Framework for the Harmonization of the Legal Environment on Adolescent Sexual and Reproductive Health in East and Southern Africa

A review of 23 countries in the region

ACKNOWLEDGEMENTS

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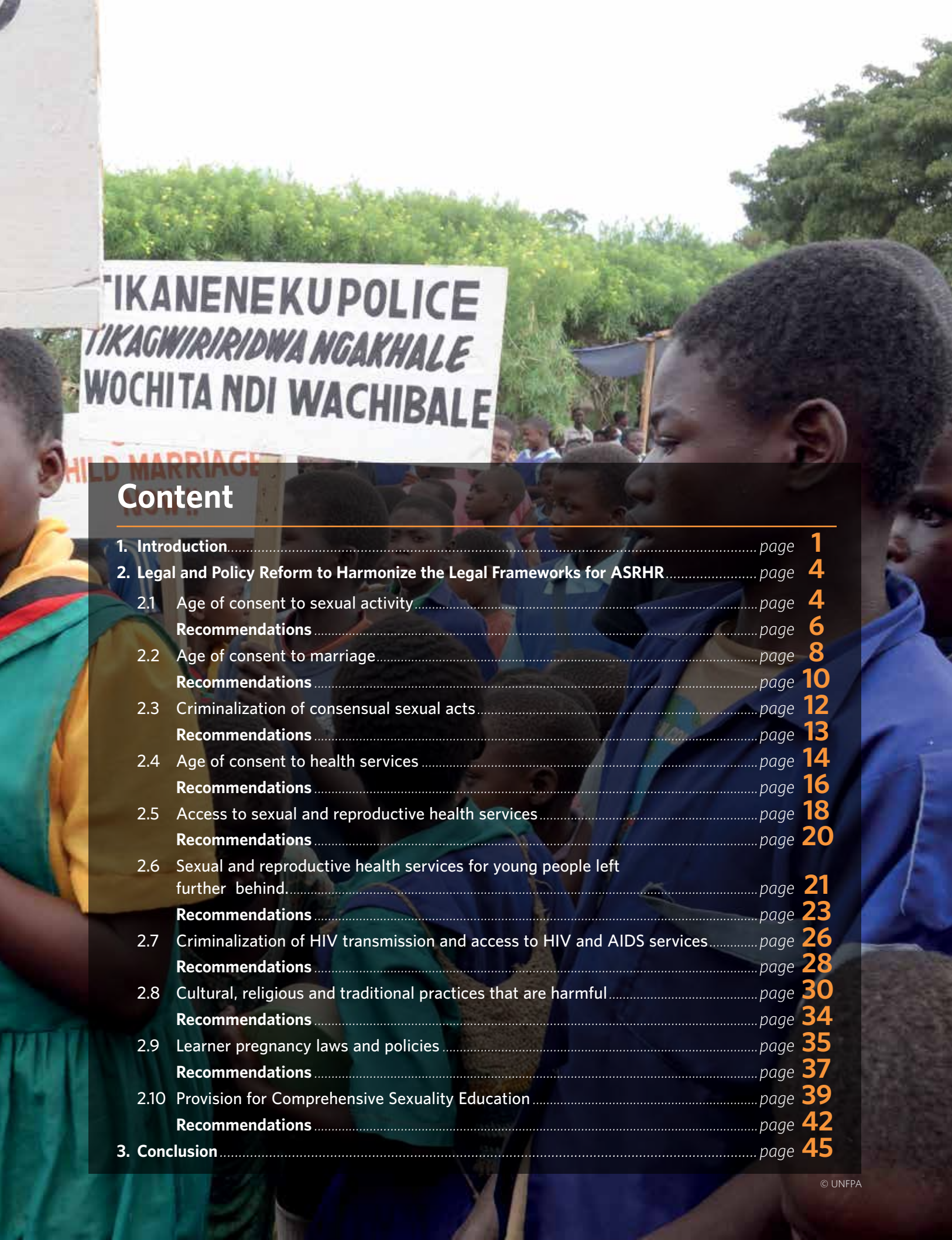

Content


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1. INTRODUCTION

This framework is designed to provide legal guidance to States in the harmonizing of policies and laws relating to Adolescent Sexual and Reproductive Health and Rights (ASRHR) in East and Southern Africa, and in aligning them with international and regional commitments.

The framework arises from a study on the Harmonization of the Legal Environment on ASRHR conducted in 2015-16. The study assessed the laws and policies that affect adolescents' (aged 10 to 19) sexual and reproductive health and rights in 23 East and Southern African (ESA) countries. The report indicated a disjuncture between the relevant policies and laws in the majority of these countries. Furthermore, it demonstrated that many countries' laws do not comply with international and regional commitments, notwithstanding such countries having ratified, acceded to or being signatories to relevant international and regional instruments, such as:

- Universal Declaration of Human Rights[1]
- Convention on the Elimination of all Forms of Discrimination Against Women[2]
- International Covenant on Civil and Political Rights[3]
- United Nations Convention of the Rights of the Child[4]
- United Nations General Comment on Adolescent health and development in the context of the Convention on the Rights of the Child[5]
- Joint General Recommendation No 31 of the Committee on the Elimination of Discrimination Against Women/ General Comment No 18 of the Committee on the Rights of the Child on harmful practices[6]
- International Conference on Population and Development (ICPD) Programme of Action of 1994[7]
- Framework of actions for the follow-up to the Programme of Action of the International Conference on Population and Development Beyond 2014[8]
- African Charter on Human and People's Rights[9]

[1] Available at http://www.un.org/en/documents/udhr/.
[2] Available at http://www.un.oeg/womenwatch/daw/cedaw/text/econvention.htm.
[3] Available at http://www.ohchr.org/en/proffesionalinteres/pages/ccpr.aspx.
[4] Available at http://www.ohchr.org/en/proffesionalinterest/pages/crc.aspx.
[5] Available at http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G03/427/24/PDF/G0342724.pdf?OpenElement.
[6] Available at http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CEDAW/C/GC/31/CRC/C/GC/18&.
[7] Available at http://www.unfpa.org/sites/default/files/event-pdf/PoA_en.pdf.
[8] Available at http://icpdbeyond2014.org/uploads/browser/files/framework_of_actions_revised.pdf.
[9] Available at http://www.achpr.org/instruments/achpr/.


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- The African Women's Protocol to the African Charter on Human and Peoples' Rights[10]
- African Charter on the Rights and Welfare of the Child[11]
- African Youth Charter[12]
- General Comments on Article 14 (1) (d) and (e) of the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa[13]
- General Comment No 2 on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c) of the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa[14]
- The Continental Policy Framework on Sexual and Reproductive Rights[15]
- Plan of Action on Sexual and Reproductive Health Rights[16]
- The Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Young People in East and Southern Africa[17]

These international and regional treaties and commitments underscore the importance of ASRHR. The International Conference on Population and Development (ICPD) Plan of Action adopted in 1994 recommended to the international community a set of important population and development objectives. Among these objectives are education, especially for girls; gender equity and equality; infant, child and maternal mortality reduction; and the provision of universal access to reproductive health services, including family planning and sexual health.[18] The ICPD Beyond 2014[19] notes that, despite aggregate gains in sexual and reproductive health indicators, marked disparities and inequalities persist across and within countries. The achievement of universal access to sexual and reproductive health and rights will depend on strengthening health systems by expanding their reach and comprehensiveness in a holistic manner.[20]

On the African continent, which is faced with the challenge of HIV and AIDS, this epidemic must be tackled through promotion of the provision of HIV and AIDS-related education and services, and measures to eliminate stigma and discrimination. Realizing that the gender inequalities that are associated with HIV infections are driven by practices such as child marriage and female genital mutilation (FGM), a range of treaties have been enacted to provide clear guidance to States Parties as to legislative and policy measures that need to be taken in order to better protect vulnerable groups. Adolescents and young people were also identified as a vulnerable group that needs to be protected and educated, not only in relation to HIV and AIDS, but also on the whole spectrum of sexual and reproductive health and rights and services. This is a new challenge for the continent where, generally, young people's sexuality is taboo and not considered a suitable topic for discussion. Therefore, while commitments are made on a regional level to secure ASRH services, it appears that their implementation remains elusive and this is particularly due to lack of a rights-based approach to the provision of ASRH services.

This framework translates international and regional law requirements into useful legal strategies adapted to the domestic level for the realization of the rights of adolescents and young people to sexual and reproductive health in line with their evolving capacities and towards graduating to a healthy adulthood. The framework gives recommendations based on applicable core legal values and principles that are gleaned from a range of conventions, charters, guidelines and declarations.

[10] Also known as the Maputo Protocol available at http://www.achpr.org/instruments/women-protocol/.
[11] Available at http://www.au.int/sites/default/files/Charter_En_Africa_Charter_on_the_Rights_and_Welfare_of_the_Child_AddisAbaba_July1990.pdf.
[12] Available at http://www.au.int/en/sites/default/files/AFRICAN_YOUTH_CHARTER.pdf.
[13] Available at http://www.achpr.org/files/instruments/general-comments-rights-women/achpr_instr_general_comments_art_14_rights_women_2012_eng.pdf.
[14] Available at http://www.achpr.org/files/instruments/general-comments-rights-women/achpr_instr_general_comment2_rights_of_women_in_africa_eng.pdf.
[15] Available at http://ps.au.int/sites/default/files/SRHR%20English_0.pdf.
[16] Maputo Plan of Action for the Operationalization of the Continental Framework and Reproductive Health and Rights 2007-2010 available at http://ps.au.int/sites/default/files/static/carmma/MPoA.pdf?q=ps/sites/default/files/static/carmma/MPoA.pdf.
[17] Available at http://www.unesco.org/new/fileadmin/MULTIMEDIA/HQ/HIVAIDS/pdf/ESACommitmentFINALAffirmedon7thDecember.pdf.
[18] Ibid.
[19] Available at http://icpdbeyond2014.org/uploads/browser/files/framework_of_actions_revised.pdf.
[20] Ibid at para 24.

We are equal to boys and can also contribute to society," said 17-year-old Lidia Suale Saide. Lidia knows what it means to stand up for these beliefs. One year ago, she refused her mother's attempt to marry her off. She said she wanted to become a doctor instead. "I want to become independent and free of the harms and expectations placed on girls in my community," she told UNFPA.

- MAPUTO, Mozambique

2. LEGAL AND POLICY REFORM TO HARMONIZE THE LEGAL FRAMEWORKS FOR ASRHR

The themes identified by the *Study on the Harmonization of the Legal Environment for Adolescent Sexual and Reproductive Health in East and Southern Africa* as requiring the greatest and most urgent efforts for improving access to ASRHR were laws pertaining to ages of consent to sexual activity, to marriage and to medical treatment; laws enabling or restricting ASRHR; the criminalization of consensual sexual activity and of HIV transmission; the protection of sexual and reproductive health and rights of vulnerable adolescents and young people such as those who are HIV-positive and those with disabilities; legal restrictions on harmful cultural practices; and learner pregnancy policy and comprehensive sexuality education in schools as well as for out-of-school youth.

For each theme, key legislative provisions are outlined in a manner that can be adapted for inclusion in country-specific policy and legislation. **Thus, this framework does not present a 'model law' but suggests ideas for legal provisions that protect adolescents while enhancing their access to ASRHR.**

This framework will have maximum value in terms of implementation if governments, the relevant Regional Economic Communities (RECs) and civil society become actively involved in realizing the highly important values, rights, principles and recommendations contained herein. The aim is to give guidance as to how deficiencies in laws and policies can or should be addressed and corrected. Intersectoral collaboration and enhanced human resource capability is crucial in implementing laws and policies in the ESA region. The framework is based on a human rights approach, since adolescents and young people need to exercise their human rights fully and without fear. Their involvement in developing laws and policies that directly affect their sexual and reproductive health and rights must be promoted and prioritized.

2.1 Age of consent to sexual activity

Sexual activity must always be consensual; where it is not, a crime has been committed. Prior to adolescence, children are generally considered by the law to be too immature to consent to any form of sexual activity. During adolescence, children are in a phase of development from childhood to adulthood, and during this time their capacities are evolving. Each adolescent may differ in the rates at which he or she matures physically, emotionally and intellectually. Families and communities may differ in their cultural, religious and values-based approaches to the correct stage at which it is permissible for young people to become sexually active. Nevertheless, it is common for young people to be interested in and to engage in sexual activity. Despite all the diverse views and practices regarding sexual debut among young people, it is important to have clarity about the age at which young people may legally consent to sexual activity. The decision about where to draw the line of legal consent is a difficult one. On the one hand, laws tend to concentrate on the criminal dimensions – in particular, to protect children from receiving sexual attention from adults. However, the drawing of these legal parameters must be carefully considered, as **this age delineation has many other implications, one of which is to draw young people into the net of the criminal justice system for consensual acts.**

It is important for adolescents and young people to know where this legal age is set so that they can delay sexual debut until the appropriate age. Many States will consider it logical to align this age with the upper age of childhood. However, due to the fact that sexual activity below the age of consent results in criminalization of young people, setting the age too high draws young people into the criminal justice system – a problem that will be discussed further below. Thus, deciding on the appropriate age requires balancing both protection and autonomy rights for young people.

A common feature of the majority of the East and Southern African countries is that their bodies of legislation do not set the age of consent to sexual activity in a clear provision. The age of consent to sexual activity must be gleaned from a reading of statutory provisions that relate to criminal sexual conduct. This makes it difficult for young people and the community at large to ascertain what the minimum legal age for sexual activity is.

It is a reality that many young people engage in sexual activity before the age of consent to marriage or sex. The average age for sexual debut ranges across the ESA region, from 15 years in Angola and 16 years in Mozambique, to 19 years in Namibia and 20 years in Burundi. Worldwide, more than 15 million girls aged 15 to 19 years give birth every year, with 19 per cent of young women in developing countries becoming pregnant before they turn 18.[21] Girls under 15 years account for 2 million of the 7.3 million births that occur to adolescent girls under 18 every year in developing countries.[22] While there are a variety of causes underlying this phenomenon, including child marriage, it is conceivable that a fair number of these births are the result of consensual sexual activity and experimentation.

