AGE OF ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS SERVICES FOR ADOLESCENTS IN SELECTED EASTERN AND SOUTHERN AFRICAN COUNTRIES

Hivos people unlimited

REGIONAL SRHR FUND

Sweden Sverige

1 INTRODUCTION

Countries in Africa have committed to ensuring that adolescents have access to the necessary services and support, including information to enable them to enjoy the highest attainable standards of sexual and reproductive health (SRH). At the international and regional levels, countries have agreed on the standards that should be implemented through laws and policies to guide practices including the delivery of SRH services for adolescents and young people. However, challenges are still there. Early and unintended pregnancies remain a pressing concern in Eastern and Southern Africa (ESA), the magnitude of adolescent fertility rate (AFR) being in the ranges of 66.9-85.9 live births per 1000 adolescent girls aged 15-19 years.[1] Consider this against the world average which is 39 live births per 1000 adolescent girls aged 15-19 years. Yet, Zambia, the United Republic of Tanzania, the Democratic Republic of Congo, Malawi and Uganda have adolescent fertility rates (AFR) of more than 100 live births per 1000 adolescent girls aged 15–19 years.[2] Teenage pregnancy is driven by several interrelated economic, cultural, environmental and personal factors.[3] These include structural barriers to accessing and using contraceptives.[4]

Eastern and Southern Africa is home to an estimated 1.74 million adolescents living with HIV. These represent 60% of the global total.[5] Adolescent girls are especially vulnerable and bear a disproportional burden of HIV because of interrelated factors including physical, cultural, political and structural barriers.[6] In ESA, adolescent girls and young women aged 15–24 years account for 27% of new HIV infections and were three times as likely to acquire HIV than their male counterparts.[7] This demonstrates that there are challenges about the availability and accessibility of services, and among others, the challenges are about consent to access among children, adolescents and young people.[8]

The interventions the World Health Organisation (WHO) has recommended include that laws and policies should align with the protection, promotion and fulfilment of adolescents' right to health.[9] Legal and regulatory frameworks should ensure that necessary services including SRHR services are available and accessible to adolescents without discrimination.[10] Laws and policies should protect rights and enable adolescents to access services. Key duty-bearers including parents and guardians, health and social workers, teachers and other adults play a critical role to ensure that adolescents realise and enjoy the rights stipulated in the various standard-setting documents.

An important challenge this technical brief aims to address is the age of consent to SRHR services. Legal and regulatory frameworks can create potential conflicts between

[1] S. Choonara et al., "Early and Unintended Pregnancy in Eastern and Southern Africa: Analysis of Adolescent Sexual and Reproductive Health and Rights Policies," *BMJ Glob Health* 9, no. 4 (2024).
[2] Ibid.
[3] Niren Ray Maharaj, "Adolescent Pregnancy in Sub-Saharan Africa – a Cause For concern," *Frontiers in Reproductive Health* 4 (2022).
[4] WHO, adolescent pregnancy https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy 2024.
[5] UNICEF Children, HIV and AIDS Regional snapshot: Eastern and Southern Africa 2018

protection and autonomy, especially for younger adolescents. Further, because childhood and adolescent sexuality is a taboo area, legal and regulatory frameworks dealing with adolescent sexual and reproductive intersect with cultural and social norms. When laws are not clear about how to address a specific issue, for instance, access to contraception, the gaps may be filled by interpretations by duty-bearers using social and cultural norms that run counter to human rights principles. This contributes to creating barriers for young adolescents, for instance, to access contraceptives.

Further, even if some laws are not directly related to access to services, they indirectly contribute to creating structural barriers to access because they impact on sexual conduct and behaviours. These include laws that criminalise sex work,

[6] UNICEF HIV Treatment, Care, And Support For Adolescents Living With Hiv In Eastern And Southern Africa https://www.unicef.org/esa/media/8791/file/Adolescents-HIV-Eastern-Southern-Africa-2021.pdf

[7] The urgency of now: AIDS at a crossroads. Geneva: Joint United Nations Programme on HIV/AIDS; 2024. Licence: CC BY-NC-SA 3.0 IGO.

[8] A. Grimsrud et al., "The Future of Hiv Testing in Eastern and Southern Africa: Broader Scope, Targeted Services," *PLoS Med* 20, no. 3 (2023).

[9] https://iris.who.int/bitstream/handle/10665/255418/WHO-FWC-MCA-17.05-eng.pdf?sequence=1

[10] Health for the World's Adolescents A second chance in the second decade https://iris.who.int/bitstream/handle/10665/112750/WHO_FWC_MCA_14.05_eng.pdf?sequence=1

abortion, and non-heterosexual acts. While they do not prohibit services directly, they can reinforce views and attitudes that are biased towards certain groups and therefore impacting on their access to the SRH services.

This technical brief outlines the current legal and policy frameworks on age of consent in five focal countries, Malawi, Kenya, Uganda, Zambia and Zimbabwe, and analyses the impact on children's adolescents' and young people's access to SRHR services. It concludes with recommendations on how the legal and policy frameworks could be improved to ensure access to SRHR services for adolescents and young people.

