

CONTEXTUAL ANALYSIS ON THE AGE OF CONSENT
FOR ADOLESCENTS' ACCESS TO SRH SERVICES IN MALAWI

1. INTRODUCTION

Sexual and Reproductive Health Rights (SRHR) are integral to socio-economic development.¹ The government of Malawi holds this view as reflected in the newly launched long-term development framework dubbed Malawi 2063. In the framework, the government commits to addressing the key challenges and barriers to youth development and to protect their health and well-being.² It specifically states that the youth, will be empowered with the necessary sexual and reproductive health information and services.³ Given that on top of government agenda are the youth and adolescents, with respect to their age related needs, this report provides some analysis and recommendations which could be useful in ensuring that the relevant policies and operational frameworks such as the National SRHR Policies and Malawi Vision 2063 are responsive to opportunities and strengths as well as challenges and bottle necks around access and utilisation of SRH Services. The relevance of this report is that it contributes to providing evidence as well as recommendations that deal with one of the barriers to access of SRH services institutionalised by the application of principles that set restrictions on age at which adolescents can consent to services. The coming out of the President's Emergency Plan for AIDS Relief (PEPFAR) to advocate for lowering age of consent for children to access HIV testing in Malawi,⁴ shows the significance of the barriers presented by setting of age of consent. This Malawi contextual analysis attempts to provide evidence on the impact of the age of consent to SRHR.

2. CONTEXTUAL ANALYSIS

Demographic

The biggest proportion of the Malawi population is youthful, with about 56% of the population under the age 20.⁵ According the 2018 National Census Report, the population within the age group of 10-24 made up 35% for National Population. The age group 10-19, which according to the United Nations is what is defined as adolescents,⁶ makes up to 26% of the country's population.⁷ Of the 26%, 2,317,256 are female and 2,251,992 are male, together adding up to 4,569,248. Despite the age group 10-19 years forming almost quarter of Malawi's population, it is disadvantaged in multiple ways.

Adolescent SRHR Situation in Malawi

Overall, in the Health Sector Strategic Plan II 2017-2022, the Government of Malawi acknowledges that adolescent health indicators remain poor,⁸ whilst progress is being recorded for the other age groups, and on some indicators.⁹ Given that SRHR is such a broad subject area, a select indicator will be used to highlight what the situation is for adolescents. According to the 2016 Malawi Demographic Health Survey (MDHS) the proportion of adolescent girls of age 15-19 who had begun childbearing was at 29%, an increase from 26% in 2010.¹⁰

¹Guttman Policy Institute Sexual and Reproductive Health and Rights Are Key to Global Development: The Case for Ramping Up Investment, February 5, 2015 Sexual and Reproductive Health and Rights Are Key to Global Development: The Case for Ramping Up Investment | Guttman Institute

²Malawi Government Malawi Vision 2063: An Inclusively Wealthy and Self-reliant Nation (pg 5)

³Malawi Government Malawi Vision 2063: An Inclusively Wealthy and Self-reliant Nation (pg 38)

⁴U.S. President's Emergency Plan for AIDS Relief (PEPFAR) Malawi Information Memo for Ambassador Scott: Fiscal Year 2020 PEPFAR

⁵Planned Country Allocation and Strategic Direction, Malawi January 14, 2020, <https://copsdata.amfar.org/PlanningLetters/2020/Malawi.pdf>

⁶UNICEF https://data.unicef.org/topic/adolescents/overview/National_Census_Report

⁷National Statistical Office 2018 Malawi Population and Housing Census (pg 50)

⁸Government of the Republic of Malawi Health Sector Strategic Plan 2017-2022 (pg 20)

⁹National Statistical Office (NSO) [Malawi] and ICF. 2017. Malawi Demographic and Health Survey 2015-16. Zomba, Malawi, and Rockville, Maryland, USA. NSO and ICF (pg 94).

¹⁰National Statistical Office (NSO) [Malawi] and ICF. 2017. Malawi Demographic and Health Survey 2015-16. Zomba, Malawi, and Rockville, Maryland, USA. NSO and ICF (pg 69)

The trajectory of the increase is not so good considering that for a period of eighteen years, before 2010, childbearing among adolescent girls only declined from 35% in 1992 to 26% in 2010.¹¹ It must be recognized that in the MDHS, the indicator for adolescent child bearing only consider the age group 15-19, leaving out the age group 10-14. Considering that girls are getting pregnant even before their menstrual periods become regular, and most girls usually begin menstruating between the ages of 9 and 16,¹² it should make sense to believe that the uncounted numbers could expose a situation worse than it appears. Furthermore, early sexual debut is high in Malawi, with around 14% of young people having sexual intercourse before the age of 15 (19% being male, and 9% being female).¹³ To illustrate this point further, reference is made to the two Ministry of Health's Bi-annual YFHS Bulletins which are produced from District Health Information System (DHIS2). The Second Edition of the YFHS Bulletin show that between January and June 2019, 857 adolescent girls of ages 10-14 across Malawi accessed ante-natal services.¹⁴ Again in the same age group of girls, 278 accessed post abortion care.¹⁵ In the six months that followed, July-December 2019, the number of adolescent girls age 10-14 who accessed antenatal services increased by 30%.¹⁶ This increase is not even associated with impact COVID-19.

