Abstract

From a child rights perspective, HIV/AIDS serves to illuminate how cultural norms and legal precepts facilitate or constrain the protection of the child from HIV infection and from its individual and collective impacts. Recognition of human rights in the design, implementation, and evaluation of governmental policy can point the way toward actions which are not only necessary but, in public health terms, most effective. This article summarizes the three situations—children infected, affected, and vulnerable—and three levels of governmental obligations—to respect, protect, and fulfill rights—which should be considered when identifying children's specific needs and rights in the context of HIV/AIDS. The article then proposes a method to analyze systematically the confluence between HIV/AIDS and children's rights, creating opportunities for a synergy between those involved in HIV/AIDS prevention, care, and research, and others engaged to the promotion and protection of the rights of the child.

Du point de vue des droits de l'enfant, le VIH/SIDA révèle comment les normes culturelles et les lois en vigueur favorisent ou restreignent la protection de l'enfant à l'égard du VIH et des conséquences de la pandémie sur le plan individuel et collectif. La prise en considération des droits de la personne dans l'élaboration, la mise en oeuvre et l'évaluation des politiques gouvernementales peut nous aider à déterminer les actions qui sont non seulement nécessaires, mais aussi les plus efficaces en termes de santé publique. Cet article résume les trois situations—enfants infectés, affectés et vulnérables—et trois niveaux d'obligations gouvernementales—respecter, protèger et appliquer pleinement les droits de la personne—qui doivent être pris en considération pour l'identification des besoins spécifiques de l'enfant et de ses droits dans le contexte du VIH/SIDA. Cet article présente ensuite une méthode d'analyse systématique de la confluence entre la réponse au VIH/SIDA et les droits de l'enfant. Enfin, il permet d'entrevoir des actions synergiques pouvant être entreprises par ceux qui travaillent dans le domaine de la prévention, des soins et de la recherche sur le VIH/SIDA, ainsi que par ceux qui oeuvrent pour la promotion et la protection des droits de l'enfant.

Desde una perspectiva de los derechos de la infancia, el VIH/SIDA muestra cómo las normas culturales y las leyes en vigor favorecen o constriñen la protección de la infancia con respecto al VIH y a las consecuencias de la pandemia sobre el plano individual y colectivo. El reconocimiento de los derechos humanos en el diseño, aplicación, y evaluación de las políticas gubernamentales puede orientar hacia acciones que, no sólo son necesarias, sino más eficaces en términos de salud pública. El artículo resume las tres situaciones (niños/as infectados, afectados, y vulnerables) y los tres niveles de obligaciones gubernamentales (respetar, proteger, y garantizar los derechos humanos) que deben considerarse cuando se identifican las necesidades específicas de la infancia, así como de otros derechos relacionados en el contexto de VIH/SIDA. El artículo propone más adelante un método de análisis sistemático de la confluencia entre el VIH/SIDA y los derechos de la infancia. Este punto permite abrir el camino hacia acciones sinérgicas entre quienes trabajan en el campo de la prevención, cuidado, e investigación sobre el VIH/SIDA, y quienes se han comprometido con la promoción y la protección de los derechos de la infancia.

CHILDREN CONFRONTING HIV/AIDS: Charting the Confluence of Rights and Health

Daniel Tarantola and Sofia Gruskin

In 1990, as the devastating impact of HIV/AIDS epidemics on the lives of children was becoming more apparent, the first human rights document to focus specifically on the rights of children—the Convention on the Rights of the Child (CRC)—came into being.[1] The availability of this document, ratified within a few years by almost every nation in the world, shed new light on government responsibility for ensuring that children no longer be the objects of decisions affecting them, but subjects taking an increasing role in these decisions as their capacity to do so evolves.[2]

Every day around the world 1,500 children are born with HIV infection, 90 percent of them in the developing world.[3] In addition, an unknown number of children through the age of 18 acquire HIV infection from unsafe blood and blood products, unsterile medical injections performed inside and outside formal health care settings, the sharing of needles in illicit drug use, and through sex, including sexual abuse. Although these modes of HIV transmission are the same as those affecting adults, the very construct of childhood forces us to consider them from another perspective.

The complex relationship of children to adult support and decision-making has often been hidden by a tendency to regard children as a homogeneous entity, regardless of sex, age, and evolving intellectual capacity. The CRC defines the child as every human being below the age of 18 years.[4] From

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a child rights perspective, HIV/AIDS serves to illuminate how cultural norms and legal precepts facilitate or constrain the capacity of the child to decide. From a health perspective, the relationship between childhood and HIV/AIDS must take into account the evolving capacity of boys and girls to participate, at different stages of their physical and intellectual development, in decisions relevant to the future course of their lives. This is crucial not only to promoting and protecting children's rights but to a dynamic understanding and response to their needs in the face of the HIV/AIDS epidemics, and in the broader context of child health and development.

HIV/AIDS in the lives of children may impact negatively on the extent to which their rights are respected, protected, or fulfilled, and, conversely, violations or neglect of their rights may increase children's vulnerability to HIV/AIDS.[5] The work presented here is an attempt to raise some questions and to map out issues relevant to the child in the context of HIV/AIDS from the perspective of the CRC. The CRC provides the basic framework for analyzing the impact of HIV/AIDS on children, the response to the epidemic, and the tools for evaluating governmental response which follow.