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[21] UNESCO, *Emerging evidence, lessons and practice in comprehensive sexuality education: A global review,* 2015 p 13. Underlying causes are child marriage, gender inequality, obstacles to human rights, poverty, sexual violence and coercion, national policies restricting access to contraception and age-appropriate sexuality education, lack of access to education and reproductive health services, underinvestment in adolescent girls' human capital.

[22] UNFPA, *Motherhood in childhood: Facing the challenge of adolescent pregnancy,* 2013 p v.

International commitments

- According to the United Nations Committee on the Rights of the Child's *General Comment on Adolescent Health and Development*, adolescence is a period characterized by rapid physical, cognitive and social changes, including sexual and reproductive maturation; the gradual building up of the capacity to assume adult behaviours and roles involving new responsibilities and requiring new knowledge and skills. While adolescents are in general a healthy population group, adolescence also poses new challenges to health and development owing to their relative vulnerability and pressure from society, including peers, to adopt risky behaviour.
- The Adolescent Health General Comment sets out guiding principles on adolescent sexual health and provides, among others, that:
  - Appropriate guidance must be given, in a manner consistent with the evolving capacities of the child, in the exercise by the child of the rights recognized in the Convention; and
  - Legal and judicial measures and processes are to be guaranteed under domestic law, including setting a minimum age for sexual consent, marriage and the possibility of medical treatment without parental consent.
- The Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Young People in East and Southern Africa[23] also urges the relevant ministers to review – and where necessary amend – existing laws and policies on the age of consent, child protection and teacher codes of conduct to improve independent access to sexual and reproductive health services for adolescents and young people and to provide improved protection.

Recommendations

It is recommended that the following rights and values be recognized: Adolescence is a phase during which children's capacity evolves towards full adult capacity, and these evolving capacities must be respected and considered:

- Adolescents and young people of any age have the right of access to adolescent sexual and reproductive health services (ASRHS);
- Setting the age of consent to sexual activity at an appropriate level requires a balancing of the rights to protection and autonomy for adolescents and young people.

It should be noted that the setting of the age of consent to sexual activity need not interfere with a family's right to guide their children's sexual behaviour according to their values and beliefs, but rather sets a legal limit – the breach of which may result in the State taking legal action.

It is recommended that countries adopt laws that contain the following sorts of provisions:

- Clearly set out the minimum age of consent to sexual activity, which is recommended to be 16 years;
- Harmonize the age of consent for adolescent boys and girls;
- Make special provisions for adolescent boys and girls whose legal capacity is diminished, e.g. the mentally challenged, and include a definition of mental disability;[24]

[23] Available at http://www.unesco.org/new/fileadmin/MULTIMEDIA/HQ/HIVAIDS/pdf/ESACommitmentFINALAffirmedon7thDecember.pdf.

- Special defences, such as an adult accused being able to raise a legal defence that the complainant appeared older than the minimum age of consent, need to be re-considered;
- The criminalization of marital rape should be considered in countries where this is not the case;
- Where the age of consent to sexual activity is set at 18 years, there is a need to reconsider the age, taking into account the evolving capacities of adolescents and young people and the potentially negative impact of such an approach on access to sexual and reproductive health for adolescents and young people and unnecessary criminalization of young people. Setting the minimum age of consent to sexual activity at 18 years limits access to services as it leads to adolescents being denied sexual and reproductive health (SRH) services on account of their not being legally permitted to engage in sex. Access to services not only involves their curative effect but also provides the opportunity to obtain information. Being ready for marriage is different from being ready for sex. If there are no specific legal provisions in this respect, the danger exists that service providers will use their own judgement, value systems and moral opinions when providing such services;
- Where one adolescent is older than the age of consent and the other is younger, there is a 'no prosecution' rule or a legal defence if the age difference between them is no more than two years.

[24] A definition of a 'person who is mentally disabled' can be framed as follows: "A person affected by any mental disability, including any disorder or disability of the mind, to the extent that he or she, is-
(a) unable to appreciate the nature and reasonably foreseeable consequences of a sexual act;
(b) able to appreciate the nature and reasonably foreseeable consequences of such an act, but unable to act in accordance with that appreciation;
(c) unable to resist the commission of any such act; or
(d) unable to communicate his or her unwillingness to participate in any such act."

2.2 Age of consent to marriage

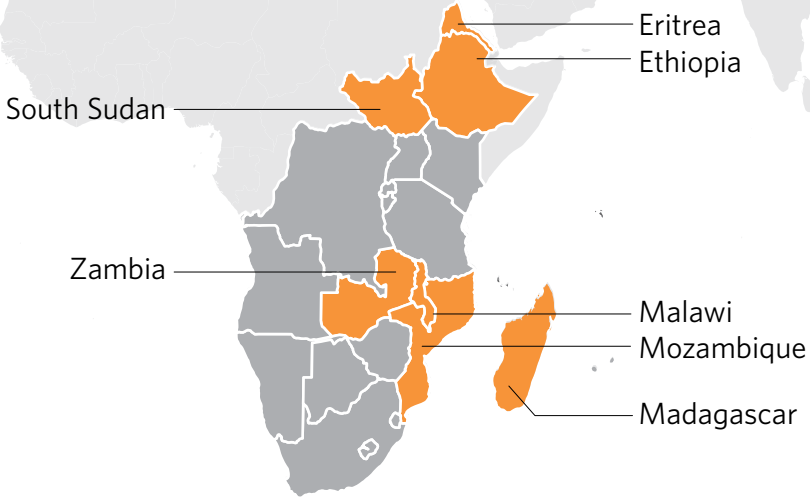
The ESA region includes five countries that are among the 20 countries that have very high rates of child marriage. In Mozambique, 56 per cent[25] of girls are married before the age of 18 years and so are half of all girls in Malawi.[26] Multiple harms are caused by child marriage, particularly for girls who are denied their rights to health, education and development. Girls married during adolescence tend to be very dependent on their husbands and disempowered in numerous ways. Their physical immaturity leads to increased risk of complications during pregnancy and childbirth. The harm is inter-generational, because a young mother whose own development is stifled will be less able to ensure the full development of her children.

One third of girls in the developing world are married before the age of 18 and one in nine are married before the age of 15.[27] Some of the ESA countries under review are regarded as "child marriage hotspots".[28] They include (percentage of adolescent girls married before the age of 18 are indicated in brackets): Mozambique (56 per cent), South Sudan (52 per cent), Malawi (50 per cent), Madagascar (48 per cent), Eritrea (47 per cent), Zambia (42 per cent) and Ethiopia (41 per cent). In countries where child marriage occurs, child brides become mothers at an early age, often because they are under intense social pressure to prove their fertility. Child marriage additionally encourages the initiation of sexual activity at an age when girls' bodies are still developing and when they know little about their sexual and reproductive health and rights, including their right to access family planning.[29]

In a positive move, the Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Young People in East and Southern Africa committed to eliminating child marriage by 2020. The relevant Ministers agreed to review and, where necessary, amend the laws pertaining to the age of consent to marriage.

The UNFPA Study on the Harmonization of the Legal Environment on ASRHR in East and Southern Africa found that **only seven of the ESA countries set the age of consent to marriage at 18 years without exceptions**. These countries are Eritrea, Kenya, Mozambique, Rwanda,

Child marriage hotspots



[25] Mozambique DHS 2011: 48.2.
[26] Malawi DHS 2010: 49.6.
[27] See http://www.icrw.org/child-marriage-facts-and-figures.
[28] Ibid.
[29] UNFPA, *Marrying too Young, End Child Marriage*, 2012.

South Sudan, Ethiopia and Uganda. However, it must be noted that the rate of child marriage remains high in several of these countries, despite the legal limitation regarding the age of consent to marriage. However, harmonization between constitutions and laws, and between civil law and customary law marriages, will have to be achieved if child marriage is to be eradicated. Some customary law practices relate to betrothal (a mutual promise or contract for a future marriage) rather than marriage, such as *ukuthwala* (abducting young girls and forcing them into marriage) in South Africa. These practices are often harmful and lead to child marriage. Such practices should also be prevented where one of the parties is below the age of 18 years. It is a concern that, in all the countries where exceptions to marriage below 18 years are allowed, the age for girls to consent to marriage is lower than the age set for boys. It is thus clear that girls' protection will require priority in law reform efforts.

International instruments

- *The Universal Declaration on Human Rights* (UDHR) provides in article 16 that men and women of full age have the right to marry and found a family and are entitled to equal rights to marriage, during marriage and at its dissolution. Furthermore, that marriage shall be entered into only with free and full consent of the intending parties.
- *The Convention on the Elimination of All Forms of Discrimination Against Women* (CEDAW) provides, in article 16(1), that men and women have equal rights to enter into a marriage; that they have the same right to freely choose a spouse and to enter into marriage only with their free and full consent. More importantly, article 16(2) of CEDAW states that the betrothal and marriage of a child shall have no legal effect, and all necessary action, including legislation, shall be taken to specify a minimum age for marriage.
- *The African Women's Protocol to the African Charter on Human and People's Rights* calls on States Parties to ensure that women and men enjoy equal rights and are regarded as equal partners in marriage. Article 6 specifically provides that appropriate national legislative measures should be taken to guarantee that:
  - the minimum age of marriage for women shall be 18 years;
  - no marriage shall take place without the free and full consent of both parties;
  - monogamy is encouraged as the preferred form of marriage and that the rights of women in marriage and family, including in polygamous marital relationships, are promoted and protected;
  - every marriage shall be recorded in writing and registered in accordance with national laws, in order to be legally recognized.
- *The African Charter on the Rights and Welfare of the Child* provides for the protection of children against harmful social and cultural practices in article 21. Article 21(2) provides that child marriage and the betrothal of girls and boys should be prohibited and that effective action, including legislation, should be taken to specify the minimum age of marriage to be 18 years and make registration of all marriages in an official registry compulsory.

[30] *In Madzuru and Another v Minister of Justice, Legal and Parliamentary* Affairs CCZ 12/2015 the Constitutional Court of Zimbabwe declared section 22(1) of the Marriage Act inconsistent with the Constitution insofar as it provides for an age of marriage that is below 18 years.

Recommendations

All countries should set the age of marriage at 18 years, without exceptions, and penalties for those who give away children to marriage should be enacted. There is also a need for education and engagement, particularly with traditional and religious leaders and communities, around the negative consequences of child, early and forced marriage.

It is recommended that the following rights and values be recognized:

- Marriage must always be consented to freely by both parties;
- There must be no gender discrimination in the age of consent to marriage;
- All marriages must be legally registered;
- The age of marriage set in the civil law must be enforced and customary law needs to be harmonized with the provision in the civil law.

A legal framework that better protects children against child marriage will contain legislative provisions that:

- Clearly stipulate that marriage can be entered into only by parties who are consenting to marriage, which consent should amount to "free and personal consent";
- Establish the minimum age of consent to marriage at 18 years, without exceptions;
- Outlaw the differentiation between girl and boy children when it comes to the minimum age of consent to marriage;
- Address the disharmony between ages of consent to marriage under common/civil law and those provided for under customary or religious laws, by setting one minimum age of consent to marriage that is applicable to all legal systems; and
- Enact provisions to place an onus on members of a community to report any marriage where either or both of the parties are below the age of consent to marriage as stipulated by law.

Laws can and should distinguish between prospective and retrospective operation. The elimination of child marriage going forward is easier to achieve. However, where people (including those who married as children) have been married for some time when the new law comes into effect, harmful effects may occur if blanket provisions annul or void such marriages, particularly where children have been born as a result of the union. A cautious approach on how to deal with such marriages is required. It is recommended that existing marriages brought about by force or coercion should be considered voidable, at the instance of the 'injured' party, rather than be automatically void.[31]

In some countries, the Constitution expressly protects customary and religious laws, which in some instances set a lower minimum age of consent to marriage. It is advisable that in those countries where this is the case, constitutional provisions should be reviewed to explicitly repeal any age of consent to marriage in customary or religious laws if such age is below 18 years.

In some countries, for example Namibia, giving away in marriage a child who is below the minimum age of marriage as set in civil law is considered to be a harmful cultural, social or religious practice, and is punishable by law.[32] ESA countries are advised to consider the adoption of similar provisions.

[31] The draft **SADC Model Law on eradicating child marriage and protecting children already in marriage** proposes that the following provisions be included in national legislation (section 21 of the draft law):

(1) Every child marriage contracted before the commencement of this Law, shall be voidable at the option of-
  (a) one party or both parties to the marriage, where one party was a child or both parties were children at the time the marriage was contracted;
  (b) a child to the marriage, where the child is married to an adult person;
  (c) one party or both parties to the marriage, where both parties are children; or
  (d) a third party, in consultation with an appropriate authority.

(2) A court shall, on petition of a child or person referred to in subsection (1), dissolve the marriage that was contracted before the commencement of this Law.

The Chief Justice shall prescribe rules for the procedures and processes relating to the dissolution of a voidable child marriage.

[32] E.g. section 226 of the Namibian Child Care and Protection Act 3 of 2015 under the heading "Harmful cultural, social and religious practices" provides as follows:

(2) A person may not give a child out in marriage or engagement if such child does not consent to the marriage or engagement or is below the minimum age for marriage contemplated in section 24 of the Marriage Act, 1963 (Act No 25 of 1961).

(3) A -
(a) child requires the consent of the minister responsible for home affairs in order to marry; and
(b) person below the age of 21 years also requires the consent of his or her parent, parents or guardian in terms of section 10(10) of this Act in order to marry.

(4) A person who contravenes subsection (1) or (2) commits an offence and is liable on conviction to a fine not exceeding N$50 000 or to imprisonment for a period not exceeding ten years or to both such fine and such imprisonment.

