

**FEMALE ADOLESCENTS' REPRODUCTIVE HEALTH RIGHTS:  
ACCESS TO CONTRACEPTIVE INFORMATION AND SERVICES IN  
NIGERIA AND SOUTH AFRICA**

**by**

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## DECLARATION OF ORIGINALITY

I, the undersigned, hereby declare that this thesis, which I submit for the degree Doctor Legum in the Faculty of Law at the University of Pretoria, is my own work and has not previously been submitted for a degree at another university.

I have correctly cited and acknowledged all my sources.

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## SUMMARY

As adolescents grow into adulthood and begin to engage in sexual relations, they become vulnerable to sexual and reproductive ill-health. Female adolescents, in particular, are susceptible to sexually-transmitted infections such as HIV, and are at risk of unintended pregnancies. In sub-Saharan Africa, in particular, the HIV and AIDS epidemics are spreading rapidly, also among the adolescent population. Because of this, the imperative to invest in the sexual and reproductive health of female adolescents, who bear a heavier burden of sexual and reproductive ill-health, cannot be greater. Hence, there is a need to advocate the protection of female adolescents' reproductive health rights and their access to contraception.

The thesis examines the nature, extent and realisation of the right of adolescent girls in Nigeria and South Africa to reproductive health care through their access to contraceptive information and services. Specifically, it investigates the barriers which make access to contraceptive services and information impossible, despite the existence of national, regional and international human rights frameworks which guarantee adolescent girls access to sexual and reproductive health care services and information. Also, the consequences occasioned by the existence of these barriers are examined.

The thesis argues that in order to put a halt to the negative impact associated with adolescent sexuality, it is necessary that the various obstacles in the way of adolescent girls' access to contraceptive services and information be removed. Especially, the thesis maintains that society in Nigeria and South Africa undergoes wide-ranging changes in attitude since the benefits resulting from such changes with regard to female adolescents' access to contraceptives will greatly overshadow its supposed undesirable and harmful effects.

## OPSOMMING

Soos wat adolessente volwasse word en begin om in seksuele verhoudings betrokke te raak, word hulle kwesbaar vir geslags- en reprodktiewe gesondheidsprobleme. Veral adolessente meisies word blootgestel aan seksueel-oordraagbare infeksies soos MIV, en hulle loop die risiko van ongewenste swangerskappe. In sub-Sahara Afrika, in die besonder, versprei die MIV en VIGS epidemies baie vinnig, ook onder die adolessente bevolking. Dit is dus van die uiterste belang dat daar belê word in die seksuele en reprodktiewe gesondheid van adolessente meisies omdat hulle 'n swaarder las dra van seksuele en reprodktiewe gesondheidsprobleme. As gevolg hiervan is daar 'n behoefte daaraan om die beskerming van adolessente meisies se reprodktiewe gesondheidsregte, asook hulle toegang tot voorbehoedmiddels, te bepleit.

Die verhandeling ondersoek die aard, strekking en verwesenliking van die reg van adolessente meisies in Nigerië en Suid-Afrika tot reprodktiewe gesondheidsorg deur middel van hulle toegang tot inligting betreffende voorbehoedmiddels en -dienste. In die besonder ondersoek dit die struikelblokke in hul weg wat verhinder dat hulle toegang tot voorbehoedmiddels en -dienste geniet, ten spyte daarvan dat daar op die nasionale, regionale en internasionale vlakke menseregte-raamwerke bestaan wat adolessente meisies se reg op toegang tot seksuele en reprodktiewe gesondheidsorgdienste en –inligting, waarborg. Die reperkussies van die bestaan van hierdie struikelblokke word ook ondersoek.

Die verhandeling voer aan dat, om die negatiewe impak geassosieer met adolessente seksualiteit te bekamp, dit nodig is om die vele struikelblokke in die weg van adolessente meisies se toegang tot voorbehoeddienste en –inligting, te verwyder. Die verhandeling voer aan dat die gemeenskappe in Nigerië en Suid-Afrika 'n verreikende verandering in hul gesindheid sal moet ondergaan, aangesien die voordele wat dit vir adolessente meisies se toegang tot voorbehoedmiddels teweeg sal bring die veronderstelde onwenslike en skadelike gevolge aanmerklik sal oortref.

## DEDICATION

*This work is dedicated to my husband Olusolami. You are treasured for your patience, understanding and love!*

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*Oluremi Savage-Oyekunle*

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## ABBREVIATIONS AND ACRONYMS

ACHPR	African Charter on Human and Peoples Rights
ACRWC	African Charter on the Rights and Welfare of the Child
AHI	Action Health Incorporated
AIDS	Acquired Immune Deficiency Syndrome
AYC	African Youth Charter
CEDAW	Convention on the Elimination of Discrimination Against Women
CRA	Child Rights Act
CRC	Convention on the Rights of the Child
CRLP	Center for Reproductive Law and Policy
CRR	Center for Reproductive Rights
CTOP	Choice on Termination of Pregnancy Act
CYPA	Children and Young Persons Act
EC	Emergency Contraception
FHI	Family Health International
FLHE	Family Life and HIV Education
FP	Family Planning
FWCW	Fourth World Conference on Women
HCP	Health Care Provider
HIV	Human Immunodeficiency Virus
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic Social and Cultural Rights
ICPD	International Conference on Population and Development
IPPF	International Planned Parenthood Federation
ISHP	Integrated School Health Policy
IUD	Intrauterine Device

MDG	Millennium Development Goals
NACA	National Agency for the Control of AIDS
NAFCI	National Adolescent Friendly Clinic Initiative
NDHS	National Demographic and Health Survey
NGO	Non-Governmental Organisation
NYP	National Youth Policy
PHC	Primary Health Care
PMCT	Prevention of Mother to Child Transmission
PRB	Population Reference Bureau
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
UDHR	Universal Declaration on Human Rights
UK	United Kingdom
UN	United Nations
UNAIDS	United Nations Joint Programme on AIDS
UNFPA	United Nations Population Fund
UNGA	United Nations General Assembly
UNICEF	United Nations Children Fund
VDPA	Vienna Declaration and Programme of Action
VVF	Vesico Vaginal Fistula
WACA	West African Court of Appeal
WHARC	Women's Health and Action Research Centre
WHO	World Health Organisation

# CHAPTER 1

## INTRODUCTION

### Outline

- 1 Contextual background**
- 2 Problem statement**
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## 1 Contextual background

... it is time for urgent action by our governments, young people and civil society to reaffirm the rights of young people to a better future. We have a duty to make good quality HIV and sexuality education and SRH services a reality for all.<sup>1</sup>

Until recently, adolescents were considered a relatively healthy group. They were considered relatively free of the heavy burden of disease that is part of the lives of adults and infants.<sup>2</sup> However, research has shown that, as they grow into adulthood and begin to engage in sexual relationships, adolescents increasingly are exposed to risks which predispose them to ill-health.<sup>3</sup> In addition to becoming susceptible to contracting sexually-transmitted infections (STIs), including HIV, because sexual relations among adolescents' are often unplanned, the majority of adolescent girls are also at risk of unintended pregnancies.<sup>4</sup>

These risks to their sexual and reproductive health (SRH), coupled with the fact that adolescents represent a staggering 1.2 billion population world-wide,<sup>5</sup> underscore the urgent need to invest in young people's SRH, including their access to contraceptive information and services.

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<sup>1</sup> Statement made by Sheila Tlou, Director, UNAIDS Regional Support Team for Eastern and Southern Africa and Chairperson of the High-Level Group during launch of *HIV and Sexuality Education: Time to Act Now Report* (2013) available at [http://www.unesco.org/new/en/media-services/single-view/news/young\\_people\\_today\\_time\\_to\\_act\\_now/back/9597/](http://www.unesco.org/new/en/media-services/single-view/news/young_people_today_time_to_act_now/back/9597/) (17 March 2014).

<sup>2</sup> K L Dehne & G Riedner *Sexually transmitted infections among adolescents: The need for adequate health services* (2005) 1, available at <http://whqlibdoc.who.int/publications/2005/9241562889.pdf> (17 March 2014).

<sup>3</sup> A Bankole & S Malarcher 'Removing barriers to adolescents' access to contraceptive information and services' (2010) 41 *Studies in Family Planning* 117.

<sup>4</sup> D Shaw 'Access to sexual and reproductive health for young people: Bridging the disconnect between rights and reality' (2009) 106 *International Journal of Gynecology and Obstetrics* 132; Dehne & Reidner (n 2 above) 1.

<sup>5</sup> UNICEF *Demographic trends for adolescents: Ten key facts* available at <http://www.unicef.org/sowc2011/pdfs/Demographic-Trends.pdf> (8 May 2013).

In developing countries where 88 per cent of adolescents reside, and in sub-Saharan Africa, especially, where adolescents account for more than one in every five inhabitants,<sup>6</sup> the need to ensure access to contraceptive information and services for adolescents (especially female adolescents) is urgent. In sub-Saharan Africa, STIs and HIV - the leading causes of loss of health among women of reproductive age - predominantly affect adolescent girls.<sup>7</sup>

In addition to their susceptibility to STIs and HIV, is the problem of teenage pregnancy which, according to the United Nations Population Fund (UNFPA), is rampant as over 7.3 million girls under the age of 18 give birth annually in developing countries.<sup>8</sup> Similarly, a large number of maternal deaths recorded among this group of people can be attributed to complications arising from pregnancy and childbirth<sup>9</sup> and female adolescents constitute a large proportion of women who undergo unsafe abortion procedures.<sup>10</sup>

The necessity of protecting the reproductive health of women (and female adolescents) vulnerable to SRH illnesses, prompted the first official recognition of reproductive rights as a human right in 1968 during the International Conference on Human Rights held in

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<sup>6</sup> UNICEF *Demographic trends for adolescents* (as above).

<sup>7</sup> M T Mbizvo & S Zaidi 'Addressing critical gaps in achieving universal access to sexual and reproductive health (SRH): The case for improving adolescent SRH, preventing unsafe abortion, and enhancing linkages between SRH and HIV interventions' (2010) 110 *International Journal of Gynecology and Obstetrics* S3; A Glasier *et al* 'Sexual and reproductive health: A matter of life and death' (2006) 368 *Lancet* 1597 & 1599.

<sup>8</sup> Out of this number, 2 million of the births occur among girls under the age of 15 years. See UNFPA *Motherhood in childhood: Facing the challenge of adolescent pregnancy* (2013) 2, 4-5 & 13 available at <http://www.unfpa.org/webdav/site/global/shared/swp2013/EN-SWOP2013-final.pdf> (17 March 2014).

<sup>9</sup> UNFPA *Motherhood in childhood* (as above) 18-19.

