Regional Issues Brief:

RIGHTS OF CHILDREN AND YOUNG PEOPLE TO ACCESS HIV-RELATED SERVICES

For the Asia-Pacific Regional Dialogue of the Global Commission on HIV and the Law

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Bangkok, Thailand
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This Regional Issues Brief has been written to provide an overview of an area of enquiry that the Global Commission on HIV and the Law is examining – issues of law and HIV pertaining to young people. It has been undertaken through a literature review of laws and documentation of their enforcement in the context of Asia and the Pacific. It serves as an information resource and complements the report of the Regional Dialogue for Asia and the Pacific that was held under the auspices of the Global Commission on HIV and the Law in Bangkok on 16 and 17 February 2011.

It is estimated that there were 160,000 children and adolescents living with HIV in Asia in 2009. Programmes to prevent mother-to-child-transmission have expanded to reach 32% of pregnant women living with HIV in Asia in 2009. Access to pediatric HIV treatments is still very limited. At the end of 2009, only 44% of children in Asia in need of antiretroviral therapy were receiving it. Many children who have been living with HIV since birth are approaching adolescence, presenting new challenges for programmes originally designed for young children. In Asia, new infections among young people aged 15-24 primarily occur among those most at risk, particularly young males who have sex with other men, young people who inject drugs and young people engaged in sex work.

In the Pacific, the vast majority of children and young people living with or affected by HIV are in Papua New Guinea. In Papua New Guinea it was estimated that 3,100 children aged 0-14 were living with HIV in 2009, and HIV prevalence among young people aged 15-24 was estimated to be 0.6%. HIV prevalence among young females (0.8%) was estimated to be more than twice as high as HIV prevalence among males (0.3%).

Most countries in the region have signed or ratified international conventions and agreements that recognise the rights of children and young people to the highest attainable standard of health including to access information essential for their health and development. States have an obligation to protect and safeguard these rights. The human rights of children and young people are defined by the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Convention on the Rights of the Child (1989). General Comment 14 on the right to health and ICESCR states:

“Children and adolescents have the right to the enjoyment of the highest standard of health and access to facilities for the treatment of illness. The Convention on the Rights of the Child directs States to ensure access to essential health services (and)… links these goals with ensuring access to child-friendly information about preventive and health-promoting behaviour and support to families and communities in implementing these practices. Implementation of the principle of non-discrimination requires that girls, as well as boys, have equal access to adequate nutrition, safe environments, and physical as well as mental health services. There is a need to adopt effective and appropriate measures to abolish harmful traditional practices affecting the health of children, particularly girls, including early marriage, female genital mutilation, preferential feeding and care of male children… States parties should provide a safe and supportive environment for adolescents, that ensures the opportunity to participate in decisions affecting their health, to build life skills, to acquire appropriate information, to receive counselling and to negotiate the health-behaviour choices they make. The realization of the right to health of adolescents is dependent on the development of youth-friendly health care, which respects confidentiality and privacy and includes appropriate sexual and reproductive health services.”

The Convention on the Rights of the Child establishes the principle that the best interests of the child shall be the primary consideration in all actions concerning children (article 3), the right to non-discrimination (article 2), right to life, survival and development (article 6) and the right to have views affecting the child heard and given due weight, in accordance to age and maturity of the child (article 12 and 13).

The Convention on the Rights of the Child sets the upper limit of childhood at 18 years. This standard is not consistently

2  Data from UNICEF: http://www.unicef.org/infobycountry/papuang_statistics.html
reflected in laws of states in Asia and the Pacific. Within each jurisdiction there is often also a disparity between the age at which parental consent is required for medical treatment and the ages of consent for heterosexual sex and (where it is not illegal) homosexual sex.

Young people may have difficulties accessing HIV-related services because of lack of enforceable legal protections from discrimination, in addition to constraints faced by young people due to laws relating to age of legal capacity. Many young people face discrimination in accessing services, or in the way services are provided, by reason of their age (including sexual and reproductive health services, harm reduction services such as needle and syringe programmes and opioid substitution programmes, HIV testing, treatment, care and support services, and services for orphans and vulnerable children).

The laws of some jurisdictions provide that young people have an affirmative legal right of access to certain specified health and welfare services (see sections 4 and 7 below). However, there are very few jurisdictions that provide a legal remedy for discrimination in accessing services on the grounds of being a young person. Australia’s Age Discrimination Act 2004 makes it unlawful to discriminate on the basis of young person’s age in a number of areas of public activity, including work, accommodation, education, access to goods, facilities, services and premises, requests for information and the administration of government laws and programmes.
2. Age of legal capacity to consent to medical interventions

The age of legal capacity to consent to medical interventions varies between jurisdictions. This has relevance to HIV and sexually transmitted infection (STI) testing, HIV treatment, reproductive health services and harm reduction services such as opioid substitution therapy. Common law and civil law jurisdictions generally recognise that consent to testing or treatment may be given by a parent or legal guardian of a person who is below the age of legal capacity. Customary and religious laws operate alongside formal laws. This may mean that consent on behalf of children by adults other than parents (such as extended family members, village elders or religious leaders) may play a role in decisions regarding the welfare of children that are recognised by informal law.

