



Harmonizing the Legal Environment for Adolescent Sexual and Reproductive Health and Rights

*A review of 23 countries in
East and Southern Africa*



ACKNOWLEDGEMENTS

A number of individuals and organizations contributed to the development and implementation of this study. We would like to acknowledge the financial support of the United Nations Population Fund (UNFPA) East and Southern Africa Regional Office and the Swiss Agency for Development and Cooperation (SDC) which made this study possible.

Special thanks goes to Dr. Asha Mohamud and Ms. Renata Tallarico for providing necessary guidance concerning the design and implementation of the study; Ms. Maria Bakaroudis, Ms. Maja Hansen, Ms. Ruth Chirimuta, Ms. Celine Mazars and Mr. Kizito Nsanzya for their support in reviewing the report and ensuring a smooth validation of the findings; and Dr. Adabayo Fayoyin, Ms. Lindsay Barnes, Ms. Corrie Butler for editing and designing the final summary brief and report. Also thanks to UNFPA country staff and government focal points in Angola, Botswana, Burundi, Comoros, Democratic Republic of the Congo, Ethiopia, Eritrea, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Seychelles, South Africa, South Sudan, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe, who provided in-country logistical support and review of the study. And a special thanks to other members of the UN family, including United Nations Educational, Scientific and Cultural Organization (UNESCO) and United Nations Programme on HIV/AIDS (UNAIDS) for their technical support.

Special thanks goes to the Centre for Child Law based at the Law Faculty at the University of Pretoria for their technical expertise and research skills needed to complete this project – namely, Prof. Ann Skelton, Ms. Karabo Ozah and Ms. Carina Du Toit. Finally, the report and its legal framework could have not been possible without the support and guidance of the African Union Commission (AUC) Human Resource, Science and Technology Department, Southern African Development Community (SADC), Intergovernmental Authority on Development (IGAD), East African Community (EAC), Common Market for Eastern and Southern Africa (COMESA) and SADC Parliamentary Forum.





Content

Introduction	page 4
Legal frameworks	page 6
1. Age of consent to sexual activity	page 7
2. Age of consent to marriage	page 8
3. Age of consent to health services	page 9
4. Criminalization of consensual sexual acts among adolescents	page 10
5. Criminalization of HIV transmission	page 11
6. Sexual and reproductive health services for young people further left behind	page 13
7. Cultural, religious and traditional practices that are harmful	page 15
8. Pregnant learner retention and re-entry law and policy	page 17
9. Provision of comprehensive sexuality education	page 18
Conclusion	page 20

SEXUAL AND REPRODUCTIVE HEALTH: A FUNDAMENTAL HUMAN RIGHT



Sexual and reproductive health is an intrinsic part of an adolescent's development and a fundamental right for all. Yet, far too often, it is the missing piece of a puzzle in a young person's journey from adolescence to adulthood.

Across East and Southern Africa, millions of adolescents and young people face barriers to exercising their right to sexual and reproductive health information and care. Many are forced into marriages and are vulnerable to unintended pregnancies, risky childbirth, unsafe abortions and sexually transmitted infections, including HIV. Even those who are equipped with the right information may not access the health services they need to protect themselves.

However, this reality is changing.

As passionate advocates of young people, UNFPA is seeing significant advancements in the health and development needs of young people. Countries are recognizing the pivotal importance of addressing these needs as investments in a better and brighter future today and for generations to come.

Bold commitments have been made by governments across the region in a number of international and regional declarations, conventions and agendas, which point to the important shift in safeguarding all rights, including sexual and reproductive health and rights for young people. These also provide clear guidance to countries in enacting laws and policies that better protect vulnerable groups, including adolescents.

UNFPA is proud to partner with the contributors including the AUC, SADC, IGAD, EAC, COMESA and SADC Parliamentary Forum, to share the highlights of a first-of-a-kind study, providing an analysis of the international and regional conventions and commitments made by 23 countries in East and Southern Africa, and their corresponding laws and policies that affect adolescent sexual and reproductive health and rights.

Drawing from regional and international instruments, the study provides a mirror with which States can individually and collectively assess how they are measuring up to their commitments.

The study shows that despite promising gains in sexual and reproductive health, there are still disparities that persist across many countries, further highlighting that many young people continue to be left behind.

The ability to achieve healthy and empowered adolescents and young people hinges on a supportive legal and policy environment. This will ensure that every person can exercise their fundamental right to sexual and reproductive health.

Dr. Julitta Onabanjo

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INTRODUCTION

About the study

The study reviews the laws, policies and related frameworks in 23 countries in East and Southern Africa (ESA) that create either impediments to, or an enabling environment for, adolescent sexual and reproductive health and rights. The assessment resulted in the development of a harmonized regional legal framework, which translates international and regional legal provisions into useful strategies. It gives recommendations based on applicable core legal values and principles gleaned from a range of conventions, charters, political commitments, guidelines and declarations.

This document provides a summary of findings from the comprehensive study and key recommendations for further legal reform to improve the sexual and reproductive health of adolescents and young people across the region.