Children Confronting HIV/AIDS: Infected, Affected, and Vulnerable

As the pandemic pursues its course, its impact on the lives of children in the developing world and in marginalized communities in the industrialized world is increasingly felt. Infected by HIV, affected by the impact of the HIV epidemics, and vulnerable to acquiring HIV infection, infants, young children, adolescent girls and boys are confronting new challenges to their health and development.[6,7]

Children *infected* with HIV/AIDS, girls and boys diagnosed with HIV or presumed to be living with HIV, suffer the physical consequences of infection through increased morbidity, stunted growth, disability, and premature death. Furthermore, their condition creates psychological stress and may expose them to stigma and discrimination, including loss of entitlements to educational, health, and social services.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that, of the 30.6 million people who were living with HIV in December 1997, 1.1 million were children

born with HIV infection.[8] Of these children, the majority are in Africa and in Asia. While the number of children infected around birth can be estimated, there is an enormous gap in data on the incidence of infection among children as they grow into adulthood. There is an acute lack of information on how, when, and to what extent girls and boys become infected, and whether this is through early sexual activity, sexual abuse, substance use, or exposure to unsterile blood, blood products, and skin-piercing instruments.[9] Insufficient research on children living with HIV/AIDS has translated into a lack of information about effective care and support programs for these children.

A first step in fulfilling their obligations to children is for governments to design prevention, care, and research programs in light of appropriately collected information. Governmental obligations extend to ensuring that all children, including those living with HIV/AIDS, have access to health services, treatment, education, and social programs. Some governments have achieved considerable progress in this direction; others have yet to respond adequately to rising needs. Children's quality of life can be improved if the coping capacity of families is enhanced, either by increasing their abilities to support themselves, or through direct social support.

Children are *affected* when their close or extended family, their community, and, more broadly, the structures and services which exist for their benefit are strained by the consequences of the HIV/AIDS pandemic.[10] The most devastating impact on children is when their immediate family environment and support system is challenged by the sickness, disability, and premature death from AIDS of one or both of their parents.[11] The emotional impact of such a trauma, including living through the deprivation of parental support and loss of childhood, creates serious obstacles to the child's development. Furthermore, as a result of the reduced ability of infected parents and extended families to sustain their livelihood, children may have to be removed from their homes, leave school, enter employment, or seek a life on the streets. Finally, children of parents living with HIV/AIDS are often marginalized or discriminated against because they too are assumed to be infected.

The impact of HIV/AIDS on children also results in diminished access to the services and structures needed for their survival and development. For example, schools may be forced to reduce the number of school hours, merge several classes, or even close after having lost teachers to AIDS. Health services may be so overwhelmed by growing demands for HIV/AIDS care, which consumes ever increasing amounts of staff time and financial resources, that the coverage and quality of routine child health programs may suffer.

Governments must strive to prevent and alleviate some of the impact of HIV/AIDS on these children. This entails providing assistance to affected families so that, to the maximum extent possible, children remain within existing family structures and receive needed care. It is also the responsibility of governments to ensure that children are supported through alternative systems of protection and assistance when their family's coping capacity has been exhausted, and that they are protected against all forms of abuse and exploitation.

Children are *vulnerable* to HIV/AIDS to the extent that they are born, grow, and become sexually active in a world which has added the risk of acquiring HIV infection to many of the situations which mark their childhood.[12] Children's capacity to modulate this risk depends on the degree of their awareness and their ability to minimize behaviors that may result in their exposure to HIV infection, such as unprotected sex or injecting drug use. Behaviors resulting in HIV infection are influenced by the social environment in which children evolve and the availability of, and access to, services intended for their benefit. In many countries, children's vulnerability to HIV/AIDS is increased because they are denied access to information and to sexual and reproductive health services and, even when these are available, they are seldom designed to meet children's specific needs.

But vulnerability to HIV is even more acute for children in exceptionally difficult circumstances. These children suffer not only the direct consequences of physical or mental abuse, negligent treatment, exploitation, survival on the street, inadequate alternative systems of protection, violence, armed conflict, and resulting population displacements, but

as a result of these situations, their vulnerability to HIV/AIDS is amplified.[13]

Every governmental effort towards realizing the enabling conditions necessary for children's harmonious and safe development is a step towards reducing children's vulnerability to HIV/AIDS. Governments must offer children access to quality services and work to create a friendlier environment for them—so that they can become true participants in our collective response to HIV/AIDS.

The Advent of the Rights of the Child: the Four General Principles

Violations of the rights of children can be the result of their real or perceived HIV status or that of their family members or communities, and can also make those not already infected more vulnerable to infection. Discrimination, exploitation, and abuse point to just some of the human rights violations which have exacerbated the effects of the pandemic on the lives of children around the world. Nonetheless, governmental attention and commitment to the rights of children has permeated international fora in recent years.

International human rights documents ranging from the International Covenant on Civil and Political Rights (ICCPR) to the CRC contain legally binding provisions specifically detailing the human rights of children, and nearly every article in the general human rights instruments apply equally to children and to adults.[14,15] While none of the human rights treaties contain specific elaborations of the rights of adults or children in the context of HIV/AIDS, the treaty monitoring bodies have, to varying degrees, expressed their commitment to explore the implications of HIV/AIDS for governmental obligations under their treaties.[16] In addition, governments have stated their responsibility for both ensuring the rights, health, and well-being of children and for reducing the impact of HIV/AIDS on individuals and communities in the political commitments contained in the declaration and programs of action from recent international conferences.[17] Relevant conference documents include the 1990 World Summit for Children, the 1993 World Conference on Human Rights, the 1994 International Conference on Population and Development, the 1995 World Summit for Social Develop-

ment and Fourth World Conference on Women, and the 1996 World Congress on the Sexual Exploitation of Children.[15] The commitments are there. Yet both the pandemic and the violations continue to grow. Recognition of the applicability of the human rights framework to the design and evaluation of HIV/AIDS policies and programs could go a long way toward reducing the impact of the pandemic on the lives of children.