2.3 Criminalization of consensual sexual acts

South Africa and Kenya are two of several countries that have criminalized consensual sexual acts among adolescents. In both countries, the legislation was subject to constitutional challenges. The legal challenge was successful in South Africa but failed in Kenya, which means that Kenya continues to treat such consensual acts as criminal offences. The common factor in both countries' cases is the recognition that the criminalization of consensual sexual acts among adolescents and young people is not appropriate for the following reasons:

- It is a denial of the evolving capacities of adolescents and their normative development insofar as adolescent sexual and reproductive rights are concerned;
- It infringes other rights such as a right to dignity and privacy;
- It stigmatizes adolescent sexuality;
- It may result in adolescents and young people not seeking sexual and reproductive health services and information, in fear of prosecution;
- It may result in gender-skewed convictions;
- It unnecessarily brings adolescents and young people into the criminal justice system.

Some countries criminalize defilement, which can be a consensual act, and this also often results in the criminalization of adolescents and young people. In most cases, it is boys who are convicted and end up in prison. It is important to keep in mind that the original intention of laws that criminalize consensual sex (such as statutory rape or defilement) are aimed primarily at preventing adults from engaging in sexual behaviour with children. The setting of an age of consent to sexual relations with another person leads to the creation of a crime for those situations where the parties to the act fall on either side of the age of consent – e.g. a 16-year-old with a 15-year-old. Thus, laws need to be reviewed to consider whether they are having the effect of criminalizing adolescents and young people, rather than the original targets of the law. Law reform is encouraged to eliminate or at least limit such criminalization of consensual sexual acts between peers.

International commitments

- The criminalization of consensual sexual activities among adolescents and young people is directly at odds with the approach set out in international treaties insofar as the recognition of adolescent evolving capacities and the promotion of an educative approach to adolescent sexual and reproductive health are concerned. Criminalization is not in line with the guiding principle of the *Adolescent Health General Comment*, which states that the right of adolescents to access appropriate information is crucial if States Parties are to promote cost-effective measures, including through laws, policies and programmes, with regard to numerous health-related situations. Furthermore, according to the *Adolescent Health General Comment*, legal measures and processes in the context of the rights of adolescents to health and development require States Parties to ensure that specific legal provisions are guaranteed under domestic law.
- The *African Youth Charter*[33] provides that in order to realize the right to health of young people, the following actions need to be taken:
  - Securing the full involvement of youth in identifying their reproductive and health needs and designing programmes that respond to these needs, with special attention given to vulnerable and disadvantaged youth;

[33] Available at http://www.un.org/en/africa/osaa/pdf/au/african_ youth_ charter_ 2006.pdf.

- Providing access to youth-friendly health services, including contraceptives, antenatal and postnatal services;
- Instituting programmes to address health pandemics in Africa such as HIV and AIDS and tuberculosis;
- Instituting comprehensive programmes to prevent the transmission of sexually transmitted infections and HIV by providing social and behaviour change communication and awareness creation, as well as making protective measures and reproductive health services available;
- Expanding the availability and encouraging the uptake of voluntary counselling and confidential testing for HIV;
- Providing timely access to treatment for young people living with HIV and AIDS, including prevention of mother-to-child transmission, post-rape prophylaxis, antiretroviral therapy, and creation of health services specifically for young people;
- Providing food security for people living with HIV and AIDS;
- Instituting comprehensive programmes, including legislative steps to prevent unsafe abortions;
- Providing technical and financial support to build the institutional capacity of youth organizations to address public health concerns, including issues regarding youth with disabilities and young people married at an early age.

• The criminalization of consensual sexual acts goes against the efforts to achieve the aforementioned objectives, as adolescents' sexuality is then subject to judicial scrutiny and stigma that may hamper their normal development in accordance with their evolving capacities and autonomy. They may avoid seeking advice or assistance in sexual matters from medical practitioners or guidance counsellors because they fear being charged and arrested, despite their conduct being consensual.

Recommendations

The appropriate solution is for countries to decriminalize consensual sexual acts among adolescents and young people, and to focus on comprehensive educative approaches that will enable adolescents and young people to make informed choices in relation to their sexual and reproductive health and rights, and needs.

It is recommended that the following rights and values be recognized:

- Adolescents' evolving capacities, normative sexual development, and sexual experimentation must be recognized.
- Adolescents' dignity and privacy rights must be respected.
- Stigmatization and criminalization of normative consensual behaviour is an approach that contradicts ASRHR.
- Fear of prosecution may prevent access to ASRHR and impede informed sexual decision making.

It is recommended that the legal framework should contain the following provisions:

- Definitions of sexual acts that fall within the purview of the legal framework.
- Adolescents who are both below the age of consent to sexual activity are not charged with crimes arising from their consensual sexual interaction with one another.
- Where one adolescent is older than the age of consent and the other is younger, there is a 'no prosecution' rule or a legal defence if the age difference between them is no more than two years.

- Statutory rape charges are used where the older person is an adult, not where both are consenting adolescents or are close in age.
- Any sexual act that is not consensual amounts to exploitation or abuse, which is punishable in accordance with the relevant laws.
- If there is a register of sex offenders, consensual acts between adolescents and young people do not result in the listing of those young people on the register.
- Diversion or community-based sentences, as opposed to imprisonment, are available for those adolescents and young people who are convicted of statutory offences because they fall outside of the two year age difference rule.

Countries are also urged to move away from archaic terms such as "defilement" or "sexual outrage", and to adopt more appropriate terminology that specifically delineates concepts such as "child sexual exploitation", "abuse", "rape" or "statutory rape".

2.4 Age of consent to health services

Establishing rules for minors' consent for medical care has been one of the more difficult issues to face policy makers. On the one hand, it seems eminently reasonable that parents should have the right and responsibility to make health care decisions for their minor children. On the other hand, in some cases it may be more beneficial for young people to have access to confidential medical services than it is to require that parents be informed of their child's condition, needs and choices. Adolescents and young people who are sexually active, pregnant or infected with a sexually transmitted infection, those who abuse drugs or alcohol, and those who suffer violence or abuse at home or suffer from emotional or psychological problems, may avoid seeking assistance if they must involve their parents. Recognizing this reality, many countries explicitly authorize a minor to make decisions about his or her own medical care. However, balancing the rights of parents and the rights of adolescents and young people remains a topic of debate.

Patient autonomy and respect for personal dignity are central to the provision of ethically sound health care. In order to exercise their autonomy, it is submitted that all persons, including adolescents and young people, should have the moral and legal right to make decisions regarding their medical treatment when they are capable of doing so. If the patient is not capable of making a decision with respect to treatment, this decision should generally be made by a substitute decision maker on behalf of the patient.

Studies show that young people, and in some instances adolescent girls in particular, are most adversely affected by the HIV, AIDS and TB epidemics, as well as high prevalence of violence, trauma and injuries.

In East and Southern Africa, young women aged 15 to 24 years are twice as likely as young men of the same age to be living with HIV.[34]

Although non-communicable diseases are relatively uncommon in adolescents, the high prevalence of risk factors, such as malnutrition or poor nutrition and a sedentary lifestyle, will fuel the rising prevalence of lifestyle diseases, particularly hypertension and diabetes. A high teenage pregnancy rate means that high maternal mortality rates adversely affect many adolescents. Mental health conditions are also prevalent in adolescents and young people. These are often linked with abuse of alcohol, tobacco and drugs or violence against adolescents and young people.

[34] UNESCO, *Emerging evidence, lessons and practice in comprehensive sexuality education: A global review*, 2015 p 13.

As a group, adolescents and young people are less likely to recognize their symptoms, and are more likely to underestimate their importance and to delay seeking assistance.

Fear of the outcome, worries about stigma, and concerns that they may not be treated well at a clinic - all contribute to late presentation.

In many clinics there is insufficient space to guarantee privacy and some health care professionals do not treat adolescents and young people with dignity and respect. Lack of access to health services, especially with regard to contraception, and health promotion, represents an important barrier to better health outcomes for adolescents and young people.

There are several components of informed consent to medical care that are important to consider, especially when caring for adolescents. First, patients should receive explanations in an understandable language, including concerning the potential risks and benefits of the proposed treatment. Second, the provider should assess the patient's understanding of the information given to him or her. Third, the provider should assess the patient's ability to make the necessary decision(s). Finally, the provider should determine that the patient is not coerced into a particular medical alternative. Empirical data indicate that adolescents may have well-developed decision-making skills and are capable of complex decisions. Their ability to give informed consent, however, may be limited by law.[35]

International instruments

- The United Nations General Comment on Adolescent Health and Development in the context of the Convention on the Rights of the Child is, *inter alia*, grounded on the principle that States Parties are required to ensure that specific legal provisions are guaranteed under domestic law, including with regard to setting a minimum age for sexual consent, marriage *and the possibility of medical treatment without parental consent*.
- Insofar as States Parties' responsibilities are concerned, Paragraph 41 of the Adolescent Health General Comment states that, in accordance with articles 24, 39 and other related provisions of the Convention, States Parties should provide health services that are sensitive to the particular needs and human rights of all adolescents, paying attention to the following characteristics:
  - Availability. Primary health care should include services sensitive to the needs of adolescents, with special attention given to sexual and reproductive health and mental health;
  - Accessibility. Health facilities, goods and services should be known and easily accessible (economically, physically and socially) to all adolescents, without discrimination;
  - Acceptability. While fully respecting the provisions and principles of the CRC, all health facilities, goods and services should respect cultural values, be gender sensitive, be respectful of medical ethics and be acceptable to both adolescents and the communities in which they live;
  - Quality. Health services and goods should be scientifically and medically appropriate, which requires the availability of personnel trained to care for adolescents, adequate facilities, and scientifically accepted methods.

[35] *Minor's Rights Versus Parental Rights: Review of Legal Issues in Adolescent Health Care* available at http://www.medscape.com/viewarticle/456472_3.

- In terms of Paragraph 337 of the F*ramework of Action for the follow-up to the programme of action of the International Conference on Population and Development Beyond 2014*, States should fund and develop, in partnership with young people and health-care providers, policies, laws and programmes that recognize, promote and protect young people's sexual and reproductive health and rights and lifelong health. All programmes serving adolescents and youth, whether in or out of school, should provide referral to reliable, quality sexual and reproductive health counselling and services.
- Paragraph 338 of the above-mentioned Framework of Action requires States to remove legal, regulatory and policy barriers to sexual and reproductive health services for adolescents and youth, and ensure information and access to contraceptive technologies; as well as the prevention, diagnosis and treatment of sexually transmitted infections and HIV, including the HPV vaccine; and referrals to services dealing with other health concerns such as mental health problems.
- Under the ESA Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Young Persons in East and Southern Africa, the Ministers of Education and Health of 20 countries in East and Southern Africa in 2013 specifically committed, *inter alia*, to integrate and scale-up youth-friendly HIV and SRH services that take into account social and cultural contexts to improve age-appropriate access to and uptake of high quality SRH services and commodities, *including condoms, contraception, HPV vaccine, HIV counselling and testing (HCT) (now known as HIV Testing Services/ HTS), HIV/STI treatment and care*, family planning, safe abortion (where legal), post-abortion care, safe delivery, prevention of mother-to-child transmission (PMTCT) and other related services for young people in and out of school.

Recommendations

It appears that the following countries are providing for an age of consent to access HIV testing and counselling services in terms of policy: Angola, Botswana, Ethiopia, Malawi, Mozambique, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe. The ages range from 12 to 18 years. The following countries have no legal provisions regulating the age of consent to medical treatment: Angola, Botswana, Burundi, Comoros, Eritrea, Kenya, Malawi, Mauritius, Mozambique, Seychelles, South Sudan, Uganda and Zimbabwe. While Lesotho, Namibia, South Africa, Swaziland and Zanzibar have comprehensive legislative provisions dealing with the age of consent to medical treatment, medical procedures and HIV testing and counselling, the remainder of the ESA countries have limited provisions in this respect.

In line with the international standards referred to, it is recommended that those countries which have no or limited legal provisions (as opposed to policy) in place regulating the age of consent to medical treatment, medical procedures, HIV testing and counselling and the age of consent to access contraceptives should adopt legislative provisions in this respect. Except for South Africa, no country appears to be regulating the age of access to contraceptives. It is recommended that this aspect be included in the legislation of all ESA countries.

In addition, the attitudes of service providers and hours of operation are major obstacles to accessing SRH among young people and it is recommended that services should seek to maintain youth-friendly health service standards.

It is recommended that the following rights and values be recognized:

- Non-discrimination, which includes non-discrimination on grounds of disability, sexual orientation, health status such as HIV status and mental health status, and any other grounds which violate human rights;
- Appropriate guidance in the exercise of rights, which entails to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of his or her rights to medical treatment, procedures, HIV testing and counselling and access to contraceptives;[36]
- Respect for the views of the child to ensure that adolescents are given a genuine chance to express their views freely on all matters affecting them, including health issues; and
- Legal and judicial measures and processes which, in the context of the rights of adolescents to health and development, require a commitment to ensure that specific legal provisions are guaranteed under domestic law, including the possibility of accessing medical treatment without parental consent.

It is further recommended that legislative provisions should include the following:

- Respect for the views of an adolescent or young person when accessing services;
- Differentiation between medical treatment and medical procedures, as well as differentiation between minor and major medical procedures, and differentiation between medical treatment and preventive or curative services;
- An age of consent to medical treatment without parental assistance, where possible, to be set at 12 years;
- An age of consent to medical procedures (possibly with parental assistance);
- An age of consent to HIV testing (to consider setting it at 12 years);
- Irrespective of the age decided upon, there should be a proviso that an adolescent or young person should be of sufficient maturity and should have the mental capacity to understand the benefits, risks and effects of the treatment, procedure or testing;
- Provisions indicating the manner of assessment of sufficient maturity and mental capacity;
- Provisions indicating which persons or what institutions may give consent when parental consent is required and cannot be obtained;
- Pre- and post-HIV testing and counselling should be mandatory;
- The duty of protecting confidentiality of HIV test results must be shared by relevant role players and be guaranteed;
- An age of consent to access contraceptives should be indicated (to consider below 18 years old in line with available evidence of average age of sexual debut in country).