Methodology

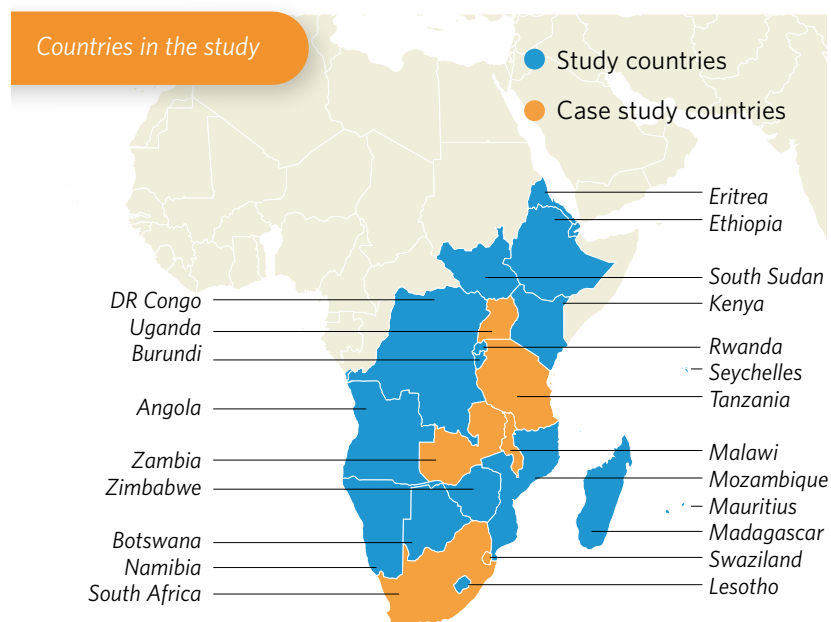
The legal review was conducted from 2015 to 2016 through a detailed perusal of various laws and policies, as well as a study of other frameworks that set out the legal environment for adolescent sexual and reproductive health and rights in ESA countries. Because the legislative and policy provisions that impact adolescent sexual and reproductive health and rights are multifaceted, the desktop review identified themes of relevant laws and policies in order to guide the assessment of the different countries. Laws and policies were assessed against the following themes: (1) age of consent to sexual activity; (2) age of consent to marriage; (3) age of consent to health services; (4) criminalization of consensual sexual activity among adolescents; (5) criminalization of HIV transmission; (6) sexual and reproductive health services for young people further left behind; (7) cultural, religious and traditional practices that are harmful; (8) pregnant learner retention and re-entry laws and policy; and (9) provision of comprehensive sexuality education.

Furthermore, country case studies were undertaken in six of the twenty-three countries, noted in the map below. These case studies have brought to the fore the experiences of various stakeholders in the field of sexual and reproductive health and rights, ranging from government officials to young people themselves. This in-depth review in six countries was done by

combining a review of literature with concrete experiences of youth and key stakeholders. This included interviewing adolescents and young people, health-care providers, representatives of the education sector, non-governmental organizations and legal experts.

The study was validated by the AUC, COMESA, EAC, IGAD and SADC, as well as other regional stakeholders, including young advocates.

Limitations to the study include availability of respondents, number of country case studies and a focus placed on urban areas. However, this report provides vital information that will help harmonize the law and policy environment affecting adolescent sexual and reproductive health across the region.



“

Usually, countries in the region have a high age of consent. As a young person, I can say without a doubt that this becomes a huge barrier for us in getting information about our health, like knowing our HIV status. These situations prevent us from exercising our basic human right.

”

- Gogontlejang Phaladi, a young person from the African Youth and Adolescents Network on Population and Development (AfriYAN), Botswana

LEGAL FRAMEWORKS RELEVANT TO ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

Regional

- African Charter on Human and People's Rights (1981)
- African Charter on the Rights and Welfare of the Child (1990)
- The African Women's Protocol to the African Charter on Human and People's Rights (2003)
- The Continental Policy Framework for Sexual and Reproductive Health and Rights (2005)
- Plan of Action on Sexual and Reproductive Health and Rights (2006)
- African Youth Charter (2006)
- Model Law on HIV in Southern Africa (2008)
- General Comments on Article 14 (1) (d) and (e) of the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (2012)
- The ESA commitment made by ministers of health and education in 21 ESA countries to scale up comprehensive sexuality education (CSE) and SRH services for adolescents and young people (2013)
- General Comment No 2 on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c) of the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (2014)
- The SADC Parliamentary Forum Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage (2016)

International

- Universal Declaration of Human Rights (1948)
- International Covenant on Civil and Political Rights (1966)
- Convention on the Elimination of All Forms of Discrimination against Women (1979)
- Convention of the Rights of the Child (1989)
- International Conference on Population and Development (1994)
- General Comment No 4 on Adolescent health and development in the context of the Convention on the Rights of the Child (2003)
- General Comment No 20 on the Implementation of the Rights of the Child during Adolescence (2016)
- Framework of actions for the follow-up to the Programme of Action of the International Conference on Population and Development Beyond 2014
- Joint General Recommendation No 31 of the Committee on the Elimination of Discrimination against Women/ General Comment No 18 of the Committee on the Rights of the Child on harmful practices (2014)