[11] Ahna Suleiman and K. Harden, "The Importance of Sexual and Romantic Development in Understanding the Developmental Neuroscience of Adolescence," *Developmental Cognitive Neuroscience* 17 (2015).

2 ADOLESCENTS, SEX AND SEXUALITY: A CONCEPTUAL BACKGROUND

Adolescents' experiences with sex and sexuality are shaped by various social, cultural, and developmental factors. Before addressing technical issues like laws or policies, it is crucial to understand the broader context, including societal attitudes, beliefs, and values that influence adolescents' behaviours and their access to information and services. However, it is also important to understand adolescence and sexuality from a human development perspective so that laws and policies are not misaligned with natural developmental trajectories of children.

The developmental science of adolescence reveals that at puberty, brain and physiological changes prepare the individual to become capable of reproducing. During the post-pubescent stage, love, romance and sex become the central preoccupations of the adolescent.[11] Adolescents will start to engage in non-penetrative and low-level sexual conduct, and with increasing age is also an increasing likelihood of penetrative sexual conduct. A study conducted in 2020 in Rwanda among 811 participants between the ages of 12 and 14 indicated that 81% had engaged in non-penetrative sex and 7 percent in penetrative sex.[12] By the age of 19 the percentage of adolescents engaging in penetrative sex was over 50%.

Adolescent's interest in love, sex and romance is a normal development trajectory mediated by the brain and hormones.[13] The changes the adolescent undergoes will reflect in risk-taking behaviour which is necessary to catapult

[12] Valens Mbarushimana, Susan Goldstein, and Daphney Nozizwe Conco, "Sexual Experiences among Early Adolescents Aged 12-14 Years in Four Districts of Rwanda: A Cross-Sectional Study," *medRxiv* (2024).
[13] Ahna Ballonoff Suleiman et al., "Becoming a Sexual Being: The 'Elephant in the Room' of Adolescent Brain Development," *Developmental Cognitive Neuroscience* 25 (2017).
[14] Suleiman and Harden, "The Importance of Sexual and Romantic Development in Understanding the Developmental Neuroscience of Adolescence."
[15] Ibid.
[16] Amy T. Schalet, "Must We Fear Adolescent Sexuality?," *Medscape General Medicine* 6, no. 4 (2004).

adolescents into meeting potential mates, and to risk 'falling' in love.[14] This risk-taking behaviour should not be viewed a problematic but as integral to normative development. Indeed, engaging in sexual intercourse by itself is not necessarily risky or problematic. "Developing a romantic and sexual identity is the focus of adolescence and sex can be a healthy, normative part of adolescent life."[15] Certainly, adolescents may be disproportionally affected by negative consequences of sex such as unwanted pregnancy and STIs, but if given adequate information, education, services and support, the negative consequences can be limited. In an ideal environment that supports autonomy and sexual agency, adolescents may develop high resilience to counter the negative consequences of engaging in sexual conduct.

It is important for society to approach adolescents with empathy, to support them as they deal with issues of such as sexual desire, both their own and of others. It implies that adults must engage adolescents openly on matters of sex and sexuality, and provide the necessary information, services and other support to enable the adolescent to go through this phase with as much bodily and psychological integrity as they can appropriate, and to empower them to make positive decisions about sex and relationships.

However, culture and social norms may be at odds with developmental science. Adults may approach adolescent sexuality as primarily a moral issue and with fear that unless adolescents are controlled and sexuality is suppressed, something bad will happen to society.[16] Indeed, policies may also position adolescents as vulnerable, and construct risk as inherent to adolescents and young people.[17] Policies may overemphasise the negative repercussions of young people's sexual practices and hold them responsible for preventing negative SRHR outcomes. Young people who become pregnant or start engaging in sexual conduct early may be blamed for inviting trouble for themselves.

The intersection of laws and policies may create barriers to consent to services that is not direct, for example, where a law is silent about providing care to the adolescent, the duty-bearer would fill in this gap with an interpretation that is based on social and cultural norms that restrict the young person's sexual agency.

It is crucial, therefore, to appreciate the fact that underlying the inability to provide SRHR to adolescents are social and cultural norms about adolescent sex and sexuality, so that proposed interventions should not only be legal and policy reforms, but also advocacy to persuade societies and cultures to transform their norms, attitudes and practices around adolescent sexuality.

[17] Ingrid Lynch et al., "Vulnerable Youth or Vulnerabilising Contexts? A Critical Review of Youth Sexual and Reproductive Health and Rights (SRHR) Policies in Eastern and Southern Africa," *Sexuality Research and Social Policy* (2024).