[36] Special protection should be given to adolescents and young people involved in medical research. Such research must be cleared by research committees and may only be done with the consent of the adolescent and his or her parents or legal guardian.

2.5 Access to sexual and reproductive health services[37]

Sexual and reproductive health is a state of complete physical, mental and social wellbeing and is not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Sexual and reproductive health therefore implies that people are able to have a satisfying and safe sex life, and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed of, and to have access to, safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods for regulation of fertility, which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth, and provide them with the best chance of having a healthy infant.

In line with the above understanding of sexual and reproductive health, reproductive health care is defined as "The constellation of methods, techniques and services that contribute to reproductive health and well-being through preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases."

Almost all (98 per cent) of the unsafe abortions worldwide take place in developing countries, where abortion is often illegal. Even where abortion is legal, adolescents may find it difficult to access services. Data on abortions, safe or unsafe, for girls between the ages of 10 and 14 in developing countries are scarce, but rough estimates have been made for the 15 to 19 age group, which accounts for about 3.2 million unsafe abortions in developing countries each year.[38] Health risks caused by adolescent pregnancy are high and include higher rates of maternal mortality than for older women.

Sub-Saharan Africa accounts for 44 per cent of all unsafe abortions among adolescents between the ages of 15 and 19 in the developing world (excluding East Asia).[39] The issue of abortion is certainly a sensitive one for a number of people. However, the solution does not lie in hoping that the phenomenon of unsafe abortion will disappear. The unsafe abortion rate among adolescents is estimated to be 26 per 1,000 women aged 15–19 in Africa (compared to an average of 16 per 1,000 women in the developing world).[40]

While programmes should aim to eliminate the reasons leading to abortion, it is important also to deal with the issue of unsafe abortion squarely. Policy makers and human rights institutions must encourage healthy debate around the issue and about the ravages caused by unsafe abortion. In the final analysis, it has to be recognized that unsafe abortion is the third-highest cause of maternal death and ill health.

The goal of reducing maternal mortality and morbidity cannot be achieved without dealing with unsafe abortion through positive legislative change.

[37] Most of the information under this section has been gleaned from the document "Sexual and Reproductive Health and Rights: Continental Policy Framework" African Union Commission, 2006. The Continental Policy Framework on Sexual and Reproductive Health and Rights was adopted by the African Ministers of Health at the 2nd African Union Conference of Health Ministers held in Gaborone, Botswana in October 2005 and endorsed by the Summit of the African Heads of State and Government in Khartoum, Sudan in January 2006.
[38] UNFPA, *Motherhood in childhood: Facing the challenge of adolescent pregnancy,* 2013 p 20.
[39] Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Young People in East and Southern African (ESA), Cape Town, 7 December 2013.
[40] Ibid.

International instruments

- The Convention on the Elimination of All Forms of Discrimination Against Women, in Article 16, guarantees women the same rights as men to decide freely and responsibly on the number and spacing of their children, and to have access to the information, education and means to enable them to exercise these rights. Additionally, Article 12 provides that States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on the basis of equality for men and women, access to health care services, including those related to *family planning*.
- The African Women's Protocol to the African Charter on Human and People's Rights, perhaps the most comprehensive gender-specific provision on women's right to health, specifies, among other things, women's rights to:
  - control their fertility;
  - decide whether to have children and the number of the children;
  - choose any method of contraception;
  - safe protection and to be protected against STIs, including HIV;
  - access to adequate, affordable and accessible health services; and
  - abortion.
- The Plan of Action on Sexual and Reproductive Health Rights (Maputo Plan of Action), which seeks to take the African continent forward towards the goal of universal access to comprehensive sexual and reproductive health services by 2015, has, as one of its nine focus areas, the reduction of incidences of unsafe abortion.
- Under the Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Young Persons in East and Southern Africa, the Ministers of Education and Health in 20 African countries committed to integrate and scale up youth-friendly HIV and SRH services that take into account social and cultural contexts, to improve age-appropriate access to and uptake of high quality SRH services and commodities, including condoms, contraception, HPV vaccine, HIV testing services, HIV/STI treatment and care, contraception, safe abortion (where legal), post-abortion care, safe delivery, prevention of mother-to-child transmission (PMTCT) of HIV, and other related services for young people, in and out of school;
- Under the Addis Ababa Declaration on Development in Africa beyond 2014, States Parties commit, among other matters, to expand access for all women and adolescent girls to timely, humane and compassionate treatment of unsafe abortion complications and, in accordance with national laws and policies, provide for access to safe abortion services.

Recommendations

Adolescents and young people have a right to access comprehensive sexual and reproductive health services. This is a package of services, including preventive and curative services.

Except for South Africa and Mozambique, which have decriminalized elective abortion under specific circumstances, all other countries in the ESA region have legislative provisions criminalizing abortion with some exceptions, such as where continued pregnancy would endanger the mother's life or health, and where the pregnancy was the result of rape or incest.*

It is recommended that the following values and rights be recognized:

- The values of human dignity, the achievement of equality, security of the person, non-racialism and non-sexism, and the advancement of human rights and freedoms which underlie a democratic dispensation;
- The right of persons to make decisions concerning reproduction and to security in and control over their bodies;
- Both women and men, including adolescents, have the right to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and women have the right of access to appropriate health-care services to ensure safe pregnancy and childbirth;
- The decision to have children is fundamental to women's physical, psychological and social health, and universal access to reproductive health-care services includes family planning and contraception, and safe abortion services, as well as sexuality education and counselling programmes and services;
- The State has the responsibility to provide reproductive health to all and to provide safe conditions under which the right of choice can be exercised without fear or harm;
- Elective abortion in clearly prescribed circumstances is a life-saving procedure, aimed at reducing mortality and morbidity; and
- Abortion is not a form of contraception.

It is recommended that countries give serious consideration, in line with international standards, to providing for safe and legal abortion for all women, including adolescents, by way of legislation. Such legislation should include:

- The legislation needs to follow a rights-based approach and must make it clear that adolescents have a right to access all ASRHS. ASRHS comprises a full range of services, including preventative and curative services, of which safe abortion is only one service;
- Legislation needs to provide for the establishment of youth-friendly clinics to provide ASRHS, including the proper resourcing of clinics at the State's expense;
- Legislation needs to set out the norms and standards for youth-friendly clinics, including which services will be accessible at the clinic, training of staff and confidentiality requirements;
- Abortion needs to be decriminalized.
- Elective abortion needs to be available subject to conditions depending on the period of gestation. The conditions become more restrictive as the pregnancy progresses;
- Countries need to provide safe and legal abortion services where the pregnancy is the result of rape or incest, irrespective of the age of the female;
- A minimum age of consent to abortion;
- Clarification that the term 'woman' includes adolescents who are pregnant;
- The law needs to set out which persons are qualified to carry out safe and legal abortions, together with the correct norms and standards to be adhered to by the clinic or hospital where such terminations are carried out;
- Persons involved in providing unsafe abortions, or who are not qualified to provide safe abortions, must be subjected to criminal sanctions.

* UNFPA, *Harmonization of the Legal Environment on Adolescent Sexual and Reproductive Health in East and Southern Africa, 2017*

2.6 Sexual and reproductive health services for young people left further behind

Sexual and reproductive health and rights (SRHR) are usually understood as the rights of all people, regardless of their nationality, age, sex, gender, health or HIV status, to make informed and free choices with regard to their own sexuality and reproductive well-being, on condition that these decisions do not infringe on the rights of others. Vulnerable adolescents and young people include those with disabilities, young sex workers, those living with HIV and those who are part of the LGBTI community (lesbian, gay, bisexual, transgender and intersex persons).[41]

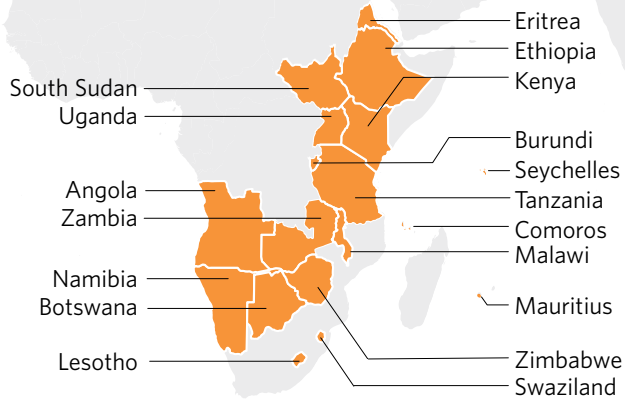
With regard to persons with disabilities, it is estimated that this group makes up 10 per cent of the world's population. A disproportionate 20 per cent of all persons living in poverty in developing countries are persons with disabilities. Stigma, prejudice, and denial of access to health services, education, jobs, and full participation in society make it more likely that a person with a disability will live in poverty.[42]

With regard to persons in same-sex relationships, it should be noted that homosexuality is still illegal in the majority of African countries. The ESA countries under review where this is the case include Angola, Botswana, Burundi, Comoros, Eritrea, Ethiopia, Kenya, Lesotho, Malawi, Mauritius, Namibia, Seychelles, South Sudan, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.[43]

Sexual health cannot be defined, understood or made operational without a broad consideration of sexuality, which underlies important behaviours and outcomes related to sexual health. The working definition of sexuality is: a central aspect of being human throughout life and encompassing sex, gender identities and roles, sexual orientation and reproduction. Sexuality is experienced and expressed in thoughts, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors. Sexual orientation, on the other hand, refers to an enduring pattern of emotional, romantic, and/or sexual attraction to men and women, or to both sexes. Sexual orientation also refers to a person's sense of identity based on those attractions, related behaviours, and membership in a community of others who share those attractions.[44]

The advancement of sexual and reproductive health and rights for adolescents, acknowledging and including those underserved groups such as LGBTI persons, sex workers, HIV-positive youth and those living with a disability, calls for the development of an inclusive agenda that promotes the quality of life and the right to choose whether and when to have children; the right to exercise sexuality free of violence and coercion; the right to protect fertility; and the right to access modern techniques for the prevention, diagnosis and treatment of sexually transmitted infections.

Countries in East and Southern Africa where homosexuality is illegal



[41] ICPD Conference 1994.
[42] WHO/UNFPA Guidance Note *Promoting sexual and reproductive health for persons with disabilities* 2009 p 3.
[43] Amnesty International *Facts and figures* available athttp://www.amnestyusa.org/sites/default/files/making_love_a_crime_-_facts__figures.pdf..

International instruments

- Since the 1990s, various United Nations conference agendas advocated for the advancement and promotion of sexual and reproductive rights. These conferences reiterated that countries should adopt an inclusive view of human rights to health that goes beyond the right to health services. These conferences included the Vienna Conference in 1993 on human rights; the Cairo Conference in 1994 on population and development; and the Beijing Conference in 1995 on women. These conferences transformed the traditional understanding of the right to health by directing attention to girls' and women's rights to bodily autonomy, integrity and choice in relation to sexuality and reproduction. These conferences thus affirmed a more inclusive meaning for the right to health: for women and girls, in particular, the right to health is not only about obtaining health services or providing nutrition, clean water and sanitation, but also includes the right to decision-making, control, autonomy, choice, bodily integrity and freedom from violence and fear of violence.
- The Convention on the Elimination of all Forms of Discrimination Against Women, in Article 5, urges States Parties to take all appropriate measures to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or superiority of either of the sexes *or on stereotyped roles for men and women*.
- Article 26 of the International Covenant on Civil and Political Rights provides that all persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.
- The above-mentioned Covenant – the main international treaty on civil and political rights – is important in relation to sexual orientation because in 1994, in the case of **Toonen vs Australia**, the Human Rights Committee held that the references to "sex" in Articles 2, paragraph 1 (non-discrimination) and 26 (equality before the law) of the ICCPR should be taken to include sexual orientation. As a result of this case, Australia repealed the law criminalizing sexual acts between males in its State of Tasmania. With this case, the Human Rights Committee created a precedent within the UN human rights system in addressing discrimination against lesbians, gays and bisexuals.
- The Adolescent Health General Comment specifically mentions the principle of non-discrimination, which includes non-discrimination on the grounds of sexual orientation and health status, such as HIV status and mental health status.
- The Convention on the Rights of Persons with Disabilities entered into force on 3 May 2008. The Convention is the most rapidly negotiated and adopted international human rights convention in history. Several articles of the Convention have direct relevance to SRH, reproductive rights, and gender-based violence:
  - Article 9 calls for accessibility, including access to medical facilities and to information.
  - Article 16 requires States Parties to take measures to protect persons with disabilities from violence and abuse, including gender-based violence and abuse.

[44] *National Adolescent Sexual and Reproductive Health and Rights Framework Strategy* South Africa Department of Social Development 19 Feb 2015 p 18-19.

- Article 22 asserts the equal rights of persons with disabilities to privacy, including privacy of personal health information.
- Article 23 requires States to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood, and relationships, including in the areas of family planning, fertility, and family life.
- Article 25 requires that States ensure equal access to health services for persons with disabilities, with specific mention of SRH and population-based public health programmes.

- The SADC Model Law on HIV/AIDS in Southern Africa, adopted by the SADC countries on 24 November 2008, provides that the State shall consider the decriminalization of commercial sex work and consensual sexual relationships between adult persons of the same sex as specific measures that may enhance HIV prevention.

Recommendations

There is an obligation on governments to make provision for services and referrals for vulnerable adolescents and young people. The lack of specific provision for the protection of the SRHR of adolescents and young people with disabilities is glaring. Although mainstreaming of the issues is considered to enable inclusivity, there is a need for focused attention to SRH services of adolescents and young people with disabilities, particularly in relation to balancing their special needs while being respectful to their fundamental rights. This includes the point that provision needs to be made for institutions where adolescents and young people can report to or obtain assistance if their SRHR are violated.

