because the government refused to extend the programme any further.25 The Constitutional Court held that the Department of Health acted unreasonably in failing to roll out its PMTCT programme. They were ordered to end all prohibitions on the provision of PMTCT outside of research sites and to extend the programme.26

3.3 Access to sexual and reproductive health services

Adolescents are at high risk of HIV infection. In 2009 41% of all new HIV infections were in persons between the ages of 15 – 24.27 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 or care-givers.

The Model Law on HIV and AIDS in Southern Africa 2008 which was developed by SADC’s Parliamentary Forum provides in sections 13(5) and (6) that children should be able to consent independently to HIV testing, treatment and care.28 Section 23(3) of the East African Community HIV and AIDS Management Bill (2010) provides that the term “guardian” must be viewed broadly when considering whether an adult has the authority to provide proxy consent for a child to be tested for HIV.

Examples of good practice:

- *In a number of countries ages of consent to medical treatment are set in law.* This enables eligible children to consent independently to various forms of medical treatment including accessing HIV testing and contraceptives (see Table 2 below).

Table 2: Age of consent to various health interventions in selected African countries

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>AGE OF CONSENT</th>
<th>AGE OF MAJORITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burundi</td>
<td>21</td>
<td>21</td>
</tr>
<tr>
<td>Botswana</td>
<td>No age of consent to medical treatment, but boys can consent to male circumcision at 16</td>
<td>18</td>
</tr>
<tr>
<td>Cote d’Ivoire</td>
<td>No age set in law</td>
<td>18</td>
</tr>
<tr>
<td>Ghana</td>
<td>No age set in law</td>
<td>18</td>
</tr>
<tr>
<td>Kenya</td>
<td>No age set in law, a minor may consent to HIV testing if they are married, pregnant or at high risk of HIV infection</td>
<td>18</td>
</tr>
<tr>
<td>Lesotho</td>
<td>12, contraceptives 12 and HIV testing 12</td>
<td>18</td>
</tr>
<tr>
<td>Mauritius</td>
<td>18, HIV testing permissible independently if the minor has understanding</td>
<td>18</td>
</tr>
<tr>
<td>Namibia</td>
<td>18</td>
<td>21</td>
</tr>
<tr>
<td>Nigeria</td>
<td>16</td>
<td>18</td>
</tr>
<tr>
<td>Seychelles</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>Senegal</td>
<td>No age set in law, HIV testing 15</td>
<td>18</td>
</tr>
<tr>
<td>South Africa</td>
<td>12, contraceptives 12 and HIV testing 12</td>
<td>18</td>
</tr>
<tr>
<td>Tanzania</td>
<td>No age set in law</td>
<td>18</td>
</tr>
<tr>
<td>Zambia</td>
<td>21</td>
<td>Not defined</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>No age set in law</td>
<td>18</td>
</tr>
</tbody>
</table>

Source: UNICEF (2011) and Centre for Human Rights (2010)

---

26 Minister of Health v Treatment Action Campaign 2002 (4) BCLR 356 (CC).
A number of countries have also specified the age at which children can consent to other sexual and reproductive health services such as HIV testing and accessing contraceptives. For example, in Lesotho the Children’s Protection and Welfare Act 2011 provides that a child of 12 may consent independently to medical treatment if they of “are sufficient maturity and have the mental capacity to understand the benefits, risks, social and other implications of the treatment or operation”29. Likewise in Senegal the HIV/AIDS Law provides in Article 12 that a minor over the age of 15 may consent independently to HIV testing.30 In South Africa, children can access contraceptives independently from the age of 12.31

Some countries have recognised the role played by caregivers by vesting them the legal authority to provide proxy consent to medical treatment. For example, in Cameroon, section 23(5) of Article 38 of Ordinance No. 81/02 on Alimony provides that a “person who does not have parental responsibility for a particular child, but has care and control of the child may subject to the provisions of this Act, do what is reasonable in all the circumstances of the case for the purpose of safeguarding or promoting the child’s welfare.” This type of legal recognition of persons other than parents and guardians means that the adults caring for orphans and vulnerable children are able to make decisions on their behalf.

