

**DOES THE SOUTH AFRICAN LAW AND POLICY FRAMEWORK FACILITATE
ADOLESCENT ACCESS TO HIV PREVENTION TOOLS?**

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Submitted in fulfilment of the requirements for the *Master Research Degree*,
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Declaration and signed statement of originality and compliance:

I, Jacintha Toohey declare that:

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Declaration by supervisor

As the candidate's supervisor, I agree to the submission of this thesis.

Signed:

Associate Professor Ann Strode

Date: 28 January 2017

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BIBLIOGRAPHY

JOURNAL ARTICLES

- Alexandre, KB... et al. 'Progress and Perspectives on HIV-1 microbicide development.'(2016)
Virology 497 69-80.
- Bekker, LG...et al. 'Adolescents and HIV vaccine trials: what are the clinical trial site issues?' (2005).
Journal of the International Association of Physicians in AIDS Care 4(4) 93-97.
- Bhamjee, S., Essack, Z., & Strode, A. 'Amendments to the Sexual Offences Act dealing with consensual underage sex: Implications for doctors and researchers.' (2016). *South African Medical Journal* 106(3) 256-259.
- Bhana, A ...et al. 'Standards for reporting of sex/sexual activity of minors in a research context' (2010). *South African Medical Journal* 100(10) 642-644.
- Blake, S...et al. 'Condom availability Programs in Massachusetts High Schools: Relationships with Condom Use and Sexual Behaviour.' (2003). *American Journal of Public Health* 960.
- Burton, R., Giddy, J., & Stinson K. 'Prevention of mother-to-child transmission in South Africa: an ever-changing landscape.' (2015). *Obstetric Medicine* 5-12.
- American Academy on Circumcision, Task Force on Male circumcision 'Male Circumcision' (2012).130.3 *Pediatrics* e756-e785.
- Coetzee, S. 'Pregnant learners' sexual rights: a constitutional perspective.' (2012). *Southern African Public Law* 27(2) 487-507.
- Committee on HIV Prevention Strategies in the United States, Institute of Medicine 'No time to Lose: Getting more from HIV Prevention' (2001). 118-120.
- Delaney-Moretlwe, S...et al. 'Providing comprehensive health services for young key populations: needs, barriers and gaps.' (2015). *Journal of the International AIDS Society* 35.
- Donovan, P. 'Falling teen pregnancy, birthrates: What's behind the declines?' (1998). *The Guttmacher Report on Public Policy* 1(5) 6.
- Essack, Z., Toohey, J., & Strode A. 'Reflecting on adolescents' evolving sexual and reproductive health rights: canvassing the opinion of social workers in KwaZulu-Natal, South Africa.' (2016). *Reproductive Health Matters* 24 (47) 195-204.
- Frieden, TR... et al. 'Applying public health principles to the HIV Epidemic.' (2005). *The New England Journal of Medicine* 353(22) 2397-2402.
- Gilmour, E., Karim, S., & Fourie, H. 'Availability of condoms in urban and rural areas of KwaZulu-Natal, South Africa.' (2000). *Sexually Transmitted Diseases* 27 (6) 353-357.

- Han, J., & Bennish, LM. 'Condom access in South African schools: Law, policy, and practice.' (2009). *Plos Medicine* 6(1) e1000006.
- Heywood, M. 'Preventing mother-to-child HIV transmission in South Africa: background, strategies and outcomes of the Treatment Action Campaign case against the Minister of Health.' (2003). *South African Journal of Human Rights* 19 278–315.
- Holt, K...et al. 'Assessment of service availability and health care workers' opinions about young women's sexual and reproductive health in Soweto, South Africa.'(2012). *African Journal of Reproductive Health*, 16(2) 283-294.
- Jaspan, HB...et al. 'Inclusion of adolescents in preventive HIV Vaccine Trials: public health policy and research design at a crossroads.' (2008). *Journal of Acquired Immune Deficiency Syndrome* 47(1) 86-92.
- Jaspan, HB... et al 'Protecting South Africa's children from HIV; giving them our best shot.' (2005). *South African Journal of Science* 216-217.
- Jayathunge, PHM... et al. 'Male Circumcision and HIV Transmission; What Do We Know?' (2014). *Open AIDS Journal* 8(1) 34.
- Kumar, S., & Preetha, GS. 'Health Promotion: An Effective Tool for Global Health.' (2012). *Indian Journal Community Medicine* 37(1) 5-12.
- Mann, J. 'Responding to HIV/AIDS: a historical perspective.'(1998). *Health and Human Rights* 2(4) 5-8.
- Mann, J., & Gostin, L. 'Towards the development of a human rights impact assessment for the formulation and evaluation of public health policies' (1994). *Human Rights and Health* 1(1) 58-80.
- McClure, CA...et al. 'Challenges to conducting HIV preventative vaccine trials with adolescents.' (2004). *Journal of Acquired Immune Deficiency Syndrome* 36 (2) 726-733.
- McQuoid-Mason, D. 'Decriminalization of consensual sexual conduct between children: What should doctors do regarding the reporting of sexual offences under the Sexual Offences Act until the Constitutional Court confirms the judgment of the Teddy Bear Clinic case?' (2013). *South African Journal of Bioethics and Law* 6(1)10-12.
- McQuoid-Mason, D. 'Mandatory reporting of sexual abuse under the Sexual Offences Act and the 'best interests of the child.' (2011). *South African Journal of Bioethics and Law* 4(2) 74-78.
- McQuoid-Mason, D. 'Is the mass circumcision drive in KwaZulu-Natal involving neonates and children less than 16 years of age legal? What should doctors do?' (2013). *South African Medical Journal* 103(5) 283-284.

- Miller, MA., & Sentz, JT. 'Vaccine-preventable diseases' in DT Jamison (ed) *Disease and Mortality in Sub-Saharan Africa* (2006).163-178.
- Morris, BJ... et al. 'Review: a critical evaluation of arguments opposing male circumcision for HIV prevention in developed countries.' (2012). *AIDS Care* 24(12) 1565–1575.
- Singh-Grewal, D... et al. 'Circumcision for the prevention of urinary tract infection in boys: A systematic review of randomized trials and observational studies' (2005). *Archives of Disease in Childhood* 90(8) 853-858.
- Pelzer, AJ., Ngwenya, CG., & Summerton, JA. 'The HIV/AIDS epidemic in South Africa: trends, impacts and policy responses.' (2004). *Health and Health Care in South Africa* 109-170.
- Pettifor, A... et al. 'A cluster randomized-controlled trial of a community mobilization intervention to change gender norms and reduce HIV risk in rural South Africa: study design and intervention.' (2015). *BMC Public Health* 15(752) 83.
- Proudlock, P., & Jamieson, L. 'The Children's Act - providing a strong foundation for caring for vulnerable children.' (2008). *South African Child Gauge* 35-40.
- Robins, S. 'Sexual Politics and the Zuma Rape Trial.' (2008). *Journal of Southern African Studies* 411-427.
- Simelela, N. 'A brief history of South Africa's response to AIDS.' (2014). *South African Medical Journal* 104 (3) 1 249-251.
- Strode, A. 'But is this really the 'parent' or 'guardian'? Practical strategies for consent to child research in South Africa.' (2016). *South African Journal of Bioethics and Law* 35-38.
- Strode, A., van Rooyen, H., & Makusha, T. 'Is it lawful to offer HIV self-testing to children in South Africa?' (2013). *The Southern African Journal of HIV Medicine* 151-154.
- Strode, A ...et al. 'Reporting underage consensual sex after the Teddy Bear case: a different perspective: research.' (2013). *South African Journal of Bioethics and Law* 6(2) 45-47.
- Strode, A., & Grant, B. 'A critical review of the extent to which the HIV/AIDS and Human Rights International Guidelines have been implemented in the Southern African Development Community.' (2007). *Obiter* 28(1) 70-83.
- Strode, A... et al. 'Reporting underage consensual sex after the Teddy Bear case: A different perspective.' (2013). *South African Journal of Bioethics and Law* 45-47.
- Strode, A., & Slack, C. 'Sex, lies and disclosures: Researchers and the reporting of under-age sex.' (2009). 10(2) *Southern African Journal of HIV Medicine* 8-10.

- Strode, A. 'Using the concept of 'parental responsibilities and rights' to identify adults able to provide proxy consent to child research in South Africa.' (2011). *South African Journal of Bioethics and Law* 4(2) 69-73.
- Strode, A., & Slack, C. 'Child privacy rights: A 'Cinderella' issue in HIV-prevention research.' (2013). *Southern African Journal of HIV Medicine* 14(3) 108-110.
- Strode, A., Slack, C., & Essack, Z. 'Child consent in South African law: Implications for researchers, service providers and policy-makers.' (2010). *South African Medical Journal* 100(4) 247-249.
- Strode, A... et al. 'Failing the vulnerable: Three new consent norms that will undermine health research with children.' (2014). *Southern African Journal of HIV Medicine*. 46-49.
- Strode, A... et al. 'Preparing for success: Facilitating independent access to new HIV prevention tools for adolescents in South Africa.' (*Article is still with the authors*).
- Strode, A., Toohey, J., & Slack, C. 'Addressing legal and policy barriers to male circumcision for adolescent boys in South Africa.' (2016). *South African Medical Journal* 1173-1176.
- Strode, A., Slack, C., & Z Essack. 'Child consent in South African law: Implications for researchers, service providers and policy-makers.' (2010). *South African Medical Journal* 100(4) 247-249.
- Strode, A... et al. 'Reporting underage consensual sex after the Teddy Bear case: A different perspective.' (2013). *South African Journal of Bioethics and Law* 45-57.
- Szabo, R., & Short, R. 'How does male circumcision protect against HIV infection?' (2000). *Biomedical Journal* 320(7249) 320.7249 (2000): 1592-1594.
- Tanser, F 'Methodology for optimising location of new primary health care facilities in rural communities: A case study in KwaZulu-Natal, South Africa.' (2006). *Journal of Epidemiological Community Health* 60(10) 846-850.
- Tobian, A... et al. 'Male circumcision for the prevention of acquisition and transmission of sexually transmitted infections: the case for neonatal circumcision.' (2010). *Archives of Pediatrics & Adolescent Medicine* 164 (1) 78-84.
- van Rooyen, H., Strode, A., & Slack, C. 'HIV testing of children is not simple for health providers and researchers: Legal and policy frameworks guidance in South Africa.' (2016). *South African Medical Journal* 106 (5) 451-453.
- Vawda, Y., & Maqutu, L. 'Neonatal circumcision – violation of children's rights or public health necessity?' (2011). *South African Journal of Bioethics and Law* 36-42.
- Weiss, H... et al. 'Male circumcision for HIV prevention: Current research and programmatic issues.' (2010). *AIDS (London, England)* 24(4) S61-S69.

Wouters, E., van Rensburg, H., & Meulemans, H. ‘The National Strategic Plan of South Africa: what are the prospects of success after the repeated failure of previous AIDS policy?’ (2010). *Health Policy and Planning* 25 171-185.

TABLE OF CASES

Teddy Bear Clinic for Abused Children and Prevention of Child Abuse and Neglect (RAPCAN) v Minister of Justice and Constitutional Development 2013 CCT 12/13 ZACC 35.

Teddy Bear Clinic for Abused Children and Another v Minister of Justice and Constitutional Development and Another 2014 (2) SA 168 (CC).

S v Zuma and Others 2006 (CC358/05) ZAKZHC 22.

TABLE OF STATUTES

Criminal Law [Sexual Offences and Related Matters] Amendment Act Amendment Act 5 of 2015

s15

s16

Sexual Offences Act 23 of 1957

Children’s Act 38 of 2005

s9

s10

s13

s110

s129

s130

s132

s133

s134

Constitution of the Republic of South Africa Act 108 of 1996

s12

s13

s27 (1)

s28

s29

s30

s31

s36

s39

SOUTH AFRICAN NATIONAL POLICIES AND DOCUMENTS

South Africa Department of Education National Policy on HIV and AIDS for Learners and Educators in Public Schools and Students and Educators in Further Education and Training Institutions. Pretoria: Dept. of Education (2012).

South Africa Department of Health and Department of Basic Education. Integrated School Health Policy. Pretoria: Dept. of Health and Dept. of Education (2012).

South Africa Department of Health National Contraception and Fertility Planning Policy and Service Delivery Guidelines: A companion to the National Contraception Clinical Guidelines. Pretoria: Dept. Of Health (2012).

South Africa Department of Health National HIV Counselling and Testing Policy. Pretoria: Dept. of Health (2015).

South Africa Department of Health. National Contraceptives Guidelines. Pretoria: Dept. of Health (2012).

South Africa Department of Health. Youth and Adolescent Health Policy. Pretoria: Dept. of Health (2001).

South African National AIDS Council National Strategic Plan for STIs HIV and TB for 2012-2016. South African National AIDS Council (2012).

South African National Department of Health National Adolescent Sexual and Reproductive Health and Rights Framework Strategy. (2014-2019) Pretoria: Dept. of Health (2015).

The South African Expanded Programme on Immunisation Schedule (1995).

ONLINE SOURCES

AIDS Vaccine Advocacy Coalition ‘HIV Vaccines and Microbicides Resource Tracking Working Group’ 2014 Resource Tracking Working Group available at: <http://www.avac.org/resource-tracking#>, accessed on 25 January 2017.

AIDS.gov ‘How do you get HIV or AIDS?’ available at: <https://www.aids.gov/hiv-aids-basics/hiv-aids-101/how-you-get-hiv-aids/>, accessed on 26 August 2016.

Amazeza Info Services Vaccine Helpline ‘Vaccine Schedules for South Africa for 2015’ available at: <http://www.amazeza-info.co.za/wp-content/uploads/2011/08/2015-Newschedule-products-final-15102014.pdf>, accessed on 20 May 2016.

Mail and Guardian Online ‘AIDS and children. Mothers to Adolescents: An AIDS-free future’ Special Reports, 27 November 2015 available at: <http://mg.co.za/article/2015-11-27-00-mothers-to-adolescents-an-aids-free-future>, accessed on 14 September 2015.

AVERTing HIV and AIDS ‘HIV Prevention Programmes Overview’ available at: http://www.avert.org/hiv-prevention-programmes.htm#footnote1_d5lot79, accessed on 03 November 2015.

AVERTing HIV and AIDS ‘Key Affected Populations, HIV and AIDS’ available at: <http://www.avert.org/professionals/hiv-social-issues/key-affected-populations>, accessed on 25 January 2017.

AVERTing HIV and AIDS, ‘HIV and AIDS in South Africa’ available at: <http://www.avert.org/professionals/HIV-around-world/Sub-Saharan-Africa/South-Africa>, accessed on 26 March 2016.

AVERTing ‘Searching for a cure for HIV and AIDS’ available at: <http://www.avert.org/professionals/hiv-science/vaccines-microbicides>, accessed on 05 November 2015.

AVERTing HIV and AIDS ‘Voluntary Medical Male Circumcision for HIV Prevention’ available at: <http://www.avert.org/voluntary-medical-male-circumcision-vmmc-hiv-prevention.htm#sthash.3vex7AVJ.dpuf>, accessed on 25 January 2017.

AVERTing HIV and AIDS Global HIV and AIDS Statistics’ (2017) available at: <http://www.avert.org/global-hiv-and-aids-statistics>, accessed on 24 January 2017.

AVERTing HIV and AIDS, ‘HIV and AIDS in South Africa’ (2015) available at: <http://www.avert.org/professionals/HIV-around-world/Sub-Saharan-Africa/South-Africa>, accessed on 26 March 2016.

Cambridge Dictionary available at: <http://dictionary.cambridge.org/dictionary/english/contraceptive>, accessed 09 January 2017.

Centres for Disease Control ‘HIV among Youth’ CDC 27 April 2016 available at: <https://www.cdc.gov/hiv/group/age/youth/>, accessed on 26 January 2017.

Department for International Development ‘Sexual and reproductive health and rights: A position paper’ (2004) available at: <http://www.hivpolicy.org/Library/HPP000499.pdf>, accessed on 25 January 2017.

Joint United Nations Programme on HIV/AIDS ‘UNAIDS calls for 20 billion condoms by 2020’

(2016) available at:

http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2016/february/20160212_condoms, accessed 03 March 2016.

Joint United Nations Programme on HIV/AIDS and World Health Organisation ‘Male circumcision: global trends and determinants of prevalence, safety and acceptability’ (2007) available at:

http://www.unaids.org/sites/default/files/media_asset/jc1360_male_circumcision_en_2.pdf,

accessed on 25 January 2017.

World Health Organisation ‘Information Package on Male Circumcision and HIV Prevention’ Insert 3

available at: http://www.who.int/hiv/pub/malecircumcision/infopack_en_3.pdf, accessed on 17

January 2017.

Statistics South Africa ‘Mid-year population estimates, 2010’ Statistical Release available at:

<https://www.statssa.gov.za/publications/P0302/P03022010.pdf>, accessed on 31 August 2015.

Statistics South Africa ‘Millennium Development Goals 6: Combat HIV/AIDS, malaria and other

diseases 2015’ available at: http://www.statssa.gov.za/MDG/MDG_Goal6_report_2015_.pdf,

accessed on 25 January 2016.

The Medical Male Circumcision ‘MMC Programme in South Africa’ MMC available at:

<http://www.mmcsinfo.co.za/partners>, accessed on 24 January 2017.

UNAIDS Joint United Nations Programme on HIV/AIDS ‘Fact sheet’ (2016) available at:

<http://www.unaids.org/en/resources/fact-sheet>, accessed on 17 January 2017.

UNAIDS Joint United Nations Programme on HIV/AIDS ‘Global AIDS update’ (2016) available at:

<http://www.unaids.org/en/resources/documents/2016/Global-AIDS-update-2016>, accessed 24

January 2017.

UNAIDS Joint United Nations Programme on HIV/AIDS Global Report ‘UNAIDS Report on the Global AIDS Epidemic’ (2012) available at:

http://www.unaids.org/sites/default/files/media_asset/20121120_UNAIDS_Global_Report_2012_with_annexes_en_1.pdf, accessed on 26 August 2016.

UNAIDS Joint United Nations Programme on HIV/AIDS Global Report ‘UNAIDS Report on the Global AIDS Epidemic’ (2013) available at:

http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Global_Report_2013_en_1.pdf,

accessed on 13 February 2015.

UNAIDS Joint United Nations Programme on ‘HIV/AIDS World AIDS Day Report’ (2011) available at:

http://www.unaids.org/sites/default/files/media_asset/JC2216_WorldAIDSday_report_2011_en_1.pdf, accessed on 20 February 2015.

UNAIDS Joint United Nations Programme South Africa ‘HIV and AIDS estimates’ (2015) available at: <http://www.unaids.org/en/regionscountries/countries/southafrica>, accessed on 24 January 2017.

UNAIDS. Joint United Nations Programme on HIV/AIDS ‘The Gap Report’ (2014) available at: http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf, accessed on 13 February 2015.

United Nations Children’s Fund ‘Progress for children: a report card on adolescents’ (2012) available at: https://www.unicef.org/media/files/PFC2012_A_report_card_on_adolescents.pdf, accessed on 08 September 2015.

World Health Organisation ‘HIV and adolescents: guidance for HIV testing and counselling and care for adolescents living with HIV: recommendations for a public health approach and considerations for policy-makers and managers’ (2013) available at: http://apps.who.int/iris/bitstream/10665/94334/1/9789241506168_eng.pdf, accessed on 27 January 2017.

World Health Organization Media Centre Fact sheet N°360 (2015) available at: <http://www.who.int/mediacentre/factsheets/fs360/en/>, accessed on 30 October 2015.

World Atlas Leading Causes of Death in South Africa (2016) available at: www.worldatlas.com/articles/leading-causes-of-death-in-south-africa.html, accessed on 24 January 2017.

ONLINE JOURNALS AND NEWSPAPER ARTICLES

Baerecke, L....et al. ‘Raising an AIDS-free generation: Evaluation of the Global Fund Orphans & Vulnerable Children Programme’ NACOSA (2016) available at: <http://www.nacosa.org.za/wp-content/uploads/2016/07/RAISING-AN-AIDS-FREE-GENERATION-Evaluation-of-the-Global-Fund-OVC-Programme.pdf>, accessed on 25 January 2017.

Blandy, F. ‘SA Govt. under fire at Aids conference’ Mail and Guardian 19 August 2006 available at: <http://mg.co.za/article/2006-08-19-sa-govt-under-fire-at-aids-conference>, accessed on 25 January 2017.

Spotlight ‘Condoms in schools’ Engaging with South Africa’s National Strategic Plan for HIV, STIs and TB December 2016 available at: <http://www.spotlightnsp.co.za/2015/06/10/condoms-in-schools/#content-wrapper>, accessed on 18 January 2017.

- Essack, Z...et al ‘Overcoming key obstacles to adolescent involvement in HIV vaccine & microbicide trials: a roadmap for stakeholders’ (2008) HIV AIDS Vaccines Ethics Group in collaboration with the Global Campaign for Microbicides available at: [http://www.global-campaign.org/clientfiles/essack,slack-strode\(2008\)towardsaroadmap.pdf](http://www.global-campaign.org/clientfiles/essack,slack-strode(2008)towardsaroadmap.pdf), accessed on 24 January 2016.
- Malan, M ‘SA has highest number of new HIV infections worldwide – Survey, BHEKISISA, Mail and Guardian 01 Apr 2014 available at: <http://mg.co.za/article/2014-04-01-SA-holds-highest-number-of-new-HIV-infections-worldwide-survey>, on 03 March 2016, accessed on 01 August 2015.
- McNeil, J ‘A History of Official Government HIV/AIDS Policy in South Africa’ South African History Online available at: <http://www.sahistory.org.za/topic/history-official-government-hivaids-policy-south-africa>, accessed on 4 December 2016.
- Staff Writer, ‘Risk of HIV and Aids remain alarmingly high among SA teens’ SA breaking news 01 February 2016 available at: <http://www.sabreakingnews.co.za/2016/02/01/risk-of-hiv-and-aids-remain-alarmingly-high-among-sa-teens/>, accessed on 09 January 2017.
- Strode A & Grant K. ‘Children and HIV: Using an evidence-based approach to identifying legal strategies that protect and promote the right of children infected and affected by HIV and AIDS’ (7-9 July 2011) Working Paper prepared for the Third Meeting of the Technical Advisory Group of the Global Commission on HIV and the Law available at: http://apps.who.int/iris/bitstream/10665/128049/1/WHO_HIV_2014.8_eng.pdf., accessed on 03 September 2015.
- Strode, A., & Slack C. ‘Selected Ethical-Legal Norms in Child and Adolescent HIV Prevention Research in South Africa: Consent, Confidentiality and Mandatory Reporting.’ (2014). Pietermaritzburg: HAVEG available at: <http://www.saavi.org.za/haveg/selective.pdf>, accessed on 26 January 2017.

TABLE INTERNATIONAL TREATIES, CONVENTIONS AND DOCUMENTS

- Amnesty International USA ‘Sexual and Reproductive Health Rights-Fact Sheet’ available at: <https://www.amnestyusa.org/our-work/issues/women-s-rights>, accessed on 03 September 2015.
- Assembly, U. G. (2014). Vienna Declaration and Programme of Action, 12 July 1993, A/CONF. 157/23.

Assembly, United Nations General. ‘Convention on the Rights of the Child. ‘Office of the United Nations High Commissioner for Human Rights. 1989.

Assembly, United Nations General. ‘International Covenant on Economic, Social and Cultural Rights’ (ICESCR) (1996) 993: United Nations, Treaty Series.

Convention of the Right of the Child General Comment No. 12 (2009) ‘The Right of the Child to be Heard’ available at: <http://www2.ohchr.org/english/bodies/crc/docs/AdvanceVersions/CRC-C-GC-12.pdf>, accessed on 09 October 2016.

United Nations Committee on Economic, Social and Cultural Rights International Covenant General Comment No. 22 ‘Right to sexual and reproductive health’ (2016) (E/C.12/GC/22).

Joint United Nations Programme on HIV/AIDS -General Assembly Special Session on HIV/AIDS ‘Declaration of Commitment on HIV/AIDS’ (2011) UNAIDS available at: http://www.unaids.org/sites/default/files/sub_landing/files/aidsdeclaration_en_0.pdf, accessed on 03 September 2015.

Joint United Nations Programme on HIV/AIDS, ‘Global Fact Sheet’ (2016) available at: <http://www.unaids.org/en/resources/fact-sheet>, accessed on 09 January 2017.

UN Committee on the Rights of the Child (CRC) General Comment No. 2 (2002) ‘The Role of Independent National Human Rights Institutions in the Promotion and Protection of the Rights of the Child’ (2002) CRC/GC/2002/2 available at: <http://www.refworld.org/docid/4538834e4.html>, accessed 25 January 2017.

United Nations Committee on the Rights of the Child (CRC) General Comment No. 3(2003) ‘HIV/AIDS and the Right of the Child’ (33rd Session) Doc.CRC/GC/2003/3 available at: <http://www.refworld.org/docid/4538834e15.html>, accessed 26 January 2017

United Nations Committee on the Rights of the Child (CRC) General Comment No. 4 (2003) ‘Adolescent Health and Development in the Context of the Convention on the Rights of the Child’ (2003) CRC/GC/2003/4 available at: <http://www.refworld.org/docid/4538834f0.html>, accessed on 18 January 2017.

United Nations High Commissioner for Human Rights and Joint United Nations Programme on HIV/AIDS ‘International Guidelines on HIV/AIDS and Human Rights’ (2006) Consolidated Version, HR/PUB/06/9, OHCHR and UNAIDS available at: <http://www.refworld.org/docid/4694a4a92.html>, accessed on 14 September 2015.

United Nations General Assembly Resolution adopted by the General Assembly on 10 June 2011’ (2011) available at: https://www.unodc.org/documents/southeastasiaandpacific/2012/02/hlm-hiv/20110610_UN_A-RES-65-277_en.pdf, accessed on 25 January 2017.

- United Nations Committee on the Elimination of Discrimination against Women (CEDAW), CEDAW General Recommendation No. 24: Article 12 of the Convention (1999) A/54/38/ available at: <http://www.refworld.org/docid/453882a73.html>, accessed 25 January 2017.
- United Nations General Assembly, International Covenant on Economic, Social and Cultural Rights, 16 December 1966, United Nations, Treaty Series available at: <http://www.refworld.org/docid/3ae6b36c0.html>, accessed online 09 January 2017.
- UNAIDS United Nations Children’s Fund ‘Turning the tide against AIDS will require more concentrated focus on adolescents and young people’ (2016) available at: <http://data.unicef.org/hiv-aids/adolescents-young-people#sthash.g0L013yF.dpuf>, accessed 01 September 2015.
- United Nations Development Programme - Global Commission on HIV and the Law ‘HIV and the Law: Risks, Rights and Health’ (2012) available at: <http://www.hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-N.pdf>, accessed on 09 January 2017.
- United Nations Population Fund, World Health Organisation and Joint United Nations Programme on HIV/AIDS ‘Position statement on condoms and the prevention of HIV, other sexually transmitted infections and unintended pregnancy’ (2015) available at: http://www.unaids.org/en/resources/presscentre/featurestories/2015/july/20150702_condoms_prevention, accessed on 26 January 2017.
- United Nations Population Fund, World Health Organisation and Joint United Nations Programme on HIV/AIDS ‘Condoms and HIV prevention: position statement by UNAIDS, UNFPA and WHO’ (2004) available at: <http://www.unfpa.org/resources/condoms-and-hiv-prevention-position-statement-unaid-unfpa-and-world-health-organization#sthash.rLXiKsHS.dpuf>, accessed on 09 September 2015.
- World Health Organisation Medical eligibility criteria for contraceptive use 5th ed. (2015).
- World Health Organisation ‘Microbicides’ available at: <http://www.who.int/hiv/topics/microbicides/microbicides/en/>, accessed 15 January 2017.
- World Health Organisation ‘Statement on HIV testing and counselling: WHO, UNAIDS re-affirm opposition to mandatory HIV testing’ (2012) available at: http://www.who.int/hiv/events/2012/world_aids_day/hiv_testing_counselling/en/, accessed on 17 January 2017.

World Health Organisation 'WHO and UNAIDS announce recommendations from expert consultation on male circumcision for HIV prevention' (2007) available at:

<http://www.who.int/hiv/mediacentre/news68/en/>, accessed on 26 January 2017.

World Health Organization 'Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations' (2014) available at:

http://apps.who.int/iris/bitstream/10665/128049/1/WHO_HIV_2014.8_eng.pdf, accessed on 14 September 2015.

World Health Organization 'Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations', (2014) WHO, 88 available at:

http://apps.who.int/iris/bitstream/10665/128049/1/WHO_HIV_2014.8_eng.pdf, accessed on 03 November 2015.

World Health Organization. Reproductive Health. Medical eligibility criteria for contraceptive use.

World Health Organization, 2010.

THESES

Al-eisawi, Z' *Combinations Between Platinum Drugs and Bortezomib and Changes in Nature of Administration in Ovarian Tumour Models*' (unpublished LLD thesis, University of Sydney) 2013.

BOOKS

Boezaart, T 'Child Law in South Africa' Cape Town: *Juta and Company Ltd* (2009).

Committee for the Study of the Future of Public Health. 'Future of Public Health' *Institute of Medicine (US)*. (1988).

Mann, J 'Human Rights and Public Health.' in J Mann (eds) *Health and Human Rights: A Reader* (1999).

Mubangizi, JC' *The protection of human rights in South Africa: A legal and practical guide*' Cape Town: *Juta and Company Ltd* (2004).

Nadasen, S. *Public health law Health Law in South Africa*' (2000) *Indiana: Indiana University Press* (2008).

Pilcher, J and Wagg, S 'Thatcher's Children? Politics, Childhood and Society in the 1980s and 1990s.' *Routledge* (2005).

TABLE OF CONTENTS

Title page	i
Declaration of originality	ii
Acknowledgements	iii
Bibliography	v
Table of Contents	xviii
Acronyms	xxii

CHAPTER ONE: ADOLESCENT RISK OF HIV IINFECTION

1.1. Introduction.....	1
1.2. Framing the public health response to HIV prevention	6
1.3. Literature review	9
1.4. Purpose of this review.....	11
1.5. Methodology	12
1.6. Key research focus	14
1.6.1. The main research question	15
1.6.2. Structure of the dissertation	15
1.7. Conclusion	15

CHAPTER TWO: THE PUBLIC HEALTH AND HUMAN RIGHTS RESPONSE TO HIV

2.1. Introduction.....	17
2.2. The development of public health and human rights response.....	17
2.3. South Africa’s public health response to HIV prevention	23
2.4. The current HIV prevention response.....	26
2.4.1. Access to education and information about HIV Prevention	29
2.4.2. Access to voluntary HIV counselling and testing (HCT).....	30
2.4.3. Access to male and female condom access	31
2.4.4. Access to male medical circumcisions	33
2.4.5. Access to potential implementation of innovative biomedical prevention strategies - microbicides and an HIV vaccine	36
2.5. Conclusion	37

CHAPTER THREE: THE LEGAL FRAMEWORK

3.1. Introduction.....	37
3.2. General principles: overview of the legal framework.....	39
3.2.1. The Constitution	44
3.2.2. Statutory provisions relating to the sexual and reproductive rights of children.....	45
3.3. Legal provisions relating to access to five key methods of HIV prevention	47
3.3.1. Access to education and information about HIV prevention	47
3.3.2. Access to HIV counselling and testing (HCT)	47
3.3.3. Access to male and female condom access	49
3.3.4. Access to male medical circumcisions	50
3.3.5. Access to potential implementation of innovative biomedical prevention strategies - microbicides and an HIV vaccine.....	52
3.4. Conclusion	52

CHAPTER FOUR: THE POLICY FRAMEWORK

4.1. Introduction.....	54
4.2. General principles underpinning the policy framework and an overview of this framework	54
4.3. Policies relating to adolescent access to HIV prevention	57
4.3.1. Access to education and information about HIV prevention	57
4.3.2. Access to voluntary HIV counselling and testing (HCT).....	62
4.3.3. Access to male and female condom access	65
4.3.4. Access to male medical circumcisions	68
4.3.5. Access to potential implementation of innovative biomedical prevention strategies – microbicides and an HIV vaccine	70
4.4. Conclusion	70

CHAPTER FIVE: A REVIEW OF THE EXTENT TO WHICH THE SOUTH AFRICAN LEGAL AND POLICY FRAMEWORK FACILITATES ACCESS TO HIV PREVENTION FOR ADOLESCENTS

5.1. Background.....	72
5.2. Introduction.....	74

5.3. Applying the Impact Assessment and Four Key Child- Oriented Rights to adolescent access to HIV Education and Information	75
5.3.1. To what extent does ‘standard’ represent ‘good’ public health?	75
5.3.2. Is the law and/or policy respectful and protective of child-oriented human rights?	75
5.3.3. How can the best possible combination of law and policy facilitate further the main public health agenda?	76
5.3.4. Does the law and/or policy facilitate adolescent access to HIV prevention?	76
5.3.4. Does the law and/or policy facilitate adolescent access to HIV prevention?	76
5.3.5. Discussion	77
5.4. Application of the Impact Assessment and Four Key Child- Oriented Rights to adolescent access to HIV Testing and Counselling (HCT)	81
5.4.1. To what extent does standard represent ‘good’ public health?	81
5.3.2. Is the law and/or policy respectful and protective of child-oriented human rights?	82
5.4.3. How can the best possible combination of law and policy facilitate further the main public health agenda?	86
5.4.4. Does the legal and policy framework facilitate adolescent access to HIV prevention?	86
5.4.5. Discussion	86
5.5. Application of the Impact Assessment and Four Key Child- Oriented Rights to adolescent access to barrier contraceptives (Male and Female Condoms)	88
5.5.1. To what extent does the national response meet ‘good’ public health standard?	88
5.5.2. Is the law or policy respectful and protective of the child-oriented human rights?	88
5.5.3. How can the best possible combination of law and policy facilitate further the main public health agenda?	91
5.5.4. Does the law or policy facilitate adolescent access to HIV prevention?	91
5.5.5. Discussion	91
5.6. Application of the Impact Assessment and Four Key Child- Oriented Rights to adolescent access in relation to Medical Male Circumcision	94
5.6.1. To what extent does the national response meet ‘good’ public health standard?	94
5.6.2. Is the law or policy respectful and protective of the child-oriented human rights?	94
5.6.3. How can the best possible combination of law and policy facilitate further the main public health agenda?	98
5.6.4. Does the law or policy facilitate adolescent access to HIV prevention?	98
5.6.5. Discussion	98

5.7. Application of the Impact Assessment and Four Key Child- Oriented Rights to adolescent access to future potential HIV Prevention Tools which is Limited to a Microbicide and HIV vaccine	101
5.7.1. To what extent does the national response meet ‘good’ public health standard?	101
5.7.2. Is the law or policy respectful and protective of the child-oriented human rights?	101
5.7.3. How can the best possible combination of law and policy facilitate further the main public health agenda?	102
5.7.4. Does the law or policy facilitate adolescent access to HIV prevention?	102
5.7.5. Discussion	103
5.8. Conclusion	103

CHAPTER SIX: DISCUSSION AND CONCLUSION

6.1. Background	104
6.2. Introduction	104
6.3. Summary of Key Findings	107
6.3.1. The legal and policy framework on access to education and information relating to HIV prevention is adequate only with regard to school going youth	108
6.3.2. The legal and policy framework deals directly with 3 HIV prevention methods (testing, condoms and male circumcision) and this facilitates access by adolescents over 12	108
6.3.3. The failure of the Children’s Act to expressly deal with prevention services leaves a gap regarding the age at which children can independently consent to such interventions	108
6.3.4. There are a number of legal and policy strengths within the framework	109
6.3.5. There are a number of gaps and weaknesses in the legal and policy framework	109
6.4. Recommendations for possible future law and policy reform	110
6.5. Conclusion	112

ACRONYMS

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
DBE	Department of Basic Education
DOH	Department of Health
DSD	Department of Social Development
HCT	HIV counselling and testing
HIV	Human immunodeficiency virus
HPV	Human papilloma virus
MMC	Medical male circumcision
MCWH	Maternal, child and women's health
MDGs	Millennium Development Goals
NSP	National Strategic Plan for HIV, STIs and TB (2012-2016)
PEP	Post-exposure prophylaxis
PHC	Primary health care
PLHIV	Persons living with HIV
PMTCT	Prevention of mother to child transmission of HIV
PrEP	Pre-exposure prophylaxis
OVC	Orphans and vulnerable children
SANAC	South African National AIDS Council
SAPS	South African Police Service
SBCC	Social and behaviour change communication
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TB	Tuberculosis
UN	United Nations
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
WHO	World Health Organization

CHAPTER ONE: ADOLESCENTS RISK OF HIV INFECTION

1.1.Introduction

HIV/AIDS is a major global issue estimating 1.1 million HIV-related deaths; 36.7 million people living with HIV and 2.1 million newly infected people around the world in 2015.¹ This is in contrast to 2001 in which an estimated 3.4 million new infections occurred, indicating a decline in new infections.² Recent global surveys have highlighted evidence of an increase in HIV-related knowledge, condom use and the global health plan to scale-up care programs, such as universal access to Anti-Retroviral Treatment (ART).³ Regardless, the rate of HIV incidence continues to pose a challenge amongst certain key populations and it remains a burden in many resource-limited countries as the epidemic continues to claim lives every day particularly with various sub-populations (such as men who have sex with men) who often have limited access to treatment and prevention interventions.⁴

Africa bears a significant burden of HIV.⁵ Notably, an estimated 70 per cent of the overall global burden is in the sub-Saharan region which accounts for the highest number of HIV infected.⁶ In 2015, there was

¹AIDS.gov. 'How do you get HIV or AIDS?' (2015) *AIDS.gov*, available at <https://www.aids.gov/hiv-aids-basics/hiv-aids-101/how-you-get-hiv-aids/>, (accessed on 26 August 2016.). 'The Human Immunodeficiency Virus (HIV) is a disease which, once a person becomes infected attacks the immune system, destroys all the healthy immune system cells (also known as antibodies) which defend the body against infections and illness such as tuberculosis (TB) and cancers. HIV at an advanced level then develops into the Acquired Immunodeficiency Syndrome (AIDS). HIV is transmitted mainly through the transfer of bodily fluids from infected individuals (this includes transmission through blood, breast milk, semen and vaginal emissions) and it is not transmitted through daily contact with individuals (for example through hugging, kissing, touching, food and water. There are a number of factors that place an individual at risk to HIV infection, this includes, unprotected sex (both anal and vaginal); sharing of needles or syringes; blood transfusions; unsterile and unsafe medical procedures or operations (such as unsterile male circumcision, ear piercing, etc.); and health worker accidental needle stick injuries'.