1. AGE OF CONSENT TO SEXUAL ACTIVITY

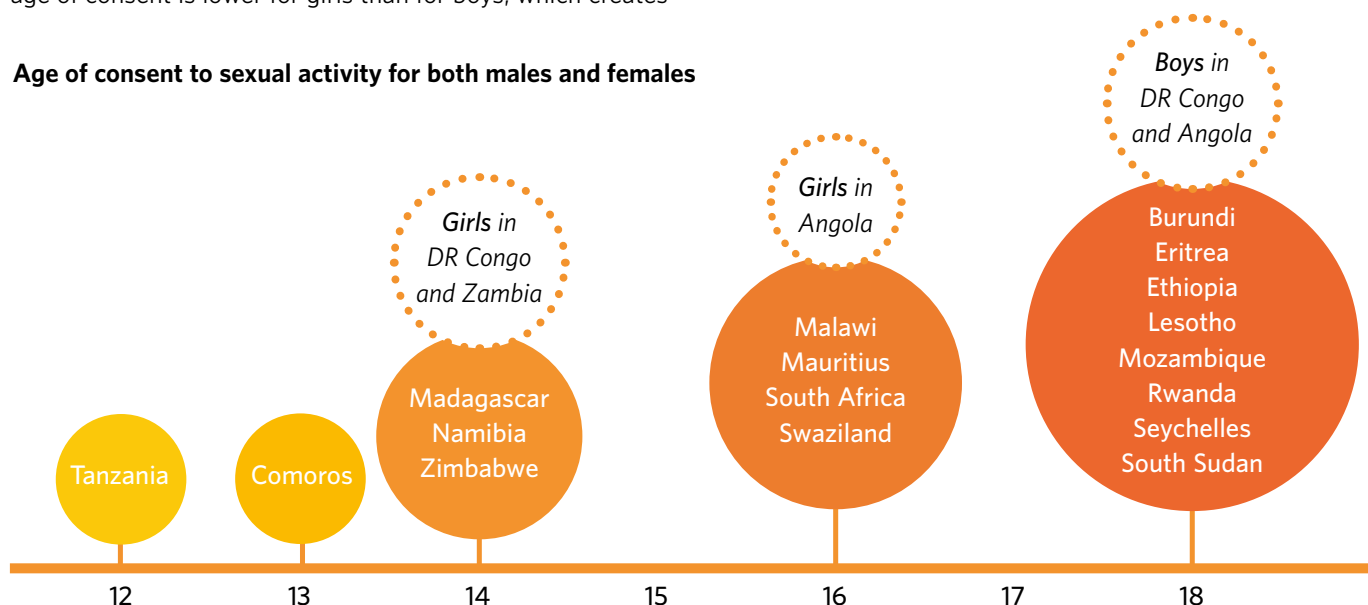
Overview of findings

The average age for sexual debut ranges across East and Southern Africa, from 15 years in Angola and 16 in Mozambique, to 19 years in Namibia and 20 in Burundi¹. Yet, the law on age of consent to sexual activity in the region does not necessarily reflect the reality. The majority of countries do not have a minimum age of consent to sexual activity clearly set out in their legislation. This means the age of consent needs to be gleaned from a reading of sections that relate to criminal sexual activities. This makes it difficult for young people and the community at large to determine, with certainty, what the minimum legal age is. In some countries where the age of consent is stated, the age of consent is lower for girls than for boys, which creates

further barriers to accessing services. Clearly defining the age of consent in the law does not encourage sexual activity - it provides further options for an adolescent or young person to make safe decisions about their health.

Setting an appropriate age of consent to sexual activity requires a balance of rights to protection and the recognition of the evolving capacity and autonomy of adolescents and young people as they age. For example, a 12-year-old child will not require the same level of service as an 18-year-old. If laws support access to adolescent sexual and reproductive health and rights, this can delay sexual debut by encouraging and enabling informed decision-making.

Age of consent to sexual activity for both males and females



Proposed reform

Recommendations in law:

- Clearly set out the minimum age of consent to sexual activity. The age of consent to sexual activity will have to align to the age of consent to sexual and reproductive health services, including contraceptives.
- Consider narrowing the legal defences available to adults who engage in sexual activity with a child below the age of consent. Claiming that the child appeared older should not be considered sufficient to justify any unlawful behaviour.
- Harmonize the age of consent for both adolescent boys and girls: both should have the same minimum age.

Recommendations in policy:

- Provide guidance on the recognition of the evolving capacities of adolescents and normative sexual development.

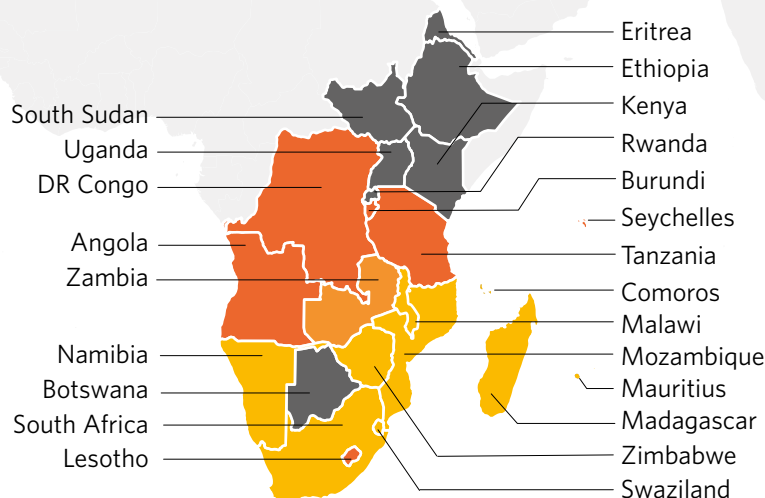
2. AGE OF CONSENT TO MARRIAGE

Overview of findings

Child marriage is wide-spread across the region, with approximately 36 per cent of girls married before the age of 18². The combination of customary and statutory laws in many countries complicates the age of consent to marriage. In most instances, there is conflict between the different legal systems. The age of consent to marriage is not clear or codified for the majority of cases in customary law and is, in

most instances, much lower than 18 years of age. Only six countries have set the minimum age of consent to marriage at eighteen years or above, without exception. In addition, six countries have differing age of consent to marriage for males and females, with an average of 15 years for females and 18 years for males.

- 18 years, without exception
- 18 years, with exception
- 16 years
- Discrepancy between girls and boys



Proposed reform

Recommendations in law:

- Set the minimum age of consent to marriage to 18 years, without exception and differentiation between boys and girls.
- Countries in SADC to adopt the Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage.
- Prohibit and criminalize under the law the giving out of a child in marriage or facilitation of a child marriage.
- Ensure the minimum age of consent to marriage takes precedence over any cultural, traditional or religious customs and practices and include a provision that child and forced marriages are harmful practices.
- Enact a rigorous birth registration system in order to ensure effective compliance with the minimum age of consent to marriage.
- Consider voidable any child marriage, concluded before any law criminalizing child marriage came into operation.

