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MAKING ACCESS A REALITY:

ADDRESSING AGE OF CONSENT BARRIERS IN EAST AND SOUTHERN AFRICA.

INTRODUCTION

Adolescents constitute the largest proportion of the population in East and Southern Africa. In sub-saharan Africa, adolescents aged 10 to 19 constitute 23% of the region's population[1]. Ensuring the health and well-being of this young population is key for a healthy and productive population and their contribution to national development.

Adolescents are impacted by Sexual and Reproductive Health (SRH) challenges, with adolescent girls being disproportionately impacted. Adolescent girls experience early sexual debut often as a result of sexual abuse which predisposes them to unintended pregnancy and Sexually Transmitted Infections (STIs) including HIV[2]. Due to social stigma and discrimination related to premarital pregnancy, adolescent girls often resort to unsafe and illegal abortions. Those who continue with the pregnancy sometimes suffer from pregnancy complications resulting in maternal mortality.

Adolescence also brings with it developmental aspects requiring adolescents to have access to accurate information and services to aid them in circumventing SRH challenges, develop positive health seeking behaviours and enhance their health outcomes. However, adolescents often face myriad of barriers in accessing SRH information and services. These include; age of consent requirements, negative attitudes of health care providers, inadequate laws and policies to guide adolescent-friendly service provision, conservative traditional and religious beliefs and inadequate human and financial resources[3].

AGE OF CONSENT BARRIERS

A majority of the countries in East and Southern Africa have made international, regional and national commitments that ensure adolescent access to SRH information and services[4]. While most of these countries have made strides in aligning with such commitments by developing policies that enable adolescents to access SRH information and services, they are often not supported by legal reform.

Where laws exist, they are often ambiguous about the age of consent requirements for access to SRH information and services as most of them focus on age of consent to sexual activity and/or marriage. Age of consent to sexual activity has therefore been used as the benchmark for determining age of consent for SRH services. This is exacerbated by traditional and religious beliefs about adolescent sexuality and perceptions that adolescents do not possess sufficient capacity and maturity to consent to services when they are deemed unable to consent to sexual activity.

Age is often used as a determinant of maturity and capacity to access to SRH services. Laws, policies and practice do not recognize the evolving capacities of the adolescent to consent for SRH services or participate in decision making on issues affecting their lives. Age of consent laws and policies require third party consent from a parent, guardian or trusted adult to enable them access SRH services. These laws and policies deny adolescents access to services by not recognizing independent access to SRH services where an adolescent can access services based on their ability to understand the risks, benefits and consequences of the service.

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[1]UNICEF. (2019). Adolescent Demographics

[2]UNFPA. (2012). From Childhood to Womanhood: Meeting the Sexual and Reproductive Health Needs of Adolescent Girls

[3]Center for Reproductive Rights. (2017). Capacity and Consent: Empowering Adolescents to Exercise their Reproductive Rights.

[4]UNFPA. (2017). Harmonizing the Legal Environment for Adolescent Sexual and Reproductive Health and Rights

Some countries managed to address age of consent barriers by setting a lower age of consent for some SRH services such as HIV testing and treatment. These include Malawi, South Africa and Uganda who have set the minimum age of consent to HIV testing and counseling to 12 years.[5] This, however, is a practice that needs to be emulated for other SRH services.

Countries in East and Southern Africa have varying minimum ages of consent with the lowest being 12 and the highest at 18. South Africa and Lesotho provide for a lower age of consent to SRH services such as contraception and HIV testing and treatment at a minimum age of 12 years whereas Namibia has a minimum age of 14 years. Zambia and Zimbabwe have a minimum age of consent to SRH services at 16 but has variations across services with some policies not setting a specific minimum age of consent. Eswatini and Tanzania have a higher age of consent for SRH services with a minimum age at 18.[6]

ADDRESSING AGE OF CONSENT BARRIERS

Due to a lack of harmonized laws and policies on age of consent coupled with a lack of standards and guidelines for the same, health care providers lack adequate guidance to ensure provision of high quality SRH services which meet the rights and needs of adolescents. Where standards and guidelines do not exist or are unclear, health care providers use their personal discretion – which is often influenced by their personal values and beliefs – to make decisions regarding provision of services. As such, clear laws and policies that recognize and respect the rights of the child and their evolving capacity should be developed to guide health care provider practices in providing SRH services.

