

# Choices for a better Future

SPECIAL PULL-OUT  
SUPPLEMENT TO THE  
**Mail & Guardian**

October 28 to November 3 2011



United Nations Population Fund

# Do adolescents have the right to have sex?



**Amuzweni Lerato Ngoma**

**S**outh Africa has ratified a number of declarations that uphold the promotion of Sexual and Reproductive Health and Rights such as CEDAW, the International Conference on Population and Development (Cairo 1994, ICPD+10), and the Beijing Platform for Action. Furthermore, the Sexual Offences Act (Act 32, 2007) prescribes the age of consent for 16 years. This makes it a criminal act and offence for a person to have sex with a minor. When an adult person, considered to be older than 16 years, engages in a sexual act with a minor, they are seen to have committed an act of statutory rape. In this setting, the Act criminalises an act of sex for people aged under 16 years. According to the Sexual Offences Act, therefore, adolescents can be said not to have the right to have sex.

However, tensions between various legal prescripts in the country. For example, the South African Constitution provides for women's reproductive rights. Women have the right to make choices on reproductive matters. In the implementation of the Constitution (Act 108, 1996), the Choice on Termination of Pregnancy Act (Act 92, of 1996) allows for adolescents as young as 12 years to choose and access an abortion without the consent of a parent or caregiver.

The prevailing social environ-

ment provides for contradictory messages and teachings on whether adolescents have the right to have sex. On the one hand, there exists the normative rule that sex is an adult activity. The prevalent discourse on sex is that it requires mental and physical maturity, primarily because of the responsibilities with which it comes. This messaging is typically what is taught to children and adolescents.

At the same time, society in general provides for another parallel and probably more ubiquitous message and teaching. In this setting, through television shows, there exists consistent messaging that constructs sex as a cool thing and as a triumph. In a consumerist society, sex is used to sell products, services and brands. The sales language of any new product is how "sexy" it is. Deriving from the norm that everyone wants to have sex and, by deduction, everyone will want to have the product or service being sold. This has led to a situation in which selling sex become the norm in society.

In colloquial language, which is mainly responsible for the socialisation of citizens, terms like "give it up", "throw it down", "ulahlile" are prevalent and represent what adolescents use and respond to. Empirical evidence suggests that this process is normal, but has repercussions. The Medical Research Council (MRC) (Youth at Risk Survey) states that "heightened sexual awareness is part of

adolescent development". While this is a normal process, sexual awareness is often characterised by experimentation, which has the potential of placing adolescents at risk of unprotected sexual activity, unplanned pregnancy and sexually transmitted infections, including HIV.

This situation has led to the sexual debut age of adolescents dropping to as low as 14 years nationally; the age at which 14% of adolescents have had sex. The MRC's (Youth Risk Behaviours) survey showed that 37.5% of adolescents had had sex, with significantly more male (45.2%) than female (30.2%) adolescents. The worrying factor here is that among those who have had sex, the national prevalence for having had one or more sexual partners in the past three months was 52.3%, with no significant variation by gender.

The survey states that adolescents are engaging in unsafe sexual practices, in some cases resulting in pregnancies. As much as 70% of the adolescents having sex were not using condoms when engaging in sexual acts. This clearly would put a burden on the health system if the balance between what is correct in terms of sexual behaviour for adolescents and social norms is achieved. The law on who can and cannot have sex in South Africa must be as unambiguous as the alcohol and tobacco laws.

Reproductive health and peer



**Sex is used to sell products, services and brands** — ©UNFPA/Frisone.

education programmes focus on access and activities such as family planning advice, access to contraceptives and the choice on termination of pregnancy. Perhaps the emphasis of these programmes

should simply be on abstinence.

**Amuzweni Lerato Ngoma** is the knowledge manager at the National Youth Development Agency

# Sexuality is inborn

Larger age gap promotes HIV infections



**S**exuality is an essential part of the human condition. It does not develop at puberty, and it certainly does not wait for our parents to say that it's okay. Sexuality is with us from birth. Much talk about whether adolescents have a "right" to their sexuality is like asking whether eyes have right to be blue.