In civil law countries, the age of legal capacity to consent to medical interventions such as an HIV test is established by legislative codes. Generally this legislation defines legal capacity for all legal matters, not just in relation to medical interventions. For example, the Civil Law of China states that a person has full legal capacity at the age of 18 years or above, and that a citizen who has reached the age of 16 but not the age of 18 and whose main source of income is his own labour shall also be regarded as a person with full capacity.6

In common law countries (former British colonies), legal capacity to consent to medical interventions is determined by case law and legislation. Legislation often supplements the common law principle established by case law that the authority to consent to medical interventions on behalf of a child rests with the child’s parent or guardian. Common law recognises that minors may give an effective consent to medical treatment once they have sufficient maturity to understand the nature and consequences of the treatment, known as the ‘mature minor’ principle.7

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6 Article 11, Civil Law of the People's Republic of China.
7 Gillick v West Norfolk A.H.A[1984] 1 Q.B. 581
3. Access to HIV testing and treatment

Access to HIV testing is an entry point to counselling on HIV risk and to care for those who test positive. For children, expansion of prevention of mother-to-child transmission programmes has enabled early detection of HIV infection among mothers, prevention of transmission from mother to child, and better outcomes for babies and their mothers. For young people, access to HIV testing may be limited by age of consent laws.

Given the sensitivity of an HIV test result, careful consideration needs to be given as to whether laws that impose age restrictions on testing except with parental consent may act as a disincentive to young people knowing their HIV status and seeking treatment and care. Age limitations often do not recognize children’s evolving capacities, their right to participate in decisions regarding their own treatment and wellbeing, and their best interests.8

A recent review of sexual health laws of Asian countries argues that it is particularly important that the principles of evolving capacity and rights to confidentiality are taken into account:9

“Persons under 18 years of age face particular barriers in accessing sexual health services, care, and information. The necessity of consent for health services and procedures is fundamental. While in regard to minors, parents or guardians may retain formal powers to consent, respect for the principles of the evolving capacity of the child and his or her best interest can result in under-18s accessing appropriate and necessary services without recourse to parental involvement or consent. The principle of evolving capacity suggests that older adolescents should be able to access services without consent of parents or guardians. In addition, the right to enjoy confidentiality in regard to sexual health services and care should be respected.”

For the purposes of a WHO/UNAIDS/UNICEF regional consultation on HIV testing and counselling held in 2007, Goyena conducted a review of laws relating to HIV testing in a selection of Asia Pacific countries (China, Thailand, Philippines, Papua New Guinea, Malaysia).10 Goyena reported the following findings:

(i) In all countries reviewed, persons 18 years and over are considered to have the capacity to give consent to medical interventions such as HIV testing. In some countries, the ‘mature minor’ exception may apply.

(ii) There are no legal provisions or policy guidelines regarding the HIV testing of unaccompanied minors (or those whose parent, legal guardian, or next of kin cannot be located), abandoned, orphaned, street children, or minors engaged in prostitution who are not in the custody of the appropriate government authority.

(iii) There are no national statutory provisions or national policy guidelines regarding HIV testing of orphans or children in institutional settings.

(iv) In 2006, the Chongqing City Children’s Welfare Institution announced it would conduct HIV testing of all newly admitted children, the first time in China that HIV testing is to be carried out for children in orphanages.

(v) In the Philippines, the HIV law makes reference of the HIV testing of minors (defined as those below 18) in the context of capacity to give written informed consent (the rules require written informed consent by a parent or guardian).11 In China, Hong Kong, and Thailand, reference instead is made to civil code provisions regarding the age when a person is capacitated to engage in civil activities.

The *Philippine AIDS Prevention and Control Act of 1998* encourages voluntary consent, but does not provide that a mature minor can give a valid consent:

“Section 15. Consent as a requisite for HIV testing. — No compulsory HIV testing shall be allowed. However, the State shall encourage voluntary testing for individuals with a high risk for contracting HIV: Provided, That written informed consent must first be obtained. Such consent shall be obtained from the person concerned if he/she is of legal age or from the parents or legal guardian in the case of a minor or a mentally incapacitated individual. A Minor is defined as a person who is below 18 years of age.”12
Goyena’s review recommended that countries develop specific and uniform policy and guidelines on HIV testing and counselling of the population groups which have been left out in previous policy and guidelines, such as: minors, minors unaccompanied or without a parent, legal guardian, and next of kin; and orphans and minors in institutional settings.

At the 2007 WHO/UNICEF/UNAIDS consultation, Sakai (UNICEF Cambodia) reported that few countries have specific policies and guidelines addressing HIV testing among children, how to elicit informed consent from children, or guidance on how to ensure the best interest of the child are considered.13 UNICEF also reported that challenges for obtaining consent to testing include:

(i) laws and policies related to consent are absent or unclear, or contradictory;
(ii) legal age of consent is set at a higher age than average age at which adolescents become sexually active or experiment with drugs, and therefore may inhibit willingness to test;
(iii) appropriate arrangements may not exist for consent where no parent or guardian is available (orphans, abandoned children, street children);
(iv) parents may refuse to provide consent for testing of a child for fear that the HIV positive status of an infant will indicate the HIV positive status of a parent.

**Lao PDR**

Lao PDR passed a *Law on the Protection of Rights and Interests of Children* in 2007, which includes specific provisions on the care of children and education for children affected by HIV and AIDS. Article 17 states as follows:14

Care of Children Affected by HIV/AIDS

The State and society shall create conditions for children affected by HIV/AIDS to have access to health care and education, to live with their family and to be protected from all forms of discrimination from the community and society.