There are several factors contributing to the increase in teenage pregnancies. The first is that there is high unmet need of the contraceptives for adolescents. Unmet need for contraceptives is defined as the sum of the proportion of currently married women who are not using contraceptives but want to stop having children (to limit) and those that was to postpone the next pregnancy for at least two years (to space).¹⁷ Unmet need is slightly higher among adolescent(15-19) married women at 22% percent compared to any other age group.¹⁸ The contraceptive use among sexually unmarried adolescent girls was at 37.5% in 2016 when for all married women it was at 58.1%.¹⁹ Among sexually active, unmarried women of ages 15-49, only 43% use a modern contraceptive method,²⁰ of which, 32% were adolescents (15-19).²¹

Health outcomes in relation to HIV are equally not good for adolescents. The 2019 National estimates for HIV showed that new infections for HIV in Malawi were highest among adolescent girls and young women of ages (15-24), estimated at 6895.²² Indicators for adolescents on HIV testing are not also good. According to the 2017 MPHIA results, only 28% of adolescent girls (15-19) and 17% of adolescent boys (15-19) were aware of their HIV status,²³ compared to 73.9% of the age group 15-65 years.²⁴ The low proportion of adolescents knowing their HIV status could partially be a result of the structural barriers and restrictions on adolescents' access to SRH services including the age of consent as PEPFAR suggest.²⁵

¹¹National Statistical Office (NSO) [Malawi] and ICF. 2017. *Malawi Demographic and Health Survey 2015-16*. Zomba, Malawi, and Rockville, Maryland, USA. NSO and ICF (pg 73)

¹²The Reproductive Health Directorate, Ministry of Health National Family Planning Reference Manual for Malawi November 2020 (pg 279)

¹³Ministry of Health Malawi & PEPFAR (2018) *Malawi Population-Based HIV Impact Assessment: MPHIA 2015-2016: Final report* (pg 100).

¹⁴Reproductive Health Directorate, Ministry of Health, YFHS Bulletin Jan-June 2019, Second Edition (pg 2-3)

¹⁵Reproductive Health Directorate, Ministry of Health, YFHS Bulletin Jan-June 2019, Second Edition (pg 2-3)

¹⁶Reproductive Health Directorate, Ministry of Health, YFHS Bulletin July- December 2019, Third Edition (pg 2)

¹⁷National Statistical Office (NSO) [Malawi] and ICF. 2017. *Malawi Demographic and Health Survey 2015-16*. Zomba, Malawi, and Rockville, Maryland, USA. NSO and ICF (pg 97)

¹⁸National Statistical Office (NSO) [Malawi] and ICF. 2017. *Malawi Demographic and Health Survey 2015-16*. Zomba, Malawi, and Rockville, Maryland, USA. NSO and ICF (pg 98)

¹⁹National Statistical Office (NSO) [Malawi] and ICF. 2017. *Malawi Demographic and Health Survey 2015-16*. Zomba, Malawi, and Rockville, Maryland, USA. NSO and ICF (pg 107)

²⁰National Statistical Office (NSO) [Malawi] and ICF. 2017. *Malawi Demographic and Health Survey 2015-16*. Zomba, Malawi, and Rockville, Maryland, USA. NSO and ICF (pg 101)

²¹National Statistical Office (NSO) [Malawi] and ICF. 2017. *Malawi Demographic and Health Survey 2015-16*. Zomba, Malawi, and Rockville, Maryland, USA. NSO and ICF (pg 101)

²²National AIDS Commission Annual HIV Estimates Jan – Dec 2019

²³Ministry of Health, Malawi. *Malawi Population-Based HIV Impact Assessment (MPHIA) 2015-2016: Final. Report*. Lilongwe, Ministry of Health. October 2018 (pg 56).

²⁴Ministry of Health, Malawi. *Malawi Population-Based HIV Impact Assessment (MPHIA) 2015-2016: Final. Report*. Lilongwe, Ministry of Health. October 2018 (pg 55).

²⁵U.S. President's Emergency Plan for AIDS Relief (PEPFAR) Malawi Information Memo for Ambassador Scott: Fiscal Year 2020 PEPFAR Planned Country Allocation and Strategic Direction, Malawi January 14, 2020, <https://copsdata.amfar.org/PlanningLetters/2020/Malawi.pdf>

In the 1994 Constitution of the Republic of Malawi the law is not explicit on SRHR.²⁶ However there are provisions in various sections in which sexual and reproductive health and rights are implied. For instance, the right to health is covered in section 30 under right to development,²⁷ in section 24 on women's rights,²⁸ children's rights in section 23,²⁹ and non-discrimination in section 30.³⁰ In all those sections the provisions could all be expanded to implicate the right to sexual and reproductive health for adolescents and everyone.

It was until 2013 when an explicit legislation on sexual and reproductive health was enacted in the name of Gender Equality Act. Part six of the Act exclusively focusses on sexual and reproductive health rights.³¹ Within part six, section 19(1), contains provisions for right holders stating that "every person has the right to adequate sexual and reproductive health..."³² The second part of SRHR legal provisions in the Gender Equality Act imposes the duty and provides guidelines and sanctions for violation of the guidelines to health care providers with respect to guaranteed sexual reproductive health rights provided in sections 19 and 20 of the legislation. Section 20(1) imposes obligations to health officers to respect the sexual and reproductive health rights of every person without discrimination,³³ respect the dignity and integrity of every person accessing sexual and reproductive health services,³⁴ provide family planning services to any person demanding the services irrespective of marital status or that person is accompanied by a spouse.³⁵ It also mandates health care providers to record the manner in which information imparted to the person seeking reproductive health or family planning was given and whether it was understood.³⁶ Most important to mention is that the Act in sec 20(f) stipulates that health care providers should obtain written consent of a person being offered SRH services or family planning services before performing any procedure of offering any service.

Legal Position Age of Consent on Access to SRHR by Adolescents

The Gender Equality Act in Section 20(1c) prohibits the practice of requiring third parties to consent to access of SRH services.³⁷ The Act is consistent with Article 5 of the Convention on Rights of Children (CRC), a legal and human rights normative instrument which Malawi ratified, which encourages parents to deal with rights issues "in a manner consistent with the evolving capacities of the child". As children develop their own capacities to make decisions as well as to take responsibility of their decisions, the convention consequently limits powers parents have over the children.³⁸ The consistency of the Gender Equality Act to the CRC is also aligned to the interpretive guidance provided in the General Comment No.2 on Article 14 of the Maputo Protocol which clarifies obligations states parties have of ensuring that reproductive rights of adolescents are protected. The General Comment prohibits third parties interfering with adolescents' right to access SRH services.³⁹ Even at international stage, the United Nations Rights system on use of the term protection, mean that Member States are obliged to prevent violations by third parties.⁴⁰

²⁶United Nations Population Fund (UNFPA) Malawi country assessment of the cycle of accountability for sexual, reproductive, maternal, child and neonatal health and human rights (2016) 32.