The four general principles of the CRC, *non-discrimination, best interests of the child, survival and development,* and *participation* are useful for conceptualizing the complex nature of the rights of children and their relation to HIV/AIDS: they are rights-holders and active agents in their own lives and are at the same time vulnerable and in need of special protection.[18] These principles are set forth as ordinary articles in the CRC but acquired a special status during the first session of the Committee on the Rights of the Child (the Convention's monitoring body). The Committee determined that these rights should be used as the lens through which realization of all rights in the Convention are analyzed, implemented, and evaluated.[19] This concept is unique to the CRC; no other human rights treaty contains rights which are meant to be discussed both in and of themselves, and as a means to analyze governmental progress towards implementation of other rights. A brief summary of the content of the four general principles follows:

- **Non-Discrimination** requires that all children are protected from discrimination of any kind.[20] Children are protected on the same grounds laid out in other human rights instruments, but additional general protections are specified based on ethnic origin and disability, as well as the status of parents or legal guardians. Adverse discrimination relating to refugee or minority status is also explicitly forbidden with respect to certain articles. Confronting the stigma which remains attached to HIV/AIDS, children may benefit from specific protections from discrimination, for example based on disability, or on their own or their parent's real or perceived health status.
- **Best Interests of the Child** gives the child's interests equal footing with the interests of parents, families,

communities, and the state.[21] The Convention explicitly identifies the few instances when it considers the best interests of the child to be the primary consideration, but as a general principle the child's best interests are equal to the interests of others. It is understood that this concept is flexible and will respond to the evolving capacities of the child, living conditions, cultural norms, and expectations. Concern for the best interest of the child is of paramount importance in devising and implementing HIV/AIDS prevention, care, and research programs.

- **Survival and Development** is understood as the precondition of all other rights.[22] This concerns not only children's right not to be killed arbitrarily at the hands of the state, but also their right to benefit from economic and social policies which will allow them to survive into adulthood and to develop in the broadest sense of the word.[23] Born to the world in the time of AIDS, children have a right to survival and development which includes their ability to benefit from governmental policies which will help them to progress into adulthood.
- **Participation** concerns the child's right to express an opinion, have it heard, considered, and given due weight.[24] This is perhaps the most radical provision of the Convention in that it requires adults, who normally wield power in affairs which concern children, to make it possible for children to express their views, and obliges adults to adequately consider these views with respect to all matters, whether within the family or the broader community. The child's right to express an opinion and have it heard must be given due weight in devising and implementing HIV/AIDS prevention, care, and research programs.

Governments on the Forefront: Respect, Protect, and Fulfill Rights

These four general principles—non-discrimination, best interest of the child, survival and development, and participation—have direct implications for HIV/AIDS as it impacts on children. The interplay of these principles should guide

governments with respect to any actions they have taken or may be considering taking that may impact on child health and development. These obligations may go far beyond policies and programs directly and consciously targeted at children. For example, a governmental decision concerning the reallocation of public space may result in the closing of a socially secure environment in which children had been able to play, thereby pushing them toward unsafe gathering sites. From an HIV/STD perspective, this suppression of conditions favorable to the enhancement of social skills in children may increase their likelihood of engaging in unsafe behaviors which, in turn, may expose them to a higher risk of acquiring HIV/STD infection. While from a CRC perspective the right of the child to rest and leisure (Article 31) is the only right immediately and directly applicable, recognition of the four general principles can help mediate this process and lead to a decision best for all concerned.

The example of education

States are responsible for not violating rights directly, as well as for ensuring the conditions which enable the realization of our rights as fully as possible. This is understood as an obligation on the part of governments to *respect, protect,* and *fulfill rights*. While these principles can be applied to governmental obligations as they relate to every right, every person, adult or child, and every action taken, the following analysis uses these obligations to consider the right to education as it applies to governmental action that may concern children infected, affected, or vulnerable to HIV/AIDS.

Respect:

The duty to respect requires governments to refrain from directly violating rights.[25] For example, for children infected with HIV, the right to education would be respected if access to primary school education were ensured. In contrast, this right would not be respected if a government barred children from attending school on the basis of their HIV status. For children affected by HIV, the extent to which governments respect the right to education may be reflected in a government's choice to sustain or close a primary school in a community hard-hit by HIV/AIDS. For children vulnerable

to HIV, respect of the right to education means that, for example, the government must provide and not withhold education to incarcerated children.