The State must create conditions for children affected by HIV/AIDS to receive policies on health protection and care as follows:

1. Take measures to prevent transmission of HIV/AIDS, particularly mother-to-child transmission of HIV/AIDS;
2. Provide counselling for children infected with HIV/AIDS. Children should not be forced to be tested for HIV/AIDS, and their HIV/AIDS status should be kept confidential;
3. Provide care and treatment to children infected with HIV/AIDS, including providing them with antibiotics and other medicines;
4. Encourage the society and community to support and assist children infected with HIV/AIDS.

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4. Access to sexual and reproductive health services

A regional review of Asian sexual health laws found:

Laws that erect barriers to accessing contraception or safe abortion services have the affect of reducing the sexual wellbeing of girls and women, in that they are denied the fundamental right to determine if and when sexual activity will become reproductive. Other laws fail to provide adequate access to goods and services in the context of sexual assault (such as forensic tests as well as treatment of injuries and STIs).15

Access to sexual health promotion information and condoms for young people can be restricted by laws that criminalize homosexuality or sex outside of marriage. Nineteen countries in the Asia Pacific region criminalize sex between men (see Regional Issues Brief on Criminalization). In Pakistan and Afghanistan, premarital sex contravenes religious laws. In these jurisdictions, authorities may be reluctant to support publication of health promotion information or dissemination of condoms and lubricant targeted at populations other than adult married couples.

China’s Population and Family Planning Law 2001 guarantees access to certain services. Article 19 provides that the State shall create conditions conducive to individuals being assured of an informed choice of safe, effective, and appropriate contraceptive methods. Safety or recipients of birth control procedures must be ensured. Article 21 provides that couples of reproductive age who practice family planning shall be able to obtain technical services free of charge under the basic items as specified by the State.

In the Philippines, state agencies are obligated to provide sexuality education and health services to young girls and to provide women with appropriate, timely, complete, accurate information and education on family planning methods and HIV prevention and management. In providing education and information in these areas, the government is required to pay due regard to:16

“(1) the natural and primary right and duty of parents in the rearing of the youth and the development of moral character and the right of children to be brought up in an atmosphere of morality and rectitude for the enrichment and strengthening of character;

(2) the formation of a person’s sexuality that affirms human dignity; and

(3) ethical, legal, safe, and effective family planning methods including fertility awareness.”

Lao PDR’s Law on the Protection of Rights and Interests of Children (2007), states:17

“The State creates conditions for children affected by HIV/AIDS to receive education and to participate in various activities in school without discrimination.”

Disclosure of the HIV/AIDS status of children is forbidden.

In Indonesia, there are contradictory laws that may create confusion regarding young people’s rights to reproductive health services. This confusion may particularly disadvantage adolescents. The Law on Population Development and Development of Family (2009) states that every citizen has the right to obtain information and receive education related to reproductive rights.18 The Law also states that the government is responsible for providing information, services, and technology for family planning including information and educational materials on reproductive health for (prospective) married couples and adolescents.19 However, Indonesia’s Criminal Code contains legal provisions that criminalize supplying information to people relating to the prevention and interruption of pregnancy (see Articles 534, 535 and 283).20 The Health Law, 2009 states that every individual has the right to a healthy and safe reproductive life and sexual life free from coercion and/or violence; however this is only with a lawful partner, and the right to determine one’s reproductive life and to be free from discrimination, coercion or violence is subject to respecting noble values and religious norms.21

16 Magna Carta of Women of 2009 (Phil.), Section 17.
18 Article 5 of Law No. 52/2009.
19 Articles 20 to 29; UNESCO (2010) Education sector response to HIV, drugs and sexuality in Indonesia Jakarta: UNESCO, p.27.
20 Left without a choice: Barriers to reproductive health in Indonesia (2010) London: Amnesty International
21 Article 72.
5. Access to harm reduction services for young people who use illicit drugs

Harm reduction programmes for people who use drugs generally target adults, even though children initiate drug injecting as early as 12 years of age. The age of first injection is commonly between the late teens and early twenties. Civil society groups have argued that there has been a consistent lack of focus on young people in policies and programmes relating to injecting drug use. Guidance issued by WHO, UNODC and UNAIDS states that HIV prevention programmes for people who inject drugs should not have age restrictions, i.e. there should be no minimum age requirement for accessing services.

**Australia**

Policy directives encourage harm reduction services to consider the individual circumstances of children. For example, the policy in New South Wales states:

"Depending on the age of the child, a clinical decision may be required to determine that it is appropriate to provide injecting equipment. It is essential that advice be provided regarding drug and alcohol and other support services prior to provision of injecting equipment."

The practical application of this policy is that workers must act to reduce potential harm and maximise the opportunity to engage the client in order to assess their situation and their exposure to harms. It is important that interventions do not discourage the client from continuing to use the service, where this is appropriate, as this may place them at further risk. The following actions must be undertaken:

- attempt to engage the child to assess the level of risk (including risk of exposure to blood borne virus)
- assess whether the provision of clean equipment is appropriate
- assess the extent of any other risks faced by the child and provide appropriate support, advice or other interventions
- prior to providing equipment NSP staff must provide the child with information on alcohol and other drugs support services available to the child
- make a report to the Department of Community Services.

Under Section 24 of the *Children and Young Persons (Care and Protection) Act 1998*, needle and syringe exchange programme (NSP) staff may report concerns about risk of harm relating to a young person. NSP staff should also endeavour to reduce vulnerability to the risk of harm relating to a young person through the provision of support and referral to appropriate alcohol and other drugs (AOD) and youth specific services.

**Indonesia**

It is important that schools address issues relating to HIV prevention and injecting drug use in the curriculum, particularly in countries with significant HIV epidemics among people who use drugs. UNESCO has argued that drug education should address prevention rather than focusing only on the legal penalties for illicit drug use. In 2010, UNESCO reported the following situation in Indonesia:

"Although the new Law on Narcotics (No. 35/2009) and the Strategic Plan of the Bureau of Narcotics Control consider the education sector to be a strategic partner, there is no clear guideline to integrate drug information and education into the school curriculum. In fact, partnership with schools seems directed toward monitoring and reporting of drug abuse incidence rather than drug education and prevention. There is a lack of designed regular information and education guidelines to deal with drug abuse…

Law on Narcotics, Chapter X (Guidance and Supervision) article 60 suggests that to prevent children from using and abusing drugs, information on Narcotics should be incorporated into the primary and secondary school curriculum. Although there has never been any clear guideline about the execution of such a mandate, BNN has been working with and through schools. The National Strategy of the National Narcotic Board…"
in drug prevention is mandated through Ministry of Social Affairs for community-based prevention and to Ministry of National Education for school-based prevention. The school-based prevention strategy emphasizes the promotion of preventive measures through life-skills education and the development of Information, Education, and Communication (IEC) materials and advocacy strategies. In reality, however, repressive measures were used more often rather than the promotion of preventive measures.

A UNESCO survey in 2005 suggested that most Indonesian schools used monitoring mechanisms to “capture and report” students involved in drug use or other drug related crime. Most schools then expelled students.25

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6. Access to sex education, HIV education and condoms in schools

Sex education and HIV education in schools

A regional review of sexual health laws observed:26

"Many different sectors of law are essential to ensure adequate education in general and adequate sexuality education in particular. These sectors include administrative regulations regarding educational curricula, and constitutional provisions on rights to education; equality and non-discrimination law (regarding sex, gender, sexual orientation, race, religion, disability, health status and national status among other grounds). Other important laws engaged to support effective sexuality education include those protecting freedoms of speech and expression, and laws guaranteeing both teachers and students safe and non-discriminatory environments."

Legislation in the Philippines, Cambodia, China, Vietnam and Pohnpei state of Federated States of Micronesia specifically requires HIV education in schools (see Annex I). The Marshall Islands has legislated to require health education within the school curriculum, although sex is not specifically referred to in the law.27 Many countries including Bangladesh and India have policies (e.g. National HIV/AIDS Policies) requiring HIV education in schools, but this is often not backed up by legislation.

In China, access to sex education in schools is required by the Population and Family Planning Law of the People’s Republic of China of 2001, the Law of the People’s Republic of China on the Protection of Minors of 1991 and the Regulations on AIDS Prevention and Treatment of 2006. These laws require schools to provide age-appropriate education in sexual health and HIV prevention. China’s Ministry of Education issued Guideline on HIV/AIDS Prevention Education in High Schools in 2003 and school HIV/AIDS prevention education was introduced into the curriculum. The guideline states that ten courses of HIV prevention education in high schools should be arranged, comprising two courses in each academic year. The goal is to raise students’ awareness on HIV prevention, equip students with the knowledge and skill to prevent HIV, help students develop healthy lifestyle and encourage students to care for people infected with or affected by HIV, rather than to discriminate and stigmatize.

Vietnam’s Law on HIV/AIDS Prevention and Control of 200628 imposes explicit obligations on educational institutions. Under this law, the Ministry of Education and Training bears primary responsibility for developing school curricula on sexual and reproductive health, including HIV prevention and control. The Ministry also bears responsibility for directing education institutions to implement the curricula, and educational institutions are responsible for providing that curricula to their students.

A on sexuality education in Asia, which looks at laws, policies, strategies and assessments on sexuality education in 13 countries in the region found:29

- Three of the 13 countries (Bangladesh, Cambodia and India) have overt reference to rights in their policy or strategic documents on education and HIV or SRH (sexual and reproductive health). Cambodia, China, Philippines and Vietnam have national laws on HIV, which underpin multisectoral programmes, including education.
- Progress is being made across Asia in almost all the countries regarding some form of sexuality education in secondary and, in some cases, primary education. However, there is still a long way to go. School-based sexuality education is not as comprehensive as it could be and coverage of sexuality education programmes is generally limited; less than half of the schools are implementing programmes.
- Detailed and comprehensive policies and strategies have been prepared by very few education ministries. Cambodia has comprehensive policies specific to the education sector for HIV, SRH and school health together with a costed sector-wide strategic plan and an operational plan. Vietnam also has a detailed policy and an action plan on reproductive health and HIV for secondary education. Indonesia has integrated school health

26 Bhardwaj K, Divan V. op cit p.151.
27 Communicable Diseases Prevention and Control Act 1988 §1510 (Marshall Islands)
28 Article 12(4).
and HIV education into its national Education Sector Plan.