Recommendations in policy:

- Develop comprehensive policies that address root causes of child and forced marriages, such as poverty alleviation programmes.

3. AGE OF CONSENT TO HEALTH SERVICES

Overview of findings

AIDS is still the leading cause of death among adolescents in Africa. Adolescents are the only age group in which deaths due to AIDS are increasing³. This outlines the immense need to eliminate barriers for this age group to access quality health services and medical treatment.

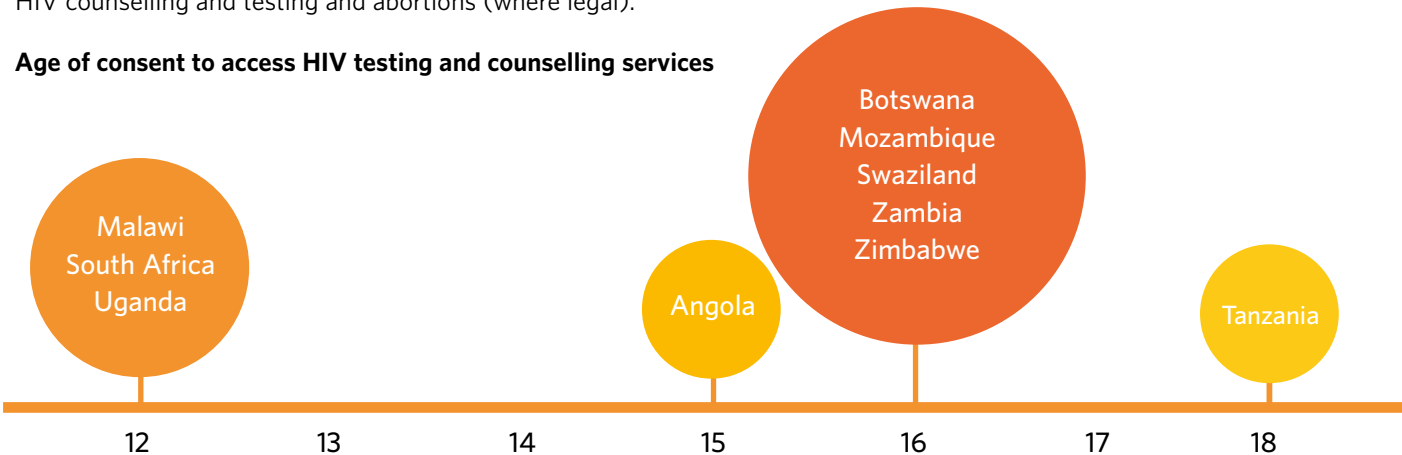
Some countries have policies that aim to enable access to sexual and reproductive health services for adolescents and young people without discriminating based on age. However, these policies are not sufficient. Clear legislative provisions need to be in place that take into account young people's autonomy and evolving capacities.

The majority of countries in the region do not have clear laws and policies that determine the age of consent to medical treatment, including access to contraceptives, HIV counselling and testing and abortions (where legal).

This 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. This uncertainty also creates a barrier to accessing services. Health-care providers end up using personal discretion on 'an appropriate age' instead of practising within the legal framework.

Three countries (Malawi, South Africa and Uganda) have made legislative provision for the age of consent to sexual and reproductive health services by setting the minimum age at twelve years. This best practice can be emulated by the rest of the region in order to improve young people's access to services and decrease termination of pregnancies, morbidity and mortality, including HIV infections.

Age of consent to access HIV testing and counselling services



Proposed reform

Recommendations in law:

- Set the age of consent to 12 years for HIV testing, pre- and post-counselling and contraceptives without parental consent. Emergency measures should be included if parental consent cannot be obtained.
- Clearly state in additional provisions in legislation that health-care providers need to respect the views and opinions of the adolescent or young person accessing a service and their right to confidentiality.
- Set the age of consent based on the adolescent's sufficient maturity to understand the risks, benefits and consequences of the medical treatment. The law should guide health-care providers on how they can assess this maturity.

Recommendations in policy:

- Create guidelines for the provision and institutionalization of sexual and reproductive health services.
- Develop a policy that sets out the benefits of broad access to adolescent sexual and reproductive health.

4. CRIMINALIZATION OF CONSENSUAL SEXUAL ACTS AMONG ADOLESCENTS

Overview of findings

Some countries criminalize consensual sexual acts among adolescents. In most of these cases, boys are convicted and sent to prison. The criminalization of consensual sexual activities among adolescents and young people is directly at odds with the approach set out in international treaties that recognize adolescents' evolving capacities. The criminalizing of consensual sexual acts among adolescents is an impediment to their right to access sexual and reproductive health services and leads to stigmatization of the normal

sexual development of young people. In addition, it can delay or prevent young women from seeking contraception and lead to unintended pregnancies or HIV infection.

Countries need to decriminalize consensual sexual acts among adolescents and focus on educative approaches that will instead enable and empower young people to make informed choices about their sexual and reproductive health and rights and their needs.

Kenya

Defilement - that being sexual acts with consent - with a person under the age of 18 and among persons under the age of 18 is criminalized.

Namibia

Consensual sexual acts with persons under the age of 14 are criminalized. However, there is a close-in-age defence of three years.

South Africa

Consensual sexual acts among adolescents are decriminalized as long as the age difference is not more than two years.

Uganda

'Child-to-child sex' is criminalized and must be dealt with in accordance with the Children's Act.