Protect:

The duty to protect points to governmental obligations regarding private action, in that the government is responsible for preventing rights violations by non-state actors, including individuals, groups, and organizations, and if a violation does occur, ensuring that there is a legal means of redress that people know about and can access.[26] For infected children, protecting the right to education would impose an obligation on the government to take action against a private school which excluded children on the basis of their HIV status. A situation concerning children affected by HIV could include orphans who have lost both parents to AIDS and whose surviving relatives want to remove them from primary school in order for them to work in a factory. Their right to education would be protected if the government ensured that these children were able to pursue their primary education. The vulnerability of adolescents to HIV can increase if they are denied access to reproductive health education. In protecting the right to education of adolescents in the context of HIV, the government should ensure that, for example, extremist religious groups do not successfully oppose that such education be made available.[27]

Fulfill:

The duty to fulfill requires governments to take administrative, legislative, budgetary, judicial, and other measures towards the full realization of rights.[28] With respect to children infected with HIV, governments must fulfill their right to education by enacting laws that ensure that, for example, in the development of vocational education, this education is available and accessible to children with HIV on an equal basis with other children.[29] In the case of children affected by HIV/AIDS, governments must work to fulfill the right to education by taking measures which ensure that strains on the economic capacity of HIV-affected communities do not result in children being withdrawn from school. The vulnerability of children to HIV/AIDS can be exacerbated if govern-

ment fails to fulfill its obligation to develop an educational program realistically targeted to the needs of children.

Government Action

An agenda for governmental action can be created by recognizing the convergence of the three situations in which children are confronting a world with AIDS (children infected, affected, and vulnerable) and the three levels of government obligations which exist for every right (respect, protect, and

Table 1. Governmental obligations with respect to the rights of the child in the context of HIV/AIDS

	Children infected with HIV	Children affected by HIV/AIDS	Children vulnerable to HIV/AIDS
Respect	Government to refrain from directly violating rights of children on the basis of their HIV status	Government to refrain from directly violating rights of children affected by the HIV/AIDS pandemic	Government to refrain from directly violating rights of children which impact on their vulnerability
Protect	Government is responsible for preventing rights violations by non-state actors against children living with HIV/AIDS, and for providing some legal means of redress	Government is responsible for preventing violations by non-state actors that would increase the burden of HIV/AIDS on affected children, and for providing some legal means of redress	Government is responsible for preventing rights violations by non-state actors that may increase children's vulnerability to HIV/AIDS, and for providing some legal means of redress
Fulfill	Government to take administrative, legislative, judicial and other measures towards realization of the rights of children living with HIV/AIDS	Government to take administrative, legislative, judicial and other measures towards the realization of the rights of children affected by HIV/AIDS	Government to take administrative, legislative, judicial and other measures towards the realization of the rights of children in order to minimize their vulnerability to HIV/AIDS

fulfill). This approach incorporates the promotion and protection of the rights of the child into the diversity of responses needed to bring the pandemic under control and mitigate its impact. Table 1 summarizes the three situations and three levels of obligations which should be considered when identifying children's specific needs and related rights in the context of HIV/AIDS.

A human rights framework can help identify when governmental action is abusive, whether intentionally or unintentionally. Recognition of human rights in the design, implementation, and evaluation of governmental policy can point the way toward actions which are not only necessary but, in public health terms, most effective. These actions may, under specific circumstances, include restrictions on human rights if strictly necessary to ensure the public's health.[30,31] Several criteria have to be met, however, for these decisions to be acceptable under international human rights law: the action has to be taken in accordance with the national law; the action has to be in the interest of a legitimate objective; it has to be strictly necessary to achieve this goal; it must be the least restrictive alternative; and it must not be imposed in an unreasonable or discriminatory way.[32] A clear example of where restrictions may be regarded by governments as necessary for public health and consistent with human rights is routine childhood immunization, a mandated public health measure equally applicable to all eligible children in a society.

Is There an Age for Childhood and an Age for HIV?

There is inconsistency between the age range used by the CRC to define "children" and the age groupings used to analyze HIV epidemic trends. This impacts on the ways population subsets targeted for prevention are defined and, therefore, on the ways services are delivered. While the CRC maintains that the term "children" includes every individual under the age of 18, for the purpose of epidemiological surveillance, 0-14 year-olds are considered "children" and those 15-18 are included in the 15-49 "adult" category. The arbitrariness of this grouping categorizes all boys and girls in the 0-14 age group as "children," regardless of the age at which they become sexually aware, initiated, and active. The assump-

tion inherent in this grouping is that individuals over the age of 15 are equally as likely to be sexually active as all those between the ages of 19 and 49, and thus equally at risk of acquiring HIV (or other STDs) through sexual contacts. However, retrospective analysis of reported AIDS cases for which age-specific information is available suggests that the majority of all HIV infections acquired by "adults" occur in the 15-24 year-old age group.[33]

It is possible to collect age-specific information in research and prevention intervention projects conducted in well-defined study populations, but few national epidemiological surveillance systems currently have the capacity to collect and analyze such data with the degree of accuracy required to make such an analysis meaningful to policy and program design or evaluation.[34] Recognition that countries around the world were seldom able to provide such detailed information led the World Health Organization (WHO), on the global level, to decide in the late 1980s to collect information from countries for the 0-14 and 15-49 year age groups for the purpose of global AIDS surveillance. The WHO reinforced the implications of this decision when they used this 0-14 "child" and 15-49 "adult" categorization in the development of the ten HIV/AIDS "Priority Prevention Indicators" in 1993-1994.[35] These indicators, which have been further elaborated by UNAIDS, are meant to enable the monitoring of HIV/STD trends around the world, and to facilitate comparison between countries and over time.