²⁷Malawi Constitution of 2010 sec 30(2).

²⁸Malawi Constitution of 2010 secs 24 & 24(2).

²⁹Malawi Constitution of 2010 sec 23 (5b).

³⁰Malawi Constitution of 2010 sec 30.

³¹Gender Equality Act of 2013 secs 19 & 20.

³²Gender Equality Act of 2013 sec 19(1).

³³Gender Equality Act of 2013, sec 20 (1a).

³⁴Gender Equality Act of 2013, sec 20 (1b).

³⁵Gender Equality Act of 2013, sec 20 (1b).

³⁶Gender Equality Act of 2013, sec 20 (1f).

³⁷Gender Equality Act of 2013 20(1).

³⁸Cook RJ & Dickens BM 'Recognizing adolescents' 'evolving capacities' to exercise choice in reproductive health care (2000) 70 International Journal of Gynecology & Obstetrics 3-21 (pg 15)

³⁹General Comment No.2 on Article 14 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa para 43.

⁴⁰Office of the High Commissioner United Nations Human Rights Information Series on Sexual and Reproductive Health and Rights Updated 2020.

However, it is worth noting that section 20(1c) of the Gender Equality did not mention that “irrespective that she is accompanied by a guardian”, which may suggest that the omission was implicit recognition of the rights or guardians to consent to SRH services by adolescents. This reasoning can be counter-argued using two premises. The first being that section 20(f) of the Gender Equality Act, emphasizes that the consent should only be provided by the person accessing the service. The second premise could be based on the non-discrimination principle. The non-discrimination principle is recognized in Section 20(1a) of the Gender Equality as well as the provided in the Constitution in section 30 in which the two legal instruments guarantee protection to adolescents’ equal treatment before the law to access SRH services just like everyone else.

Section 20(1) of the Malawi Constitution prohibits any form of discrimination on any ground, though not explicitly stated,⁴¹ including on grounds of age. With the sole purpose of guaranteeing equality, the Constitution in the exact phrasing states that

“discrimination of persons in any form is prohibited and all persons are, under any law, guaranteed equal and effective protection against discrimination on grounds of race, color, sex, language, religion, political or other opinion, nationality, ethnic or social origin, disability, property, birth or other status.”⁴²

Interpreted broadly, what this provision says is that adolescents by virtue of being human, are protected by law like everyone else to enjoy SRHR without interference of third parties.

However, the Code of Ethics for Medical practitioners in Malawi as established by the Medical Practitioners and Dentists Act No. 17 of 1987,⁴³ section 1(5) prohibits discrimination of any form, section 5(6) provides that health practitioners are urged to ensure that informed consent is obtained before any procedure is carried out on a patient. In the same section, it is indicated that the people that may not be allowed to give informed consent are minors and psychiatric patients. However, the provision still empowers health practitioners to make final decision in the best interest of the concerned person if practitioner’s stand differs with parents or guardians’ positions.⁴⁴

What is not clear in Malawi legal framework is what “minor” means. It may generally as used internationally mean a person under 18, or in other words a child, as also internationally defined, which should be taken as to be the case considering that the 1948 Public Health Act a child is defined as a person under the age 18. But our own legal framework has defined children differently in different statutes. In Malawi context, the specification of age in relation to providing consent to certain services is more conspicuous in HIV and AIDS program. The HIV and AIDS Prevention and Management Act of 2018 stipulates in section 13 that a person who is at least thirteen years of age may access voluntary counselling and testing without the consent of a parent or a legal guardian.

⁴¹Constitution of the Republic of Malawi

⁴²Malawi Constitution, Section 20 (1)

⁴³Medical Council of Malawi Medical Practitioners and Dentists Act No. 17 of 1987 <http://medicalcouncilmw.org/about.htm>

⁴⁴Medical Council of Malawi Code of Ethics <http://medicalcouncilmw.org/ethics.htm> ⁴⁵Malawi Constitution of 1994

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The lack of clarity on the age at which the term minor is used in the Medical Practitioners and Dentists Act has led to the confusion among the healthcare practitioners because they apply it differently and contradicting one another. For instance, this situation is manifested in two responses from health care providers and have vast experience in adolescent and youth SRHR programming and have coordinated the YFHS program in their districts for not less than five years.

The risk is that the health care providers that have negative attitude towards adolescents accessing SRHR may use the Medical Practitioners and Dentists Act to prevent adolescents under age 18 from accessing SRH services. This is also pointed out by United Nations Population Fund (UNFPA) which argues that unclear laws and policies on age of consent to medical treatment, including access to contraceptives, HIV counselling and testing and abortions (where legal) can lead to confusion as to when young people can themselves consent to medical treatment themselves and when they need consent from a parent or guardian.




However, there are two key things that may nullify that provision in Medical Practitioners and Dentists Act. The first is that it was promulgated in 1987, before the 1994 Constitution which had the first bill of rights included, notwithstanding the fact that it was developed before the Gender Equality Act was promulgated in 2013. The relevance of citing that Medical Practitioners and Dentist Act was developed before the 1994 Constitution is that in Section 5, the constitution provides that any Act of Government or any law that is inconsistent with the provisions of the Malawi Constitution shall, to the extent of such inconsistency, be invalid.⁴⁵ Having established that, with regard to SRH services, the Gender Equality Act should be the most direct and relevant reference document to provide guidance to the health care providers. That legal guidance is that the law leaves it open for adolescents irrespective of age to access SRH services without the interference of a third party, which includes parents.