<sup>10</sup> E Durojaye 'Realizing access to sexual health information and services for adolescents through the Protocol to the African Charter on the Rights of Women' (2009) 16 *Washington and Lee Journal of Civil Rights and Social Justice* 137.

Teheran. During this conference, the right of parents ‘to determine freely and responsibly the number and spacing of their children’ was first acknowledged.<sup>11</sup>

Recognised today under national laws and international human rights instruments, reproductive rights<sup>12</sup> are a group of rights which relate to the ability of women to make decisions on issues which affect their reproductive health.<sup>13</sup> These rights, based upon principles of human dignity and equality, recognise the right of everyone to make decisions on their reproductive health without coercion and fear.<sup>14</sup>

After its initial recognition, the use of human rights to advance the protection of sexual and reproductive health rights gained momentum through two United Nations (UN) Conferences that were held in the 1990s: the International Conference on Population and Development held in Cairo (ICPD);<sup>15</sup> and the United Nations Fourth World Conference on Women (Beijing conference).<sup>16</sup> The ICPD laid the foundation with regards to the recognition of women’s human rights as a sustainable approach towards achieving development agenda and population targets<sup>17</sup> and in terms similar to the

<sup>11</sup> Para 16 Proclamation of Teheran 1968, available at <https://www1.umn.edu/humanrts/instree/l2ptichr.htm> (2 April 2012). The right was further affirmed by the General Assembly of the UN in art 4 of the Declaration on Social Progress and Development 1974, available at <http://www1.umn.edu/humanrts/instree/s1dspd.htm> (2 April 2012).

<sup>12</sup> CRR *Reproductive rights are human rights* available at [http://reproductiverights.org/sites/crr.civicaactions.net/files/documents/pdf\\_RRHR\\_06.pdf](http://reproductiverights.org/sites/crr.civicaactions.net/files/documents/pdf_RRHR_06.pdf) 5 (2 April 2012).

<sup>13</sup> WHO & UNFPA *Mental health aspects of women’s reproductive health: A global review of literature* (2009) 4, available at [http://whqlibdoc.who.int/publications/2009/9789241563567\\_eng.pdf](http://whqlibdoc.who.int/publications/2009/9789241563567_eng.pdf) (2 April, 2012); L Knudsen *Reproductive rights in a global context: South Africa, Peru, Uganda, Denmark, United States, Vietnam and Jordan* (2006) 2.

<sup>14</sup> Knudsen (as above) 2.

<sup>15</sup> Programme of Action of the International Conference on Population and Development (ICPD), Cairo, Egypt, Sept 5-13, 1994, U.N. Doc. A/CONF.171/13/Rev. (1995), available at [http://www.unfpa.org/webdav/site/global/shared/documents/publications/2004/icpd\\_eng.pdf](http://www.unfpa.org/webdav/site/global/shared/documents/publications/2004/icpd_eng.pdf) (2 April, 2012).

<sup>16</sup> Beijing Declaration and the Platform for Action, Fourth World Conference on Women, Beijing, China, September. 4-15 1995, U.N. Doc. A/CONF.177/20 (1996), available at <http://www.un.org/womenwatch/daw/beijing/pdf/BDPfA%20E.pdf> (15 December, 2009).

<sup>17</sup> ASTRA Network *Reclaiming and redefining rights: Setting the Adolescent and Young People SRHR Agenda Beyond ICPD+20* (2014), available at <http://www.astra.org.pl/repronews/98-new-publication-reclaiming-and-redefining-rights-setting-the-adolescent-and-young-people-srhr-agenda-beyond-icpd-20.html> ( 17 March 2014).

World Health Organisation (WHO),<sup>18</sup> it defined reproductive health in paragraph 7.2 of its Programme of Action as:

A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes in all matters related to the reproductive system etc.<sup>19</sup>

Reproductive health, therefore, implies that people should be able to have satisfying and safe sex lives, have the ability to reproduce and the freedom to decide whether, when and how often they wish to do so.<sup>20</sup> Attached to this last condition, is the right of women (including girls) to be informed of and have access to safe, effective, affordable and acceptable methods of family-planning services of their choice, as well as other methods for the regulation of fertility, including the right of access to appropriate health care services that will enable them to get safely through pregnancy and childbirth when they want to.<sup>21</sup>

The Beijing conference, in addition to re-affirming the ICPD definition of reproductive health, aided the advancement of the right of women to reproductive health as an important component of the right to health, by affirming that equality should be a determining factor in matters relating to sexuality and sexual relations and, also, that issues concerning reproduction and reproductive health should be free from discrimination, coercion and violence.<sup>22</sup>

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<sup>18</sup> The WHO defines reproductive health as a state of complete physical, mental and social well-being in all matters relating to the reproductive system at all stages of life. See C AbouZahr *Background paper on reproductive health* (1999) available at <http://info.worldbank.org/etools/docs/library/48331/Background%20paper%20on%20RH.pdf> (29 March 2012).

<sup>19</sup> Para 7.2 ICPD Programme of Action 1994.

<sup>20</sup> Para 7.2 (as above); N I Aniekwu 'A legal perspective on reproductive health and gender-specific human rights in Nigeria' (2004) 1 *Journal of Medicine and Biomedical Research* 21.

<sup>21</sup> R Cook and M Fathalla 'Advancing reproductive rights beyond Cairo and Beijing' (1996) 22 *International Family Planning Perspectives* 115; C Packer *The right to reproductive choice: A study in international law* (1996) 1.

<sup>22</sup> Paras 94 & 96 Beijing Declaration and the Platform for Action 1995; Cook & Fathalla (as above) 115.

According to Cook and Fathalla, the Cairo and Beijing conferences may be seen as an acknowledgment by states that improving women's reproductive health goes beyond the focus on science and health care to identifying steps that need to be taken by government to correct past injustices to women.<sup>23</sup> This recognition links new conceptions of health to the struggle for social justice and respect for the human dignity of women.<sup>24</sup>

The definitions of reproductive health as contained in the ICPD Programme of Action and the Beijing Declaration<sup>25</sup> reveal the overlapping nature of the concepts of sexual health and reproductive health.<sup>26</sup> While both concepts entail supporting normal biological functions associated with pregnancy and childbirth, they also aim to reduce the adverse outcomes associated with the occurrence of sexual activities. This includes enabling persons of all ages to have safe and satisfying sexual relationships by tackling obstacles such as gender discrimination, inequalities in access to health services, restrictive laws, sexual coercion and gender-based violence.<sup>27</sup> It is necessary to point out

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<sup>23</sup> Cook & Fathalla (as above) 115.

<sup>24</sup> C Shalev *Rights to sexual and reproductive health: The ICPD and the convention on the elimination of all forms of discrimination against women*, available at <http://www.un.org/womenwatch/daw/csw/shalev.htm> (10 October 2010).

<sup>25</sup> Para 7.2 ICPD Programme of Action 1994; para 94 Beijing Declaration and the Platform for Action 1995. In the ICPD Programme of Action, sexual health was incorporated into reproductive health. In the definition, statements about sexual health were drawn from a WHO Technical Report of 1975 which explained the concept of sexual health as something "enriching" that "enhances" personality, communication and love". It went further by stating that "fundamental to this concept are the right to sexual information and the right to pleasure. See WHO *Defining sexual health: Report of a technical consultation on sexual health* (2006) 1 available at [http://www.who.int/reproductivehealth/publications/sexual\\_health/defining\\_sexual\\_health.pdf](http://www.who.int/reproductivehealth/publications/sexual_health/defining_sexual_health.pdf) (20 September 2014); WHO *Gender and human rights: Defining sexual health* available at [http://www.who.int/reproductivehealth/topics/gender\\_rights/defining\\_sexual\\_health/en/](http://www.who.int/reproductivehealth/topics/gender_rights/defining_sexual_health/en/) (20 September 2014).

<sup>26</sup> Glasier *et al* (n 7 above) 1596.

<sup>27</sup> Glasier (as above). See also WHO *Measuring sexual health: Conceptual and practical considerations and related indicators* (2010) 2 available at [http://whqlibdoc.who.int/hq/2010/who\\_rhr\\_10.12\\_eng.pdf](http://whqlibdoc.who.int/hq/2010/who_rhr_10.12_eng.pdf) (20 September 2014).

that subsequent consultations and meetings have resulted in the formulation of a definition for sexual health that is distinct from that of reproductive health.<sup>28</sup>

Over the years there have been reviews of the 1994 ICPD Programme of Action with the intention of ascertaining the level of progress that has been achieved in the protection of women's reproductive health rights and to modify the Programme of Action where appropriate.<sup>29</sup> Especially, the Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development exposed the need for governments to take more urgent action in relation to the protection of adolescent SRH, maternal mortality, unsafe abortion, HIV and AIDS.<sup>30</sup>

Because the ICPD Programme of Action and the Beijing Platform for Action are soft law<sup>31</sup> and, therefore, lack effective enforcement measures, additional human rights treaties incorporating mechanisms for holding governments legally accountable for their failure to protect and fulfil the reproductive rights of women (including adolescent girls) have been adopted. These treaties include the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which mandates state parties to ensure the full development and advancement of women and girls by guaranteeing their rights to

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<sup>28</sup> Accordingly, sexual health has been defined as 'a state of physical, emotional, mental, and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction, or infirmity. Sexual health needs a positive and respectful approach to sexuality and sexual relationships, and the possibility of having pleasurable and safe sexual experiences that are free of coercion, discrimination, and violence. For sexual health to be attained and maintained, the sexual rights of all individuals must be respected, protected, and satisfied'. See WHO *'Measuring sexual health: Conceptual and practical considerations and related indicators'* (as above) 10. While the concepts of reproductive health and sexual health overlap, emphasis in the thesis is placed on adolescent girls' right to access contraceptive information and services for the protection and enjoyment of their reproductive health and rights.

<sup>29</sup> The Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development was used to modify the 1994 ICPD Programme of Action. The Key was adopted at the twenty-first special session of the General Assembly (1999) available at <http://www.un.org/popin/unpopcom/32ndsess/gass/215a1e.pdf> (29 March 2012).

<sup>30</sup> Paras 53, 54, 58 and 70 Key Action document (as above).