Zambia

Same-sex gross indecency among children is criminalized and children are liable to community service or counselling upon conviction.

Proposed reform

Recommendations in law:

- Clearly set out the minimum age of consent to sexual activity. The age of consent to sexual activity will have to align to the age of consent to sexual and reproductive health services, including contraceptives.
- Ensure two adolescents who are close in age - when one adolescent is below the age of consent for sexual activity and the other is over the age of consent - is not criminalized. This is called 'close-in-age defence'.
- Harmonize the age of consent for both boys and girls.
- Enact special legal provisions for adolescents whose legal capacities are diminished, for example, those who are mentally challenged. These legal provisions should also include a clear definition of mental disability.

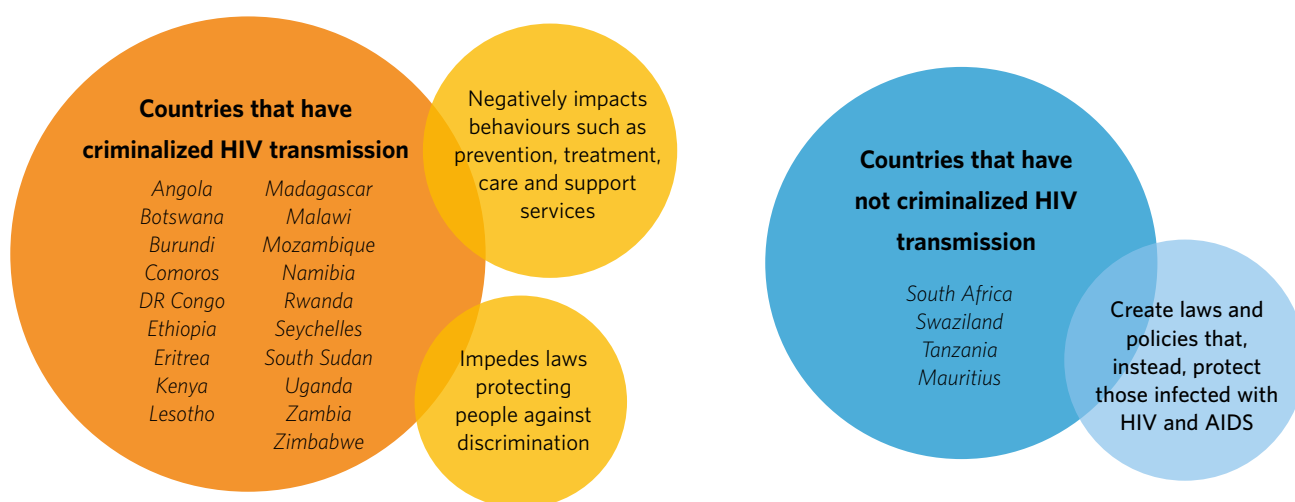
5. CRIMINALIZATION OF HIV TRANSMISSION

Overview of findings

Most countries in the region have legislative provisions criminalizing the transmission of HIV or a disease that may explicitly cause death. Some, however, have laws protecting people living with HIV against discrimination.

The majority of countries in the region criminalize infecting others with HIV, whether the case is intentional or negligent. However, this overly-broad application of criminal law to

HIV transmission creates a real risk of increasing stigma and discrimination against people living with HIV and can drive them further away from prevention, treatment, care and support services. Countries such as South Africa have also shown that criminalizing HIV transmission can infringe on the right to privacy to an extent that is not justified, as it requires inquiry into intimate medical histories and sexual affairs.



Proposed reform

Recommendations in law:

- Decriminalize transmission with no exceptions.
- Monitor application of the general criminal law focused on intentional transmission of HIV to ensure it is not used inappropriately.
- Redirect legislative reform and law enforcement towards addressing sexual and other forms of violence against women, discrimination and human rights violations against people living with HIV.
- Ensure that civil society including women's and human rights groups, representatives of people living with HIV and other key populations is fully engaged in developing and reviewing HIV laws and their enforcement.

Recommendations in policy:

- Significantly expand access to proven HIV prevention (including positive prevention) programmes and support voluntary counselling and testing for couples, voluntary disclosure and ethical partner notification.
- Include educational and counselling programmes in policy to encourage early disclosure of the HIV status of a child born with the virus.
- Promote gender equality in education and employment, providing developmentally appropriate sexuality education that addresses relevant topics outlined in the *International Technical Guidance* and accommodates developmental diversity and facilitates the internalization of sexual health messages.

“

A youth-friendly corner is where we get to know each other, know how our bodies develop and know how we are going to enjoy our lives. If I am confused about relationships or something about my body, I feel free to ask one of the peer educators.

- Tanyara, 16, Zimbabwe

”

6. SEXUAL AND REPRODUCTIVE HEALTH SERVICES FOR YOUNG PEOPLE FURTHER LEFT BEHIND

Overview of findings

In East and Southern Africa, there are an estimated 2.4 million sexually active adolescent girls (aged 15-19 years) who have an unmet need for family planning – this is expected to rise to 3.4 million by 2030 if access to family planning methods does not improve⁴.

The majority of countries in the region do not have provisions that clearly set out the right of adolescents to access sexual and reproductive health services. However, regional and international commitments and treaties ratified by countries in the region outline and provide guidance for ensuring sexual and reproductive health and rights.

There are noticeable gaps in the specific provisions for the protection of the sexual and reproductive health and rights of vulnerable adolescents and youth, including individuals with disabilities, in the majority of the 23 countries. There is a need for focused attention on adolescents and young people with disabilities, particularly in relation to their special needs.