The aggregation of age groups into the two "children" and "adult" categories for epidemiological purposes at the national and global levels is further carried through in the delivery of health and social services. From a rights perspective, the fact that this epidemiological information is used for the targeting and monitoring of services and programs is problematic. One can see that using the 0-14 and 15-49 age groupings has the potential to obscure relevant developmental, psychological, sexual, and societal factors which affect children's lives differently than adults. For example, a young person of 14 with an STD runs the risk of being referred to pediatric services and, only a few months later, to an adult STD clinic, neither of which is well-equipped to meet young people's needs.

The collection of information on children in a manner consistent with the CRC would not only recognize that those under 18 are children with different levels of understanding and needs, but would bring into focus sexual and epidemiological factors which have not received sufficient attention. For example, from both an epidemiological and a rights perspective, the fact that children under 18 have not yet attained "the age of majority" could help underscore HIV/STD infection trends which may be due to rights violations, including sexual abuse. This recognition would, in turn, call for targeted HIV prevention and care interventions combined with human rights protections, which might not occur under the current categories. Different age cut-offs also exist for the legal "age of consent" for consensual sex.[36] In many countries, there is a difference between the age of consent for females and for males; in addition, in countries where same-sex sex is legal, there is a difference in the age of consent for engaging in sexual activity with a person of the same or different sex. The arbitrariness of the application of these cut-off ages to the analysis of sexual behaviors and HIV/STD trends is pertinent to those working on HIV/AIDS, and those more directly concerned with the promotion and protection of the rights of the child, in interpreting epidemiological trends and the extent to which the rights of the child are fulfilled.

The inconsistency in age groupings and in the targeting of programs will probably remain for years to come. It is essential that studies be conducted to explore the dynamics and determinants of HIV/STD infection and of situations and behaviors leading to infection in girls and in boys, from their birth through the age of 18. Estimates of the number of children born with HIV infection acquired perinatally are usually extrapolated from HIV prevalence rates among pregnant women. However, little is known about the number of children who become infected through breast-feeding in their first years of life and through unsterile skin-piercing medical or other practices, blood transfusion, sexual contacts, or injecting drug use as they grow older. The invisibility of "adolescents...caught between childhood and adulthood, in terms of both their social status and physical development" is detrimental to the protection of the rights of the child, both con-

cerning recognition of actions that jeopardize their health and development, such as sexual abuse, but also to the development of effective prevention strategies realistically targeted to their needs.[37]

Ignoring Gender?

Epidemiological data from countries where heterosexual transmission of HIV predominates show that teenage girls have higher rates of HIV-infection than boys of the same age.[38] As adolescent girls and boys grow through early adulthood, this difference tends to narrow so that by their mid-thirties, about as many men as women live with HIV infection. The differential in HIV incidence in younger age groups has been attributed in part to patterns of sexual partnership (adolescent girls having sexual contact with older males who are more likely than younger ones to be HIV-infected), as well as to the biological and physiological vulnerability of younger girls to HIV infection and other STDs. Furthermore, societal and cultural norms defining female and male gender roles may make it difficult for younger women to impose safer sex practices on their sexual partners.[39] Differentials determined by sex or gender roles in relation to HIV/STD infection are not systematically considered in the collection and analysis of HIV/STD epidemiological data, nor are they sufficiently studied or built into the design of prevention and care programs.

In countries where the HIV/AIDS pandemic has matured, some 15-16 year-old girls attending antenatal clinics for their first pregnancy are already infected with HIV, but no information is available as to the cause of this infection (i.e., whether it involves sex or another mode of transmission).[40] The degree to which gender factors influence the relative risk of becoming infected through various routes of transmission during childhood, and how it may influence patterns of access to care and to the quality of care provided to boys and girls once HIV infection has set in, remains unknown. There is increasing recognition that the collection and analysis of epidemiological and prevention information concerning adults must be disaggregated by sex. Yet there has been little attention given to the fact that the information collected on "children" younger than 15 generally fails to differentiate by

sex. In addition to obscuring such differences as may occur in the natural history of HIV infection, this may result in neglect of the very real differences between female and male adolescents and calls into question the efficacy of prevention programs which have failed to recognize these differences.

On the global level, it is worth noting that, of the ten WHO Prevention Indicators (PI) mentioned earlier, seven call for the collection of data on "people" or "individuals," and of the remaining three, two are specific for females (PI 8 and 10: prevalence of positive serology for syphilis and HIV, respectively, in women attending antenatal clinics), and one for males (PI 9: incidence of urethritis in men). The first seven indicators which call for data on "people" or "individuals" concern such issues as knowledge of preventive practices (PI 1), condom availability (PI 2 and PI 3), reported number of non-regular sexual partners (PI 4), reported condom use in the most recent sexual intercourse at risk (PI 5), and STD case management (PI 6 and PI 7).[41] Although these seven indicators may have been applied to males and females separately in studies validating population surveys for the measurement of these indicators, the lack of attention to gender in the way they have been set out remains of concern. This is particularly the case since these indicators are used to monitor progress in HIV prevention and to influence HIV/AIDS-related policy development and program design.

These prevention indicators should require separate measuring and reporting for males and for females, and possibly the inclusion of additional indicators to monitor the sex-differentials in rates and in trends. In line with the recommendations made at the 1995 UN Fourth World Conference on Women, these indicators should be reformulated to reflect gender specificity.[42] Drawing attention to gender differences is important and urgent as their recognition may enhance the impact of national responses to HIV/AIDS.