<sup>31</sup> The term 'soft law' is used to describe international agreements that do not have legally binding force.

enjoy fundamental freedoms on a basis of equality with men,<sup>32</sup> including in their decisions relating to reproduction and family planning.<sup>33</sup> Other international human rights instruments protecting women's and girls' right to reproductive health include the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Convention on the Rights of the Child.<sup>34</sup>

Africa is part of the attempts to protect the right to SRH of women and adolescent girls. In addition to the African Charter on Human and Peoples' Rights (ACHPR) and the African Charter on the Rights and Welfare of the Child (ACRWC) which recognise the right to health of everyone, including children,<sup>35</sup> in 2005 the Protocol to the African Charter on the Rights of Women in Africa (African Women Protocol) entered into force as a supplemental instrument to the ACHPR.<sup>36</sup>

The adoption of the African Women Protocol, lauded as a major step in the protection of women's rights in the continent,<sup>37</sup> explicitly provides for the protection of the reproductive health rights of women. Apart from containing provisions for the right of women to control their fertility<sup>38</sup> and to choose methods of contraception,<sup>39</sup> it makes provision for the right to be provided with adequate information and education<sup>40</sup> on

<sup>32</sup> Art 3 CEDAW Convention 1979 <http://www2.ohchr.org/english/law/cedaw.htm> (2 April 2012). See also arts10 (h); 12.1; 12.2; 14(2)(b).

<sup>33</sup> Art 16(1)(e) CEDAW; para 21 General Recommendation 21 CEDAW Committee *Compilations of general comments and recommendations adopted by human rights treaty bodies Vol. II* available at [http://www.bayefsky.com/general/hri\\_gen\\_1\\_rev9\\_vol\\_ii.pdf](http://www.bayefsky.com/general/hri_gen_1_rev9_vol_ii.pdf) (15 November 2012).

<sup>34</sup> Art 12(1) ICESCR; Arts 24(1) & 24(2)(f) CRC.

<sup>35</sup> Art 16 ACHPR & Arts 14(1), 14(2)(b) & 14(2)(f) ACRWC.

<sup>36</sup> The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa had initially been adopted by the members of the African Union at the 2nd Ordinary Session Assembly of the Union in July 2003. See *The Protocol on the Rights of Women in Africa: An instrument for advancing reproductive and sexual rights* available at [http://reproductiverights.org/sites/default/files/documents/pub\\_bp\\_africa.pdf](http://reproductiverights.org/sites/default/files/documents/pub_bp_africa.pdf) (16 August 2009).

<sup>37</sup> R Rebouché 'Health and reproductive rights in the Protocol to the African Charter: Competing influences and unsettling questions' (2009) 16 *Washington and Lee Journal of Civil Rights and Social Justice* 79.

<sup>38</sup> Art 14(1)(a) Women Protocol 2005.

<sup>39</sup> Art 14(1)(c) Women Protocol.

<sup>40</sup> Art 14(2)(a) Women Protocol.

reproductive health.<sup>41</sup> In defining the term ‘women’, the protocol specifically provides that ‘women mean persons of female gender including girls’.<sup>42</sup>

## 2 Problem statement

In many parts of the world, including Africa, increasing numbers of adolescents have sex before marriage. As well, the age of sexual initiation among young adults is, increasingly, lower.<sup>43</sup> Apart from the reality that adolescents engage in pre-marital sex out of curiosity,<sup>44</sup> other factors exist that are responsible for female adolescents’ involvement in sexual activities. These factors include gender norms that entrench patriarchy<sup>45</sup> and poverty which makes transactional sex common.<sup>46</sup> Additional factors include the predominance of child marriages due to cultural and religious beliefs, dated notions about adolescent sexuality, and policies and programmes emphasising abstinence until marriage rather than comprehensive sexuality education. These factors have contributed to female adolescents’ vulnerability to sexual and reproductive ill-health.<sup>47</sup>

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<sup>41</sup> The Women Protocol also makes provision for the right to medical abortion under art 14(2)(c).

<sup>42</sup> Art 1(k) Women Protocol.

<sup>43</sup> R Cook *et al* ‘Reproductive health and human rights, integrating medicine, ethics and law’ (2003) 277; M J Hindin *et al* ‘Adolescent sexual and reproductive health in developing countries: An overview of trends and interventions’ (2009) 35 *International Perspectives on Sexual and Reproductive Health* 58. See also H D Boonstra, ‘Advancing sexuality education in developing countries: Evidence and implications’ (2011) 4 *Guttmacher Policy Review* 17.

<sup>44</sup> A M Sunmola *et al* ‘Reproductive, sexual and contraceptive behaviour of adolescents in Niger State, Nigeria’ (2002) 6 *African Journal of Reproductive Health* 82-92.

<sup>45</sup> This makes it difficult for girls to say ‘no’ to sex, due to the reason that it is seen as a part of societal expectation for girls to satisfy male sexual urges with rejection of ‘societal expectations’ exposing the girl to likelihood of being sexually violated.

<sup>46</sup> A Skelton ‘Girls socio-economic rights in South Africa’ (2010) 26 *South African Journal on Human Rights* 152; P I Okonta ‘Adolescent sexual and reproductive health in the Niger Delta Region of Nigeria-Issues and Challenges’ (2007) 11 *African Journal of Reproductive Health* 113-124.

<sup>47</sup> Cook *et al* ‘Reproductive health and human rights’ (n 43 above) 277. See also E Durojaye ‘Access to contraception for adolescents in Africa: A human rights challenge’ (2011) 44 *Comparative International Law Journal of Southern Africa* 3. There are currently alarming rates of teenage pregnancies, deaths from unsafe abortions and an increasing incidence of sexually transmitted infections.

The protection of female adolescents' reproductive health is a matter of great concern that has not received the attention it deserves.<sup>48</sup> Unintended pregnancies, STIs and other reproductive health problems among this group are a major problem throughout the world, and in Africa, because of increasing levels of sexual activity and unsafe sexual practices.<sup>49</sup> The current high prevalence of STIs and the rapid spread of the HIV and AIDS epidemics<sup>50</sup> in the African sub-region have led to an increase in advocacy for the protection of female adolescents' reproductive health rights and the use of contraception as a means of prevention and control of teenage pregnancies and STIs.<sup>51</sup>

The use of contraception is integral to the realisation of health in women, especially when it is used to prevent pregnancies that are too early,<sup>52</sup> too close together or too numerous.<sup>53</sup> It has been rightly stated that the ability of young girls to make effective and informed choices on the protection of their SRH depends on their being properly informed of the range of options that they have<sup>54</sup> and without which, they become vulnerable to a host of negative consequences.<sup>55</sup> As levels of HIV infection increase, guaranteeing female adolescents' access to contraceptive information and services is

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<sup>48</sup> WHO *The health of young people: A challenge and a promise* (1993) 20 available at [http://whqlibdoc.who.int/publications/1993/9241561548\\_eng.pdf](http://whqlibdoc.who.int/publications/1993/9241561548_eng.pdf) (1 April, 2012).

<sup>49</sup> O L Akintade 'Awareness, use and barriers to family planning services among female students at the National University of Lesotho, Roma, Lesotho' University of Limpopo (2010) 1.

<sup>50</sup> After South Africa, Nigeria has the second largest number of persons infected with HIV in Africa. Although the prevalence rate in Nigeria is much lower than in South Africa, Nigeria has the largest population in Africa. See E Durojaye and V Balogun 'Human rights implications of mandatory pre-marital HIV testing in Nigeria' (2010) 24 *International Journal of Law, Policy and the Family* 252.

<sup>51</sup> World Bank *Intensifying action against HIV/AIDS in Africa: Responding to a development crisis* (1999) available at <http://siteresources.worldbank.org/AFRICAEXT/Resources/aidstrat.pdf> (3 August 2012); S Panday *et al Teenage pregnancy in South Africa: With a specific focus on school-going learners* (2009) available at <http://www.education.gov.za/LinkClick.aspx?fileticket=ulqj%2BsyccM%3D&...> (3 August 2012).

<sup>52</sup> As seen in the case of teenage pregnancies.

<sup>53</sup> L Becker *Understanding contraceptive choices* available at <http://www.medicalchronicle.co.za/understanding-contraceptive-choices/> (4 August 2012).

<sup>54</sup> Skelton (n 46 above) 141-163.

<sup>55</sup> CRR *Gaining ground: A tool for advancing reproductive rights law reform* 14 available at [http://reproductiverights.org/sites/crr.civicaactions.net/files/documents/pub\\_bo\\_GG\\_advocacy.pdf](http://reproductiverights.org/sites/crr.civicaactions.net/files/documents/pub_bo_GG_advocacy.pdf) (1 October 2011).

vital as an important approach in curbing the intensity and future impact of the pandemic.<sup>56</sup>

However, despite the benefits credited to the effective use of contraceptives,<sup>57</sup> adolescent girls rarely use contraceptives as they are continually faced with various factors that hinder their access to contraceptive services and information. These factors range from the struggle for the recognition of female adolescents' right to autonomy<sup>58</sup> to the culture of silence which permeates matters relating to sexuality in African societies<sup>59</sup> and to the existence of myths and misinformation about contraceptives, as well as insufficient training and the unfriendly attitude of health providers involved in the provision of contraceptive services.<sup>60</sup> Because of these factors, adolescent girls -

<sup>56</sup> The majority of new infections and mortality resulting from HIV/AIDS complications are found in Africa. Worst affected by these SRH challenges are female adolescents in the region. See UNAIDS *Epidemic update* (2007) available at [http://data.unaids.org/pub/epislides/2007/2007\\_epiupdate\\_en.pdf](http://data.unaids.org/pub/epislides/2007/2007_epiupdate_en.pdf) (3 April 2012); UNADIS *Global AIDS epidemic report* (2010) 130 available at [http://www.unaids.org/documents/20101123\\_globalreport\\_em.pdf](http://www.unaids.org/documents/20101123_globalreport_em.pdf) (2 April 2012).

<sup>57</sup> WHO *Update on family planning in Sub-Saharan Africa in repositioning family planning: Guideline for advocacy action* (2010) available at [http://www.who.int/reproductivehealth/topics/family\\_planning/fp\\_advocacytool\\_kit.pdf](http://www.who.int/reproductivehealth/topics/family_planning/fp_advocacytool_kit.pdf) (7 August 2012).

<sup>58</sup> Women are traditionally not recognised as autonomous subjects, who can make decisions concerning their lives and health. The situation naturally extends to girls who do not have information on how to access contraceptives, neither can they negotiate safe sex. See R Cook 'Human rights and reproductive self-determination' (1994-1995) 44 *American University Law Review* 976; F Adjetej 'Reclaiming the African woman's individuality: The struggle between women's reproductive autonomy and African society and culture' (1995) 44 *American University Law Review* 1356; Sunmola *et al* (n 44 above) 82-92; R Cook 'International Human Rights and Women's Reproductive health' (1993) 24 *Studies in Family Planning* 73; D E Mbambo *et al* 'Factors influencing adolescent mothers' non-utilisation of contraceptives in the Mkhondo Area' (2006) 11 *Health SA Gesondheid* 22-31.