In relation to lesbian, gay, bisexual, transsexual and inter-sex (LGBTI) people, the most notable concern is the criminalization of same-sex relationships. In some countries, homosexual acts committed in respect of minors are subject to increased penalties, irrespective of consent. Some countries specifically criminalize male homosexual acts with

inference that sexual acts, between females are excluded. This creates further barriers in accessing health information and services.

Young women and girls face significant discrimination which results in a higher number of deaths and complications related to pregnancy, childbirth and unsafe abortion. The risk of dying during childbirth is twice as high for women aged 15 to 19 years as it is for women in their 20s⁵. The lack of access to contraceptives and safe abortion, even where legal, drives many young women to have unsafe abortions in order to terminate unintended pregnancies, including those who were raped.

This can be avoided through provisions that respond to their unique needs, including contraception, counselling, post-abortion care and safe abortions, where legal. For example, in South Africa, abortion-related deaths and injuries are estimated to have reduced by over 90 per cent since the introduction of the Choice on Termination of Pregnancy Act⁶.

Although the majority of countries criminalize abortion, some provide room for exceptions. The narrow and unclear legal exceptions for abortion are often at the discretion of health-care providers. This creates additional challenges for those who fall under the categories for which exceptions are made.

Case study: Malawi

“Had I not received information earlier, I would now have two kids and maybe STIs too. You are not able to make the correct choices in relation to sexual and reproductive health if you do not have the correct information.” - *Young person from Malawi*

Although Malawi has well-intended policies related to sexual and reproductive health, there is a lack of allocated resources to implement them successfully. Young people indicated that they are deterred from accessing services because of negative experiences they have had with a health-care provider when seeking services. They indicated that in many cases, the health-care provider might be their neighbour or a friend of their parents, who may break confidentiality and tell their parents. In addition, some young people do not like the model that allows youth-friendly services to be available only on particular days as this limits their access. This was illustrated by one young woman: “If you need emergency contraceptives and have to wait for two days, you are going to have a serious problem.”

Case study: Tanzania

The application of customary and religious laws over statutory policies is a barrier to the acceptance and uptake of contraceptives and condoms. This is further impacted by the lack of accessible youth-friendly health centres across the country.

Acceptance of adolescent sexual and reproductive health and rights is slowly improving but cultural beliefs and taboos are still barriers to ensuring young people have adequate access to information and services.

Non-governmental organizations noted that there are no special programmes for sex workers or people who inject drugs. Vulnerable groups like orphans will also struggle to access services because health-care providers believe children do not need sexual and reproductive health services. Orphans will most often have no support structure and are more dependent on state services.

Case study: South Africa

The South African Children's Act of 2005 provides that a child aged 12 years or older may consent to medical treatment without parental consent if he/she is of sufficient maturity and stage of development. Parental consent to abortion is not required, irrespective of the age of the child.

These comprehensive provisions are found in Sections 129 to 134 of the South African Children's Act 38 and could be considered a best practice.

That said, challenges remain for young people with disabilities - for example, there are no sign language interpreters or braille facilities at state clinics. This means young people with disabilities rely on an accompanied caregiver or parent, which impedes their ability to access services. Health-care providers have confirmed that they have no capacity to assist people with disabilities.

Proposed reform

Recommendations in law:

- Follow a rights-based approach in legislation, making it clear that any adolescent – no matter their status, orientation or background – has a right to access sexual and reproductive health services and information.
- Address gender inequality and promote women's right to property, inheritance and custody so that there are fewer risks if they decide to disclose their status or leave a relationship.
- Ensure broader access to prevention services, such as contraceptives to reduce recourse to abortion.
- Ensure abortion services, where legal, are not subject to minimum age of consent requirements or parental consent.
- Ensure availability of quality post-abortion care to all girls and young women.
- Integrate and scale-up youth-friendly health services, including confidential and voluntary HIV testing and counselling, HIV/STI treatment and care, voluntary family planning, safe abortion (where legal), post-abortion care, safe delivery, prevention of HIV/STI mother-to child transmission and other related services for young people, in and out of school.
- Provide for the establishment of youth-friendly clinics, including proper resourcing from the state and setting norms and standards, including which services will be accessible, training of staff and confidentiality requirements.
- Amend laws that criminalize same-sex relationships to align with SADC Model Law on HIV and AIDS.

Recommendations in policy:

- Promote sexual and reproductive health policies that improve access to family planning services as preventive action.
- Make provisions for adolescents and young people to report or obtain assistance if their sexual and reproductive health and rights are violated at an institution.
- Include strategies that educate and raise awareness among parents and communities to prevent stigmatization, prejudice and denial of health services to adolescents with disabilities or those who are HIV-positive, who engage in sex work, who are out of school, who inject drugs, who belong to the LGBTI community or who are associated with other sexual minority groups.