One notable concern is the criminalization of same-sex relationships. In some ESA countries homosexual acts committed in respect of minors are subject to increased penalties, irrespective of consent. Some countries, such as Lesotho and Mauritius, specifically criminalize male homosexual acts, with the inference that sexual acts committed between females are excluded.

It is recommended that the following values in the realm of SRHR with regard to vulnerable adolescents and young people, including those with disabilities and those living with HIV, be recognized:

- The inculcation of a core value system that does not ascribe to gender stereotyping or other prejudices, but instead promotes and emphasizes non-discriminatory attitudes, respect for human dignity, gender equality, gender equity, receipt of rights with responsibility, accountability, empathy and tolerance;
- The equipping of adolescents and young people with a sense of inner-belief, self and mutual respect where an understanding towards their own sexuality and that of others, regardless of gender, gender identity, gender expression, sexual orientation, disability, race, ethnicity, nationality etc., is deepened and respected;
- The responsibility of governments to provide comprehensive sexuality education that emphasizes non-discriminatory attitudes and respect;
- The augmentation of the skills and capacity of adolescent and young people to be assertive and exercise self-agency and choice in order to negotiate and take informed decisions about their SRHR and to report cases when their sexual rights are infringed or violated;
- The creation of an environment where adolescents and young people feel free to access SRHR services and information, and exercise personal choice in decisions guided by friendly, non-judgemental and empathetic

health, social and community workers, and with the support of family, on their SRHR;

- The breaking down of barriers with the aim of establishing a philosophy of positive knowledge and health-seeking behaviour among adolescents and young people; and
- The ideal of protecting adolescents and young people from coerced sexual experiences, exploitative sexual and reproductive relationships, sexual and gender-based violence, STIs (including HIV), substance abuse, unintended pregnancies, etc.

With regard to law and policy, it is recommended that –

- There needs to be a legal principle of non-discrimination against vulnerable adolescents and young people in the provision of sexual and reproductive health services;
- School, tertiary education institutions, and workplace policies should have clear provisions that protect adolescents and young people from discrimination based on their HIV status;
- With regard to adolescents with disabilities in particular, stigma, prejudice, and denial of access to health services, education, jobs, and full participation in society should be addressed through awareness-raising campaigns;
- Comprehensive sexuality education provided to adolescents and young people should not discriminate on grounds of sexual orientation, disability and HIV status; and
- Those ESA countries which still have legal provisions prohibiting and criminalizing homosexuality should give consideration to removing such provisions, in line with the SADC Model Law on HIV/AIDS in Southern Africa. Although the Model Law pertains to adults, its provisions need to be applicable to adolescents.

2.7 Criminalization of HIV transmission and access to HIV and AIDS services

In some countries, criminal law is being applied to those who transmit or expose others to HIV infection. There are no data indicating that the broad application of criminal law to HIV transmission will achieve either criminal justice or prevent HIV transmission. Rather, such application risks undermining public health and human rights. Because of these concerns, UNAIDS[45] urges governments to limit criminalization to cases of intentional transmission, for example, where a person knows his or her HIV-positive status and acts with the intention to transmit HIV, and does in fact transmit it. In other instances, the application of criminal law should be rejected by legislators, prosecutors and judges.

In particular, criminal law should not be applied to cases where there is no significant risk of transmission or where the person:

- Did not know that s/he was HIV-positive;
- Did not understand how HIV is transmitted;
- Disclosed his or her HIV-positive status to the person at risk (or honestly believed the other person was aware of his/her status through some other means);
- Did not disclose his or her HIV-positive status because of fear of violence or other serious negative consequences;
- Took reasonable measures to reduce risk of transmission, such as practicing safer sex through using a condom or other precautions to avoid higher risk acts; or
- Previously agreed on a level of mutually acceptable risk with the other person.

UNAIDS has called upon governments to:

- Avoid introducing HIV-specific laws and instead apply general criminal law to cases of intentional transmission;
- Issue guidelines to limit police and prosecutorial discretion in application of criminal law (e.g. by clearly and narrowly defining "intentional" transmission, by stipulating that an accused person's responsibility for HIV transmission be clearly established beyond a reasonable doubt, and by clearly indicating those considerations and circumstances that should mitigate against criminal prosecution); and
- Ensure that any application of general criminal laws to HIV transmission is consistent with their international human rights obligations.

Extending criminal liability beyond cases of deliberate or intentional HIV transmission – to reckless conduct – should be avoided. Such broad application of the criminal law could expose large numbers of people to possible prosecution without their being able to foresee their liability for such prosecution. Prosecutions and convictions are likely to be disproportionately applied to members of marginalized groups, such as sex workers, men who have sex with men, and people who use drugs.

These groups are often blamed for transmitting HIV, despite their having insufficient access to HIV prevention information, services or commodities, or the ability to negotiate safer behaviours with their partners due to their marginalized status. In jurisdictions where HIV transmission has been criminally prosecuted, the very few cases that are prosecuted out of the many infections that occur each year often involve people from ethnic minorities, migrants or men who have sex with men.

[45] Joint United Nations Programme on HIV/AIDS. See Policy Brief: Criminalization of HIV Transmission, available at http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/dataimport/pub/basedocument/2008/20080731_jc1513_policy_criminalization_en.pdf.

Women often learn that they are HIV-positive before their male partners do because they are more likely to access health services, and thus they are blamed for "bringing HIV into the relationship". For many women, it is also either difficult or impossible to negotiate safer sex or to disclose their status to a partner for fear of violence, abandonment or other negative consequences.

Women may face prosecution as a result of their failure to disclose.

In such situations, the better way to protect women from exposure to HIV is to enact and enforce laws protecting them from sexual violence, discrimination based on gender and HIV status, and inequality in employment, education, and domestic relations, including property, inheritance and custody rights.

International instruments and SADC Model Law

- Guideline 4 of the OHCHR and UNAIDS (2006) International Guidelines on HIV/AIDS and Human Rights (UNAIDS, Geneva) states that criminal and/or public health legislation should not include specific offences against the deliberate or intentional transmission of HIV, but rather should apply general criminal offences to these exceptional cases. Such applications should ensure that the elements of foreseeability, intent, causality and consent are clearly and legally established to support a guilty verdict and/or harsher penalties.
- Articles 3, 7 and 12 of the Universal Declaration of Human Rights and Article 12 of the International Covenant on Economic, Social and Cultural Rights emphasize, in particular, the individual's rights to privacy, the highest attainable standard of health, freedom from discrimination, equality before the law, and liberty and security of the person.
- On 24 November 2008, at its 24th Plenary Assembly session convened in Arusha, Tanzania, the Southern African Development Community (SADC) Parliamentary Forum adopted the Model Law on HIV/AIDS in Southern Africa. Many SADC Member States are party to treaties relevant to HIV and AIDS, such as the International Covenant on Civil and Political Rights (1966), the Convention on the Rights of the Child (1989), and the Convention on the Elimination of All Forms of Discrimination Against Women (1979). In addition, there are numerous non-binding but persuasive documents that inspired the Model Law, such as the International Guidelines, the UNGASS Declaration of Commitment on HIV/AIDS (2001), and the Millennium Development Goals (2000). All SADC members are party to the African Charter on Human and People's Rights (1981), and subscribe to the Abuja Declaration and Plan of Action on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (2001), and the Maputo Declaration on HIV/AIDS, Tuberculosis, Malaria and Other Related Infectious Diseases (2003).
- The Model Law also builds on instruments previously adopted under the auspices of SADC, such as the SADC Protocol on Health (1999), the SADC Code on HIV/AIDS and Employment (1997), the SADC Declaration on Gender and Development (1997) and the Addendum to the Declaration on Gender and Development by SADC (1998), the Maseru Declaration on the Fight against HIV/AIDS in the SADC Region (2003), and the SADC Protocol on Gender and Development (2008).

Essentially, the Model Law –

- Provides for the protection of vulnerable and marginalized groups, which include adolescents and young people, women, sex workers, injecting drug users, refugees, immigrants, prisoners, internally displaced persons, indigenous and mobile populations, men who have sex with men, lesbians, transgenders and bisexuals;

- Addresses the root causes of HIV transmission such as cultural practices and attitudes;
- Emphasizes the importance of information, education and communication;
- Rejects coercive approaches to HIV.

Moving away from coercive approaches to HIV-related legislation, the Model Law pledges to 'ensure that the human rights of people living with or affected by HIV are respected, protected and realized in the response to AIDS'. A careful analysis of the Model Law shows that this pledge has been upheld throughout its content. Indeed, the Model Law does not include any provision that restricts access to information, or that provides compulsory disclosure of HIV status, or that subjects certain groups to compulsory HIV testing. *Most importantly, the Model Law does not provide for the criminalization of HIV transmission.*

Recommendations

Notwithstanding the fact that most of the countries under review have legislative provisions criminalizing the transmission of HIV, countries such as Angola, Ethiopia, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, South Africa, Tanzania, Uganda and Zambia also have laws protecting people living with HIV against discrimination. Mauritius, South Africa, Swaziland and Tanzania appear to be the only countries that have no specific provisions on the criminalization of HIV transmission.

The inappropriate or overly broad application of criminal law to HIV transmission creates a real risk of increasing stigma and discrimination against people living with HIV, thus driving them further away from HIV prevention, treatment, care and support services. An increasing number of adolescents and young people living with HIV were born with the virus and often have never been told of their status. Criminalization of HIV transmission could trap in the net of criminality this group of adolescents and young people who, through no fault of their own, are not aware of their HIV-positive status.

In some countries, such as South Africa, there is a realization that HIV-specific statutory offence/s will infringe the right to privacy to an extent that is not justified. The transmission of or exposure to HIV in the context of consensual sexual relationships involves the most intimate aspects of human interaction. The enforcement of an HIV-specific offence will call for inquiry into the medical histories and sexual affairs of both the accused and his or her sexual partner/s. Such infringement of privacy may not be justified in circumstances where the creation of an HIV-specific offence is not based on evidence establishing a need for such offence/s; where such offence/s may serve no purpose additional to the existing common law offences; and would have no impact on diminishing or preventing the spread of HIV.

It is generally believed that such offence/s would be counterproductive to public health efforts to curb the spread of the disease; would entrench further discrimination and stigmatization of persons with HIV; and would drain scarce resources from the most effective HIV prevention programmes, such as targeted education campaigns, condom distribution initiatives, and the provision of voluntary, accessible testing, counselling and medical treatment.

It is therefore recommended, in line with the SADC Model Law on HIV/AIDS, that countries give serious consideration to decriminalizing the transmission of HIV. As pronounced in the Model Law, States should take special measures to ensure effective protection against the transmission of HIV, in particular for vulnerable and marginalized adolescents and young people, through means such as the

provision of information, education, and male and female condoms.

Eight of the countries under review do not form part of SADC. These countries are Burundi, Comoros, Eritrea, Ethiopia, Kenya, Rwanda, South Sudan and Uganda. It is recommended that the non-SADC countries that have criminalized the transmission of HIV give serious consideration to amending their laws in this regard.

Instead of applying criminal law to HIV transmission, governments need to expand programmes which have been proven to reduce HIV transmission, while protecting the human rights both of people living with HIV and those who are HIV negative. Such measures include providing HIV information, support and commodities to people so they can avoid exposure to HIV through practising safer behaviours; increasing access to voluntary confidential HIV testing and counselling; and addressing HIV-related stigma and discrimination. Prevention programmes should include positive prevention efforts which empower people living with HIV, including adolescents and young people, to avoid transmitting HIV to others, to be made aware of their HIV-positive status in the case of vertical transmission, to voluntarily disclose their positive status in safety, to avoid new sexually transmitted infections, and to delay HIV disease progression.

Governments need to strengthen and enforce laws against rape (inside and outside marriage), and other forms of violence against women and children; improve the efficacy of criminal justice systems in investigating and prosecuting sexual offences against women and children; and support women's equality and economic independence, including through concrete legislation, programmes and services. These are the most effective means by which to protect women and girls from HIV infection and it is recommended that this be given the highest priority.

Governments should abide by international human rights conventions on equal and inalienable rights, including those related to health, education and social protection of all people, including people living with HIV. It is recommended that HIV-specific criminal laws, laws directly mandating disclosure of HIV status, and other laws which are counterproductive to HIV prevention, treatment, care and support efforts, or which violate the human rights of people living with HIV and other vulnerable groups, be repealed.

The following recommendations should be considered:

- The application of general criminal law only to the intentional transmission of HIV, and the monitoring of the application of general criminal law to ensure it is not used inappropriately in the context of HIV;
- The redirection of legislative reform and law enforcement towards addressing sexual and other forms of violence against women, and discrimination and other human rights violations against people living with HIV and people most at risk of exposure to HIV;
- Ensuring that civil society, including women's and human rights groups, representatives of people living with HIV and other key populations, is fully engaged in developing and/or reviewing HIV laws and their enforcement;
- Promoting gender equality in education and employment, providing age-appropriate sexuality and life skills education (including negotiation skills) to children, adolescents and young people, and enacting and enforcing laws to promote women's rights to property, inheritance, custody and divorce, so that women can avoid and leave relationships that place them at risk of exposure to HIV;
- There is a need to significantly expand access to proven HIV prevention (including positive prevention) programmes, and support voluntary counselling and testing for couples, voluntary disclosure, and ethical partner notification.

2.8 Cultural, religious and traditional practices that are harmful

Traditional and cultural practices reflect values and beliefs held by members of a community for periods often spanning generations. Every social grouping in the world has specific cultural, religious or traditional practices and beliefs, some of which are beneficial to all members, while others are harmful to a specific group, such as women. It must be emphasized that this theme deals only with practices that are harmful to adolescents and young people, and not those that do not impact negatively on the health and well-being of this group of people. It is also important to note that the majority of harmful practices involve adolescent girls and women, which makes them particularly vulnerable.