From an HIV/STD prevention and care perspective, policies and programs must recognize the different needs, and expression of these needs, among boys and girls. Gender sensitivity should extend to the identification of information equally useful and accessible to girls and to boys, as well as attention to the ways in which assumptions about gender roles may impact on the design of prevention strategies and

services. Different treatment of girls and boys in the context of HIV prevention and care, and more broadly as concerns their health and development, draws attention to the specter of gender-based discrimination. Examples of discrimination in this context include the provision of contraception to young boys which is denied to young girls, with the stated rationale that access might prompt girls to be sexually active. Each of the major human rights documents prohibits distinctions which are made against a person which results in their being treated unfairly and unjustly on the basis of their sex. The prohibition of discrimination does not mean that differences should not be acknowledged, only that different treatment must be based on reasonable and objective criteria. Therefore, applying different approaches to information collection, analysis, and use in policy and programs affecting girls and boys should be based on the valid recognition of gender-related differentials in risk and vulnerability and minimize the influence of prescribed gender roles and cultural norms.

From Concept to Practice

The work presented here is an initial attempt to make explicit the confluence of issues affecting children living in a world with AIDS. Using a simple analytical framework in the form of a three-by-three table, this work began by recognizing the obligations of governments with respect to the three situations in which the AIDS pandemic can impact on the health and development of children, where they are infected with, affected by, and/or vulnerable to HIV/AIDS. This proposed approach to exploring the relationship between rights and health in children extends beyond HIV/AIDS, and can be used to explore a broad range of infectious diseases affecting children, as well as other challenges to their health and development such as malnutrition or physical and mental abuse.

The Annex provides a preliminary analysis of the convergence between the response to HIV/AIDS and the rights of the child. This table is intended only to serve as a methodological illustration of the linkages between HIV and the rights of the child, and is by no means intended to be exhaustive. For each of the three situations confronted by children living in a world with AIDS, selected issues relevant to their

HIV/AIDS prevention, care, and research are detailed and the immediately relevant CRC provisions provided. The four general principles of the CRC should be understood as applicable to any analysis of the issues presented in this Annex.

Application of the three-by-three table presented earlier (Table 1) to each of the situations set out in the Annex may help to determine the specific actions needed to respect, protect, and fulfill the rights of children infected with, affected by, or vulnerable to HIV/AIDS. A reverse analysis could also be conducted where, using the issues detailed in the Annex and taking CRC articles as entry points, it would be possible to suggest how the respect, protection, and fulfillment of rights may impact on the survival and development of children confronting HIV/AIDS.

Linking human rights to HIV/AIDS in these ways may contribute not only to increased awareness of some of the manifest health consequences of the lack of respect, protection, or fulfillment of the rights of the child, but also to improved strategies for alleviating the impact of HIV/AIDS on the lives of children. However, the likelihood of successful action is dependent on the willingness and capacity of those concerned with HIV/AIDS and those engaged in human rights work at the local, national, and international levels to realize the potential synergy of their respective actions and the benefits of combining efforts.

Conclusions

The synergistic relationship between the promotion and protection of rights and sound public health policies and programs is increasingly being recognized. Far more attention than in times past is also being given to the meaning and implications of the rights of children to their health and development, as well as to the roots and consequences of the HIV/AIDS epidemics. However, to translate this awareness into effective actions will require the involvement of young people and the combined efforts of governments, intergovernmental and nongovernmental institutions, the private sector, and communities. This approach could then be used to stimulate governmental accountability on what is being done—and not done—for children living in a world with AIDS.

Much work lies ahead to establish and promote the links between the rights of the child and child health and development—with respect to HIV/AIDS as well as other diseases and health conditions. Empirical knowledge and experience acquired through community-based work, linked to policy and program-based research, will be necessary to better shape the governmental and other responses necessary for the survival and development needs of children.

References

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3. UNAIDS and WHO, *Report on the Global HIV/AIDS Epidemic* (Geneva, 1997): p. 3.

4. The Convention on the Rights of the Child defines more fully the child as "Every human being under the age of 18 unless, under the laws of the country, majority is attained earlier;" CRC, see note 1, art.1.

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15. S. Gruskin, K. Pflaker, "Are the Rights of the Child Relevant to Women's Human Rights?" in: *Women's International Human Rights*, D.