Areas of concern:

Some regional guidance does not recognise the evolving capacity of children. For example, section 23(2) of the East African Community HIV and AIDS Management Bill 2010 does not recognise the capacity of children to consent independently to HIV testing before adulthood. This is problematic as there is some evidence that a lack of an independent age of consent to medical treatment acts as a barrier to adolescents accessing services.32

Very few African countries have legislation which sets an age at which children may consent independently to medical treatment, HIV testing or accessing contraceptives. This means that in these countries children will only have the capacity to independently consent to medical treatment when they become adults thereby creating a barrier to children accessing sexual and reproductive health services;

In some countries, which do recognise the evolving capacity of children, legislation does not take a consistent approach to this principle. For example, in Senegal, children of 15 and over can consent to HIV testing but the law does not recognise their capacity to consent to medical treatment or contraceptives. In other countries, although evolving capacity is recognised, constraints are placed on the testing. For example, in Mauritius, children who wish to consent independently to HIV testing must request the testing in writing.33 In Kenya, children’s evolving capacity is not recognised and children can only consent independently to HIV testing in a narrow range of circumstances - namely if they are married, pregnant or at risk of HIV infection.34 In South Africa several key health interventions with children all have different age and capacity requirements, as set out in Table 3 below. These requirements do not appear to be linked to a coherent understanding of capacity or the nature of the intervention being consented to and this makes it difficult for health care providers to provide services to adolescents; and

In many countries the role played by caregivers is not recognised and they are unable to provide proxy consent for children in their care to receive medical treatment. For example, in Kenya only parents or guardians can provide proxy consent to HIV testing.35 This means that for orphans and vulnerable children who do not have parents or guardians it is very difficult to access HIV testing if they do not have the capacity to consent independently.

30 Article 12, law No. 06/2009 on HIV and AIDS.
31 Section 134, Children’s Act (2010, South Africa).
35 Ibid.
### Table 3: Disparate approaches to child capacity in South Africa

| Approach 1: No express age or capacity requirement provided in law | Termination of pregnancy |
| Approach 2: Children must reach a certain age and demonstrate capacity | Medical treatment |
| | HIV testing for children under 12 |
| Approach 3: Children must be a certain age | HIV testing |
| | Access to contraceptives and contraceptive advice |
| Approach 4: Children must be of a certain age and meet other requirements | Operations: 12 + ‘the child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the surgical operation’ + they are duly assisted by his or her parent or guardian |
| | Male circumcision 16 + ‘proper counselling’ + in the prescribed manner |

### 3.4 Access to HIV education and information

The 2010 UNAIDS Global Report on the Epidemic found that although knowledge and understanding of HIV has increased among young people aged 15 – 24 in many instances it remains inadequate. For example, less than half the young people living in 15 of the most affected African countries can correctly answer five basic questions about HIV and its transmission (these countries are Botswana, Burundi, Cameroon, Central African Republic, Chad, Congo, Côte d’Ivoire, Guinea-Bissau, Kenya, Malawi, Nigeria, South Africa, Togo, the United Republic of Tanzania and Zambia).36

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.”37

Examples of good practice:

- **Legislation requiring the state to provide HIV information or education to children.** A number of countries have included obligations to provide HIV education in HIV-specific laws. For example, Kenya’s *HIV and AIDS Prevention and Control Act* provides that the ministry responsible for education must provide information on the causes and modes of HIV transmission.38 In a similar approach the *Prevention and Control of HIV and AIDS Act (2007)* of Sierra Leone requires the government to endeavor to provide HIV education.39 Significantly, the Kenyan legislation requires the state to provide such education in “public and private schools at primary, secondary, and tertiary levels, including informal, non-formal and indigenous learning systems.”40

Areas of concern:

- **In many countries the obligation to provide HIV education is only contained within policy documents.** A 2011 review of the laws and policies on HIV and sexuality education in eight African countries found that in most instances the obligations to provide such education were contained in policies rather than laws. Mozambique lacked a law or a policy on this subject. Without such obligations, the quality and coverage of such education may vary within a state.41