<sup>59</sup> African cultures frown upon open discussions of SRH. Words used to express SRH are often indirect to reflect the silence expected in such matters. I Onyeka *et al* 'Unintended pregnancy and termination of studies among students in Anambra State, Nigeria: Are secondary schools playing their part?' (2011) 15 *African Journal of Reproductive Health* 114; G Sedge *et al* 'Unwanted pregnancy and associated factors among Nigerian women' (2006) 32 *International Family Planning Perspectives* 175-18; E Ogbaje & E Igharo 'Contraceptive security in Nigeria: assessing strengths and weaknesses' (2009) available at [http://deliver.jsi.com/dlvr\\_content/resources/allpubs/countryreports/NG\\_ContSecuStreWeak.pdf](http://deliver.jsi.com/dlvr_content/resources/allpubs/countryreports/NG_ContSecuStreWeak.pdf) (18 July 2012); C P Nnorom *et al* *Extent of adolescents' knowledge of sexual and reproductive health and rights in Nigeria: Implications for development* (2008) 4-8 available at <http://epc2008.princeton.edu/download.aspx?submissionId=80707> (17 July 2012).

<sup>60</sup> P Maharaj *et al* *Reproductive health and emergency contraception in South Africa: Policy context and emerging challenges* (2007) 17, 30, 34-36 available at <http://sds.ukzn.ac.za/files/WP%2048%20WEB.pdf> (13 August 2012); Ogbaje & Igharo (as above) 1 & 19; Lisa M Williamson *et al* 'Limits to modern

even where married - continually encounter difficult issues which affect their access to contraceptive information and services.

Although Nigeria and South Africa are signatories to human rights instruments<sup>61</sup> guaranteeing the protection of female adolescents SRH rights, including their right to access contraceptive information and services, the reality of female adolescents' lives in the two countries point to a different reality as they encounter sexual, social and cultural challenges which make it difficult for them to access contraceptives information and services or make healthy SRH decisions.<sup>62</sup>

Nigeria's Constitution<sup>63</sup> does not expressly provide for a right to health care<sup>64</sup> but other rights contained in the Constitution are relevant to ensuring female adolescents' access to contraceptives and other reproductive health care services.<sup>65</sup> In addition, numerous health policies and laws guarantee adolescents access to SRH care information and services.<sup>66</sup> Also, Nigeria's need to deal with its adolescents' reproductive health issues, particularly in response to the HIV and AIDS epidemics, has resulted in the introduction

contraceptive use among young women in developing countries: a systematic review of qualitative research' (2009) 6 *Reproductive Health* available at <http://www.reproductive-health-journal.com/content/6/1/3> (18 July 2012); Mbambo *et al* (n 58 above) 22-31.

<sup>61</sup> Both countries have ratified or are signatories to the CEDAW (Nigeria - 13 June 1985; South Africa - 15 December 1995), the Women's Protocol to the African Charter on Human and Peoples' Rights (Nigeria - 16 December 2004, South Africa - 17 December 2004), the Convention on the Rights of the Child (Nigeria - 19 April 1991, South Africa - 16 June 1995), the Programme of Action of the ICPD, the Beijing Platform for Action, among others.

<sup>62</sup> *Adolescent reproductive health/youth development: Improving the sexual and reproductive health of young people through successful youth programming* available at <http://www.arfh-ng.org/youth.php> (1 March 2012); K Wood *et al* 'Blood blockages and scolding nurses: barriers to adolescent contraceptive use in South Africa' (2006) 14 *Reproductive Health Matters* 109-118.

<sup>63</sup> Nigerian Constitution 1999.

<sup>64</sup> The only claim to the right to health is contained in Chapter 2 of the Constitution which provides for 'fundamental objectives and directive principles of state policy' which are not justiciable (secs 6(6) (c) & 17(3) Nigerian Constitution 1999).

<sup>65</sup> Nigerian Constitution 1999: Sec 33 - right to life; sec 34 - right to dignity; sec 35 - right to liberty; and sec 37 - right to privacy.

<sup>66</sup> Child Rights Act cap C50 Laws of the Federation of Nigeria 2004; National Health Policy and Strategy 2004; National Reproductive Health Policy 2001 & National Policy on Health and Development of Adolescents and Young People 2007.

of the Family Life and HIV Education (FLHE) curriculum in schools.<sup>67</sup> It is, however, doubtful whether these measures have resulted in adolescent girls' access to contraceptive information and services, in particular, or other reproductive health care services generally.<sup>68</sup>

Apart from being a signatory to human rights instruments guaranteeing the protection of SRH, South Africa recognises the right of adolescent girls to health care as well as their right to reproductive health freedom.<sup>69</sup> In addition, similar provisions exist in the Children's Act,<sup>70</sup> the National Health Act<sup>71</sup> and the Choice on Termination of Pregnancy Act (CTOP).<sup>72</sup> Considering the extent of the above laws it is expected that the access of female adolescents in the country to contraceptive information and services will be guaranteed.<sup>73</sup> However, this is not the case. Instances abound demonstrating that South African girls cannot access contraceptives or other SRH care services as a result of the impeding factors earlier highlighted.<sup>74</sup>

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<sup>67</sup> O C Nwaorgu *et al* 'Family Life and HIV/AIDS Education (FLHE) in schools in Enugu State: Baseline study of reproductive health issues among in-school adolescents in Enugu State' (2009) 13 *African Journal of Reproductive Health* 17-32.

<sup>68</sup> According to NACA, the HIV prevalence rate among young women aged 15-24 years in Nigeria is estimated to be three times higher than that of their male counterparts. Also, teenage pregnancy rates in the country is exceedingly high as the current birth rate in the country is estimated at 123 per 1 000 women aged 15-19 years. See NACA *Key statistics on HIV in Nigeria* available at [http://naca.gov.ng/index2.php?option=com\\_docman&task=doc\\_view&gid=110&Itemid=268](http://naca.gov.ng/index2.php?option=com_docman&task=doc_view&gid=110&Itemid=268) (9 June 2014); UNFPA country indicators – Nigeria in *The state of the world's midwifery 2011*, available at [http://www.unfpa.org/sowmy/resources/docs/country\\_info/profile/en\\_Nigeria\\_SoWMy\\_Profile.pdf](http://www.unfpa.org/sowmy/resources/docs/country_info/profile/en_Nigeria_SoWMy_Profile.pdf) (24 June 2013).

<sup>69</sup> Secs 9,10,11,12, 14, 27 and 28(1) (c) Constitution of the Republic of South Africa 1996. It is noteworthy to point out that the rights guaranteed in Secs 9, 10, 11 and 12 are non-derogable.

<sup>70</sup> Children's Act No. 38 of 2005. Specifically secs 13 and 129-134.

<sup>71</sup> National Health Act No. 61 of 2003. See sec 2(c) (i) and (iv) which relate to the state's responsibility to respect, fulfil and protect health rights.

<sup>72</sup> Choice on Termination of Pregnancy Act 92 of 1996

<sup>73</sup> Maharaj *et al* (n 60 above) 28- 29. Rates of teenage and unintended pregnancies are especially high in the country. More than one third of women have their first child by the age of 19 with a majority of the pregnancies being described as unplanned and often unwanted.

<sup>74</sup> Skelton (n 46 above) 153; Maharaj *et al* (as above) 31-32, 38.

### 3 Purpose of study

This thesis examines the nature, extent and realisation of the right of adolescent girls in Nigeria and South Africa to reproductive health care through their access to contraceptive information and services. Included in this right is their ability to make informed decisions and to exercise autonomy<sup>75</sup> in relation to their SRH. Specifically, the thesis examines the barriers that exist which prevent the various treaties and laws guaranteeing the right to health care including SRH care from having the desired effect of ensuring that female adolescents (both married and unmarried) have the necessary access to contraceptive information and services.

In a bid to properly examine these barriers, the thesis assesses the reproductive health laws in place in the two jurisdictions with a view to determining their level of compliance with the normative values of international reproductive health rights so as to ascertain whether the problems adolescent girls experience in accessing contraceptives occur as a result of legal barriers, only, or are due to other socio-economic and cultural factors as well.

Reasons for the selection of the two countries as the subject of this thesis include:

- a. Nigeria and South Africa both display societal factors reflecting the subordination of women due to cultural factors which place men as 'natural' superiors over women.
- b. The two countries are signatories to various international human rights instruments and declarations such as the CRC, ICESCR, CEDAW, the ACRWC, the ICPD Programme of Action, the Beijing Declaration and Platform for Action and

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<sup>75</sup> Autonomy in this regard relates to the ability of female adolescents to take independent decisions on whether to access health care for contraception.

- the African Women Protocol, all of which provide for the recognition and protection of women's reproductive health care rights.
- c. Although the two countries exhibit different legal traditions and histories, both are governed by an array of domestic legislation aimed at addressing their populations' health rights. Legislation granting the right to reproductive health care to women and adolescent girls is clearly defined in South Africa. In the case of Nigeria, it is not. Reasons for differences between the two countries in this regard may be enlightening.
  - d. Both countries are regarded as sub-regional economic powers on the African continent. The ability of adolescents to effectively access health care information and services has important implications for the two countries' economic development.

#### **4 Research questions**

The thesis examines the right of adolescent girls in Nigeria and South Africa to access contraceptive information and services, as well as the barriers in existence which make access to these services difficult or impossible. This objective leads to the following research questions:

1. Are the legal frameworks of Nigeria and South Africa on reproductive health consistent with international human rights provisions?
2. What are the barriers or challenges faced by adolescent girls when they seek to access contraceptive information and services in South Africa and Nigeria?
3. What are the effects of these barriers in their realisation of access in Nigeria and South Africa?
4. What are the international best practices relating to female adolescents' access to contraception? What may Nigeria and South Africa learn from these best practices?

## 5 Significance of study

Considering that the Millennium Development Goal (MDG) 5 requires that by 2015, countries achieve universal access to reproductive health through an increase in contraceptive use and a reduction in adolescent birth rates,<sup>76</sup> coupled with the extent to which the HIV and AIDS epidemics are currently ravaging the sub-Saharan African region and the high levels of infection among adolescent girls, the importance of female adolescents (both married and unmarried) having access to relevant contraceptive information and services is not debatable.

In light of this fact, the study will provide information on the barriers which exist in female adolescents' access to contraceptive information and services in Nigeria and South Africa. As well, it will provide information on whether a further regulatory framework is needed and the relevant areas where better enforcement of existing legislation is necessary. Additionally, the study will assist in assessing the information female adolescents in Nigeria and South Africa receive concerning contraception and their SRH, generally, and will indicate whether such information is adequate.