These harmful cultural, religious or traditional practices include female genital mutilation (FGM); traditional male circumcision conducted in unhygienic places by unqualified people; forced feeding of women; early marriage or a union simulating marriage; the various taboos or practices which prevent women from controlling their own fertility; nutritional taboos and traditional birth practices; son preference and its implications for the status of the girl child; female infanticide; early pregnancy; sexual initiation ceremonies or rites of passage; virginity testing; and violence against children, adolescents and young people suffering from some form of disability. FGM is known to be practised in at least 25 countries in Africa. Infibulation (involving excision plus the removal of the female labia and the sealing of the two sides, through stitching or natural fusion of scar tissue) is practised in Djibouti, Egypt, some parts of Ethiopia, Mali, Somalia and the northern part of the Sudan. Excision and circumcision occur in parts of Benin, Burkina Faso, Cameroon, the Central African Republic, Chad, Côte d'Ivoire, the Gambia, the northern part of Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Mauritania, Nigeria, Senegal, Sierra Leone, Togo, Uganda and parts of the United Republic of Tanzania.[46]

As early as the 1950s, United Nations specialized agencies and human rights bodies began considering the question of harmful traditional practices affecting the health of women, in particular female genital mutilation. The activities of human rights bodies in this field have resulted in noticeable progress in recent years. Traditional practices have become a recognized issue concerning the status and the human rights of women and female children.

Most of the harmful cultural practices encountered in ESA pertain to women and young girls, although some harmful practices involve young adolescent males only. In particular, these practices relate to initiation ceremonies or rites of passage, where sexual initiation, including forced male circumcision, may take place. Malawi, South Africa and Zambia have a host of practices that adversely affect young adolescent males during initiation ceremonies, where traditional circumcisions are performed on young men in an unhygienic manner and without pain killers, sometimes causing genital maiming and even death. In these countries, some practices encourage or even force both males and females to lose their virginity, sometimes not to a partner of their choosing.

[46] OHCHR Fact Sheet No 23 *Harmful Traditional Practices Affecting the Health of Women and Children* available at http://www.ohchr.org/Documents/Publications/FactSheet23en.pdf.

International instruments

Numerous international and regional instruments, either directly or indirectly, prohibit harmful cultural, religious or traditional practices:

- The International Covenant on Civil and Political Rights (ICCPR) prohibits discrimination on the basis of sex, and mandates States Parties to "ensure that any person whose rights or freedoms as herein recognized are violated shall have an effective remedy." (Article 2). In addition, the ICCPR protects individuals from "torture or cruel, inhuman or degrading treatment" and arbitrary or unlawful interference with his or her privacy. (Articles 7 and 17.)
- More recently, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and the Convention on the Rights of the Child (CRC) focus on the rights of women and girls and also provide a basis for the elimination of FGM as a human rights violation.
- CEDAW (1979) defines discrimination against women as:

  "...any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field." (Article 1.) Although not explicitly mentioned, the practice of FGM fits within the definition of discrimination against women as set forth in CEDAW. It is a practice exclusively directed towards women and girls with the effect of "nullifying their enjoyment of fundamental rights." Whatever the common justifications for the practice of FGM, whether cultural or religious, FGM causes great short-term and long-term physical and mental harm to its victims and perpetuates the fundamental discriminatory belief of the subordinate role of women and girls.

  In addition, States Parties to CEDAW are required to: "modify the social and cultural patterns of conduct ... with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women." (Article 5.)
- Further support for the principle that FGM is a form of gender discrimination pursuant to CEDAW can be found in the General Recommendation Nos. 14, 19 and 24 from the Committee on the Elimination of Discrimination against Women (CEDAW). These recommendations note the severe health and other consequences for women and girls subjected to FGM; identify FGM as a form of violence against women; and recommend that States Parties take measures to eliminate the practice of FGM. (See below: UN Treaty Monitoring Committees.)
- The Convention on the Rights of the Child (CRC) places with the government the ultimate responsibility for ensuring that the fundamental rights of children are recognized and protected. The guiding standard established by the CRC is "the best interests of the child." (Article 3.)
  - Article 19 requires States Parties to "take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence ...while in the care of parent(s), legal guardian(s) or any other person who has the care of the child." (Article 19(1).)
  - Article 24 requires States to "take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children." (Article 24(3).)
  - The country reports of the Committee on the Rights of the Child consistently recognize FGM as a harmful traditional practice that is against the best interests of the child and repeatedly call for its elimination. (See: Concluding Observations of the Committee on the Rights of the Child:

Ethiopia (1997), (Para. 6); Concluding Observations of the Committee on the Rights of the Child: Sudan (1993), (Para. 13); Concluding Observations of the Committee on the Rights of the Child: Togo (1997), (Para. 24)).

- Article 1 of the UN General Assembly Declaration on the Elimination of Violence Against Women defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life." (Article 1.) Article 2 explicitly identifies FGM as such a form of violence against women. (Article 2(a).)
- Furthermore, the United Nations General Assembly has repeatedly called for more attention to the practice of FGM and for more efforts by States for its elimination and protection of women and girls from the practice.[47]
- General Assembly Resolution 61/143 (2007) reminded States that they must not use customs, traditions, or religious beliefs as excuses for avoiding their obligation to eliminate violence against women and girls.
- On December 20, 2012, the United Nations General Assembly passed a unanimous resolution condemning FGM (UN Document A/RES/67/146). The resolution urges all countries to condemn the practice of FGM, to implement and enforce legislation banning FGM, and to establish programmes raising awareness about FGM. The resolution further calls for all countries to allocate the necessary resources to protect women and girls from FGM, including refugee women and women migrants.[48]
- In 2010, the Commission on the Status of Women adopted a resolution entitled Ending Female Genital Mutilation. This resolution recognizes that female genital mutilation is a human rights violation that results in irreparable harm and constitutes a serious threat to the health of women and girls. The resolution sets forth specific multilevel State recommendations in order to eliminate FGM. The resolution calls on States to condemn the practice, enact and enforce legislation prohibiting FGM, as well as penalties for violations of prohibitions. In addition, the resolution:
  - 13. Urges States to review and, where appropriate, revise, amend or abolish all laws, regulations, policies, practices and customs, in particular female genital mutilation, that discriminate against women and girls or have a discriminatory impact on women and girls and to ensure that provisions of multiple legal systems, where they exist, comply with international human rights obligations, commitments and principles, including the principle of non-discrimination.
  - 15. Calls upon States to develop policies, protocols and rules to ensure the effective implementation of national legislative frameworks on eliminating discrimination and violence against women and girls, in particular female genital mutilation, and to put in place adequate accountability mechanisms at the national and local levels to monitor adherence to and implementation of these legislative frameworks.
- The African Charter on the Rights and Welfare of the Child (African Charter) follows the standard established by the CRC, that the "best interests of the child shall be the primary consideration" by an individual or authority in addressing issues related to children. (Article 4(1).) The Charter protects against discrimination and children's rights to survival, protection, privacy, and physical, mental, and spiritual health. (Articles 3, 5(2), 10, 14(1).)

[47] See: United Nations, General Assembly Resolutions and Secretary-General Reports on Traditional or Customary Practices Affecting the Health of Women and Girls; Report of the Secretary-General (Fifty-third Session, 10 September 1998) A/RES/53/354, paras. 17-18); United Nations, General Assembly Resolution on Traditional or Customary Practices Affecting the Health of Women and Girls; Report of the Third Committee (30 January 2002) A/RES/56/128; United Nations, General Assembly Resolution on Traditional or Customary Practices Affecting the Health of Women and Girls, Report of the Third Committee (7 February 2000) A/RES/54/133.

[48] See: United Nations, General Assembly Calls for Elimination of Female Genital Mutilation (Sixty-seventh General Assembly, 20 December 2012.

Furthermore, the African Charter requires Member States of the Organization of African Unity to:

"...take all appropriate measures to eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child and in particular:

- Those customs prejudicial to the health or life of the child; and
- Those customs and practices discriminatory to the child on the grounds of sex or other status." Article 21(1).

- The more recent Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (the Maputo Protocol) mandates States Parties to "...adopt such other legislative, administrative, social and economic measures as may be necessary to ensure the prevention, punishment and eradication of all forms of violence against women." (Article 4.) This Protocol also specifically directs States Parties to prohibit and eliminate harmful practices, explicitly including FGM:
  - "Article 5 – Elimination of Harmful Practices

    States Parties shall prohibit and condemn all forms of harmful practices which negatively affect the human rights of women and which are contrary to recognized international standards. States Parties shall take all necessary legislative and other measures to eliminate such practices, including:

    Creation of public awareness in all sectors of society regarding harmful practices through information, formal and informal education and outreach programmes;

    Prohibition, through legislative measures backed by sanctions, of all forms of female genital mutilation, scarification, medicalization and para-medicalization of female genital mutilation and all other practices in order to eradicate them;

    Provision of necessary support to victims of harmful practices through basic services such as health services, legal and judicial support, emotional and psychological counselling as well as vocational training to make them self-supporting;

    Protection of women who are at risk of being subjected to harmful practices or all other forms of violence, abuse and intolerance."
- The 1998 Banjul Declaration on Violence against Women – Inter-African Committee on Traditional Practices and the Gambia Committee on Traditional Practices Affecting the Health of Women and Children (GAMCOTRAP) strongly condemns the practice of FGM and the misuse of religious argument to promote the practice.
- The Joint General Recommendation No. 31 of the Committee on the Elimination of Discrimination against Women/General Comment No. 18 of the Committee on the Rights of the Child on harmful practice *inter alia* places an obligation on States Parties to repeal, without further delay, all legislation that condones, allows or leads to harmful practices, including traditional, customary or religious laws and any legislation that accepts the defence of honour as a defence or mitigating factor in the commission of crimes in the name of so-called honour;
- Under the Addis Ababa Declaration on Development in Africa beyond 2014, States Parties commit, among others, to protect the dignity and rights of women and girls by eradicating all harmful practices, including early and/or forced marriages, and female genital mutilation/cutting, through adopting and enforcing laws that prohibit such practices and creating awareness around the harmful health consequences.

Recommendations

International standards make it clear that all forms of harmful cultural, religious or traditional practices must be outlawed. It is encouraging to note that the majority of ESA countries have adopted legislation to prohibit such practices, although there is a concern that these practices still occur despite legislative protection. For example, in Swaziland, this protection is thwarted by traditional leaders in respect of the practice known as kwendisa (the marrying of an underage girl to an older man). In Lesotho, there is a lack of complete enforcement. It is doubtful that any of these harmful customary law practices have been codified, and therefore civil law prohibiting the same must essentially take precedence.

Although national legislation and international standards are vital in tackling the issue of harmful cultural, religious or traditional practices, there is an urgent need for a parallel programme that addresses the cultural environment where these practices are rooted, in order to eliminate the various justifications used to perpetuate them and to work together with communities to retain some of the positive meaning behind harmful practices while replacing them with symbolic, non-harmful ones. It is the duty of countries to modify the social and cultural attitudes of both men and women, with a view to eradicating customary practices based on the idea of the inferiority or superiority of either sex or on stereotyped roles of gender.

It is recommended that countries, to the extent that this has not already been done, need to–

- Ensure sufficient enforcement mechanisms, possibly by substantially increasing existing penalties and also through education and information campaigns;
- Adopt legislation prohibiting practices harmful to the health of women, children, adolescents and young people, and ensure that all types of harmful practices prevalent in the country are targeted (such as FGM, virginity testing and child marriage);
- Enact provisions to regulate safe and hygienic traditional and religious male circumcision;
- Provide for consent to be given for non-harmful cultural, religious or traditional practices where the adolescent is of sufficient age and maturity to give consent;
- Specifically enact legislative provisions prohibiting the giving out of a child in marriage (or a union simulating marriage) or engagement if such child is below the minimum age of 18, with no exceptions;
- Establish a national committee to eliminate harmful cultural, religious or traditional practices;
- Establish a monitoring body or use existing bodies, such as human rights institutions, to implement the official policy adopted;
- Invest in educational campaigns and awareness raising mechanisms to eliminate prejudices against women and children;
- Ensure that Parliament fulfils its oversight role to protect adolescents and young people and cooperate with and consult religious institutions and their leaders and other traditional leaders and authorities in order to eliminate/modify harmful cultural, religious or traditional practices;
- Revise constitutional provisions permitting harmful cultural, religious or traditional practices; and
- Provide for extraterritorial jurisdiction of courts and law enforcement in cases where borders are crossed to perform harmful practices.

2.9 Learner pregnancy laws and policies

Adolescent pregnancy and the stigmatization that accompanies it continue to expose deep-rooted prejudices that exist globally. The prevailing attitude of vilifying pregnant adolescent girls leads many schools to opt for a punitive response by banishing pregnant girls from school and not allowing them to return. This response leads to the further alienation of pregnant teens when they so desperately need support and encouragement to successfully complete their schooling. The motivation behind discrimination is the view that a pregnant adolescent, who visibly displays the signs of her supposed misconduct, must be punished by exclusion. This will also avoid peers from emulating the same behaviour.

Statistics regarding adolescent pregnancy have been quoted earlier. Worldwide, more than 15 million girls aged 15 to 19 years give birth every year, with 19 per cent of young women in *developing countries* becoming pregnant before they turn 18.[49] Girls under 15 years account for 2 million of the 7.3 million births that occur to adolescent girls under 18 every year in developing countries.[50]

The educational consequences of learner pregnancy and parenting are twofold: young mothers and fathers run a risk that they will not obtain the educational skills needed to become self-supporting, economically productive citizens, and this in turn results in their children entering the educational system with economic and developmental disadvantages. The importance of providing adolescents with the knowledge, skills, attitudes and values they need regarding their sexuality and the accompanying social responsibilities cannot be over-emphasized. The principle that it is best for learners to abstain from sexual activity should be stressed, but this advice should be offered within the provision of broader ASRHR services, including contraception and safe abortion where that is legally possible.