- **Even where legislation on HIV education exists it often does not require such education to be provided in private or faith-based schools.** Without such obligations requiring universal coverage many children may not have access to information on how to protect themselves from HIV and how to live with it.42

---

39 Part II, Prevention and Control of HIV and AIDS Act (2007, Sierra Leone)
41 Centre for Human Rights, Faculty of Law, University of Pretoria (2011) Legal and policy issues related to HIV and young people in selected African countries. Pretoria, South Africa.
• Laws requiring HIV education for children do not require a link between information and access to services. Providing access to HIV prevention services within schools appears to be more politically sensitive than the provision of education services. No examples were found of laws that gave children the right to access sexual and reproductive health services at schools, although there were examples of children having such rights at community facilities.42

3.5 Access to harm reduction measures

HIV transmission through injecting drug use is an emerging epidemic in a number of African countries including Kenya, Mauritius, South Africa, and the United Republic of Tanzania.43

Guideline 4 of the International Guidelines on HIV and Human Rights provides that “the criminal law should not be an impediment to measures taken by States to reduce the risk of HIV transmission among injecting drug users and to provide HIV-related care and treatment for injecting drug users”.44

Example of good practices:
• Legislation that enables HIV prevention measures to be provided to drug users without criminal penalty. The Mauritian HIV and AIDS Act allows any institution or non-governmental organisation to supply, syringes and needles as part of therapy provided to persons dependant on dangerous drugs.45

Areas of concern:
• Only one African example of legislation facilitating access to harm reduction services for injecting drug users. It is of concern that only one African country (Mauritius) has legislation facilitating access to harm reduction measures for injecting drug users.
• Developing legislative models, which enable young people to access harm reduction services without criminal sanction. Children who inject drugs are particularly vulnerable as service providers may not wish to provide services to young persons.46

3.6 Guardianship, property rights and social protection

Given the high numbers of orphaned children in Africa their guardianship has become a key issue. Guardians take responsibility for amongst others, caring and maintaining the child, assisting them with decision-making and protecting any financial or property interests. Although a child’s guardians are ordinarily their parents, in the context of HIV with the high numbers of orphans many children have been left without guardians. Article 5 of the CRC speaks to these very significant concerns for children:

“respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or 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”.

Read with the United Nations General Assembly Resolution 64/142 Guidelines on the Alternative Care of Children47, international standards provide a robust law and policy framework for the protection of orphaned children. The guidelines 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 including the legal recognition of such arrangements to facilitate access to grants and make decisions such as consent to medical treatment; and

---

45 Section 14, HIV and AIDS Act (Mauritius).
46 In Canadian use must be 18 or older in order to access drug injection sites. PHS Community Services Society v. Canada, 2011 SCC 44, [2011] 3 S.C.R. 134.
• No child should be without the support and protection of a legal guardian or other recognised responsible adult or competent public body.

Example of good practices:

• A number of countries have adopted new children’s laws, which recognise the parental responsibilities and rights of a number of persons other than biological parents. For example, the Children’s Act, in Ghana defines a parent to include those who have taken on parental responsibilities and the Lesotho Children’s Protection and Welfare Act 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.” Likewise, the South African Children’s Act 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 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.

• Some countries have amended or introduced laws, which simplify the process of transferring guardianship from one adult to another. For example, the South African Children’s Act 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. Section 6 of the Uganda Children Act 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.

• Many countries have introduced child-specific forms of social protection to support orphans and vulnerable children. This has been in a number of different ways, for example, some countries have legislated broad socio-economic rights within children’s statutes, such as section 10(1) of the Lesotho 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”. Others provide social services to all children. For example, Zimbabwe offers free health care to children under five. Likewise, in Malawi there is free primary school education and grants for books and clothing. 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.

• A number of countries have introduced a range of policies to protect orphans and vulnerable children. Table 4 below shows that in East and Southern Africa (ESA) that although less than half the countries have laws protecting orphans and vulnerable children, 77.3% of countries have policies or strategies dealing with orphans and vulnerable children.