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[5]*UNFPA. (2017). Harmonizing the Legal Environment for Adolescent Sexual and Reproductive Health and Rights*

[6]*ARASA. (2019). Sexual and Reproductive Health, HIV, TB and Human Rights in Southern and East Africa*

Age of consent requirements often use the concept of maturity as its foundational basis which is discriminatory as some adolescents, despite being minors, may possess the necessary maturity as may be the case for emancipated minors. Laws and policies should therefore recognize adolescents evolving capacity and develop related standards and guidelines which provide guidance to health care providers on how to objectively assess maturity to enable adolescents' independent access to services.

Where clear laws and policies exist, negative health care providers attitudes related to adolescent sexuality may pose access barriers based on the adolescent's age. Therefore, governments should ensure pre-service and in-service training of health care providers to address personal beliefs and attitudes and enable provision of non-judgmental adolescent-friendly SRH services.

Adolescent-friendly services should have adequate financial and human resources to ensure the availability of essential reproductive health commodities and adequate human resource for the provision of high quality SRH services. The services should be inclusive and address the rights and needs of adolescent key populations including adolescents living with disabilities and adolescent refugees[7].

RECOMMENDATIONS

Policy Makers & Government

We call on policy makers and government representatives to;

Develop or review existing Laws to address age of consent barriers for adolescent access to SRH information and services. Laws should recognize the rights and needs of the child.

Harmonize laws and policies to address identified gaps and barriers to adolescent access to SRH information and services which are guided by the principles of the 'best interests of the child' and 'evolving capacities'.

Develop standards and guidelines to guide health care providers during service delivery in providing adolescent-friendly information and services. The standards and guidelines will ensure the provision of high standards of care while providing clear ethical standards in accordance with laws and policies to avert any ethical or legal dilemmas.

Develop pre-service and in-service training protocols on provision of adolescent-friendly health services. The training should also focus on desexualizing SRH services so that they are prioritized and provided as other health services are.[8]

Allocate appropriate financial and human resources to ensure, in policy and practice, the provision of high quality adolescent-friendly services. This will ensure adequate infrastructure, commodities and human resource for high quality health service provision.


9 INDUSTRY, INNOVATION AND INFRASTRUCTURE
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7 AFFORDABLE AND CLEAN ENERGY
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Civil Society Organizations (CSOs)

We call upon CSOs, young people and other key stakeholders to;

- Advocate for laws and policies that address age of consent barriers for adolescent access to high quality SRH information and services.
- Meaningfully engage adolescents in the formulation and review of laws, policies and service delivery to co-create solutions that address their rights and needs.
- Engage parents, traditional and religious leaders to promote parent-child dialogue that balances their duties and best interests of the child.
- Raise awareness on the rights of adolescents and existing legal and policies gaps that hinder their access to SRH information and services.

> “Adolescent-friendly services should have adequate financial and human resources”

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About The Policy Brief

This Policy Brief aims to support law, policy and practice that promotes and protects adolescents' access to SRH information and services in East and Southern Africa. It provides recommendations to policy makers, government officials, CSOs and other stakeholders on actions to be undertaken to make access to information and services a lived reality.

The Policy Brief is informed by contextual analyses on age of consent requirements for adolescent access to SRH services conducted in Kenya, Malawi, Zambia and Zimbabwe as well as years of experience in undertaking discourse on adolescent SRH in the region.

The Policy Brief is part of the Consent to Access (#Consent2Access) Campaign aimed at advocating for improved laws, policies and practices on age of consent for adolescent access to SRH information and services in East and Southern Africa. The campaign is being undertaken by the Regional SRHR Fund with support from the Swedish development cooperation agency, Sida – through the Embassy of Sweden in Lusaka.

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