3 TERMS AND CONCEPTS, AND THE CONUNDRUM OF AGES AND NUMBERS

Age of consent to SRH services can present a maze one must negotiate through because of the multiple terms that describe intersecting age ranges;

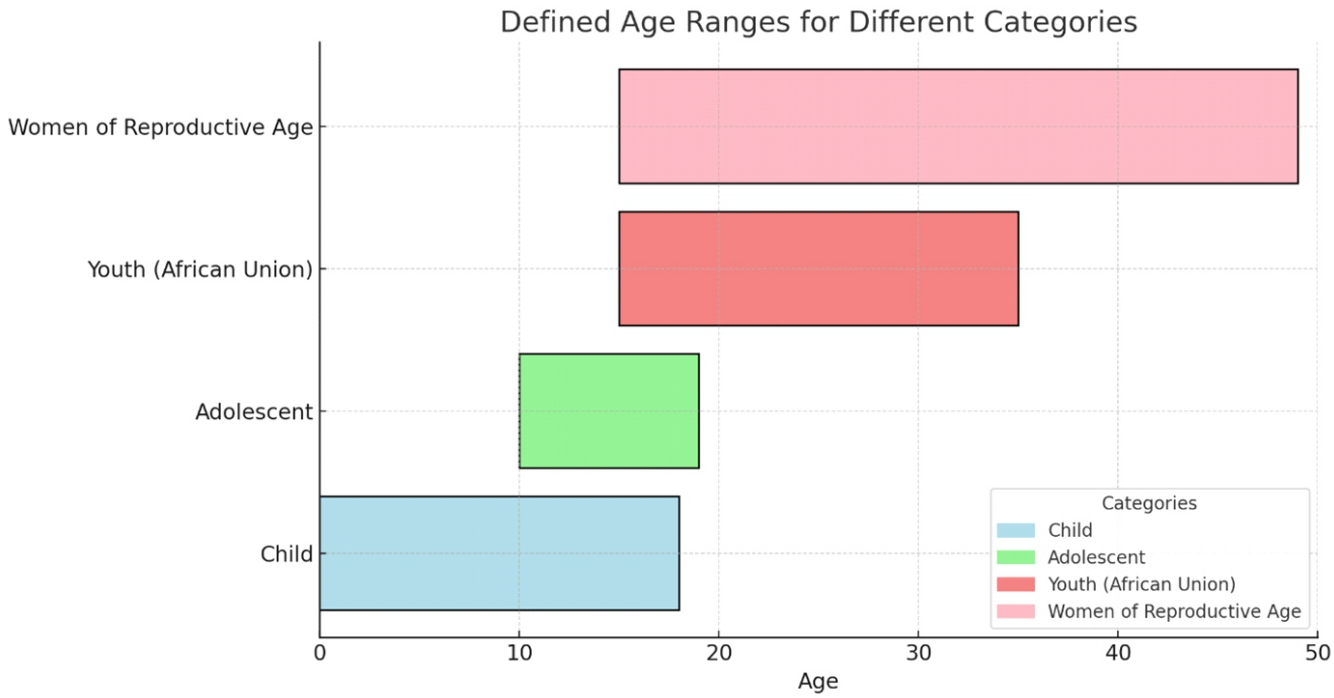


FIGURE 1 AGE RANGES

- A child is a legal term. The consensus in the African regional law is that a child is a person below the age of 18.
- Adolescent is a public health term meaning a person between the age of 10 and 19.
- Young people or youth according to the African Union's Youth Charter is the age range between 15 and 35.
- Women of reproductive age is the range between 15 and 49.

Using the terms and concepts may have implications, for instance, focusing on adolescent SRHR may miss pubescent children who need SRH services and support even if they are not yet 10. Further, reproductive health programming may be biased against very young adolescents between the ages of 10 and 14 because they do not fall within the reproductive age range.

4 THE SRHR FRAMEWORK

Prior to the modern human rights regime, matters of sexuality and reproduction were relegated to the private domain, to the home and bedroom. Laws did not play any role to facilitate sexual development. When a regulatory framework addressed anything related to sexuality and reproduction it was to criminalise unwanted behaviours. Only recently at the International Conference on Population and Development (ICPD) of 1994 did sexual and reproductive rights come into the global and public domain. Advocates for sexual and reproductive health and rights made it clear that these were not new rights, but rights already recognized in national and international laws and applied to human sexuality and reproduction. This is why the comprehensive definition of SRHR is as follows:

Sexual and reproductive health is a state of physical, emotional, mental and social well-being in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction or infirmity. Therefore, a positive approach to sexuality and reproduction should recognize the part played by pleasurable sexual relationships, trust and communication in promoting self-esteem and overall well-being. All individuals have a right to make decisions governing their bodies and to access services that support that right.

Achieving sexual and reproductive health relies on realizing sexual and reproductive rights, which are based on the human rights of all individuals to:

- have their bodily integrity, privacy and personal autonomy respected
- freely define their own sexuality, including sexual orientation and gender identity and expression
- decide whether and when to be sexually active
- choose their sexual partners
- have safe and pleasurable sexual experiences
- decide whether, when and whom to marry
- decide whether, when and by what means to have a child or children, and how many children to have
- have access over their lifetimes to the information, resources, services and support necessary to achieve all the above, free from discrimination, coercion, exploitation and violence

Therefore, SRHR are based on the standards set in various national and international legal documents including the African Union's African Charter on the Rights and Welfare of the Child (ACRWC), and the United Nations International Convention on

the Rights of the Child (CRC). The treaty monitoring bodies that oversee implementation of these legal instruments by states have developed the following principles of children rights:

1) Non-discrimination/Equality
2) Best interests of the child
3) Life, survival and development
4) Participation/Inclusion

These principles are critical guidance when framing laws and policies on consent to access for children, including for SRH services.