²Joint United Nations Programme on HIV/AIDS 'The Gap Report' (2014) 12 *UNAIDS*, available at: http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf, (accessed on 13 February 2015 12.).

³Joint United Nations Programme on HIV/AIDS, 'Global Report', *UNAIDS Report on the Global AIDS Epidemic* (2012) *UNAIDS* available at: http://www.unaids.org/sites/default/files/media_asset/20121120_UNAIDS_Global_Report_2012_with_annexes_en_1.pdf, accessed on 26 August 2016.

⁴Ibid 16.

⁵Joint United Nations Programme on HIV/AIDS, 'Global Report, *UNAIDS Report on the Global AIDS Epidemic*'. (2013) 2, *UNAIDS*, available at: http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Global_Report_2013_en_1.pdf, accessed (Accessed on 13 February 2015.

⁶World Health Organization, 'Media Centre Fact Sheet N°360' (2015) available at: <http://www.who.int/mediacentre/factsheets/fs360/en/>, accessed on 30 October 2015.

an estimated 25.5 million people living with HIV in sub-Saharan Africa.⁷ Of this estimate, women accounted for 56 per cent and young girls accounted for 25 per cent of new infections of the total adult statistics.⁸

Regional data—2015

Region	People living with HIV (total)	New HIV infections			AIDS-related deaths (total)	Total number accessing antiretroviral therapy
		Total	Aged 15+	Aged 0–14		
Eastern and southern Africa	19.0 million [17.7 million–20.5 million]	960 000 [830 000–1.1 million]	910 000 [790 000–1.1 million]	56 000 [40 000–76 000]	470 000 [390 000–560 000]	10 million
Latin America and the Caribbean	2.0 million [1.7 million–2.3 million]	100 000 [86 000–120 000]	100 000 [84 000–120 000]	2100 [1600–2900]	50 000 [41 000–59 000]	1.1 million
Western and central Africa	6.5 million [5.3 million–7.8 million]	410 000 [310 000–530 000]	350 000 [270 000–450 000]	66 000 [47 000–87 000]	330 000 [250 000–430 000]	1.8 million
Asia and the Pacific	5.1 million [4.4 million–5.9 million]	300 000 [240 000–380 000]	280 000 [220 000–350 000]	19 000 [16 000–21 000]	180 000 [150 000–220 000]	2.1 million
Eastern Europe and central Asia	1.5 million [1.4 million–1.7 million]	190 000 [170 000–200 000]	190 000 [170 000–200 000]	---*	47 000 [39 000–55 000]	320 000
Middle East and North Africa	230 000 [160 000–330 000]	21 000 [12 000–37 000]	19 000 [11 000–34 000]	2100 [1400–3200]	12 000 [8700–16 000]	38 000
Western and central Europe and North America	2.4 million [2.2 million–2.7 million]	91 000 [89 000–97 000]	91 000 [88 000–96 000]	---*	22 000 [20 000–24 000]	1.4 million

* Estimates were unavailable at the time of publishing

Figure 1: Regional Statistics of the Global Burden – 2015⁹

⁷AVERTing HIV and AIDS, ‘Global HIV and AIDS Statistics’ (2017) available at <http://www.avert.org/global-hiv-and-aids-statistics>, accessed on 24 January 2017.

⁸Joint United Nations Programme on HIV/AIDS ‘Global AIDS update’ (2016) *UNAIDS*, available at: <http://www.unaids.org/en/resources/documents/2016/Global-AIDS-update-2016>, (accessed 24 January 2017).

See) and see also Joint United Nations Programme on HIV/AIDS, ‘World AIDS Day Report’ (2011) *UNAIDS*, available at: http://www.unaids.org/sites/default/files/media_asset/JC2216_WorldAIDSday_report_2011_en_1.pdf, (accessed on 20 February 2015.)

⁹ Ibid.

The table above illustrates of the estimate numbers of people living with HIV, by region, 2015.¹⁰ The epidemiological data provide a broad snapshot of the regional HIV burden but important details are explained below.

Currently, South Africa's leading cause of death is due to HIV/AIDS and has the highest number of people living with HIV with an estimate burden of 7 million, an average of 4 million women above 15 years and 240 000 children below the age of 14.¹¹ Furthermore, studies indicate that young adolescent girls and young women in South Africa appear to have a higher HIV prevalence and the incidence of HIV is seemingly on a steady rise since surveys conducted in 2005, 2008 and 2012.¹²

According to recent HIV/AIDS statistical data in South Africa, adolescents between the ages of 10-19 years living with HIV has doubled.¹³ Furthermore, the prevalence among persons 15-49 years of age is 17, 9 per cent, which is the highest rate of HIV infection amongst this age group anywhere in the world.¹⁴ Young people (aged 10-24 years old) are particularly vulnerable to HIV infection and their sexual and reproductive rights (SRHs) are in many countries under-developed or weak.¹⁵ This is concerning as there is evidence that this age group of young people engage in behaviours that increase their risk of HIV acquisition and there are many contextual factors that contribute to their vulnerability to HIV.¹⁶ For example, adolescent risk factors include early sexual debut, gender inequality, age-gap related power imbalances, multiple sexual partners, inadequate sex education, limited to access to health-care;

¹⁰Joint United Nations Programme on HIV/AIDS, 'Fact sheet' (November 2016) available at: <http://www.unaids.org/en/resources/fact-sheet>, accessed on 17 January 2017.

¹¹World Atlas "Leading Causes of Death in South Africa" (2016) available at www.worldatlas.com/articles/leading-causes-of-death-in-south-africa.html, accessed on 24 January 2017.

See also Joint United Nations Programme – South Africa 'HIV and AIDS estimates' (2015) available at <http://www.unaids.org/en/regionscountries/countries/southafrica>, accessed on 24 January 2017.

See also AVERTing HIV and AIDS, 'HIV and AIDS in South Africa' (2015) available at: <http://www.avert.org/professionals/HIV-around-world/Sub-Saharan-Africa/South-Africa>, accessed on 26 March 2016.

¹² M Malan 'SA has highest number of new HIV infections worldwide – Survey' *BHEKISISA – Mail and Guardian Online* 01 Apr 2014, available at <http://mg.co.za/article/2014-04-01-SA-holds-highest-number-of-new-HIV-infections-worldwide-survey-on-03-March-2016>, accessed on 01 August 2015.

¹³AIDS and children. Mothers to Adolescents: An AIDS-free future' *Mail and Guardian Online – Special Reports* 27 November 2015 available at: <http://mg.co.za/article/2015-11-27-00-mothers-to-adolescents-an-aids-free-future>, accessed on 14 September 2015.

¹⁴ Statistics South Africa 'Mid-year population estimates, 2010' (2011) *Statistical Release – Statistics South Africa*, available at: <https://www.statssa.gov.za/publications/P0302/P03022010.pdf>, accessed on 31 August 2015.

¹⁵ Department for International Development 'Sexual and reproductive health and rights: A position paper' (2004) available at: <http://www.hivpolicy.org/Library/HPP000499.pdf>, accessed on 25 January 2017 8.

¹⁶ Ibid.

unprotected sex, living without parents, sexual abuse, peer pressure, engaging in risky sex due to drug or substance abuse, and being targets of illegal and abusive situations.

In 2013, it was reported that there were 670,000 young people globally were living with new infections between the ages of 15 to 24 years old.¹⁷ Of this total, 250,000 adolescents fell in the age category of 15-19 years.¹⁸ Among these statistics are young women and adolescent girls who are at very high risk of HIV infection as it was estimated globally that every year approximately 380 000 adolescent girls and young women (aged 10-24 years) are infected.¹⁹

Furthermore, it is submitted that teenage pregnancy is a marker of the levels of unprotected sex, and therefore the continued high rates of teenage pregnancy alert us to the high-risk nature of many sexual encounters among teenage girls. Notably, 39 per cent of ‘...15-19-year-old girls in South Africa have been pregnant at least once and 49 per cent of adolescent mothers are pregnant again within the subsequent 24 months of which 1 in 5 of these pregnant adolescents is HIV positive’.²⁰

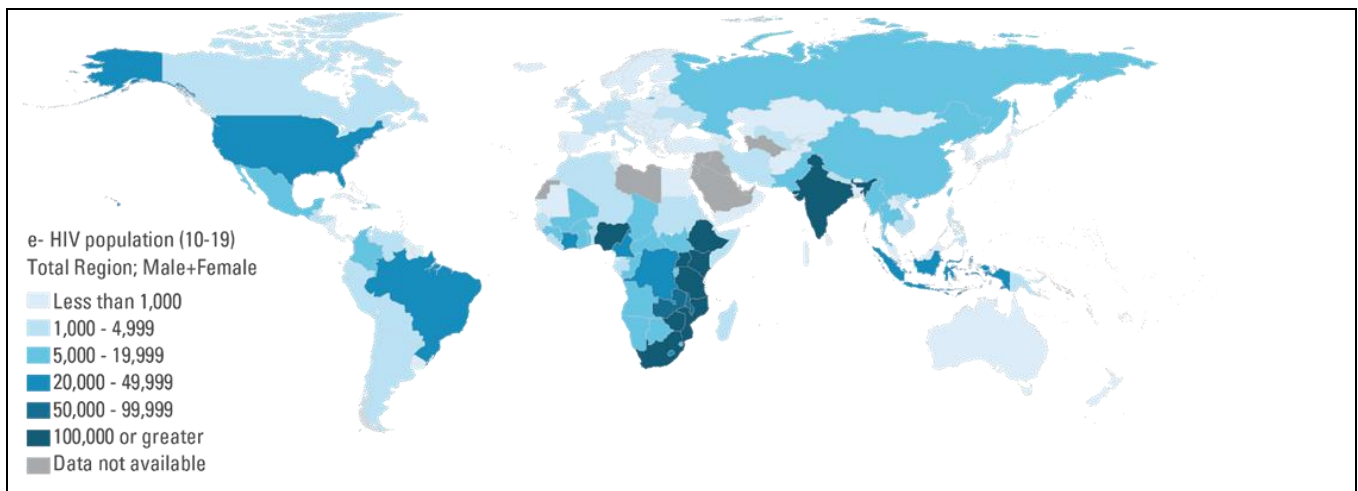


Figure 2: Adolescents (Aged 10-19) Living with HIV (Global)

¹⁷United Nations Children’s Fund ‘Progress for children: A report card on adolescents’ (2012) *UNICEF* available at: https://www.unicef.org/media/files/PFC2012_A_report_card_on_adolescents.pdf, accessed on 08 September 2015. See also AIDS2016. ‘Scientific Programme Highlights’(2016) available at: <http://www.aids2016.org/Media-Centre/The-Latest/Blog/ArticleID/36>, accessed on 04 March 2017.

¹⁸ Ibid.

¹⁹The Gap Report (note 2 above) 20.

²⁰ L Baerecke... et al. ‘Raising an AIDS-free generation: Evaluation of the Global Fund Orphans & Vulnerable Children Programme’ (2016) *The Networking HIV/AIDS Community of South Africa* available at: <http://www.nacosa.org.za/wp-content/uploads/2016/07/RAISING-AN-AIDS-FREE-GENERATION-Evaluation-of-the-Global-Fund-OVC-Programme.pdf>, accessed on 25 January 2017.

The diagram above illustrates the estimated numbers of adolescents living with HIV, by region, 2013.²¹

The incidence of HIV infection among young people appears to have increased thus they remain a vulnerable group because of a number of persistent risk factors (such as poor access, availability and acceptance of health services) that increase HIV acquisition. In addition, young people, in particular adolescents face a number of challenges due to their age-related vulnerability and can vary on their emotional, intellectual and social capacity.²² Being vulnerable means that young people are potentially exposed to or involved in some form of sexual activity and therefore the need to address prevention interventions is important.²³ Since adolescents fear exposure to stigma and discrimination this population group is less inclined to make use of current health services, which means they continue to be removed from accessing key interventions.²⁴ The South African government's response to reach adolescents needs to increase as failing to provide effective support and access to essential services means that the number of AIDS-related deaths will only increase among young people.

Given the seriousness of the HIV epidemic and the high risk of infection amongst adolescents, steps to prevent new infections are critically important. The current South African public health response builds on a series of historical actions and events leading to a framework to HIV AIDS prevention and subsequent culmination to the current National Strategic Plan for STIs HIV and TB for 2012-2016

²¹United Nations Children's Fund - UNAIDS 2016 Estimates 'Turning the tide against AIDS will require more concentrated focus on adolescents and young people' (2016) *UNICEF – UNAIDS 2016 ESTIMATES*, available at <http://data.unicef.org/hiv-aids/adolescents-young-people#sthash.g0L013yF.dpuf>, (accessed 01 September 2015.).

Note: [Map disclaimer](#): – 'The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations. Final boundary between the Republic of Sudan and the Republic of South Sudan has not yet been determined. *Dotted line represents approximately the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the parties.'

²² AE Strode and K Grant 'Children and HIV: Using an evidence-based approach to identifying legal strategies that protect and promote the right of children infected and affected by HIV and AIDS' (7-9 July 2011) *Working Paper prepared for the Third Meeting of the Technical Advisory Group of the Global Commission on HIV and the Law*. 'Children evolve through distinct developmental stages, including infancy (0–6 years), middle childhood (6–10 years), early adolescence (10–14 years) and late adolescence (14–18 years). These developmental stages require legislators to consider both the evolving capacity of children as they develop cognitively as well as their different vulnerabilities'.

See also World Health Organization 'Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations', (2014) p 27, available at: http://apps.who.int/iris/bitstream/10665/128049/1/WHO_HIV_2014.8_eng.pdf, accessed on 01 September 2016 27.

²³ S Coetzee 'Pregnant learners' sexual rights: A constitutional perspective' (2012) 27(2) *Southern African Public Law* 1-2.

²⁴ O Shisana, T Rehle, LC Simbayi, 'South African National HIV Prevalence, Incidence and Behaviour Survey, 2012' (2014) Human Sciences Research Council's (HSRC), available at: <http://www.hsrc.ac.za/uploads/pageContent/4565/SABSSM%20IV%20LEO%20final.pdf>, accessed 31 August 2015.

(hereafter the NSP).²⁵ The NSP takes into account the broader development agenda of South African government and its international, regional and national obligations. It is firmly located within the Constitutional framework of South Africa and strives towards its vision of human dignity, non-racialism, non-sexism and the rule of law. Since 1994, government policies and programmes have endorsed the principles of equality, quality and access. HIV and TB are driven by structural factors outside of health sector, such as poverty, unemployment, and poor housing.

Other important aspects, aims to reduce the effects of HIV on key populations by making accessible critical interventions such as basic education on HIV in schools, HIV testing and condoms. Included in the strategic objectives of the NSP is to ‘addresses the specific access needs of particular groups and key populations, including, but not limited to, women (pregnant, with child-bearing potential or post-menopausal), men, adolescents, children and persons with disabilities. The NSP has defined ‘key populations’ as ‘...those most likely to be exposed to, or to transmit, HIV and/or TB’.²⁶

The HIV prevention interventions included in the NSP are combined into three main categories biomedical, behavioural and structural risk factors which aim to ensure that there is, for example, improved access to child- and adolescent- friendly HIV health service packages. The structural factors are beyond this dissertation, however, it does examine three of the biomedical interventions and they are HIV testing, male circumcision and new scientific interventions. It also deals with two behavioural interventions namely, access to information and education and condoms. For the purpose of this thesis the selected interventions that are analysed have been packaged to include access to a) information and education on HIV and b) access to sexual and reproductive health (SRHs) services and key entry points to services such as c) voluntary counselling and testing, d) HIV education in schools and e) future HIV prevention technologies as the focus on whether or not the legal framework facilitates access and not on implementation of these methods.²⁷

²⁵ South African National AIDS Council ‘National Strategic Plan for STIs HIV and TB for 2012-2016’ (2012) SANAC, available at: [http://www.gov.za/sites/www.gov.za/files/nationalper cent20strategicper cent20planper cent20onper cent20hivper cent20stisper cent20andper cent20tb_0.pdf](http://www.gov.za/sites/www.gov.za/files/nationalper%20strategicper%20planper%20onper%20hivper%20stisper%20andper%20tb_0.pdf), accessed on 10 November 2015.

²⁶Ibid 6.

²⁷ UNICEF. (note 21 above).

1.2. Framing the public health response to HIV prevention

The earliest global responses to the epidemic made an effort to stop the spread of HIV from infected to uninfected persons focusing much attention on populations groups such as men who have sex with men, immigrants from developing countries and needle-using drug users. These marginalized groups were heavily stigmatized and bore the burden of discrimination as the cause of the spread of the HIV disease.²⁸ The first global AIDS strategy which was developed by the World Health Organization (WHO) in 1986-87, called the WHO global AIDS strategy. This strategy defined HIV/AIDS in terms of individual risk behaviors. The aim of the strategy was to help countries establish as widely as possible national AIDS programmes, information and services to help change individual behavior. During the period 1986-89 the goal to change individual behaviour was the initial approach for countries to set in motion plans, programmes, information and health and social services.²⁹ During this time, discrimination and other human rights violations toward those infected by HIV and those living with AIDS was directed at those who were HIV infected and living with AIDS leading to many human rights violations. This led to an awareness and understanding that the HIV/AIDS epidemic was not only an individual behavioural issues but also economic, political, social, and cultural issues.

In 2000 a group of activists at the XIII International AIDS Conference, in Durban, South Africa, joined forces demanding access to treatment and an end to the enormous health inequities.³⁰ The response was based on the principle that the HIV/AIDS was largely a public health issue and the response the epidemic required interventions from national health authorities rather than local.³¹ It was during the 2000's that much change occurred, from calling countries to global action and commitment of the Millennium Development Goals, the United Nations General Assembly Special Session on HIV/AIDS (UNGASS)

²⁸ J Mann 'Responding to HIV/AIDS: a historical perspective' (1998) 2(4) *Health and Human Rights* 5-8.

See also TR Frieden et al. 'Applying Public Health Principles to the HIV Epidemic' (2005) 353(22) *The New England journal of medicine* 2397-2402.

²⁹ Ibid.

³⁰ World Health Organisation, Joint United Nations Programme on HIV/AIDS and United Nations Children's Fund 'Global HIV/AIDS Response: Epidemic Update and Health Sector Progress Towards Universal Access: Progress Report health sector progress towards universal access: progress report 2011' (2011) available at: http://www.unicef.at/fileadmin/media/Infos_und_Medien/Info-Material/HIV_AIDS/2011HIVreport-Nov28en.pdf, accessed on 03 September 2015.

³¹ TR Frieden et al. 'Applying Public Health Principles to the HIV Epidemic' (2005) 353(22) *The New England Journal of Medicine* 2397-2402. 'Controlling epidemics is a fundamental responsibility of the government, working in concert with physicians, patients, and communities. There is a delicate balance between protecting the public and the individual right to privacy. Until we implement prevention programs with proven efficacy more widely, make voluntary screening and linkage to care a normal part of medical care and expand screening in community settings, and improve treatment, risk reduction, monitoring, and partner notification, we will continue to miss opportunities to reduce the spread of HIV infection.'

approved the Declaration of Commitment on HIV/AIDS, to launch of the Global Fund to Fight AIDS, Tuberculosis and Malaria, to various other innovative global health funding platforms and financial and political support to combat HIV/AIDS.³²

What soon became a reality was that HIV/AIDS is a public health issue and therefore important fundamentals of the public health was required in order to respond to the epidemic from an international, regional and national level. This approach included applying standardized treatment and drug regimens, less complex clinical monitoring, increased wide spread coverage in limited resource settings, improving human resources for health and involving people living with and affected by HIV in designing and rolling out effective antiretroviral therapy programmes (which is discussed later in chapter two). Thus public health can be described as ‘what we as a society do collectively to ensure conditions exist in which people can be healthy’.³³ This means that a good public health response seeks to promote and protect the health (including physical, mental and social well-being) of the population at large.³⁴ The conditions in which people can be healthy means that the broader societal context needs to be taken into account where the result is that a number of legal and human rights challenges that give rise to a broad range of conflicting issues in the sphere of public health. Notwithstanding, it is accepted that HIV/AIDS primarily poses major challenges as a public health concern it was recognised several decades ago that interventions to respond to the epidemic should be based on both public health and human rights principles (more detail is provided in Chapter two on the development of both the public health and human rights approach to combatting HIV/AIDS).³⁵ This includes implementation of effective comprehensive intervention programmes which are enabled by effective laws and policy, sufficient funding, and strong political backing.³⁶ The global community has recognised that an effective public health response requires a unified commitment at both international and national level. This includes creating legal obligations on United Nations’ member states to develop strategic legal and policy frameworks and ensuring effective implementation of public health framework (including comprehensive intervention packages).³⁷ As such

³² Global HIV/AIDS Response (note 29 above) .

³³ AM Rothstein ‘Rethinking the meaning of public health’ (2002) *The Journal of Law, Medicine & Ethics* 30.2 144-149.

³⁴ S Kumar and GS Preetha ‘Health Promotion: An Effective Tool for Global Health’ (2012) 37(1) *Indian J Community Med* 5-12.

³⁵ Mann (note 27 above). Note also that the inter-relationship between public health and human rights is dealt with in Chapter two in this thesis.

³⁶ United Nations Development Programme - Global Commission on HIV and the Law ‘HIV and the Law: Risks, Rights and Health’ (2012) available at: <http://www.hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-N.pdf>, accessed 15 September 2015 6.

³⁷ Ibid.

it has been recognised that laws and policies can play a role as a barrier or facilitator to the success of an effective public health standard to combatting HIV.³⁸ Laws and policies that place limitations on certain human rights such as dignity, privacy and access to health care services such as HIV prevention methods have the effect of increasing vulnerability to high risk sexual behaviour which in turn further exacerbates the impact of HIV infection.³⁹

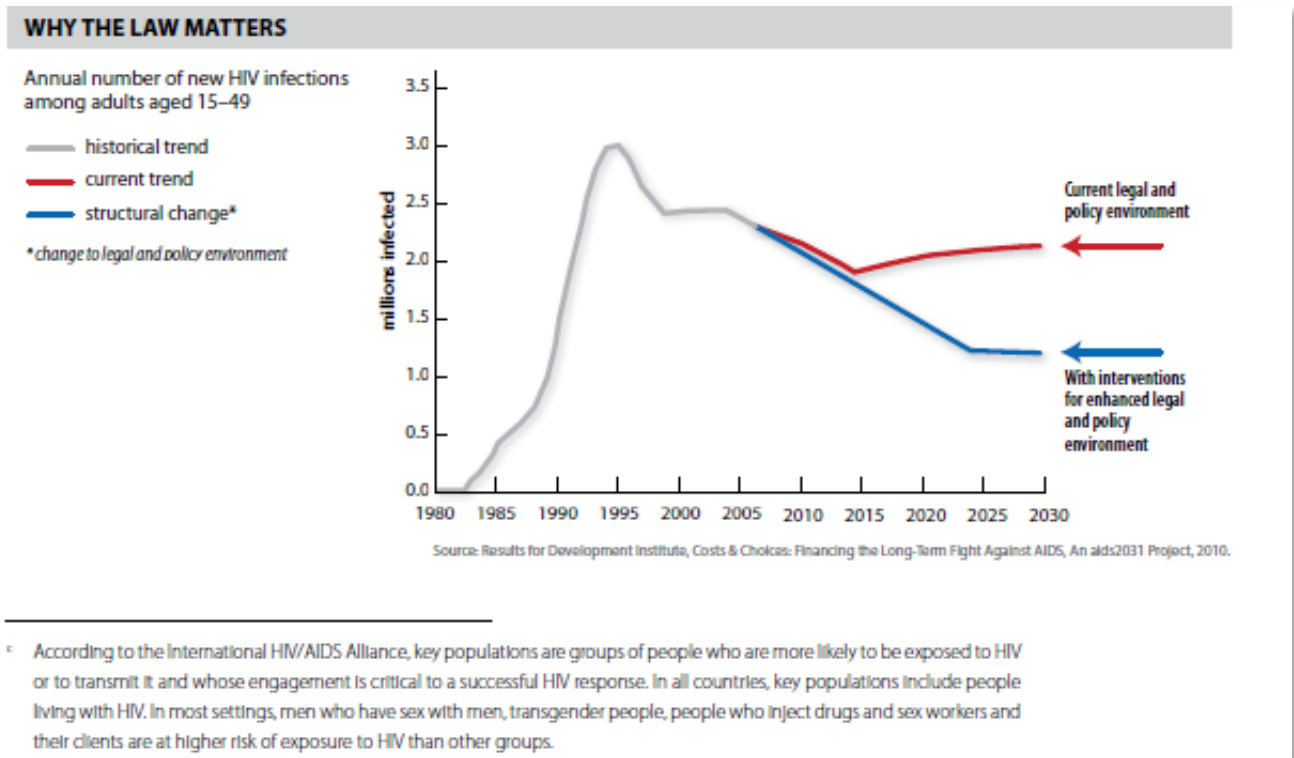


Figure 3: Impact of Laws and Policy on the Public Health Response⁴⁰

The figure above illustrates of the potential impact of laws and policy frameworks on HIV/AIDS: where the law has been amended to, for example promote access to HIV prevention interventions.⁴¹

1.3.Literature review

Recently there has been some reform on national legal and policy framework to make provision for the realisation of Sexual and Reproductive Health Rights (SRHRs) by creating such mechanisms to include

³⁸ Ibid.

³⁹ Ibid.

⁴⁰ Graph adapted from ‘Global Commission on HIV and the Law ‘HIV and the Law: Risks, Rights and Health’ (note 37 above) 11.

⁴¹ Ibid.

sexual reproductive health rights for children. However, there has systematic review as to determine whether laws and policies meet the public health standard set out in the NSP.⁴² There is very little detailed literature on whether South Africa's laws and policies facilitate or hinder access to HIV prevention services to children.

Some authors, however, have already considered the issue of whether certain aspects of the legal framework are enabling or not. For example, several authors such as Strode and Slack have produced a number of articles dealing with barriers to independent access regarding certain health mechanisms where the issue of a child's right to privacy arises.⁴³ Authors such as McQuoid- Mason, and Strode et al, have identified ethical-legal complexities in criminalizing underage sex.⁴⁴ Furthermore, authors have written about adolescent (between the peer group of 12-15) consensual underage sex and whether criminalizing this is inconsistent with the Constitution and that this would result in creating a barrier to young persons accessing services such as HIV counselling and testing, or STI treatment.⁴⁵

Similarly, much has been written on the way in which the legal requirement of mandatory reporting of underage consensual sex can act as a barrier to the accessing of critical HIV prevention services. Mc Quoid-Mason argues that a mandatory duty to report underage sexual activity is unconstitutional as it infringes the best interests of the child and their right to privacy, whereas Strode and Slack contend that

⁴² J Han and ML Bennish 'Condom access in South African Schools: Law, Policy, and Practise' (2009) 6(1) *PLoS Medicine* 25.

⁴³ AE Strode & C Slack 'Child privacy rights: A 'Cinderella' issue in HIV-prevention research' (2013) 14(3) *Southern African Journal of HIV Medicine*, 109.

⁴⁴ Ibid McQuoid-Mason and Strode et al.

⁴⁵ See D McQuoid-Mason 'Decriminalisation of consensual sexual conduct between children: What should doctors do regarding the reporting of sexual offences under the Sexual Offences Act until the Constitutional Court confirms the judgment of the Teddy Bear Clinic case?' (2013) *South African Journal of Bioethics Law* 6(1) 10-12.

See also A Strode et al. 'Reporting underage consensual sex after the Teddy Bear case: A different perspective' (2013) *South African Journal of Bioethics and Law* 6(2) 45-57. Note that these articles were written before the matter between the *Teddy Bear Clinic for Abused Children and Prevention of Child Abuse and Neglect (RAPCAN) v Minister of Justice and Constitutional Development* 2014 (1) SACR 327. In this case an application was brought before the Constitutional Court to test the constitutional validity made by the North Gauteng High Court, Pretoria. The court held that certain sections 15 and 16 of the Criminal Law [Sexual Offences and Related Matters] Amendment Act Amendment Act (No. 5 of 2015) criminalising consensual sexual conduct between children aged 12-16 years old infringed their constitutional rights to privacy, dignity and bodily integrity. The court went further to state that the consequence of criminal liability for consensual peer sexual activities was not in their best interests. Resultantly, the constitutional court held that sections 15 and 16 was inconsistent with the constitution and the offending sections were referred to parliament for amendment. The Criminal Law [Sexual Offences and Related Matters] Amendment Act Amendment Act (No. 5 of 2015) [10] has since been signed into law which now decriminalises consensual sexual activity and sexual penetration insofar as it relates to adolescents aged 12-15 who engage in such conduct with each other; and when one child was 12-15 and the other 16-17, provided that there is no more than a two-year age difference between them.

the reporting requirement should only apply to ‘exploitative’ underage consensual sex.⁴⁶ Bhana et al recommends that researchers ought to work with non-governmental organisations in dealing with decriminalisation underage sex cases where reporting may be required as this could assist in minimizing the harshness of reporting such activity to the police.⁴⁷

Additionally, some of the authors have expressed opinions about the laws relating to male circumcision and whether the law enables or hinders the mass roll-out of such HIV prevention programmes at a national level. For example, Mc Quoid-Mason has argued that the implementation of the Kwa Zulu-Natal roll-out programme on mass circumcision, in particular, the targeting of Zulu male neonates or children under 16 years is unconstitutional and not in line with the Children’s Act as it is an infringement of their human rights.⁴⁸ Whereas, Vawda argues that placing a limitation on the right of neonates where there it is sufficient proof that circumcision as an HIV intervention could be seen as a justifiable measure to protect public health.⁴⁹

There has also been much academic debate on whether adolescents should be involved autonomously (and if so what adequate mechanisms are then established) in research such as HIV biomedical prevention methods. HIV biomedical prevention approaches include (but are not limited to) microbicides and vaccine trials.⁵⁰ Although there is growing recognition toward the importance of adolescents’ participation in research of future prevention interventions, a number of obstacles in both law and policy have been identified to the involvement of adolescents in HIV prevention research. This includes issues of consent to enrollment, confidentiality, mandatory reporting duties on those interacting with adolescents, whether the legal-framework is either over-protective or under-protective of children and

⁴⁶ D McQuoid-Mason ‘Mandatory reporting of sexual abuse under the Sexual Offences Act and the ‘best interests of the child’ (2011) 4(2) *South African Journal of Bioethics Law* 74.

⁴⁷ A Bhana, S Swartz, A Davids ‘Standards for reporting of sex/sexual activity of minors in a research context’ (2010) *South African Medical Journal* 100(10) 642.

⁴⁸ D McQuoid-Mason. ‘Is the mass circumcision drive in KwaZulu-Natal involving neonates and children less than 16 years of age legal? What should doctors do?’ (2013) 103(5) *SAMJ* 283 and A Strode... et al. ‘Reporting underage consensual sex after the Teddy Bear case: A different perspective’ (2013) 6(2) *South African Journal of Bioethics and Law* 45.

⁴⁹ YA Vawda & L N Maqutu ‘Neonatal circumcision – violation of children’s rights or public health necessity?’ (2011) *South African Journal of Bioethics and Law* 4(1) 41.

⁵⁰ HB Jaspan, et al ‘Protecting South Africa’s children from HIV; giving them our best shot’ (2005) 36(1) *South African journal of science* 216; See also H Jaspan..., et al. ‘Inclusion of adolescents in preventive HIV vaccine trials: public health policy and research design at a crossroads’ 47(1) *Journal of Acquired Immune Deficiency Syndrome* 88; LG Bekker, et al. ‘Adolescents and HIV Vaccine Trials What Are the Clinical Trial Site Issues?’ (2005) 4(4) *Journal of International Association Physicians AIDS Care* 93; CA McClure et al. ‘Challenges to conducting HIV preventative vaccine trials with adolescents.’ (2004) 36(2) *J Acquired Immune Deficiency Syndrome* 733.

that the vast lack of stakeholders' awareness and uncertainty around current national laws pertaining to children's participation in health research such as microbicide and vaccine trials.⁵¹

The unintended consequence of this is that laws make it difficult to do medical research on children and children may not be able to access new/potential HIV prevention products where it is approved for adults, even though they are a key population. South Africa is currently hosting major HIV prevention research, which includes trials of HIV vaccines and microbicides.⁵²

In summary, there is clear evidence that South Africa has undergone major developments in the legal and policy framework in order to realise sexual reproductive health rights for children in line with the public health response to HIV prevention. Further consideration is required as to whether national legal and policy frameworks are enabling of the public health agenda to combat HIV amongst targeted populations such as adolescents.

1.4. Purpose of this review

This study acknowledges that many aspects of the South African legal framework, at first glance, enables adolescents to access HIV prevention interventions and supports important aspects of adolescent sexual and reproductive rights. For example, section 28 of the Bill of Rights sets out a number of Constitutional rights for children, which are also protected in various national laws.⁵³ For instance, Section 134(1) of the Children's Act 38 states that a child over 12 years, may be provided with condoms without assistance from an adult, and section 134(2) provides that a child over the age of 12 can be given contraceptives other than condoms.⁵⁴

It is recognized that there been no prior in-depth examination of the adequacy of South Africa law and policy provisions for, specifically, adolescents to access current and future HIV prevention tools. This study conducts an analysis to identify strengths and weaknesses, challenges and gaps within the legal

⁵¹ Z Essack, C Slack, and A Strode 'Overcoming key obstacles to adolescent involvement in HIV vaccine & microbicide trials: a roadmap for stakeholders' (2008) *HIV AIDS Vaccines Ethics Group in collaboration with the Global Campaign for Microbicides*, available at: [http://www.global-campaign.org/clientfiles/essack,slack-strode\(2008\)towardsaroadmap.pdf](http://www.global-campaign.org/clientfiles/essack,slack-strode(2008)towardsaroadmap.pdf), accessed on 24 January 2016.

⁵² Z Al-eisawi 'Combinations between Platinum Drugs and Bortezomib and Changes in Nature of Administration in Ovarian Tumour Models' (2013) (unpublished LLD thesis, University of Sydney, 2013) 20.

⁵³ Constitution of the Republic of South Africa, 1996, Chapter 2.

⁵⁴ Section 134(1) of the Children's Act, No. 38 of 2005.

and policy framework describing children's rights (including their SRH rights) and to explore the extent to which the framework's ability to promote access to future intervention methods. This includes but not is limited to analysis of the law for example, the Constitution of the Republic of South Africa, 1996 and the Children's Act, No. 38 of 2005.

This examination is important as statistics indicate that adolescents remain at high risk of HIV acquisition. Furthermore, as shown above, laws and policies can have a direct impact on facilitating public health interventions. The outcomes of this review make recommendations for law and policy reform where needed. This study will not empirically assess the extent to which the framework is implemented in practice.

1.5. Methodology

The review of this study is applied to a selection of five key HIV prevention methods taken from the NSP. These HIV prevention interventions include access to a. information and education on HIV, b. voluntary HIV counselling and testing, c. condoms, d. medical male circumcision and e. future HIV prevention technologies such as a microbicide and an HIV vaccine.

Throughout this review, it is argued that child protection laws, and the national policy framework ought to facilitate children's access to HIV prevention interventions. The 'sample' of laws, regulations and policies that will be examined to determine whether they meet the public health standard set out in the NSP. These include (but are not limited to) the following provisions in the Children's Act, No. 38 of 2005, Constitution of the Republic of South Africa, 1996, the Integrated School Health Policy, 2012, the Department of Basic Education's Integrated Strategy on HIV, STIs and TB 2012 – 2016, the National HIV Counselling and Testing Policy Guidelines, 2015, the National Youth Policy (NYP) 2009-2014, the National Contraception Clinical Guidelines, 2012 and the Expanded Programme on Immunisation in South Africa, EPI (SA). For the purpose of this study only the most relevant law and policy have been reviewed. It is possible that additional policies exist but they were excluded because they did not deal with the subject matter in detail.

The thesis draws on specific human rights on the premise that every person has basic human rights, including children. The application is weighed against children's' rights and established children's sexual and reproductive rights ideology in the context of HIV prevention. As such the research method

comprises an in-depth conceptual analysis of relevant laws, policies based on key child-oriented human rights which are guided by the Convention on the Rights of the Child (hereafter referred to as the CRC), Universal Declaration of Human Rights and other human rights treaties. The international and national normative standards discussed are based in part on the General Comment No. 2 of the CRC, the South African Constitution and the Bill of Rights.⁵⁵ This study is guided by four overarching key child-oriented which include:

- i. the best interests of the child standard;
- ii. the right to dignity, privacy, bodily and psychological integrity;
- iii. the right to freedom of expression, opinion and participation in all matters concerning the child; and
- iv. the right to the highest attainable standard of physical and mental health. More specifically that children have rights and are not merely the possessions of their parents.⁵⁶ Bearing in mind that both child-centred and other rights may be limited or prohibited, but this must be justified and rationally connected to the extent of its purpose.