## 6 Existing studies

Various scholars have written on different aspects of women's human rights, including their right to health. These scholars either analyse the concept of the right to health, generally, or they write specifically on issues relating to access to reproductive health care by women (including adolescents).<sup>77</sup> In analysing the connection between health

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<sup>76</sup> Millennium Development Goal 5B is on universal access to reproductive health. While adolescent pregnancy rates have declined in some regions, it is still high in sub-Saharan Africa. Also while contraceptive prevalence rates have increased when compared to the 1990's, unmet needs is still high in the region. See United Nations The Millennium Development Goals Report (2014) 31 & 32 <http://www.un.org/millenniumgoals/2014%20MDG%20report/MDG%202014%20English%20web.pdf> (23 September 2014).

<sup>77</sup> S Gruskin 'Health and human rights' in S Gruskin *et al Perspectives on health and human rights* (2005) 3-57; S Sheldon 'Feminism and health care law' in S Sheldon *et al Feminist Perspectives on Health Care Law* (1998)

and human rights, Gruskin<sup>78</sup> holds that there are two approaches. The first focuses on the methods through which health policies, practices and programmes promote or violate human rights through their implementation. The second examines how violations of human rights have serious health consequences.<sup>79</sup>

The problem of reproductive health is a global concern. Some view reproductive health as not just a major health issue, but also a developmental and human rights issue which cuts across disciplines and which has impacts that are capable of affecting the society at large.<sup>80</sup> Women's reproductive health, generally, raises sensitive issues in many legal traditions as it is related to sexuality and morals<sup>81</sup> which, in turn, are reflected in laws and regulations that endeavour to control women's conduct by limiting or denying them access to reproductive health services.<sup>82</sup>

MacPhail is of the view that the provision of services that allow women to manage their reproductive health is fundamental to women's health and that encouraging the use of contraceptive services is important for meeting HIV prevention goals; a practice which is

1-13; R J Cook 'Gender, health and human rights' in *health and human rights: A reader* (1999) 251-264; M Fathalla 'The impact of reproductive subordination on women's health' (1995) 44 *American University Law Review* 1179-1189, Skelton (n 46 above); N I Aniekwu 'The evolution of reproductive health and rights in international humanitarian law' (2008) 1 *Akungba Law Journal* 327-341; F Adeleke *Comparative abortion jurisprudence: Reproductive rights paradigm* (2013).

<sup>78</sup> Gruskin *et al* (as above) 35.

<sup>79</sup> In different ways, the promotion, protection or violations of human rights have direct and indirect impacts on the well-being of an individual. See J Mann *et al* 'Health and human rights' (1994) 1 *Health and Human Rights* 6-23.

<sup>80</sup> Though both sexes have issues relating to reproductive health, it has been severally acknowledged that women and, therefore, adolescent girls bear a major burden of diseases related to their reproductive functions and potentials, a situation which is worsened by their low socio economic status as well as complications from infections and unwanted pregnancies. See Cook *et al* 'Reproductive health and human rights' (n 43 above); G Sedgh *et al* 'Meeting young women's sexual and reproductive health needs in Nigeria' Guttmacher Institute (2009) available at [www.guttmacher.org](http://www.guttmacher.org) (23 April 2012).

<sup>81</sup> The present reproductive rights movement arose from feminist campaigns which advocated women's equality, while asserting that the enjoyment of reproductive and sexual freedom was the means to self-determination, full participation in society, and liberation from patriarchal control. See A Hooton 'A broader vision of the reproductive rights movement: Fusing mainstream and latina feminism' (2005) *Journal of Gender, Social Policy and the Law* 59-86.

<sup>82</sup> Cook 'Human rights and reproductive self-determination' (n 58 above) 73-86.

more cost-effective in preventing the birth of HIV positive children than increasing the provision of mother-to-child transmission drugs.<sup>83</sup> Fathalla argues that empowering women with the ability to control their fertility is a basic requirement for women's health and well-being. For him, state actions, whether in restricting access to reproductive health care or through the failure to fulfil its obligations to protect women's reproductive health rights, constitute a violation of women's rights which has negative consequences.<sup>84</sup>

Adeleke asserts that state parties are to take necessary measures to eliminate discrimination against women in the field of health care and ensure their access to SRH care services, including those related to family planning.<sup>85</sup> According to him, the inability and refusal to protect the reproductive rights and choices of women (female adolescents' inclusive) affect their right to bodily integrity and worsen women's vulnerability.<sup>86</sup> This thesis advances Adeleke's argument further by indicating instances of acts of cultural and societal subordination which affect the enjoyment of female adolescents' access to contraceptives and emphasise the importance of the observation of human rights in strengthening the position in society of women and adolescent girls.

In examining the situation of Nigerian female adolescents in relation to their access to contraceptives, Durojaye analyses the laws and policies relating to health and access to contraception which exist with a view to determining whether the laws are consistent with obligations owed under international human rights law.<sup>87</sup> Apart from discovering the existence of inconsistencies in the laws, especially in relation to the violation of the

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<sup>83</sup> C MacPhail *et al* 'Contraception use and pregnancy among 15–24 year old South African women: a nationally representative cross-sectional survey' (2007) *BMC Medicine BMC Medicine* available at <http://www.biomedcentral.com/1741-7015/5/31> (22 April 2012).

<sup>84</sup> Fathalla (n 77 above) 1179-1180.

<sup>85</sup> F A R Adeleke. 'Reproductive right or reproductive fallacy? The extreme provisions of the Choice of Termination of Pregnancy (CTOP) Act 1996 in South Africa' (2010) 16 *Fort Hare Papers* 29.

<sup>86</sup> Adeleke 'Comparative abortion jurisprudence' (n 77 above) 4.

<sup>87</sup> E Durojaye 'Realising access to contraception for adolescents in Nigeria: A human right analysis' University of the Free State (2010) 6.

right of adolescents to consent to treatment and issues relating to confidentiality, he notes that there is a tendency for the policies to contain very elaborate provisions on access to contraception without corresponding provision in the laws.<sup>88</sup>

Similar to feminists development of ‘the woman question’ to challenge the gender blindness of laws, Durojaye posits a need for asking a concurrent ‘female adolescent question’ to contest the gender-neutral nature of laws and policies relating to access to contraception for adolescents in Nigeria. Asking the question will force policy-makers to consider how decisions taken by them in relation to contraception affect the lives of female adolescents so that laws and policies, which are a barrier to access, can be removed, on the one hand, and ensure that the laws themselves assist in removing issues that impede access to contraception, on the other.<sup>89</sup>

Building on the work of Durojaye, this thesis considers the compatibility of the relevant national laws in Nigeria and South Africa with international and regional human right treaties, and carries out a comparative analysis of the barriers affecting access to contraceptives services and information in the two countries. The analysis includes examining the barriers to policy and legal enforcement so as to discover, specifically, those issues and factors that are impediments to adolescent girls’ access to these important SRH services and the consequences occasioned by the persistence of these barriers.

In a subsequent article Durojaye concludes that reproductive health eludes a lot of people globally because of factors relating to inadequate knowledge about human sexuality, poor quality reproductive health information and services, the prevalence of high-risk sexual behaviour, and discriminatory social practices towards women and girls. He argues that female adolescents are particularly vulnerable to reproductive health

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<sup>88</sup> Durojaye ‘Realising access to contraception for adolescents in Nigeria’ (as above) 8-9.

<sup>89</sup> Durojaye ‘Realising access to contraception for adolescents in Nigeria’ (as above) 13.

problems because of their lack of information and access to contraceptives in most countries.<sup>90</sup>

Skelton notes that adolescent girls' health needs are often overlooked as a specific category warranting targeted services. She argues that the existence of measures and attitudes which limit access to preventive measures and other services has prompted the UN Committee on the CRC to issue general comments relating to HIV and AIDS and the Rights of Children.<sup>91</sup> The thesis argues that the provision of relevant information relating to access to contraceptive information and services to female adolescents will not result in an increase in promiscuity, but, instead, will lead to the adoption of responsible sexual behaviour, which is required to achieve objectives relating to the reduction of STIs and teenage pregnancies. This will strengthen the socio-economic position of the adolescent female as an important member in the society.

For Ngwena, access to reproductive health services is an important variable in the realisation of reproductive and sexual health. According to him, a lack of access to contraceptives not only undermines efforts towards the prevention of the spread of STIs, especially in a region like Africa, where HIV is endemic, but also diminishes available choices in decision-making about sexual activities which more often than not leads to unwanted pregnancies.<sup>92</sup> Dehne and Riedner are of the view that STIs among adolescents are of paramount concern as the highest reported rates are found in

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<sup>90</sup> Durojaye 'Access to contraception for adolescents in Africa' (n 47 above) 1-29.

<sup>91</sup> General Comments 3 and 4. See also Skelton (n 46 above) 151-152.

<sup>92</sup> In determining the extent of domestic health services human rights compliance, the cardinal benchmark is to be that of accessibility and availability. Health services must not be discriminatory, must be in harmony with the needs of people, the services that are available, must be accessible physically, economically and in terms of information. See General Comment 14 of the ICESCR and General recommendation 24 of the CEDAW Committee. See also C Ngwena *Sexual health and human rights in the African region'* (2012) available at [http://www.ichrp.org/files/papers/185/140\\_Ngwena\\_Africa\\_2011.pdf](http://www.ichrp.org/files/papers/185/140_Ngwena_Africa_2011.pdf) (21 April 2012).

adolescents who make up to 60 per cent of new infections. Also, half of all people living with HIV originate from this group.<sup>93</sup>

## 7 Research methodology

Due to the importance attached to the reproductive health rights of women generally, there exists an abundance of literature on the different aspects of reproductive health rights of women and adolescent girls. As a result, the method of research used in this thesis is a desk-top literature study. The literature study consists of:

- Books and articles on female adolescents' reproductive health rights, especially those in relation to access to contraceptive information and education.
- International human rights instruments and declarations on the reproductive health rights of women/girls as an important source that will be used continuously. The jurisprudence of the relevant treaty bodies is examined, including their general comments, general recommendations and concluding observations on Nigeria, South Africa and other countries, where applicable.
- Relevant legislation and judicial decisions of both countries on the topic also form an important component of the research. In this instance, case law relating to access to reproductive health care information, education and services are considered where appropriate and available.
- The web sites of several relevant institutions, such as the WHO, UNFPA, UNAIDS and NGOs working in the area of women/adolescent reproductive health rights are resourced. The websites of these institutions are updated from time to time with literature.
- The comparative method is used to analyse and evaluate domestic legislation and materials relating to the access of adolescent girls in Nigeria and South Africa to contraceptives and the barriers which exist in this regard. Empirical research in

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<sup>93</sup> Dehne & Reidner (n 2 above).

Nigeria and South Africa on female adolescents' reproductive health, especially that relating to the access and use of contraception is be referred to and reported on where available.