5 LEGAL AND POLICY PROVISIONS ON AGE OF CONSENT IN FOCUS COUNTRIES

The brief shall examine primarily laws and policies and will reference relevant documents to provide the context in which the laws and policy provisions on consent to services should be understood for a particular country. While SRHR services are a diverse package, the brief identifies three areas, HIV services, contraception and post-abortion care which are critical areas for children, adolescents and young people.

Identifying specific laws that articulate both the specific service and consent for children, adolescents and young people is challenging because some laws do not explicitly or directly address consent or are not specific for children and adolescents. In most cases, one must consider multiple legal and policy sources to appreciate how they apply to young people seeking to a specific service. This can be a complex endeavour. This technical brief takes an approach that simplifies a complex area by identifying only those laws and policies that are explicit or close on the issues of consent for a particular service for children. Focusing on three areas, HIV services, contraception and post-abortion also enables a comparison across the focus countries.

5.1 KENYA

HIV Services

The HIV and AIDS Prevention and Control Act – Section 14(1)(b) requires written consent of a parent or legal guardian unless the child is pregnant, married, a parent or engaged in risky behaviour that they can contract HIV. On the other hand, the Kenya HIV Prevention and Treatment Guidelines, 2022 says that HIV testing and services for adolescents above 10 require parental consent, a child below 14 years requires parental consent for HIV diagnosis unless they are an emancipated minor. Individuals of 15 and above can consent to services.

Contraception

On contraception, Section 16(1) of the Children Act recognises the right of every child to have the highest attainable standard of health care in accordance with the Constitution. However, the same section provides that for SRH services, the child would require the express consent of parents.

The most relevant policy document on contraception is the National Reproductive Health Policy 2022 – 2032, and on consent it says that matters of consent regarding a child, that is, a person under 18 years, shall align with the laws which places the responsibility on the government, parents and guardians. This points to laws including the Children Act.

Post-abortion care

There is no explicit law or policy in post-abortion care. It would be reasonable to assume that it would be like contraceptive care.

HIV Services

Section 13 and 14 of the HIV and AIDS (Prevention and Management) Act provides that a child of 13 and above can consent to HIV testing and counselling (HTC), while those below 13 require parental consent. The Malawi HIV Testing Services Guidelines (2016) align with the law because they explain that a person who is 13 or older can consent to services. However, the guidelines add that a person below the age of 13 who is a mature minor can also consent. The guidelines define a mature minor as pregnant, married or sexually active.

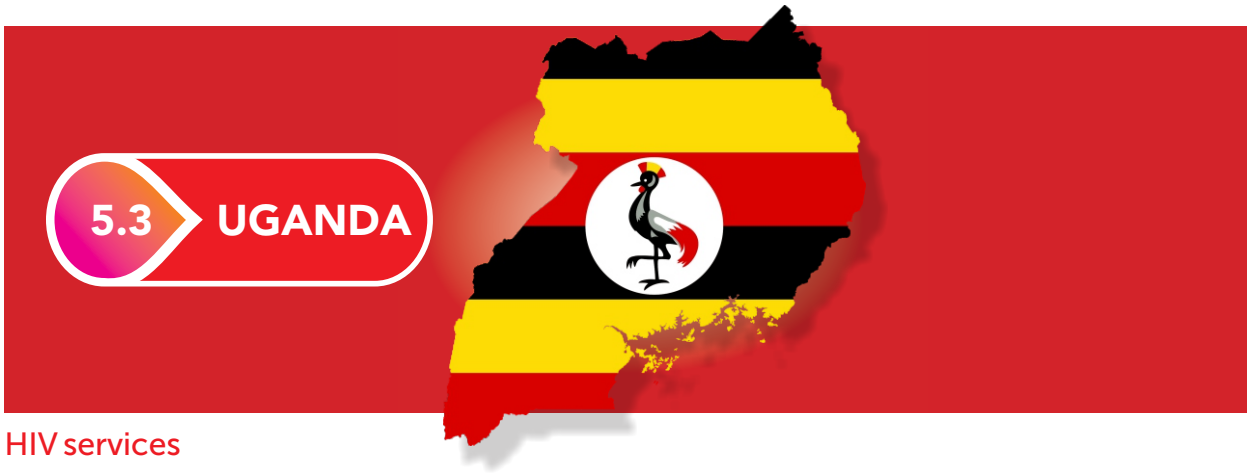
Contraception

Section 19(1)(g) of the Gender Equality Act recognises every person's right to choose an appropriate method of contraception. Section 20(1)(c) requires provision of services regardless of whether the person is married, and spousal consent is not required. The Malawi National Reproductive Health Service Delivery Guidelines (2014 – 2019) describe the requirement of consent but do not describe specifically for children.

The Youth Friendly Health Services Strategy (YFHS) 2022 – 2030 says this in the foreword signed by the Minister of Health, that: "... stakeholders and partners ... unanimously agreed that 'all sexually active adolescents and young people should access SRHR services regardless of age'. In this regard, service providers should not deny SRHR services to young people who voluntarily come to the service delivery points to access the services they need."