- The main enabling vehicle for sexuality education is the national strategic plan on HIV. All 13 countries have a multisectoral plan that includes activities for the education sector. However, there is a lack of alignment; the strategies are generally not included in mainstream education sector plans.

- The progressive empowerment of adolescents is taking place in all 13 countries through life skills education, integration of sexuality education in the curriculum, through co-curricular activities, including peer education and, increasingly, through access to health services.

- Constraints on empowerment include the quality of teaching and learning in sexuality education; lack of comprehensive information (high-risk behaviours are often omitted, as are social issues such as gender relations); lack of learner involvement in programme design; and lack of a regular assessment of learning outcomes.

Sexuality education in Asia: Laws and policies

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<th>Education sector policy on HIV</th>
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An earlier regional study of HIV/AIDS and sexual and reproductive health education in selected countries in the Asia and Pacific region was published in 2000. Although in some respects outdated, this study has some useful findings that are likely to still be valid. The countries included were Brunei, Cambodia, China, Indonesia, Malaysia, Mongolia, Myanmar, Papua New Guinea, Philippines, Thailand and Vietnam. When the study was undertaken, China, Vietnam, Cambodia and Papua New Guinea were the only countries that explicitly mentioned condoms within secondary school curriculum. Other key findings included:

“The education most students receive in most countries is focused upon the biology of sexual reproduction and not upon sexual practice in social context. Where sex is discussed in social terms, the family usually frames it. These emphases are reflected in the titles given to HIV/AIDS and sexual and reproductive health education programmes. For example, in Malaysia such work takes place within the context of Family Health Education; in Thailand in Life and Family Education; in Vietnam in Population Education, and in Indonesia and Mongolia in Adolescent Reproductive Health. That ‘sex’ is not used in curricula titles points to the sensitivity of the subject matter. ‘Sex education’; therefore, clearly does not describe what most countries do.

Sexual activity is typically framed as something that should occur between husband and wife and where sex is positioned outside of marriage and reproduction it is nearly always discussed as a ‘problem’. For example, in lesson plans from Thailand and the Philippines sex between unmarried young people and sex with sex workers is actively discouraged.

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30 Adapted from Clarke D. op cit p.32.

Homosexuality is only mentioned explicitly in the curricula of two countries. The first is the Philippines where it is mentioned as an ‘emergent sexual behaviour’. The second example occurs in Mongolia where homosexuality appears in the Adolescent Reproductive Health Program under the topic of sexual behaviour and orientation.

Curricula documents from most countries make reference to the prevention of pregnancy and sexually transmissible diseases...Where condoms (or contraception or disease prevention) are discussed, this is typically so in relation to biology or family planning.”

India has sex education programmes aimed at children in schools at secondary level. There is an ongoing debate on the curriculum of sex education. Attempts by state governments to introduce sex education as a compulsory part of the curriculum have been opposed by some political parties, who claim that sex education “is against Indian culture” and would mislead children.32

Myanmar has a long-standing life skills programme for young people. Nepal has been working with International Planned Parenthood Foundation (IPPF) and other partners in recent years on sexuality education in schools.33

UNESCO has conducted situation and response analyses relating to HIV in many countries in the region. For example, UNESCO reviewed progress of schools in addressing HIV in Indonesia in a report published in 2010.34 Findings included:

(i) In 2004 the Ministry of National Education published “HIV/AIDS Prevention Strategy through Education” to integrate HIV into school curricula and how teachers should be informed and trained to carry out the mandate. Although this policy document was socialized nationally, it appears to be neglected as many in the field were unaware of it.

(ii) In 2008 Ministerial Decree No. 39 on Guidance and Supervision of Student Activities (Pembinaan Kesiswaan) was enacted in which HIV and Drug Abuse prevention are mandatory activities. This opens opportunities to impart information on HIV and life skills within existing curricular.

(iii) The Ministry has been collaborating with UN Agencies and NGOs in publishing teachers and training manuals on sexual and reproductive health, HIV, and drug abuse. Due to limited resources, however, distribution and utilization of these important materials are very limited.

(iv) HIV has been included in the school curricula in junior and senior secondary schools through the minimum standard requirements of subject matter, which provide guidelines for school textbook writers and teachers. However, reference to this standard in textbooks is not coherent, with varying quality.

(v) Not all provincial and municipal offices are actively engaged in HIV education in schools. In Papua, where the HIV epidemic has been generalized, information on HIV is being mainstreamed within the school curricula from the primary level in select districts. Teachers receive in-service training on HIV and students are trained as peer educators.

A recent regional review of Western Pacific sexual health laws cautioned that laws requiring community consultation in relation to school HIV education can limit access to information:35

“While laws, such as the Philippines AIDS Prevention and Control Act, that provide for community consultation regarding the content and scope of courses on sexuality education can promote the right to participate, caution must be exercised to ensure consultation does not threaten the comprehensiveness, accuracy, or evidence-based nature of information disseminated to students. A health and human rights approach requires that sexual health information be based on medical evidence and not on political or religious ideology or grounded in harmful gender stereotypes that perpetuate discrimination, contribute to social exclusion or marginalization, or compromise sexual health. Caution must also be exercised to ensure that blanket bans on use of materials deemed (vaguely and provocatively) "sexually explicit" do not undermine efforts to educate students about sexuality, by limiting their access to information that is essential to enabling them to develop and express safely their sexuality and their exercise and enjoyment of sexual health.”