⁴⁵Malawi Constitution of 1994



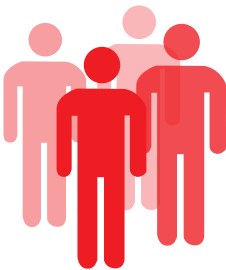
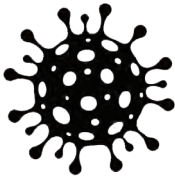
Policy Environment on Adolescent Consent to SRHR and Adolescents

Just as the Malawi's laws are not explicit in addressing the issue of age of consent for medical treatment including SRH services, there are similarly grey areas in the in the policy frameworks as the table shows.

Table 1: Program specific policies directions on age of consent

SERVICE	POLICY POSITION ON AGE OF CONSENT
 <p>Contraception</p>	<p>Contraception</p> <p>The Malawi National Reproductive Health Service Delivery Guidelines 2014–2019 expressly state that adolescents do not require parental consent to access contraceptive commodities and services. It does not specify some age group within the adolescents larger age group implying that it currently applies to all adolescents. The YFHS training Manual however brings some inconsistency. On one hand it also highlights that there is no prescribed minimum age for contraceptive use in Malawi. On another it stipulates that 'service guidelines allow for youth of age 16 and up to access contraception without parental consent.⁴⁶ However, Malawi National Reproductive Health Service Delivery Guidelines 2014–2019, National Family Planning Reference Manual for Malawi and the 2010 Preservice Education Family Planning Reference Guide do not prescribe anything on around age 16. The document that contains such provision could be located.</p> <p>Emergency Contraception</p> <p>The Emergency Contraception Strategy 2020 does not mention anything about consent despite being elaborate on adolescent use of the emergency contraceptives</p>
 <p>Abortion and Post Abortion</p>	<p>Abortion services are legally restrictive, only permissible if the pregnant women's life is in danger. There is no stated age at which adolescents may need to have parental consent.</p> <p>Policy direction on age of consent is not clear in the service delivery guidelines including the 2001 National Post Abortion Care Strategy</p> <p>The age of consent for access to Antenatal Care is unclear.</p>
 <p>Ante-natal Care</p>	<p>The age of consent for access to Antenatal Care is unclear.</p>

⁴⁶Ministry of Health Youth Friendly Health Services Strategy Training Manual: Participants Handbook, Second Edition Page 58.

SERVICE	POLICY POSITION ON AGE OF CONSENT
 <p>HIV Testing & HIV Self Testing</p>	<p><i>HIV Testing</i> As a general guidance in the National HIV Testing and Counselling guidelines, parental consent is required for persons aged 12 and below. According to the HIV and AIDS Management Act of 2017, anyone under 13 is required to have a third party to provide consent. However, the HIV testing guidelines does provide exceptions for some adolescents under 13. The guidelines provide that those under 13 but have shown sufficient maturity can access HIV testing service.</p> <p><i>HIV Self Testing</i> According to the Malawi HIV Self-Testing Operational Guidelines of 2018, the HIV self-testing protocols aligns with National HIV Testing guidelines. Adolescents older than 13 years of age are legally able to consent for HIV testing without the presence of a guardian. Adolescents between 13-17 years of age should receive more in-depth counselling and assistance to ensure they fully understand the HIVST. Additional measures to ensure there is no coercion among this population may be needed. Anyone under 13 years of age will need to be tested by a trained provider in a facility-based or community-based setting</p>
 <p>Post-exposure Prophylaxis (PrEP) and Anti-Retroviral Therapy</p>	<p><i>PreEP</i> There is no explicit policy position on the age at which adolescents accessing PrEP can consent to the service. The Malawi Clinical HIV Guidelines 2018 is silent on age of consent.</p> <p><i>ARV</i> National Antiretroviral Therapy guidelines are unclear on age of Consent.</p>
 <p>Voluntary Male Medical Circumcision (VMMC)</p>	<p>According to the Malawi Voluntary Medical Male Circumcision Communication Strategy, “parents and guardians of adolescent males (age 10 - 15) may also be required to give consent for their children to undergo VMMC.” Key to note in the statement is the use of “may”. It means there could be some instances in which adolescents can access the service without parental consent. The guidelines are not clear on what would be the considerations.</p>
 <p>Sexually Transmitted Infections (STI)</p>	<p>The National Guidelines for STI management recommend that for minors, health care providers should “obtain verbal consent to conduct physical examination” without specifying if adolescents can provide the consent and if guardians should also provide the consent.</p>



Despite the grey areas, the government's position on adolescents' access to all other SRH services is expressly and implicitly very supportive to adolescents accessing SRH services without requiring parental consent. For example, the most recent National Sexual and Reproductive Health Policy of 2017-2022 prioritizes youth as one of the ten thematic components. In this policy, one of the statements reads; "all young people shall have access to quality youth friendly health services that are safe, guard their right to privacy, ensure confidentiality, and provide respect and informed consent, while also respecting their cultural values and religious beliefs."⁴⁷ It must be understood that the phrase "young people" based on definition provided in the youth friendly health services program includes adolescents since the target group for the youth friendly health services(YFHS) is 10-24.⁴⁸ Important to note also in that statement is the mention of "youth friendly health services" which implies the SRHR Policy reaffirms or aligns with the policy documents developed for the YFHS program such as the National Youth Friendly Health Services Strategy 2015-2020 and the National Minimum Standards for YFHS 2015-2020. According to the YFHS minimum standards, the services provided under YFHS program include contraceptives, HIV testing, Antenatal care, post abortion care to mention a few.