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17. World Summit for Children, 1990; World Conference on Human Rights, 1993; International Conference on Population and Development, 1994; The World Summit for Social Development, 1995; Fourth World Conference on Women, 1995; World Congress on the Sexual Exploitation of Children, 1996. [Editor's note: see also "The Highest Priority: Making Use of UN Conference Documents to Remind Governments of Their Commitments to HIV/AIDS" in this issue for further elaboration of international conference documents and their specific mention of HIV/AIDS.]
18. G. Van Bueren, see note 2.
19. Committee on the Rights of the Child, General Guidelines, CRC/C/5, paragraph 14.
20. CRC, see note 1, art. 2.
21. CRC, see note 1, art. 3.1.
22. CRC, see note 1, art. 6.
23. Thomas Hammarberg, "Children," in: *Economic, Social and Cultural Rights: A Textbook*, A. Eide, C. Krause, A. Rosas (eds.) (Dordrecht: M. Nijhoff, 1995), pp. 289, 292.
24. CRC, see note 1, art. 12.
25. A. Eide et al., see note 5.
26. Ibid.
27. United Nations Population Fund, Programme of Action, adopted at the International Conference on Population and Development, September 5-13, 1994, Cairo, Egypt, paragraph 7.46.
28. A. Eide et al., see note 5.
29. CRC, see note 1, art. 28.1.b., which provides that vocational education must be made "available and accessible to every child."
30. United Nations Economic and Social Council, "The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights," UN Doc. E/CN.4/1985/4, Annex.
31. S. Gruskin, A. Hendriks, K. Tomasevski, "Human Rights and Responses to HIV/AIDS," see note 11, pp. 326-340.
32. Ibid.
33. UNAIDS and WHO, see note 3.
34. Ideally, HIV incidence data (i.e., the proportion of those infected over a given period, usually a year) should be collected by single-year age groups so as to provide information which reflects the dynamics of HIV spread. Incidence data are commonly derived from annual differences in the prevalence (i.e. proportion of children/young adults in a specific age category who are infected at a given point in time). This extrapolation is possible for younger age groups whose exposure to HIV is likely to be recent, but is increasingly problematic as adults grow older, since the age at which they became infected can no longer be ascertained.
35. T. Mertens, M. Caraël, et al., "Prevention Indicators for Evaluating the Progress of National AIDS Programmes," *AIDS* 8 (1994):1359-1369.
36. The arbitrariness of what determines who is a child and who is an adult in society is noted in the work of the Committee on the Rights of

the Child. See M. Santos Pais, "The Convention on the Rights of the Child," in: *Manual on Human Rights Reporting*, Revised Version (United Nations, International Training Centre of the ILO, & United Nations Centre for Human Rights, 1996), pp. 1-75.

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38. A.J. Nunn, J.F. Kengeya-Kayondo, S.S. Malamba, et al., "Risk Factors for HIV-1 Infection in Adults in a Rural Ugandan Community: a Population Study," *AIDS* 8 (1994):81-86.

39. M. Caraël, A. Buvé, K. Awusabo-Asare, "The Making of HIV Epidemics: What Are the Driving Forces?" *AIDS* 11(suppl B) (1997):S23-S32.

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42. In fact, the Platform for Action calls for data that is "collected, analyzed and disaggregated by...sex and age." See Fourth World Conference on Women, *Report of the Fourth World Conference on Women*, Beijing, September 4-15, 1995, UN Doc. A/Conf. 177/20, October 17, 1995, Annex II, para. 109(a).

Annex: 1. The Child Infected With HIV

Issues in HIV/AIDS prevention, care, and research	Specific issues relevant to this population	Immediately relevant CRC articles* (by key words)
Care and support issues	Knowledge of HIV status	13: Information 16: Privacy 17: Access to information sources
	Participation in and exclusion from research and consent issues	13: Information 16: Privacy 17: Access to information sources 19: Protection against all forms of abuse, including negligent treatment 24: Highest attainable standard of health and facilities for treatment 25: Periodic review of treatment
	Psychological and social support from family and services	18: Common responsibility of parents 19: Protection against all forms of abuse, including negligent treatment 20: Care if deprived of family environment 23: Disability 24: Highest attainable standard of health and facilities for treatment 26: Social insurance 27: Standard of living 39: Reintegration after exploitation
	Access to and quality of care	24: Highest attainable standard of health and facilities for treatment 25: Periodic review of treatment 26: Social insurance
	Prevention and treatment of opportunistic infections	24: Highest attainable standard of health and facilities for treatment 25: Periodic review of treatment
	Access to prescription drugs	24: Highest attainable standard of health and facilities for treatment 26: Social insurance
	Immunization	24: Highest attainable standard of health and facilities for treatment
Child growth and development	Access to educational, vocational, and recreational opportunities	28: Education 29: Personality and abilities 31: Rest and leisure (engage in play) 32: Child labor and economic exploitation

*** The four general principles (Article 2, Article 3, Article 6, Article 12) should be considered for each issue presented.**

1. The Child Infected With HIV (cont.)

Issues in HIV/AIDS prevention, care, and research	Specific issues relevant to this population	Immediately relevant CRC articles (by key words)
	Sexuality and sexual health and reproductive health	13: Information 15: Freedom of association 16: Privacy 17: Access to information sources 19: Protection against all forms of abuse, including negligent treatment 24: Highest attainable standard of health and facilities for treatment 29: Personality and abilities 39: Reintegration after exploitation
	Nutrition, including infant feeding	23: Disability 24: Highest attainable standard of health and facilities for treatment 27: Standard of living
Children in difficult circumstances	Adoption	9: No forced separation 11: Illicit transfer and non-return of children 19: Protection against all forms of abuse, including negligent treatment 20: Care if deprived of family environment 21: Adoption 24: Highest attainable standard of health and facilities for treatment

2. The Child Affected by HIV/AIDS

Impact on family and community	Children whose parents or siblings are living with HIV/AIDS	9: No forced separation 18: Common responsibility of parents 20: Care if deprived of family environment 27: Standard of living
	Children orphaned by AIDS	19: Protection against all forms of abuse, including negligent treatment 20: Care if deprived of family environment 21: Adoption
	Exhaustion of extended family's coping capacity	18: Common responsibility of parents 19: Protection against all forms of abuse, including negligent treatment 26: Social insurance 27: Standard of living 32: Child labor and economic exploitation 36: Protection against all other forms of exploitation 39: Reintegration after exploitation