That being said, a debate over whether adolescents have a right to enact their sexuality – by engaging in various sexual behaviours – is now playing out.

The data suggests that "early" sexual debut is statistically associ-

ated with a higher chance of getting HIV. There are some anomalies, however.

According to the 2008 HSRC survey, in KwaZulu-Natal, the province with the highest HIV prevalence, only 4.9% of youth report having sex before their 15th birthday. Compared to the Northern Cape, the province with the lowest prevalence, with 7.3% of young people reporting sex before 15, this may seem strange. But underneath these data lie social and structural factors that determine both early sexual debut and HIV infection.

Let's take a closer look at the causes of early sexual debut.

- The 2004 national survey of sexual behaviour and HIV among young people in South Africa by the Reproductive Health Research Unit at Wits found that socio-economic circumstance is a major predictor of age at first sex, with poorer young people more likely to start having sex early.
- Other significant associations were shown with gender-based violence, with significant associations with self-reported threats of violence or use of physical

force.

- Orphaned teenagers were 1.4 times more likely to have sex by the age of 13. Though these statistics do not give us a clear picture of sexual debut by adolescents with adolescents, they do suggest some areas we might want to look at for the roots of the issue. Economic and social marginalisation as well as gender-based subjugation seem to be key factors.

In a developmental democracy one would expect legislation to seek to uplift the mar-

ginalised and subjugated, not to criminalise people for behaviour driven by their impoverished circumstances.

A recent study found that 18-to-24-year-olds in South Africa practised "safer" sexual behaviours than their peers in the US, and yet had incredibly higher odds of infection. Though there are clear epidemiological, and may even be biological, reasons for this, the one factor that stood out was that, on average, young South African women were having sex with men four years older, while for Americans the age gap was at 2.6 years.

## United Nations Population Fund

*Cont from page 2*

We have known for a long while that age-disparate sex in South Africa is a prime driver of new HIV infections. If more teens chose partners their own age instead of older ones (usually for the emotional and physical security that sugar daddy-type men specifically offer) we might even see a decline in HIV infections.

There are many tools we have at our disposal to delay sexual debut, chief among which is open and early parental discussion about sex and sexuality. As part of our national parent campaign, loveLife implements (Born Free Dialogues), which capacitate families to have the conversations that have been shown through extensive research to delay sexual debut and reduce the lifetime chances of contracting HIV.

Drivers of risky sex include factors such as low self-esteem, an uncertain identity, harmful gender norms and a perception that there is no real opportunity within reach. We need to recognise that young people's sexual behaviour is determined in part by a society arranged against them, unresponsive to their needs and imposing limits on their life prospects.

When two teenagers are thinking of having sex, it is clear that they are not deterred by the opinions of adults or their peers, or by a more general social opprobrium surrounding teenage sex evidenced in traditional and faith-based communities. So what reason do we have to believe?

[www.lovelife.org.za](http://www.lovelife.org.za)



**Criminalising teenage sex only entrenches the incorrect and out-dated view that sex is something especially dirty and sinful, the core idea that underlies the on-going stigma and silence around HIV/AIDS that makes our response to the epidemic so difficult. that a law (especially if seldom enforced) would deter them. Surely building young people from the "inside", with personal motivation and control, is something we as a society should be focusing on, rather than trying to externally control our young people, denying them agency and stunting their personal development.**

# From silence to response on Gender (IN) Equality & HIV



## SANAC Women's Sector

**Chairperson: Mmapaseka Letsike**

**R**ecently South Africa celebrated National Women's day, I was reminded about the recent Women conferences, discourses and discussions taking place everywhere- which really revealed how much work is still needed to enhance the situation of women and girls. While women and girls living with and affected by HIV are on the frontlines of the HIV response, our involvement in policy setting and related decision-making processes remains a major challenge and resources remain largely inaccessible for women's groups, in particular those living with HIV.