Post-abortion care

Section 19(1)(a) of the Gender Equality Act recognises everyone's right to access sexual and reproductive health services. Implicitly this includes post-abortion care services. Now, the Standards and Guidelines for Postabortion Care 2020 do state the requirement of consent for the woman. However, it is not clear whether woman here includes a female below the age of 18.



HIV services

Section 12 of the HIV and AIDS Prevention and Control Act, 2014, empowers a person of 12 years and above to consent to an HIV test. The National HIV Testing Services Policy and Implementation Guidelines 2022 explain that a child of 12 and above can consent to HIV testing and services. A person below 12 requires parental consent. However, where a parent is missing or unreasonably withholds consent, then the health system provides a substitute guardian to consent for the child.

Contraception

There is no law that explicitly provides for contraception or even SRHR generally. The National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights 2017, on the other hand, states that any person of reproductive age can receive contraceptive services. Further, all adolescents are eligible for health services – consent is only mentioned for tubal ligation and vasectomy.

Post-abortion care

There is no law that is explicit on post-abortion care. Both the National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights, and the Adolescent Health Policy Guidelines and Service Standards 2012 are not explicit on consent.

HIV services

Zambia has no specific law on HIV. However, the Zambia Consolidated Guidelines for Treatment and Prevention of HIV Infection recognise the age of consent to HIV services as 16. It also enables adolescents in risk group to consent, and these include – abused, married, pregnant, involved in commercial sex, have multiple sexual partners, refuses condoms, or is head of household.

Contraception

Zambia's Gender Equity and Equality Act of 2015 Provides for the right of a 'woman' to access SRHR services. Section 2 defines girl as a female not yet 18, and woman as female aged 18 and above. It should be noted that the definition of child according to Section 266 of the Constitution is "person who has attained, or is below, the age of eighteen years."

The Children's Code Act of 2022 recognises the right to health of a child but provides no guidance on consent to access to SRH services such as contraception. However, Section 127(5) recognises that a child of the age of 16 or above may consent to the taking of paternity samples. An inference could be drawn that a child of 16 and above could consent to equivalent services such as contraceptives.

The Zambia Family Planning Guidelines and Protocols, on the other hand, facilitates access for girls to all types of services dealing with RH including FP, without requiring consent of spouses, parents/guardians or relatives if it is aligned with the law. However, for girls under 16, they must be mature to understand the services.

Post-abortion care

The Termination of Pregnancy Act of 1972 provides for the lawful procurement of the miscarriage of a woman. In the Zambian legal regime, woman may be understood in terms of the Gender Equity and Equality Act to mean a female aged 18 and above.

The Standards and Guidelines for Comprehensive Abortion Care in Zambia 2017 define medical age of consent as a child with sufficient maturity at the age of 18 years or above (who) can be treated as an adult and is legally competent to decide on all forms of

treatment, and medical and surgical procedures. The guidelines direct providers to encourage minors to consult parents or guardians about their pregnancy. If the minor refuses, the provider should not insist on parental consent. Elsewhere, the guidelines direct that for a medical or surgical procedure, parental approval be documented. Further, the best interest of the minor should take precedence over parental consent. Furthermore, a minor who is pregnant under 16 years is entitled to terminate the pregnancy because it can only be a result of rape. However, the health provider should encourage her to seek parental consent.

5.5 ZIMBABWE

HIV services

There is no law specific on HIV, but the Public Health Act S.35 requires any person with legal capacity to give informed consent for any procedure. Other provisions including Sections 2(1), 35, 42, and 126(3)(a) suggest that a person under 18 is a minor and has limited legal capacity to give their own consent.

According to the Guidelines for HIV Prevention, Testing and Treatment of HIV in Zimbabwe 2022, parental consent for child below 16 is required, except for mature and emancipated minors. A mature minor or emancipated minor is not defined in this policy but an earlier one, the Zimbabwe National Guidelines on HIV Testing and Counselling. This policy describes that a mature minor should demonstrate the following:

- Maturity to make a decision on their own
- Appreciation of the seriousness of HTC and the test result
- Requisite physical, emotional and mental development
- A degree of responsibility for their life such as living independently or heading a household.

The policy also states that where a parental consent cannot be obtained, the health care worker can exercise the "best interest" principle and seek approval from the person in charge of the clinic to do an HIV test. To determine best interests, the HCW will look at factors such as:

- If the diagnosis is needed to facilitate care and treatment of an ill child
- The child is a survivor of child abuse
- A child is sexually active
- A child is concerned about M-to-C transmission
- A child has been exposed to risk of HIV transmission
- A child is concerned that given an HIV positive result, they will be denied access to care by a parent.

Contraception

Section 76(1) of the Children's Act states that surgical or other treatment upon a minor requires the consent of a parent, but if it is refused or cannot be obtained, a magistrate would make authorisation upon an application being made to that office. A minor is defined as a person below the age of 18 (Section 2(b)).

Another law or regulating impacting on access to SRH related drugs for children is Section 52(2) of the Medicines and Allied Substances Control Regulations, 1991, Statutory Instrument 150 of 1991, created under the Medicines and Allied Substances Control Act [Chapter 15:03]). The provision prevents selling any medicine to any person below the age of 16.

There is in the offing the Medical Services Amendment Bill, 2024, designed to align the Medical Services Act [Chapter 15:13] with the Constitution, on access to health services. Among others, it would recognise every child's right to health care services and ensure that the rights of children to health are prioritised over parents' and guardians' right to determine the moral and religious upbringing of their minor children.

Post-abortion care

Section 76(1) of the Children's Act would also apply here, as well as the Medicines and Allied Substances Control Regulations, 1991. The Medicines Amendment Bill, 2024 is likely to have a positive impact on promoting access to post-abortion care for adolescents and young women. However, there is a new National Comprehensive Abortion Care Guidelines in Zimbabwe promulgated in 2024, but all efforts to access these guidelines, during the drafting of the brief, were unsuccessful.

5.6 ANALYSIS

Consent regimes should enable children to access sexual and reproductive health services and should also align with the principles of child rights articulated above. On the one hand, the consent regime should not constitute an unnecessary barrier to services. On the other, consent should also not create or increase vulnerability by subjecting children to decision-making that is beyond their capacity to make, because they it may result in them making a decision that is not in their best interests. Balancing access and autonomy is crucial. Ideally, laws and policies should enable consent for a person who has the capacity to give informed consent. However, it does not mean that anyone that does not have capacity would be barred from accessing the SRH services they need. Rather, the legal and policy regimes must provide for alternative ways to secure the child's informed consent through a parent or guardian, even where the child refuses parental involvement.

Generally, across the five focal countries, HIV/AIDs services have got a more flexible scheme on consent for children, adolescents or young people, than do contraception and post-abortion care. In Kenya, the age of consent is not young-people friendly. However, the policy says individuals of 15 and above can consent. According to Malawi's

law children 13 years old can consent to HTS, as well as a mature minor. In Uganda, the law enables a person of 12 years and above to consent to HIV testing, and policy acknowledges and supports this position. Uganda however adds something unique which is that for children without a parent or who cannot obtain parental consent, there will be some other authorised 'substitute' parent figure to provide that consent, meaning, that, a child will not be left without support. In Zambia the law is not explicit on consent of young people for HIV testing and services, but the policy indicates 16 as the age of consent. Zambia's policy also outlines risk groups that should consent regardless of age including an abused, married, and pregnant child, and those engaged in commercial sex work, engage in multiple partner sex and refuse to use condoms.

One of the features of the laws and policies is the enabling of consent for emancipated, or mature minors, or young people at risk. The various focal countries have different ways of couching this. In some countries the idea of enabling consent for them appears to be related to their being at risk or a lost cause. In Malawi a mature minor is one who is married, pregnant or sexually active. In Zambia it includes a long list including abused child, a child engaged in commercial sex work, or a child having multiple sex partners. In Zimbabwe, the policy pays more attention to the best interests of child even if they are in a risk group, for instance, if they are sexually active.

However, when it comes to contraception and post-abortion care, the consent regime for children becomes more inflexible. Much as the child-related laws of the focal countries do recognise the right of children to access health services and SRH services, consent for the child is either restricted or not articulated clearly. Even the concepts of mature, emancipated minors or at-risk groups are described mostly in laws and policies relating only to HIV services and not access to contraception or post-abortion care. Further, media sources reveal that in Kenya and Uganda the issue of children's, adolescents and young peoples' consent in SRHR is controversial in society, with some sectors opposing provision of SRH care or services to children unless there is parental involvement. In Malawi, even if it may not be visibly controversial, one observes that while a government policy mentions the need to ensure availability of RH services to every young person, the very same policy does not make the effort to articulate how this would be enabled.

The simple analysis above that most countries have not yet achieved a clear alignment of laws and policies on consent to SRH services with child rights standards. Some laws and policies are based on age rather than capacity of the child to provide informed consent. Other laws recognise consent for children because they are mature or emancipated but without ensuring the proper safeguards to ensure informed consent.

6 THE BEST PRACTICE

While there is no single country among the focal countries that can be highlighted as the better model for consent to SRH services for children, best practices can still be gleaned from aspects of some of the countries consent regimes. This technical report identifies a best practice from South Africa, especially through the eyes of a court decision.

The High Court of South African heard the matter between the Christian Lawyers Association and the Minister of Health regarding the consent stipulated under the Termination of Pregnancy Act (TPA) 1996. The bone of contention was that the Christian Lawyers Association believed that the way the provisions of the TPA were formulated practically enabled children, that is, persons below the age of 18, to terminate pregnancies without parental consent. In other words, the professional association did not want children to decide by themselves to terminate pregnancy, but to always involve parents. They believed the responsibility to terminate a pregnancy rested with the parents who had the best interests of the child at heart. However, the High Court of South Africa determined that age was not the issue. What was important was that the person had the capacity and provided informed consent. If, therefore, a health care provider determined that the person could give informed consent, then the services be provided regardless of the age. However, those who could not consent because they were not mature enough need support to provide informed consent to safeguard their best interests.

