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AND CHILDREN'S RIGHTS**

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**HIV/AIDS AND ITS IMPACT ON  
CHILDREN IN SOUTH AFRICA**

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## **1. INTRODUCTORY REMARKS**

I wish to express my sincere appreciation to the Congress organizers for arranging a plenary session on HIV/Aids as well as a workshop session. It is indeed an honour to be invited to present a legal perspective on what has become the major issue facing South Africa viz the HIV/Aids pandemic and how we can possibly save human lives by a wide range of interventions including legal ones. With the limited time at my disposal, the focus of my presentation will be the position of children who are vulnerable in increasing numbers- some are condemned to an early death while others suffer exploitation such as rape and abuse and while yet others lose a parent-in some cases ending up as “orphans” who are deprived of the joys of childhood. What I am going to say on the subject will alarm many of you .

Some intervention is desperately needed to ensure that children’s rights as set out in Section 28 of the Constitution of South Africa are adequately protected.

## **2. HIV/AIDS IN SOUTH AFRICA – MYTH OR MAJOR CRISIS?**

South Africa has recently celebrated ten years of democracy. Much has been achieved in transforming our society to provide equal opportunity to all, end discrimination and move towards a non-sexist, non-racist society. Much has been achieved in promoting the socio-economic condition of the majority of our people although unemployment and poverty levels continue to be major challenges facing our government. The high poverty levels and poor nutrition and living conditions certainly aided the spread of the HIV virus.

While there was a visible and genuine concern by the ANC -prior to assuming power in 1994-to deal firmly with the HIV/Aids crisis-not much was done to effectively contain the pandemic as there was both a lack of focus and mixed signals on how serious the crisis was and how best to deal with it. There are those who believe that there was a failure by the political leaders to refute aids denialists and the attendant failure to provide appropriate treatment to those who were ill, mixed messages on the safety and efficacy of Anti-Retrovirals( ARV’s) in the public health sector which also impacted on firm measures taken to prevent mother to child transmission. This failure by the Government was acknowledged last year by a former Cabinet Minister as “a mistake. We were wrong, now we must take the correct route” (source Sankie Mahanyale-Mail& Guardian April 8-15 2004 cited by Heywood ‘Price of Denial’ p 18)

The time for Denial or ignoring the seriousness of the pandemic could result in catastrophe-dealing with HIV/Aids will require a major effort and an

exceptional response. Defining the crisis is essential and extra-ordinary efforts will now be required to ensure the peaceful transformation of our society.

## 2.1 INCIDENCE IN SUB-SAHARAN AFRICA=UNAIDS SURVEY

Sub-Saharan Africa according to UNAIDS is the worst hit region in the world affected by HIV/Aids While having only 10% of the world's population it is home to two thirds of all people living with HIV. Seven Southern African countries including South Africa have adult prevalence rates of 20% or more. The incidence among young persons aged 15-24 is the highest but no indication is given of the prevalence among children. In a recently completed study (March 2005) (Aids in Africa: Three Scenarios to 2025) a gloomy picture is presented if governments fail to take effective measures to stop the spread of HIV/AIDS. While the virus has impacted on countries differently and South Africa has in place the most sophisticated set of measures to prevent transmission, the study concludes that an increase in the number of children orphaned by Aids in Africa is bound to continue until 2020 even with the best case scenario.

## 2.2 INCIDENCE IN SOUTH AFRICA

Official Government figures indicate that there are 5.6 million South Africans living with HIV and about 500,000 in need of antiretroviral treatment. For every ten persons affected, six are women and at the present time there may be many more that are unaware of their status. Neither the President in his "State of the Nation" address at the opening of this year's parliamentary session nor the Minister of Finance in his recent Budget Speech mentioned HIV/Aids. Children are largely ignored in statistical information. There is no exact figure on the number of children who are HIV positive but experts in the area believe that at least 5% are infected (persons under the age of 14)- between 250,000 to 300,000.

## 2.3 STATISTICS SOUTH AFRICA-REPORT 2005 = "MORTALITY AND CAUSES OF DEATH IN SOUTH AFRICA, 1997-2003)

### Comment

Last month, Statistics South Africa released its long awaited report "Mortality and causes of death in South Africa. This official government body provided figures which show that South Africa's daily death rate had increased by 57% in the six years to 2002 while the population grew by only 10%.The rise in deaths was particularly high in those aged between 20-49-the sexually most active age but mortality was not attributed to HIV/Aids but rather to opportunistic infections associated with HIV such as influenza, tuberculosis and pneumonia. It was conceded by the Statistician General that "the data provided in the death notification forms do not allow determination of HIV infections or Aids related mortality. (Sunday Times 20 February 2005) Death from Aids and HIV of working age adults is underplayed in the Report which did not list these in the top ten causes of death.