2011 marks thirty years into the HIV epidemic, HIV-related stigma and discrimination persist, and continue to pose significant barriers to successful HIV responses. Women living with HIV experience particular forms of stigma and discrimination, especially in relation to our perceived or actual roles as mothers and carers, in accessing services such as sexual and reproductive health, and in claiming our rights. Women belonging to key affected populations are often doubly stigmatised on the basis of

gender and age, sexual orientation and gender identity, use of drugs, experience of prison, disability, migration status, or profession - including sex work. HIV response requires great effort to eliminate the stigma and discrimination faced by women living with HIV and other key affected women, particularly within health services.

The dual epidemic of HIV and violence against women and girls, and the fact that violence is both a cause and consequence of HIV, are now widely recognised. As a result, new policy and legislative frameworks, and advocacy and funding campaigns are increasingly in place. Nonetheless, women and girls continue to be subjected to multiple and overlapping forms of violence, such as psychological, sexual, physical, institutional, and structural violence, reinforced by harmful socio-cultural practices. Many marginalised women, including women in sex work; women who use drugs; and lesbian, bisexual, and transgender women and men, are also especially exposed to violence. The HIV response must improve efforts to address violence against women and girls, particularly against women living with HIV.

Since 2001, attention to the gender dimensions of HIV has grown. The HIV epidemic has necessitated increased focus for advancing gender equality to ensure better and more successful HIV prevention, treatment, care, and support. It is critical to build stronger alliances between the HIV movement and the women's rights movement: to reinforce advocacy for gender equality and equity, within the context of HIV, and to enable all women to seek greater autonomy over our sexual and reproductive health and rights, as well as greater economic independence.

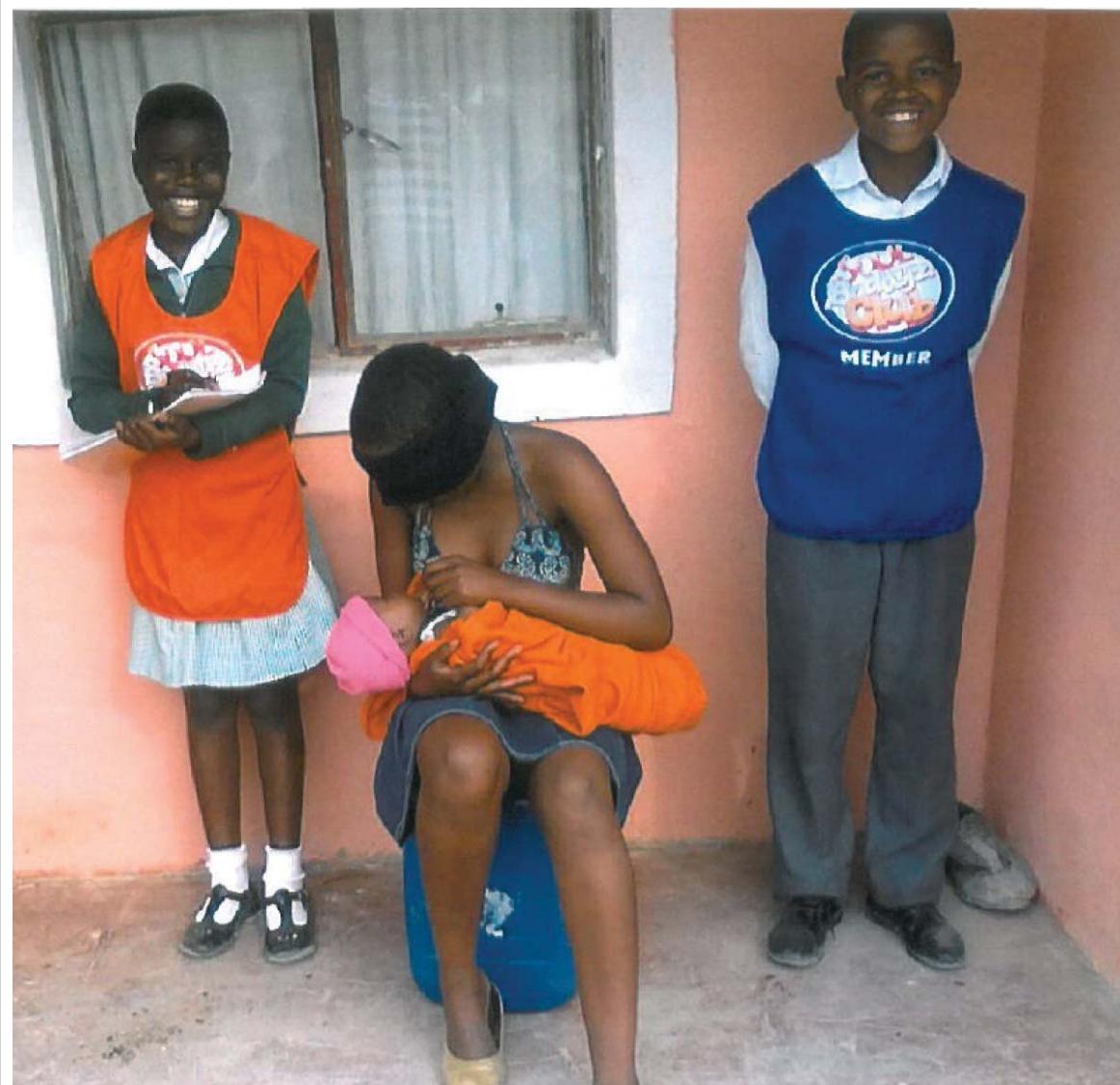
While significant progress is being made to increase HIV-free delivery, women face major challenges in terms of securing their sexual and reproductive health and rights, at risk of being treated as 'vessels' and 'vectors' of sick babies and disease. While prevention of HIV transmission to babies has served as an important entry point for HIV prevention and treatment services for women and families, this approach alone is reductionist and inadequate, while we focus on children we need to prioritise women and mothers. Moreover, utilisation of anti-natal