There are concerns that while HIV education at school may introduce students to the biological nature of HIV and the modes of its transmission, students may not receive an explanation of the social factors driving the epidemic,

32 See e.g. Orissa government against sex education in schools. Times of India 11 June 2007; Bihar gets goose bumps over sex study (2011) http://www.telegraphindia.com/1110124/jsp/bihar/story_13434808.jsp
33 Personal communication, Justine Sass, UNESCO, March 2011.
such as the stigma and discrimination and the factors creating vulnerability of men who have sex with men (MSM) and transgender people, sex workers and their clients, and people who use drugs. In response to the Report of the Commission on AIDS in Asia (2009), UNESCO highlighted the importance of HIV education in schools refocusing on those who are most at risk:

“HIV prevention efforts in school should deal with the behaviors that cause 95% of all HIV infections among adolescents. On-going HIV and AIDS prevention and adolescent sexual and reproductive health education programmes in Asia-Pacific schools must incorporate the issues of injecting drug use, male-to-male sex and sex work as part of the core curriculum in order to increase the epidemiological and public health impact of these programmes. Where, for political, religious or other reasons, discussion of these behaviors in the school setting is deemed inappropriate or otherwise currently not possible, schools should design and implement extracurricular responses for adolescents who engage in risk behaviors, or seek linkages to adolescent-friendly services outside of schools.”36

Condoms in schools

No references were found to laws specifically mandating condom distribution in schools in Asia and the Pacific, although condom vending machines have been installed in colleges in India37 and in 2010 there were reports of a school in China distributing condoms to students to mark World AIDS Day.38

In Australia, two states have introduced regulations specifically prohibiting condom vending machines in schools.39 Education on condoms is not permitted in the Philippines.40

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40 Clarke D. op. cit p.49.
7. Access to other services by children affected by HIV

Laws relating to child protection, non-discrimination, and rights of care and support affect the health and wellbeing of children affected by HIV, including orphans and vulnerable children.

**Papua New Guinea (PNG)**

In 2006, a joint UNICEF/Government review of children affected by AIDS in PNG called for legislation to limit and regulate the growth of institutional care and make it subordinate to a carefully developed national family and community care system.41 The report noted that: increasing AIDS-related deaths usually result in the mushrooming of orphanages and other types of formal and informal institutions, care centres, shelters and drop-in centres; unless they are regulated, these institutions can be detrimental to the rights of children and families - their growth is costly and draws resources away from support for family and community care, and unregulated institutions can serve as the basis for widespread abuse of child rights and as centres for child trafficking.

The *Lukautim Pikinini Act* (Child Protection Act) commenced in 2010, which prohibits institutional care and identifies orphans and other vulnerable children as requiring rights-based care and support. The Act provides for provincial Lukautim Pikinini Councils and Local Lukautim Pikinini Committees throughout PNG. A child is defined as a person up to 18 years. A national child protection policy is being developed and will provide the policy framework for the protection and care of orphans and other vulnerable children. There is also Four-Year National Strategy for the Protection, Care and Support of Children Vulnerable to Violence, Abuse and Exploitation in Papua New Guinea.

**India**

India’s *Policy Framework for Children and AIDS* (2007) addresses needs of children affected by HIV. The draft HIV/AIDS Bill42 recognizes the needs of orphans including for guardianship of older siblings for purposes such as admission to schools and operating bank accounts. It also recognizes the right of children and young persons to access health care services and information in their own right. This is particularly important for children living on the streets or living on their own. It also provides for protection of inheritance and property rights and recognizes community-based alternatives to institutionalization for vulnerable and affected children.

**China**

Many children in Henan Province who were infected with HIV by state hospital blood transfusions received no compensation. The NGO Asia Catalyst has reported difficulties faced by children accessing care in this province.43 “The children described lengthy legal processes in an effort to win compensation for their infection with HIV, involving what they described as fraudulent court documents produced on the hospitals' behalf. …The courts in Henan refuse to accept any cases related to HIV/AIDS… A number of laws and policies require China to give children access to health care without discrimination. The (China) *Law on the Prevention and Treatment of Infectious Diseases* states:

> The state and the community shall show concern about and help patients with infectious diseases, pathogen carriers and patients suspected of having infectious diseases, and make it possible for them to receive timely medical treatment. No work units or individuals shall discriminate against patients with infectious diseases, pathogen carriers and patients suspected of having infectious diseases.

The 2006 AIDS Management Regulations prohibit discrimination against people living with HIV/AIDS. Yunnan Province … stipulates that health facilities that refuse access to care to people with HIV/AIDS face fines. Despite this framework, discrimination remains a problem in part because of enforcement: …it is not clear how many health care facilities have in fact been fined since the regulations were passed in 2006. Additionally, accessing their legal rights is still a challenge for people with AIDS. … Legal aid is not widely available, and given their limited economic resources, a priority for people with HIV/AIDS may be paying for high treatment costs rather than hiring a lawyer.”

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43  “I Will Fight to My Last Breath”: Barriers to AIDS Treatment for Children in China Asia Catalyst, April 2009.
In 2009, UNICEF reported the following law and policy developments relevant to care of children affected by HIV:44

**Cambodia**

**China**

**Indonesia**
Development of *National Strategic Plan 2007 – 2010* and *a National Strategy for Children and Young People (2008 - 2010)*

**Malaysia**
The Child Protection Act 2001 has been enforced, whereby the provisions under this act encompass all children including children affected by AIDS.