2. The Child Affected by HIV/AIDS (cont.)

Issues in HIV/AIDS prevention, care, and research	Specific issues relevant to this population	Immediately relevant CRC articles (by key words)
Impact on services	Loss of educational and vocational opportunities	28: Education 32: Child labor and economic exploitation 39: Reintegration after exploitation
	Diminished access to prevention, care, and social services	18: Common responsibility of parents 24: Highest attainable standard of health and facilities for treatment 26: Social insurance 27: Standard of living
Exploitation of children	Greater likelihood of family reliance on child labor	19: Protection against all forms of abuse, including negligent treatment 27: Standard of living 28: Education 31: Rest and leisure (engage in play) 32: Child labor and economic exploitation 36: Protection against all other forms of exploitation 39: Reintegration after exploitation
	Greater risk of sexual exploitation	19: Protection against all forms of abuse, including negligent treatment 27: Standard of living 28: Education 29: Personality and abilities 31: Rest and leisure (engage in play) 34: Protection against sexual exploitation and sexual abuse 36: Protection against all other forms of exploitation 39: Reintegration after exploitation

3. The Child Vulnerable to HIV/AIDS

Issues in HIV/AIDS prevention, care, and research	Specific issues relevant to this population	Immediately relevant CRC articles (by key words)
Growth and development	Physical and mental development	9: No forced separation 10: Family reunification 13: Information 17: Access to information sources 18: Common responsibility of parents 19: Protection against all forms of abuse, including negligent treatment 24: Highest attainable standard of health and facilities for treatment 27: Standard of living 28: Education 29: Personality and abilities 31: Rest and leisure (engage in play) 32: Child labor and economic exploitation 33: Protection from illicit use of narcotic drugs 34: Protection against sexual exploitation and sexual abuse 36: Protection against all other forms of exploitation 39: Reintegration after exploitation
	Recognition of sexuality, sexual orientation, and standard of sexual and reproductive health	13: Information 15: Freedom of association 16: Privacy 17: Access to information sources 19: Protection against all forms of abuse, including negligent treatment 24: Highest attainable standard of health and facilities for treatment 29: Personality and abilities 34: Protection against sexual exploitation and abuse 39: Reintegration after exploitation
Personal characteristics and social role	Recognition of risk-taking behavior	13: Information 17: Access to information sources 29: Personality and abilities
	Autonomy	7: Right to acquire nationality 8: Preservation of identity 14: Freedom of thought, conscience, and religion 15: Freedom of association 18: Common responsibility of parents 28: Education 29: Personality and abilities

3. The Child Vulnerable to HIV/AIDS (cont.)

Issues in HIV/AIDS prevention, care, and research	Specific issues relevant to this population	Immediately relevant CRC articles (by key words)
Awareness and skills	Ability to modulate risk of acquiring HIV infection (negotiation, sexual practices, condoms, other preventive behaviors)	13: Information 17: Access to information sources 24: Highest attainable standard of health and facilities for treatment 29: Personality and abilities 34: Protection against sexual exploitation and sexual abuse
Livelihood: exploitation of children	Child labor	19: Protection against all forms of abuse, including negligent treatment 27: Standard of living 28: Education 31: Rest and leisure (engage in play) 32: Child labor and economic exploitation 36: Protection against all other forms of exploitation 39: Reintegration after exploitation
	Sexual exploitation	19: Protection against all forms of abuse, including negligent treatment 27: Standard of living 28: Education 29: Personality and abilities 31: Rest and leisure (engage in play) 34: Protection against sexual exploitation and sexual abuse 36: Protection against all other forms of exploitation 39: Reintegration after exploitation
Services and programs	Access to education	13: Information 17: Access to information sources 27: Standard of living 28: Education 29: Personality and abilities
	Access to health services (including sexual health and reproductive health)	18: Common responsibility of parents 23: Disability 24: Highest attainable standard of health and facilities for treatment 26: Social insurance

3. The Child Vulnerable to HIV/AIDS (cont.)

Issues in HIV/AIDS prevention, care, and research	Specific issues relevant to this population	Immediately relevant CRC articles (by key words)
	Access to social services	18: Common responsibility of parents 23: Disability 24: Highest attainable standard of health and facilities for treatment 26: Social insurance 27: Standard of living
Children in difficult circumstances	In times of conflict and internally displaced	23: Disability 24: Highest attainable standard of health and facilities for treatment 38: Protection and care 39: Reintegration after exploitation
	Institutionalization (prison, mental institutions, etc.)	23: Disability 24: Highest attainable standard of health and facilities for treatment 25: Periodic review of treatment 37: Appropriate assistance 40: Special concerns/privacy
	Homelessness	20: Care if deprived of family environment 23: Disability 24: Highest attainable standard of health and facilities for treatment 26: Social insurance 27: Standard of living
	Exposure to violence	18: Common responsibility of parents 19: Protection against all forms of abuse, including negligent treatment 27: Standard of living 31: Rest and leisure (engage in play) 32: Child labor and economic exploitation 36: Protection against all other forms of exploitation 37: Special protections 39: Reintegration after exploitation
	Injecting drug use by children	33: Protection from illicit use of narcotic drugs 39: Reintegration after exploitation
	Asylum seekers and refugees	8: Preservation of identity 10: Family reunification 11: Illicit transfer and non-return of children 20: Care if deprived of family environment 22: Refugee status 23: Disability