In a briefing held at the South African Parliament on 15 March 2005, the President of the Medical Research Council characterized this aspect of the Report as "obviously not correct" According to a "National Burden of Disease" study conducted by MRC researchers on deaths in 2000, 29.8% were caused by

HIV/Aids. He also mentioned that the HIV prevalence among mineworkers stands at up to 25% . Another major impact was on the public hospitals where many beds are filled with people living with HIV/Aids.

He also mentioned that “Many people who die from this disease are in their 20’s and 30’s-economically active people, who often leave behind family units that have lost a breadwinner.” According to one NGO (Heywood-The Price of Denial p 22) there are at least 600 aids related deaths a day!

#### 2.4 ROLE OF NGO’S -TREATMENT ACTION CAMPAIGN

Combating HIV/Aids is a task which Government alone cannot handle. This was recognized already in the 1990’s when a partnership was established between the government and civil society. The most prominent of the non-governmental organizations is the “Treatment Action Campaign” which was established in December 1998.It was instrumental in supporting the Government’s moves to get cheaper drugs on to the market thus staving off a legal challenge by multinational companies to have legislation struck down which permitted the importation of cheap drugs and the local manufacture of generics Unhappily ,much of the relationship thereafter has been characterized by conflict .

The important task of saving lives was becoming highly politicized and confrontational. With the ambivalence in governmental circles on the safety of ARV’s, the TAC mobilized public support and resorted to an effective civil disobedience campaign which highlighted the need for the government to make available ARV’s for children and adults suffering with Aids. The TAC fired public awareness of the crisis in a well run campaign advocating the right to health and life. It did this fully recognising that “in the 21<sup>st</sup> century poverty remains the greatest determinant of inequality and human rights violations. The objective of the TAC has been to save lives”( Heywood, Price of Denial p23/4)

The private sector and many community based organizations are also playing an increasingly active role in preventing the spread of the virus and assisting those who are tested positive.

#### 2.5 JUDGMENT OF THE CONSTITUTIONAL COURT ON ROLL OUT PROGRAMME OF ARV’S TO COUNTER MTCT

The TAC’s first major confrontation with the Government was aimed at making available AZT (an ARV) to HIV positive pregnant women in order to reduce the risk of mother to child transmission. The failure of the government after several years to initiate a programme aimed at addressing the problem resulted in the Minister of Health being challenged in Court for the government’s failure to respect the fundamental rights to health, life and children’s rights as guaranteed under the Constitution. In a land mark decision ,a unanimous Constitutional Court in July 2002 ordered the Minister to roll out a plan for the provision of treatment aimed at limiting mother to child transmission at centres where practical.(Minister of Health and Others v Treatment Action Campaign and Others (N0 2) 2002 (5) SA 721 (CC)

## 2.6 REVIEW OF PROGRESS MADE BY PUBLIC HEALTH SECTOR-TREATMENT CENTRES

The tardiness of the Government in rolling out the treatment plan following the Constitutional Court judgment led to a vociferous campaign by the TAC which received extensive media coverage and influenced public opinion. More than a year later, in November 2003, the Cabinet adopted an extensive Operational Plan for HIV/Aids treatment to provide aids treatment. To date about 29,000 people are on ARV treatment at public facilities (75% of these in the three provinces of the Western Cape, Gauteng and KwaZulu-Natal falling far short of the target of 53 000 set by the President in his State of the Nation speech in February 2004. There are presently only 113 sites in the country providing treatment services.

The 2005 Budget provides for a significant increase in the allocation for HIV/AIDS (from R1.2 Billion in 2004/5 to R1.5 Billion in 2005/6) but it is not clear how much has been specifically earmarked for the ARV rollout programme. The bulk of the funding will be spent on education and social development-77% of which will be sent to the nine provinces as conditional grants. In terms of the National Plan for HIV/Aids – a total R6.6 Billion has been budgeted for the next three financial years (March 2005-February 2008) which clearly signals the allocation of greater resources by Government for HIV/AIDS programmes. The focus would appear to be on community and home based care rather than a rapid IRV rollout treatment of persons with HIV/AIDS (Source IDASA Budget Information Service-Budget Brief No 152- HIV and AIDS Allocations: A First Look at Budget 2005 by Nhlanhla Ndlovu 25 February 2005).