The school should aim to enable the learners whose futures could be jeopardized to achieve success in the classroom and in their personal lives. It is essential for the learner concerned that her education should continue with as little disruption as possible. Alternative suitable arrangements must be made to cover the curriculum. This means that lesson notes and assignments must be made available to her and that she must take responsibility for completing and returning the assignments to the school for continuous assessment. Schools should also enable parents and guardians to play a more active role in the sexuality education of their children by presenting parent involvement and educational support programmes.

Section 26(3) of the Child Act 10 of 2008 in South Sudan protects the female adolescent from being expelled from school due to pregnancy or motherhood or being hindered from continuing her education after one year of nursing.

A country that has to be singled out for having adopted a comprehensive learner pregnancy policy in recent times is Namibia. It is known as the Education Sector Policy for the Prevention and Management of Learner Pregnancy.

- The goal of this policy is to improve the prevention and management of learner pregnancy in Namibia, with the ultimate aim of decreasing the number of learner pregnancies and increasing the number of learner-parents who complete their education.
- Regarding sexual and reproductive health, the policy requires schools to strive to ensure that learners, both boys and girls, are educated about the benefits of abstinence, the risks of engaging in sexual activity at a young age, the appropriate use of contraception, and the right of both male and female learners to free and informed choice in respect of sexual matters. A trained and full-time Life Skills teacher is required to adequately fulfil this task. However, as an interim measure, the Principal should designate at least two specific teachers and/or teacher-counsellors for this task. All such personnel should be role models with whom

[49] UNESCO, *Emerging evidence, lessons and practice in comprehensive sexuality education: A global review,* 2015 p 13..
[50] UNFPA, *Motherhood in childhood: Facing the challenge of adolescent pregnancy,* 2013 p v.

learners can easily identify, and they should encourage active learner participation in discussing these issues. The lessons should include information on sexual and reproductive health, gender equality, mutual respect in relationships, self-esteem, assertiveness, empowerment, interpersonal communication skills, the right to sexual autonomy, and alcohol-related issues. Girls should be targeted with information on how to avoid placing themselves in situations of sexual vulnerability, such as by accepting gifts from older men. Boys should be targeted for information on girls' right to refuse sexual activities. Both boys and girls should be targeted for programmes teaching that healthy relationships should not be based on financial/transactional considerations. Schools will be encouraged to provide Comprehensive Sexuality Education (CSE). The principal should work with the programme organizers on strategies to increase the number of learners reached, with the aim of ensuring that all learners are exposed to CSE.

- In addition, the policy requires schools to ensure that the school and the school hostel environments are safe and that learners are free from sexual harassment or sexual abuse by learners, teachers or other staff. Any non-professional relationship or sexual involvement of a teacher with a learner, whether or not it results in pregnancy, will be considered to be a serious violation of the Code of Conduct for the Teaching Service. Failure to comply with this Code of Conduct must be dealt with in terms of Namibia's Public Service Act. This means that the misconduct could lead to suspension, followed by an enquiry, with the ultimate result being possible dismissal and criminal charges where the actions in question constitute a crime.
- In cases where prevention measures fail and learners become pregnant, the school should endeavour to manage the situation by supporting pregnant learners, expectant fathers and learner-parents to combine continuation of their education with the responsibilities of parenthood, without compromising the best interests of the infant or the learner. This process should be collaborative between the school, the pregnant learner, the expectant father and their families, and should involve participatory decision-making.
- Each situation should be assessed and evaluated individually, with sensitivity to the learner's health, financial situation, options for child care, family support or lack of support, the timing of the delivery in relation to the school calendar, and the needs of the newborn child. The school should respect each learner's right to confidentiality. To ensure that the best interests of the infant and pregnant learner/expectant father/learner-parents are met, the school should encourage efficient coordination among service providers. The aim of this policy is to ensure that the female learner who becomes pregnant and the male learner who shares responsibility for the pregnancy are treated as equally and fairly as possible. Due to the biological differences between learner-mothers and learner-fathers, the learner-mother will be excused from school for a period based on her health needs and the needs of the infant, while the learner-father will not be excused from school. The differential treatment of mothers and fathers in this policy is modelled on the similar approach taken in Namibia's labour laws. It must be noted that the leave of absence provided for the pregnant learner/learner-mother is not in the nature of punishment and therefore need not be applied in the same way to the learner-father. It should also be noted that allowing the learner-father to remain in school does not mean that his role in parenting is being ignored. Schools should help both the mother and the father understand their different roles and responsibilities during this time.

International instruments

- The African Charter on the Rights and Welfare of the Child provides, in Article 11(6), for the right of every child to an education and requires States Parties to have all appropriate measures in place to ensure that children who become pregnant before completing their education shall have an opportunity to continue with their education on the basis of their individual ability.
- The Ministerial Commitment on Comprehensive Sexuality Education and Sexual Reproductive Health Services for Adolescents steps up the obligations and requires the relevant ministers to:
  - Maximize the protective effect of education through Education for All by keeping children and young people in school, which reduces HIV risk, maternal mortality and improves gender equality, whilst ensuring access to educational opportunities for those living with HIV and young women who are pregnant; and
  - Strengthen gender equality and rights within education and health services, including measures to address all forms of sexual violence, abuse and exploitation in and around school and community contexts while ensuring legal and other services for boys and girls, young men and women.
- The Addis Ababa Declaration on Development in Africa Beyond 2015 calls on States Parties to:
  - Review, revise and amend or abolish all laws, policies, practices and customs that have a discriminatory impact on women and youth, especially girls, without distinction of any kind, and ensure that the provisions of multiple legal systems comply with international human rights regulations and laws; and
  - Create a supportive environment to keep the girl child, including married girls and pregnant girls, in school at all levels of education and ensure admission and re-entry to school after delivery.

Recommendations

Only half of the ESA countries reviewed have legislation and policies on the management of learner pregnancy and re-entry after delivery. Angola, Burundi, Comoros, DRC, Eritrea, Ethiopia, Lesotho, Madagascar, Mauritius and Seychelles appear to be lacking legislative provisions or policies in this respect. The majority of those countries that do have policies tend to approach learner pregnancy from a punitive perspective and this is clear from some of the policies that bar learners from returning to the school or that expel them on grounds of pregnancy. These approaches are not in line with international obligations. A more accommodating approach that follows general principles guided by a rights-based framework and considers an individual learner's needs and circumstances would be more appropriate.

It is recommended that the following goals of a comprehensive learner pregnancy framework be recognized:

- To create a well-publicized policy of inclusion and support for learners in cases where pregnancy has occurred;
- To increase learner education about sexual responsibility and sexual health to prevent second pregnancies among learner-parents;
- To promote the continued education of pregnant learners, expectant fathers and learner-parents;
- To promote shared responsibility for the

pregnant learners, expectant fathers and learner-parents between themselves, the extended family, the school and other line ministries;

- To neutralize stigmatization of and discrimination against pregnant learners;
- To promote participatory decision-making among all stakeholders; and
- To maintain a school environment free from sexual harassment or abuse, with consequences in place for perpetrators.

It is further recommended that the legislation or policy should apply not only to schools but also to other training, vocational or educational institutions, and needs to –

- Make provision for respect for the privacy of the pregnant learner;
- Adopt a non-punitive approach to adolescent pregnancy;
- Clearly state that adolescent girls should not be withdrawn or excluded from a school or institution due to pregnancy or marriage;
- Provide for time frame within which a learner has to notify the school or institution of the pregnancy as a matter of choice;
- Include measures for the retention of pregnant learners and allowing them to continue with their education until they are close to delivery;
- Make it clear that learner pregnancy is not a disciplinary issue and does not result in the expulsion of the pregnant learner;
- Make provision for referral of the learner to health and other related services she or he may require;
- Not exclude/expel the learner who is responsible for the pregnancy where he was in a consensual relationship with the pregnant girl;
- Obligate the school or institution to report to the educators' bodies and Ministry of Education where the pregnancy is as a result of a relationship with a teacher or rape by a teacher or other staff member;
- Provide for re-entry after delivery, based on the learner's readiness, and not exclude the learner's return to school or the institution based on rigid rules;
- Ensure that the consent of parents, husbands or families is not a requirement for the re-entry of the learner into school or an institution;
- Provide for support to the learner during pregnancy, birth and re-entry by a trained staff member at school or the institution, which may include state-provided financial and psychosocial support;
- Provide for collaboration by the Ministry or Department of Education with other relevant Ministries or Departments in providing support;
- Include measures aimed at de-stigmatizing pregnancy among adolescents, and using the opportunity to inform and educate other learners on the importance of obtaining SRH information and services so as to prevent pregnancies.

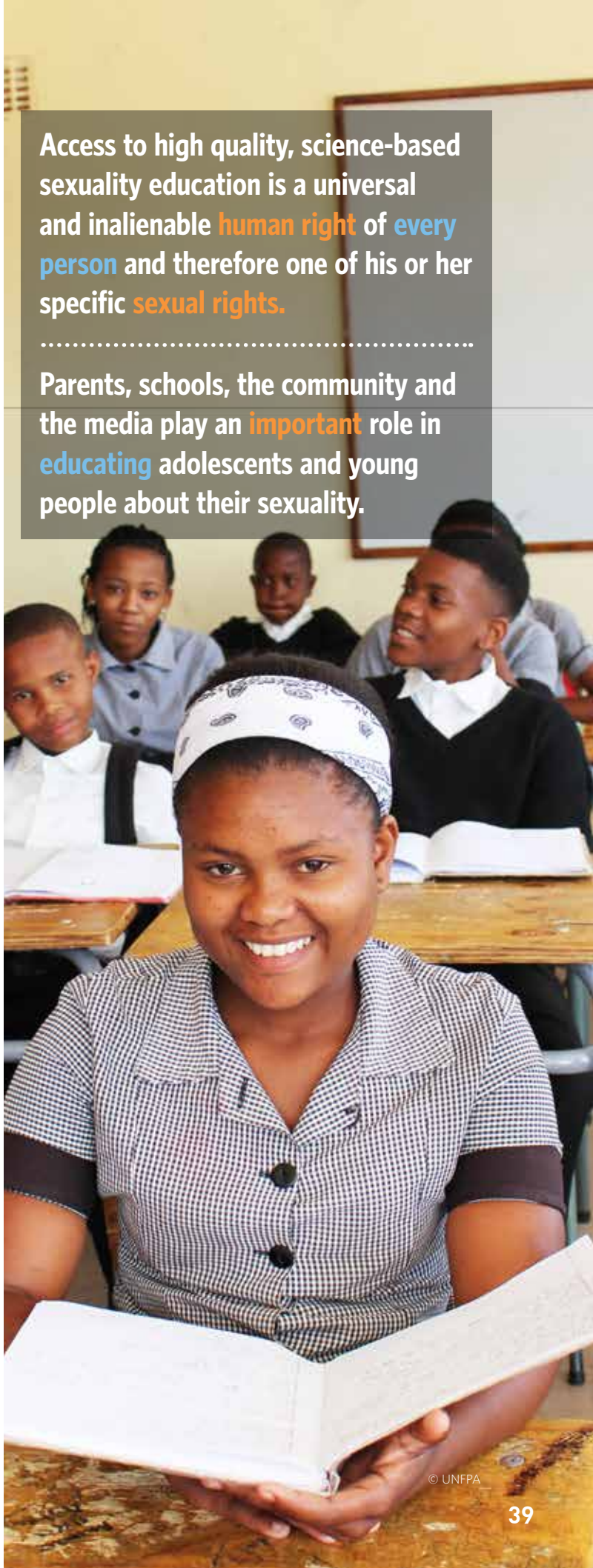
2.10 Provision for Comprehensive Sexuality Education[51]

Comprehensive Sexuality Education (CSE) needs to be a compulsory part of education in order to attain the optimal development of any person from early childhood. CSE must also be understood in the framework of human rights. Access to high quality, science-based sexuality education is a universal and inalienable human right of every person and therefore one of his or her specific sexual rights. It must be emphasized that CSE is not only a matter for schools and vocational institutions. It should be seen in its totality, which includes interaction between adolescents and young people as well as adults and the community as a whole. Parents, schools, the community and the media play an important role in educating adolescents and young people about their sexuality.

As guarantors of the fulfilment of these universal rights, countries have the duty to take all necessary and sufficient measures to ensure that CSE is offered within the education system. Accordingly, neither States, parents nor legal guardians have the option of preventing minors from receiving CSE, nor may they exempt themselves from the responsibility to promote and impart it. Sexuality education is essential to the full development of health, as defined by the World Health Organization (WHO), which implies the total well-being of the person, rather than merely reproductive health. It is not just a matter of preventing sexually transmitted diseases, but involves a much broader approach related to the complete development, well-being and health of the person. There is clear evidence that CSE has a positive impact on sexual and reproductive health, notably contributing towards reducing sexually transmitted infections (STIs), HIV, and unintended pregnancy.[52]

Access to high quality, science-based sexuality education is a universal and inalienable human right of every person and therefore one of his or her specific sexual rights.

Parents, schools, the community and the media play an important role in educating adolescents and young people about their sexuality.



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[51] Most of the information under this section has been gleaned from *Science-Based Sexuality Education: Madrid Consensus Paper* 2011 available at www.desexologia.com.

[52] UNESCO, *Emerging evidence, lessons and practice in comprehensive sexuality education: A global review,* 2015 p 7.

CSE is appropriately understood from a positive and holistic standpoint. It has to do with the well-being of people and with an education for life, love, autonomy, freedom, and respect; with respect for people's dignity and individual value; with guarantees of non-discrimination of any nature; with gender equality; with the eradication of violence and sexual abuse in couples and family relationships; and with enabling people to discover the richness found in differences and in personal growth. Ultimately, it means to advocate for a full and healthy life in which people are able to experience their sexuality in a happy and responsible way, as part of the complete development of their personality. A key factor in the successful achievement of these objectives is the early beginning of sexuality education. Every institution that deals with people should be involved in comprehensive education, including the subject of sexuality, understanding that this is a lifelong process and adapting its contents to the needs of each developmental stage. In addition to the legal framework and the perspective of health and well-being, the contents of this sexuality education should be designed with the following parameters in mind:

- A gender- and rights-based perspective;
- Respect for diversity, including non-discrimination;
- Cultural and social context specificity (including work with communities);
- Sexual abuse prevention, working with children as both potential victims and potential aggressors.