# Building vital life skills



Soul Buddyz Club brings essential knowledge to primary schools



**Teenage mom with friends from the Soul Buddyz Club**

**S**oul Buddyz Club is a national intervention based at over 7000 schools and run by the Soul City Institute. The clubs are run by facilitators and the children (8-14 years) in primary schools engage with materials and projects to build their knowledge, self esteem, social skills and organisational skills.

One of the Soul Buddyz Club activities for 2011 was to research what it feels like to be a teenage parent. Teenage mothers and fathers were interviewed by the Soul Buddyz Clubs and they then used this information to have discussions with other children in their school about teenage pregnancy. Some of the stories gathered are published below.

#### Girl 1

"I got pregnant when I was 13 years old. I did not know that young girls got pregnant too. I had this boy at high school who was so popular with girls and I thought I was lucky to have him talk to me being a grade 8 learner. He said he loved me and I was charmed. He asked to see me and made me do things that made me differ-

ent. I got pregnant and he said I must never mention his name because if I ever do I will be sorry. I was afraid to tell anyone and he decided to leave the school and go and stay in the city while I was left behind with a fatherless child. My parents were so angry that they told me to leave school and take care of the child. The child was so sick and people said he needs custom from his father's surname but he had no father! My father had rejected me and never ate the food I cooked at home let alone buying anything for me or the baby. I struggled with my unemployed mother. Three years later my father said I can go back to school if I wanted to."

#### Boy 1

"My life was full of events since I was a popular soccer star at my school. Girls wanted my attention left and right and I took this as a compliment and I availed myself for every charm passing my way. I had so many girlfriends I even lost count. My peers urged me to have sex with the girls so that I can keep them happy and to show the strength I have as shown in my

soccer skills.

I had sex with three girls which I am not so proud with now (sic). One of the girls fell pregnant and when she told me I was so scared to tell my parents. But she came with her elders to report the pregnancy to my house. I lied and said I did not know anything about the pregnancy and that the girl had other boyfriends. My mother was very firm and told me to own up if I am responsible. Then the second girl came with her grandmother the following week to report her pregnancy, I also denied the pregnancy. My mother reported to my father who works in the city about the pregnancy. My father was furious with me and he asked me to leave school and come to the city and work. I left school and found a job as a conductor for a bus company. The job was not paying much since I was now responsible for two children.

I was not a good father to my children as they grew up in with their mothers. I was bitter to see my peers completing their high school and furthering their studies."

#### Girl 2

I am a girl of 15 years. I'm my grandmother's girl. I do not live with my parents as my father has another woman! My stepmom always finds fault in whatever I do. In her eyes I am a waste since her children will not have enough of my father's love, care and attention if I am around. I wasted food and money, which could have been her children's.

My father is not pleased with his wife's doing but he has little control over the situation since he is always at work. When he comes home my stepmom has a lot to tell him which he did not witness so it is always my stepmom's word against mine and my father is torn between his love for me and the love of his family.

My mother, on the other hand, has her new home with a man who has no place to accommodate another man's child. I had to fight off his advances once since he sees me as woman not a child. Unfortunately my mother could not believe me. I left their home with no interest to visit them anymore. I think I am better off without my mother and her man's love. Although I really love my father I am resigned to visiting him at his house with my stepmom scolding. This is all because my parent had me when they were still children themselves. TEENAGE PREGNANCY! That's how their behaviour is affecting me now. My life is empty where the parents are concerned but I am very grateful to have my grandmother who loves me unconditionally. I envy those children who have parents and I think it would have been better if my parents were dead and I had to struggle with my grandmother who could have had a grant from the government for an orphan instead of struggling while both parents couldn't provide for their children. The lesson for me in all this is that I will never have a child until I have a job so that I can support her. I do not want my child to go through a similar experience.

These are just three of the many true stories gathered by the Soul Buddyz Club children. What Soul Buddyz Club found striking in these stories is the complete absence of awareness of the children of the consequences of having sex. Neither of the teenagers even considered having safe sex nor preventing pregnancy. HIV or other sexually transmitted disease is not even mentioned or thought about in the interviews.

clinics is hampered by judgmental attitudes and ill-treatment by certain healthcare providers, particularly for marginalised women. These rights violations undermine efforts to improve all maternal and child health, as well as HIV care. Integrated sexual and reproductive health and HIV prevention, care, and treatment services must be available and accessible for all women and girls, within and beyond the anti-natal setting.

HIV prevention research has yielded promising results, with recent breakthroughs in women-centered prevention technologies. However, access to existing technologies continues to pose challenges as women globally cite an unmet demand and need for female condoms. While most notably the proof of concept for a microbicide has been achieved, much more investment needs to be directed to research in women-centred prevention technologies (such as microbicides and female condoms; pre- and post-exposure prophylaxis; microbicides for women with HIV), as well as in ensuring availability of and access to these technologies for all women.

While South Africa and globally is increasingly recognising the need for comprehensive, rights-based, and evidence-informed, sexuality education, consistent access to comprehensive gender-sensitive sexuality education within and outside schools, particularly for young women in all their diversity, is still inadequate or even lacking. Young women and girls require the necessary knowledge and skills to protect themselves against HIV, to uphold the rights of those who have HIV, and for all to lead healthy, productive lives.

Women leaders, providing care in their communities, are becoming increasingly mobilised and visible – yet they still lack adequate recognition, support, training, supplies, or remuneration for all their work. In addition, female health service providers living with HIV experience significant levels of stigma and silence, affecting their own health seeking behaviour for effective treatment. Women and girls further seek to more equitably share caregiving with men and boys in their communities. It is also crucial to engage men and boys for social change, as supporters of women's rights and gender equality, mainly to addressing negative male behaviour and changing harmful gender norms such as early marriage, male domination of decision making, intergenerational sex and widow inheritance.

All women and girls from every region of South Africa and beyond articulates a clear desire for an HIV response that engages and addresses women and girls in all their diversity, regardless of age, HIV status, sexual orientation, or socio-economic status amongst others. Increase in uptake of HIV services will only occur when services respond to the realities and needs of all women and girls, including those of us living in rural and hard-to-reach areas, young women, women living with HIV, women with disabilities, transgender women, women who have sex with women, women involved in sex work, refugees, women who use drugs, and indigenous women.