### 3 IMPACT OF HIV/AIDS PANDEMIC ON CHILDREN

Children are affected by HIV/ Aids in many ways. Where there is a family member who is ill, valuable resources in mainly poverty stricken situations, have to be spent on medicines and receiving treatment. This leads to financial hardship and consequently malnourishment .These children cannot continue with studies as there are no resources to pay school fees, purchase uniforms and meet needs such as travel and meals. .Where a parent dies, children become “orphans”, head of households and often lose whatever property their parent/s owned thus ending up on the streets. There are no definitive studies on the exact number of street children but It is well known that they are subject to sexual and other abuse and about 75% of those tested contract the virus.

Juveniles who are arrested by the police continue to be locked up with adult prisoners and a high percentage is sodomised by inmates who are HIV positive. Even among those youth who are kept in “places of safety”-youth detention centres, the incidence of HIV is high. Yet there is no priority being given to having these children tested, treated and protecting their rights. Such children do not qualify for

social welfare grants unless the necessary documentation such as an official identity document or a birth certificate is produced among the poor and destitute, there are problems in accessing such documentation. In such situations, grants and any form of financial assistance is not possible.

### 3.1 Section 28 of the Constitution

South Africa is in a unique position having a comprehensive provision in the Bill of Rights aimed at protecting Children's Rights. For the purposes of this paper, I shall quote those parts that are relevant to our discussion:

Section 28(1) every child has the right -

- (b) To family care or parental care, or to appropriate alternative care when removed from the family environment;
- (c) To basic nutrition, shelter, basic health care services and social services
- (d) To be protected from maltreatment, neglect, abuse or degradation;
- (g) Not to be detained except as a measure of last resort...the child has the right to be kept separately from detained persons over the age of 18.
- (h) To have a legal practitioner assigned to the child by the state and at state expense, in civil proceedings affecting the child, if substantial injustice would otherwise result.

(2) A child's best interests are of paramount importance in every matter concerning the child.

### 3.2 INCIDENCE OF HIV/AIDS AMONG CHILDREN

A major recent and first comprehensive study (The National Household HIV Prevalence and Risk Survey of South African Children- HSRC May 2004) revealed that 5.4% of children between two and 18 are HIV positive. The breakdown into age groups is as follows:

6.2%	between ages	2-9
4.7%		10-14
5%		15-18

This high level of infections has shocked and baffled those engaged in the treatment of HIV/AIDS as they attempt to

- (i) identify social and community risk factors that make children vulnerable to HIV infection;
- (ii) determine the number of orphans and child headed households
- (iii) work out necessary interventions
- (iv) assess children's knowledge of HIV/Aids.

The data revealed that 3.3% of children surveyed were maternal orphans and in the 15-18 group - 25% had lost at least one parent. Three percent of children between the ages of 12-18 were head of households. This is markedly higher than the 0,6% recorded in the 1999 survey. South Africa is estimated to have more than a million aids orphans and this figure is projected to double by 2007. According to one observer "the worse is still to come " - a view endorsed in the latest UNAIDS study on Aids in Africa 2025 which estimates that there already 11 million aids orphans in sub-Saharan Africa.

### 3.3 TREATMENT PLAN FOR CHILDREN

The 5.4% infected rate translates to between 250,000 to 300,00 children .The National Treatment Plan has concentrated on adult sufferers .There are only 4 of the 113 treatment sites which have a paediatric unit. (March 2005). The needs of children have to date been largely ignored. One may legitimately ask whether this neglect violates the Rights of Children as recognized and protected in our Constitution. How can this situation be changed so that Children's Rights are not mere paper rights but actively protected and promoted?

There are very real legal barriers which must be eliminated if we are to save young lives and provide treatment to those young people afflicted by the virus.

In a study prepared for the Henry J Kaizer Foundation in 2003,well known HIV/AIDS Liesl Gernholz concluded that:

"children are the worst affected. She summarized her findings as follows :  
"They are affected by the epidemic in many ways-they are orphaned by it, they live with HIV/AIDS, they experience stigma and discrimination (whether or not they have HIV/AIDS ),they live in households poorer than those that are not affected and are more vulnerable to abuse and exploitation. The epidemic is eroding many of the gains made for children in South Africa since 1994 and is undermining their rights to among other things, equality, education, social security, nutrition and particularly health care " ( extracted from HIV testing and treatment, informed consent and AIDS orphans.= Community Law Centre publication 2002/3).