In addition, this study attempts to conduct the assessment by applying the key questions extracted from the ‘Four-Step Impact Assessment for Public Health and Human Rights’.⁵⁷ The Impact Assessment is a theoretical model which is described and applied in detail in Chapter five. For the purpose of this review the Impact Assessment has been slightly adapted to take into account the special needs of children. The aim of this approach in the review is to establish whether the legal and policy framework facilitate the public health response (in other words access to the current available HIV prevention interventions) and promote child-specific human rights. Some of the features of the assessment are adapted to accommodate updated principles for the purpose of this thesis (see Appendix 1 for the original ‘Four-Step Impact Assessment: Public Health and Human Rights’.⁵⁸

⁵⁵ United Nations Committee on the Rights of the Child (CRC), ‘General comment No. 2: The Role of Independent National Human Rights Institutions in the Promotion and Protection of the Rights of the Child’, (2002) CRC/GC/2002/2, available at: <http://www.refworld.org/docid/4538834e4.html>, (accessed 25 January 2017). See also the Constitution of the Republic of South Africa, 1996, Chapter 2.

⁵⁶ J Pilcher and S Wagg *Thatcher's Children? Politics, Childhood and Society in the 1980s and 1990s* (1996) 36. See also The International Covenant on Economic, Social and Cultural Rights (ICESCR), 1976, Article 12 provides for ‘the right of everyone to the enjoyment of the highest attainable standard of physical and mental health...’

⁵⁷ J Mann and L Gostin ‘Towards the development of a human rights impact assessment for the formulation and evaluation of public health policies’ (1994) 1(1) *Human Rights and Health* 60.

⁵⁸ J Mann ‘Human Rights and Public Health’ in J Mann (eds) *Health and Human Rights: A Reader* (1999) 54.

The Impact Assessment is thus comprised of four crucial questions. These questions have been adapted slightly to include an assessment of laws and policies against the public health standard, together with the four key child-specific human rights to include:

- a) To what extent does the public health standard represent ‘good’ public health?
- b) Is the policy or law respectful and protective of the child-oriented human rights (including access to adolescent SRHR services)?
- c) How can the best possible combination of policy and law facilitate further the main public health agenda?
- d) Does the law or policy facilitate adolescent access to HIV prevention?⁵⁹

The systematic review of the South African legislative and policy framework should thus take into account critical child-oriented rights when applying the Impact Assessment. This application is used throughout Chapter five under the five selected HIV prevention interventions taken from the NSP. The main features of the law will be extracted from the Constitution and the Children’s Act and other applicable corresponding laws and policies.

The use of the term ‘adolescent’ and ‘young person’ are used interchangeably, although, for the purpose of this review the term adolescents is referred to as the target population according to the WHO guidance. The use of the word children is used when rights are referred to from the Children’s Act and from the Constitution.

The review and discussion are conducted in light of relevant literature, based on important issues authors have already argued, that is available and sourced from various databases such as Juta, Lexis Nexis, EBSCO Host, UKZN library, Google Scholar and JSTOR.⁶⁰

⁵⁹ J Mann ‘Human Rights and Public Health’ in J Mann (eds) *Health and Human Rights: A Reader* (1999) 54. ‘The Four-Step Impact Assessment is an academic framework initiated and published by Jonathan Mann and colleagues at the Francois-Xavier Bagnoud Center for Health and Human Rights at the Harvard School of Public Health. The assessment takes into account the negotiation of objectives between human rights and public health. Such an approach takes into account a measure of each discipline's respective overlap to expose infringement of goals. Such infringement or confluence can be mapped out in what Mann and colleagues proposed in a 2 by 2 table, as illustrated below. The Four-Step Impact Assessment: To what extent does the proposed policy or program represent ‘good public health’? Is the proposed policy or program respectful and protective of human rights? How can we achieve the best possible combination of public health and human rights quality? How serious is the public health problem? Is the proposed response likely to be effective? What are the severity, scope and duration of the burdens on human rights resulting from the proposed policy or program? To what extent is the proposed policy or program restrictive and intrusive?’

⁶⁰ J Mann (note 56 above) 46-53.

1.6.Key research focus

This study focusses on a selection of five key HIV prevention methods (access to information and education on HIV; voluntary HIV counselling and testing; condoms; medical male circumcision and future HIV prevention technologies such as a microbicide and an HIV vaccine). The NSP has been used because it is the overarching framework for South Africa's public health and human rights response to the epidemic. The methods taken from the NSP are the framework in this review for assessing whether the current legal and policy framework in South Africa facilitate access to adolescents as it is important to determine the extent to which South Africa response meets the public health and human rights goals

1.6.1. The main research question

Does South Africa's legal and policy framework facilitate access to key HIV prevention interventions adolescents?

1.6.2. Structure of the dissertation

The thesis is divided into 6 (six) chapters, as follows:

- Chapter One: Adolescent risk of HIV infection
- Chapter Two: The public health and human rights response to HIV
- Chapter Three: The Legal framework
- Chapter Four: The Policy Framework
- Chapter Five: A review of the extent to which the South African legal and policy framework facilitates access to HIV prevention for adolescents
- Chapter Six: Discussion and Conclusion

1.7. Conclusion

South Africa has the highest burden of the HIV/AIDS disease in the world and is the main cause of death amongst children aged 10-19 years which means that children are at increased risk and particularly vulnerable. This is fueled by numerous related reasons such as early sexual debut, unprotected sex, inadequate sex education and limited access to health care. Thus, mechanisms which promote and protect

children's sexual and reproductive health rights need to be assessed to determine whether laws and policies facilitate or create an enabling environment for a good public health standard.⁶¹

This concludes Chapter one which sets out the global burden of disease, HIV as a public health issue, the focus on the legal and policy framework on the SRH rights of children (which is not an empirical assessment the extent to which the framework is implemented in practice) and the structure of the thesis in the following chapters. Throughout this thesis, it will be argued that child laws and policies ought to facilitate children's access to HIV prevention interventions set out in the national public health agenda for combatting HIV but these must be inter-dependent and weighed against each other from a human rights perspective which promotes and protects child-specific human rights.

⁶¹ Han (note 42 above) 25.

CHAPTER TWO: THE PUBLIC HEALTH AND HUMAN RIGHTS RESPONSE TO HIV PREVENTION

2.1. Introduction

The previous introductory chapter provided a broad overview of the enormity of the HIV epidemic and the public health response to combat HIV. Particularly South Africa has the highest rate of HIV infection in the world, with approximately 6.9 million people living with HIV.⁶² This chapter focusses on the historical background of the public health and human rights response in South Africa to the current National Strategic Plan for STIs HIV and TB for 2012-2016 (hereafter referred to as the NSP). The chapter describes the five selected HIV prevention interventions that set the framework for this study with specific focus on how the NSP has made these accessible to adolescents. One of the unique features of the HIV epidemic has been that since its earliest days' human rights activists argued that public health responses to HIV ought to be based on human rights. The section below describes the development of these human rights principles.

2.2. The development of public health and human rights response

Continual efforts have been made by the global community to combat HIV/AIDS. The international community has also issued important human rights norms relating to HIV prevention amongst children. These are contained in the Convention on the Rights of the Child (CRC) which was adopted by the general assembly of the United Nations on the 20 November 1989 and opened for signature on the 26 January 1990. Sixty-one countries signed to the CRC and the Convention became enforceable on the 2nd September 1990. The implications of this enforcement means that state parties to the CRC will align their national programs with the provisions of the treaty.

The Convention on the Rights of the Child has served to create a clear normative framework for state responsibilities to realise children's rights.⁶³ The Convention has brought about a new international understanding of children's position in society and of the role of the law in providing a framework for

⁶²AIDS.gov (note 1 above)

⁶³ United Nations UN General Assembly 'Convention on the Rights of the Child' (adopted on 20 November 1989), United Nations, Treaty Series, vol. 1577 United Nations, p. 3, available at: <http://www.refworld.org/docid/3ae6b38f0.html>, accessed on 08 September 2015 3.

the realisation of children's rights.⁶⁴ Where previously, the law primarily viewed children as a vulnerable population in need of control and protection from harm, the CRC recognises children themselves as rights-holders who are entitled to participate in society to the extent that their evolving capacities allow. State parties to the CRC are required to create national legal frameworks that are compatible with the CRC and that provide for the rights of the child.⁶⁵ This means that regarding HIV, '... rights-based law and policy has been seen to play a vital role in creating effective national responses to the epidemic, reinforcing the interdependence of all of a child's basic human rights in reducing, or increasing, his or her vulnerability to HIV.'⁶⁶

Article 5 of the CRC recognises that as children grow older they have evolving decision-making capacity.⁶⁷ This should influence the weight given to the opinion of the child in matters affecting him/her and his/her ability to give legal consent.⁶⁸ Accordingly the CRC requires the best interests of the child to be a primary consideration in decisions that affect them.⁶⁹

South Africa is a member state to the United Nations, Convention on the Rights of the Child. The United Nations Committee on the Rights of the Child (CRC) General Comment No. 3 'HIV/AIDS and the Right of the Child' (33rd Session) (hereafter referred to General Comment No. 3) states that 'children are deserving of special protection because of the vulnerable state of development and easily susceptible to all forms of human rights violations.' As such the South African national laws and policies have been developed to such an extent that it can be said that children's rights and interests have evolved to recognise and incorporate, for example, their ability to make certain decisions on their own corresponding at the appropriate stage of development as well as provision of children's rights and responsibilities that go with these decisions.

This means that the South African legal and policy framework is to create an effective, enabling environment that facilitates the implementation of, for example, the public health agenda to provide children with access to health care facilities which includes a comprehensive package of interventions which aim to promote access to HIV prevention. The package of interventions which support access to

⁶⁴ Strode and Grant (note 22 above).

⁶⁵ Convention on the Rights of the Child (note 63 above).

⁶⁶ Strode and Grant (note 22 above).

⁶⁷ Convention on the Rights of the Child (note 63 above).

⁶⁸ Strode and Grant (note 22 above).

⁶⁹ Convention on the Rights of the Child (note 63 above).

HIV prevention includes adolescent access to SRH services such as testing and screening of HIV, medical male circumcision and access to both male and female condoms.

A number of General Comments including, General Comment No. 3 have been included in the CRC which sets out how state parties to the CRC should respond to HIV prevention amongst young people. Furthermore, General Comment No. 3 in the context of HIV/AIDS provides that a child-oriented approach is to ensure that children have the right to participate and express views in all matters concerning the child (article 12).⁷⁰

In addition, the CRC serves as a legally enforceable mechanism for certain rights, recognizing children and adolescents' capacity to make decisions about matters concerning them as well as a right to privacy. It therefore creates obligations on state parties to remove those barriers to accessing essential health information and care and to ensure that health care providers are trained to assess the capacity of adolescents to make decisions regarding their reproductive health.

There is also provision of several articles that impact on policy-making regarding the reproductive health of adolescents in the CRC. For example, Article 24 of the CRC obliges State parties to recognise the right of the child to 'the enjoyment of the highest attainable standard of health' and to facilities for the treatment of illness and rehabilitation of health.⁷¹ This means that state parties are to ensure that no child is deprived of his or her right of access to such health care services, including HIV voluntary counselling and testing services essential to a child's ability reduce risk of HIV infection, access to awareness, education, and information and life skills through various channels.⁷² These services must additionally be provided) in a safe setting so that children, including adolescents, (article 17, B- 18, 19) are adequately protected from HIV infection and to ensure that children are factored into research that aims to prevent HIV/AIDS.

⁷⁰ United Nations Committee on the Rights of the Child (CRC), General comment No. 3 (2003): HIV/AIDS and the Rights of the Child' (Child, 17 March 2003), CRC/GC/2003/3 available at: <http://www.refworld.org/docid/4538834e15.html>, accessed 25 January 2017.

⁷¹ Article 24 of the CRC (note 63 above).

⁷² Articles 13, 15A, 16, 17, 24, 28 of the CRC (note 63 above).

Ever since the 1990's, a number of United Nations conference plans have progressed in the promotion the advancement of sexual and reproductive rights reiterating that countries adopt a human rights approach to health beyond the mere right to access health services. For example, the Vienna Conference on human rights; the Cairo Conference on population and development; and the Beijing Conference on women; acknowledge that there be a more inclusive meaning for the right to health, in particular for women and girls.⁷³ This means that the right to health includes access to health services, clean water and sanitation must also factor in rights such as autonomy, bodily integrity, decision-making and freedom from violence.⁷⁴

Additionally, it has been acknowledged that promoting sexual and reproductive health (SRH) means that young people, in this study adolescents, are entitled to their sexual and reproductive health rights (SRHRs). These rights include the right to access essential SRH services, information, education and HIV counselling and testing and are underpinned by human rights such as a right to health, freedom from discrimination and privacy. As such states are to ensure legal protection of SRHRs for the realisation and enjoyment of all people.

A major part of current global response toward combatting HIV and AIDS, has been on recognising and promoting sexual and reproductive health (SRH). SRHRs are usually understood as rights for everyone concerning decisions that affect their sexual and reproductive health regardless of their nationality, age, sex, gender, health or HIV status, to make informed and free choices with regard to their own sexuality and reproductive well-being, on condition that these decisions do not infringe on the rights of others.

SRHRs are primarily found in the 1994 International Conference on Population and Development (ICPD) of Action a legal framework established in Cairo in 1994. SRHRs are interlinked to human rights and

⁷³ These conferences transformed the traditional understanding of the right to health by directing attention to girls and women's rights to bodily autonomy, integrity and choice in relation to sexual and reproduction. See also the United Nations General Assembly, Vienna Declaration and Programme of Action (, 12 July 1993), A/CONF.157/23 available at: <http://www.refworld.org/docid/3ae6b39ec.html>; UNWOMEN Fourth World Conference on Women 'The Beijing Declaration and Platform for Action' (1995) UN Fourth World Conference on Women, available at: http://www.unwomen.org/~media/headquarters/attachments/sections/csw/pfa_e_final_web.pdf; and United Nations Population Fund 'The Programme of Action Adopted at the International Conference on Population and Development (ICPD), Cairo' (1994) available at: https://www.unfpa.org/sites/default/files/event-pdf/PoA_en.pdf, accessed online 26 November 2015.

⁷⁴ South African National Department of Health 'National Adolescent Sexual and Reproductive Health and Rights Framework Strategy. 2014-2019' (2015) National Department of Health, 3, available at: http://www.dsd.gov.za/index2.php?option=com_docman&task=doc_view&gid=578&Itemid=39, accessed online 26 November 2015 3.

there are a number of international human rights which form the basis of the Programme of Action. These include the International Covenant on Economic, Social and Cultural Rights that require states to recognise the right of everyone to the enjoyment of the highest attainable standard of mental and physical health (including the benefits of new technology/scientific developments) (Articles 12.1, 15.1, 23.2, and 23.3); Convention on the Elimination Of All Forms of Discrimination Against Women (CEDAW) which was adopted in 1979, CEDAW seeks to address gender-based discrimination; as well as other conventions and declarations which aim to promote SRHRs. It is noted in the UN Committee on the Elimination of Discrimination against Women (hereafter referred to as CEDAW) that:

[t]hat every child has the right to life, and that States shall ensure to the maximum child survival and development; including the child's best interests shall be a primary consideration. The Convention recognises the right of children to be heard and has recognised the significant impact that HIV could have on the rights of children such that...the issues of HIV/AIDS and other sexually transmitted diseases are central to the rights of women and adolescent girls to sexual health. Adolescent girls... in many countries lack adequate access to information and services necessary to ensure sexual health... [and] are often unable to refuse sex or insist on safe and responsible sex practices...States parties should ensure the rights of female and male adolescents to sexual and reproductive health education... in specially designed programmes that respect their rights to privacy and confidentiality.⁷⁵

Some of the key elements in the Programme of Action include 1) voluntary, informed family planning services; 2) pre-natal care; 3) prevention and treatment of HIV/AIDS, STIs and cervical cancer; 4) prevention and treatment for violence against women and girls; 5) access to safe abortion services; and 6) health counselling, education and information on sexual health. South Africa has developed the National Adolescent Sexual and Reproductive Health and Rights Framework Strategy. 2014-2019 (hereafter referred to as the National ASRH&R Framework Strategy) which is a culmination of various international conferences and documents:

Since the 1990s various United Nations conference agendas advocated for the advancement and promotion of sexual and reproductive rights. These conferences reiterated that countries should adopt an inclusive view of human rights to health that goes beyond the right to health services. The Vienna Conference on human rights; the Cairo Conference on population and development; and the Beijing Conference on women

⁷⁵United Nations Committee on the Elimination of Discrimination against Women (CEDAW)), CEDAW General Recommendation No. 24: Article 12 of the Convention (Women and Health), 1999, A/54/38/Rev.1, Chap. I, available at: <http://www.refworld.org/docid/453882a73.html>, accessed 25 January 2017.

affirmed a more inclusive meaning for the right to health: for women and girls, in particular; “the right to health is not only about obtaining health services or providing nutrition, clean water and sanitation but also the right includes the right to decision – making, control, autonomy, choice, bodily integrity and freedom from violence and fear of violence.”⁷⁶

In 1996, the United Nations Joint Programme on HIV/AIDS (UNAIDS) together with the United Nations Office of the High Commissioner for Human Rights called a consultation with experts on HIV/AIDS and human rights. This meeting led to the development of the International Guidelines on HIV/AIDS and Human Rights (hereinafter referred to as the Guidelines). This was as a major breakthrough as it represented the acknowledgement that HIV/AIDS was not only a public health concern but also a human rights issue. The Guidelines include twelve points which describe governments duty to ensure a national response that includes appropriate legal framework and other responses to combatting the HIV/AIDS epidemic was to include a human-rights as well as a public health response.⁷⁷

In 2000, 193 countries made a unified commitment to achieve the goals set out in the eight Millennium Development Goals (MDGs) by the end date of 2015. In particular, MDG 6 aimed to combat HIV/AIDS by 2015, which cannot be fully achieved if SRHRs are not promoted and protected in national legal and policy frameworks using a human rights approach with a focus on key and vulnerable populations.⁷⁸

In 2001 at the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS where it was stated that the ‘...realisation of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS. Respect for the rights of people living with HIV/AIDS drives an effective response.’ These principles, in essence, in promoting human well-being require:

- a) balancing of the goals of human rights and public health;
- b) addressing broad societal causes such as poverty and gender inequality; and

⁷⁶ South African National Department of Health ‘National Adolescent Sexual and Reproductive Health and Rights Framework Strategy. 2014-2019’ (2015) National Department of Health, 3, available at: http://www.dsd.gov.za/index2.php?option=com_docman&task=doc_view&gid=578&Itemid=39, ccessed on 26 November 2015 3.

⁷⁷ A Strode and B Grant ‘A critical review of the extent to which the HIV/ AIDS and Human Rights International Guidelines have been implemented in the Southern African Development Community’ (2007) *Obiter* 70.

⁷⁸ Amnesty International USA ‘Sexual and Reproductive Health Rights-Fact Sheet’ p 3, available at: <https://www.amnestyusa.org/our-work/issues/women-s-rights>, accessed online 03 <https://www.amnestyusa.org/our-work/issues/women-s-rights>, accessed on 03 September 2015 3.

c) repealing public health interventions that devalue rights or aggravate societal problems will not address disease prevention or containment.⁷⁹

In 2012, 186 countries committed, as part of a global response to AIDS response, committed to the 2011 United Nations Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS.⁸⁰ The aim was to take collective steps to attain 15 targets goals by 2015. The 2011 United Nations Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS (hereafter referred to as the UN 2011 Political Declaration on HIV/AIDS) has 10 objectives. These objectives aim to encourage countries to implement effective HIV prevention strategies nationally, with a particular focus on key populations and vulnerable groups (including adolescents). The objectives include decreasing sexual transmission by 50percent; eliminating gender inequalities and gender-based violence; eliminating stigma and discrimination; and promoting laws and policies that ensure the full realization of all human rights and fundamental freedoms.⁸¹

The World Health Organisation Consolidated Guidelines on HIV prevention, diagnosis, treatment and care for key populations, July 2014 (hereafter referred to as the WHO guidelines) describes four (4) critical enablers which are strategic to the effective implementation of the public health agenda.⁸² The WHO guidelines define these enablers under the following categories 1) law and policy; 2) stigma and discrimination; 3) community empowerment; and 4) violence. The WHO guidelines list these categories as enablers because if governments do not address these issues it is very difficult to provide a good public health response to combatting HIV. Thus, all these enablers, if successfully addressed, aim to facilitate the effective elimination of HIV. Nevertheless, if these enablers are not addressed, they can create barriers and thus undermine the public health agenda in combating HIV.⁸³ For example, laws which do not recognise the evolving capacity of children to consent to sexual and reproductive health services can

⁷⁹ Joint United Nations Programme on HIV/AIDS - General Assembly Special Session on HIV/AIDS 'Declaration of Commitment on HIV/AIDS' (2011) UNAIDS, available at: http://www.unaids.org/sites/default/files/sub_landing/files/aidsdeclaration_en_0.pdf, accessed on 03 September 2015.

⁸⁰ United Nations General Assembly 'Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS - Resolution adopted by the General Assembly on 10 June 2011' (2011) UN General Assembly, available at: https://www.unodc.org/documents/southeastasiaandpacific/2012/02/hlm-hiv/20110610_UN_A-RES-65-277_en.pdf, accessed on 25 January 2017.

⁸¹ Ibid.

⁸² World Health Organization 'Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations', (2014) WHO, 88, available at: http://apps.who.int/iris/bitstream/10665/128049/1/WHO_HIV_2014.8_eng.pdf, accessed on 03 November 2015 88.

⁸³ Ibid 89.

have a disparate impact on orphans and vulnerable children (OVC).⁸⁴ Thus it can be said that law and policy that is implementable must be practical.

Thus laws, policies and programmes should therefore be adapted to ensure that responses to HIV and AIDS prioritise a child's best interests, rights and needs.⁸⁵ The focus on this dissertation covers one of these four critical enablers, which is law and policy and whether this critical enabler within the South African context is creating a barrier or facilitating access to key public health, HIV prevention interventions.

2.3. South Africa's public health response to HIV prevention

Following the first AIDS-related death in South Africa in 1981, the South African government was initially slow to respond to the HIV-AIDS epidemic.⁸⁶ In 1988, the AIDS unit, within the Department of Health, was established to raise awareness and the National AIDS Coordinating Committee of South Africa (NACOSA) was formed outside of government to put pressure on the state regarding its AIDS policy.⁸⁷

The South African government's initial response to HIV was in many regards considered coercive in nature. For example, HIV testing was obligatory and those who were HIV positive were forced to disclose their status and placed in quarantine.⁸⁸ High risk behavior patterns that were driving the epidemic (such as men who have sex with men and sex workers were perceived as carriers) were the target of government's response to try to prevent the further spread of HIV infection by placing people who were already infected in isolation.⁸⁹ Furthermore, the exclusion of People Living with HIV or AIDS (PLHAs) from different sectors such as the workplace and schools seemed to be a justifiable means to combat HIV and AIDS.⁹⁰ The apartheid government passed two HIV specific pieces of legislation pre-1994 (Cameron, 1993). Both aimed at the active exclusion of people living with HIV from various spheres of

⁸⁴ Strode and Grant (see note 22 above).

⁸⁵ Ibid.

⁸⁶ NP Simelela 'A brief history of South Africa's response to AIDS' (2014) 104 (3) 1 *S Afr Med J* 249.

⁸⁷ Ibid.

⁸⁸ AJ Pelsler, C Ngwena, and JV Summerton 'The HIV/AIDS epidemic in South Africa: Trends, Impacts trends, impacts and Policy Responses' in policy responses' In HCJ Van Rensburg (ed.) *Health and health care in South Africa* (2004) 109.).

⁸⁹ Ibid.

⁹⁰ E Wouters, HCJ van Rensburg and H Meulemans 'The National Strategic Plan of South Africa: What are the prospects of Success after the Repeated Failure repeated failure of Previous AIDS Policy?' (2010) 25 *Health Policy and Planning* 171-185.

life such as the workplace and schools. This coercive response brought on the rise of a human rights movement to advocate in favor of a rights-based approach that is balanced with both the public health response and human rights elements to achieving sustainable well-being for all.⁹¹

The post-apartheid government's response initially emphasized home-based care for infected and affected people, and neglected Antiretroviral Treatment (ART).⁹² In May 1994, marked South Africa's first democratic elections where Nelson Mandela became president, and the Minister of Health was Dr. Nkosazana Clarice Dlamini-Zuma. Of the new government's, Reconstruction and Development Programme (RDP), combatting HIV/AIDS became one of the 22 lead projects. The RDP was made of three structures with a focus on including civil society in writing government HIV/AIDS policy. The three structures comprised (1) an HIV/AIDS and STD Advisory Group; (2) a Committee on NGO Funding; and (3) a Committee of HIV/AIDS and Sexually Transmitted Disease (STD) Research. The new government was praised by AIDS activists and organisations for their commitment to addressing the disease. President Nelson Mandela in August accepted the 'National AIDS Plan for South Africa' launched NACOSA. The plan focussed on a number ways of HIV prevention including public education campaigns, mobilising local, provincial, national and international resources and appropriate care, treatment and support for those infected with HIV/AIDS.⁹³ A movement for the rights of those living with HIV emerged in 1998, called the Treatment Action Campaign (TAC). This movement demanded that HIV treatment for those requiring it be accessible to all South Africans.

South Africa's response to HIV/AIDS developing a national policy and strategic plan has to date evolved to appropriately response to the crisis of HIV/AIDS in the country. Following the formation of the National AIDS Coordinating Committee of South Africa (NACOSA), which urged government to develop an AIDS policy, South Africa had its first National AIDS Plan for South Africa. After a country-wide consultation with a number of international bodies, in 1994, to formulate the National AIDS Plan for South Africa.⁹⁴ This national plan included three main goals which included the prevention of HIV in a number of activities such as education and mass media campaigns promoting HIV prevention;

⁹¹ Strobe and Grant (note 22 above) 70.

⁹² J McNeil 'A History of Official Government HIV/AIDS Policy in South Africa' South African History Archives Online, available at: <http://www.sahistory.org.za/topic/history-official-government-hivaids-policy-south-africa>, accessed on 4 December 2016.

⁹³ Ibid.

⁹⁴ Human Sciences Research Council Press 'HIV/AIDS national policies and legislation' (2004), HRSC Press, available at: file:///C:/Users/FINALper cent20THESIS/Downloads/An_Audit_of_HIV_AIDS_Policies_-_HIV_AIDS_National_Policies_and_Legislation.pdf, accessed on 08 October 2016.

decreasing HIV and STIs through a treatment, care and support programme; and rallying of resources at local, national and provincial level support.⁹⁵

Later the Department of Health, having adopted the AIDS plan, renaming it the HIV/AIDS and STD Programme (1995-1996) and in 1997 undertook a review of the national AIDS plan. The review included a number of key recommendations, for example, to increase political commitment, to prioritize the national response to HIV/AIDS and to protect the human rights of those living and affected by HIV/AIDS.⁹⁶

In 2000 universal access to ART was established as a human rights issue. The South Africa government approved a plan making antiretroviral treatment (ART) publicly accessible in 2003. Antiretroviral (ARVS) are now a significant part of HIV prevention as they reduce viral load and infect ability.

Still post 2000 state policies on HIV were linked to a denialist view on HIV, and as a result the devastating effects of HIV were particularly felt during 1998-2008.⁹⁷ In 2006, the government's response to the epidemic changed after the controversial court case of then Former Deputy-President, Jacob Zuma was on trial for charge of rape.⁹⁸ Part of his testimony was that he took a shower after having sex with the woman to reduce his chances of contracting HIV.⁹⁹ This sparked intense criticism including an attack from Stephen Lewis, at the International AIDS Conference in Toronto, who accused the South African government of being negligent.¹⁰⁰ By the end of 2006, the South African government announced a pledge to improve access to ARTs and developed a draft framework for combatting AIDS.¹⁰¹

The next phase of the AIDS response included better access to ART and the prevention of mother-to-child transmission (PMTCT) along with a commitment from government to implementing the HIV/AIDS and STI Strategic Plan for South Africa which took place over the following five (5) years 2000-

⁹⁵ Ibid.

⁹⁶ Ibid.

⁹⁷ Avert (note 10 above).

⁹⁸ S Robins 'Sexual Politics and the Zuma Rape Trial*' (2008) 34(2) *Journal of Southern African Studies* 411-427.

⁹⁹ *S v Zuma* [2006 (CC358/05)] zagphc 45, available at: <http://www.saflii.org/za/cases/ZAGPHC/2006/45.pdf>, accessed on 25 January 2017 45.

¹⁰⁰ F Blandy 'SA Govt under fire at AIDS conference' Mail and Guardian Online 19 August 2006, available at: <http://mg.co.za/article/2006-08-19-sa-govt-under-fire-at-aids-conference>, accessed on 25 January 2017.

¹⁰¹ NP Simelela, and WDF Venter 'A brief history of South Africa's response to AIDS' (2014) 104 (3) 1 *South African Medical Journal* *S Afr Med J* 249-251.

2005.¹⁰² This plan included specific goals toward care and support, prevention, treatment, legal and human rights.¹⁰³ South Africa has the largest antiretroviral treatment (ART) rollout programme which by 2012 has exceeded its target of reaching over 80per cent of HIV infected people.

By 2000, South Africa had a five-year plan with specific targets focusing on treatment, care, support, prevention, human rights with the aim of reducing new infections and decreasing the effects on people living with those affected by HIV/AIDS. This strategic plan was called the HIV AIDS and STI Strategic Plan 2000-2005.¹⁰⁴ By 2011, the third National Strategic Plan for STIs, HIV and TB, 2012-2016 (hereafter referred to as the 'NSP') had been developed. The NSP focusses on prevention programmes targeting marginalised groups such as sex workers, men who have sex with men and adolescents.

2.4. The current HIV prevention response

In 2011, the South African government developed its third National Strategic Plan (NSP).¹⁰⁵ This is the current NSP which guides the state's response to HIV, including HIV prevention. It focusses on on-going programmes with marginalised groups such as sex workers, men who have sex with men and adolescents.¹⁰⁶

The NSP is based on the UNAIDS vision of 'zero new HIV infections, zero discrimination and zero aids-related deaths'.¹⁰⁷ A wide range of goals were set out to be achieved by 2016 in support of both national, regional and international commitments. These commitments include the eight Millennium Development Goals (MDGs); the 2001 UNGASS Declaration of Commitment; the 2006 Political Declaration on Universal Access; 2011, Resolution 65/677: Intensifying Our Efforts to Eliminate HIV and AIDS); and the Universal Access to HIV Prevention, Treatment, Care and Support: From Countries to Regions to the High-Level Meeting on AIDS and Beyond 2011 Road Map; amongst others.¹⁰⁸

¹⁰²AVERTing HIV and AIDS, 'HIV and AIDS in South Africa' (2015) *AVERT*, available at: <http://www.avert.org/professionals/HIV-around-world/Sub-Saharan-Africa/South-Africa>, accessed on 26 March 2016.

¹⁰³ *Ibid.*

¹⁰⁴ HIV/AIDS National Policies and Legislation (note 85 above) 1.

¹⁰⁵ NSP (notes 24 above) 12.

¹⁰⁶ NSP (note 24 above) 13.

¹⁰⁷ UNAIDS Global Report (note 3 above) 4.

¹⁰⁸ The Millennium Development Goals; the 2001 UNGASS Declaration of Commitment on HIV/AIDS; the 2006 Political Declaration on Universal Access; 2011, Resolution 65/677: Intensifying Our Efforts To Eliminate HIV And AIDS); and the Universal Access to HIV Prevention, Treatment, Care and Support: From Countries to Regions to the High Level Meeting on AIDS and Beyond 2011 Road Map.

With regard to HIV prevention the NSP aims to reduce the incidence of new HIV infections by 50per cent and minimize the impact of HIV and AIDS AND TB on individuals, families, communities and society by improving access to suitable treatment, care and support.

There are five main goals in the NSP that aim to:

- a. Halve the number of HIV infections by applying a comprehensive prevention package;
- b. Halve the number of TB infections and deaths;
- c. Ensure that at least 80per cent of people who are eligible for treatment for HIV are receiving it;
- d. Ensure that the rights of people living with HIV are protected and promoted; and
- e. Halve the stigma related to HIV and TB.

The NSP sets out four objectives to achieving the goals described above. These include

- i. Addressing the social, structural and behavioural drivers of HIV, STI and TB vulnerability through prevention, care and impact;
- ii. Preventing new HIV, STI and TB infections by implementing a combined comprehensive prevention package including preparations of future technologies;
- iii. Sustained health and wellness aimed at decreasing HIV/AIDS and TB deaths; and
- iv. Promoting and the protection of human rights for those living with HIV and to help improve access to justice.¹⁰⁹

The NSP describes ‘key affected populations’ as those people who are most vulnerable to acquiring HIV.¹¹⁰ Key populations include, those who engage in risky behaviour, those who have no access to essential HIV services, young people (particularly those between the ages of 15 to 24 years old) who are not attending school and uncircumcised males.¹¹¹ People who belong to key affected populations (KAPs) include sex workers, men who have sex with men and children.¹¹² Young people are prioritized as a high-risk group and are a key focal point for the NSP. Reducing adolescent pregnancy is highlighted as a priority.

HIV.

¹⁰⁹ NSP (note 24 above) 15.

¹¹⁰ NSP (note 24 above) 25.

¹¹¹ NSP (note 24 above) 26

¹¹² AVERTing HIV and AIDS ‘Key Affected Populations, HIV and AIDS’ (2017) available at: <http://www.avert.org/professionals/hiv-social-issues/key-affected-populations>, accessed on 25 January 2017.

In preventing new HIV, TB and STI infections, three key interventions (namely behavioural and social interventions, biological interventions and structural interventions) in the NSP make up the combination prevention mix which are packaged slightly differently depending on the target key population group. Firstly, behavioural and social interventions are those prevention interventions that aim to, for example, delay sexual debut, address sexual social, cultural and gender norms, increase in use of condoms, targeting intergenerational relationships, and education for those at risk to HIV infection.¹¹³ Secondly, biological (biomedical) interventions are those which aim to, for example, strengthen the prevention of mother-to-child-transmission (PMTCT) programme, the continuing mass roll-out medical male circumcision programme included in the access to SRH services package aimed to prevent HIV and STIs, prevention and early treatment of STIs, introducing those living with HIV to treatment according to national guidelines, and provision of contraceptives, especially barrier methods such as male and female condoms. Thirdly, the structural interventions are those interventions focussing on those who have migration experience or whose sexual partners who are migrants, challenging gender inequality and women's vulnerability to HIV, especially in the socio-economic dynamic, and gender based violence and sexual abuse, as well as addressing sexual abuse and improving access to services for victims of sexual assault.¹¹⁴

Thus, the focus of the NSP is to take into account broader development agenda of the South African government and its international, regional and national obligations. The Constitutional framework regulates the content of all laws and policies, primarily through its Bill of Rights and government in realising everyone's right to access to health care services. As such national laws, policies and programmes are to express the principles of equality, quality and access to HIV prevention interventions.

¹¹³ NSP (note 24 above) 23.

¹¹⁴AVERTing HIV and AIDS 'HIV Prevention Programmes Overview' (2016) http://www.avert.org/hiv-prevention-programmes.htm#footnote1_d5lot79, accessed on 03 November 2015. Notes that 'structural interventions seek to address underlying factors that make individuals or groups vulnerable to HIV infection. These can be social, economic, political or environmental. For many people, the simple fact that 90 percent of the world's HIV infections occur in developing countries is evidence that social, economic and political structures drive risk behaviours and shape vulnerability.' Hijra celebrating a ruling by the Indian Supreme Court recognising transgender people as a distinct gender Structural interventions are much more difficult to implement because they attempt to deal with deep-rooted socio-economic issues such as poverty, gender inequality and social marginalisation. They can also be reliant on the cooperation of governments to achieve law or policy reforms. For example, laws that criminalise same-sex relationships often hinder men who have sex with men from accessing condoms. A woman's subordinate status can affect her ability to negotiate condom use while a lack of infrastructure such as transport, prevents many people from accessing health clinics. By successfully addressing these structural barriers, individuals are empowered and able to access HIV prevention services. Examples of structural interventions: 1) Interventions addressing gender, economic and social inequality; 2) Decriminalise sex work, homosexuality, drug use and the use of harm reduction services; 3) Interventions to protect individuals from police harassment and violence; 4) Laws protecting the rights of people living with HIV.'

The most significant HIV prevention methods referred to in the NSP which are relevant to adolescents include access to education and information, HIV counselling and testing, condoms, medical male circumcision and future prevention interventions such as a vaccine and a microbicide.¹¹⁵

2.4.1. Access to education and information about HIV Prevention

South Africa in 2000 launched the HIV and AIDS Life Skills Education programme in all public schools. The aim was to introduce HIV education in school curriculums to educate school goers and to prevent new HIV infections as well as support for those with HIV, implemented through the Life Orientation programme.

The NSP includes a strategy toward providing a comprehensive HIV life-skills education curriculum on sexual and reproductive health rights for all adolescents (targeting learners in schools) to be a part of the compulsory curricula to address issues of social norms that are harmful and increase adolescents risk behaviours to HIV infection.¹¹⁶ Government has also set in place initiatives which aim to further the goals set out in the NSP. For example, the Department of Basic Education (DOBE), Department of Health (DOH) and Department of Social Development (DSD) are to ensure that key structures and mechanisms are in place which serve complement the NSP's objective to 'address social, economic and behavioral drivers of HIV through the education, health and social systems' - this will be discussed in Chapter three and four under the legal and policy framework.¹¹⁷

The NSP sets out that there must be programmes in place that address the social, economic and behavioral drivers of HIV care, prevention and impact. This includes, reducing the vulnerability of young people to HIV infection making considerable efforts toward school retention and providing post-school education and work opportunities. SRH education has been recognized as a protective measure against HIV infection and a key prevention intervention suggesting that children who attend school are less likely to become infected with HIV if they are educated about HIV and provided youth specific life skills to

¹¹⁵ NSP (note 24 above) 23.