The methodology for designing CSE programmes should:

- Ensure content quality and comprehensiveness;
- Be age-appropriate;
- Be gender and rights based;
- Guarantee the empirical evidence underlying contents and arguments and, therefore, their scientific basis;
- Provide opportunities to explore and clarify values and attitudes and develop/strengthen skills related to healthy sexuality and SRHR;
- Promote and sustain risk-reducing behaviour, including health-seeking behaviour and links/referrals to health services;
- Involve adolescents in the design of the programmes and their contents;
- Include participatory learning activities that stimulate critical thinking and expression;
- Be realistic;
- Be non-judgemental.

The following strategies are particularly relevant to the promotion of sexuality education:

- Messages targeting decision makers in different fields should be designed to include the following:

a. The public health perspective, with a cost-benefit approach and arguments that support the benefits of investing in CSE. Not only does CSE do no harm, it is also conducive to complete human development and reduces medium- and long-term health costs.

b. The State's responsibility and duty to ensure investment in individual health and well-being, in addition to institutional and social benefits. The State has a role to play in the context of interpersonal relations by promoting values education and the incorporation of models of non-violent affective relationships.

c. The human rights framework, which spotlights the role of the State, as well as that of regions, provinces, autonomous communities, federal entities, departments, municipalities, and any other level of government, as guarantors of respect for human rights, including sexual rights. It is incumbent on States to include science-based sexuality education in the education curriculum and to ensure that sufficient human and economic means are available for its implementation.

d. The social justice perspective, since sexuality education contributes to equality, non-discrimination, and the empowerment of vulnerable and disadvantaged groups.

- If sexuality education programmes are to be implemented effectively, the education and

health systems must coordinate their efforts around sexuality education and the promotion of complete health. This, among other things, implies that CSE has the potential to create the demand for SRH services and the health sector then has the obligation to supply quality, youth-friendly SRH services to young people.

- Political advocacy must employ science-based and convincing arguments. These arguments are premised on four essential principles: human rights, gender equality, personal autonomy in decision-making, and acceptance and respect for diversity. It is necessary to identify conceptual errors and inaccuracies in opposing arguments publicly, making the distinction between values and scientific data, and using relevant empirical evidence to substantiate arguments in favour of sexuality education.
- It is important to demand that States comply with international human rights legal instruments.
- It is necessary to standardize messages about sexuality education intended for political agents and decision makers and for society as a whole.
- It is necessary to recognize accomplishments and maintain a positive outlook concerning the progress made, while retaining a critical perspective as to what remains to be done and the specific concerns being addressed.
- Networking among the institutions and agents involved in sexuality education is essential for its implementation. It is necessary to develop resources that facilitate networking and ensure that professionals have access to them (web, consensus papers, educational programmes, etc.).
- It is necessary to design and promote specific professional training programmes for educators. This training should be part of the university curricula (pre-service teacher training) and also be offered through in-service training for educators already working in the field. Training should include:

  a. The use of participatory pedagogical tools: understanding, listening, learning; use of interactive learning activities to not only impart facts but also explore and clarify values and attitudes and develop/strengthen skills and behaviours that promote healthy SRH;

  b. Science-based content based on previously developed international standards.

In a ten-country review of school curricula pertaining to sexuality education in the ESA region, it was found that, overall, the Botswana and Swaziland curricula stood out as the strongest. An impressive added feature of Swaziland's HIV curriculum (Module 1 was reviewed) was that it links the curriculum to a detailed set of broader social and legal changes required to reach the same aims.[53]

International instruments

- The ICPD of 1994 urged States to, where appropriate, remove legal, regulatory and social barriers to reproductive health information and care for adolescents, and to protect and promote the rights of adolescents to reproductive health education, information and care, and to greatly reduce the number of adolescent pregnancies.
- One of the guiding principles of the Adolescent Health General Comment is respect for and protection of civil rights and freedoms, which includes the right to information. The right of adolescents to access appropriate information is crucial if States Parties are to promote cost-effective measures, including through laws, policies and programmes, with regard to numerous health-related situations, including those covered in articles 24 and 33, such as family planning, prevention of accidents, protection from harmful traditional practices, including early marriages and female genital mutilation, and the abuse of alcohol, tobacco and other harmful substances.

[53] UNESCO/UNFPA *Sexuality Education: A ten-country review of school curricula in East and Southern Africa* 2012 p 5.

- The Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Youth in East and Southern Africa commits States Parties to the following goals insofar as CSE is concerned:
  - Initiate and scale-up age-appropriate CSE during primary school education to reach most adolescents before puberty, before most become sexually active, and before the risk of HIV transmission or unintended pregnancies increases; and
  - Ensure that the design and delivery of CSE and SRH programmes include ample participation by communities and families.[54]
- The Framework of Actions for the follow-up to the Programme of Action of the International Conference on Population and Development Beyond 2014 recommends, in para 165, that States should implement their commitments to promote and protect the rights of girls by enacting and implementing targeted and coordinated policies and programmes that concretely address:

  (a) ensuring gender parity in access to school;

  (b) providing comprehensive sexuality education;

  (c) reducing adolescent pregnancy;

  (d) enabling the reintegration of pregnant girls and young mothers into education at all levels, with a view to empowering girl children and young women to achieve their fullest potential; and

  (e) eliminating harmful traditional practices, such as child, early and forced marriage, and female genital mutilation/cutting.

Recommendations

Although the majority of the ESA countries have provisions in their diverse policies indicating that CSE is key and should be given attention, and 20 countries endorsed the ESA Commitment, not all countries have CSE curricula in schools that are compulsory and examinable.[55]

It is worth noting that some countries' policies have a negative approach aimed at instilling fear in adolescents towards sexual and reproductive health. There is a need to evaluate existing curricula in order to align them with international standards. Every country is diverse and has religious, moral and traditional nuances that may influence how CSE is taught in schools. However, these should not be a bar to, in line with international commitments and in particular the ESA Ministerial Commitment, revise existing curricula that fall short of the required standard.

It is recommended that the following values and rights be recognized:

- Sexuality is a central aspect of being human.
- Adolescents and young people have a right to be informed about science-based sexuality.
- Informal sexuality education is inadequate for an evolving society.
- Adolescents and young people are exposed to many new sources of information that is frequently distorted, unrealistic, and degrading, particularly for women.
- There is a need for sexual health promotion.
- Sexuality education should be age-

[54] UN International Technical Guidance on CSE 2009 available at http://unesdoc.unesco.org/images/0018/001832/183281e.pdf; UNFPA Operational Guidance for Comprehensive Sexuality Education available at http://www.unfpa.org/sites/default/files/pub-pdf/UNFPA%20Operational%20Guidance%20for%20CSE%20-Final%20WEB%20Version.pdf.

[55] Young people today: Time to Act Now "East and Southern Africa Commitment One Year in Review 2013-2014" available at http://youngpeopletoday.net/wp-content/uploads/2014/12/ESACommitment-Progress_AnnualReport-DIGITAL.pdf.

appropriate with regard to the adolescent's or young person's level of development and understanding, and be culturally and socially sensitive with a gender perspective.

- Sexuality education should be based on human rights.
- Sexuality education should be based on a holistic concept of well-being, which includes health.
- Sexuality education should be firmly based on gender equality, self-determination, and the acceptance of diversity.
- Sexuality education starts in childhood and continues throughout the life cycle.
- Sexuality education is understood as a contribution towards a fair and compassionate society by empowering individuals, communities and citizenship.
- Sexuality education should be based on scientifically accurate information and should be of an acceptable quality.
- Sexuality education is a matter of rights.

It is further recommended that, when feasible, in-school CSE should be included as a stand-alone subject in the curriculum — as opposed to just a cross-cutting theme — with its own contents, dedicated teaching staff and teaching and learning materials, time frame, community of practice support for CSE teachers, and with specific evaluation such as through mandatory examinations. It is proposed that the following should be taken into account in designing content:[56]

- The contents of CSE should include the cognitive, emotional, social, psychological, and interpersonal relationship components of sexuality;
- Develop and disseminate human rights-based materials which are sensitive and tailored to different ages and needs of particular groups and which incorporate accurate science- and evidence-based information that will assist adolescents and young people to make informed choices;
- Involve adolescents in the review, content development and implementation of the programme;
- Conduct research on how adolescents view sexuality education and the main issues that concern them;
- The implementation of sexuality education programmes should involve the entire community, including educational agents beyond school walls, such as families, the media, including print and social media, health professionals, informal educators, NGOs, and street educators, in providing accurate messages on sexuality;
- Build formal linkages and referral mechanisms between school and local health services to track service utilization and CSE impact on, at the very least, early and unintended pregnancies, HIV and other STIs and gender-based violence;
- In order to include families in sexuality education, it is necessary to:
  - Involve them in the contents imparted to their sons and daughters. Integration and normalization of sexuality means taking the issue into the private sphere, while maintaining a respectful public sphere;
  - Distinguish between school and family as two areas that contribute to sexuality education but from different perspectives;
  - Conduct research to ascertain the attitudes of parents and guardians toward sexuality education and their main concerns;
- Develop specific strategies to ensure the availability of sexuality education for specific groups such as:
  - Institutionalized people
  - Seniors
  - Persons with physical, sensory, and intellectual disabilities

[56] Cf *Science-Based Sexuality Education: Madrid Consensus Paper* 2011.

  - People with chronic mental disorders
  - Immigrants or refugees/humanitarian settings
  - Minority groups (indigenous communities)
  - Key populations;
- It is essential to develop strategies for working with the media as key agents in sexuality education:
  - Media professionals should be offered training in sexuality education contents.
  - Press releases and social media posts should be issued frequently and with regularity, and include unified, simple, positive messages.
  - Scientific advances in the field should be publicized along with successful intervention programmes.
  - Youth should be involved in crafting social and behaviour change communication messages and media campaigns;
- Sexuality education programmes should be evaluated with indicators that go beyond strictly health indicators;
- Resources should be created that encourage networking among the institutions and professionals involved in sexuality education (fostering a community of practice) and ensure that practitioners have access to them (web, consensus papers, curricula, teaching and learning materials, and training programmes);
- Social sensitization messages should make the connection between sexuality education and the everyday problems of children, adolescents, and young adults;
- Professionals and institutions are responsible for conveying the need for, and presenting approaches to, sexuality education in a non-confrontational manner, dispelling the notion that sexuality education is harmful to children and adolescents and the many other misconceptions about CSE. When society, and parents in particular, understand the rationale and age-appropriate content for CSE, they participate in it, promote it, and demand it for their children. In light of the subject matter, however, excessively confrontational, biased, or complicated messages can lead to reticence and an uncooperative attitude that hampers the CSE of their sons and daughters;
- Social sensitization efforts should reach out to the entire community and should be carried out through networking among institutions, civil society, nongovernmental organizations, the media and community agents;
- There is a need for quality CSE curriculum for out-of-school youth and to develop strategies for a targeted implementation thereof;
- Consideration should be given to the adoption of a condom policy, which may include demonstrations of the correct use of condoms and the availability of condoms upon the request of learners.

3. CONCLUSION

The study on Harmonization of the Legal Environment on ASRHR revealed many contradictions between policies and laws within the 23 countries included in the desktop review. In many instances, policies were written more recently and located within a human rights framework. Such policies tend to be multidisciplinary, and therefore include health and welfare perspectives rather than being focused on judicial measures that tend to be punitive and controlling in nature. A good first step for law reformers at the domestic level is to take stock of commitments to ASRHR that have already been made through policy, and to translate these into laws. Efforts need to go beyond a piecemeal amendment of Marriage Acts and Penal Codes, though such amendments may indeed be necessary.

A particular challenge in the region is the coexistence of customary law, religious law and civil law. The harmonization of these legal systems on the issues under review is a difficult task, but is essential if real change is going to happen on the ground. Customary and religious law is not static, and can be developed. However, stronger measures may be needed to protect adolescents and young people in the interim, particularly in the areas of child marriage and harmful cultural practices. Where there is a conflict between civil law and customary or religious law, it may be argued that statutory protections should take precedence over uncodified customary or religious law practices, particularly where the latter are not protective of the rights of adolescents and young people.

The field work for the study on Harmonization of the Legal Environment on ASRHR also demonstrated that adolescents, young people, medical practitioners, teachers and counsellors generally lacked knowledge about laws pertaining to ASRHR. The rights bearers were unaware of their rights, and the service providers – while often working diligently – also did not work within a rights-based approach. This demonstrates that, as important as the legal framework is, any law reform efforts should be supported by consistent rights-based information campaigns for the rights bearers, the service providers and the broader society.

This legal framework aims to assist ESA countries in identifying deficiencies in domestic laws and policies with regard to the topics addressed, especially in relation to international and regional instruments which countries may have ratified, acceded to or are signatories of, and whose domestic laws do not adhere to such instruments. Once legal gaps, contradictions or lack of adherence to standards are identified, positive steps should be taken to correct any deficiencies. Such legal provisions are paramount in a region faced by enormous challenges in respect of HIV and other sexually transmitted infections, early and unwanted pregnancies, gender-based violence, and discrimination based on sexual orientation, to name but a few. This framework also aims to facilitate the materialization of adolescents' and young people's sexual and reproductive health rights and general well-being.

Laws and policies within each country must be harmonized and inculcated so that courts, government officials and service providers all work from the same legal framework. That harmonization must ensure that contradictions between laws and policies are removed, and that the amended law is infused with the rights-based approach evident in many of the policies. This legal framework highlights good examples from the region so that States may consider other legal models that have proved acceptable and workable in similar countries. The principles and values that are expressed in this framework should be inculcated into law and beyond that into practice, so that the rights of adolescents and young people are made tangible.

NOTES

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