Notwithstanding, one of the biggest limitation is in the inconsistent use of some critical information in the YFHS policy documents. For instance, inconsistency in specification on the age groups. In the 2015 YFHS Strategy, in some sections it indicates that it seeks to strengthen coverage and utilisation of contraceptives among young people of ages 15-24.⁴⁹ The limitation with this strategy objective is that it excludes adolescents under the age 15 from the targeted group encouraged to access contraceptives. Using that age bracket of 15-24 is arguably one of the basis on which some health care workers justify refusal of provision of contraceptives to adolescents under the age 15, in some cases up to even those under 18 are denied.⁵⁰ The inconsistency comes in another section in the same document which reads "YFHS Strategy strives towards serving young people 10 to 24 years to closely align with the Ministry of Health (MoH) life cycle approach."⁵¹

Going back to the National SRHR Policy 2017-2022, it must be noted the word "consent" appears in the document only twice. It first appears in the statement found in section 3.3.2.4 in which the policy states that "Young people shall not require parental consent for STI services, and confidentiality shall be maintained at all times."⁵² The second appearance is in section 3.6.2.1, which states "All young people shall have access to quality youth friendly health services that are safe, guard their right to privacy, ensure confidentiality, and provide respect and informed consent, while also respecting their cultural values and religious beliefs."⁵³ It can be appreciated that the Ministry of Health was mindful of the importance of the issue of consenting to services by young people and adolescents based on the two statements. Reading the laws and policies together, despite the contradictions and inconsistencies, overall policy direction strongly suggest that government is empowering young people including adolescents to access SRH services without the condition of having a third party.

⁴⁷Ministry of Health for Republic of Malawi National Sexual Reproductive Health and Rights Policy (2017) 30.

⁴⁸Ministry of Health National Youth Friendly Health Services Strategy 2015-2020 (pg 1)

⁴⁹Ministry of Health National Youth Friendly Health Services Strategy 2015-2020 (pg 26).

⁵⁰Ministry of Health National Youth Friendly Health Services Strategy 2015-2020 (pg 162).

⁵¹Ministry of Health National Youth Friendly Health Services Strategy 2015-2020 (pg 7-8)

⁵²Ministry of Health for Republic of Malawi National Sexual Reproductive Health and Rights Policy (2017) (pg 28)

⁵³Ministry of Health for Republic of Malawi National Sexual Reproductive Health and Rights Policy (2017) (pg 30)

Operationalization of related laws and policies on consent to SRHR by adolescents

As can be understood from the preceding section, whilst the policy and legal environment are generally supportive of adolescents accessing SRH services, and fairly removing the barrier of parental consent, the operationalization of the frameworks is affected by several factors discussed below.

Laws and Policies not properly harmonized

There is lack of reinforcing or emphasis of policy positions in multiple related policy documents. On some policy issues, the government policy position is not being reflected all possible relevant policy documents to reinforce such policy position.

Low awareness on existing laws and policies

There is limited knowledge on what the government policy is on certain health related issues because the information in the policy documents may have not been seen by different actors including health care providers.

Personal choice of health care providers

The situation that there is no specific law or policy that explicitly clarifies the age of consent for access to SRHR by adolescents leads to the problem giving freedom to health care providers to interpret the law and policy anyhow they wish. This results in adolescents having challenges accessing SRHR due to the negative attitude of health service providers. It has to be noted that the Ministry of Health is doing a relatively commendable job to train Youth Friendly Health Service providers to address these problems.

Confusion on definitions of young people, youth, adolescents

Another challenge created by the legal and policy frameworks centers around the definitions of both children, adolescents, and young people. The SRHR policy for example, has not defined who a young person is despite mentioning the youth in many sections. Of course, it does refer to the youth friendly health services program on several occasions, which defines young people as people of ages 10-24 irrespective of any status. However, for some health care providers who have not been trained as YFHS providers, and as established, not many are aware of the policies, they may interpret the definition based on other sources they are familiar with. For example, the majority of the service providers use the United Nations Secretariat definition, which provides the conventional definition of a child. Moreover, the United Nations agencies including WHO define young people as people aged between 10-24 and yet they also define the youth as people of ages between 15-24.⁵⁴ In the YFHS strategy, Malawi uses the definition used by the three UN agencies. To reinforce the age being targeted, it would have been of great impact if the age group was specified. The fact of the matter is that the SRHR policy has not created such a restriction. Unfortunately, there could be many who hold this view.

⁵⁴Malawi Constitution of 1994

Consequences of policy implementation challenges on adolescent access to and utilization of SRH services

Based on the background that there are gaps in legal and policy frameworks and that the gaps are affecting service delivery, this section is aimed at highlighting some of the consequences of such gaps.

Low utilization of SRH Services

The practice by a significant proportion of health practitioners informed by the policy documents that suggest that there is an age restriction at which adolescents can independently access SRH services leads to a situation where fewer adolescents access the services. The findings of the evaluation of YFHS in Malawi in 2014 showed that despite that the YFHS program had existed for about 7 years at the time of the 2014 national YFHS evaluation, only 12.6% of young people were accessing the youth friendly health services and 31.7% had ever heard of YFHS.⁵⁵ In that evaluation, there are a number of variables to appreciate the characteristics of the youth who accessed the services.

UTILISATION OF YFHS BY SELECTED BACKGROUND CHARACTERISTICS		
Background Characteristic		Percentage of interviewd youth who had ever been to a YFHS delivery point
Age	10 - 14	4.6
	15 - 19	14.4
	20-24	18.1
Sex	Male	14.7
	Female	10.6
Sexual Experience	Never Married	11.3
	Currently Married	16.6
	Previously	22.1

Source: Evaluation of YFHS 2014. Page 121, Table 6.1.3

From the table on the right above, there are a few points which adds to the proxy evidence demonstrating the impact of age of consent in access to SRHR by adolescents. The first, with regard to age, is that despite that the YFHS program targets age groups 10-24, a very small number of early adolescents utilises the services as compared to the age group 20-24. The second in relation to sex is that boys access more of the YFHS than girls. The third regarding sexual behaviour show that the services are patronised most by those that are sexually active. The fourth is concerning marital status, showing that unmarried young people are the least users of the youth friendly health services. The pattern made in this table strongly suggest that overall, the YFHS program overall is not working for adolescents. In the instances that it is working, it is mostly those in late adolescence who are accessing the services.