### 3.4 MAY A CHILD CONSENT TO BE TESTED? MAY A CHILD BE INFORMED OF HER HIV STATUS?

At the present time the law is not clear on what the appropriate age is at which children at risk may be tested.

Age of consent – there are varying ages.

3.4.1. Traditionally the law required informed consent which was linked to the age for contractual capacity. (Parental consent required if less than 21)

3.4.2 According to our present Child Care Act 74 of 1983 Section 34(7) a child may only consent to the performance of an operation on herself if she is over the age of 18 but a person above 14 will be competent to consent to medical treatment.

3.4.3 The Health Professionals Council has introduced ethical guidelines permitting treatment for those over 16 and giving the medical practitioner a discretion to treat persons under that age provided they have attained the maturity to understand the treatment offered and in the case of HIV, the nature of the test.

There is no clarity on whether the child may be informed of her positive status by the doctor.

In cases of emergency, such as rape, the doctor may treat the child within the limits of the emergency. Where medical evidence points providing the child with the best chances of recovery or revival, it is the Courts would subsequently refuse to authorize the treatment . In the past doctors at government hospitals found that they were subject to disciplinary action and even dismissal if they transgressed the rules set by the Provincial/National Health authorities. provided it is to treatment unlikely that

3.4.4 The Children's Bill re-examines the age of consent, lowering it to 12 (Section 146) and recognizing that care-givers (Section 44) who are not the children's parents and not legally appointed to care for them, may grant consent for them to be tested. The Bill has undergone major amendments which have the effect of watering down the original provisions which were aimed at expanding the rights contained in Section 28. The Bill as amended has been criticized by those promoting children's rights and there is uncertainty on when this major measure aimed at consolidating legislation on the subject will be passed by Parliament.

I may mention that the Children's Courts which are attached to the District Magistrates Court may be approached to grant consent under limited circumstances once the Children's Bill is enacted.

3.4.5 Until the Bill becomes law, consent has to be obtained by way of an application to a judge of the High Court. This procedure is expensive and time consuming- and certainly not an effective way of early intervention to protect children's lives.

3.4.6 Unless the Child Care Act is amended urgently, children will not be able to benefit from the Government's roll-out plan for ARV therapy.

Until this happens, are we acting in “the best interests of the child” as set out in Section 28 of our Constitution?

### 3.5 AIDS ORPHANS – SEXUAL ABUSE, STREET CHILDREN – NEED TO PROTECT PROPERTY RIGHTS

Even stronger and unambiguous policy decisions need to be taken to deal with the horrendous problem of “aids orphans” and children as heads of households. Associated with that is the need to devise mechanisms to prevent such children who often live in poverty to be further marginalized by being deprived of property rights (expulsion from the family home and possessions) and ending up as street children. There are no policies in place to deal with the dignity, health and welfare of such children who are frequent victims of sexual and other abuse. According to one source as many as 75% of these children are HIV positive.

The practice of locking up juvenile offenders with adults in prison cells (in conflict with Section 28) and the lack of adequate supervision of children held in detention centres known as “places of safety” adds to the avoidable high levels of HIV infections among such children. It is well documented that young persons are sodomised in these institutions where HIV/Aids is rampant.

The Child Headed Household notion is an abomination as it violates Section 28 (1) (b), (c) and (d). Resources must be found immediately to end the violation of children’s fundamental human rights. Community care centres or similar child friendly environments must be established and existing NGO facilities such as at Nkosi’s Haven, Care Topsy Foundation and many more informal care arrangements in the townships be funded by the government to absorb these children until they can be put up for adoption.. While this may not be the answer in the long run, it will protect children from sexual and other abuse as well as prevent them from taking to the streets.

A further major concern is to ensure continued access to schooling-many of these children who live in dire poverty drop out of school because they cannot afford to pay school fees ,purchase school uniforms ,school books and stationary or pay for transport. These matters are now receiving the attention of the authorities. Poverty should not bar our children from access to basic education-a right promised under our Constitution. Surely we do not want these children to enter society as intellectual dwarves!!

### 3.6 ACCESS TO WELFARE GRANTS / DISABILITY GRANTS/FOSTER CARE GRANTS

The 2005/6 Budget has set aside an increased amount to be paid in grants. However, the problems of the poor in accessing the support provided by government present difficulties which are not easy to overcome. There are also serious capacity problems in the relevant government departments to administer the programmes.

The bureaucracy in order to limit fraudulent claims and corruption has a number of regulatory measures in place. These include provision of a birth certificate and /or an Identity Book/Document and a copy of the death certificate of parent /s. As we are dealing with children who are the most vulnerable in society, some flexibility could be argued for the desperately poor as such documentation is not always available. New mechanisms need to be developed as a matter of urgency so as to permit caregivers accessing grants-even some aid in the form of food vouchers would make a difference so that these children can be fed. Malnutrition is rife in the townships and rural areas and children who are starving are ready candidates for opportunistic infections such as tuberculosis and HIV/AIDS

It is all very well to ask communities to take care of such children but in the majority of cases, these communities in the townships are themselves not coping, having unemployment levels of up to 40%

### 3.7 NEED FOR LAW REFORM TO FULFILL OBLIGATIONS IN TERMS OF SECTION 28

As the HIV/AIDS pandemic is a major crisis-urgent consideration needs to be given to fulfilling the rights promised to children in terms of Section 28. Are we not at the point where we must abandon the old requirements for informed consent and instead leave it to children who wish to be tested for HIV to do so even if there is no chance of them being infected? If a child is found to be positive ,it may be desirable that the mother be informed of the status and that both receive counselling when the disclosure is made. While respecting the right to privacy, is the argument not a compelling one to have all persons especially vulnerable children tested on a regular basis ?In this way, policy makers will have a more accurate picture of the seriousness of the pandemic and where necessary arrange for early treatment which would alleviate suffering and enable such children to live longer and healthier lives. There is evidence to show that those on treatment are less likely to spread the virus.

Another point in relation to treatment of children is that both local and international pharmaceutical companies need to be compelled by law to manufacture paediatric dosages of ARV's.

Those children, who grow up in households where one or more members are ill, suffer a stigma and discrimination. Everything possible must be done to ensure that such families are able to live as normally as possible and that children are not barred from admission to schools as has happened in the past. While discrimination can be challenged in the courts, access to legal services and advice remains beyond the means of those needing it the most. While section 28 (1) (h) provides that a child has the right to have a legal practitioner assigned to her by the state, the enforcement of this right has been difficult

#### **4. DENIALISM OR COMMITMENT TO PROTECT FUNDAMENTAL HUMAN RIGHTS ?**

The South African Government has a commitment to protect the fundamental rights of all who live in South Africa. The extent of the HIV/AIDS crisis cannot be ignored. There are enough scientific studies to demonstrate that urgent and effective action is needed. Fighting the scourge of poverty and creating employment are critical challenges facing the country. It is a fact that South Africa has the largest HIV/AIDS programme of any African country but much more needs to be done. Ensuring food security for disadvantaged communities is a high priority and innovative thinking and methods are required to ensure that children do not suffer from malnutrition and that the justice system deals more effectively with those who rape and otherwise abuse children. Whilst complementary health care needs to be more easily available, tougher measures need to be taken against those who mislead the public by marketing products for HIV/AIDS which have not been scientifically proven to help those afflicted with the virus.

The Department of Health has serious human resources problems. There are simply not enough medical doctors available in the public sector to ensure that even where the supply ARV's are available, that medication can be prescribed to those who need it. Health personnel such as nursing staff and social workers need to be attracted to and their services retained in the public sector. Nursing staff with appropriate training should be able to provide treatment at the primary health care centres.

#### **5. CONCLUDING REMARKS**

There is hope that South Africa will be able to handle the HIV/AIDS pandemic. There are indications that educational and lifestyle programmes are creating awareness among the youth of the need to practice safe sex but this will have to be accompanied by policies directed at strengthening the rights of women. Fortunately, the private sector including big business is playing an expanded role in encouraging persons to be tested and where necessary be provided with treatment. As mentioned earlier, the government should mobilize people who are at risk, especially children, to undergo tests and rollout treatment where appropriate. Non Governmental Organizations have a critical role to play and may I stress, in partnership with the Government, to expand the rollout of treatment for HIV/AIDS sufferers. Equally important is a strong global response to make available resources to sub-Saharan countries including South Africa to make available substantial financial and human resources if the fundamental human rights, particularly of vulnerable children are to be protected and advanced.

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