## 8 Limitation of the study

The study focuses on the barriers to female adolescents' (married and unmarried) access to contraceptive information and services and not on barriers to their access to all reproductive health care services. As well, the study is restricted to female adolescents. Therefore, it does not include male adolescents or adult women. Also, even though the WHO defines an adolescent as someone between the ages of 10-19, this study refers to adolescent girls as girls between the ages of 12 and 18. The reason for this limitation is the belief that girls begin to acquire awareness of their sexuality from the age of 12 years. As well, several human rights treaties regard adolescents as adults when they reach the age of 18.

Though the concepts of sexual health and reproductive health overlap, as explained above, they are separate and distinct. Emphasis in this study is placed on adolescent girls' right to access contraceptive information and services for the protection and enjoyment of their reproductive health and the implications which denial of access may have on their reproductive health as opposed to their sexual health. In addition, to achieve the purpose of study, the focus is placed on both married and unmarried adolescent girls since both groups of adolescents may be affected by the consequences occasioned by inaccessibility to contraceptive information and services.

## 9 Definition of terms

### 9.1 Adolescence

‘Adolescence’ is a period of transition from childhood to adulthood. Characterised by the onset of puberty, it is the stage during which adolescents begin to undergo physical, psychological, sexual and biological change.<sup>94</sup> The WHO defines an adolescent as someone between the ages of 10 and 19.<sup>95</sup> As remarked above, I use the term adolescence to refer to females between the ages of 12 and 18.

### 9.2 Contraception

‘Contraception’ refers to a means of preventing the occurrence of pregnancy, either by artificial or natural means. It is the use of various devices, drugs, agents, sexual practices or surgical procedures to prevent conception or impregnation.<sup>96</sup> ‘Contraceptives’ refer to agents, other than abstinence, used to temporarily prevent the occurrence of pregnancy. While traditional birth control methods include the withdrawal method,<sup>97</sup> ‘modern contraceptives’ are contraceptives based on the scientific knowledge of the process of conception and include the condom, pill, injectable, intra uterine device (IUDs), implants and female / male sterilisation. Generally, the decision to use contraceptives by female adolescents should be preceded by a medical examination by a health care provider who should determine not only the most effective type of contraceptive for the adolescent, but also whether she possesses the necessary

<sup>94</sup> I O Morhason-Bello *et al* ‘Sexual behaviour of in-school adolescents in Ibadan, South-West Nigeria’ (2008)12 *African Journal of Reproductive Health* 90.

<sup>95</sup> Early adolescence begins from 10 years to 14 years; late adolescence has been categorized as the period between 15 –19 years. Young persons are people between the ages of 15 and 24. See WHO: *The Health of Young People*’ (1993) 1, quoted by Cook *et al* ‘Reproductive health and human rights’ (n 43 above) 276.

<sup>96</sup> M L Manena Netshikweta ‘Knowledge, perception and attitudes regarding contraception among secondary school learners in the Limpopo Province’ UNISA (2007) 18-19; MNT *What is contraception? What is birth control?* (2009) available at <http://www.medicalnewstoday.com/artides/162762.php> (2 October 2014).

<sup>97</sup> Also known as ‘coitus interruptus’. It involves the withdrawal of the penis from the vagina so that ejaculation occurs outside of the vagina.

understanding and intelligence to comprehend the nature of proposed treatment.<sup>98</sup> The various methods of modern contraception are briefly discussed below:

### 9.2.1 Barrier contraceptives

Barrier method contraceptives are designed to prevent pregnancy by stopping sperm from entering the uterus. Usually removable, the barrier method contraceptive includes the male and female condom<sup>99</sup> and it can be used by women and adolescent girls. Other barrier method contraceptives include the diaphragm,<sup>100</sup> contraceptive sponge<sup>101</sup> and the cervical cap.<sup>102</sup>

### 9.2.2 Hormonal contraceptives

Hormonal method contraceptives are contraceptive that make use of hormones to regulate or stop ovulation, thereby preventing pregnancy. Unlike the condom, which can be personally used by female adolescents and women, the service of a health care

<sup>98</sup> See *Gillick v. West Norfolk and Wisbech Area Health Authority and Another* (1986) 1 AC 112, (1985) 3 All ER 402.

<sup>99</sup> The male condom is made of latex or polyurethane and is usually placed upon the male sexual organ in order to stop sperm from entering into the vagina. The female condom is a thin, flexible plastic pouch that is inserted into a woman's vagina before the occurrence of sexual intercourse. Like the male condom, it not only prevents sperm from entering the uterus but also reduces the risk of STIs and is usually disposed of after a single use. See NIH *What are the different types of contraception?* available at <http://www.nichd.nih.gov/health/topics/contraception/conditioninfo/Pages/types.aspx#barrier> (2 October 2014); *Birth Control: Non-hormonal methods* available at [http://www.sexualityandu.ca/birth-control/birth\\_control\\_methods\\_contraception/non-hormonal-methods](http://www.sexualityandu.ca/birth-control/birth_control_methods_contraception/non-hormonal-methods) (2 October 2014).

<sup>100</sup> The diaphragm is a shallow, flexible cup made of latex or soft rubber that is inserted into the vagina before intercourse in order to block sperm from entering the uterus. Although the diaphragm must remain in place for 6 to 8 hours after intercourse in order to prevent pregnancy, it however needs to be removed within 24 hours. See NIH *What are the different types of contraception?* (n 99 above); *Birth Control: Non-hormonal methods* (n 99 above).

<sup>101</sup> The contraceptive sponge is a soft, disposable, spermicide-filled foam sponge that is inserted into the vagina before sexual intercourse. It acts by blocking sperm from entering into the uterus while the spermicide in the sponge kills the sperm cells. The sponge needs to be left in place for at least 6 hours after intercourse but it should be removed within 30 hours after intercourse. Also the contraceptive sponge does not prevent STIs and should be used with a condom. See NIH *What are the different types of contraception?* (as above); *Birth Control: Non-hormonal methods* (n 99 above).

<sup>102</sup> The cervical cap is a deep silicone cap that fits against the cervix and prevents sperm and bacteria from entering the uterus. However, like the diaphragm and contraceptive sponge, the cervical cap does not prevent STIs and should be used with a condom. See NIH *What are the different types of contraception?* (as above); *Birth Control: Non-hormonal methods* (as above).

provider is required in order to use hormonal contraceptives.<sup>103</sup> Examples of hormonal contraceptives include the pill,<sup>104</sup> hormonal injection,<sup>105</sup> contraceptive patch<sup>106</sup> and vaginal rings,<sup>107</sup> among others.

### 9.2.3 Emergency contraceptives

Emergency contraceptives are contraceptives that can be used to prevent pregnancy in the first few days after intercourse.<sup>108</sup> Often referred to as the morning-after pill, emergency contraceptives prevent ovulation or fertilisation and is intended for

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<sup>103</sup> Hormonal contraceptives act in different ways, depending on the type of hormones used. While some hormonal contraceptives prevent ovulation, others thicken the cervical mucus in order to block sperm from reaching the egg. The services of a health care provider are required before the use of hormonal contraceptives to carry out the necessary medical examinations in order to determine the appropriate type to be used; see NIH *What are the different types of contraception?* (as above).

<sup>104</sup> Types of contraceptive pills include Progestin-only pills (POP) and Combined oral contraceptive (COC) pills. POPs thicken the cervical mucus, thereby making it difficult for sperm to travel into the uterus or to enter the fallopian tube. The COC, which contains different combinations of synthetic estrogens and progestin (estrogens and progestin are female hormones), interferes with the ovulation process in order to prevent conception. Either of the pills is taken once daily but the service of a health provider is needed to determine the type of pill that best meets the woman's or adolescent girl's needs. The use of the pill alone without the condom, while preventing pregnancy, does not protect against HIV and other STIs. See NIH *What are the different types of contraception?* (as above).

<sup>105</sup> This method involves the administration of an injection containing progestin either in the arm or buttocks once every three months. While the hormonal injection is 99.7% effective in preventing pregnancy, it may cause a temporary loss of bone density and is therefore administered only to those unable to take other contraceptive methods. It should be noted that the loss of bone density is generally regained after discontinuing use of the injection. Also, patients using injectable birth control are advised to eat a diet rich in calcium and vitamin D while using this medication. See NIH *What are the different types of contraception?* (as above).

<sup>106</sup> The contraceptive patch is a thin, plastic patch that is stuck to the skin so as to release hormones into the bloodstream. The patch, which can either be placed on the lower abdomen, buttocks, outer arm, or upper body, is applied once a week for 3 weeks. No patch is used on the fourth week in order to enable menstruation. The patch prevents pregnancy by stopping the ovaries from releasing an egg; it also thickens the cervical mucus so as to make it harder for sperm to get into the uterus. The patch does not protect against STIs. See NIH *What are the different types of contraception?* (n 99 above).

<sup>107</sup> The ring is soft, flexible, clear plastic ring which measures 54mm in diameter and is inserted into a woman's vagina where it slowly releases two female hormones (estrogen and a progestin) for three weeks. The woman removes it in the fourth week and reinserts a new ring 7 days later after the menstrual cycle. The vaginal ring is only used based on the health provider's recommendation after the necessary health examination is done to determine suitability. See NIH *What are the different types of contraception?* (as above).

<sup>108</sup> Emergency contraceptives are intended for occasional use, when primary methods of contraception fail in order to prevent the occurrence of pregnancy. See Association of Reproductive Health Professionals *the Difference between Medical Abortion and Emergency Contraceptive Pills*, available at <http://www.arhp.org/publications-and-resources/clinical-fact-sheets/mifepristone-ec> (2 October 2014).

emergency use following unprotected intercourse, contraceptive failure or misuse,<sup>109</sup> rape or coerced sex.<sup>110</sup> The emergency contraceptive pill, which can be used up to 72 hours after unprotected sex, is more effective when used within the first 24 hours after sexual intercourse. While emergency contraceptives should not be replaced with the daily contraceptive pill, according to the WHO any woman of reproductive age may require the emergency contraceptive pill at some point in order to avoid an unwanted pregnancy.<sup>111</sup>

#### 9.2.4 Intra uterine device contraceptives

The Intra Uterine Device (IUD) is a T-shaped device that is inserted into the uterus to prevent pregnancy. Requiring professional expertise for its insertion, the IUD can be used effectively for as long as five years or more. It can be removed by the health care provider when conception is desired or when the recommended length of time has expired. Types of IUDs include the copper IUD<sup>112</sup> and hormonal IUD.<sup>113</sup>

#### 9.2.5 Sterilisation

Sterilisation is a permanent form of contraception that prevents a woman from getting pregnant or prevents a man from releasing sperm. It includes tubal ligation, a surgical procedure where a woman's fallopian tubes are severed and sealed in order to prevent

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<sup>109</sup> Contraceptive failure or misuse involves situations where the woman or female adolescent forgets to take her daily pill or where a condom becomes damaged during sexual intercourse.