¹¹⁶ NSP (note 24 above) 22. Note also that the Departments of Basic Education, Health and Social Development have set in place the Integrated School Health Programme (ISHP) which covers age-appropriate sexual and reproductive health and rights services, sexuality, and education. This package is to be available in all schools, including private and special schools.

¹¹⁷ NSP (note 24 above) 37.

manage their social challenges during their developmental years.¹¹⁸ It is thus important that government departments such as DOBE and DOSD to implement programmes on SRH education, including life skills education and HIV information, through school curriculums.¹¹⁹

2.4.2. Access to voluntary HIV counselling and testing (HCT)

South Africa's launch of the HIV counselling and testing (HCT) campaign in April 2010 resulted in an increase of testing from 19.9 per cent to 37.5 per cent (of men) and 28.7 per cent to 52.6 per cent (of women) between 2008 and 2012. Young people, between the ages of 15 to 24 years, carry a disproportionately high burden (approximately 40 per cent) of new HIV infections, yet their access to HIV counselling and testing (HCT) remains low.¹²⁰ Limited or no access to HIV testing and treatment services, stigma and discrimination related to HIV and AIDS, and fear of results of testing for HIV are but a few of the reasons for this. Another reason for the low access is the difference in whether an individual lives in an urban or rural setting. In one study, it was revealed those who live in rural areas are less likely to test than people living in urban areas.¹²¹

HCT is an important key entry point for HIV diagnosis, treatment, care, programs and integration with other health services is important. Through links with other health care services, access to HCT can make a major impact on the broader goals toward eliminating the HIV epidemic.¹²² HCT provides an important opportunity for patient education on HIV disease and adherence to HIV care, particularly for those with positive test results. HCT can serve as a starting point to bring adolescents into other important HIV interventions such as care, treatment and prevention. A person whose test results are negative has an opportunity to then be linked to health care services that can also reduce risk of HIV infection. Adolescents are less likely to have access to HIV testing and counselling services, yet they remain at high risk of HIV infection where HCT can serve as a key tool for early detection.¹²³

¹¹⁸ NSP (note 24 above) 38.

¹¹⁹ NSP (note 24 above) 77.

¹²⁰ O Shisana, T Rehle, LC Simbayi, 'South African National HIV Prevalence, Incidence and Behaviour Survey, 2012' (2014) *Human Sciences Research Council's (HSRC)*, available at: <http://www.hsrc.ac.za/uploads/pageContent/4565/SABSSM%20IV%20LEO%20final.pdf>, accessed 31 August 2015.

¹²¹ Ibid.

¹²² NSP (note 24 above) 42.

¹²³ South Africa National Department of Health 'The National Consolidated Guidelines for the Prevention of Mother-to-Child Transmission of HIV (PMTCT) and the Management of HIV in Children, Adolescents and Adults' (2014) Department of Health available at: <http://www.kznhealth.gov.za/family/HIV-Guidelines-Jan2015.pdf>, accessed on 21 April 2016.

The South African government has made considerable effort to scale-up on access and availability to HCT through health and non-health care facilities throughout the country. As a result, HCT has become increasingly available in national public health facilities in recent years. In accordance with the current local and international norms developed by the Department of Health (DOH) guidelines for HIV Counselling and Testing (HCT) and various other national department plans, policies and programmes which refer to the objectives in the NSP. Key elements of HCT include a term called the 5C's, which are confidentiality, counselling and consent, correct test results and the integration into other health care services.¹²⁴

The NSP provides strategic efforts to ensure all South African can make the most of access to voluntary HCT as a first stage for diagnosis and treatment of HIV. This includes the getting 25 per cent of all South Africans to test annually and 70 per cent to have at least one test.¹²⁵ In May 2015, the Pharmacy Council of South Africa made available for pharmacies to sell take-home HIV testing kits in the hope that it would facilitate access and encourage more people to test for HIV.¹²⁶

2.4.3. Access to male and female condom access

There are a number of different contraceptive methods available depending on the reason for their use. For example, a particular contraceptive method could be used to prevent unplanned pregnancy but will not be effective in reducing the risk of HIV, such as oral contraceptives, vaginal rings and combined injectable contraceptives. For the prevention of HIV/STI infection or transmission, the only available contraceptive in the form of barrier protection is the female and male condom.¹²⁷ Condoms are inexpensive, cost effective, their use does not require assistance of medical or healthcare personnel, and they can be utilised by anyone who is sexually active.

Condom use is a critical prevention element in a comprehensive, effective and sustainable approach to HIV and across the continuum of response to all HIV epidemic types.¹²⁸ Existing research demonstrates

¹²⁴ World Health Organisation *Statement on HIV testing and counseling: WHO, UNAIDS re-affirm opposition to mandatory HIV testing*. (2012) WHO, available at: http://www.who.int/hiv/events/2012/world_aids_day/hiv_testing_counselling/en/, accessed on 17 January 2017.

¹²⁵ NSP (note 24 above) 42.

¹²⁶ Avert (note 10 above).

¹²⁷ World Health Organization *Medical eligibility criteria for contraceptive use*. 5th ed (2015).

¹²⁸ United Nations Population Fund, World Health Organization and Joint United Nations Programme on HIV/AIDS *Condoms and HIV prevention: position statement by UNAIDS, UNFPA and WHO* (2004) available at:

that the correct and consistent use of condoms significantly reduces, but does not eliminate, risk of HIV infection. To achieve the protective effect of condoms, people must use them correctly and consistently, at every sexual encounter. Failure to do so diminishes the protective effect and increases the risk of acquiring a sexually transmitted infection (STI) because transmission can occur with even a single sexual encounter.¹²⁹ One of the factors contributing to the spread of HIV is the low condom use amongst adolescents.

The use of condoms is a critical prevention method that provides dual protection as an effective method to reduce the risk of HIV infection (including other sexually transmitted diseases) and unplanned teenage pregnancy. With the high rate of early sexual debut, South African adolescents are especially vulnerable to HIV infection and unplanned pregnancy. Research reveals that adolescent sexuality and pregnancy has increased by 15.8 percent being young women below the age of 20 years¹³⁰. This means that ongoing high risk sexual behavior amongst adolescents continues and a major public health response at national law and policy development is required for the effective implementation of contraceptives.

South Africa has responded to the HIV epidemic by making widely available access and available the condom programme through health facilities. However, this does not necessarily mean that condoms reach those who are at high risk. Evidence shows that the correct and consistent use of condoms is 98 percent effective in preventing HIV and STIs.¹³¹ The distribution of condoms between 2007 and 2010 increased by 60 per cent from 308.5 million to 495 million condoms. However, the use of condoms over recent years has decreased to 68 per cent since last sexual encounter.

The use of condoms as a barrier method contraceptive in preventing HIV transmission among adolescents remains low. This is due to a number of factors, such as limited access to condoms particularly in the case in rural settings where schools have large numbers of youth and condom distribution is rarely undertaken. Only a small percentage increase in terms of condoms per adult male (aged 15-49) which represent 12.7 percent in 2007 to 14.5 percent in 2010. However, during the same period, female condom distribution increased from 3.6 million to 5 million (39 per cent increase). Adolescents who are engaged

<http://www.unfpa.org/resources/condoms-and-hiv-prevention-position-statement-unaid-unsfpa-and-world-health-organization#sthash.rLXiKsHS.dpuf>, accessed on 09 September 2015.

¹²⁹ Ibid.

¹³⁰ P Donovan 'Falling Teen Pregnancy, Birthrates: What's Behind the Declines?' (1998) 1(5) Guttmacher Policy Review 1.

¹³¹ Joint United Nations Programme on HIV/AIDS UNAIDS *UNAIDS calls for 20 billion condoms by 2020* (2016) available at: http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2016/february/20160212_condoms, accessed 03 March 2016.

in sexual activity often do not have the necessary knowledge, resources and decision making skills to practice safe sex and thus participate in unprotected sex exposing themselves to the risk of unplanned teenage pregnancy, HIV and other sexually transmitted diseases. There is still a need to educate and promote the use of the female condom. It has been widely acknowledged that female condoms are not readily available as they should be. More recently, in South Africa the use of condoms has fallen. In 2008 it was reported that 85 percent young males aged 15-24 years old had used a condom during their last sexual encounter, but in 2012, this had number had fallen to 68 per cent.

Part of the objectives in the NSP comprehensive package is to increase consistent use (specifically among key populations), to provide mass roll-out and distribution of male and female condoms. It also provides that the behavioural component is a key element to address adolescent high risk behaviour patterns and thus key activities are planned which decrease risk HIV infection and increase protective measures against HIV infection and this includes encouraging the way of male and female condoms are used. At national level, it was anticipated that the implementation of the male and female condom distribution would reach a target distribution of 1 (one) billion male condoms and 25 (twenty-five) million female condoms respectively by the year 2016.¹³²

2.4.4. Access to male medical circumcisions

Male circumcision is the removal of the foreskin, which is the thin layer of skin that extends over the tip of the penis.¹³³ Traditionally male circumcision has been regarded as a cultural and religious practice

¹³² Statistics South Africa *Millennium Development Goals 6: Combat HIV/AIDS, Malaria and Other Diseases 2015* (2015) available at: http://www.statssa.gov.za/MDG/MDG_Goal6_report_2015_.pdf, accessed on 25 January 2016.

¹³³ AVERTing HIV and AIDS *Voluntary Medical Male Circumcision For HIV Prevention* (2016) available at: <http://www.avert.org/voluntary-medical-male-circumcision-vmmc-hiv-prevention.htm#sthash.3vex7AVJ.dpuf>, accessed on 25 January 2017. Note that 'In the mid-2000s, male circumcision was found to reduce the female-to-male sexual transmission of HIV by 60 percent. As a result, since 2007, the World Health Organisation (WHO) and UNAIDS have recommended voluntary medical male circumcision (VMMC) as a key component of HIV prevention in countries with high HIV prevalence and low levels of male circumcision. To date, 14 countries in Southern and Eastern Africa have initiated programmes to expand the provision of male circumcision (Botswana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe). 2WHO recommendations for the implementation of VMMC for HIV prevention ... WHO and UNAIDS recommend VMMC programmes in countries where it will have the greatest public health benefit. These include countries with a high HIV prevalence among the general population (over 15 percent) and where the vast majority of men are not circumcised (80 percent). VMMC is also recommended in countries where HIV prevalence is between 3 and 15 percent among the general population where HIV transmission occurs primarily via heterosexual transmission. ...it is recommended that VMMC is included as part of a comprehensive HIV prevention strategy which includes HIV testing and counselling; treatment for sexually transmitted infections; the promotion of safe sex practices and the distribution of condoms as well as their correct and consistent use. ...While male circumcision has been found to reduce the female-to-male sexual transmission of HIV,

around the world. There are many reasons why parents and boys select circumcision for example, it is performed for either religious (after the birth of the baby boy), such as in Islamic or Jewish communities and for cultural practices (during the initiation process on adolescent boys) such as amongst the Xhosa community. In both instances, the circumcision performed by a person who, in accordance to the custom, carries out the circumcision. In recent years, however, the practice of cultural circumcision has come under much criticism for the manner in which the circumcisions have been performed and resulted in botched circumcisions. Legislature, in an attempt to curb harmful practice that were detrimental to children, have enacted laws regulating religious and cultural circumcision. In addition to this a provision has set out for to regulate male circumcision for medical reasons.

Medical circumcision is the surgical removal of the foreskin. Studies indicate that circumcision for medical reasons serves as a preventative method against HIV acquisition.¹³⁴ There is good evidence from randomized controlled trials that male circumcision is associated with reduced incidence of HIV acquisition and lower prevalence of human papillomavirus (HPV) infection, and herpes simplex virus type 2 (HSV-2) transmission, as well as a decreased likelihood of bacterial vaginosis (BV) in female partners.¹³⁵ Review of the literature revealed a consistently reported protective effect of 40 per cent to 60 per cent for male circumcision in reducing the risk of HIV acquisition among heterosexual males in areas with high HIV prevalence due to heterosexual transmission.

It is biologically plausible that having been circumcised may provide protection against STIs (including HIV).¹³⁶ Possible mechanisms for the protective effect of circumcision include the fact that the foreskin's thin inner surface is susceptible to micro-tears and abrasions (especially during sexual activity), which provides a port of entry for pathogens. The foreskin also contains a high density of HIV target cells (i.e. Langerhans cells, CD4 T cells, macrophages), which facilitates HIV infection of host cells.¹³⁷

circumcised men can still become infected with HIV, and if HIV-positive, can infect others. WHO makes it clear that: 'Male circumcision should never replace other known effective prevention methods'.

¹³⁴ BJ Morris... et al. 'Review: a critical evaluation of arguments opposing male circumcision for HIV prevention in developed countries.' (2012) *AIDS Care* 24(12) 1565–1575.

¹³⁵ AAR Tobian, RH Gray, and TC Quinn 'Male circumcision for the prevention of acquisition and transmission of sexually transmitted infections: The case for neonatal circumcision.' (2010) *Archives of Pediatrics & Adolescent Medicine* 164 (1) 78.

¹³⁶ H Weiss... et al. 'Male circumcision for HIV prevention: Current research and programmatic issues' (2010) *AIDS (London England)* 24(4) S61-S69.

¹³⁷ PHM Jayathunge... et al. 'Male Circumcision and HIV Transmission; What Do We Know?' (2014) *Open AIDS Journal* 8(1) 34.

Studies reveal that men who have been circumcised were significantly less likely to be HIV-positive, and that the protection afforded to those having been circumcised greater for those circumcised who had been circumcised before sexual debut.¹³⁸

In 2010, South Africa responded by rolling out a national Voluntary Medical Male Circumcision (VMMC) programme.¹³⁹ This aimed to reach approximately 4.3 million uncircumcised males by 2016, with KwaZulu-Natal being the first province to roll-out VMMC services and by late 2012.

In addition, medical male circumcision for young children provides protection against a range of common medical conditions such as urinary tract infections.¹⁴⁰ It is thus that an estimated one-third of uncircumcised males will suffer at least one foreskin-related medical condition in a lifetime.¹⁴¹ There have been a number of benefits of medical male circumcision which include urinary tract infections, genital cancers and future possible exposure to risk of acquisition to HIV or sexually transmitted infections (STIs).¹⁴² It has been argued that neonatal circumcision is a simpler procedure than adolescent or adult circumcision and has a very low rate of adverse events, which are usually, minor (0.2–0.4 per cent). Adolescent or adult circumcision can be ‘...associated with bleeding, hematoma or sepsis, but these are treatable when undertaken in a clinical setting with experienced providers. In contrast, circumcision undertaken by inexperienced providers with inadequate instruments, or with poor after-care, can result in serious complications’.¹⁴³

The NSP, as part of a comprehensive package of sexual and reproductive health services, has a focus on medical male circumcision as an essential part of a male SRH package.¹⁴⁴ This includes the provision for

¹³⁸ R Szabo, Robert, and RV Short ‘How does male circumcision protect against HIV infection?’ (2000) *British Medical Journal* 320 (7249) 1592. See also NSP (note 24 above) 26.

¹³⁹ The Medical Male Circumcision ‘MMC Programme in South Africa’ available at <http://www.mmcsinfo.co.za/partners>, accessed on 24 January 2017.

¹⁴⁰ BJ Morris ‘Review: a critical evaluation of arguments opposing male circumcision for HIV prevention in developed countries’ (2012) *AIDS Care* 24(12) 1565-1575. See also D Singh-Grewal et al. ‘Circumcision for the prevention of urinary tract infection in boys: A systematic review of randomized trials and observational studies’ (2005) *Archives of Disease in Childhood* 90(8) 853-858.

¹⁴¹ *Ibid.*

¹⁴² American Academy of Pediatrics ‘Circumcision Policy Statement’ (2012) *Pediatrics* 130(3) 1-4.

¹⁴³ Joint United Nations Programme on HIV/AIDS and World Health Organisation ‘Male circumcision: global trends and determinants of prevalence, safety and acceptability’ (2007) available at: http://www.unaids.org/sites/default/files/media_asset/jc1360_male_circumcision_en_2.pdf, accessed on 25 January 2017. See also World Health Organisation ‘Information Package on Male Circumcision and HIV Prevention’ (2007) available at: http://www.who.int/hiv/pub/malecircumcision/infopack_en_3.pdf, accessed on 17 January 2017.

¹⁴⁴ NSP (note 24 above) 43.

including the practice of traditional circumcision as part of a comprehensive package of sexual and reproductive health services.¹⁴⁵ The NSP describes as part of a mechanism of measuring the implementation of the roll-out of medical male circumcision under one of a number of core indicators. As such the indicator measuring the number of men medically circumcised, which are reached by the year 2016, is aimed to be 1, 6 million males throughout the South African health services. The NSP identifies medical male circumcision (for both adults and neonates) as a key HIV prevention strategy.

2.4.5. Access to potential implementation of innovative biomedical prevention strategies – microbicides and an HIV vaccine

Research and innovation play an important part in identifying, developing and implementing new technologies to address the challenge of eliminating HIV.¹⁴⁶ Thus the South African government recognises the need to prepare for the use of alternative new combination prevention interventions. As such the NSP includes that efforts be made to prepare for the potential implementation of innovative biomedical prevention strategies, such as microbicides, and a HIV vaccine, as well as treatment as prevention.¹⁴⁷ For the purpose of this study, a review of future, potential implementation of new technologies will focus on microbicides and an HIV vaccine.

According to the World Health Organisation, microbicides are both vaginal and rectal compounds (or commonly referred to as creams, gels, films, or suppositories) that could protect against sexual transmission of HIV and other sexually transmitted infections (STIs).¹⁴⁸ Researchers are conducting and preparing for the development an effective and safe microbicide and is included in the NSP as a biomedical intervention.¹⁴⁹ Likewise, there is no vaccine to prevent HIV infection. Developing a safe and effective vaccine would be the best method of HIV prevention in the same way epidemic levels of highly infectious diseases such as polio, measles, smallpox and yellow fever have been eliminated.¹⁵⁰ Notwithstanding there has been much scientific work done in the area of vaccine research. For example,

¹⁴⁵ NSP (note 24 above) 43.

¹⁴⁶ NSP (note 24 above).69.

¹⁴⁷ NSP (note 24 above) 45.

¹⁴⁸ World Health Organisation 'Microbicides' available at: <http://www.who.int/hiv/topics/microbicides/microbicides/en/>, accessed 15 January 2017.

¹⁴⁹NSP (note 24 above) 45.

¹⁵⁰MA Miller, and JT Sentz 'Vaccine-preventable diseases' in DT Jamison (eds) (2006) *Disease and Mortality in Sub-Saharan Africa* 163-178. See also note that this study was sponsored by the National Institutes of Health (NIH), the United States military, and the Thai Ministry of Health, of which 16, 000 Thai men and women were enrolled.

in 2009, the Thai RV144 vaccine study indicated that 31 per cent of participants who were given the vaccine than those who received the placebo.¹⁵¹ The implications of this outcome is that for the first time in 30 years research on a HIV/AIDS vaccine there appears to be neutralising antibodies (also known as bnAbs, which is an antibody response). Further research is being conducted to establish whether the neutralising antibodies can protect people from HIV infection.¹⁵² In 2013, a phase I trial (HVTN 097) was conducted to test the RV144 in South Africa, this was followed by planned phase II and III trials for 2015. The results are anticipated to allow for the ALVAC protein prime boost vaccine. There is no specific description of the aims of HIV prevention in the NSP toward a vaccine.¹⁵³

2.5. Conclusion

This chapter has focused on providing a description of key interventions that aim to promote access to HIV prevention interventions. In the following two chapters this thesis looks critically at the legal and policy provisions. It is clear that the current approach adopted by the South African government is in line with international best practice on HIV prevention and is premised on human rights norms and standards. The following chapter describes the South African legal framework developments in relation to children's sexual and reproductive health rights.¹⁵⁴

¹⁵¹AVERTing 'Searching for a cure for HIV and AIDS' (2016) available at <http://www.avert.org/professionals/hiv-science/vaccines-microbicides>, accessed on 05 November 2015.

¹⁵²Ibid.

¹⁵³NSP (note 24 above) 3.

¹⁵⁴National ASRH&R Framework Strategy (note 75 above) 3.

CHAPTER THREE: THE LEGAL FRAMEWORK

3.1. Introduction

Key to an effective public health response is that laws and policies act as key enablers to adolescent access to HIV prevention interventions.¹⁵⁵ Legal and policy frameworks that limit access to health care services violate rights including everyone's right to health. For example, the government's initial policy on PMTCT limited access to this form of HIV prevention resulting in the unnecessary deaths of approximately 330,000-500,000 during 2000-2005, had Antiretroviral treatment programmes been implemented sooner.¹⁵⁶ Contrastingly, laws and policy mechanisms that have been structured to promote

¹⁵⁵ AIDSmap 'HIV and Criminal Law-The role of the law in the global response to HIV' available at: <http://www.aidsmap.com/The-role-of-the-law-in-the-global-response-to-HIV/page/1441838/>, accessed on 26 January 2017. Further it is important notes that '[n]evertheless, notes Justice Cameron, 'the law is a blunt instrument. Dominant social policy can be mistaken in how it seeks to employ the law, and the actual implementation of even well-directed policy can be crude and misjudged. Hence the intrusion of legal instruments and mechanisms in public health can be counter-productive and harmful. 'To these ends, the law can be a protective 'shield' or a punitive 'sword'. It has been argued that, in the context of HIV, punitive laws can create legal barriers that impede effective HIV/AIDS interventions by penalising people with – or at heightened risk of acquiring – HIV through criminal sanctions or other policies.7 For example, in many jurisdictions around the world, a substantial number of individuals at highest risk of acquiring HIV – notably people who use drugs, sex workers, and men who have sex with men – are criminalised, and yet it is argued by UNAIDS and its partners that punitive approaches often drive the targets of these punitive laws underground, limiting their ability to access HIV information, prevention, treatment, care and support.8 Consequently, UNAIDS recommends the removal of punitive laws, policies and practices that block effective AIDS responses, and greater support to law, law enforcement and access to justice that protects the human rights both of people living with HIV and those who are HIV-negative, and supports access to programmes that are proven to reduce the risk of HIV transmission. Recommended reforms to legislation and the legal environment include: removing criminal offences against men who have sex with men removing criminal sanctions on sex work so as to promote empowerment of sex workers allowing the provision of harm-reduction programmes, informed by evidence, for people who use drugs enacting privacy and anti-discrimination laws that protect people living with HIV strengthening legal prohibitions on all forms of gender-based violence, including rape within marriage enacting laws that ensure that sexual-health education and HIV-prevention services and commodities are available to all people living with, and at risk of acquiring, HIV.'

¹⁵⁶ See R Burton, J Giddy, and K Stinson 'Prevention of mother-to-child transmission in South Africa: an ever-changing landscape' (2015) *Obstetric Medicine* 8(1) 5-12. 'The lost benefits of ART, 2000–2005: 'Harvard researchers calculated the lost benefits of ART, in terms of a lack of PMTCT and treatment programmes in South Africa from 2000 to 2005. They considered it would have been feasible to start rolling out PMTCT and ART programmes in 2000, and that this should have achieved at least 50 per cent coverage by 2005, as drug prices fell and international support increased. They compared what would have been possible in South Africa with what happened in Botswana and Namibia, neighbouring countries with similar HIV epidemics. Botswana started its PMTCT programme in 1999, and Namibia in 2001. By 2005, 70 per cent of pregnant women in both countries received PMTCT. In contrast, in South Africa, they calculated that 23 per cent of women received PMTCT in 2005, with less than 10 per cent in 2004, and less than 3 per cent in preceding years. They estimated a minimum of 35,000 preventable infant infections occurred during 2000–2005, based on the assumption that single-dose nevirapine had been available to 50 per cent of pregnant women by 2005. This figure is likely an underestimate of actual deaths. They calculated a conservative estimate of 60,000 infant infections per year. However, as the authors note, government statistics suggest 105,000 infant infections a year. Using this higher figure gives 62,000 preventable infant infections.32 A similar model was applied to adult mortality from HIV infection: assuming limited availability of ART treatment programmes, they estimated there were between 330,000 and 500,000 preventable adults deaths from HIV in the years 2000–2005.' See also M Heywood 'Preventing mother-to-child HIV

and protect certain rights for children, have the effect of strengthening the public health response in combating HIV. For example, laws which recognise children's evolving capacity to consent to sexual and reproductive health services such as the Children's Act which allows a child from the age of 12 to access contraceptives (including condoms) promotes good public health outcomes including HIV prevention.

Chapter two of this dissertation described the South African response to combatting the HIV/AIDS epidemic. More specifically the main foci of the public health response is found in the current NSP regarding developing a comprehensive prevention package for eliminating HIV/AIDS as it relates to key vulnerable populations groups. Importantly the national response makes provision in the HIV prevention intervention programme, access to a number of modalities for adolescents.¹⁵⁷

The HIV/AIDS epidemic raises major legal and human rights challenges that involve a broad range of issues. Notably the public health approach to HIV/AIDS should be supported by legal system that protects and promotes underlying human rights and address the structural issues fuelling the HIV epidemic. This chapter focusses on how South African government has set about incorporate certain child-specific rights into the legal framework. As such laws require an examination of the rights of all people, in accordance with national and international human rights standards, to determine in what way existing legal structures affect vulnerability to HIV/ AIDS. The chapter, however, does not review whether these laws enable or hinder access to HIV prevention modalities, which will be done in Chapter five in the analysis.

3.2. General principles: overview of the legal framework

The South African government, as a member to a number of international instruments therefore, has an obligation to ensure whether by way of legislation or policies that it does not create an environment that undermine the rights of children. As such national norms are to include rights and values such as respect for human dignity, life, freedom of expression, privacy and access to health care services (including reproductive health care services) are for all people in South Africa and this includes children.¹⁵⁸

transmission in South Africa: Background, strategies and outcomes of the Treatment Action Campaign case against the Minister of Health' (2003) *SAJHR* 19 278–315.

¹⁵⁷ NSP (note 24 above) 8.

¹⁵⁸ Sections 27 (1) and (2) of the Constitution of the Republic of South Africa Act 108 of 1996.

South Africa ratified the United Nations (UN) Convention on the Rights of the Child (the UNCRC) 20 years ago, (1995).¹⁵⁹ This is significant because article 12 of the UNCRC states that:

‘States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.’

Furthermore, the UN Committee on the Rights of the Child published a General Comment on Article 12. The Comment states that, ‘the right of all children to be heard and taken seriously constitutes one of the fundamental values of the Convention.’¹⁶⁰ The Comment goes on to say that ‘the views expressed by children may add relevant perspectives and experience and should be considered in decision-making, policymaking and preparation of laws and/or measures as well as their evaluation.’¹⁶¹ Thus state parties are to ensure that the child is able to express her or his views “in all matters affecting her or him.... the child must be heard if the matter under discussion affects the child...”¹⁶²

South Africa law specifically entrenches a child’s right to participate in any matter concerning them in Section 10 of the Children’s Act. It states that ‘[e]very child that is of such an age, maturity and stage of development as to be able to participate in any matter concerning that child has the right to participate in an appropriate way and views expressed by the child must be given due consideration.’¹⁶³

Moreover, the South African Constitution requires the courts to consider public international law when interpreting the rights in the Constitution.¹⁶⁴ As such South Africa has incorporated a number of international human rights treaties into its domestic legal framework, amongst these are child-specific standards such as the Convention on the Rights of the Child, 1989; the Amendment to article 43(2) of

¹⁵⁹ Convention on the Rights of the child (note 63 above).

¹⁶⁰ Convention of the Right of the Child (note 63 above) General Comment No. 12 ‘The right of the child to be heard’ available at: <http://www2.ohchr.org/english/bodies/crc/docs/AdvanceVersions/CRC-C-GC-12.pdf>, accessed online 15 September 2016.

¹⁶¹ Ibid at para 12.

¹⁶² Ibid at para 26.

¹⁶³ The Children’s Act (note 53 above).

¹⁶⁴ Section 39 of the Constitution of the Republic of South Africa Act 108 of 1996

the Convention on the Rights of the Child, 1995 and the International Convention Economic, Social and Cultural Rights.¹⁶⁵

According to Article 1 of the Convention on the Rights of the Child a child is a person below the age of eighteen (18), unless under certain circumstances, the child attains majority sooner.¹⁶⁶

There are two broad principles underlying children's rights which are 1) that children have a need for protection and 2) that their evolving capacity needs to be respected and taken into consideration in matters concerning their well-being. It is thus important that a child's capacity whether to make decisions independently, or assisted by their parents/guardians or caregiver(s) or specifically by the parent includes a consideration of the age, maturity and stage of development.

The Children's Act describes a 'child', as a person below 18 years.¹⁶⁷ Recognizing that children are one the one hand vulnerable and in need of special protection and on the other hand have evolving capacities of children – depending on their age and capacity to act independently, children, in certain circumstances are able to make decisions and act on their own without assistance from their parents. Broadly stated the law has developed to a stage where at certain ages a child has capacity to act on their own. For example, it is generally accepted that a child between the ages of 0-7 years old has no legal capacity to act. However, a child from the age 7-14 years old, certain provisions in the law provide for a child to act independent of their parents. For instance, a child may consent to his or her own medical treatment or operation without the consent of the parent(s) or caregiver.¹⁶⁸ More recently, the law has been amended to include access to health care services for children between the ages of 12 and 15 years since the legal age of consent to sex is 16 years old.¹⁶⁹

¹⁶⁵ United Nations General Assembly, International Covenant on Economic, Social and Cultural Rights Treaty Series available at: <http://www.refworld.org/docid/3ae6b36c0.html> accessed online 15 September 2016 3.

¹⁶⁶ Convention on the Rights of the Child (note 64 above)

¹⁶⁷ The Children's Act (note 54 above).

¹⁶⁸ T Boezaart *Child Law in South Africa* Cape Town: Juta and Company, (2000).

¹⁶⁹ Ibid. See also World Health Organisation Consolidated Guidelines (note 82 above) which states that '[a]dolescents [are] [i]ndividuals between the ages of 10 and 19 years old are generally considered adolescents. Adolescents are not a homogenous group; physical and emotional maturation comes with age, but its progress varies among individuals of the same age. Also, different social and cultural factors can affect their health, their ability to make important personal decisions and their ability to access services. This document primarily uses the term 'adolescents'. 'Other terms covering overlapping age groups include: Youth: This term refers to individuals between the ages of 15 and 24. Young people: This term refers to those between the ages of 10 and 24.'

A child's capacity to consent [independently] plays a major part in their ability to access health care services. More specifically, without enabling legal mechanisms in place that provide age thresholds to access these services implies that children's rights to basic health care may be undermined and in turn act as a barrier to the effective implementation of particular public health agenda to combat HIV/AIDS in children.¹⁷⁰

Over the past fifteen years, the legal framework relating to children has changed dramatically. The international human rights framework is guided by the Universal Declaration of Human Rights and its corresponding human rights treaties provide a framework for member states to establish their own national legal framework when interpreting and applying children's rights, in response to HIV prevention. The international standards discussed in this chapter are based, in part on the Convention on the Rights of the Child (CRC), which are widely adopted and establish four key principles which will be applied when interpreting children's rights. There are four overarching key child-oriented rights included in this chapter and these are:

- a. The best interests of the child standard
 - i) The Children's Act requires that when the best interests of the child standard are applied, consideration must be given to the nature of the relationship between the child and the parents, or any specific parent; or any other care-giver or person relevant in those circumstances; the attitude of the parents, or any specific parent, towards the child; and the exercise of parental responsibilities and rights in respect of the child.¹⁷¹
- b. The right to dignity, privacy, bodily and psychological integrity
 - i) Chapter 2 of the Children's Act describes how the provisions in the law are to be interpreted and applied in the context of children's rights within the Act itself and in relation to others laws that include provisions on child protection. Section 6(2) (b) states that a child's dignity is to be respected at all times, when it involves matters concerning the child.¹⁷²
- c. The right to freedom of expression, opinion and participation in all matters concerning the child

¹⁷⁰ Boezaart (note 168 above) 207.

¹⁷¹ The Children's Act (note 54 above).

¹⁷² Ibid.

- i) The right of all children to be heard and taken seriously
- ii) States are to establish national laws that recognise children's views are important, and should not be seen as mere possessions of their parents, particularly in matters concerning the best interests of the child, the right to health, dignity and bodily integrity.¹⁷³

¹⁷³The United Nations Convention on the Rights of the Child *South Africa's Periodic Country Report on the United Nations Convention on the Rights of the Child* available at: https://www.unicef.org/southafrica/SAF_resources_uncrcreport16.pdf, accessed on 26 January 2017. 'South Africa has ratified the UN Convention on the Rights of the Child (the UNCRC) in 1995. This is significant because article 12 of the UNCRC states that: 'States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.' See also The Comment goes on to say that: 'The views expressed by children may add relevant perspectives and experience and should be considered in decision-making, policymaking and preparation of laws and/or measures as well as their evaluation.' 'These processes are usually called participation. The exercise of the child's or children's right to be heard is a crucial element of such processes. The concept of participation emphasizes that including children should not only be a momentary act, but the starting point for an intense exchange between children and adults on the development of policies, programmes and measures in all relevant contexts of children's lives.' In 2002, the UN General Assembly adopted a resolution entitled, 'A world fit for children'. The following call to action was included in the Resolution: 'Listen to children and ensure their participation. Children and adolescents are resourceful citizens capable of helping to build a better future for all. We must respect their right to express themselves and to participate in all matters affecting them, in accordance with their age and maturity (Resolution S-27/2., above at para 7, page 3); Article 7 of the African Charter on the Rights and Welfare of the Child, on freedom of expression, states: Every child who is capable of communicating his or her own views shall be assured the rights to express his opinions freely in all matters and to disseminate his opinions subject to such restrictions as are prescribed by laws.' The African Charter on the Rights and Welfare of the Child available at: http://www.unicef.org/esaro/African_Charter_articles_in_full.pdf, accessed online 26 September 2016. The Children's Act 38 of 2005 states that 'Every child that is of such an age, maturity and stage of development as to be able to participate in any matter concerning that child has the right to participate in an appropriate way and views expressed by the child must be given due consideration.' See also *MEC for Education: Kwazulu-Natal and Others v Pillay* 2008 (2) BCLR 99 (CC) para 56 available at <http://www.saflii.org/za/cases/ZACC/2007/21.html>, accessed online 26 September 2016. In addition, 'the significance of learners' views on issues that most directly impact upon them was expressed in a Constitutional Court case regarding corporal punishment in schools. Here Sachs J lamented the fact that no learner voices were contained in the papers: 'The children concerned were from a highly conscientised community and many would have been in their late teens and capable of articulate expression. Although both the state and the parents were in a position to speak on their behalf, neither was able to speak in their name. . . Their actual experiences and opinions would not necessarily have been decisive, but they would have enriched the dialogue' In another Constitutional Court judgment about whether a learner was entitled to an exemption from her school's dress code, both Langa CJ and O'Regan J stressed the need for the learner's own thoughts to have been factored into the decision. Stating that it was unfortunate that this was not so. Langa CJ focused on the fact that the learner in question was 15 years old, making her voice on the issue even more important because she was fast approaching adulthood: 'It is always desirable, and may sometimes be vital, to hear from the person whose religion or culture is at issue. That is often no less true when the belief in question is that of a child. Legal matters involving children often exclude the children and the matter is left to adults to argue and decide on their behalf. . . The need for the child's voice to be heard is perhaps even more acute when it concerns children of Sunali's age who should be increasingly taking responsibility for their own actions and beliefs.' Furthermore, the Act goes further to include that there be attention given to the capacity of the parents, or any specific parent, or of any other caregiver or person, to provide for the needs of the child, including emotional and intellectual needs; the likely effect on the child of any change in the child's circumstances, including the likely effect on the child of any separation from both or either of the parents; or any brother or sister or other child, or any other care-giver or person, with whom the child has been living. According to the Children's Act 'parent' is any person who has parental responsibilities and rights in respect of a child. The Children's Act also provides that factors such as the practical difficulty and expense of a child having contact with the parents, or any specific parent, and whether that difficulty or expense will substantially affect the child's right to maintain personal relations and direct contact with the parents, or any specific parent, on a regular basis; the need for the child to remain in the care of his or her parent, family and extended family; and to maintain a connection with his or her family, extended family, culture or tradition. Regard is to

- d) The right to the highest attainable standard of physical and mental health
- i. States are to implement mechanisms to promote health care and services including a legal and policy framework which supports and facilitates the implementation of the public health agenda with the effect of protecting and promoting the interests of the public health agenda.¹⁷⁴

While the state is to ensure that rights are to be protected and promoted, it must be borne in mind that not all rights are absolute and can thus be limited and in certain instances individual human rights can be limited where there is a greater societal benefit to the public.¹⁷⁵ Section 36 of the Bill of Rights provides for grounds when a right can be limited. The determination of whether a right may be limited or not is based on a two-pronged approach, firstly it would need to be determined whether the right has in fact been limited (or violated) and secondly, if the limitation is reasonable and justified.¹⁷⁶ This approach will be discussed further in Chapter five under the review of selected laws afforded to children in the context of their access to HIV prevention interventions.¹⁷⁷

South Africa has incorporated a number of international human rights treaties into its domestic legal framework, amongst these are child-specific standards such as the Convention on the Rights of the Child, 1989; the Amendment to article 43(2) of the Convention on the Rights of the Child, 1995 and the International Convention Economic, Social and Cultural Rights¹⁷⁸.

3.2.1. The Constitution

be given to the child's age, maturity and stage of development; gender; background; and any other relevant characteristics; including physical and emotional security and his or her intellectual, emotional, social and cultural development; any disability or chronic illness which the child may suffer.'

¹⁷⁴ Mann, J (note 57 above) 28. See also the United Nations General Assembly *International Bill of Human Rights A/RES/217(III) A-E* available at: <http://www.refworld.org/docid/3b00f08b48.html>, accessed online 26 September 2016. See also the United Nations Convention on the Rights of the Child (UNCRC). Note that the right to access to health care services, found in the Bill of Rights, is a constitutional right afforded to all South Africans (including children). This means that the South African government is obliged, under international and regional law to put in place laws, policies and programmes that enable all people within the country to have access to such health services. See also ICESCR (note 56 above).

¹⁷⁵ J Mubangizi *The protection of Human Rights in South Africa: A Legal and Practical Guide* (2004) Cape Town: Juta and Company Ltd. 59-60.

¹⁷⁶ Section 36 of the Constitution, 1996. Note that the latter approach is determined by a detailed enquiry based on 5 key elements: 1) what is the nature of the right; 2) what is the importance and purpose of the limitation; 3) what is the nature and extent of the limitation; 4) is there a connection between the limitation and its purpose; and 5) are there less restrictive means to achieving the same purpose?

¹⁷⁷ Mubangizi (note 175 above) 59-60.

¹⁷⁸ ICESCR (note 56 above).

The South African Constitution is the supreme law which means that all laws are to be consistent and underpin the founding values afforded by the Constitution which includes a range of fundamental in a Bill of Rights.¹⁷⁹ These rights include international first-generation rights (traditional civil and political rights), second-generation rights (social, economic and cultural rights) and third generation rights (environmental rights).¹⁸⁰ First-generation rights include those rights which pertain to equality, life and the right to freedom of expression. Several second-generation rights are guaranteed in the Constitution. These include the right to adequate housing, health care services and basic education.¹⁸¹

Section 28 of the Constitution provides a number of specific children's rights.¹⁸² Children are regarded as a highly vulnerable group and as such require special attention to promote and ensure their rights are fully realised.

Thus, the Constitution recognises the evolving capacities of children and makes provision for both the child's protection, autonomy, and other important rights such the best interests as the most important factor concerning matters of the child and a right to basic health care services.¹⁸³

3.2.2. Statutory provisions relating to the sexual and reproductive rights of children

In terms of second generation rights, South Africa has thus adopted a wide range of laws (described below) which enable society to realise children's' rights in the context of HIV prevention, for example, the right to basic education, information and to access health care services.

¹⁷⁹ The Constitution of the South Africa, 1996.

¹⁸⁰ Mubangizi (note 175 above) 53.

¹⁸¹ Ibid 119.

¹⁸² Section 28 of the Constitution of South Africa provides that '(1) Every child has the right— (a) to a name and a nationality from birth; (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; (e) to be protected from exploitative labour practices; (f) not to be required or permitted to perform work or provide services that— (i) are inappropriate for a person of that child's age; or (ii) place at risk the child's well-being, education, physical or mental health or spiritual, moral or social development; (g) not to be detained except as a measure of last resort, in which case, in addition to the rights a child enjoys under sections 12 and 35, the child may be detained only for the shortest appropriate period of time, and has the right to be—(i) kept separately from detained persons over the age of 18 years; and (ii) treated in a manner, and kept in conditions, that take account of the child's age; (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; and (i) not to be used directly in armed conflict, and to be protected in times of armed conflict. (2) A child's best interests are of paramount importance in every matter concerning the child. (3) In this section 'child' means a person under the age of 18 years.'

¹⁸³ The Constitution of South Africa (note 179 above).

3.2.2.1. Children's Act

The Children's Act 38 of 2005 and the Children's Amendment Act 41 of 2007 (hereafter referred to as the Children's Act) was enacted to form primary legal instrument providing a broad range of child protection. The Children's Act aims to give effect to a number of rights afforded to children as described in the Bill of Rights by upholding the 'best interests' standard' and the right to access basic health care [services]. The legal provisions described in this chapter, form the focus of national norms which outline the key components which address children's access to HIV prevention services and amongst others include definition of the term child (closely linked with the child's legal capacity to make independent decisions and the right to participate in decision-making processes concerning his/her own well-being), the best interests standard, confidentiality and privacy, as well as the right to access sexual and reproductive health care services.¹⁸⁴ Thus ensuring that the national framework meets with its international obligation to protect children in promoting, protecting and fostering the development and well-being of children in all spheres of life¹⁸⁵. With an overarching intention to protect the health of children (including reproductive health right) described in section 9 of the Children's Act that, 'in all matters concerning the care, protection and well-being of a child the standard that the child's best interest is of paramount importance, must be applied'.¹⁸⁶

3.2.2.2. Criminal Law (Sexual Offences and Related Matters) Amendment Act, No. 32 of 2007 and Criminal Law (Sexual Offences and Related Matters) Amendment Act, No. 5 of 2015

The Criminal Law (Sexual Offences and Related Matters) Amendment Act, No. 32 of 2007 (hereafter referred to as (Sexual Offences Act) aims to deal with all aspects of the laws as comprehensively as possible, relating to sexual offences. The Sexual Offences Act also provides protective provisions for

¹⁸⁴ Children's Act (note 54 above)

¹⁸⁵ P Proudlock and L Jamieson 'The Children's Act - providing a strong foundation for caring for vulnerable children' (2010) available at: https://open.uct.ac.za/bitstream/11427/4069/1/CI_popart_cafirmfoundation_2010-04.pdf, accessed on 17 January 2017.

¹⁸⁶Section 7 (1) of the Children's Act. Whenever a provision of this Act requires the best interests of the child standard to be applied, the following factors must be taken into consideration where relevant, namely— (g) the child's— (i) age, maturity and stage of development; (ii) gender; (iii) background; and (iv) any other relevant characteristics of the child; (h) the child's physical and emotional security and his or her intellectual, emotional, social and cultural development; (l) the need to protect the child from any physical or psychological harm that may be caused by— (i) subjecting the child to maltreatment, abuse, neglect, exploitation or degradation or exposing the child to violence or exploitation or other harmful behaviour; or (ii) exposing the child to maltreatment, abuse, degradation, ill-treatment, violence or harmful behaviour towards another person. See also Section 9 of the Children's Act.

sexual offences against children with the aim of recognizing that children are vulnerable and in need to special protections. The Act sets the age of consent to sex at 16 years.¹⁸⁷ However a recent amendment to the Act allows for children between 12 to 16 years who engage in consensual sexual acts with partners in the same age category or those less than two-year age gap are no longer committing a criminal offence.¹⁸⁸ The age of consent to sex and possible criminal law sanctions associated with under age sex have been identified as a potential barrier to HIV prevention.¹⁸⁹

3.2.2.3. South African Schools Act

SA Schools Act provides for universal system of schooling. The South Africa Schools Act No. 84 of 1996 (hereafter referred to as the Schools Act) deals with the provision of a uniform system for the organisation, governance and funding of schools, repealing past discriminatory and intolerant laws relating to schools. The Schools Act aims to provide an education that strives for high quality, strong foundation within the structure of a national education system for all learners that is non-racist, non-sexist, tolerant which encourages economic well-being and protects and promotes the rights of the learners, parents and educators, and promote creating uniform standards for education. This Act forms the principled framework for the provision of education and health services to learners.

3.3. Legal provisions relating to access to five key methods of HIV prevention

In terms of South Africa law there are wide range of laws (described below) which aim to regulate the rights of children to access a number of sexual and reproductive health care services such as the right to basic education, information, HIV testing and counselling and access to condoms.

¹⁸⁷ Section 15 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act, No. 32 of 2007.

¹⁸⁸ S Bhamjee, E Zaynab and AE Strode 'Amendments to the Sexual Offences Act dealing with consensual underage sex: Implications for doctors and researchers' (2016) *South Africa Medical Journal* 106(3) 256-259. Also the Criminal Law (Sexual Offences and Related Matters) Amendment Act Amendment Act, No. 5 of 2015 (hereafter referred to as the Sexual Offences Amendment Act) aims to amend the Sexual Offences Act to safeguard that children of the particular age group of 12 to 16 years who engage in consensual sexual acts with each other from being held criminally liable.

¹⁸⁹ This issue is discussed further in Chapter five of this thesis.

3.3.1. Access to education and information about HIV prevention

The South African law includes that everyone has a Constitutional right to education and access to information.¹⁹⁰ It is a requirement that all laws encompass this provision which means that children too, have a Constitutional right to access basic health care information.

Section 29 of the Constitution refers to everyone's right to education which deals with right to a basic education, which the state is to make available and accessible through realistic measures.¹⁹¹

Section 13 of the Children's Act refers to the information on health care which provides that every child has the right to access to information on the promotion and prevention and treatment of their health in terms of ill-health, disease and sexuality and reproduction.¹⁹²

The Schools Act, does not deal with HIV prevention in the national school curriculum but rather in policy documents which will be dealt with the next chapter.

3.3.2. Access to HIV counselling and testing (HCT)

The South African law makes provision for the right to make certain choices over one's own body as set out in Section 12(2) of Constitution which provides that everyone has a Constitutional right to bodily and psychological integrity.¹⁹³ This includes the right to make his or her own decisions regarding reproduction, control over one's own body and to medical or scientific experiments without one's informed consent.¹⁹⁴

The Children's Act provides four norms law makes provision for children to access HIV testing in Section 130 of the Children's Act. Subject to section 132 of the Children's Act, a child may not be tested for HIV unless it serves the best interests of the child and the prescribed consent provisions have been complied with. The HIV test may take place after authorization by the court, where it needs to be

¹⁹⁰ Sections 29 and 32 of the Constitution.

¹⁹¹ Section 29 of the Constitution.

¹⁹² Section 13 (1) of the Children's Act (note 54 above).

¹⁹³ Section 12 of the Constitution.

¹⁹⁴ Ibid.

determined whether a health care worker or any other person who in came in contact with a substance from the child, may have contracted HIV from during a medical procedure.¹⁹⁵

Section 130 (2) of the Children's Act provides the consent requirements that must be met before an HIV test can be carried out on a child. The consent requirements include that the child must be 12 years or older or if the child is younger than 12 and is sufficiently mature to understand the risks, benefits and implications of the test. Where the child is below 12 or not adequately mature to consent then the parent (or caregiver, or provincial head of social development; designated child protection organisation or superintendent or person in charge of the hospital and the child has no parent or caregiver then the children's' court) may consent to an HIV test.¹⁹⁶

Section 132 of the Children's Act provides that firstly the child must receive pre- and post- test counselling for the HIV test. Secondly, the test must be carried out by a properly trained person. Thirdly, the child must have been mature enough to understand all the benefits, risks and social implications of the HIV test and the parent (or care-giver) must have 'knowledge of the test.

The Children's Act provides in Section of 133 states that a child's HIV/AIDS status may not be disclosed without consent. However, if a child is HIV-positive and the status of the child needs to be disclosed, this may only be done where the child who is older than 12 (or if younger than 12, has sufficient maturity to understand the consequences of disclosing his or her status). Otherwise, where the child is younger 12 or lacks sufficient maturity to understand the implications of disclosing his or her HIV status, the parent or care-giver, a designated child protection organisation (arranging the placement of a child which is below 12 years), a superintendent or person in charge of a hospital, or if there is no parent or care-giver (or no designated child protection organisation arranging the placement of the child) a children's court may consent (including where consent is unreasonably withheld or a parent or caregiver is in capable of providing consent) and it is in the best interests of the child.¹⁹⁷

¹⁹⁵ Section 130 of the Children's Act (note 54 above).

¹⁹⁶ Section 130 (2) (b)-(e) of the Children's Act (note 54 above).

¹⁹⁷ Section 133(a) (b) (c) of the Children's Act (note 54 above).

In contrast the Sexual Offences Act states that any person with knowledge of a sexual offence against a child must report this to the police. This approach which limits a child's right to privacy in favour their criminal justice has resulted in many complexities for health care workers providing HIV prevention to adolescents.¹⁹⁸

3.3.3. Access to male and female condom access

The right to contraceptives falls under the right to contraceptives in terms of the legal framework. Section 12(2) of the Constitution provides that everyone has a right to bodily and psychological integrity, which includes the right to decide over one's reproduction.¹⁹⁹

In terms of the legal framework, everyone has the right to access contraceptives and this includes children. However, section 134 of the Children's Act provides for access to contraceptives in such a way that no person may refuse to sell condoms to a child where the child is over 12 years; or where a child has requested condoms and they are above 12 years with condoms (where such condoms are provided or distributed free of charge).²⁰⁰ For a child to be provided other forms of contraceptives (other than condoms), on his/her own request and without parental or care-giver consent the child must be

- a) at least 12 years of age;
- b) given proper medical advice;
- c) medically examined to establish that this child does not have any medical reasons prohibiting the use of a certain type of contraceptive.

The Children's Act provides that a child who has access to contraceptives or is given advice on contraceptives has the right to confidentiality in respect of the Act. However, this is subject to section 110(1) of the Act, which obliges health care workers to report cases of physical or sexual abuse, or

¹⁹⁸ A Strode et al. 'Reporting underage consensual sex after the Teddy Bear case: A different perspective' (2013) *South African Journal of Bioethics and Law* 6(2) 45 and Bhamjee (note 189 above). This issue is discussed further in Chapter five of this thesis.

¹⁹⁹ Section 12(2) of the Constitution.

²⁰⁰ Section 134 of the Children's Act (note 54 above).

negligence to the Department of Social Development or a designated child protection organisation or the police.²⁰¹

3.3.4. Access to male medical circumcisions

The Constitution in Section 12 (2) provides a right for everyone to bodily integrity and this includes the right to make decisions over one's reproduction.²⁰² Furthermore, in Section 30 and Section 31 of the Constitution provides for everyone to the right to make decisions over choice of language, culture and religion they wish to use and to practice, provided this is not inconsistent with any other provision in the Bill of Rights.²⁰³

The law provides certain protective mechanisms for children concerning social, cultural and religious practices and this is found in Section 12 (1) of the Children's Act which states that 'every child has the right not to be subjected to social, cultural and religious practices that are detrimental to his/her well-being has the right to participate in any matter concerning them'.²⁰⁴

The law proscribes the circumcision of males below the age of 16 years, except as set out in Section 12 (8) of the Children's Act which allows for circumcisions below the age of 16 for religious or medical reasons, provided the legal requirements in the Act and the Regulations are complied with. If the boy is older than 16 but younger than 18, the Children's Act states that the circumcision may take place for any reason for males above 16 years but below 18years. However, the Children's Act provides special provisions in instances where it concerns cultural practice of circumcision on males 16-18years. These must be complied with before a cultural circumcision is performed. In addition to the Children's Act is Part II of the Consolidated Regulations Pertaining to The Children's Act, 2005 (Consolidated Regulations) which provides some further detail relating to circumcision for social or cultural purposes and circumcision for religious purposes.

²⁰¹ Section 110 of the Children's Act (note 54 above).

²⁰² Section 12(2) of the Constitution.

²⁰³ Section 30 and 31 of the Constitution.

²⁰⁴ The Children's Act (note 54 above).

Similarly, in section 6(1) of the consolidated regulations, circumcisions performed for religious purposes on male children must be performed according to the practice of that religion and performed by a medical practitioner or person properly trained to perform circumcisions. Section 6 (2) states that the medical must ensure that a) sterile gloves are worn while performing the circumcision and dispose of them after each circumcision, b) each instrument is disposed of after each circumcision unless sterilised in accordance with medical standards, c) no direct contact with blood, body fluid or foreign substances between the child and the person performing the circumcision or any other person or the child, and d) any instruments including human tissue is disposed of according to medical standards for surgical instruments and human tissue. Furthermore section 6(3) states that consent for circumcision for religious reasons, where a child is under 16 years, must be given by a) both parents of the male child, and if more than one person has guardianship or parental responsibilities and rights agreement exists, both persons, must consent using Form 2. If the boy is older than 16 years, the same format for consent is to be obtained using Form 3.

The law provides that a circumcision for religious purposes must be done according to the practices of the religion and follow the prescribed method, which includes that it be carried out either by a medical practitioner or a properly trained person of that religion, using the prescribed sterile equipment, conditions and procedures.²⁰⁵ The Consolidated Regulations Pertaining to the Children's Act in Section 6 (3) provides that religious circumcision of boys below the age of 16 can only take place where both parents and guardians have consented which must be recorded on Form 3 of the Regulations.²⁰⁶

Secondly, male circumcision can take place for boys below the age of 16 years for medical reasons, following the recommendation of a medical practitioner.²⁰⁷ The Consolidated Regulations Pertaining to the Children's Act does not give any further details on the matter of who must consent, nor does it contain any documentation to be completed and the conditions in regard to the manner which should be followed.

²⁰⁵ The Children's Act No. 38 of 2005: General Regulations Regarding Children (2010).

²⁰⁶ Ibid.

²⁰⁷ Children's Act (note 54 above).

Thirdly, Section 12 (9) provides that where a male child is over the age of 16, he may be circumcised for any reason, on condition that several requirements are met. The Children's Act requires that a male older than 16 years and younger than eighteen years must have consented, himself, to the circumcision.²⁰⁸ This can take place only after he has been provided proper counselling and in the prescribed manner.²⁰⁹

Where the circumcision is for cultural reasons, Section 5 of the Consolidated Regulations deals with the requirements to be met for males older than 16 but younger than 18 years who intend to be circumcised for social and cultural practices.²¹⁰ Section 5(1) provides that boys older than 16 years may be circumcised for social or cultural purposes. However, the circumcision may only be *carried out* once the boy has consented to his own circumcision (in the prescribed manner, using Form 2 (which found in the Consolidated Regulations), only after the boy has been counselled by a parent, guardian, caregiver or social service professional. The circumcision must be in line with the social or cultural practice of the child and carried out by a medical practitioner has knowledge of the social or cultural practice and is a properly trained person who can perform circumcisions.

In addition, section 5(2) prescribes the conditions which the medical practitioner follow in order carry out the circumcision. It states that the medical practitioner must ensure that sterile gloves are worn and disposed of them after each circumcision; that the instrument(s) is disposed of after each circumcision (unless each instrument is sterilised in line with medical procedures; that no direct contact with blood, body fluid or foreign substances between the child and the person performing the circumcision or any other person or the child; and all instruments including human tissue are to be disposed following standard medical procedures for the disposal of surgical instruments and human tissue. The law also provides, in Section 12(10) of the Children's Act, that a male child has the right to refuse the circumcision depending on his age, level of maturity and development.

3.3.5. Access to potential implementation of innovative biomedical prevention strategies - microbicides and a HIV vaccine

²⁰⁸ The Children's Act (note 54 above).

²⁰⁹ Ibid.

²¹⁰ Section 5 of the General Regulations (note 205 above).

Currently, the Constitution and the legal framework do not have express legal provisions on adolescent access to future HIV prevention methods such as an HIV vaccine or microbicides. However, it may be possible for children may be able to consent for some general categories in the law which may imply that they may be able to consent to at certain ages and this could facilitate access to these services.²¹¹ This will be discussed in further detail in the review in Chapter five.

3.4. Conclusion

In this chapter the legal framework has been discussed. In summary, it is held that the Constitution recognizes that the evolving capacities of children must be taken into account while creating laws that form protective mechanisms. The rights that have been created, such as right to both basic education, basic health care and bodily integrity as well as a number of child-specific rights which are cross-cutting such as the right to child participation and the best interests of the child. These core rights create a framework for HIV prevention for adolescents. The legislative framework deals expressly with three of the interventions being researched in this thesis, namely HIV testing, male circumcision and contraceptives (more specifically in the context of HIV prevention, condoms). However, the two interventions, namely the right access to HIV prevention education, information and future technologies are not expressly dealt with in the legal framework.

In the next chapter, the policy framework is discussed which sets out in more detail the way in which the policy provisions described above are to be implemented.

²¹¹ AE Strode... et al. 'Preparing for success: Facilitating independent access to new HIV prevention tools for adolescents in South Africa.' (Article is still in progress with the authors).

CHAPTER FOUR: THE POLICY FRAMEWORK

4.1. Introduction

The policy framework is an important element of the legal framework as generally they detail the manner in which the norms and principles established in the law services ought to be provided to the public.²¹² It has been submitted that in the context of a public health response to HIV policies should be structured in such a way that they ‘provide an operating framework’ that promotes the national response.²¹³ Using this approach means that policies can serve as enablers to the public being able to access health care and ensure that their human rights are protected. Policies can also ensure that principles are maintained and are used to guides to national and international responses to combat HIV.²¹⁴

This chapter focusses on how the South African government has set about incorporating child-specific and SRH rights in the development of a policy framework and strategic plans in response to HIV/AIDS. Policies equally require an examination of the rights of all people (including adolescents), in accordance with national and international human rights standards, to determine whether child-specific and SRH rights have been included in reducing vulnerability HIV, which will be done in Chapter five.

4.2. General principles underpinning the policy framework and an overview of this framework

Dating back to just over twenty years ago, South Africa’s response to HIV/AIDS was initially very slow.²¹⁵ Nevertheless, the development of national policy and strategic plans have evolved exponentially in the last decade to frame an appropriate response to the crisis of HIV in South Africa.²¹⁶ More recently, a nuanced approach to the definition of a child and the various stages of childhood has been included in the policy framework.²¹⁷ In terms of international norms, the United Nations Population Fund (UNFPA) along with the World Health Organization (WHO) and United Nations Children’s Fund (UNICEF) define adolescence a child as between the ages of 10-19. In other words, they extend adolescents beyond the

²¹² A policy has been defined as ‘the basic principles by which a government is guided’ Online Dictionary available at: <http://www.businessdictionary.com/definition/policy.html>, accessed on 22 December 2016.

²¹³ HIV/AIDS national policies and legislation (note 94 above) 1.

²¹⁴ HIV/AIDS national policies and legislation (note 94 above) 1.

²¹⁵ See Chapter Two of this thesis for more detail on the history of the public health response to HIV in South Africa.

²¹⁶ Ibid.

²¹⁷ See Chapter Three of this thesis for the legal definition of a child in the Constitution of the Republic of South Africa, 1996 and the Children’s Act, 2005.

legal definition of a child in international law.²¹⁸ The UNFPA breaks this age category down further by classifying early adolescence as being the ages of 10-14 years and late adolescence being the ages of 15-19. In South Africa, the National Adolescent Sexual and Reproductive Health and Rights Framework Strategy 2014-2019 (hereafter referred to as the National ASRH&R Framework Strategy) aligns itself with the broad definition that adolescence is between the ages of 10-19 years. Similarly, the current National Strategic Plan on HIV (NSP) (2012-2016) also uses this age range when identifying youth as an at-risk category deserving special attention.²¹⁹

In order to address the need of adolescents the government has developed a very broad National Adolescent Sexual and Reproductive Health and Rights Framework Strategy 2014-2019 (hereafter referred to as the National ASRH&R Framework Strategy).²²⁰ This forms a framework of principles which can be used to integrate and develop access to SRHRs into the public health agenda.²²¹ The National ASRH&R Framework Strategy was adopted by the government to achieve a number of very ambitious objectives. They include the reducing the incidence of high risk teenage pregnancies, abortion and sexually transmitted diseases, including HIV/AIDS amongst other things'.²²² It aims to promote sexual and reproductive health rights by calling for an '...inclusive adolescent health agenda that promotes quality of life, the right to exercise one's sexuality free of violence and coercion; the right to seek pleasure with respect for other people's rights and the right to access modern techniques for the prevention, diagnosis and treatment of sexually transmitted infections.'²²³

As such, the National ASRH&R Framework Strategy has five key priority areas supplemented by objectives that includes, amongst others, improved, comprehensive SRHR information and education and revised legislation, policies, strategies and guidelines on ASRH&R.²²⁴ The National ASRH&R Framework Strategy specifically targets the needs of key population groups such as adolescents (including those with disabilities) within the country.²²⁵ The National ASRH&R Framework Strategy forms a good overarching framework for all other HIV prevention policies targeting adolescents as it

²¹⁸ The Convention on the Rights of the Child defines a child as a person under the age of 18. South Africa has adopted a similar approach, see Chapter Three of this thesis for more detail.

²¹⁹ NSP (note 24 above) 25.

²²⁰ National ASRH&R Framework Strategy (note 74 above) 8.

²²¹ Ibid 9.

²²² Ibid 2.

²²³ Ibid 6.

²²⁴ Ibid 16.

²²⁵ Ibid 25.

aligns itself to the South African Constitution, the Bill of Rights, a number of guiding principles and international conventions.²²⁶

In essence the current South African policy framework addressing adolescent access to HIV prevention is premised on the following child- oriented rights set out in detail in the previous chapter including:

- a. the best interests of the child standard;
- b. the right to dignity, privacy, bodily and psychological integrity;
- c. the right to freedom of expression, opinion and participation in all matters concerning the child;
and
- d. the right to the highest attainable standard of physical and mental health.²²⁷

South Africa has developed many policies and guidelines, the table below clusters the most significant of these policies into three categories. These include are set out in the following table:

Broad based health policies	School Health policies	Sexual and Reproductive Health policies for youth
National HIV Counselling and Testing Policy Guidelines, 2015 (hereafter referred to as the HCT national policy)	Integrated School Health Policy, 2012 (ISHP)	Integrated Strategy on HIV, STIs and TB 2012 – 2016 (hereafter referred to as DBE Integrated Strategy on HIV, STIs and TB)
Department of Health’s, National Contraception Clinical Guidelines, 2012 (hereafter referred to as the Contraception Policy)		
The National Contraception and Fertility Planning Policy and Service Delivery Guidelines, 2012 (hereafter referred to as the Fertility Planning Policy)		

²²⁶ Ibid 3.

²²⁷ Ibid ICESCR (note 56 above).

South African National Guidelines for Medical Male Circumcision under Local Anesthesia, 2010 (hereafter referred to the SAMMC guidelines)		
Expanded Programme on Immunisation in South Africa (hereafter referred to as the EPI Schedule)		

4.3. Policies relating to adolescent access to HIV prevention

There are a large number of policies that deal with adolescent sexual and reproductive health either broadly or in an indirect manner. This study has elected to focus on the following of policies as they (a) deal directly with HIV prevention or (b) expressly address adolescent sexual and reproductive health.

The five-key means of HIV prevention which were described in Chapter Two are used as the framework for clustering these policies. In other words, this study examines whether there are any policies which deal with access to HIV information, condoms, HIV testing, medical male circumcision and access to potential new HIV prevention tools.

4.3.1. Access to education and information about HIV prevention

There are a number of policies which deal directly with access to information on HIV prevention but this thesis only focusses on two when discussing access to education and information about HIV prevention. The first is the Integrated School Health Policy, 2012 (ISHP) which was developed as a combined commitment between the Department of Health (DOH), Basic Education (DOBE) and Social Development (DSD) to ensure the implementation of the ISHP for all learners in all schools. Building on previous policies such as the School Health Policy and Implementation Guidelines 2003, and the Youth and Adolescent Health Policy 2001, ISHP takes into account the objectives of the NSP which deal with screening, prevention, treatment and care and support to infected and affected youth.²²⁸ It aims to

²²⁸ Ibid.

reach all school health services, targeting all school going children at both a primary and a secondary school level.²²⁹ ISHP is a primary health care package that focuses on health promotion, providing age-appropriate health education and reproductive health (SRH) services for older learners.²³⁰

The ISHP package includes a health education and promotion component, which is incorporated into the school curriculum through the Life Skills programme focussing ‘...on addressing both the immediate health problems of learners (including those that constitute barriers to learning) as well as implementing interventions that can promote their health and well-being during both childhood and adulthood’.²³¹ The Life Skills programme aims to integrate into the whole curriculum, HIV and AIDS and other important life skills into the school curriculum with the effect of preventing and reducing the rate of HIV incidence as well as to provide care and support for learners affected HIV/AIDS for all learners (Grade 1-12). The Life Skills programme focusses on training educators to implement Sexual and Reproductive Health (SRH) and TB programmes in the curriculum.

The Department of Basic Education (DOBE) has set about the implementation of the HIV and AIDS Life Skills Education Programme, established in the Life Orientation (also known as the life skills programme) which derives its mandate from the National Policy on HIV and AIDS for Learners and Educators in Schools, 1999 (hereafter referred to as the National Policy on HIV/AIDS for Learners). The National Policy on HIV and AIDS for Learners states that its national policy seeks to keep in line with international norms which include the right to education, bodily integrity, opinion and the best interests of the child standard. Given the severity of the epidemic, the National Policy on HIV and AIDS for Learners aims to set out that school-going children are to receive education, integrated into a life-skills programme on HIV/AIDS. The main reason for implementing the HIV education programme is to prevent HIV infection by providing learners with appropriate information and to protect themselves.

²²⁹ The Department of Health ‘The Youth and Adolescent Health Policy’ ‘This document presents a holistic and integrated approach to health that covers children and youth aged 10 to 24 years, both in and out of school. The policy outlines a range of strategies to address health priorities, such as promoting a safe and supportive environment, providing information, building skills, providing counselling and improving health services. Schools are identified as one of seven intervention settings where these strategies can be applied.’

²³⁰ The Department of Health and Department of Basic Education ‘Integrated School Health Policy’ (2012) Department of Basic Education available at: https://www.health-e.org.za/wp-content/uploads/2013/10/Integrated_School_Health_Policy.pdf, accessed on 08 September 2015.

²³¹ Ibid.

ISHP as part of the comprehensive primary health package is incorporated into the Primary Health Care (PHC) package within the Care and Support for Teaching and Learning (CSTL) framework with ‘...specific objectives to provide prevention and promotion services that address the health needs of school going; children and youth with regard to both their immediate and future health; to support and facilitate learning through identifying and addressing health barriers to learning; and to facilitate access to health and other services where required...’.²³² Through the mechanism of the ISHP, in the short-term, counselling on sexual and reproductive health issues and services via mobile health units will be offered to all senior and Further Education and Training (also known as FET) phase learners - as well as to intermediate learners, where required.²³³ ISHP includes the provision of dual protection contraception and HIV counselling and testing (HCT), as well as screening for STIs, an exacerbating factor in the spread of HIV²³⁴.

In secondary schools, there is special provision for addressing sexual and reproductive health issues which includes information on nutrition and exercise; personal/environmental hygiene; diseases such as HIV and TB; abuse such as sexual/ physical/emotional abuse; sexual and reproductive health such as contraception, sexually transmitted infections (STIs) and HIV/AIDS; male circumcision including male medical circumcision (MMC); teenage pregnancy; choice of termination of pregnancy (cTOP), prevention of mother-to-child transmission (PMTCT); HIV counselling and Testing (HCT) and stigma mitigation; and mental health issues including drug and substance abuse/depression/anxiety and suicide.²³⁵

DBE Integrated Strategy on HIV, STIs and TB defines sexuality education as an ‘...age-appropriate, culturally relevant approach to teaching about sex and relationships...providing an individual with opportunities to explore their values and attitudes and to build decision-making, communication and risk reduction skills about many other aspects of sexuality’.²³⁶ The policy provides definitions on when a child may consent to the onsite package of services.²³⁷ However, all learners below the age of 18 years do require written consent of their parent or caregiver before any health care services are offered. It also states that those who are older than 14 years may consent to their own medical treatment, although they

²³² Ibid.

²³³ Ibid.

²³⁴ The Integrated School Health Policy (note 230 above) 7.

²³⁵ The Integrated School Health Policy (note 230 above) 13.

²³⁶ Ibid.

²³⁷ Ibid.

are advised to inform and discuss their treatment with their parent or caregiver. The policy also includes that learners who do not assent to screening or provision of services should not be coerced.

DBE Integrated Strategy on HIV, STIs and TB has four key objectives and these include the provision of services that focus on health needs of school-going children; identifying health barriers to support learning; to enable access to health services; and to create a safe environment for children.²³⁸ DBE Integrated Strategy on HIV, STIs and TB has seven requirements set out to reaching three outcomes. The seven requirements of the DBE Integrated Strategy on HIV, STIs and TB are 1) to align with governments plans; 2) impact of HIV and TB on schooling environment 3) to serve as a protective factor 4) to provide a duty of care in schooling, for learners, educators and officials; 5) to alignment with the NSP 2012 – 2016 and 6) to collect lessons learned from existing evidence on the response rates that have been successful; and 7) to develop a sustainable, comprehensive and measured response. The three outcomes aim to 1) increase knowledge and skills of HIV, STIs and TB targeting learners, educators and officials; 2) decrease the rate of high-risk sexual conduct of learners educators and officials; and 3) to decrease barriers to retention in school, in particular for vulnerable learners.

The provisions of the policy aim to address those children who are, for various reasons, not attending school. The package of services available in the policy include education on male circumcision, contraception and SRH.²³⁹

²³⁸ Ibid. The Integrated School Health Policy (note 230 above) 11.

²³⁹ Ibid.

The school health package is summarized in table 1 below.

Health Screening	On-site service	Health Education
Foundation phase (Gr R-3)		
<ul style="list-style-type: none"> • Oral health • Vision • Hearing • Speech • Nutritional assessment • Physical assessment (Gross & fine motor) • Mental Health • Tuberculosis • Chronic illnesses • Psychosocial Support 	<ul style="list-style-type: none"> • Parasite control: De-worming and bilharzia control (where appropriate) • Immunisation • Oral health (where available) • Minor ailments 	<ul style="list-style-type: none"> • Hand washing • Personal & environmental hygiene • Nutrition • Tuberculosis • Road safety • Poisoning • Know your body • Abuse (sexual, physical and emotional abuse)
Intermediate phase (Gr 4-6)		
<ul style="list-style-type: none"> • Oral health • Vision • Hearing • Speech • Nutritional assessment • Physical assessment • Mental Health • Tuberculosis • Chronic illnesses • Psychosocial Support 	<ul style="list-style-type: none"> • Deworming • Minor ailments • Counselling regarding SRH (if indicated), and provision of and referral for services as needed 	<ul style="list-style-type: none"> • Personal & environmental hygiene • Nutrition • Tuberculosis • Medical and Traditional Male circumcision • Abuse (sexual, physical and emotional abuse including bullying, violence) • Puberty (e.g. physical and emotional changes, menstruation & teenage pregnancy) • Drug & substance abuse
Senior phase (Gr 7-9)		
<ul style="list-style-type: none"> • Oral health • Vision • Hearing • Speech • Nutritional assessment • Physical assessment incl. anaemia • Mental Health • Tuberculosis • Chronic illnesses • Psychosocial support 	<ul style="list-style-type: none"> • Minor ailments • Individual counselling regarding SRH, and provision of or referral for services as needed 	<ul style="list-style-type: none"> • Personal & environmental hygiene • Nutrition • Tuberculosis • Abuse (sexual, physical and emotional abuse including bullying, violence) • Sexual & reproductive health • Menstruation • Contraception • STIs incl. HIV • MMC & Traditional • Teenage pregnancy, CTOP, PMTCT • HCT & stigma mitigation • Drug and substance abuse • Suicide
Further Education and Training (FET) (Gr 10-12)		
<ul style="list-style-type: none"> • Oral health • Vision • Hearing • Speech • Nutritional assessment • Physical assessment incl. anaemia • Mental Health • Tuberculosis • Chronic illnesses • Psychosocial support 	<ul style="list-style-type: none"> • Minor ailments • Individual counselling regarding SRH needs, and provision of or referral for services as needed 	<ul style="list-style-type: none"> • Personal & environmental hygiene • Nutrition • Tuberculosis • Abuse (sexual, physical and emotional abuse including bullying, violence) • Sexual & reproductive health • Menstruation • Contraception • STIs incl. HIV • MMC & Traditional • Teenage pregnancy, CTOP, PMTCT • HCT & stigma mitigation • Drug and substance abuse • Suicide

Figure 3: The Four Phases of Implementation of the School Health Package²⁴⁰

The figure above illustrates the manner in which primary health care package is set out according to the different stages of learners’ development.

²⁴⁰Ibid 14.

4.3.2. Access to voluntary HIV counselling and testing (HCT)

The current policy guidelines are the very recent National HIV Counselling and Testing Policy Guidelines, 2015 (hereafter referred to as the HCT national policy).²⁴¹ The HCT national policy provides for different models for the delivery of HCT, namely, client-initiated counselling and testing (CICT) (or voluntary counselling and testing (VCT)), and provider-initiated counselling and testing (PICT), both of which can be applied in the case of children. In the provision of HCT for children, healthcare providers can employ both models, but should take account of the specific requirements for counselling children and/or their parents and caregivers.²⁴²

HIV counselling and testing (HCT) has experienced a rapid growth since it was launched in 2000. The program was originally known as voluntary counselling and testing (VCT) mainly implemented in public health facilities through “lay counsellors” and Professional Nurses. Lay counsellors delivered pre-and post-test counselling whilst professional nurses would conduct the rapid test. In 2004 the country then expanded the models to include stand-alone VCT and non-medical sites in community settings. In 2010 first HCT policy guidelines, the National HIV Counselling and Testing Policy Guidelines (hereafter referred to as the HCT policy), were published officially released expanding the then VCT to include Client-initiated Counselling & Testing (CICT) and Provider-initiated Counselling & Testing (PICT). Provider Initiated Counselling & Testing (PICT) was mandated to be implemented in all public health facilities. Since then, evidence based models have emerged, evolved and expanded targeting specific settings and population groups. Options include HCT through community-based health services; stand-alone, mobile services, workplace services, home-based (home to home and patient index models).

The HCT models aim to reach men, couples, children, adolescents, prisoners, migrant workers and other closed institutional settings where people will be unlikely to seek HCT on their own. The National HCT

²⁴¹ The Department of Health ‘National HIV Counselling and Testing Policy Guidelines’ (2015) ‘HCT guidelines’ available at: <https://www.health-e.org.za/wp-content/uploads/2015/07/HCT-Guidelines-2015.pdf>, accessed on 26 September 2016.

²⁴² NSP (note 24 above) 42. Note also that the ‘client-initiated or voluntary counselling and testing has been widely used as a model for the provision of HIV counselling and testing in South Africa. This is a client-initiated approach, meaning that a child or the parent or caregiver of a child wanting to have the child tested will actively seek out facilities that offer HIV testing. Also, PICT has been introduced as a means of increasing uptake of HCT. In this model, healthcare providers recommend HCT to clients (children or their parents or caregivers) attending a healthcare facility. The decision to accept or reject the recommendation to test remains with the client. PICT services are offered as a routine standard of care, regardless of the reason for presenting at a health facility.’ See National HIV Counselling and Testing Policy Guidelines (note 241 above).

campaign has seen a rapid expansion and increase in access to HCT for the general population, however despite the great success, the campaign revealed glaring gaps which led to the need to update the HCT policy.²⁴³ The current national policy is the National HIV Counselling And Testing Policy Guidelines, 2015 (known as the RSA HCT Updated Guidelines, hereafter referred to as the national HCT policy) makes provision for children and adolescents to be tested within the context of a youth-friendly service, and provides guidance with regard to issues of consent, pre-and post-test counselling taking into account the age and maturity of adolescents who undergo HCT. The national HCT policy aligns to the strategic framework set out in the NSP, in particular sub-objective two, by maximising opportunities for testing and screen and ensuring all South Africans are tested for HIV and focussing on the goal of halving of HIV infection.

The HCT national policy recommends that healthcare providers initiate HIV testing when they are treating or caring for: HIV-exposed infants; abandoned babies; infants younger than 18 months who may be at risk of HIV infection; infants older than 18 months who may be at risk of HIV infection; breast-fed babies of HIV-positive mothers; children not identified by PMTCT (prevention of mother-to-child transmission) programmes; young people; or child survivors of sexual assaults.²⁴⁴

It covers various aspects of HIV testing and counseling services including; availability, convenience, quality, affordability and acceptability to all those who need the service HCT facilities, including rapid test kits, condoms and information. Even if resources are available, people may not have access if these resources are not located in sufficient proximity to the people who need them. Access may also be low if there is a lack of adequately trained personnel to provide quality services. HIV positive individuals should receive appropriate counselling and assistance linking to prevention, care and treatment services. All clients accessing HCT should be linked to prevention, care and treatment services. It is the responsibility of HCT programs and all HCT providers to ensure that HCT clients and patients are linked to care. HCT alone is of limited value unless it is linked with other services. It is a key component of HIV prevention, care and support, and treatment services, and as such it is critical to ensure that HCT clients and patients are linked with additional services as needed.

Therefore, all learners, educators, school support staff who are living with or affected by HIV, STIs and/or TB in the Basic Education Sector have the right to access an essential package of health and social

²⁴³ This took place between April 2010 and June 2011.

²⁴⁴ The HCT guidelines (note 241 above).

services which will be provided in schools, educational institutions and offices, this will include information on counselling, treatment, care and support or referral to providers of these services. Protocols for the voluntary counselling, screening, testing and/or referral of anyone in the Basic Education Sector are still to be developed.²⁴⁵

The guiding principles for the implementation of the HCT national policy include the promotion of the best interests of the child; protection of human rights; a right to dignity (which includes a right to privacy and confidentiality) and a right to access health care services.²⁴⁶ Thus the following principles have been set out in the national HCT policy when dealing with children:

- a) information on HIV prevention, treatment and care that is relevant, appropriate and accessible and understandable must be provided;
- b) for HIV testing, the child must be able to participate fully in the decision making and consent process regarding HIV testing (including taking into account the views of the child)
- c) an HIV test can only be done if it is in the best interests of the child;
- d) there must be post-test access to treatment, care and support for the child;
- e) the HIV test results must be kept confidential.²⁴⁷

In line with the law, the HCT national policy sets out that the age of consent for an HIV test is 12 years old, and that the person must have sufficient maturity and mental capacity. The child must be able to understand the benefits, risks, social and other implications of the HIV test and may thereafter give consent for HIV counselling and Testing (HCT). The HCT national policy also makes provision for circumstances where a child does not have parents or a legal guardian or is in the care of a child protection facility, or is in a child-headed household, the decision is then made by the healthcare worker who is to take into consideration the best interests of the child.²⁴⁸ If the HIV test is in the best interests of the child, the healthcare worker, in consultation with another healthcare worker may proceed with the HIV counselling and testing.²⁴⁹

The HCT national policy also provides for a definition of a caregiver. Part of Circular minute no.2 of 2012, of the Department of Health through Child, Youth and School Health Directorate states that

²⁴⁵ The HCT guidelines (note 241 above) 21.

²⁴⁶ The HCT guidelines (note 241 above) 49.

²⁴⁷ The HCT guidelines (note 241 above) 34.

²⁴⁸ The HCT guidelines (note 241 above) 34.

²⁴⁹ The HCT guidelines (note 241 above) 36.

Children's Amendment Act (Act No.41 of 2007) in Chapter 1, Section 1(1) a caregiver is any person (other than a parent or guardian) who in fact cares for the child. This includes a foster parent, a person who cares for the child (with implied or express consent of a parent or guardian), a person who cares for the child in the temporary safety care facility, a person who heads a child and youth care facility or shelter where the child is placed, a youth care worker caring for the child who lacks family care in the community, and a child who is the head of a child-headed household²⁵⁰. The policy guidelines make provision for a number of special circumstances where children would need HIV counselling and testing, including, HIV counselling and testing for child survivors of sexual assault, HIV testing among infants and children less than 18 months, testing abandoned babies, HIV testing among children \geq 18 months of age, testing children receiving orphan and vulnerable children (OVC) services who have lost a parent to HIV/AIDS or an unknown cause.²⁵¹

In line with the Children's Act, the national HCT policy sets out clear guidelines as to how HCT should be conducted from the pre-test counselling, HIV testing to post-test counselling session.²⁵² Although it does not give any specific guidelines regarding counselling of children it does describe the general content that should be covered in counselling sessions.

Finally, the HCT national policy framework includes scope for the use of self- testing of HIV.²⁵³ However, the policy states that HIV self-testing is currently not recommended and supported in South Africa as there is still more research and support required on the implementation of this method.²⁵⁴

4.3.3. Access to male and female condom access

The policy framework for access to contraceptives is included in the Department of Health's, National Contraception Clinical Guidelines, 2012 (hereafter referred to as the Contraception Policy). The contraception policy is informed by the World Health Organization Medical Eligibility Criteria (WHO MEC) and is linked to the policy framework, principles and clinical guidelines of the National Contraception and Fertility Planning Policy and Service Delivery Guidelines, 2012.²⁵⁵

²⁵⁰ The HCT guidelines (note 241 above) 36.

²⁵¹ The HCT guidelines (note 241 above) 40.

²⁵² The HCT guidelines (note 241 above) 37.

²⁵³ The HCT guidelines (note 241 above) 13.

²⁵⁴ Ibid.

²⁵⁵ World Health Organization (note 127 above) 99-107.

One of the aims of the effective implementation of the guidelines is to further the goals of the NSP in reducing HIV transmission.²⁵⁶ The contraception policy contains four chapters in relation to contraceptive services. These include 1) an introduction to clinical guidelines for contraception; 2) clinical guidelines for method provision; 3) contraception for special needs (adolescents, menopausal women, disabled women and women with chronic conditions) and 4) contraception and HIV.

The contraception policy outlines the various types of contraceptive methods according to the person's individual needs. It goes further to state that everyone should have access to information that is accurate, unprejudiced as to the various types of contraceptives available in order to make an informed decision. This in addition to a review of edibility and assessment criteria of the individuals needs or circumstances. Furthermore, the contraception policy guidelines emphasise the promotion of the dual method contraceptives against the acquisition or transmission of HIV and STI infection. This includes both male and female condoms, together with all other contraceptives to HIV, STI and pregnancy prevention²⁵⁷.

Chapter three of the contraception policy guidelines is dedicated to contraception for special needs including adolescents, menopausal women, disabled women and women with chronic conditions.²⁵⁸ The guidelines provide that owing the high rate of teenage pregnancy and HIV infection, it is imperative that age-appropriate, effective access to sexual and reproductive health care is made available to adolescents. This includes 'youth-friendly' education and information, counselling and testing of HIV to make informed decisions about their sexual and reproductive health. The guidelines describe a number of contraceptive methods available to adolescents, however, for the purposes of this study, condoms are the main method of prevention to HIV infection. The use of condoms is encouraged to those adolescents who engage in sexual activity. The contraception policy indicates that there is no need for a prescription and should be immediately effective on the correct and consistent use in addition to HIV, STI prevention and prevention of pregnancy.

²⁵⁶ Ibid.

²⁵⁷ Government of South Africa – Department of Health 'National Contraception Clinical Guidelines' (2012) 'National Contraception Clinical Guidelines' available at: http://www.gov.za/sites/www.gov.za/files/Contraception_Clinical_Guidelines_28jan2013-2.pdf, accessed on 31 August 2015.

²⁵⁸ The World Health Organisation defines adolescents as young people between the ages of 12 and 19.

Box 16: Summary of contraceptive methods for young people

- Abstinence (including secondary abstinence)
- Delay sexual debut or
- Barrier method (strong reinforcement of condom use) with:
 - emergency contraception
 - highly effective contraception:
 - combined hormonal contraception
 - progestogen-only injection
 - Cu IUD
 - LNG-IUS
 - progestogen-only implant
- Emergency contraception to be promoted and accessible in the event of unprotected intercourse, method misuse or failure

Figure 4: A summary indicating the various methods of contraceptives available to young people²⁵⁹

Thus, adolescents who face difficulty in using condoms will require counselling and the promotion of emergency contraception in the event that the condom failed or used incorrectly where there is risk of pregnancy.²⁶⁰

The National Contraception and Fertility Planning Policy and Service Delivery Guidelines, 2012 (hereafter the fertility planning policy) sets out the contraception and family planning guidelines for all South Africans. Both the contraception policy and the fertility planning policy have been expanded to include policy changes, amongst others, the special service delivery and clinical considerations for adolescents.

The South African Department of Education is in the process of developing a set of policy guidelines to regulate access and availability the distribution of condoms in schools.²⁶¹ However, no final policy has been issued as yet.

²⁵⁹ Graph adapted from the National Contraception Clinical Guidelines Department of Health (note 257 above) 61.

²⁶⁰ The National Contraception Clinical Guidelines (note 257 above). See also Chapter 3: Contraception for special needs Adolescents, menopausal women, disabled women and women with chronic conditions.

²⁶¹ The Department of Basic Education 'Draft Department of Basic Education National Policy on HIV, STIs and TB' (2015) 'DOBE on HIV, STIs and TB' available at: <http://www.education.gov.za/Portals/0/Documents/Legislation/Callper cent20forper cent20Comments/DBEper cent20Generalper cent20Noticeper cent20HIVper cent20Policyper cent205per cent20Mayper cent202015.pdf?ver=2015-05-11-090105-123>, accessed on 31 August 2015.

4.3.4. Access to male medical circumcisions

Currently, the policy framework for medical male circumcision can be found in the Department of Health, South African National Guidelines for Medical Male Circumcision under Local Anesthesia, 2010 (hereafter referred to the MMC guidelines). The MMC guidelines provide the definition of male circumcision, how it is generally performed, and the details on the various methods, risk, benefits and implications of the different methods to circumcision.²⁶² The MMC guidelines include information for parents who wish to have their minor boys circumcised and the aftercare involved. The guidelines also indicate that boys who are older than 16 may consent to their own circumcision provided they give informed consent, and are counselled by their parents of the risks and benefits involved in the circumcision. Where male circumcision is performed at adolescence, the MMC guidelines provide a proviso that health care workers are to respond to an adolescent male's request for circumcision in a manner that is not in conflict with the law and takes into account the confidentiality of the adolescent.²⁶³

The MMC guidelines prompt health care workers to be familiar with the laws regarding consent requirements involving male children.²⁶⁴ The MMC guidelines also indicate that there are different ages where a male child may consent autonomously depending on different procedures. Therefore, adolescent boys who have sufficient maturity to understand all the risks and benefits linked to circumcision must do so only after they have given their informed consent, irrespective of parental involvement (which in a legal requirement). The adolescent's access to such services must be treated confidentially. This means that adolescent boys who, by law, are able to provide independent consent, the health care worker must respect their child's confidentiality by not informing the parent, unless the child has consented.²⁶⁵

²⁶² The Department of Health 'South African National Guidelines for Medical Male Circumcision under Local Anaesthesia' (2010). MMC guidelines states on page xii '[m]ale circumcision removes the foreskin, the fold of skin that covers the head of the penis, surgically. It is widely practised for religious and traditional reasons, often within the first two weeks after birth, or at the beginning of adolescence as a rite of passage into adulthood. It is also done for medical reasons to treat problems involving the foreskin'. Also 'during a male circumcision, the foreskin is freed from the head of the penis (glans) and removed. In a newborn baby, circumcision is simpler and quicker than in adolescents and adults. Superficial wound healing after male circumcision in adults generally takes 5 – 7 days. However, about 4 – 6 weeks are needed for the wound to heal fully. In babies and young boys, the healing time is considerably shorter, around one week.' See also 'The decision of an adult or young man to be circumcised, and the decision of a parent to have his or her son circumcised, should be based on culture, religion, personal preference, and based on information from a health care worker.'

²⁶³ MMC guidelines (note 262 above) 1-1.

²⁶⁴ MMC guidelines (note 262 above) 3-1.

²⁶⁵ Ibid. See also Committee on the Rights of the Child. General Comment No. 3 'HIV/AIDS and the rights of the child' (UN Document CRC/GC/2003/3) para. 20 'Children are more likely to use services that are friendly and supportive, provide a wide range of services and information, are geared to their needs, give them the opportunity to participate in

The MMC guidelines stipulate that health care workers in human rights principles must make a know that, adolescents too, have a right to use health services and thus should always apply the best interest standard, recognising his evolving capacities and his ability to make autonomous decisions.²⁶⁶ In addition the MMC guidelines provide that counselling must be provided before and after the circumcision.²⁶⁷

The MMC guidelines describe the documentation of informed consent for circumcision²⁶⁸. This includes that adolescent receives information of the risks and benefits of the procedure in an understandable manner. Additionally, information that is provided verbally should be supported by written information. The MMC guidelines describe that the adolescent should be given sufficient opportunity and time to ask questions before signing the consent form.²⁶⁹

Concerning circumcisions that are carried out for traditional reasons, has been met with an opportunity for tradition to take place in safer clinical conditions owing to the high incidence of complications as a result of traditional circumcisions performed by traditional providers. The MMC guidelines promote the introduction of medical male circumcision into traditional circumcisions or in a local clinic, linked to the ceremony, under a local anaesthetic procedure.²⁷⁰

Appendix 3.2. of the MMC guidelines provide a sample information sheet for adult and adolescent on the definition of male circumcision, who conducts the circumcision, how medical male circumcision is conducted, the risks and benefits, problems that may occur and procedures to follow before and after medical male circumcision.²⁷¹ In addition, Appendix 3.3 of the MMC guidelines provide a sample consent form for adult and adolescent males. Chapter 6 of the MMC guidelines provides procedures where circumcision is done on male babies. The procedure is described as first having the consent of parent or legal guardian who must be informed about how the circumcision will be carried out, what type of anaesthetic will be used, the risks involved and the care after the circumcision is carried out should be provided. Appendix 6.1. provides information for parents who wish their child be circumcised and, if the

decisions affecting their health, are accessible, affordable, confidential and non-judgmental, do not require parental consent and are not discriminatory.’

²⁶⁶ MMC guidelines (note 262 above) 3-2.

²⁶⁷ MMC guidelines (note 262 above) 3-5.

²⁶⁸ MMC guidelines (note 262 above) 3-10.

²⁶⁹ Ibid.

²⁷⁰ MMC guidelines (note 262 above) 3-13.

²⁷¹ MMC guidelines (note 262 above) 3-14.

child is able to give his own consent, how the consent of the child should also be obtained. The MMC guidelines also include an example of a consent form is provided in Appendix 6.2.

4.3.5. Access to potential implementation of innovative biomedical prevention strategies – microbicides and an HIV vaccine

Although there is no official policy guidance on future technologies such as an HIV vaccine or microbicides, the state's response to the recently registered HPV vaccine is a good example of how the Department of Health may also roll-out an HIV vaccine in the future. There is however, the Expanded Programme on Immunisation in South Africa, the EPI Schedule which was introduced in 1995 and initially covered the six diseases many additional vaccines that have become available.²⁷² The EPI Schedule is not a closed list and governs when and how to access vaccines in the state system. Furthermore, since future prevention methods are still under development there is no current policy framework in place. For example, the HPV vaccine is available to girls from the age of 9 years HPV6 HPV7; (from 9 years) HPV7; 8 (from 9 years) 9 years HPV – bivalent vaccine for girls only. There are provided in 2 doses six months apart. From March 2014 HPV, will be given to grade 4 girls in public schools only as the start of the programme. The HPV - quadrivalent vaccine – for boys and girls is not available in the public health sector. Course consists of 2 doses, six months apart for children 9 -13 years of age or 3 doses – 0, 2 and 6 months for older adolescents. Bivalent vaccine – for girls only. Course consists of 2 doses, six months apart for girls 9 -14 years of age or 3 doses – 0, 1 and 6 months for older girls. If not given at six years, as products are currently only licensed as a single dose.²⁷³ This means that in terms of the current policy approach it is possible that an HIV vaccine could be added to this programme.

4.4. Conclusion

In this chapter the policy framework has been discussed. In summary, the Constitution creates a right to both basic education and bodily integrity as well as a number of child-specific rights which are cross-cutting such as the right to child participation. These core rights create a framework for HIV prevention

²⁷²Expanded Programme on Immunization (EPI) Immunization schedules in the WHO African region, 1995' (1996) 'EPI Schedule' *Weekly Epidemiology Records* 71(12) 90-94.

²⁷³ Amayeza Info Services' Vaccine Helpline 'Vaccine Schedules for South Africa for 2015' available at: <http://www.amayeza-info.co.za/wp-content/uploads/2011/08/2015-Newschedule-products-final-15102014.pdf>, accessed on 20 May 2016.

for adolescents. The legislation framework deals expressly with four of the interventions being researched in this thesis, namely education, HIV testing, condoms and male circumcision. However, access to future interventions appears to a policy vacuum. Likewise, policies must be framed in line with the best interests of the child, a child's right to confidentiality, and the right to be able to participate in matters concerning his/her own health. In describing the policy framework for access to HIV prevention for adolescents there seems to be four interventions that are expressly dealt with, these are the right to education and information on HIV, HIV testing and counselling, the right to access condoms and the right to male circumcision. However, one intervention, namely the right access to future technologies is not expressly dealt with in the policy framework. An in-Dept.h review of both law and policy framework will be discussed in Chapter five.

The South African government has recognised that there are still a number of challenges in the promotion of young people's sexual and reproductive health and rights (SRHRs). After an examination of various reports and plans, it was realized that there were still major challenges to the integration of adolescents SRHRs in the country.²⁷⁴

²⁷⁴National ASRH&R Framework Strategy (note 74 above) 2.

CHAPTER FIVE: A REVIEW OF THE EXTENT TO WHICH THE SOUTH AFRICAN LEGAL AND POLICY FRAMEWORK FACILITATES ACCESS TO HIV PREVENTION FOR ADOLESCENTS

5.1. Background

In the context of HIV, legislation is seen to play a protective role and can be used to encourage an environment in which an adolescent's sexual and reproductive health rights are recognized.²⁷⁵ While there is no express right to be protected against HIV infection, a number of obligations are placed on states to take steps to ensure that children's sexual and reproductive rights are enabled. UNAIDS argue that where basic human rights are infringed and/or limited by creating barriers to accessing HIV prevention interventions, this has the negative consequence of increasing the individual's vulnerability to the risk of HIV infection. States' obligations to enable children's sexual and reproductive rights can be found in Article 24 of the CRC, the General Comment No. 3 on HIV/AIDS and the rights of the child.²⁷⁶ The objectives of the General Comment No. 3 include strengthening understanding of child specific HIV related issues, promoting the realization of children's human rights, identifying measures and good practices to combat the scourge of HIV among children, and contributing to the formulation and promotion of child oriented responses to the HIV crisis, at both the national and international level, in the context of HIV/AIDS prevention.²⁷⁷ Guideline 6 of the International Guidelines on HIV and Human Rights provides that governments ought to create legislation, adopt measures and take necessary steps to ensure the availability of and access to HIV services, goods and information about HIV/AIDS prevention, treatment, and care.²⁷⁸ As such '...every person has basic human rights, and children have rights and are not merely the possessions of their parents.'²⁷⁹ Any limitation on child-centred or other

²⁷⁵ World Health Organization 'Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations', (2014) available at: http://apps.who.int/iris/bitstream/10665/128049/1/WHO_HIV_2014.8_eng.pdf, accessed on 14 September 2015.

²⁷⁶ Article 24 of the UN Committee on the Rights of the Child (CRC), General comment No. 3 (2003)'HIV/AIDS and the Rights of the Child' CRC/GC/2003/3 available at: <http://www.refworld.org/docid/4538834e15.html>, accessed 26 January 2017.

²⁷⁷ Ibid.

²⁷⁸ Office of United Nations High Commissioner for Human Rights and Joint United Nations Programme on HIV/AIDS 'International Guidelines on HIV/AIDS and Human Rights' (2006) HR/PUB/06/9 available at: <http://www.refworld.org/docid/4694a4a92.html>, accessed on 14 September 2015.

²⁷⁹ Ibid.

rights must be justified and rationally connected to its purpose.²⁸⁰ Furthermore, the UN Political Declaration on HIV/AIDS of 2006 urges State parties to address

the rising rates of HIV infection among young people to ensure an HIV-free future generation through the implementation of comprehensive, evidence-based prevention strategies, responsible sexual behaviour, including the use of condoms, evidence- and skills-based, youth-specific HIV education, mass media interventions and the provision of youth-friendly health services.²⁸¹

Numerous challenges continue to persist, including the increased risk of HIV and AIDS amongst adolescents. This chapter will conduct a systematic review of the relevant legal and policy framework to determine whether developments regarding access to health care services (in particular, adolescent access to HIV prevention interventions) in the current public health landscape facilitates the public health response to the prevention of new HIV infections by improving access to protective mechanisms for adolescents.

South Africa's statutory obligation to address the state of adolescent sexual and reproductive health (ASRH) has not been ignored. While there is no express right to sexual and reproductive health, s 28 of the Bill of Rights provides that children have a right to basic health care services. Taking account of the severe nature of the HIV crisis, the right basic health care services becomes the right through which adolescent sexual and reproductive health can be recognized and fully realized. While South Africa has many good laws and policies in this regard, the main challenge lies in their effective implementation, particularly in ensuring the effective establishment, implementation and monitoring of procedures through which adolescent sexual and reproductive health can be protected.²⁸² In order to fulfil the right of adolescent access to HIV interventions, SRH services need to be strengthened. SRH services (i.e. the

²⁸⁰ Chapter 2: Bill of Rights. Rights. Limitation of rights. Section 36. (1) 'The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including a) the nature of the right; b) the importance of the purpose of the limitation; c) the nature and extent of the limitation; d) the relation between the limitation and its purpose; and e) less restrictive means to achieve the purpose. 2) Except as provided in subsection (1) or in any other provision of the Constitution, no law may limit any right entrenched in the Bill of Rights.

²⁸¹ United Nations General Assembly 'Political Declaration on HIV/AIDS' (2006) (A/RES/60/262) available at: http://data.unaids.org/pub/Report/2006/20060615_HLM_PoliticalDeclaration_ARES60262_en.pdf, accessed online 26 September 2016.

²⁸² For example, the Children's Act (no. 38 of 2005) provides that any child may access condoms without parental assistance or knowledge from the age of 12.

public health response) requires effective policy and law for their implementation and ultimately for the realization of adolescent's rights to basic health care services.

It is thus essential that the South African government use a public health framework that is underpinned by a human rights approach, which puts in place best practices to increase implementation of rights relating to the prevention of HIV/AIDS and the elimination of HIV infection by creating child-oriented plans of action, laws and policies. An effective response to combatting the HIV crisis has two aspects. Firstly, the adoption of a public health agenda which aims to provide essential HIV prevention interventions to adolescents, such as accessibility of sexual and reproductive health services including condom access and HIV education, testing and counselling. Secondly, the adoption of key strategic enablers (for example, an enabling legal framework) which address issues such as adolescents' rights to confidentiality and privacy, their right to bodily integrity and the right to participate in decisions in matters concerning themselves.

5.2. Introduction

Chapters three and four provide a broad description of the significant reform that has taken place in the current national legal and policy framework regulating sexual and reproductive healthcare provision for adolescents. This framework is meant to further the rights described in the Constitution such as children's rights (s28), the right to sexual and reproductive health choices (s12) and access to basic health care services (s27 and s28).²⁸³

Chapter five provides a critical review of the existing legal and policy mechanisms regarding adolescent sexual and reproductive health, but does not extend to an empirical assessment of the extent to which the framework is implemented in practice. It is rather a systematic review of the relevant national legal instruments to determine whether South African laws and policies have factored in adolescent sexual and reproductive health rights (ASRHRs) to HIV prevention strategies; and whether they are underpinned by a child-oriented, human rights approach. The chapter provides an assessment of the degree to which legal principles, relevant literature and policy facilitate adolescent access to existing, proven and experimental HIV prevention interventions.

²⁸³ Constitution of the Republic of South Africa Act 108 of 1996

This chapter will focus on the current framework and the extent to which it acts as a critical enabler to the existing public health agenda in South Africa. It will emphasise the important role that effective laws play in facilitating a comprehensive public health response to HIV prevention.²⁸⁴ It identify where the strengths are but will also illuminate the existence of gaps, challenges and weaknesses which limit the public health response and prevent adolescents from attaining the highest possible standard of health and well-being.²⁸⁵

5.3. Applying the Impact Assessment and Four Key Child- Oriented Rights to Adolescent Access to HIV Education and Information

5.3.1. To what extent does 'standard' represent 'good' public health?

The standard for public health access to HIV education and information in the NSP includes a strategy aimed towards providing HIV education within a comprehensive life skills curriculum in schools for all learners.²⁸⁶ This public health norm represents good practice regarding SRHR services toward HIV prevention as the South African government is responding in such a way that education and information on HIV is widely available and should be entrenched in the compulsory school curriculum. The South African Constitution affords all people of South Africa the right of access to information.²⁸⁷ Thus, children also have a Constitutional right of access to basic health care information which includes information on sexual and reproductive health.

5.3.2. Is the law and/or policy respectful and protective of child-oriented human rights?

The South African Constitution affords all people of South Africa the right of access to information²⁸⁸. Section 13 (a) of the Children's Act No. 38 of 2005 provides that every child has the right of access to

²⁸⁴ S Nadasen *Public health law Health Law in South Africa* (2000) 17.

²⁸⁵ Z Essack, J Toohey and A Strode 'Reflecting on adolescents' evolving sexual and reproductive health rights: canvassing the opinion of social workers in KwaZulu-Natal, South Africa' (2016) 24 (47) *Reproductive Health Matters* 195-204. 'In South Africa children under the age of 18 are legal minors and considered not fully capable of acting independently. However, in certain defined circumstances the law has granted minors the capacity to act independently, including regarding their sexual and reproductive health (SRH). This study found that most participants were critical about the enabling laws for adolescents to independently access SRH services and of the amended law that decriminalised consensual underage sex. Only a few participants agreed that the liberal laws protected adolescents who are sexually active to access necessary SRH services.'

²⁸⁶ NSP (note 24 above) 43.

²⁸⁷ The Constitution (note 283 above).

²⁸⁸ The Constitution (note 283 above).

information on the promotion, prevention and treatment of their health in terms of ill-health, disease and sexuality and reproduction. However, there is no express provision regarding the right to information and education on HIV/AIDS in the Children's Act. Moreover, some information regarding SRHRs in the Children's Act, for example, the right to 'contraceptive advice' and HIV testing and counselling is linked to a child's age and capacity to consent.²⁸⁹ For instance, a child at the age of 12 can access contraceptive information, as well HIV testing but below 12 would have to be linked to sufficient maturity.

On review, the policy framework focuses on learners in school and their access to information on HIV. The Department of Education has drafted its policy document called the Draft Department of Basic Education National Policy on HIV, STIs and TB, 2015, which is applicable to all learners, and staff and is intended to serve the NSP objectives to address drivers of HIV through the intervention of education and information.²⁹⁰

Life skills relating to HIV are integrated into the school curriculum through being a core part of the compulsory course on Life Orientation. The life skills programme focusses on training educators on how best to implement Sexual and Reproductive Health (SRH) and TB programmes in the curriculum.

The Integrated School Health Policy, 2012 (ISHP) aims to guide all school health services which target all school going children at both primary and secondary school level. ISHP is a primary health care package that includes sexual and reproductive health (SRH) services for older learners. The policy requires that children below the age of 18 who require any of the school health package of services, can only be provided with such if the written consent of a parent is given. Health services include the provision of information on sexual and reproductive health. The policy framework appears to be respectful of child-specific rights, making this method of HIV prevention widely accessible for school children which links to actual health services to be provided in schools.

²⁸⁹ The Children's Act 38 of 2005.

²⁹⁰ DOBE on HIV, STIs and TB (note 261 above) 13.

5.3.3. How can the best possible combination of law and policy facilitate further the main public health agenda?

The best combination of law and policy would be a right to HIV information from age 12 onwards in the Children's Act combined with a policy on out-of-school youth and their access to relevant information (where traditional forms of information such as pamphlets are not necessarily accessible).

If the framework removed the component of requiring written consent from parents, there could be a better balance between the general provisions of the law and policy to facilitate access to education and information on HIV prevention.

5.3.4. Does the law and/or policy facilitate adolescent access to HIV prevention?

Yes to some extent the framework is facilitative of adolescent access to HIV prevention but only if the child is in school as HIV prevention education and information is part of the curriculum. However, there is a need for more research into the curriculum as currently formulated to assess whether it addresses the actual risk factors faced by children, especially young women who are particularly vulnerable. The ISHP refers to both information and services which would promote access to HIV prevention. The policy framework in particular does appear to provide for adequate access to relevant information, save for in regard to out-of-school youth whose special needs and circumstances do not appear to be sufficiently recognized in the policy. Further, the provisions state that information may only be given to learners with the express written consent from their parents which potentially serves as a barrier to achieving the objectives of the policy. Furthermore, the law and policy framework does not make express provision for access to SRH services for children who are not attending school.

5.3.5. Discussion

The right to access to education and information is important, to enable children to realise their rights. In the context of access to HIV prevention, the provision of information also means that children will come to understand that they can protect themselves against acquisition/transmission of HIV by the available HIV prevention interventions. The right to access education and information also means that

misunderstanding and misinformation related to HIV transmission or prevention are reduced and children will therefore be able to make more informed choices about their sexual and reproductive health.

Article 17 of the CRC provides that a child has the right to access to information (including via mass media) in relation to their health and well-being. Article 28 states that a child has the right to education. Therefore, it is arguable that the right to information and education read together can be understood to mean that a child should be given access to HIV education/information through available and accessible modes of communication.

Furthermore, in Article 6 of the CRCs General Comment No. 3 states that for countries to have effective HIV/AIDS prevention they are to avoid deliberately withholding or misrepresenting health-related sex information and education and rather fulfill their obligation to ensure the right to life, survival and development of the child. States parties are thus required to ensure that children are able to acquire the knowledge and skills to protect themselves and others as they begin to express their sexuality. In light of Article 17 and 24 of the CRC member states are to thus provide adolescents with access to sexual and reproductive information, such as that relating to family planning and contraceptives, the dangers of early pregnancy, the prevention of HIV/AIDS and the prevention and treatment of STIs.²⁹¹

There appears to be a gap in the legal framework insofar as the protection of the rights of adolescents with regard to the best interests' standard, privacy and confidentiality and a child's right to participate in matters concerning him/herself and the right to attain the highest standard of well-being. On review of both current and draft policies, it is noteworthy that there is no express reference to the Constitutional right of best interests of the child standard nor is there express provision for a child's right to privacy. It is however given some recognition by virtue of the fact that HIV/AIDS education is part of the curriculum and the child's parents are not required to be informed that their child will be taught about HIV and AIDs. Further analysis is needed of the Life Orientation programme to ascertain the extent to which the curriculum addresses rights issues, such as the right of an HIV positive child to confidentiality. The policies do not appear to address how information will be provided to out-of- school youth. These may well be the children who are most vulnerable and in need of HIV information; for example, some such children may be sex workers. The policies thus do not take account the general principle that all children should be able to access information on HIV so that they are able to make informed decisions about their

²⁹¹ CRC General Comment No.3 (note 277 above). Articles 17, B- 18, 19 '...ensure that children are factored into research that aims to prevent HIV/AIDS.'

sexual and reproductive health rights. Similar to the outcome of the review of the legal framework, it appears that the policy framework in place does not adequately serve to facilitate adolescent access to HIV education and information.

The application of the general principles of the Children's Act makes provision for '...the best interests of the child...' ²⁹² This broad right provided in the Constitution can be applied to the right to access information and education on HIV prevention for adolescents, and would entail that the child's right to confidentiality and privacy when exercising this right be recognised. Furthermore, the Children's Act does not expressly protect a child's right to confidentiality and privacy when accessing information and education on HIV. A child's right to participation in decisions regarding their interests and freedom of expression are important rights in relation to their right to access information and education. These rights may be limited where a parent is involved, since the schooling system may be the first entry point for adolescent to access information and education about HIV. Thus, there appears to be ambiguity, on the one hand, in the law which aims to protect a child's right to participate and freely express their opinion and on the other hand, this right is limited when a parent is involved and has to provide consent to access information and education on HIV. It could be interpreted by the applying the general provisions set out in the Children's Act that '...every child that is of such an age, maturity and stage of development is to be able to participate in any matter concerning that child has the right to participate in an appropriate way and views expressed by the child must be given due consideration.' ²⁹³ Thus access to health care services (where the child is of the age at which they can give independent consent – or where there is parental consent provided may be undermined because there is no express legal provision that provides for the age of independent consent to access information and education on HIV. Furthermore, it is unclear as to when a parent is required to consent or whether a parent is involved in the consent process at all. In these circumstances, it is argued that only the legal framework could provide assistance is the consideration that children have a Constitutional right to [independently] access basic health care information, including information on sexual and reproductive health (taking into account their age, stage of development and maturity). This, read together with the general provision from s 13 of the Children's Act which states

every child has the right to...access information on health promotion and the prevention and treatment of ill-health and disease, sexuality and reproduction; access to information regarding his or her health status;

²⁹² Children's Act 38 of 2005.

²⁹³ Section 10 of the Children's Act (note 292 above).

and access to information regarding the causes and treatment of his or her health status; and confidentiality regarding his or her health status and the health status of a parent, care-giver or family member, except when maintaining such confidentiality is not in the best interests of the child.²⁹⁴

It is arguable that the Children's Act is weak since there is no express provision for access to information on HIV prevention, but it must be remembered that the Children's Act must be read and interpreted in accordance with the Constitution, specifically the Constitutional right which provides that everyone has a right to access information on health care (which includes children).²⁹⁵ Nevertheless, the absence of express provisions in the Children's Act is regrettable since it leads to uncertainty as there are no clear rules on when a child can access HIV prevention education and information independently, how this information can be accessed and what information may be accessed (in terms of age-appropriate levels). This can be a barrier to adolescent access to information regarding HIV prevention methods.

The International Guidelines on HIV/AIDS and Human Rights states that 'states should ensure that children and adolescents have adequate access to confidential sexual and reproductive health services, including HIV information, counselling, testing and prevention measures such as condoms, and to social support services if affected by HIV'.²⁹⁶ A similar approach is adopted by the Committee on the Rights of the Child which provides in 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.²⁹⁷

In developing HIV prevention programmes countries should take all necessary steps to remove all barriers that hinder a child's access to HIV prevention services related to HIV education and information. Additionally, state parties should ensure access to age-appropriate information regardless of marital status, and prior consent from parents or guardians.²⁹⁸

²⁹⁴ Ibid.

²⁹⁵ The Constitution section 27(1)(a) states that 'Everyone has the right to have access to health care services, including reproductive health care...'

²⁹⁶ Office of United Nations High Commissioner for Human Rights and Joint United Nations Programme on HIV/AIDS 'International Guidelines on HIV/AIDS and Human Rights' (2006) HR/PUB/06/9, OHCHR and UNAIDS, available at: <http://www.refworld.org/docid/4694a4a92.html>, accessed on 09 October 2016 54.

²⁹⁷ CRC General Comment No.3 (note 277 above).

²⁹⁸ General Comment No. 22 (2016) on the right to sexual and reproductive health (Article 12 of the International Covenant on Economic, Social and Cultural Rights) Geneva: United Nations Committee on Economic, Social and Cultural Rights; 2016. (E/C.12/GC/22).

Although there are no express provisions in the law and policy framework, it could nevertheless be concluded that it is not a bad normative framework within which to further the public health standard of access to education and information on HIV prevention. The challenge is that the law and policy framework require further consideration and revision since there are no explicit rules and guidance on adolescent access to HIV prevention education and information. Furthermore, it must be noted that implementation of the law and policy framework is not reviewed in this study, since this would require empirical research which lies beyond the scope of this work. Other issues that arise include whether the framework provides for children who are not in schools and will thus not have access to such education and information via the schooling system; and that there is insufficient information accessible to adolescents to make informed choices and reduce their risk of HIV acquisition. While the ISHP states that provision will be made to those children who do not attend school, the policy framework does not specify how this will take place.

It has been highlighted that knowledge levels of HIV prevention have not increased in 15 years, with 70 percent of young people not having adequate HIV knowledge/understanding.²⁹⁹ Young people need to be empowered with knowledge regarding how to prevent HIV infection in order for them to make informed choices concerning their lives (including how and whether to access HIV prevention health services). Education is an important HIV prevention tool. It has the potential to make it more likely that young girls will remain in school and be educated on HIV prevention methods, as well as to provide them with information that will help them make the right choices regarding their sexual and reproductive health. Therefore, comprehensive sex education addressing the underlying drivers in the epidemic is crucial to enable the adequate realization of constitutional rights for adolescents.³⁰⁰

The South African government is thus obliged to further develop laws, policies and programmes that enable all people within the country to have access to such health services.

Adolescents have the right to access adequate information essential for their health and development and for them to be able to realise their potential to participate meaningfully in society.³⁰¹ It is the obligation of

²⁹⁹ Mothers to Adolescents: An AIDS-free future (note 13 above).

³⁰⁰ Ibid.

³⁰¹ United Nations Committee on the Rights of the Child (CRC), General comment No. 4 (2003) 'Adolescent Health and Development in the Context of the Convention on the Rights of the Child' CRC/GC/2003/4 available at: <http://www.refworld.org/docid/4538834f0.html>, accessed on 18 January 2017.

the state to ensure that all adolescent girls and boys, both in and out of school, are provided with, and not denied, accurate and appropriate information on how to protect their health and development and practice healthy behaviour. This should include information on tobacco, alcohol and other substance use and abuse, safe and respectful social and sexual behaviour, dietary habits and physical activity.³⁰²

At a minimum, the strength of the current policy framework lies in the fact that it is drafted in line with the South African Constitution and guarantees of certain human rights which are crucial for children and which are necessary for the survival and development of children living in a society with HIV/AIDS.

5.4. Application of the Impact Assessment and Four Key Child- Oriented Rights to Adolescent Access to HIV Testing and Counselling (HCT)

5.4.1. To what extent does standard represent 'good' public health?

The standard for public health access to HIV testing and counselling in the NSP is based on a strategic plan to ensure that all South Africans optimize their use of voluntary HIV counselling and testing services, including access to latest innovations in HIV self-test kits. This represents good public health because it is the gateway to HIV prevention and treatment.

The problem is that the NSP does not include youth or adolescents who are out-of-school in the specific goals regarding HIV testing and counselling. This is particularly problematic since out-of-school adolescents are one of the most at risk populations. The issue is exacerbated by young girls' high pregnancy rates indicating that they are not protecting themselves against HIV.³⁰³ One of the key ways in which young women are able to first determine their HIV status is during the course of ordinary pregnancy screening tests.

5.4.2. Is the law or policy respectful and protective of the child-oriented human rights?

Section 12 of the Constitution provides for the right to bodily and psychological integrity. The Children's Act provides that children of 12 have a right to independent access to HIV testing.³⁰⁴ Children younger

³⁰²Ibid.

³⁰³Centers for Disease Control 'HIV among Youth' (2016) available at <https://www.cdc.gov/hiv/group/age/youth/>, accessed on 26 January 2017.

³⁰⁴Section 130 (2) of the Children's Act (note 53 above). Provides the requirements that must be met for consent

than 12 may also request independent access to HIV testing but they must demonstrate that they have the capacity to consent to such a test.³⁰⁵ In order to ensure that as many children as possible have access to HIV testing, the Children's Act allows parents, guardians and a wide range of other adults to provide proxy consent.³⁰⁶ The Children's Act has taken a very progressive approach regarding the persons who may be able to provide proxy consent for HIV testing.³⁰⁷ Recognizing the social context of the lives of many adolescents who do not necessarily live with their parents or biological guardians, the Children's Act allows persons such as the head of a child-headed household or a caregiver or a grandmother to provide proxy consent.³⁰⁸ In this regard the Children's Act promotes access to testing by sexually active adolescents who are at risk of HIV infection who would potentially not want their parents or caregivers to accompany them for HIV testing. Studies in other countries have shown that requiring parental consent can be a barrier to HIV testing for young people.³⁰⁹

The Children's Act, by setting the age of consent at 12 for independent consent, means that many sexually active teenagers would be able to establish their HIV status without the fear of having to ask for parental permission. However, a key concern raised by some authors is that requiring the test to be in the best interests of the child is an overly-restrictive provision that could act as a barrier to children accessing HIV testing.³¹⁰ They suggest that this requirement creates a higher standard for HIV testing than any other medical intervention.³¹¹ For example, a child does not need to demonstrate that male circumcision is in their best interests. They suggest further that requiring health care providers to access whether the test is in the best interests of every child is unwieldy and time consuming.³¹² They argue that HIV testing is always in a child's best interests if it will lead to treatment and care for the child.³¹³ Moreover, the law requires mandatory pre-and post-test counselling with the child or with person giving consent which

³⁰⁵ Section 130(2)(a)(ii) of the Children's Act.

³⁰⁶ See Chapter 3 (3.3.2.) of this thesis for a more detailed discussion on the persons who may provide proxy consent.

³⁰⁷ HE van Rooyen, AE Strode, and CM Slack 'HIV testing of children is not simple for health providers and researchers: Legal and policy frameworks guidance in South Africa.' (2016) *SAMJ* 106 (5) 452.

³⁰⁸ AE Strode 'Using the concept of 'parental responsibilities and rights' to identify adults able to provide proxy consent to child research in South Africa' (2011) *SAJBL* 4(2) 69. See also CM Slack and AE Strode 'But is this really the 'parent' or 'guardian': Practical strategies for consent to child research in South Africa' (2016) *SAJBL* 9(1) 35.

³⁰⁹ Van Rooyen et al. (note 308 above) 452.

³¹⁰ AE Strode and H van Rooyen and T Makusha 'Is it lawful to offer HIV self-testing to children in South Africa?' (2013) *SAJHIVMED* 14(4) 151.

³¹¹ *Ibid* 153.

³¹² *Ibid* 152.

³¹³ *Ibid*.

makes for more comprehensive test procedures.³¹⁴ The flip-side of this requirement is that it may act as a barrier to the introduction of innovative new models of testing such as the use of home-testing kits.

There is also express provision in Section 13(1) (d) of the Children's Act for privacy and confidentiality of the HIV status of a child which means that there is no obligation on the person undertaking the test to report its outcome to the child's parents or caregivers.³¹⁵ The law does have a cautionary proviso in the Children's Act that states that subject to s 110(1), health care workers are obliged to report cases of physical or sexual abuse, or negligence to the Department of Social Development or a designated child protection organisation or the police.³¹⁶ This lines up with other laws such as the Criminal Law (Sexual Offences and Related Matters) Amendment Act Sexual Offences Act No. 32 of 2007 (hereafter referred to as the Sexual Offences Act) which imposes a mandatory reporting obligation where there is knowledge of a sexual offence.³¹⁷ The Children's Act promotes child participation, freedom of expression and the right to refuse an HIV test (especially where a parent provides consent), thus a child from the age of 12 can make the independent decision as to whether to submit to an HIV test.³¹⁸

Furthermore, there is also a requirement that pre-and post-test counselling must be provided to the child concerned who must have sufficient maturity to understand the risks, benefits and social implications of the test; and the child's parent or care-giver, if the parent or care-giver has knowledge of the test³¹⁹. This implies that the child is free in the decision-making process for the HIV appears that law requires parents to be involved in the counselling if they are aware of the test.³²⁰ This requirement that the parent is counselled undermines the entire approach taken towards independent HIV testing in the Children's Act. The other provisions in the Act are clearly aimed at facilitating independent access, for example, section 133 of the Children's Act expressly provides that the child is entitled to confidentiality regarding their HIV status.³²¹ This internal contradiction in the Children's Act is problematic.

³¹⁴Section 132 of the Children's Act (note 53 above) provides that children must have counselling before and after an HIV test by a properly trained person.

³¹⁵ Section 13(1) (d) Children's Act 38 of 2005.

³¹⁶Section 15 and 16 of the Sexual Offences Act 23 of 1957 were deemed to be invalid by the court in the case of *Teddy Bear Clinic for Abused Children and Another v Minister of Justice and Constitutional Development and Another* 2014 (2) SA 168 (CC). The sections have been amended Section 15 and 16 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act Amendment Act No. 5 of 2015.

³¹⁷See Chapter 3 (3.3.2.) of this thesis for more information on sexual offences.

³¹⁸ K Grant...et al. 'Legal, ethical and counselling issues related to HIV testing of children-HIV testing of children: Legal guidelines for implementers' (2012) *Human Sciences Research Council* 1-35. See also Children's Act No. 38 of 2005.

³¹⁹ Section 132 of Children's Act (note 53 above).

³²⁰ Section 132 of Children's Act (note 53 above).

³²¹ Section 133 of the Children's Act.

In respect to the age of autonomous consent (or to the extent that the parent(s) is involved) the law facilitates access of this public health standard for adolescent access to HIV testing and counselling as it requires the testing to be in the best interests of the child as one cannot test for discriminatory or arbitrary reasons.³²² The most significant complexity is that the Children's Act has separate conditions for testing and counselling.³²³

Self-testing for children over the age of 12 years may be problematic because the Children's Act requires that the test be in the child's best interests and that it be accompanied by pre- and post-test counselling.³²⁴ This means that if for example, home testing kits are sold or distributed to children there will need to be a way in which counselling can be provided to them. This may be, for example by way of a help line.³²⁵ There is however no direct legal barrier to a child purchasing or obtaining a self-testing HIV kit, provided they are over the age of 12 years. Overall, the law is largely facilitative of and respectful of child-oriented rights.

In terms of the national policy framework the principles for independent access to HIV testing set out in the law are mirrored in the HCT national policy. However, the policy provides more detail on the principles guiding the implementation of HIV testing and counselling.³²⁶ The policy framework also promotes the principle of the best interests of the child by trying to ensure that children who are at risk are identified and provided with services and information on HIV prevention, treatment and care, in an age-appropriate and accessible manner. Furthermore, the best interests of the child must be factored in when an HIV test is to be carried out, with the resultant implication being that the results of the HIV test should remain confidential. In addition, considering the best interest's principle is reflected in the focus in the policy framework on children being able to fully participate in the decision making relating to a HIV test.

The HCT national policy further provides that informed consent to an HIV test must be given freely and voluntarily. The age of consent for an HIV test in the HCT national policy is set at 12 years. Additionally,

³²² Ibid.

³²³ Ibid.

³²⁴ Strode et al (note 22 above) 2 and van Rooyen et al (note 311 above) 153.

³²⁵ Ibid.

³²⁶ HCT guidelines (note 242 above) 36.

the child must be able to understand the risks and benefits associated with an HIV test.³²⁷ The HIV test must be carried out in the best interests of the child. There are policy guidelines for a number of special circumstances such as HIV testing for child survivors of sexual assault and orphan and vulnerable children (OVC) services who have lost their parents to HIV/AIDS or an unknown cause.³²⁸

The Integrated School Health Policy 2012 (ISHP), facilitates access to HIV testing by taking mobile health units to schools enabling at risk adolescents to be tested on the school premises.³²⁹ However, this policy appears to be out of step with the legal framework as only learners from 14 as opposed to 12 in the Children's Act can consent to HIV testing if the test is considered in the form of medical treatment requires parental consent in contradiction with the Children's Act before a child is able to access these services.³³⁰

There is no official policy on adolescent access to HIV self-testing kits and this remains a gap particularly concerning the issue of pre- and post- test counselling which is a requirement of the law concerning HIV testing for adolescents.

The principle of child participation in decision making concerning their best interests is emphasized in the national HCT policy which provide great details on the content and nature of pre- and post-test counselling regarding the HIV test. Counselling is an interactive process that aims at facilitating good decision making. This promotes child participation as it gives the child as opportunity to consider their risks and benefits of undergoing the test in a secure confidential manner with a counsellor. It can thus be concluded that the policy framework is protective and respectful of child-specific rights concerning access to HIV testing and counselling.

5.4.3. How can the best possible combination of law and policy facilitate further the main public health agenda?

³²⁷ HCT guidelines (note 242 above) 36.

³²⁸ HCT guidelines (note 242 above) 40.

³²⁹ The Integrated School Health Policy (note 217 above) 15.

³³⁰ ISHP is unclear on services that can be provided without parental consent as it simply refers to children being able to consent to medical treatment from the age of 14. It does not explain whether, for example, access to HIV testing would be considered a form of medical treatment.

There appears to be a good balance between law and policy in line with the public health goals of trying to get as many children tested as possible and this is being achieved in a very protective way. Although the age of consent to an HIV test is from the age of 12, there are protections built into law and policy such as requiring the test to be in the child's best interest, providing that the results be confidential and protecting the child's right to privacy.³³¹ This is a good balance between public health and child-specific rights, including making provision for children who are classified as orphaned and vulnerable children (OVCs) to be tested (including child-headed household children).³³² On balance the human rights protections relating to HIV testing and counselling may be a barrier to some of the future potential models such as home testing because they limit the circumstances in which children may be tested. In particular, requiring counselling to accompany a test means that it may be difficult to offer self-testing kits to children.

5.4.4. Does the legal and policy framework facilitate adolescent access to HIV prevention?

The legal and policy framework does appear to facilitate access to HIV testing and counselling as an intervention for HIV prevention generally, however, some new innovative forms of testing such as self or home-testing are not adequately provided for in the law and policy framework and maybe difficult to roll out because of the mandatory counselling requirements.

5.4.5. Discussion

The current legal and policy framework outlines the essential standards relating to the HIV testing of children in South Africa but place limits on HIV testing to only specific circumstances thus potentially creating barriers to the public health response requiring an increased uptake of regular HIV testing.³³³ The strength however, in the legal and policy framework, is that children can independently access HIV testing from the age of 12.

³³¹ Sections 130-133 of the Children's Act and HCT guidelines (note 242 above) 24.

³³² AE Strobe...et al. 'Failing the vulnerable: Three new consent norms that will undermine health research with children.' (2014) *Southern African Journal of HIV Medicine* 15(2) 47.

³³³ H van Rooyen... et al (note 308 above). The four norms include are: '(i) limiting HIV testing to defined circumstances; (ii) ensuring that consent is obtained; (iii) ensuring that counselling is provided; and (iv) ensuring that confidentiality is maintained.'

Other barriers to accessing an HIV test may be to the extent to which an HIV test must be in the best interests of the child, the health care worker does not always know how to use or apply the best interest standard of the child. In addition, counselling as a mandatory component of the HIV testing process can become a barrier where, for example, self-testing would be otherwise available on the pharmacy shelf (or via online order delivery to the door). Self-testing does not factor in pre- and post- test counselling. Strode highlights that the HCT national policy does not make provision for HIV self-testing.³³⁴ Some authors suggest that HIV self-testing should not be recommended and supported in South Africa.³³⁵ The legal framework does not expressly prohibit or regulate the offering of self-tests to children.³³⁶ Further research is still required to assess the desirability of supporting the implementation of self-testing.³³⁷

This means that law reform may be needed to account for the latest innovations such as self-testing for HIV; and where counselling of children is required to take place, to meet the evolving needs of adolescents. The law and the national HCT policy can be improved to provide clear provisions on self-testing as there is no guidance on the rights of adolescents to access readily available HIV self-test kits. As such policymakers should review the existing regulatory frameworks to create an enabling link to the public health response and to provide for how to facilitate access to HTC in various circumstances such as access to self-testing and meeting the needs of children living on the streets, adolescents in child-headed households, girls engaged in sex with older men and in multiple or concurrent sexual partnerships, and adolescent girls affected by sexual exploitation.³³⁸ Furthermore, there appears to be a lack of

³³⁴ Strode et al (note 22 above) 23 Strode et al (note 311 above) 152.

³³⁵ Strode et al (note 311 above) 153.

³³⁶ Strode et al (note 22 above).

³³⁷ Strode et al (note 311 above) ‘Self-testing involves conducting an HIV test at home or in any other convenient space without the involvement of a third party. It is increasingly being argued that it should be incorporated into national HIV-prevention programmes as one of a range of HIV counselling and testing approaches. Although this model of HIV testing is being seen as a new way of reaching under-tested populations, no studies have been conducted on offering it to children. HIV self-tests are now available in South Africa and are sold without the purchaser having to be a certain age. Nevertheless, all HIV testing in children must comply with the norms set out in the Children’s Act (2005). This article explores whether offering self-testing to children would be lawful, by outlining the four legal norms that must be met and applying them to self-HIV testing. It concludes that, although children above the age of 12 years could consent to such a test, there would be two potential obstacles. Firstly, it would have to be shown that using the test is in their best interests. This may be difficult given the potential negative consequences that could flow from testing without support and the availability of other testing services. Secondly, there would need to be a way for children to access pre- and post-test counselling or they would have to be advised that they will have expressly to waive this right. The tests are more likely to be lawful for a small sub-set of older children if: (i) it assists them with HIV-prevention strategies; (ii) they will be able to access treatment, care and support, even though they have tested outside of a health facility; and (iii) psychosocial support services are made available to them via the internet or cell phones.’

³³⁸ World Health Organisation ‘HIV and adolescents: guidance for HIV testing and counselling and care for adolescents living with HIV: Recommendations for a public health approach and considerations for policy-makers and managers’ (2013) available at: http://apps.who.int/iris/bitstream/10665/94334/1/9789241506168_eng.pdf, accessed on 27 January 2017.

harmony between the Children's Act and HCT national policy on HIV testing and the ISHP on HIV testing for sexually active learners regarding consent for testing.³³⁹ As a result of a policy that is unclear about when consent is required, health providers may be reluctant to provide HIV testing services in cases of doubt. In all circumstances the best interests of the child should be the primary consideration.

Since HIV testing is important gateway to knowing and responding to one's HIV status, this intervention plays a major part in the early detection, treatment and prevention of HIV/AIDS for those who are affected and infected.³⁴⁰ In the interest of public health, policymakers should review the legal and policy mechanisms regulating adolescent access to HIV testing and counselling by removing any legal barriers to the provision of such services. In so doing, more adolescents will be able to gain knowledge of their HIV status, and be able to access the requisite care and take steps to prevent infection. In addition, hopefully, this will reduce the risk of the acquisition or onward risk of transmission of HIV.

5.5. Application of the Impact Assessment and Four Key Child- Oriented Rights to Adolescent Access to Barrier Contraceptives (Male and Female Condoms)

5.5.1. To what extent does the national response meet 'good' public health standard?

Part of the NSP health care service package includes the aim to increase consistent use and mass roll-out of male and female condoms.³⁴¹ This includes activities that address the high risk behavioural patterns amongst adolescents and which aim to reduce risk and increase protective measures against HIV infection. This response represents good public health policy because proper and consistent use of the condom is one effective method of preventing HIV transmission amongst adolescents. It is submitted that the South African government's practice of distributing large numbers of condoms for public access with the aim of reducing HIV acquisition and also minimizing unplanned pregnancy amongst adolescents is a good public health standard.³⁴²

³³⁹ van Rooyen et al (note 308 above) 451.

³⁴⁰ Mothers to Adolescents: An AIDS-free future (note 13 above).

³⁴¹ NSP (note 24 above).

³⁴² United Nations Population Fund, World Health Organisation and Joint United Nations Programme on HIV/AIDS 'Position statement on condoms and the prevention of HIV, other sexually transmitted infections and unintended pregnancy' (2015) available at:

http://www.unaids.org/en/resources/presscentre/featurestories/2015/july/20150702_condoms_prevention, accessed on 26 January 2017.

5.5.2. *Is the law or policy respectful and protective of the child-oriented human rights?*

Section 12 (2) of the Constitution provides for the right to bodily and psychological integrity which includes the right to make decisions about reproduction.³⁴³ In terms of s 134 of the Children's Act, contraceptive access and information is available from the age of 12. The dictionary defines contraceptives as 'any of various devices or drugs intended to prevent pregnancy.'³⁴⁴ It is clear that condoms fall within the ordinary dictionary definition of contraceptives. There is no express provision for the consideration of best interests of the child standard in the Children's Act on contraceptives. However, the Children's Act implicitly recognises that the best interest of the child is paramount in the 'general principles' section of the law.³⁴⁵

Additionally, the law provides that a child who has access to contraceptives, or is given advice on contraceptives, has the right to confidentiality in this regard. It must be noted that the law regarding the right to confidentiality may be limited where there have been instances of physical or sexual abuse or negligence.³⁴⁶ As discussed in Chapters one and three of the thesis, there are circumstances that place limitations on certain human rights such as privacy, provided such limitations are justified and are rationally connected to their purpose.³⁴⁷ Moreover, the laws appear to be synchronized with the age set in the Sexual Offences Act provisions, which takes into account the child's capacity to consent to sex, by lowering the age at which condoms may be made available to children. In that the criminal law now provides that consensual sex with peers between the ages of 12 and 15 is not a criminal offence.³⁴⁸ Likewise, it is not a sexual offence if a child between 12 to 15 has sex with a 16 or 17 year old child provided there is not more than a two year age gap between them.³⁴⁹ The significance of this is that health care workers can provide services to sexually active children under 16 without fear that they are aiding and abetting the commission of a crime.

³⁴³ Section 12(2) of the Constitution.

³⁴⁴ Cambridge Dictionary, available at <http://dictionary.cambridge.org/dictionary/english/contraceptive>, accessed online 26 January 2017.

³⁴⁵ General principles section of the Children's Act.

³⁴⁶ Section 110(1) of the Children's Act (note 53 above) which obliges health care workers to report cases of physical or sexual abuse, or negligence to the Department of Social Development or a designated child protection organization or the police.

³⁴⁷ Sexual Offences Act, No. 23 of 1957. – regarding sexual offences against children.

³⁴⁸ Section 15 of the Sexual Offences Act.

³⁴⁹ *Ibid.*

Given that the Children’s Act makes access to contraceptives (including condoms) a right for children over the age of 12, a parent or a service provider cannot refuse a child such access. Accordingly, the law is highly facilitative, respectful and protective of the child-specific rights in respect to independently access to condoms, as adolescents have the statutory right to access this form of barrier method from the age of 12.

The policy framework applicable to access to contraceptives is found in the Department of Health’s National Contraception Clinical Guidelines, 2012 (hereafter referred to as the contraception policy guidelines) and is linked to the Policy Framework, Principles and Clinical Guidelines of the National Contraception and Fertility Planning Policy and Service Delivery Guidelines.³⁵⁰ Part of the aims of the guidelines include furthering the goals of the NSP in reducing HIV transmission. The contraception policy guidelines emphasize the promotion of dual method contraceptives against the acquisition or transmission of HIV and STI infection, including both male and female condoms. There is special emphasis on the inclusion of adolescents in the contraceptive policy guidelines which acknowledge the increased rate of teenage pregnancy and HIV infection, making it critical for adolescents to be able to access to condoms as an important method of HIV prevention for those adolescents engaged in sexual activity.³⁵¹ Furthermore, the contraceptive guidelines for service providers are youth friendly and includes provision for respecting for the rights of adolescents (which includes the right to privacy and confidentiality).³⁵²

Although the contraceptive policy guidelines do not expressly provide for respecting the best interests of the child, or for rights such as the right to freedom of expression or the right to participate in the decision making process where a parent refuses the child to access condoms, it does contain a general provision to the effect that adolescent access to condoms is important and that every effort must be made to facilitate adolescent access to sexual and reproductive health services.³⁵³ The most significant gap in the policy framework is that the ISHP does not expressly deal with the issue of providing condoms to adolescents as part of school health services. Given that this is such a contentious issue, it has been left up to the Department of Education to formulate guidelines in respect of this matter. To date, the

³⁵⁰ Government of South Africa – Department of Health ‘National Contraception and Fertility Planning Policy and Service Delivery Guidelines: A companion to the National Contraception Clinical Guidelines’ (2012) available at: <http://www.partners-popdev.org/wp-content/uploads/2015/08/National-contraception-family-planning-policy.pdf>, accessed 26 January 2017.

³⁵¹ Ibid.

³⁵² Ibid.

³⁵³ Ibid.

Department has not published final norms and standards on this issue. The current approach is therefore that the decision on whether or not the school will provide access to condoms to learners lies in the hands of the schools' governance structures. It is recommended that there should be clearer guidance provided in either the ISHP or in the Life Orientation programme by the Department of Education. Otherwise, the discretionary power left to individual schools can act as a direct barrier to access condoms in instances where the School Governing Body or leadership within the school prohibits or limits access to condoms by their learners at the school.

The policy is predominantly respectful of child-specific rights but would serve better as an enabler of the public health response to the HIV crisis if there were clear guidelines to support the right of adolescent access to condoms.

5.5.3. How can the best possible combination of law and policy facilitate further the main public health agenda?

There seems to be an adequate combination of law and public health, which means the achievement of the state public health goals. By allowing children from the age of 12 to have a legal right to access condoms enables the state to directly target condom services to this group. However, the law and policy are not always in sync as the policy framework is less focused on easy access to condoms by school-going youth.

5.5.4. Does the law or policy facilitate adolescent access to HIV prevention?

The law recognizes that even below the age of 16 at which they may legally consent to sex, an adolescent is able to protect themselves against HIV infection through the use of barrier methods from the age of 12. Since condom use is regarded as a high impact HIV barrier prevention method, there needs to be clearer guidelines in the policy framework on child-specific rights to access this intervention. Condom access may be the most significant entry point for HIV prevention. The current policy framework does not specify details as to when and how condoms will be accessible at schools. Furthermore, there may be barriers to uptake of providing access to condoms at schools owing to school governing bodies having the discretion to make the decision not to make condoms accessible. This could be for diverse reasons, including the fear that it would be promoting sex, that it would be contrary to religious, moral or sponsor

policy perspectives. For example, the President's Emergency Plan for AIDS Relief policy will not fund an organisation or institution where there is access to condoms in schools.³⁵⁴

5.5.5. Discussion

The South African government has a responsibility to ensure adolescents' access, in both the law and the policy framework, to information regarding contraception and the various methods of contraception despite the high incidence of HIV in adolescents and the efficacy of condoms in preventing HIV transmission, condom use rates among adolescents remain low, partly due to limited access.³⁵⁵ Considerations such as whether or not condoms should be made available in schools, since schools are one of the few locations accessible to large numbers of youth, are not being given sufficient attention. This is extremely regrettable and it is of concern that condom distribution is rarely undertaken in schools.³⁵⁶ If condoms are not provided in schools it results in other indirect barriers to access such as the time and cost of travel to sites of condom distribution.³⁵⁷ Other concerns include clinics closed by the conclusion of the school day. In addition, adolescents often face a judgmental and hostile attitude by commercial providers of condoms, and the cost of condoms in shop may be prohibitive.³⁵⁸

Currently the policy framework leaves it within the discretion of the school governing body as to whether to distribute condoms in their schools. However, most are unaware of South African policy and regulations governing condom provision in schools.³⁵⁹ This means that those schools that have strong, religious, moral objections to adolescent access to condoms would not allow make provision for availability in schools.³⁶⁰ The problem with this approach is that every school could have a different

³⁵⁴ Han (note 41 above) 0026.

³⁵⁵ See Chapter 1 to 3 of this thesis for more information on the nature of these obligations.

³⁵⁶ Han (note 41 above) 0026.

³⁵⁷ Ibid.

³⁵⁸ E Gilmour, SS Karim, and HJ Fourie 'Availability of condoms in urban and rural areas of KwaZulu-Natal, South Africa' (2000) *Sexually Transmitted Diseases* 27 (6) 353-357. See also J Han 'Condom access in South African Schools: Law, Policy, and Practise' (2009) *PLoS Medicine* 6(1) 25. See also F Tanser 'Methodology for optimising location of new primary health care facilities in rural communities: A case study in KwaZulu-Natal, South Africa' (2006) *Journal of Epidemiological Community Health* 60(10) 846-850.

³⁵⁹ South Africa Department of Education 'National Policy on HIV and AIDS for Learners and Educators in Public Schools and D Students and Educators in Further Education And Training Institutions.' (1999) available at: http://wced.school.za/branchIDC/special_ed/hiv_aids/National_policy_on_HIV-AIDS.pdf, accessed on 18 January 2017. The policy document also states that '... each school can decide whether condoms need to be made accessible within a school and if so under what circumstances.'

³⁶⁰ National Contraception Clinical Guidelines, (note 351 above) 58.

approach. This undermines the child's rights in terms of the Children's Act. The draft policy on condom access explicitly mandates that these must be available at: all schools but is yet to be implemented.³⁶¹

There are also a number of considerations that must be taken into account when the new policy is implemented such as when it will be regarded as age-appropriate to make condoms accessible at schools and at which school levels this should be done; as well as how the policy should be operationalized and implemented (for example: will condoms be available in toilets or in more discreet places, to safeguard the child's rights to privacy.) Furthermore, the policy framework needs to consider how children out of school will be reached.

Although the future policy framework makes provision for access to condoms at schools it is unclear whether the draft policy will be adopted in its current form and whether it would be implemented. Further, it is unclear whether there will be a school counsellor who be empowered or required to advise adolescents on the use of condoms, or to distribute them. Having school counsellors responsible for distributing condoms at school would be problematic, since research reveals that learners are reluctant to obtain condoms when issued by an authority figure.³⁶² It has been recommended that policymakers 'eliminate requirements that public funds be used for abstinence only education, and that states and local school districts implement and continue to support age appropriate comprehensive sex education and condom availability programs in schools.'³⁶³

The South African government in the NSP has prioritised the promotion and increased availability of male and female condoms which remain the most effective prevention technology currently available and the only prevention method capable of preventing both HIV and pregnancy.

In a recent judgment about whether consensual sexual activity of teenagers as innocent as kissing should be criminalised or not, the Constitutional Court noted that 'the majority of South African adolescents between the ages of 12 and 16 years are engaging in a variety of sexual behaviours as they begin to

³⁶¹ Department of Basic Education (note 262 above) 18.

³⁶² Han (note 41 above) 0027. See also K Holt et al 'Assessment of Service Availability and Health Care Workers' Opinions about Young Women's Sexual and Reproductive Health in Soweto, South Africa' (2012) *African Journal of Reproductive Health* 16 (2) 284. See also SM Blake... et al 'Condom availability Programs in Massachusetts High Schools: Relationships with Condom Use and Sexual Behaviour' (2003) *American Journal of Public Health* 93(6) 960.

³⁶³ Committee on HIV Prevention Strategies in the United States, Institute of Medicine. *No time to Lose: Getting more from HIV Prevention* (2001) 118-120.

explore their sexuality.³⁶⁴ Supporting this statement is the fact that it has been reported in Parliament that 717 primary school and 20 116 high-school learners fell pregnant in 2014 alone.³⁶⁵ Almost a third of new HIV infections in sub-Saharan Africa occur in young women between the ages of 15 and 24. This is not surprising, since there is a dramatic decline in overall condom usage in this age group, coupled with a low level of knowledge about HIV among young people.³⁶⁶

The South African Constitution places an obligation on the state to take proactive reasonable, evidence-based measures to prevent the transmission of HIV in order to protect and fulfil our rights to life, dignity, bodily integrity and access to healthcare services for children.³⁶⁷ Therefore, all laws and policies must provide an enabling environment for protecting adolescents from HIV infection.

5.6. Application of the Impact Assessment and Four Key Child- Oriented Rights to Adolescent Access Relation to Medical Male Circumcision³⁶⁸

5.6.1. To what extent does the national response meet 'good' public health standard?

The standard for access to medical male circumcision in the NSP represents good public health because it has been established that this is an effective form of HIV prevention.³⁶⁹ The roll-out of this HIV prevention method has been endorsed by WHO and UNAIDS.³⁷⁰ Thus, medical male circumcision (for both adults and neonates) is a key HIV prevention strategy in the NSP and is a good public health standard, albeit controversial in the eyes of some.

5.6.2. Is the law or policy respectful and protective of the child-oriented human rights?

³⁶⁴ *Teddy Bear Clinic for Abused Children and Another v Minister of Justice and Constitutional Development and Another* 2014 (2) SA 168 (CC) 46.

³⁶⁵ 'Condoms in schools' *SPOTLIGHT -Engaging with South Africa's National Strategic Plan for HIV, STIs and TB* available at: <http://www.spotlightnsp.co.za/2015/06/10/condoms-in-schools/#content-wrapper>, accessed on 18 January 2017.

³⁶⁶ *Ibid.*

³⁶⁷ *Ibid.*

³⁶⁸ This section of the dissertation is largely based on an article published by AE Strode, JD Toohey and CM Slack 'Addressing legal and policy barriers to male circumcision for adolescent boys in South Africa' (2016) *The South African Medical Journal* 106 (12) 1173-1176. My contribution to this paper was to develop the first draft and to work with the two other authors on editing finalizing.

³⁶⁹ NSP (note 24 above).

³⁷⁰ World Health Organisation 'WHO and UNAIDS announce recommendations from expert consultation on male circumcision for HIV prevention.' (2007) available at: <http://www.who.int/hiv/mediacentre/news68/en/>, accessed on 26 January 2017.

Section 12 (2) of the Constitution provides for the right to bodily and psychological integrity and this specifically refers to the right to make reproductive health choices. Section 12 (1) of the Children's Act provides a protective framework that prohibits male circumcision under the age of 16 except when circumcision is religious or medical reasons.³⁷¹ Males over 16 years old may be circumcised for any reason except where it is for cultural reasons. Special protections have been put in place that need to be met, these include counselling, and a right to refuse to undergo a circumcision and specific standards relating to the persons who may perform a circumcision.³⁷²

For the purpose of this review the focus is specifically on the provisions in the law regarding medical male circumcisions. The law states that circumcisions can be done for medical reasons but does not expressly provide a definition of the term 'circumcision for medical reasons', neither does the law provide for who must consent for circumcisions under 16 when they are done for medical reasons. Similarly, the Consolidated Regulations Pertaining to the Children's Act do not give any further details on the meaning of medical circumcisions nor does it provide a specimen consent form for the consent process for a circumcision done on the basis of medical reasons.³⁷³ The law states that circumcisions done for medical reasons must be done on the recommendation of a medical practitioner but the regulations do not provide any further guidance regarding this form of circumcision.³⁷⁴ This has resulted in uncertainty regarding whether or not circumcisions to prevent future exposure to HIV is a justifiable reason for a boy below the age of 16 to be circumcised.³⁷⁵

Although the Children's Act does not expressly use the terminology 'best interests of the child' it is clear that the drafters have articulated the circumstances and the manner in which it would be in the best interests of the child and thus permissible for a boy below the age of sixteen to be circumcised.³⁷⁶ It is clear that the drafters wish to protect younger boys who may not have the capacity to consent on their own to a circumcision and are vulnerable to a decision being imposed on them. By limiting the

³⁷¹ Section 12 (1) of the Children's Act (note 53 above).

³⁷² Ibid. See also Chapter 3 and 4 for more detail.

³⁷³ AE Strode, JD Toohey and CM Slack 'Addressing legal and policy barriers to male circumcision for adolescent boys in South Africa' (2016) *The South African Medical Journal* 106 (12) 1174. See also AE Strode & C Slack, 'Selected Ethical-Legal Norms in Child and Adolescent HIV Prevention Research in South Africa: Consent, Confidentiality And Mandatory Reporting' (2014) Pietermaritzburg: HAVEG available at: <http://www.saavi.org.za/haveg/selective.pdf>, accessed on 26 January 2017. Regulations for Children's Act (note 206 above).

³⁷⁴ The Children's Act: General regulations regarding children (note 192 above).

³⁷⁵ Strode et al (note 374 above); see also Strode & Slack (note 374 above) , and Strode et al (note 374 above).

³⁷⁶ Section 12 (1) of the Children's Act (note 53 above).

requirement of parental consent to defined circumstances where it is religious or medical reasons.³⁷⁷ The law does make provision for a child to participate in any matter concerning him.³⁷⁸ Furthermore, the Children's Act is clear about a boy's right to refuse a circumcision depending on his level of maturity and age, which reinforces the best interests of the child standard.³⁷⁹

The right to privacy is protected as at the age of 16 a boy is able to consent to circumcision without parental involvement.³⁸⁰ However, boys below the age of 16 do not enjoy the same right. This may be a problem where the national public health response requires a mass roll-out of medical male circumcision for HIV prevention in circumstances where boys are below 16.³⁸¹

In terms of the legal framework, the law is respectful of child oriented human rights and intends to provide protective measures for male circumcisions because it recognises that the circumstances in which the circumcision on younger boys (below the age of 16) may be performed should be limited because their ability to participate in this decision is limited.³⁸² It sets the age of consent to circumcision at 16, which is higher than the age of consent for many other SRH services. This is in recognition of the fact that this is a decision that requires more mature capacity than does a decision around obtaining condoms. In addition, the inclusion of the requirement of counselling before the procedure helps protect and enhance a child's participatory rights. There is a lot of literature regarding the role boys should play in deciding whether or not to be circumcised. There has been a shift towards ensuring that this decision is not made by parents alone and the way the provisions in the Children's Act have been drafted reflect this. Nevertheless, requiring counselling also ensures that boys make informed choices.³⁸³ The main aim of this law is to provide protection for older boys who are circumcised for cultural reasons.

The major barrier to access to male circumcision is the law that requires boys who are under 16 years seeking circumcision for medical reasons being required to use the services of a medical practitioner. Health care workers may find it difficult to apply consent procedures for boys aged 12 – 15 years old as there is no clarity in the law specifying who may consent and the circumstances that qualify as a

³⁷⁷ Ibid.

³⁷⁸ General regulations regarding children (note 192 above)

³⁷⁹ P Mahery and P Proudlock *Legal guide to age thresholds for children and young people* 5th edition (2011) 32.

³⁸⁰ Ibid.

³⁸¹ The Children's Act: General regulations regarding children (note 192 above)

³⁸² Sections 9, 10, 12 of The Children's Act (note 53 above)

³⁸³ There has been much discussion and debate about circumcision as a human rights issue. It is clear that the drafters of legislation have made some consideration to protect boys from making uninformed decisions regarding their own circumcision, but the issue remains controversial.

medical reason for the circumcision. The provisions in the Children's Act and the Regulations to the Children's Act do not speak clearly to each other in this regard. Since male circumcision is regarded as a high impact HIV prevention tool the law requires reform on circumcisions for medical reasons where boys are below the age of 16 years old as it would be difficult for health care workers to interpret these rights when such adolescents request medical circumcision.

Currently the policy framework for medical male circumcision can be found in the MMC Guidelines. The MMC guidelines provide for how circumcisions are generally performed and provide information for parents (for boys under the age of 16 years old) and information for boys who are older than 16 years old. The MMC guidelines make provision for adolescent males who request a circumcision to the effect that health care workers attending to the same must respond in such a way that does not conflict with the law and which takes into account the confidentiality of the adolescent.³⁸⁴ The MMC guidelines requires health care workers to be familiar with consent laws and requirements involving male children, including the age and circumstances where adolescent males may independently consent to circumcision without their parents involvement.³⁸⁵ Health care workers providers may be justifiably confused regarding the law and policy because the law implies that an adolescent may consent to his own circumcision and the policy implies that parental involvement may be required.³⁸⁶

The policy provides guidance on the ages at which a male child may consent to circumcision autonomously (which is dependent on different types of procedures). This includes adolescent boys who have sufficient maturity to understand all the risks and benefits linked to circumcision.³⁸⁷ Informed consent is a key requirement for boys of an independent consenting age, irrespective of parental involvement, and the child's confidentiality must be respected.³⁸⁸ Likewise the MMC guidelines promote

³⁸⁴ MMC Guidelines (note 241 above) 3-6

³⁸⁵ MMC Guidelines (note 241 above) 1-2.

³⁸⁶ Strode et al (note 374 above).

³⁸⁷ A Strode, C Slack & Z Essack, 'Child consent in South African law: Implications for researchers, service providers and policy-makers' (2010) *South African Medical Journal* 100(4) 247-249.

³⁸⁸ MMC guidelines (note 241 above). See also The United Nations Committee on the Rights of the Child. *General Comment No. 3: HIV/AIDS and the rights of the child*. Thirty-second session, January (2003 (UN Document CRC/GC/2003/3) para. 20 'Children are more likely to use services that are friendly and supportive, provide a wide range of services and information, are geared to their needs, give them the opportunity to participate in decisions affecting their health, are accessible, affordable, confidential and non-judgmental, do not require parental consent and are not discriminatory.'

the best interest of the child standard and recognise that the child's evolving capacity and ability to make autonomous decisions are to be recognised.³⁸⁹

The MMC guidelines provide that counselling must be provided before and after the circumcision.³⁹⁰ It also provides documentation relating to the provision of informed consent for circumcision (including the provision of information relating to the risks and benefits of the procedure in an understandable manner) and it also provides that the adolescent be given sufficient opportunity and time to ask questions before signing the consent form.³⁹¹ In addition, the MMC guidelines promote the introduction of medical male circumcision into traditional circumcisions by way of linking the ceremony to a local anaesthetic procedure.³⁹² The policy is respectful and protective of human rights in all respects except on the issue of boys over the age of sixteen being able to consent independently.³⁹³

5.6.3. How can the best possible combination of law and policy facilitate further the main public health agenda?

There would be a better HIV public health balance if the law and policy framework expressly stated that MMC as a HIV prevention tool is a legitimate health reason for circumcision in boys under 16 years. Also, there would be a better balance if the policy provided clarity regarding independent consent by boys of 16 or over to medical circumcisions.

5.6.4. Does the law or policy facilitate adolescent access to HIV prevention?

In regard to the facilitation of adolescent access to HIV prevention in the form of circumcision, there is great focus on human rights rather than public health and thus there is a degree of imbalance between the various instruments. However, harmony could be achieved if there was a proper interpretation which allowed for seeking consistency in the meaning of the Children's Act and MMC guidelines. The protective framework for male circumcisions for boys in the Children's Act is important given that many

³⁸⁹ MMC Guidelines (note 241 above) 3-5.

³⁹⁰ Ibid.

³⁹¹ Ibid.

³⁹² MMC guidelines (note 241 above) 3-19.

³⁹³ Strode et al (note 374 above) 1174.

boys die or are seriously injured every year from botched traditional male circumcisions. However, the roll out of medical male circumcision may be even further facilitated if barriers regarding parental involvement, consent and definitions for medical reasons (as discussed above) were removed.³⁹⁴

5.6.5. Discussion

The public health intervention for the implementation of medical male circumcision is a key method to addressing the spread of HIV infection amongst adolescents.³⁹⁵ It has been cautioned that male circumcision for HIV prevention alone cannot protect against HIV infection. There is recognition however that together with other HIV prevention methods, such as the consistent and correct use of condoms, would serve the most effective barrier to protection against HIV infection.

The law and policy framework provides a protective framework for boys in regard to the manner in which circumcisions take place. However, on close examination, there are some challenges that lie within these frameworks that may cause a barrier to adolescent access to this essential HIV prevention tool.

It is important, given the many detrimental outcomes of circumcisions for traditional or cultural purposes, that the law (in line with s 12(2) of the Children's Act) creates a special protective context in which such circumcisions occur and which prohibit such circumcisions to take place unless it is for religious or medical reasons where it concerns boys below the age of 16. For the purpose of the study, this discussion only focusses on circumcisions for medical reasons.

There are a number of aspects of the law outlining the conditions that must be met for circumcisions conducted for 'medical reasons' to take place, but some aspects of the law leave room for uncertainty. Firstly, the law does not expressly state who can consent to the medical circumcision when the boy is below the age of 16.³⁹⁶ Secondly there is no definition in the legal provisions for the term 'medical reasons' which leaves ambiguity as to whether circumcisions carried out in anticipation of future exposure to HIV is a justifiable medical reason to perform circumcisions on boys under the age of 16. While boys above the age of 16 may consent to their own circumcisions for any reason, the law is not clear on whether boys below the age of 16 have the same right concerning medical circumcisions because

³⁹⁴ Ibid.

³⁹⁵ AVERT (note 132 above).

³⁹⁶ Strode et al (note 374 above) 1175.

it is unclear whether the term ‘health reasons’ encompasses a circumcision for HIV prevention purposes. This can be regarded as a challenge and may be considered a barrier to the public health imperative to roll-out medical male circumcision for the purposes of the prevention of HIV infection.

Currently the policy framework provides comprehensive guidelines on how circumcisions for medical reasons can take place concerning boys below the age of 16 and for those boys older than 16.³⁹⁷ However, the policy seem to indicate that medical circumcision is a surgical procedure and thus boys would require parental involvement which implies that circumcisions conducted for HIV infection prevention require a parent to be involved and thus could be considered a barrier to achieving the main public health agenda.

While it appears that in most areas of the law and policy framework, they are protective and respectful of a child’s human rights there are aspects that require attention in order to achieve an enabling environment for public benefit. For example, there is ambiguity between law and policy regarding the circumcision of boys below the age of 16 for medical reasons and there is also a lack of clarification as to what qualifies as a medical reason for circumcision. It is recommended that law reform take place to strengthen the existing framework and to ensure that the law better addresses what the circumstances are to allow for circumcisions for health reasons and to include that circumcision for the purposes of HIV infection prevention (concerning boys below the age of 16) is a justifiable reason to perform the circumcision. Heywood opines that offering medical male circumcision as a HIV/AIDS preventative measure is definitely for medical reasons and is in the best interests of the child and constitutes basic health care.³⁹⁸ Furthermore, Heywood suggests that the Constitution provide that a decision concerning a child must always be in the best interests of the child and argues strongly that the decision to circumcise is in the best interest of the child.³⁹⁹

More recently, it has been argued that ‘...HIV prevention is a valid medical reason for a circumcision in line with previous discussions asserting the term ‘medical reasons‘ should include HIV prevention.’⁴⁰⁰ Still there are counter arguments against this in that ‘...a circumcision has to be for a current medical reason and not a possible future one.’⁴⁰¹ This study suggests that HIV prevention should be recognised

³⁹⁷ MMC guidelines (note 241 above) 3-11.

³⁹⁸ M Heywood ‘Preventing mother-to-child HIV transmission in South Africa: background, strategies and outcomes of the Treatment Action Campaign case against the Minister of Health’ (2003) *South African Journal of Human Rights* 19 278–315.

³⁹⁹Section 28(2) of the Constitution of the Republic of South Africa, 1996.

⁴⁰⁰ Strode et al (note 374 above) 1175 and also Vawda and Maqutu’s (note 48 above) 38.

⁴⁰¹ McQuoid-Mason (note 47 above) 284.

as a legitimate health reason for the circumcision and thus that law and policy should expressly provide further guidance dealing with circumcisions for HIV prevention, given the enormity of the HIV epidemic and the potential for such circumcision to facilitate the public health benefit.

It is thus suggested that there should be law reform of the Children's Act to facilitate access this key HIV prevention options as being for a legitimate health reason. In the case of under 16s the Act should spell out who can consent for medical circumcisions. It is also recommended that the Regulations should specify the minimum standards that should be followed in the procedure so as to ensure that medical circumcisions are conducted similarly to conducted for religious or cultural reasons.⁴⁰² The Regulations should also include a form that is designed to document the consent process to the circumcision for a health reason.⁴⁰³ Lastly, it is recommended that the national guidelines provide that HIV prevention be regarded as a valid 'medical' reason for circumcision on boys under 16 and should be revised to be much clearer about the consent required, similar to what would be required in the Children's Act. It is also recommended that future empirical research be conducted to establish how stakeholders, such as health practitioners, are interpreting the relevant legal provisions.

5.7. Application of the Impact Assessment and Four Key Child- Oriented Rights of Adolescent Access to Future Potential HIV Prevention Tools which is Limited to a Microbicide and HIV vaccine⁴⁰⁴

5.7.1. To what extent does the national response meet 'good' public health standard?

The national response does meet a good public health standard because it includes provision for potential implementation of scientifically proven HIV, STI prevention strategies, such as vaccines and microbicides.⁴⁰⁵ This indicates that government acknowledges that further work needs to be conducted in these efforts for effective and evolving national response in developing strategies for implementation. However, the NSP does not specifically refer to whether the state will roll these out to adolescents. Accordingly, there is no goal towards addressing the legal and policy framework to ensure that there is adolescent access to vaccines and microbicides, as well as other related HIV/STI prevention strategies.

⁴⁰²Strode et al (note 374 above) 1175.

⁴⁰³Ibid.

⁴⁰⁴Although PREP is available as an HIV prevention method, it was not expressly referred to in this study methodology thus it does not fall within the scope of this dissertation.

⁴⁰⁵NSP (note 24 above) 43.

5.7.2. *Is the law or policy respectful and protective of the child-oriented human rights?*

There is no legal framework setting out provisions relating to the access of adolescents to either a vaccine or a microbicide. The only potential Constitutional right providing for this would be the right of children to basic health care services.⁴⁰⁶ It is not clear at this point whether either of these potential new HIV products, the vaccine or microbicide, would fall within the definition of primary health care, thus entitling children to access them through the state. The Children's Act does not expressly refer to consent being required for children to access such prevention interventions. It does however, deal with children consenting to medical treatment.⁴⁰⁷ This means that children would only be able to consent independently to either a HIV vaccine or microbicide if it could be argued that they are a form of medical treatment.⁴⁰⁸ If they are a form of medical treatment then children would be able to consent to them from the age of 12 years old provided they have sufficient capacity.⁴⁰⁹ If this was the interpretation adopted, the law would be facilitative of access to these new products.

The current policy framework does not provide for access to future HIV prevention tools such as HIV vaccine or microbicide access for adolescents. However, the policy framework does include reference to a HIV vaccine in the EPI Schedule and makes it available either in the birth to 12 years schedule or in schools, which a parent would have to consent to before it was provided.⁴¹⁰ Today many more vaccines are listed in the programme.⁴¹¹ Before a vaccine is added to the list, a number of important considerations are taken into account for example, the efficacy of the vaccine, the burden of the disease which the vaccine will be used against, the implementation and cost implications and whether it should be listed into the national EPI Schedule.⁴¹²

Additionally, the policy framework is silent on protecting rights of access to new prevention methods which may yet be developed and only refers to medical treatment and operations. Currently there is no clarity as to whether microbicides and vaccines fit into these categories.

⁴⁰⁶ Section 27 of The Constitution, 1996.

⁴⁰⁷ Section 129 of The Children's Act (note 53 above).

⁴⁰⁸ Strode et al (note 212 above) (article still with authors).

⁴⁰⁹ Section 129 (2)(a) of The Children's Act (note 53 above).

⁴¹⁰ EPI (note 273 above) 19-22.

⁴¹¹ Ibid.

⁴¹² Ibid.

5.7.3. How can the best possible combination of law and policy facilitate further the main public health agenda?

The public health response is thus currently limited in this regard. There is no relevant legal and policy framework except regarding vaccines (for example, the EPI schedule). The law in this case would be regarded as protective because parental consent would be required to access such interventions; this is because, having no law or policy which addresses whether children have the capacity to consent independently means that parental consent for any of these interventions is required until the child is 18 (in other words laws create exceptions to the general rule that children have limited capacity until they are majors).

5.7.4. Does the law or policy facilitate adolescent access to HIV prevention?

The law and policy framework's lack of clear provisions on adolescent access needs to be addressed in order to determine when it would be appropriate for a child to consent independently to a HIV prevention tool such as an HIV vaccine or microbicide. In the future, it means that there needs to be consideration for child-specific rights to ensure that there is proper balance between health and human rights (for example the inclusion of the best interest standard, a child's right to participation, and the right to confidentiality).

5.7.5. Discussion

According to a review conducted, vaccinations could be regarded as medical treatment.⁴¹³ As such, the provisions for medical treatment would then apply to vaccinations which means that parental consent is not required for a child to be so vaccinated, provided the child has sufficient maturity to consent and has the mental capacity to understand the benefits, risks and social implications of the treatment.⁴¹⁴ For children under 12 or children over 12 but insufficiently mature to consent, a parent or guardian or caregiver must consent on the child's behalf. The Medicines and Related Substances Amendment Act 72 of 2008 has amended the age at which a child can be supplied with Schedule 2 substances (which includes vaccinations) to the age of 12 years old which corresponds with the age of independent consent to medical treatment as set out in the Children's Act.⁴¹⁵

It has been argued that parental consent laws in many contexts create barriers to adolescent access to SRH services, including future HIV prevention tools as they restrict adolescent access without the involvement of a parent or caregiver.⁴¹⁶ Parental consent is also an issue where adolescents do not have parents or do not reside with their parents (e.g. children living in child-headed households).⁴¹⁷

5.8. Conclusion

This chapter has reviewed the current legal and policy framework regulating adolescent access to HIV prevention modalities which appear to be both respectful and protective of the four child-oriented rights which are aimed toward facilitating the available HIV prevention modalities. However, on closer examination, there appear to be a number of aspects within the law and policy framework that need to be addressed. For instance, the law and policy framework on HIV education and information and the future implementation of new technologies is non-existent and weak and potentially create barriers to adolescent access. Other areas of the law and policy such as HIV testing and counselling, condom, and male medical circumcisions may require more clarity and harmony between law and policy so that ambiguities and confusion are eliminated when applying them; as well as requiring clear definitions that

⁴¹³ Strode et al (note 212 above) (article still with authors).

⁴¹⁴ P Mahery and P Proudlock *Legal guide to age thresholds for children and young people* 5th edition (2011) 24-25.

⁴¹⁵ Ibid.

⁴¹⁶ Pettifor et al 'A cluster randomized-controlled trial of a community mobilization intervention to change gender norms and reduce HIV risk in rural South Africa: study design and intervention' (2015) *BMC Public Health* 15(752) 83.

⁴¹⁷ Delaney-Moretwe et al 'Providing comprehensive health services for young key populations: needs, barriers and gaps' (2015) *Journal of the International AIDS Society* 18(Suppl (1): 19833.) 35.

take into account a range of circumstances which adolescents in the South African context are faced with - such as children who are not attending school, child-headed households, and children who would access HIV self-test kits.

Chapter six concludes this review and provides an assessment of the strengths, weaknesses, gaps and challenges identified in chapter five and makes recommendations for legal development and reform to enable adolescent access to current and future HIV prevention interventions, thus serving as critical enablers that would further the strategic and effective implementation of the public health agenda.

CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

6.1. Background

HIV/AIDS is still one of the major leading causes of deaths in the world with approximately 36, 7 million people living with HIV/AIDS and 2, 1 million new infections in 2015.⁴¹⁸ Although the global health plan to scale-up access to health care services and programmes has resulted in an increase in use of various HIV prevention methods and the rate of infection has decreased, there remains a high incidence rate amongst key populations. This is owing to a number of factors particularly in countries lacking resources and limited access to HIV prevention, treatment and care interventions.

Adolescents in South Africa are particularly vulnerable with recent statistics indicating that the incidence of HIV infection among young people seems to have increased⁴¹⁹ Thus adolescents remain one of the key focus population groups in terms of rate of infection owing to a number of complex factors including risky sexual behavior patterns such as transgenerational and transactional sex.⁴²⁰ Additionally, as discussed in chapter one, adolescents are challenged by, amongst many other issues, their changing psychosocial, cognitive, physiological, and neurological issues. As such there is an urgent need for action

⁴¹⁸ Joint United Nations Programme on HIV/AIDS, 'Global Fact Sheet' (November 2016) UNAIDS, available at: <http://www.unaids.org/en/resources/fact-sheet>, accessed on 09 January 2017.

⁴¹⁹ Staff Writer 'Risk of HIV and Aids remain alarmingly high among SA teens' in *SA Breaking News* 01 February 2016 available at: <http://www.sabreakingnews.co.za/2016/02/01/risk-of-hiv-and-aids-remain-alarmingly-high-among-sa-teens/>, accessed on 09 January 2017.

⁴²⁰ Ibid. 'This age-sex disparity in HIV acquisition continues to sustain unprecedentedly high incidence rates, therefore preventing HIV infection in this age group is a pre-requisite for achieving an AIDS-free generation and attaining epidemic control.'

in developing and implementing effective targeted package of HIV interventions that responds to the specific needs of adolescents to help reduce their risk of infection.

While South Africa's national public health response has made considerable progress in its efforts to reduce HIV acquisitions amongst this vulnerable group, there are still a number of gaps and weaknesses that remain in the legal and policy mechanisms that have been established which could better serve to facilitate the public health response.

Given the magnitude of the situation and impact the risk of infection has on adolescents it is essential that steps to prevent new infections take place. This means that it is not sufficient for the national response to make available HIV prevention services, but also to ensure that these services are accessible for adolescents. The current South African public health response to HIV prevention is based on the current National Strategic Plan for STIs HIV and TB for 2012-2016, the NSP. The NSP includes a comprehensive package of prevention services that takes into account the global developments on HIV prevention. This includes making available and accessible to key populations' such as children, critical interventions aimed at reducing the effects of HIV and are to be implemented in a manner that is driven by respect and protection of human rights, including dignity, and privacy, recognizing that children have rights.

As such critical interventions, such as access basic education on HIV in schools, HIV testing and condoms are therefore key to reducing the effects of HIV to prevent further increase of the spread of the disease. It is important to note that since health is an important element in a thriving society, it is critical that when government responds to an epidemic such as HIV/AIDS, the legal and policy framework and policies play a major role in the success of an effective public health standard. WHO states that laws and policies are critical enablers of the public health agenda and have the potential to either promote access to HIV prevention methods or further exacerbate the spread of the disease where there are over-protective or restrictive provisions in the framework which prevent access to essential health care services. Furthermore, it has been noted that any limits on human rights must be justifiable in terms of the Section 36 limitations in the constitution. Given the reform on national legal and policy framework to make provision for the realisation of SRHRs, it is thus essential for systematic review as to determine whether laws and policies meet the standard set out in the NSP.⁴²¹

⁴²¹ Han (note 41 above) 25.

At the outset of this thesis it was highlighted that, at a glimpse, many aspects of the South African legal framework enable adolescents to access HIV prevention methods. However, to date, there has been no in-Dept.h analysis of the extent to which the South African legal and policy framework facilitates access to HIV prevention for adolescents.

The examination in this study is important as previously stated since statistics indicate that adolescents remain at high risk of HIV acquisition. Furthermore, as shown above, laws and policies can have a direct impact on facilitating public health interventions. This analysis has been conducted to identify strengths and weaknesses, challenges and gaps within the legal and policy framework describing children's rights (including their SRH rights) and to explore the extent to which the framework's ability to promote access to future intervention methods. In addition, the outcomes of this review make recommendations for law and policy reform where needed. This study has not assessed the extent to which the framework is implemented in practice.

The review applied to a selection of five HIV prevention methods taken from the NSP which included access to

- a. information and education on HIV
- b. voluntary HIV counselling and testing
- c. condoms
- d. medical male circumcision and
- e. future HIV prevention technologies such as a microbicide and an HIV vaccine.

Throughout this review, it is argued that child protection laws, and the national policy framework ought to facilitate children's access to HIV prevention interventions and draws on specific human rights areas relating to children in four overarching key child- oriented which include:

- i. the best interests of the child standard;
 - ii. the right to dignity, privacy, bodily and psychological integrity;
 - iii. the right to freedom of expression, opinion and participation in all matters concerning the child;
- and

- iv. the right to the highest attainable standard of physical and mental health. More specifically that children have rights and are not merely the possessions of their parents.⁴²² Bearing in mind that both child-centred and other rights may be limited or prohibited, but this must be justified and rationally connected to the extent of its purpose.⁴²³

The review in this study has been framed around the Impact Assessment.⁴²⁴ This model has been found to still useful and has been adapted to assess what the strengths, weaknesses, challenges, and gaps between the public health interventions against the legal and policy framework, specifically for adolescents. This study has revealed that there are many aspects in the legal and policy framework in South Africa are strong, which in fact provide an enabling environment for adolescents to access HIV prevention interventions. Thus, promoting and protecting adolescent sexual and reproductive rights. The Impact Assessment based on four crucial questions and adapted slightly to include an assessment of both laws and policies against the public health response and key child-specific human rights included

- a) To what extent does the standard represent ‘good’ public health?
- b) Is the policy or law respectful and protective of the child-oriented human rights (including access to adolescent SRHR services)?
- c) How can the best possible combination of policy and law facilitate further the main public health agenda?
- d) Does the law or policy facilitate adolescent access to HIV prevention?⁴²⁵

6.2. Introduction

Chapter five provides a systematic review of the existing legal and policy mechanisms in determining whether the current law and policy framework have developed to such an extent to make provision for realising adolescent sexual and reproductive health rights (ASRHRs) to HIV prevention by applying a human rights approach for adolescent access to existing and proven experimental HIV prevention interventions. Thereby acting as a critical enabler to the existing public health agenda.

⁴²² Pilcher and Wagg (note 55 above) 36.

⁴²³ Ibid.

⁴²⁴ Mann and Gostin (note 56 above).

⁴²⁵ Mann (note 58 above) 54.

Chapter six provides an overview of the main study findings, conclusions and recommendations for possible future law and policy reform.

6.3. Summary of key findings

Based on this review the study is able to make the following findings:

6.3.1. The legal and policy framework on access to education and information relating to HIV prevention is adequate only with regard to school going youth

In general, it would appear that both it would appear that both the law and policy framework meet the public health standard halfway regarding access to education and information on HIV prevention. It is argued that the most significant failures in this area (a) there is no right prevention information in the Children's Act and (b) policies do not fully address reaching youth out school.

6.3.2. The legal and policy framework deals directly with 3 HIV prevention methods (testing, condoms and male circumcision) and this facilitates access by adolescents over 12

In general, the law and policy framework is well provided for with regard to access to HIV testing and counselling, condoms and for male circumcision. It appears that there has been much progress on the development of law and policy on HIV testing and counselling, condoms, and male circumcision and can be understood that in all three of the HIV prevention modalities that there are express provisions for adolescent access to these HIV prevention tools. Furthermore, the law and policy framework appear to be in sync and mostly clear regarding adolescent access to these three HIV prevention tools. Thus, the legal and policy framework on HIV testing and counselling, condoms and male circumcision is good.

6.3.3. The failure of the Children's Act to expressly deal with prevention services leaves a gap regarding the age at which children can independently consent to such interventions

The Children's Act focusses on health interventions which are therapeutic in nature and it does not create an additional category for non-therapeutic or preventative health interventions. There does however,

appear to be a lack of provisions in law and policy regarding access to future prevention methods such as a microbicide and an HIV vaccine.

6.3.4. There are a number of legal and policy strengths within the framework

The law expressly deals with three of the five prevention interventions, namely HIV testing and counselling, condoms and circumcisions. All three are protective and promote child participation rights. Other rights such as confidentiality and privacy are also accounted for which enables adolescent access to these current public health tools. There appears to be a good balance between public health and child-specific rights on all three HIV prevention interventions. The age of consent to most of these interventions is set at early adolescence (12) and this is generally before the age of sexual debut. The law relating to underage sex has also recently been reformed thus bringing it in line with the ages of consent to various other HIV prevention methods. Given that it is no longer a criminal offence for children between the age of 12-15 to have peer sex, there is now synchronicity between the criminal law and the Children's Act which allows access to most SRH services from 12.

6.3.5. There are a number of gaps and weaknesses in the legal and policy framework

Access to education and information on HIV prevention appears to be hindered by parental consent which is required for Life Orientation Skills programme in schools. Furthermore, the provisions on education and information on HIV prevention for adolescents in the legal framework are too general.

Access to HIV testing ranks high with regard to the provisions in both law and policy on the best interests of the child standard and could possibly be seen as too high in some respects such as an over focus on human rights to the detriment to the public health standard. In other words, the focus is heavily weighted in favour of creating protection and thus overly protective and undermines other rights such as Section 27 of the Constitution, which is the right to access health care services and the implications for the implementation of the public health response to combatting HIV infection. The policy on HIV testing in schools appears to be out of step with the law and thus an inconsistency in the framework with regard to the age of consent to HIV testing being 14 years (in the policy framework versus 12 years (in the law), which can serve as a barrier due to the conflict in law and policy framework. Additionally, new innovative developments to HIV testing models such as self-testing may be hindered by the legal and

policy requirement of pre- and post-test counselling where test kits are available to adolescents in pharmacies and online orders.

At present adolescent access to condoms are not made readily available in school. However, if condoms were readily available at schools there may be critical barriers to the right to access condoms such as making children go to the school clinic for condoms. On the one hand this reflects an inconsistency regarding a child's autonomy which is provided in the law to access condoms on the one hand they cannot get condoms from the school clinic unless they have parental permission. Thus, the full implementation of the right to access condoms is frustrated and therefore has potential to act as a barrier to adolescent access to condoms.

Adolescent access to male circumcision for medical reasons, in instances where the circumcision is for HIV prevention methods is undermined by the gaps and lack of synchronization between the law and the policy framework. Thus, adolescent access to male circumcision for HIV prevention reasons could be hindered due to the inconsistency between law and policy framework.

This study highlights the possible involvement of adolescents in HIV biomedical prevention methods such as a microbicide and an HIV vaccine and the acknowledgement in the scientific environment that key to the development of future technologies is the involvement of adolescents.⁴²⁶ While there have been a number of unsuccessful outcomes to studies for an effective microbicide, '...there are many promising ones currently in pre-clinical studies and in clinical trials.'⁴²⁷ As such a number of barriers have been identified that are lacking in both law and policy to adolescents in HIV prevention research. Currently South African legal and policy framework is silent on any protection and promotion of child-specific rights to adolescent involvement to biomedical research. Gaps in the law include express provision on participation in biomedical research, consent to enrollment, confidentiality, mandatory reporting duties on those interacting with adolescents, and whether the legal and policy framework is either too broad or too restrictive of child participation. Thus, creating a lot of uncertainty and a lack of

⁴²⁶ HB Jaspan... et al 'Protecting South Africa's children from HIV; giving them our best shot' (2005) *South African Journal of Science* 36(1)216; H Jaspan... et al 'Inclusion of adolescents in preventive HIV vaccine trials: public health policy and research design at a crossroads' (2008) *Journal of Acquired Immune Deficiency Syndrome* 47(1) 88; LG Bekker... et al 'Adolescents and HIV Vaccine Trials What Are the Clinical Trial Site Issues?' (2005) *Journal of International Association of Physicians AIDS Care* 4(4) 93; CA McClure... et al 'Challenges to conducting HIV preventative vaccine trials with adolescents' (2004) *Journal of Acquired Immune Deficiency Syndrome* 36(2) 733.

⁴²⁷ KB Alexandre. et al. 'Progress and Perspectives on HIV-1 microbicide development.'(2016) *Virology* 497 69.

awareness of provisions regulating children's participation in health research such as microbicide and vaccine trials.⁴²⁸ This means that adolescent access to new HIV prevention products may be hindered.

It appears that the NSP and the policy framework may present a gap in the public health standard as youth out of school are not accounted for as all provision deal with children who are school-based.

6.4. Recommendations for possible future law and policy reform

This study identified a key weakness in law and policy regarding adolescent access to education and information on HIV prevention. Recommendation for law reform include that that Children's Act could be amended to expressly include the right to adolescent access HIV education and information and for this right not to be dependent on parental consent.

With regard to adolescent access to HIV testing and counselling. The key finding identified earlier is that the best interests' standard creates a strong protection mechanism in both law and policy. In order to promote the law is slightly ambiguous as to whether parents must be involved in pre-and post-test counselling if they have knowledge of the HIV test (discussed earlier). Section 27 of the Constitution, the right to access health care services, it is recommended that law reform take place to address the conflict between the two-conflicting fundamental to appropriately response to the public health response to combatting HIV infection. Furthermore, it is recommended that policy reform take place to address the issue of HIV testing and counselling for those accessing HIV self-test kits to possibly be provided pre- and post- test counselling on the phone or online. Moreover, it is recommended that reform both law and policy framework be considered to address the conflict in age.

It is also recommended that there be greater access by on adolescents to condoms. In order for this right to be fully realized policy reform could include addressing the issue of parental consent in the Life Orientation Programme to enable, where in the future condoms are may be readily available to adolescents in the school clinics, to access these without parental permission.

The right to adolescent access to male circumcision for HIV prevention reasons where it may be hindered due to the inconsistency between law and policy framework needs to be addressed. It is thus

⁴²⁸ Z Essack...et al (note 50 above) 3.

recommended the law and policy framework be harmonized to be in line with the Children's Act since there is adequate, reasonable and justified reasons that circumcision as an HIV intervention is a medical reason and could be seen as a justifiable measure to protect public health.⁴²⁹

To improve the right to adolescent involvement in HIV biomedical prevention which currently remains unclear in the legal and policy framework, it is recommended that both the law and policy mechanisms be considered in light of both protection and promotion of child-specific rights for participation in biomedical research. As highlighted in the study findings, issues such as consent to enrollment, confidentiality, mandatory reporting duties on those interacting with adolescents, need to be express and clear in order to facilitate adolescent involvement and access to future HIV prevention interventions.

This study has identified two additional areas for reform. Firstly, both the NSP and policy framework appear to lack guidance addressing those youths out of school. It is recommended that policy reform take place to include provisions that focus targeting issues concerning out of school youth access to HIV prevention services. Secondly, it is important that health care professionals or those who will be providing health care services to adolescents are equipped with the correct resources, training and knowledge on how to deal with adolescents accessing HIV prevention tools. Currently, the obligation in the Sexual Offences Act with regard to mandatory reporting of underage sex acts as a barrier to adolescent access of HIV prevention services. As mentioned in Chapter five authors have argued that this obligation on health care professional and service providers violates the best interests of the child and their right to privacy. Recommendation for law reform include that the Sexual Offences Act be amended, where health care professionals and service providers have a mandatory reporting obligation, to rather provide for discretion in relation to circumstances where consensual sexual activity between adolescents below the age of 16 and over the age of 12 years has occurred. Furthermore, in line with authors Strode and Slack, where it was stated in chapter one, contend that the reporting requirement should only apply to 'exploitative' underage consensual sex. It is thus further recommended that policy reform take place to include provisions that set out how health care workers and service providers use discretionary power when instances for reporting of sexual offences are triggered, in circumstances concerning adolescents engaged in sexual activity where they are between the age of 12 and 16 years.

⁴²⁹Vawda & Maqutu. (note 48 above) 39-40.

6.5. Conclusion

This thesis aimed to review the current national and legal and policy framework on the SRH rights of children (excluding an empirical assessment the extent to which the framework is implemented in practice). Throughout this study, it has been stated that child laws and policies ought to facilitate children's access to HIV prevention interventions set out in the national HIV prevention plan and both law and policy must be inter-dependent and weighed against each other from a human rights perspective.

South Africa has the highest burden of the HIV/AIDS disease in the world and is the main cause of death amongst children aged 10-19 years which means that children are at increased risk and particularly vulnerable. This is fuelled by numerous related reasons such as early sexual debut, unprotected sex, inadequate sex education and limited access to health care. Thus, mechanisms which promote and protect children's sexual and reproductive health rights need to be assessed to determine whether laws and policies facilitate or create an enabling environment for a good public health standard. Given the need to ensure that there is improved access to child- and adolescent- friendly HIV health services and comprehensive packages it is important that issues around the conflicts, gaps, weaknesses in law and policy regarding when children can act autonomously concerning health care services be addressed.

This includes where the Children's Act, the Sexual Offences Act and policy contradict each other and create confusion. For example, children can legally access contraceptives from 12 years and yet are only legally allowed to consent to sex from the age of 16 (except for the recent ruling allowing for sex between consenting teenagers 12-15 years).⁴³⁰ Not only does it create confusion for educators and health care workers when counselling, providing information and services and under a legal obligation to comply with the law.

As such children below 18 years of age are considered vulnerable and deserving of special protections due to their youth, inexperience and susceptibility to peer pressure, amongst other reasons.⁴³¹ In South Africa, children under the age of 18 are legal minors and considered not fully capable of acting independently without the assistance of parents/legal guardians. However, in certain defined

⁴³⁰ Section 134 of The Children's Act (note 53 above).

⁴³¹ A Strode & C Slack, 'Sex, lies and disclosures: Researchers and the reporting of under-age sex' (2009) *Southern African Journal of HIV Medicine* 10(2) 8.

circumstances the law has granted minors the capacity to act independently, including in terms of their sexual and reproductive health (SRH) rights.⁴³² Sexual and reproductive health rights consistently feature across all branches of South African public and private law. Thus, children's SRH rights set out in the Children's Act, the Sexual Offences Amendment Act and any other related law and policies need to be aligned in order to ensure that children have the right to decide independently whether to confidentially access contraceptives (12 years and older) and the right to safer sex practices and to access sexual and reproductive health services.

In 2007, South Africa's new Children's Act came into effect expanding the scope of several existing children's rights and explicitly granting new ones.⁴³³ The Act gives to children 12 years and older a host of rights relating to reproductive health, including access to contraceptives and to information on sexuality and reproduction, and the right of consent to HIV/AIDS testing and treatment.⁴³⁴

In summary, there is clear evidence that South Africa has undergone major developments in the legal and policy framework in order to realise sexual reproductive health rights for children in line with the public health response to HIV prevention. Thus, it can be said that in general, the South African law and policy framework is facilitative of adolescent access to HIV prevention tools. However, under closer examination, efforts to improve the law and policy framework are still required. A critical challenge for HIV prevention efforts in adolescents is to ensure that these reproductive health rights are realized. Currently, for adolescents in South Africa, certain aspects of the national laws and policies may place limits to accessing HIV education and information, HIV testing and counselling condoms and circumcision and future HIV prevention methods and these aspects will require reform in order to promote the national public health agenda of combatting HIV.

⁴³² A Strode, C Slack & Z Essack 'Child consent in South African law: Implications for researchers, service providers and policy-makers' (2010) *South African Medical Journal* 100(4) 247-249.

⁴³³ Han (note 41 above) 0025.

⁴³⁴ Han (note 41 above) 25.

TABLE 1: SOUTH AFRICAN LEGAL AGE GUIDE RELATING SEXUAL AND REPRODUCTIVE HEALTH RIGHTS⁴³⁵

A child can independently consent to?	From what age	Applicable law
Condoms	12. A person may not refuse to sell or provide condoms to a child over 12.	Children’s Act 38 of 2005. Section 134(1).
HIV testing and counselling	12. If under 12 with sufficient maturity to understand benefits/risks/social implications of the test. For children under 12 who are not mature enough to consent: Parental or caregiver consent is needed.	Children’s Act 38 of 2005. Section 130
Circumcision	16. Note: Circumcision of a child 16 years or older can only be done if the child himself consented to the circumcision. Under 16: A boy under 16 can only be circumcised for religious purposes or medical reasons must be with both parents, or all guardians (if there’s more than one) consent to religious circumcision of a child under 16. A medical circumcision could be regarded as a surgical procedure and the age of consent for that is 12. The parent must assist the child to consent. Note: The Act indicates that every male child has a right to refuse to be circumcised depending on his age, maturity and stage of development.	Children’s Act 38 of 2005. Sections 12(8), (9) and (10). Department of Social Development. The Children’s Act: General Regulations regarding children: Government Gazette No 33076, Government Notice No 261, 1 April 2010. Regulation 6(3).
Vaccinations and immunisations	Vaccinations are regarded as medical treatment so the age threshold for medical treatment applies to children	Children’s Act 38 of 2005. Section 129. Communications with the legal unit of the

⁴³⁵This table is an adaption taken from P Mahery and P Proudlock *Legal guide to age thresholds for children and young people* 5th edition (2011).

	<p>requesting or requiring vaccinations without parental consent is 12. The child must also be sufficiently mature and have the mental capacity to understand the benefits, risks and social implications of the treatment. For children under 12 or children over 12 but insufficiently mature to consent: Parent or guardian or caregiver must consent on the child's behalf. Note: Amendments to the Medicines and Related Substances Act 101 of 1965. The 1965 Act has been amended by the Medicines and Related Substances Amendment Act 72 of 2008. The Amendment Act have changed the age at which a child can be supplied with Schedule 2 substances (which includes vaccinations) to age 12 to correspond with the age-threshold for medical treatment as set out in the Children's Act</p>	<p>Department of Health. April 2011. See also: Amendment of section 22A (4)(b) and 22A(6)(e) of the Medicines and Related Substances Act 101 of 1964. These provisions are to be amended by section 22 of the Medicines and Related Substances Amendment Act 72 of 2008. Note: At the time of publication, the 2008 Act has been passed by Parliament and signed by the President, but was not yet in operation.</p>
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