Table 4: Snapshot of laws and policies protecting orphans and vulnerable children in Eastern and Southern Africa

<table>
<thead>
<tr>
<th>Laws in place to protect orphans &amp; vulnerable children</th>
<th>Orphans &amp; vulnerable children right to inheritance protected in law</th>
<th>Policies/strategies in place to protect additional needs of orphans &amp; vulnerable children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Burundi</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comores</td>
<td></td>
<td>N</td>
</tr>
</tbody>
</table>

48 Section 124, Children’s Act (1998, Ghana).
50 Section 27(2), Children’s Act (2010, South Africa).
<table>
<thead>
<tr>
<th>Country</th>
<th>Law or Policy</th>
<th>Law or Policy</th>
<th>Law or Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Democratic Republic of Congo</td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eritrea</td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethiopia</td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kenya</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Lesotho</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Madagascar</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malawi</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Mauritius</td>
<td>N</td>
<td></td>
<td>N</td>
</tr>
<tr>
<td>Mozambique</td>
<td>N</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Namibia</td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rwanda</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>Seychelles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>South Africa</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swaziland</td>
<td>N</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Tanzania</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Uganda</td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zambia</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>Y</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td><strong>Total % of respondents</strong></td>
<td><strong>60 %</strong></td>
<td><strong>86 %</strong></td>
<td><strong>81 %</strong></td>
</tr>
<tr>
<td><strong>Total % of countries in the</strong></td>
<td><strong>40 %</strong></td>
<td><strong>27.3 %</strong></td>
<td><strong>77.3 %</strong></td>
</tr>
</tbody>
</table>

Source: UNAIDS: Country Snap Shots of Laws and Policies that Support or Block Access to HIV Prevention, Treatment, Care and Support in Eastern and Southern Africa (2011)

Areas of concern:

- The continued recognition of discriminatory customary laws results in children being disposed of their homes following the death of one or both parents. In many parts of sub-Saharan Africa 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.

- Many legislative reforms have a limited impact on the lives of children as they are either very narrowly crafted or not widely used. For example, although section 31(2) of the Ugandan Constitution requires parliament to enact legislation to protecting the inheritance rights of widows and widowers however, the Succession Act provides only usufructuary rights to land for widows and their children.\(^{53}\) While in Zambia although the Marriage Act provides non-discriminatory rules for property division between a husband and wife in civil law marriages this has had a limited impact as the majority of Zambians are married in terms of customary laws.\(^{54}\)


\(^{54}\) Ibid.
4. Customary law

In many parts of Africa customary law remains the dominant system for resolving disputes. This often continues to discriminate against women and girls, particularly in relation to property and inheritance rights since in many traditions, women and female children are prevented from inheriting.\textsuperscript{55} This has a domino effect on children who may be left in a state of reliance on men in their community and may be, for example, dispossessed of their home if their mother has no inheritance rights. This also has implications for the financial and social independence of children and their mothers, and often denies them choices in accessing HIV services. The custom of wife inheritance may also increase children’s vulnerability to HIV since women may be forced to accept the advances of a new husband who may already have several other wives, increasing the changes of mother-to-child transmission.\textsuperscript{56}


\textsuperscript{56} Ibid.
5. Conclusions

Children living in Africa are one of the populations most affected by the epidemic. Not only does the continent have one of the highest growing epidemics amongst adolescents but more children have been orphaned in Africa than in any other region in the world. As a result legal responses which address the changing social environment are crucial. Although there has been some law reform, especially in ESA, such progress has addressed a limited number of issues. Three overarching issues need to be addressed. Firstly, in many parts of Africa customary law remains the dominant system for resolving disputes and this continues to discriminate against women and girls, which has a domino effect on children who may be, for example, dispossessed of their home if their mother has no inheritance rights. Secondly, very few countries have recognised the evolving capacity of children in a holistic manner. Thus although some allow children to consent for example, to HIV testing at a certain age, children cannot access contraceptives or medical treatment if they are HIV-positive. Finally, children’s socio-economic rights remain underdeveloped throughout the continent making it difficult to enforce a child’s right to the highest attainable standard of health care.