This technical brief suggests that the High Court of South Africa explained consent in a manner that is better aligned with the rights of the child. Countries should not focus on a specific age as if there is anything magical about the number. What is important is whether the person, regardless of age, can give informed consent, that is, has and intellectual and emotional appreciation of the nature of the service or treatment and then is able to provide informed consent. Capacity to consent should be determined on case-to-case basis for person below the age of 18. It is, therefore, possible that one 13-year-old can give informed consent, while another 14-year-old may not. Also, the 13-year-old could give informed consent to one specific service, for instance, contraceptives, but not another, for instance termination of pregnancy.

Now, focusing on capacity to consent would also clarify how countries deal with the so called mature or emancipated minors, or at-risk groups. These groups should not be presumed to have capacity to consent, for instance, just because they are married or sexually active. Such presumptions without safeguarding the best interests of the child could expose the child to further risk if they are not capable of deciding about a service because they lack the intellectual or emotional capacity. They too might require support.

The capacity approach that ensures safeguarding child rights standards can also address situations where the child does not have a parent, or the parent unreasonably withholds consent, or the child does not want the parent involved. Such a child would

still be assisted in accordance with child rights standards. The consent regime should provide the possibility for a substituted decision-maker, empowered by law to become the child's legal guardian, who will exercise parental responsibility for the child, guided by the principle of the best interests of the child. This approach should be well articulated in law to provide security for the alternate legal guardian to not be challenge by parents. This position should also be widely disseminated to educate parent about the need to provide SRH services to children even in circumstances where the child competently refuses parental involvement.

This best practice would ensure that any child who turns up at a facility seeking SRHR services would not be returned or frustrated but would be empowered to receive the services they need. The health system empowered by laws and policies aligned with child rights standard would guarantee, always, seamless access to services regardless of whether the child has personal capacity to consent or not, and whether the child refuses parental involvement.

The logical flowchart diagram below shows how it would be possible to attend to every child who appears at the facility seeking SRHR services, and without returning the child or frustrating the child on matters of informed consent. This chart could function as guide on how laws and policies could be modelled to enable the decision-making process of the duty-bearer in the health system when encountered with three critical issues, first, a person who is a child, second, assess capacity, and third ensure provision of services based on informed consent of the child or someone who assumes responsibility if the child needs services but, for whatever reason, there is no parent. Laws and policies should not create barriers, but enable access, and all the time in accord with child rights standards and principles.