7. CULTURAL, RELIGIOUS AND TRADITIONAL PRACTICES THAT ARE HARMFUL

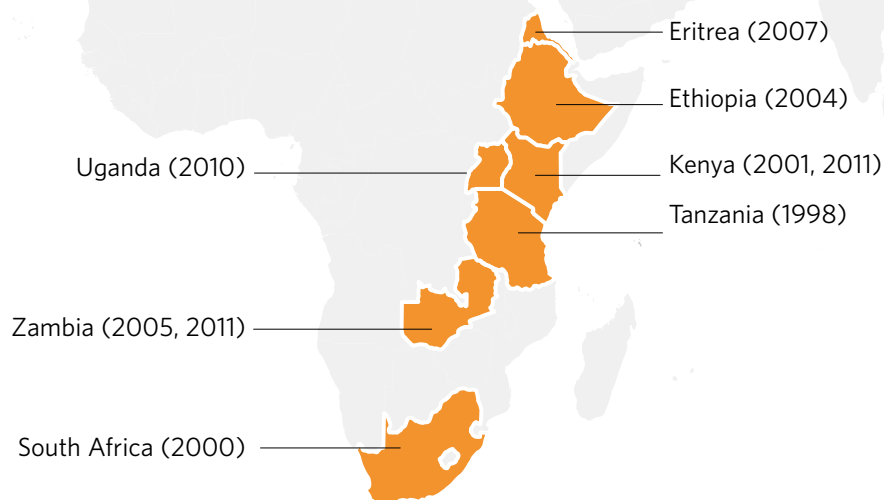
Overview of findings

Female genital mutilation (FGM) has been documented in many countries. The percentage of girls and women aged 15-49 years who have undergone FGM was highest in Eritrea (89%), Ethiopia (74%) and Kenya (27%), and lower in Tanzania (15%) and Uganda (1%)⁷.

Efforts to do away with harmful cultural practices have been strengthened by the adoption of laws that criminalize practices such as FGM, particularly in East Africa. Some countries have opted to include protection of children against harmful cultural practices in their constitutions and

child-specific legislation, including raising the age of consent to child marriage to eradicate forced and early marriages.

The recognition of customary law and existence of a dual legal system in some of the countries creates an impediment to dealing with harmful cultural practices effectively and leaves young people vulnerable. Criminalization of harmful cultural practices is a good start; however, there is a need to ensure that the legislative provisions translate into practice and are enforced against those who commit these offences.



Proposed reform

Recommendations in law:

- Explicitly prohibit cultural, religious and traditional practices that are harmful to the health of women, children, adolescents and young people, including, but not limited to: FGM, virginity testing and child or forced marriage.
- Prohibit harmful practices and include effective enforcement mechanisms that empower the state to act against perpetrators.
- Resolve any conflict between the legislation that prohibits harmful practices and religious or traditional laws, in favour of protecting women, children, adolescents and young people.
- Clearly ensure that male circumcision is conducted in safe and hygienic conditions by a trained professional.

Recommendations in policy:

- Include strategies that get greater buy-in from cultural, religious and traditional leaders to prevent harmful practices.
- Develop programmes to monitor compliance with legal prohibitions on harmful practices through existing human rights structures and institutions.

“

I know that harmful cultural practices are going to change. There is now a law that protects us but people in my community are not aware of these things. That is why they are still practising them.

”

- Catherine, 24, a young woman from Malawi who escaped child marriage at the age of 13.

8. PREGNANT LEARNER RETENTION AND RE-ENTRY LAW AND POLICY

Overview of findings

For many girls and young women, becoming pregnant means an end to an education. In fact, a five-country study in the region shows that less than five per cent of girls who drop out of school as a result of pregnancy return⁸. Keeping girls in school, despite pregnancy, is crucial to ensure opportunities for a better life and future.

Only about half of the countries in the regional study have legislation and policies on the management of learner pregnancy and re-entry after delivery. However, the majority

of those countries tend to approach learner pregnancy from a punitive perspective. This is clear from the policies that ban learners from returning to their former school, exclude them for a specific pre-determined time frame, or expel them on the grounds of pregnancy. These approaches are not in line with international obligations. An accommodating approach, which has general principles guided by a rights-based framework and takes into account an individual learner's needs and circumstances, is more appropriate.

About half
of countries
(11 out of 23)
have prevention, management and re-entry
legislation and policies on learner pregnancy



but the majority of those countries that do have policies
tend to approach learner pregnancy from a

**punitive
perspective**

Proposed reform

Recommendations in law:

- Make it clear that pregnancy is not a disciplinary issue and a non-punitive approach to pregnancy needs to be adopted.
- Provide for supportive re-entry of the pregnant learner to school after delivery, when the adolescent is ready.
- Make provisions that respect the privacy of the pregnant learner.
- Include measures for the retention of pregnant learners to continue their education until they are close to delivery.
- Obligate the school or institution to report to educator bodies and ministry of education where pregnancy is caused by a teacher or other staff member.

Recommendations in policy:

- Emphasize the importance of adolescents receiving adequate knowledge and life skills related to their sexuality.
- Include measures aimed at de-stigmatizing pregnancy among adolescents and use the opportunity to inform and educate other learners on the importance of obtaining services to prevent unplanned pregnancy.
- Pregnant learners need to be supported to continue their studies until as close as possible to delivery. They must also be referred to health and other related services. Ministries of health and education need to collaborate to provide pregnant learners with support during pregnancy and after delivery.

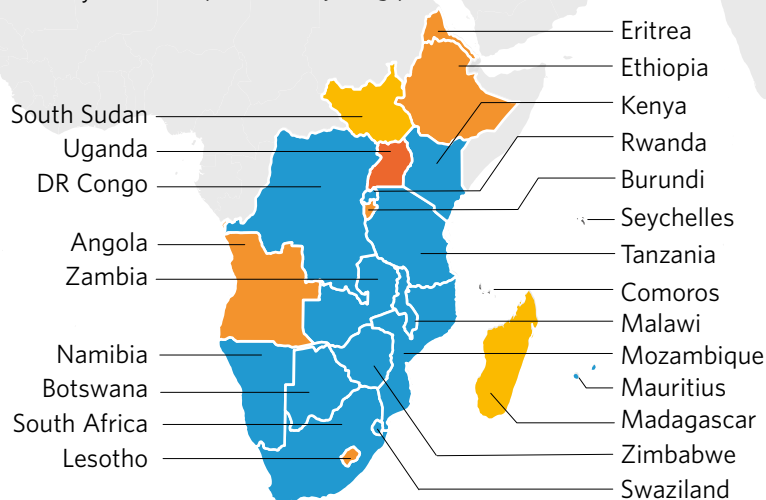
9. PROVISION OF COMPREHENSIVE SEXUALITY EDUCATION

Overview of findings

The majority of countries in the region have diverse policies that indicate integration of comprehensive sexuality education (CSE) for in- and out-of-school youth. Additionally, ministers of health and education from 20 countries in the region have endorsed the East and Southern African Commitment, which has time-bound targets to scale up CSE and sexual and reproductive health services for young people. However, only some countries have fully integrated CSE curricula for both primary and secondary