⁵⁵Ministry of Health Evaluation of the Youth Friendly Health Services in Malawi 2014, (pg 118)

High levels of school dropout as a result of lack of access to SRH services

The consequence of the inability for adolescents to access the SRH services has inevitably led to the high rates of teenage pregnancies which leads to child, early and forced marriages. The consequences are further linked to high level of school drop out by adolescent girls and ultimately poor socio-economic status of adolescents and young women. In 2016 for example, according to the Education Health Information System (EMIS) report, 6248 girls dropped out of primary school due to pregnancies,⁵⁶ which was an increase from 5739 in 2015.⁵⁷

Reinforcement of negative attitude of health care workers towards adolescents accessing SRHR

The YFHS evaluation of 2014 established that health care workers are considerably unfriendly and lack of confidentiality in providing services to adolescents and young people.⁵⁸ Even though shyness was the highest score among the reported factors contributing low utilization of YFHS, the report attributes shyness to be a product of negative attitude by service providers.⁵⁹ Nonetheless, apart from that implied factor, in some sections of the same report it is explicitly stated that there is indeed poor unfriendly attitude towards young people accessing the YFHS,⁶⁰ and some healthcare providers not only do they show a negative attitude, they also deny 'young adolescents' because according to them, believe provision of contraceptive methods to youth below 18 promotes promiscuity/immoral behaviour.⁶¹

Reinforcing the parental control: Suppressing the Adolescents' Autonomy

Another challenge which is brought by the laws and policies and the accompanying practices by health care providers is that they increase the control parents have over their children which works negatively for adolescents. Inversely, while the parental control increases, the adolescents' autonomy, even for those that demonstrate to have capacity to provide consent, is reduced significantly. One such instance is reflected in the National Sexual and Reproductive Health Policy of 2017-2022 in which one of the statements reads; "all young people shall have access to quality youth friendly health services that are safe, guard their right to privacy, ensure confidentiality, and provide respect and informed consent, while also respecting their cultural values and religious beliefs.⁶² The last part of the statement, by mentioning respect to culture and religious values already brings in legitimacy the role of culture and religion on adolescents' utilization of SRH services.

On the perspective of adolescents, the unfortunate thing is that some of the sexual activities are sanctioned by cultural institutions such as at initiation rites. At the traditional rites of passages for adolescents conducted in Malawi, promotion of sexual intercourse is one of the dominant features and yet use of contraceptives including condoms by adolescent girls is not condoned.⁶³ At some of the initiation rites, some of the initiates include girls as young as six years old.⁶⁴ This illustrates that to a significant extent, parents or guardians are controlling sexuality of adolescents, and largely for purposes child bearing considering that in one of the ethnic groups, the value of girls

⁵⁷Ministry of Education Educational Management Information System 2015 (pg 88)

⁵⁸Ministry of Health Evaluation of the Youth Friendly Health Services in Malawi 2014.

⁵⁹Ministry of Health Evaluation of the Youth Friendly Health Services in Malawi 2014 (pg 174).

⁶⁰Ministry of Health Evaluation of the Youth Friendly Health Services in Malawi 2014 (pg 177)

⁶¹Ministry of Health Evaluation of the Youth Friendly Health Services in Malawi 2014 (pg 175)

⁶²Ministry of Health for Republic of Malawi National Sexual Reproductive Health and Rights Policy (2017) 30.

⁶³K Nash et al Our girls need to see a path to the future: Perspectives on sexual and reproductive health information among adolescent girls, guardians, and initiation counsellors in Mulanje district, Malawi 2019 (pg 2)

⁶⁴Malawi Human Rights Commission 'Cultural Practices and their Impact on the Enjoyment of Human Rights, Particularly the Rights of Women and Children in Malawi' 2006 (pg 81) http://www.mwfountainoflife.org/files/4413/9395/3331/cultural_practices_report.pdf (accessed 10 May 2019).

villages.⁶⁵ Because of those cultural expectations and demands, according to another respondent, “a lot of cases where parents are very conservative, they are also dismissive of the SRH services.” The result is that “this limits adolescents’ self-efficacy to seek further care or recommend it to their peers” as one respondent put it. Most importantly, given that background, the expectation by government that there could be an increase in uptake to SRH services by adolescents is technically defeated if the policy requiring parental consent is reinforced.

The worst thing is that for the programs that have set a specific age for consenting to a service, if there is no parent or guardian, the powers are now shifted to further to the state. For example, in HIV and AIDS program an age of 13 set as a minimum age at which children or minors can access HIV testing services. Anyone under 13 is supposed to have parents or guardians to consent, according to the Section 13(1) of the HIV and AIDS Management Act of 2018. In section 13(2) the Act stipulates that where a person below the age of thirteen years who does not have a parent or legal guardian seeks VCT, the health service provider whose services are requested in order to access HIV testing shall request a social welfare officer to apply to the magistrate court for the appointment of a legal guardian of the applicant. That requirement reduces the chances adolescents in such situations to even attempt accessing the services. However, it would mean that if she wanted to access other SRH service and she is made aware of the provisions in HIV and AIDS require that she get a parent along with him/her, she or he would opt to stay home, but that would not prevent them from being sexually active.

What Government is Doing on Age of Consent for Adolescents’ Access to SRH Services?