<sup>110</sup> WHO *Emergency contraception* available at <http://www.who.int/mediacentre/factsheets/fs244/en/> (2 October 2014).

<sup>111</sup> WHO *Emergency contraception* (as above).

<sup>112</sup> The copper IUD causes an inflammatory reaction that generally prevents sperm from reaching and fertilising the egg, thereby preventing conception. The IUD is general used based on the health care provider's recommendation and is not available over the counter. The copper IUD can be used for as long as 12 years. See NIH *What are the different types of contraception?* (n 99 above).

<sup>113</sup> The hormonal IUD provides reliable, reversible contraception for up to five years. Made up of a small T-shaped frame with a small cylinder containing the hormone levonorgestrel, the IUD slowly releases the hormone that acts to make the lining of the uterus thinner and the cervical mucus thicker, in order to make it harder for sperm to enter the uterus. A disadvantage of the IUD is that it does not protect against STIs and HIV, therefore necessitating condom use. See *Birth Control: Non-hormonal methods* (as above); NIH *What are the different types of contraception?* (as above).

fertilisation. Also, a sterilisation implant can be inserted to block the fallopian tubes so that sperm cannot reach an egg. Tubal ligation is a permanent form of female sterilisation and is not advisable for use in adolescent girls.<sup>114</sup>

### 9.3 Sexuality education

‘Sexuality education’ refers to the whole process of acquiring information that assists in the formation of attitudes, beliefs and values about relationships, human anatomy, sexual development, puberty, maturity and contraception, among others.

### 9.4 Adolescent-friendly centres

‘Adolescent-friendly centres’ refer to facilities which encompass the provision of recreation activities with the provision of SRH care services to adolescents in clinical settings. The SRH care services provided at the centres not only are accessible and acceptable by adolescents but the health care providers working in the clinics are specially trained in the communication techniques to be adopted when providing the services to adolescents.

## 10 Overview of chapter contents

The thesis consists of eight chapters.

Chapter one provides a general introduction and overview of the study. In addition to providing a background to the study, the chapter briefly reviews studies already done in the field of human rights and reproductive health and gives a problem statement that highlights the current SRH situation of female adolescents, in Africa generally, and specifically in Nigeria and South Africa. The reasons for undertaking a comparative study on female adolescents’ access to contraceptive information and services in the two countries are noted as well.

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<sup>114</sup> NIH *What are the different types of contraception?* (as above).

Chapter two identifies and examines the international and regional human rights instruments (including human rights declarations) guaranteeing female adolescents' right to contraceptive information and services. Other rights supporting the right to SRH care recognised in these human rights instruments are also examined. Attention is drawn to the general comments and recommendations of treaty monitoring bodies, such as the Committee on CRC, where these are relevant to the advancement of female adolescents' SRH. An analysis of the modes of incorporation of human rights instruments in Nigeria's and South Africa's legal system is presented.

Chapter 3 provides a brief historical background of the Nigerian and South African legal systems. To discover whether Nigeria's and South Africa's domestic laws and policies correspond with international human rights norms on the right of adolescents to SRH, the chapter explores relevant national laws and policies relating to the SRH of adolescent girls, especially those guaranteeing access to contraceptive information and services.

Chapter 4 seeks to understand the concept of autonomy, including its implications for female adolescents' right to access contraceptive services and information. Particularly, taking note of the extreme sensitivity attached to adolescents' SRH issues generally the chapter examines the idea of autonomy from philosophical as well as socio-cultural viewpoints. Also, the chapter discusses the concepts of informed consent and confidentiality in relation to female adolescents' access to SRH care, including contraceptive services and information. In addition, an analysis of the best interests of children principle and its interpretation in Nigeria and South Africa is developed.

Chapter 5 investigates the access of adolescent girls (both married and unmarried) in Nigeria and South Africa to contraceptive information and services. Specifically, the chapter scrutinises the approach adopted by Nigeria and South Africa to ensure that female adolescents access sexuality education (including contraceptive information) and

contraceptive services. The deficiencies noticed in the different approaches are emphasised. In addition, approaches adopted in other jurisdictions to provide adolescent girls' with access to contraceptive services and information are explored.

Chapter 6 seeks to pinpoint and investigate the multiple barriers that prevent female adolescents from accessing contraceptive information and services in Nigeria and South Africa. In addition, it also examines the implication and consequences that result from the existence of impediments that hinder adolescent girls' access to contraceptive information and services in both countries.

Chapter 7 concludes the comparative section of the thesis. It highlights the similarities and differences noticed in the legal frameworks, the barriers and their resultant consequences, as well as the approaches adopted by the governments of Nigeria and South Africa in implementing their obligation to guarantee female adolescents access to contraceptive information and services.

Chapter 8, the conclusion of the study, consists of an overview of the conclusions reached in the different chapters. From these general conclusions are drawn and recommendations are made.

## CHAPTER 2

# LEGAL FRAMEWORK FOR FEMALE ADOLESCENTS' ACCESS TO CONTRACEPTIVE INFORMATION AND SERVICES

### Outline

- 1 Introduction**
- 2 International treaties relating to adolescents right to access to contraception**
  - 2.1 The Universal Declaration of Human Rights (UDHR)
  - 2.2 The International Covenant on Civil and Political Rights (ICCPR)
  - 2.3 The International Covenant on Economic, Social and Cultural Rights (ICESCR)
  - 2.4 The Convention on the Rights of the Child (CRC)
  - 2.5 The Convention for the Elimination of All Forms of Discrimination Against Women (CEDAW)
  - 2.6 Conclusion
- 3 Regional treaties relating to adolescents right to access to contraception**
  - 3.1 The African Charter on Human and People's Rights (ACHPR)
  - 3.2 The African Charter on the Rights and Welfare of the Child (ACRWC)
  - 3.3 The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Women Protocol)
  - 3.4 African Youth Charter (AYC)
  - 3.5 Conclusion
- 4 Other international documents on female adolescents right to access contraceptive information and services**
  - 4.1 The International Conference on Population and Development (ICPD) Programme of Action
  - 4.2 The Beijing Declaration and Platform for Action
  - 4.3 Conclusion
- 5 Chapter conclusion**

## 1 Introduction

The protection of health as a human right is fundamental for living a life of dignity and indispensable to the enjoyment of other human rights.<sup>1</sup> Over the years the demand for the protection of female adolescents' reproductive health rights through their access to contraceptive information and services has gained international prominence and been given a voice in various international and regional instruments that seek to recognise, guarantee and enforce equality between individuals, who, without the treaties, would be vulnerable.<sup>2</sup> A majority of these instruments provide for the right to health, from which the right to reproductive health care is inferred.<sup>3</sup>

Recognition of the right to health derives its origin from the Universal Declaration of Human Rights (UDHR)<sup>4</sup> and, along with other economic, social and cultural rights, is granted legal protection by the Covenant on Economic, Social and Cultural Rights (ICESCR).<sup>5</sup> From the outset, it is imperative to state categorically that this does not make it a lesser right entitled to minimal protection, unlike its counterparts contained in the Covenant for Civil and Political Rights (ICCPR)<sup>6</sup> as the distinction between the two sets of rights was eliminated at the World Conference on Human Rights where the Vienna Declaration and Programme of Action (VDPA) was adopted.<sup>7</sup> At the conference, effort was made to focus on the ideals behind the adoption of the

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<sup>1</sup> E Riedel 'The human right to health: conceptual foundations' in A Clapham & R Robinson (eds) *Realizing the right to health* (2009) 21.

<sup>2</sup> R J Cook 'Human rights and reproductive self-determination' (1994-1995) 44 *American University Law Review* 977.

<sup>3</sup> In some cases, provision is made for the access of women and female adolescents' to sex appropriate reproductive health care services, like contraception and family planning, under the Protocol to the African Charter on the Rights of Women.

<sup>4</sup> Art 25 UDHR. The UDHR was adopted by the United Nations General Assembly (UNGA) in 1948. Despite being a mere declaration and non-binding, the UDHR has acquired the status of international customary law.

<sup>5</sup> Article 12 ICESCR. Adopted by resolution 2200A (XXI) of 16 December 1966.

<sup>6</sup> Adopted via UN General Assembly resolution 2200A (XXI) of 16 December 1966.

<sup>7</sup> The Vienna Declaration and Programme of Action was adopted in June 1993 in Vienna, Austria, available at [www.ohchr.org/english/law/vienna.htm](http://www.ohchr.org/english/law/vienna.htm) (20 February 2013).

Universal Declaration<sup>8</sup> and it was expressly reiterated that ‘all human rights were indivisible, universal, interdependent and interrelated’ and the international community had an obligation to treat human rights in a fair and equal manner globally.<sup>9</sup>

Based upon the foregoing, as soon as human rights treaties are ratified, state parties assume obligations and duties to respect, protect and fulfil these rights. The obligation to respect<sup>10</sup> the reproductive rights of female adolescents requires that states refrain from restricting and obstructing adolescent girl’s access to reproductive health services or actions taken by them in realisation of their health goals.<sup>11</sup>

According to the Committee on the ICESCR, the obligation to respect requires states to desist from intruding, either directly or indirectly, upon the enjoyment of the right

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<sup>8</sup> After adoption of the UDHR, efforts shifted to the drafting of a covenant that would legally bind ratifying states to the protection of all human rights based upon the universality, interdependence and fundamental nature of human rights which all humans possess. However, differing views as to the nature and enforcement mechanism to be adopted for the two sets of rights contained in the UDHR led to the drafting of two covenants instead of one as initially proposed. It was felt that civil and political rights imposed negative duties that were capable of immediate and unconditional implementation by states, unlike socio economic rights which were perceived as imposing positive duties of performance which required progressive implementation by states due to the high level of economic resources needed for their implementation. See O De Schutter *International human rights law: Cases, materials and commentary* (2010) 16; K McLean *Constitutional deference, courts and socio- economic rights in South Africa* (2009) 4; P Alston *et al* ‘The nature and scope of states parties’ obligations under the International Covenant on Economic, Social and Cultural Rights’ (1987) 9 *Human Rights Quarterly* 156 - 229; S Liebenberg ‘The International Covenant on Economic, Social and Cultural Rights and its implications for South Africa’ (1995) 11 *South African Journal on Human Rights* 361-362; E W Vierdag ‘The legal nature of the rights granted by the International Covenant on Economic, Social and Cultural Rights’ (1978) 9 *Netherlands Journal of International Law* 103

<sup>9</sup> Para 5 Vienna Declaration (n 7 above). Subsequent human rights instruments contain both rights side by side with express reference to their enjoyment by individuals. Examples of the latter human rights instruments which contains both civil and political rights and economic, social and cultural rights include the Convention on the Rights of the Child, Convention on the Elimination of All forms of Discrimination Against Women and the Convention on the Elimination of All forms of Racial Discrimination etc, see A Eide ‘Economic, social and cultural rights as human rights’ in A Eide *et al* (eds) *Economic, social and cultural rights: A textbook* (1995) 24.