schools, ensuring it is both compulsory and examinable. It is worth noting that some country policies have a negative approach aimed at instilling fear in adolescents towards sexual and reproductive health. However, evidence shows that CSE increases knowledge of prevention of HIV and teenage pregnancy and improves condom use and ability to refuse sex among females. It has also been proven to delay initiation of first sex and significantly decrease the number of partners a young person has⁹.

- Provision of CSE
- CSE suspended
- No provision of CSE
- Unclear
- Data not available



Proposed reform

Recommendations in law:

- Ensure the curriculum is rights based and includes scientifically accurate information, as part of adolescent and young people's right to health.
- Ensure the curriculum provides developmentally appropriate sexuality education that addresses relevant topics outlined in the *International Technical Guidance* and accommodates developmental diversity and facilitates the internalization of sexual health messages.

Recommendations in policy:

- Set out the need for and benefits of CSE and the contribution it makes to reducing STIs, HIV and unintended pregnancy, based on scientific evidence.
- Align with the *International Technical Guidance* and regional commitments such as the ESA Commitment.
- Recognize the importance of delivering CSE not only in school settings but also through parents and communities that play a crucial role in educating adolescents about sexuality.



CONCLUSION

This study has shown that governments are making strong progress, demonstrating that young people's well-being is a priority – but there is much more to be done. To ensure the fulfilment of young people's potential, States need to align and harmonize with international and regional human rights laws, standards and commitments and uphold adolescents and young people's fundamental human right to sexual and reproductive health.



Age of consent to sexual activity

Many countries in East and Southern Africa do not have the minimum age of consent to sexual activity clearly set out in their bodies of legislation.

There is a need for the enactment of unambiguous legislative provisions that provide for the recognized age of consent to sexual activity. The criminalization of consensual sexual acts amongst adolescents is also an impediment to gaining access to sexual and reproductive health and leads to stigmatization of normal sexual development of young people.



Age of consent to marriage

All 23 countries have set the age of consent to marriage. However, there is disharmony between the legislative provisions and the international standards, as well as between statutory and customary law provisions.

The disharmony between legislative provisions leads to the continued practice of child marriage, which has dire consequences, particularly for young girls. The age of consent to marriage should be set at 18 years, without exception.



Age of consent to medical treatment

In many countries, the age of consent to receive medical treatment, including access to contraceptives and HIV counselling and testing, is not provided for in laws and policies.

Lack of legal and policy provision can lead to confusion as to when young people can consent to receive health services, including medical treatment. This uncertainty creates a barrier to accessing sexual and reproductive health services and allows health-care providers to enforce their own belief systems regarding an appropriate age of consent.



Criminalization of consensual sexual activity between adolescents

The criminalization of consensual sexual acts between adolescents appears to be minimal across the region.

Criminalization can result in the stigmatizing of adolescent sexual development and prohibit adolescents from accessing services in fear of prosecution. It is also directly at odds with the approach set out in international treaties, which recognizes adolescents' evolving capacities and promotes an educative approach to sexual and reproductive health and rights.



Criminalization of HIV transmission

The criminalization of infecting others with HIV is a further area needing revision across the region.

Countries such as Angola, Ethiopia, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, South Africa, Tanzania, Uganda and Zambia have laws protecting people living with HIV against discrimination. The majority of countries that criminalize the infection of others with HIV do not require such acts to be intentional as they also criminalize negligent infection. Countries need to be encouraged to revise these laws and do away with this criminalization.



Harmful cultural practices

The criminalization of harmful cultural practices is a promising start but there is a need to ensure that the legislative provisions translate into practice and are enforced against those who commit these offences.

Legislation should explicitly prohibit cultural, religious or traditional practices that are harmful to the health of women, children, adolescents and young people.



Sexual and reproductive health and rights of vulnerable adolescents

Vulnerable adolescents are not always recognized in laws and policies across the majority of countries in the region.

The lack of provisions for vulnerable adolescents creates a barrier to accessing sexual and reproductive health. Policies should address the different categories of vulnerable adolescents and set up strategies that help to eliminate discrimination. This includes identifying adolescents with disabilities and those who are living with HIV, who are sex workers, who are out of school, who belong to the LGBTI community or who associate with other sexual minorities.



Learner pregnancy and re-entry laws and policies

Only about half of the countries have legislation and policies on the management of learner pregnancy and re-entry to school after delivery. However, the majority of these policies tend to approach learner pregnancy from a punitive perspective.

There is a need to emphasize the importance of the right to education as an empowering human right, and the fact that excluding learners who fall pregnant on account of their pregnancy limits the potential of young people and perpetuates gender inequality.



Provision of comprehensive sexuality education

Although the majority of the countries have provisions in their diverse policies indicating that CSE is key, only some appear to have the curricula in schools aligned to international standards.

Every country is diverse and has religious, moral and traditional nuances that may influence how CSE is taught in its schools. However, these should not prevent the revision of existing curricula to incorporate core topics that are essential to maintaining quality and are in line with the East and Southern African Ministerial Commitment.

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Guidance and support from:



Technical and financial support by:



Research expertise by:

