



# UNAIDS Global Reference Group on HIV/AIDS and Human Rights

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## Issue Paper

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### HIV Testing of Specific Populations: Children and Adolescents

#### Defining the Issue

The Convention on the Rights of the Child (CRC) conceptualizes the rights of children, their parents, and society in an interdependent and developmental fashion. To-date, all states but one have ratified the CRC<sup>i</sup>. The CRC places an obligation on governments to ensure that as children mature, they can take an increasing role in decisions affecting their capacity. It is this complex balance of rights and responsibilities among the state, parents, and children that frames and cuts across the human rights considerations of HIV testing for children and adolescents. Children are defined by the CRC as all individuals under the age of 18 unless otherwise stated in national law. Adolescents generally fit within this definition of children although the international community has recognized that adolescents can be as young as 10 and as old as 24.<sup>ii</sup> Recognizing that adolescents span a considerable age range, the capacities and development of a 10 year old--who may rely on his or her parents to seek testing--would likely be less evolved than that of a 16 year old-- who may seek testing and treatment on his or her own. This is a critical distinction which may or may not be reflected in testing policies. Discussion of the rights of the child in relation to HIV testing policies can usefully be framed with reference to two of the overarching general principles of the CRC: 1) the best interests of the child<sup>iii</sup>; and 2) a child's right to participate in decisions affecting his or her life as a function of his or her evolving capacities.

#### Access to HIV testing

*Knowing about HIV testing:* It is important to consider the extent of the state's duty to ensure the conditions under which children/adolescents, recognizing their evolving capacities, gender and other differences, might decide to voluntarily get tested and the content of what those conditions might be<sup>iv</sup>. Testing policies rarely articulate a strategy for promoting voluntary testing and counseling, although some National AIDS plans outline their outreach campaigns for specified populations, such as pregnant women, but rarely do they include their approach to children and adolescents.

*Accessing the test:* Testing policies may or may not specify who can access testing and under what circumstances. Some policies are silent as to who can access testing. Others, such as the National AIDS Plan of Malawi specifically place age restrictions on access: individuals under the age of 13 can only be tested if their parents or legal guardians consent<sup>v</sup>. Newborns and children through the ages of 9 or 10 are generally assumed to rely upon their parents or legal guardians for health care decisions (presumptively made in their best interests). It may therefore be appropriate that HIV testing only occur with their consent. As children progress towards adolescence, however, they may want to know their status. Law, by setting a bright line age standard, or policy (explicitly or tacitly) may be an impediment to

accessing an HIV test, as well as once testing has occurred, keeping the act of testing and the test results confidential. Such chronologically-based age limitations often do not recognize the child's evolving capacities, his or her right to participate, as well as his or her best interests.

There may be laws of general application that set a uniform age of legal capacity, usually 18 years of age. In some countries, the law sets an earlier age for consensual sex, such as 16, which is sometimes younger for girls. Where a testing policy prohibits children under a certain age, unless expressly authorized by his or her parents/legal guardians from accessing testing services, this may be supporting these laws, at variance with them, or it may be an official exception to the rule.

Some policies, such as those of the State of New York in the US, use a substantive enquiry, such as whether the child has capacity to understand what an HIV antibody test entails, the consequences of being HIV infected, and why he or she may be at risk for HIV, in lieu of a strict age standard. If the child can understand, a test is given and the results communicated to the child, and to the child's parents only with the child's permission. Similarly many countries have procedures through which exceptions to the aged-based legal capacity law can be made in certain circumstances, such as "judicial by-pass" mechanisms, or appointing ombudspersons (*guardian ad litem*) when obtaining informed consent from the adult legally responsible for the child is not possible.

Even when laws and/or policies may facilitate access to testing for children and adolescents by ensuring informed consent and confidentiality, social, cultural and moral norms may present barriers, particularly for adolescent girls. Gendered expectations regarding appropriate sexual behavior may limit girls' autonomy to seek out HIV testing, even where laws and policy provide for access.

### **Purpose of Testing**

Children and adolescents may be tested for HIV in the following circumstances:

- Shortly after birth (antigen detection tests) for preventive treatments
- Individual diagnosis in case of sexually transmitted or other illnesses
- When transmission of HIV in the health care setting is suspected
- Following reported sexual abuse
- In the course of pregnancy
- On admission to orphanages or other institutions
- Among street/vagrant children

Given the sensitivities and complexities that underlie all of the reasons why children may be tested for HIV, it is crucial that the purpose of HIV testing be considered. Testing policies are often silent and do not name the circumstances under which children/adolescents are tested or offered testing. Testing policies, unless otherwise clarified will presumably cover this entire range of possibilities. Thus the potential consequences of this ambiguity must be recognized. The focus of this paper will be on testing in health care settings.

## **Site of HIV Testing**

There are some specific concerns that routinely prescribed or offered HIV testing raises for children and adolescents beyond those raised for the general population. In most situations, the question of HIV testing occurs when children/adolescents access health services for other reasons. In the case of very young children, laws, policies, or protocols may require health care professionals to test all newborns, or all newborns born to HIV infected mothers, as is proposed by the US CDC. These may require informed consent of the parents, or may assume that consent is given, and they may or may not address issues of confidentiality.

Older children may only have access to an HIV test when they are brought into health services by their parents or legal guardians.<sup>vi</sup> Testing policies may expressly or tacitly give health care professionals discretion to offer an HIV test to a child (via his/her parents). Laws and policies relating to consent may vary; depending on the circumstances. Policies addressing adolescents in health services (whether they come on their own or with their parents) sometimes amalgamate them with children, or sometimes treat them separately. In the case of India, neither children nor adolescents are mentioned; other policies consider the needs of 13-24 year olds separately from children under the age of 13, calling for youth friendly testing services designed especially for them.

Once the test has taken place, how the confidentiality of a test result is protected (by law or policy), is a further concern. This is particularly salient where a mature child seeks out testing, and a law or policy requires that the results of the test be communicated to a third party, such as the state, an insurance company, or the child's parents. Testing policies may require the health care professional to obtain consent from the child to report the results, as by the State of New York, the policy may be silent, or the laws may set forth specific requirements.

## **Precondition to access HIV/AIDS-related care and support, and/or treatment**

Assuming that children and adolescents know their HIV status, they must also learn about the availability of health care services and treatment. Most testing policies require counseling sessions to refer the individual on to appropriate care and treatment. For younger children, it is assumed that their parents will be counseled and act in their best interests to obtain necessary care. For adolescents the situation may be more complicated and policies often are silent as to how to tailor the information to suit young people as their capacities evolve, failing also to recognize the implications of gender differences between boys and girls as to how they may receive this information. It is also worth noting that legal or policy barriers may result in adolescents not being able to consent to care and treatment even if they may consent to the HIV testing services.

## **Conclusion**

Laws, policies, and social norms may individually or in combination facilitate or impede access to testing and eventually treatment for children and adolescents. This can be the case even where laws and policies about testing are themselves silent about how they affect children and adolescents. In considering how to increase access to testing and treatment (with due regard to promoting and protecting human rights), it is important to question how all three – laws, policies, and social norms interact in a given situation.

## Supporting Documents

1. CRC General Comment 3 on HIV/AIDS. This could be accessed at:

<http://www.unhcr.ch/html/menu2/6/crc/doc/comment/hiv.pdf>

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<sup>i</sup> The United States has not ratified the CRC, although the principle of “best interests of the child” is part of its common and statutory law.

<sup>ii</sup> The 1989 joint WHO/UNICEF/ UNFPA definition of adolescents is 10-19, youth as 15-24 and young people as 10-19. See UNFPA. 1998. *Technical Report No. 43: the Sexual and Reproductive Health of Adolescents: a Review of UNFPA Assistance* and <http://www.un.org.in/Jinit/who.pdf>.

<sup>iii</sup> The doctrine of “best interests of a child” places the responsibility for ensuring that the rights of the child are ensured with the parent, legal guardian, or the state as *parens patriae*. As a child's capacity evolves, so does his or her right to participate in decision making.

<sup>iv</sup> Children who are in special circumstances—either in state or other run institutions (juvenile justice facilities, mental health institutions, foster care, refugee or IDP camps)—may require specific outreach initiatives. In all cases, child-friendliness is important in pre- and post- counseling sessions, as well as in services, care, support, and treatment.

<sup>v</sup> It does not specify if the consent should be written.

<sup>vi</sup> Emergency circumstances may obviate the legal necessity to obtain consent, based on the notion of implicit consent to interventions to save life and health in an emergency; testing may be considered “necessary,” in these circumstances, in order to provide care. Testing facilities may operate within the official health care system, or by NGOs. The facilities may be stand alone centers that provide VCT; they may be part of venereal disease clinics, pre-natal health clinics, or family planning centers. It is possible that an older adolescent may chose to seek out testing at a VCT center.