Mmapaseka Letsike is the chairperson of the Sanac Women's Sector

## United Nations Population Fund

# YOUNG PEOPLE's choices dictate their future



Just over 20% of the South African population are adolescents between the ages of 10 and 19 years of age. In 2009, of the 49 320 500 persons that comprise the South African population, some 5 247 200 are aged between 10 and 14 years and 5 214 300 are aged between 14 and 19 years old. Their decisions about sexual behaviour and childbearing are critical to South Africa's future population size, dynamic and well-being. As South Africa joins the world in welcoming the world's 7 billionth baby on October 31, we need to ensure that adolescents living in a world of 7 billion people have access to comprehensive sexual and reproductive health education and services.

Although many people become sexually active during adolescence, young people often have no access to the family planning services and education they need. Some of the biggest barriers are cultural taboos about young people's sexuality. If we want to address population issues, combat maternal deaths and give young people a good, healthy start on their lives, their right to reproductive health and family planning information and services must be promoted, and changes in policies and regulations encouraged.

### The current situation

- Most people become sexually active before their 20th birthday. In South Africa the median age for sexual debut being 18. Of school going young people 38% ever had sex and 13% reported sexual debut under the age of 14.
- Many societies disapprove of pre-marital sex and consider reproductive health care for young people inappropriate. As a result, parents, educators and health care providers often are unwilling to give young people the information and services needed.
- Modern contraceptive use among adolescents is generally low, and decreases with economic status. 31% of school going adolescents in South Africa reported always using a condom during sex. Young women consistently report less contraceptive usage than men, evidence of their unequal power in negotiating safer sex or restrictions on their access to services (such as lack of information, shame, laws, health provider attitudes and practices, or social norms).
- In South Africa 19% of school going young people reported ever being pregnant or making someone pregnant. Teenage girls account for 14 per cent of the estimated 20 million unsafe abortions performed worldwide

each year, which result in some 68,000 deaths.

- Young people may hesitate to visit clinics because of lack of privacy and confidentiality, inconvenient locations and hours, high costs, limited contraceptive choices and supplies, and perhaps most importantly, negative or judgmental provider attitudes.
- Laws and policies also may restrict adolescents' access to information and services, for example, by limiting family planning to married people or those over 16, or requiring parental or spousal consent.

### Benefits of action

- Adolescents' access to comprehensive sexual and reproductive health information and services can increase their opportunities throughout their lives, starting with longer education, fewer pregnancies, a later and healthier start to childbearing, and more opportunities to engage in income-producing activity.
- Researchers estimate that universal access to family planning could save the lives of about 175,000 women each year.
- Sexual and reproductive health information and services can prevent STIs, including HIV, by promoting condom use.

### What must be done?

- Effective strategies vary according to circumstance: some young people are not sexually active, some are, some attend school while others have jobs; some live with parents while others live with peers or on the street. Messages need to reach and be relevant to the different groups.
- Successful strategies include reproductive health education in the schools; programmes for out-of-school youths, social marketing of condoms; using mass and entertainment media to disseminate messages; telephone hotlines to provide anonymous counselling; peer educators in the community; and care at multipurpose youth centres.
- Programmes should also address issues of puberty and relationships, the skills to negotiate sex and condom use, and gender norms that shape boys' notions of masculinity and limit girls' control over sex. Young people must be active participants in programme design, implementation and evaluation if any approach is to succeed.
- Promoting abstinence alone ignores reality and the family planning needs of sexually active young people as such access to comprehensive sexual and reproductive health education is essential to delay sexual debut and promote access to condoms and other contraceptives as required where young people are sexually active.

### What is UNFPA doing?

- UNFPA advocates for greater attention to young people's needs in partnership with Government. The Fund works with many partners in South Africa like NYDA, Soul City, loveLife and the SANAC Women's Sector to:
- Uphold the rights of young people, especially girls and marginalized groups, to grow up healthy and safely and to receive a fair share of social investments.
- Encourage young people's leadership and participation in decisions that affect them, including their societies' development plans.
- Give young people skills to make healthy choices and fulfill their dreams.
- Place young people at the centre of the HIV prevention response through linking sexual and reproductive health and HIV prevention services and information.

**UNFPA**  
MetroPark Building,  
351 Schoeman Street, Pretoria,  
Tel: 012 354 8401  
[www.unfpa.org](http://www.unfpa.org)