There are several initiatives taking place aimed at resolving the issue of age of consent for adolescents to access SRHR in Malawi. Ministry of Health has three approaches it is dealing with the issue of age of consent. The first is that it has engaged legislators, meeting them to present to them the issues affecting youth and adolescents around SRHR. The meeting was not exclusively on age of consent, the issue came up as one of the main issues planned for the discussion. The second approach is that the Ministry is currently attempting to deal with the ambiguities by making it clear in policy documents being developed. The first policy document highlighted is the reference manual for family planning which was almost finalized in 2020. Indeed, in this document the issue of age of consent has been clearly stated that adolescents do not need consent from parents to access family planning services. The reference manual states that family planning methods are available to adolescents and that they are not required to have parental or spousal consent to receive a contraceptive method.⁶⁶ However, with respect to that statement, this is not the first time the statement has been made, it was there 10 years ago in the Preservice Education Family Planning Reference Guide.⁶⁷

Nonetheless, it is a very powerful and useful statement but seemingly known to a very few. The limitation though is that this clarity has been made for the family planning, not the whole SRHR. With regards to making the statement to the broader SRHR, the opportunity in sight is the review and development of the second generation YFHS Strategy which will be developed in 2021 between June

⁶⁵Malawi Human Rights Commission ‘Cultural Practices and their Impact on the Enjoyment of Human Rights, Particularly the Rights of Women and Children in Malawi’ 2006 (pg 84).

⁶⁶The Reproductive Health Directorate, Ministry of Health National Family Planning Reference Manual for Malawi November 2020 (Page 278)

⁶⁷The Reproductive Health Directorate, Ministry of Health Preservice Education Family Planning Reference Guide 2010 (Page 456)

to September. Beyond policy documents, the third approach the Ministry of Health is planning to use to deal with the issue through engagement with other government ministries, agencies and departments such as Ministry of Justice, the Malawi Law Society, Malawi Human Rights Commission in order to push for promulgation of laws by either amending or developing a completely new law on age of consent.

3. CONTEXTUAL CHALLENGES AFFECTING ADOLESCENT AGE OF CONSENT FOR ACCESSING SRH SERVICES

Programmatic

Lack of Consensus on the Advocacy Goal

The advocacy activities by the different stakeholders have mixed messages due to different reasons such as limited understanding of the legal and policy framework, personal values and views to mention some. Some, very few though, are of the view that the policy should be as it is without specifying a minimum of age consent for adolescent access to SRH services so that it does not restrict access to those under the prescribed age. Some are of the view that there should be a prescription of age. For those advocating for setting an age, majority are pushing for setting it at 12, so that it aligns with the age of consent for HIV testing service, which others, like PEPFAR are advocating to lower the HIV testing age of consent.⁶⁸ This shows that even the age 12 set for HIV testing is contested with very good evidence. Only one respondent on the prescription of age category recommended putting it as low as at 9 years old.

Weak Collaboration and Lack of proper advocacy plan

Limited collaboration is one of the many challenges in the efforts aimed at addressing the issues of age of consent for adolescent access to SRH services. The disjointed efforts could be due to several reasons such as competition of resources, competition for visibility when the advocacy succeeds. However, the biggest reason could be lack of knowledge and awareness on who is doing what, where, and when. It is a positive thing that the legislators are being targeted that much, but problem could be in the message. Are they all going with the same message? Are they all making the same or similar asks? Or could they potentially be camps with the two extreme viewpoints as outlined in the preceding section?

Considering that both government and Non-Governmental Organizations are all doing advocacy around age of consent for access to SRH services, it makes sense that all interested parties join forces and have one advocacy plan. This has worked on advocacy for raising age of Marriage to 18, both government and non-governmental organizations worked together, and the collaboration to some extent continues on the bigger work focusing on child marriages through a platform called girls and not brides which has membership of over 90 Civil Society Organizations working in Malawi.⁶⁹ On the current issue of age of consent, as it stands, apart from conducting the advocacy in an uncoordinated fashion, the findings have shown that some advocacy activities are being done spontaneously, not attached to a window of opportunity. To illustrate this point, the key informant when responding to the question on what they are doing, only three mentioned that their advocacy was positioned to align with a policy review process. This is partially due to limited or inconsistent engagement by

⁶⁸U.S. President's Emergency Plan for AIDS Relief (PEPFAR) Malawi Information Memo for Ambassador Scott: Fiscal Year 2020 PEPFAR Planned Country Allocation And Strategic Direction, Malawi January 14, 2020, <https://copsdata.amfar.org/PlanningLetters/2020/Malawi.pdf>

⁶⁹ Girls Not Brides Malawi <https://www.girlsnotbrides.org/our-partnership/national-partnerships-coalitions/malawi/>



non-governmental organizations with government. The limited engagement is also as a result of weak functionality of the platforms which bring all partners in the field of SRHR for adolescents and youth and government. Government and partners are unable to timely update each other on the developments in the SRHR space, workplans as well as advocacy opportunities. A proper joint plan is needed and must include a proper mapping of all existing advocacy opportunities, joining of forces, leveraging of resources.

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Funding

Another issue that emerged a lot in the responses on the challenges the organizations are facing is limited availability of funds to conduct advocacy activities. However, with regards to the advocacy for addressing the issue of age consent in laws and policies, the limited availability or lack of resources to some organizations could be because the donors know that they have already provided funds for such activity to other organizations or alliance, or network. Alternatively, the donors may know some among themselves that has already invested in this type of work. The formation of an alliance or coming up with a joint plan could address this gap.

Religious Beliefs

The National Evaluation of YFHS in Malawi conducted in 2014 established that religious beliefs constrain access to YFHS.⁷⁰ Another study established that access to contraceptives is also limited by religious beliefs.⁷¹ According to the World Bank, effective policy translation and subsequent implementation of SRH interventions for adolescents remain a challenge in Malawi among others due to opposition to adolescent SRH issues from inside the government as well as religious and community leaders.⁷² Given such evidence on the role of religion in adolescent access to SRH, it implies that first, some adolescents on their own are unable to access to SRH services so as to adhere to religious teachings and values. In the cases that some still want to access SRH, the parents may not allow them. The situation makes it extremely difficult to imagine an environment in which parents can consent to have adolescents access SRH services.