Flow chart for providing care to adolescents

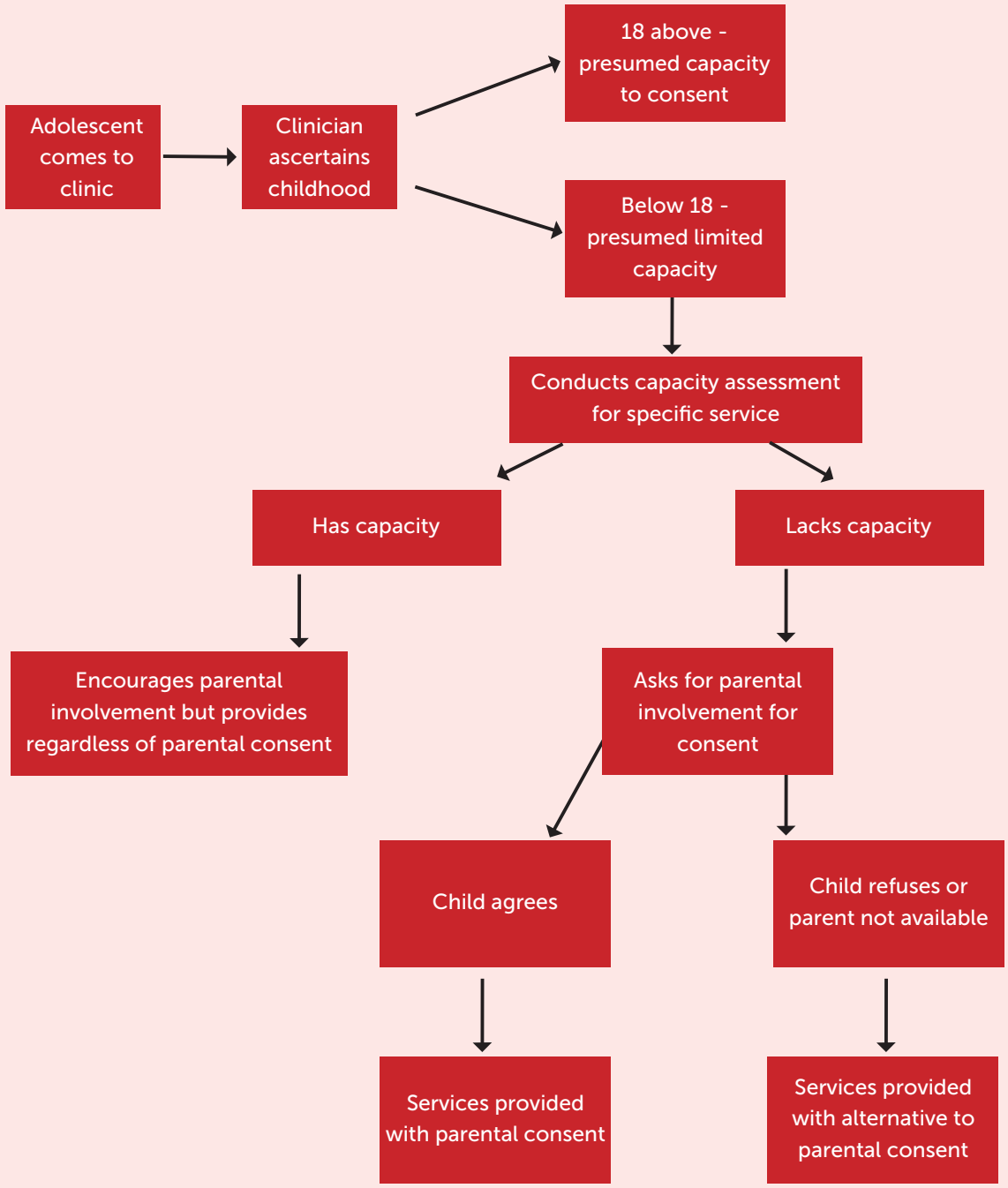


FIGURE 2 FLOW CHART

7 RECOMMENDATIONS

This section provides recommendations from research and report of the regional engagement of stakeholders from representatives from the focal countries, Zambia, Malawi, Uganda, Kenya, and Zimbabwe, hosted by Zimbabwe, to address the critical issue of adolescents' sexual and reproductive health and rights (SRHR) access.

1. There is a need to harmonise age of consent laws and policies, to align the age of consent for accessing various SRHR services, including HIV testing, contraception, and post-abortion care, to create a cohesive framework. Governments should ensure these align with international standards such as the African Charter on the Rights and Welfare of the Child (ACRWC).

2. Laws and policies governing adolescent access to SRHR services, should be simplified and disseminated to various stakeholders, and address ambiguity that causes hesitancy among healthcare providers and adolescents. Laws and policies should clearly define child-friendly SRH services.

3. Health providers should be trained to deliver non-judgmental, youth-centered, and rights-based SRHR services. The training should address biases and misconceptions that limit service accessibility for adolescents and young people.

4. There is need for community engagement and advocacy targeting parents, guardians and community leaders to reshape norms and attitudes around adolescent sexuality and reproductive health.

5. It is critical to advocate for the normalisation of comprehensive sexuality education in school and communities to empower and support the agency of adolescents, because this is necessary to encourage adolescents to demand services and build capacity for informed consent.

6. There is need to foster collaborations between governments, CSOs, and international organizations to ensure resources and expertise are pooled effectively. It is also critical to enhance multi-sectoral partnerships to address structural barriers, such financial constraints, affecting service delivery.

The following could be the urgent and critical actions to prioritise:

1. Design mechanisms to track the domestication and implementation of key frameworks like the Maputo Protocol and the ACRWC. Stakeholders including civil society should regularly review progress.

2. Laws that disproportionately restrict young adolescents (e.g., under 16 years) from accessing contraception and HIV testing without parental consent should be reviewed. States should adopt the model where substitute guardianship would fill parental consent gaps.

3. States should create youth councils or advisory boards to include adolescent voices in policy and service design processes. States should expand training programs that build advocacy skills among youth to champion SRHR issues in their communities.

4. Civil society should advocate for the full implementation of the Abuja Declaration by ensuring that at least 15% of the national health budgets are allocated to healthcare, with a clear focus on youth-friendly SRHR services. Allocation of budgets should address immediate shortages of address immediate shortages of SRHR commodities in health facilities, particularly in rural areas

5. There is need to undertake comprehensive campaigns to challenge and transform harmful or negative cultural norms around adolescent sexuality. It would be key to partner with religious and cultural leaders and young people themselves to create context-specific messaging supportive of adolescent and young people's SRHR

8 CONCLUSION

Legal frameworks are critical instruments because they enable or disable access to services through regulating conduct and recognising rights and creating enforceable obligations. Laws can make access to services for children difficult by requiring parental consent in a manner that is inflexible about the age. Policies are also crucial because they can enable services by clarifying and making laws operational and practical. Usually, health professionals pay attention to and are more familiar with the language of policies rather than laws. Laws may require interpretation which is not the purview of health professionals. Ideally, laws and policies must align rather than be discrepant, so that a health professional following policy is at the same time guided to act within the legal framework.

It is, therefore, important to have laws that are clear about consent, and recognise the rights of the child regarding consent. Even if laws may stipulate consent from broader principles, policies must offer practical and clear guidance on specific situations, on how to conduct capacity assessment, and how to ensure that a child seeking SRHR services is neither turned away nor frustrated.

There is need to reform laws and policies, but also to engage the four key stakeholders, the government, the health providers, the gatekeepers including parents, and the children themselves. Ultimately, what is needed is a cultural transformation where society would create and uphold enabling conditions for children to access SRHR with informed consent, while safeguarding their rights.

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