**Thailand**
Thailand’s Child Protection Law, passed in 2004, calls for decentralization of both management and resources to provinces and communities and requires each province to establish appropriate systems for the child protection and welfare.

**Viet Nam**
A legal review was undertaken on children affected by HIV and AIDS in Viet Nam in 2007, and a *Law on Prevention and Control of HIV/AIDS* was passed and *a National Plan of Action on Children and HIV/AIDS (2008)* was developed. A guidance document on re-integration, community-based alternative care and increased social grants for vulnerable children has been issued.

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44 Edström, J., Khan, N. (2009), *op cit* p.28.
8. Conclusion

There have been efforts to define an agenda for action on HIV-related legal issues affecting children and young people in the region. For example, a 2004 South Asia regional meeting called for action on HIV, child and youth rights. The meeting agreed the following useful checklist:45

“To fulfil the commitments made and to ensure that the rights of children and young people to be protected from HIV infection and its impact are guaranteed, the following specific actions need to be taken:

- Ensure that children and young people understand the nature and consequences of an HIV test and have the right to provide informed consent to confidential HIV testing;
- Prohibit HIV testing as a pre-condition for entry into educational programmes, and develop laws to protect students and staff who have HIV from being excluded from schools and educational institutions on the grounds of their HIV status;
- Provide age appropriate HIV/AIDS and sexual health and development education in schools, educational institutions and in non-formal settings;
- Promote the involvement of people living with HIV/AIDS in providing HIV/AIDS education. To encourage their involvement in such programmes, create a supportive programme, policy, legal and social environment including strengthening of networking within countries and the region;
- Review school curricula to ensure that the content of educational programmes does not add to the stigma experienced by people living with HIV/AIDS and vulnerable populations;
- Ensure that all young people have access to HIV prevention, information and services;
- Ensure that the best interests of children and young people are a primary consideration in HIV/AIDS policies and programmes, and that the views of children and young people are heard and respected in HIV/AIDS policy making, programme delivery and decision-making processes affecting their rights; and
- Take specific additional actions to protect the rights of children and young people living with and affected by HIV/AIDS particularly:
  - Ensure that children and young people infected with HIV have sustained and equal access to comprehensive HIV/AIDS treatment and care, including antiretroviral therapies;
  - Prohibit discrimination against children and young people living with or affected by HIV/AIDS in health care, schools, employment and social services;
  - Prevent the segregation of children and young people living with HIV from other children;
  - Eliminate barriers that keep the poorest children and young people from accessing health care and education.”

At the 2007 WHO/UNICEF/UNAIDS consultation, Sakai (UNICEF Cambodia) concluded that there is a need for:46

(i) practical guidance notes on HIV testing and children, with focus on consent, confidentiality and counselling;
(ii) a clear definition of the “best interests” of children in legislation;
(iii) lower age of consent coupled with community sensitization;
(iv) clear guidelines on the criteria for HIV testing in children; and
(v) training and resources e.g. a confidentiality handbook for staff.

Sakai concluded that policy processes are required to reach national consensus on:

(i) whose consent is needed to test, to disclose and to provide treatment if necessary;
(ii) special measures for children need to be in place before testing;

46 Scaling up HIV Testing and Counselling in Asia and the Pacific Report of a Technical Consultation Phnom Penh, Cambodia 4-6 June 2007; Dr Suomi Sakai, Representative, UNICEF Cambodia, Testing and counseling for children and adolescents: presentation.
(iii) the considerations needed for most-at-risk adolescents; and
(iv) the considerations needed for children without parent or legal guardian (e.g. street children).

In relation to schools, Clarke recommends that education policy (supported by links to laws as appropriate) should clarify the following issues:47

• the curriculum for sexuality education and its delivery;
• teacher training (pre- and in-service);
• school management of issues such as stigma and discrimination, gender-based violence and confidentiality;
• parental and community involvement;
• school health and safety; and
• access to health care and other services.

Clarke states:48

“There is general acknowledgement that a policy on HIV and SRH (sexual and reproductive health) will be effective only if it is owned by the relevant stakeholders who are responsible for its operation. This implies a participatory approach to policy formulation with stakeholder groups rather than with a narrow expert-driven technical approach that has minimal participation. The process should include the involvement of people living with HIV and representatives of the targeted age group and duty bearers.”

This principle extends to laws and law enforcement practices. Resources will be required to ensure the meaningful participation of children and young people in developing new laws and regulations that promote their rights of access to services, information and education, and in developing related policies and guidance for service providers and law enforcement personnel.49

47 Clarke D. op. cit. p.23.
48 Ibid.
Annex I: Laws relating to HIV education in schools

Cambodia


The State shall:

1. Integrate the knowledge on HIV/AIDS in subjects taught in schools. This subject shall include the causes, modes of transmission, means of prevention, consequences of the HIV/AIDS and fact about STDs, especially focusing on the life skills in accordance with promoting social value through introduction into the curriculum of all educational establishments including non-formal education systems.

2. Organize workshops and trainings of trainers on HIV/AIDS prevention and control for teachers and other instructors who will be assigned to teach on the subject.

3. Mobilize communities, associations, and organizations for their involvement in the design and implementation of HIV/AIDS education and information dissemination programmes.