Traditional Norms

Culture is a concept of power or authority.⁷³ Some cultural beliefs and norms in Malawi are practiced precisely to facilitate childbearing. The unfortunate part of it is that such practices are targeted on adolescents.⁷⁴ In some ethnic groups, there are initiation rites which teach initiates as young as six years⁷⁵ about sex and go beyond to instruct the initiates to practice sexual intercourse.⁷⁶

⁷⁰Ministry of Health for Republic of Malawi 'Evaluation of youth friendly health services in Malawi' 2014 (pg 176)

⁷¹K Nash et al *Our Girls Need to See a Path to the Future: Perspectives on Sexual and Reproductive Health information among adolescent girls, guardians, and initiation counsellors in Mulanje district, Malawi* 2019 (pg 3)

⁷²World Bank. *Policy Brief-Adolescent Girls in Malawi: Executive Summary* (2016)

⁷³S Tamale 'The right to culture and the culture of rights: A critical perspective on Women's sexual rights in Africa' (2008) 16 *Feminist Legal Studies* 159.

⁷⁴AC Munthali & MC Kok 'Gaining insight into the magnitude of and factors influencing child marriage and teenage pregnancy in Malawi' 2016 (pg 11).

<https://www.kit.nl/wp-content/uploads/2018/10/Baseline-report-Malawi-Yes-I-Do.pdf>

⁷⁵Malawi Human Rights Commission 'Cultural Practices and their Impact on the Enjoyment of Human Rights, Particularly the Rights of Women and Children in Malawi' 2006 (pg 81)

⁷⁶Malawi Human Rights Commission 'Cultural Practices and their Impact on the Enjoyment of Human Rights, Particularly the Rights of Women and Children in Malawi' 2006 (pg 105)

The initiation rites which have sex topic featuring highly in content are inextricably linked with the phenomenon of high rates of teenage childbearing in Malawi. In some parts of the country, girls are very important for the reason that they attract men to marry them for the primary goal of expanding the villages.⁷⁷ Given those factors, it can be appreciated that firstly, sexuality of adolescent girls is controlled by the traditional system. Secondly, because sexuality is controlled, it is not in the interest of parents for adolescents to be accessing reproductive health services such as contraceptives. The result is that a considerable proportion of parents are reluctant to support youth using contraceptive.⁷⁸

It is not only family planning methods that parents have reluctance to support the adolescents to access. The reluctance extends to youth friendly health services in general. In the 2014 national evaluation of YFHS in Malawi, some parents emphasized that Youth Friendly Health Services erode traditional values through the provision of SRH information, some parents going as far as to assert that provision of YFHS contradicts their traditional value of promoting abstinence before marriage. Ironically, the traditional rites of passage in which girls at six years old are told to practice sex are directed to the same unmarried girls. A relevant question in the 2014 evaluation of YFHS was whether parents would want to be notified that their children are accessing SRH services. There were mixed reactions. Some want to know, because they are parents, hence they need to know what is going on with their children. Some on the other hand indicated that they would not because if they knew they would react badly towards the children. Related to this however is that some parents indicated that they would not want to know because it is a confidential matter.⁷⁹

Behaviors and Attitude

There are behaviors of two groups of people to be discussed under this section who affect the uptake of SRH by adolescents. The first are the adolescents and the other are health care workers. For adolescents, a significant proportion is not assertive enough. The YFHS Evaluation found that “many youth are not comfortable accessing youth-friendly health services because many providers are adults; therefore, they don’t understand us.”⁸⁰ Quantitatively, it was found that about 20% of community survey respondents who reported not accessing YFHS mentioned ‘shyness’ as a reason. Whilst shyness is considered a personal characteristic, it is connected or rooted in social barriers highlighted in cultural and religious systems. With regards to health care providers, as has been established in earlier sections, a significant proportion of them act as agents of culture and religion.

The effect of religion and culture is also manifested in the judgmental attitude of service providers.⁸¹ Some health care providers for example not only do they show judgemental attitude, but they also go an extra mile, reporting the youth accessing contraceptives to their parents.⁸²

⁷⁷Malawi Human Rights Commission ‘Cultural Practices and their Impact on the Enjoyment of Human Rights, Particularly the Rights of Women and Children in Malawi’ 2006 (pg 108)

⁷⁸Ministry of Health for Republic of Malawi ‘National evaluation of youth friendly health services in Malawi’ 2014 (pg 163)

⁷⁹Ministry of Health for Republic of Malawi ‘National evaluation of youth friendly health services in Malawi’ 2014 (pg 171)





⁸⁰Ministry of Health for Republic of Malawi ‘National evaluation of youth friendly health services in Malawi’ 2014 (pg 162)

⁸¹Ministry of Health for Republic of Malawi ‘National evaluation of youth friendly health services in Malawi’ 2014 (pg 174)

⁸²A Self et al ‘Youth accessing reproductive health services in Malawi: drivers, barriers, and suggestions from the perspectives of youth and parents’ (2018) 15 Reproductive Health 6

4. Recommendations

The following are the key recommendations to be implemented in short term and long term.

-  Ministry of Health with support from Civil Society Organizations (CSOs) should undertake a process of pushing of promulgation of the law that will define scope and application of age of consent.
-  Strengthen functionality of coordination structures. Stakeholders should support the government at both national and district levels to strengthen capacity and functionality of the coordination structures so that there is effective collaboration to ensure issues on the age of consent for adolescent access to SRH services are achieved.
-  Develop health care provider guidelines on age of consent to SRH services for adolescents and young people. This should include a harmonization of policies across SRH services.
-  Promote adherence to laws, policies and ethical standards. Social and behavior change communication intervention be conducted nationwide and intensively on what current laws, policies, human rights standards are being applied to in the provision and access to SRH services to adolescent and youth. The awareness should also target existing structures responsible for enforcement of the laws and policies.

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