China

*Regulation on AIDS Prevention and Control (2006)*

Article 13: The education authority at county and upper levels shall guide, supervise and urge the higher education institutions, secondary vocational schools and ordinary middle schools to integrate HIV prevention, AIDS control and knowledge into relevant courses and conduct extracurricular educational activities. Higher education institutions, secondary vocational schools and ordinary middle schools shall organise students to study HIV/AIDS-related knowledge.

The Philippines

*Philippine AIDS Prevention and Control Act*

**Section 4. HIV/AIDS Education in Schools**

The Department of Education, Culture and Sports (DECS), the Commission on Higher Education (CHED), and the Technical Education and Skills Development Authority (TESDA), utilizing official information provided by the Department of Health, shall integrate instruction on the causes, modes of transmission and ways of preventing HIV/AIDS and other sexually transmitted diseases in subjects taught in public and private schools at intermediate grades, secondary and tertiary levels, including non-formal and indigenous learning systems: *Provided*, That if the integration of HIV/AIDS education is not appropriate or feasible, the DECS and TESDA shall design special modules on HIV/AIDS prevention and control: *Provided, further*, That it shall not be used as an excuse to propagate birth control or the sale or distribution of birth control devices: *Provided, finally*, That it does not utilize sexually explicit materials.

Flexibility in the information and adoption of appropriate course content, scope, and methodology in each educational level or group shall be allowed after consultations with Parent-Teachers-Community Associations, Private School Associations, schools officials, and other interest groups. As such, no instruction shall be offered to minors without adequate prior consultation with parents who must agree to the thrust and content of the instruction materials.

All teachers and instructors of said HIV/AIDS courses shall be required to undergo a seminar or training on HIV/AIDS prevention and control to be supervised by DECS, CHED and TESDA, in coordination with the Department of Health (DOH), before they are allowed to teach on the subject.

*Philippine AIDS Prevention and Control Act: Implementing Rules And Regulations*

**Section 13. HIV/AIDS Education in Schools**

DECS, CHED and TESDA shall develop a school-based HIV/AIDS education and information programme which shall include the HIV/AIDS education and information prototype, add-on content, and the development and provision of multi-media information and instructional materials to schools under their respective jurisdictions.

HIV/AIDS education shall be integrated into but not limited to science and health, edukasyon pantahanan at pangkabuhayan (EPP), sibika at kultura, good manners and right conduct (GMRC), and Filipino at the elementary level; in science and technology, social studies, physical education, health and music (PEHM) and values education at the secondary and tertiary levels. HIV/AIDS education is to be integrated by DECS into its non-formal education programme and in the indigenous learning systems. Instructional materials shall be provided for such purposes. DECS shall further strengthen its own school-based AIDS education project through the development and printing of audio-visual materials such as posters, comics, flipcharts, modules, tapes and film strips. Flexibility in
the formulation and adoption of appropriate course content, scope and methodology in each educational level or group shall be allowed after consultations with the Parents-Teachers-Community-Association, association of private schools, school officials and other interest groups.

**Marshall Islands**

The Ministry of Education, in consultation with the Ministry of Health Services, public and private schools, and parents of school age children, shall develop health education curriculum for primary and secondary schools in the Marshall Islands. Such curriculum shall include education about the transmission and prevention of communicable diseases; knowledge and prevention of prevalent non-communicable disease; the use and abuse of tobacco, alcohol and other drugs; preparation for adult life; knowledge about basic bodily functions; nutrition; preparation for raising families; sanitation; and health occupations. In the development of the health education curriculum, the Ministry of Education shall give due consideration to community values and the age of the students.

*Communicable Diseases Prevention and Control Act 1988*

§1510 (Marshall Islands)

**Pohnpeii State, Federated States of Micronesia**

6A-110 HIV education in schools

(1) The Department of Education, utilizing official information provided by the Department of Health Services, shall integrate instruction on the modes of transmission and ways of preventing HIV and other sexually transmitted infections in subjects taught in public and private schools at intermediate grade, secondary and tertiary levels, including non-formal and indigenous learning systems, PROVIDED that if the integration of HIV education is not appropriate or feasible, the Department of Education shall design special modules in HIV prevention and care.

(2) Flexibility in the formulation and adoption of appropriate course content, scope, and methodology in each educational level of group shall be allowed after consultation with parent teacher associations, private school associations, school officials, and other interested groups. As such, no instruction shall be offered to minors without adequate prior consultation with parents.

(3) All teachers and instructors of HIV education shall be required to undergo training on HIV prevention and care supervised by the Department of Education, in coordination with the Department of Health Services, and demonstrate proficiency in skills relating to education on the prevention of HIV and other STIs, before they are allowed to teach on the subject.

*Pohnpei Code, Title 17 Chapter 6A (Pohnpei HIV Prevention and Care Act 2007)*

**Indonesia**

The *Decree of the Ministry of National Education and Culture 1997 on HIV/AIDS Prevention 1997 No 9/U* states that all rectors of universities, directors of institutions, coordinators of private universities and the Ministry of National Education staff at the provincial level should do their utmost to increase the public’s awareness of the dangers of HIV and AIDS and to improve their awareness of the importance of healthy and responsible life practices.
UNDP is the UN’s global development network, advocating for change and connecting countries to knowledge, experience and resources to help people build a better life.

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