<sup>10</sup> The duty to respect is a negative obligation that places upon state parties, a responsibility to safeguard the rights of individuals living within their territories by abstaining from actions which interfere in the enjoyment of their rights. R J Cook & M Fathalla ‘Duties to implement reproductive rights’ (1998) 67 *Nordic Journal of International Law* 3.

<sup>11</sup> Para 14 general recommendation 24, CEDAW Committee *Compilations of General Comments and recommendations adopted by human rights treaty bodies Vol. II* available at [http://www.bayefsky.com/general/hri\\_gen\\_1\\_rev9\\_vol\\_ii.pdf](http://www.bayefsky.com/general/hri_gen_1_rev9_vol_ii.pdf) (15 November 2012).

to health.<sup>12</sup> The obligation to protect<sup>13</sup> places a responsibility on states to take needed action to prevent and stop non-state actors, like health providers, from hindering the access of adolescent girls to contraceptive services and information.<sup>14</sup> The duty to fulfil requires states to take appropriate action to facilitate and ensure that adolescent girls, who constitute a major part of society's vulnerable, access appropriate health care.<sup>15</sup>

The aim in this chapter is to examine the various international and regional human rights instruments relevant to the right of adolescent girls to access contraceptive information and services. From that examination it can be concluded whether human rights protection is afforded female adolescents' who are in dire need of contraceptive information and services. To achieve the above, apart from examining the human right instruments, the comments and concluding observations of treaty monitoring committees in charge of the conventions will be considered and highlighted and, where necessary, it will be noted whether Nigeria and South Africa have ratified the instruments.

Instruments to be analysed include the International Covenant on Civil and Political Rights,<sup>16</sup> the International Covenant on Economic, Social and Cultural Rights,<sup>17</sup> the

<sup>12</sup> Para 33 Committee on ESCR General comment 14 (2000) in *S Gruskin et al Perspectives on health and human rights* (2005) 483; *Zimbabwe Human Rights NGO Forum v Zimbabwe* (2006) AHRLR 128 (ACHPR 2006) para 152.

<sup>13</sup> Committee on ESCR General comment 14 (as above).

<sup>14</sup> To achieve this, the state is to create necessary policies, legislative and regulatory frameworks that will disabuse potential violators from carrying out their infringing acts. See paras 34 & 35 CEDAW concluding observations on Haiti CEDAW/C/HTI/CO/7 (2009); M Ssenyonjo *Economic, social and cultural rights in international law* (2009) 24; Cook & Fathalla 'Duties to implement reproductive rights' (n 10 above) 5-6; para 15 CEDAW General recommendation 24.

<sup>15</sup> To realise this duty, state parties are to take progressive measures such as the organisation of sexual and reproductive health education and awareness raising programmes that will assist further access to contraception. Currently, South Africa has the National Health Act No. 61 of 2003 which provides a framework for uniform health systems in the country. Nigeria on the other hand is yet to successfully pass its National Health Act due to various controversies that have bedevilled its adoption. See para 17 CEDAW General recommendation 24; para 18 Committee on ESCR (n 12 above) 479; Ssenyonjo (n 14 above) 25; WHO *The right to health: Fact sheet (No 31)* 27 available at <http://www.ohchr.org/Documents/Publications/Factsheet31.pdf>. (24 October 2012).

<sup>16</sup> (n 6 above).

<sup>17</sup> (n 5 above).

Convention on the Rights of the Child,<sup>18</sup> The Convention on the Elimination of all Forms of Discrimination Against Women,<sup>19</sup> the Universal Declaration of Human Rights,<sup>20</sup> the International Conference on Population and Development Programme of Action<sup>21</sup> and the Beijing Declaration and Platform for Action<sup>22</sup> at the international level. As well, the African Charter on Human and Peoples' Rights,<sup>23</sup> African Charter on the Rights and Welfare of the Child,<sup>24</sup> Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa<sup>25</sup> and the African Youth Charter<sup>26</sup> will be examined at the regional level.

## 2 International treaties relating to adolescents' right to access to contraception

Under international law, state parties are bound by the human rights instruments they ratify. The level of incorporation and the effectiveness of such treaties, however, are determined by the status of international law in the national legal systems of the ratifying states.<sup>27</sup> Some states<sup>28</sup> follow the system where all laws

<sup>18</sup> Adopted by resolution 44/25 of 20 November 1989.

<sup>19</sup> The Convention on the Elimination of all Forms of Discrimination Against Women was adopted in 1979 but it came into force on 3 September 1981. As of 26 September 2014, 188 states have acceded to the Convention.

<sup>20</sup> (n 4 above).

<sup>21</sup> ICPD - Programme of Action - A/CONF.171/13/Rev.1 available at <http://www.unfpa.org/public/publications/pid/1973> (20 September, 2012).

<sup>22</sup> The Beijing Declaration and Platform of Action - A/CONF.177/20 adopted in 1995 at the 4<sup>th</sup> World Conference on Women, available at [http://www.unesco.org/education/information/nfsunesco/pdf/BEIJIN\\_E.PDF](http://www.unesco.org/education/information/nfsunesco/pdf/BEIJIN_E.PDF) (20 September 2012).

<sup>23</sup> Adopted in 1981 vide OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982) and entered into force in October, 1986.

<sup>24</sup> Adopted in 1990 vide OAU Doc. CAB/LEG/24.9/49 and entered into force in 1999.

<sup>25</sup> The Women Protocol was adopted by the African Union on 11 July 2003 by Resolution AHG/RES.240 (XXXI) on 11 July 2003. It entered into force on 25<sup>th</sup> November 2005.

<sup>26</sup> The African Youth Charter was adopted at the 7<sup>th</sup> Ordinary Session of the Assembly of the African Union in July 2006. It entered into force on 8 August 2009.

<sup>27</sup> A O Enabulele & C O Imoedemhe 'Unification of the application of international law in the municipal realm: A challenge for contemporary international law' (2008) 12 *Electronic Journal of Comparative Law (EJCL)* 6.

<sup>28</sup> Francophone countries like Benin (art 147 Benin Constitution 1990) & Senegal (art 97 Senegal Constitution 2001) in Africa are civil law jurisdictions and monist nations as their constitutions are modelled after the French Constitution of 1958 which in article 55 restates the supremacy of internationally ratified treaties over domestic laws upon publication of the treaties. Also, Portuguese-speaking African countries like Mozambique (art 18 & 43 Mozambique Constitution 2004) and Angola (art 13 Angolan Constitution 2010) also follow the approach adopted by Francophone African countries.

adopted constitute part of a whole legal system and the ratification of a human rights instrument automatically makes it self-executing with a duty placed on the judiciary to ensure its application without need for passage of an act of parliament.<sup>29</sup> Other states follow a system which regards local and international legislations as originating from separate legal systems which gives rise to the need for the adoption and transformation of international instruments into national legislation before their application in the national arena.<sup>30</sup> The contrast created by monist and dualist theories does not function this neatly in reality. As Killander and Adjolahoun point out, while courts in jurisdictions with a monist background are reluctant to apply directly ratified international treaties,<sup>31</sup> dualist countries overlook common law transformation preconditions to quickly apply and draw inspiration from international human rights law when adjudicating human rights matters.<sup>32</sup>

In Nigeria, the mere ratification of a treaty does not guarantee its implementation or enforcement as there are constitutional requirements for the incorporation of international instruments by the Nigerian legislature before domestic enforceability can exist.<sup>33</sup> South Africa, as well, provides for the incorporation of international agreements by the legislative arm of government.<sup>34</sup> It also gives constitutional

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See M Killander & H Adjolahoun 'International law and domestic human rights litigation in Africa: An introduction' in M Killander (ed) *International law and domestic human rights litigation in Africa* (2009) 4-11.

<sup>29</sup> Self-executing treaties are treaties that are clear and precise enough to confer rights in domestic law without the need for implementation. Major proponents of this theory are Kelsen, Verdross and Scelle. See J Dugard *International Law: A South African Perspective* (2005) 47; Enabulele & Imoedemhe (n 27 above) 7.

<sup>30</sup> Example of dualist states include the United Kingdom, Ireland, Cameroon, Ghana, South Africa (sec 231(4) 1996 Constitution) & Nigeria (sec 12 1999 Constitution). In Africa, dualism is generally associated with common law countries. The mere fact that the legislature of a dualist country has not incorporated an internationally ratified treaty into its national legal system does not mean that the country is not bound by obligations imposed by the treaty as such countries can be successfully litigated against before international and regional human right adjudicatory bodies even though this might be an impossibility in the domestic courts. See D Weissbrodt & C de la Vega *International human rights law: An introduction* (2007) 343-344; P Malanczuk *Akehurst's modern introduction to international law* (1997) 63, 65-67.

<sup>31</sup> Killander & Adjolahoun (n 28 above) 6.

<sup>32</sup> Killander & Adjolahoun (as above) 11.

<sup>33</sup> Sec 12 Nigerian Constitution 1999.

<sup>34</sup> Sec 231(2) South African 1996 Constitution. This position applies to non-self-executing treaties.

backing for the automatic operation of self-executing treaties upon ratification by the state's Parliament.<sup>35</sup> Moreover, the courts are mandated to consider international law when interpreting the Bill of Rights.<sup>36</sup>

The provision of section 12 of the Nigerian constitution is noted, but it is argued that the fact that a ratified treaty has not been domesticated in the country does not prevent the courts from relying on its principles in appropriate circumstances. This position is further buttressed by the provision of the Fundamental Rights Enforcement Procedure Rules 2009 which mandates courts to respect instruments and bills of rights brought to its attention or those personally noted to further the protection of the human rights of applicants.<sup>37</sup>

Irrespective of differing positions on the status of internationally ratified documents within the two jurisdictions, the intention in this section is to analyse international conventions and declarations acceded to by Nigeria and South Africa which protect the right to health of female adolescents by accessing contraceptive services and information.

## 2.1 Universal Declaration of Human Rights (UDHR)

The UDHR<sup>38</sup> was the first legal international instrument on human rights with a universal character<sup>39</sup> that comprehensively recognised the human rights of all

<sup>35</sup> Sect 231(4) above. J D Mujuzi 'The Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa: South Africa's reservations and interpretative declarations' (2008) 12 (2) *Law, Democracy and Development* 43. See also E M Ngolele 'The content of the doctrine of self-execution and its limited effect in South African law' (2006) 31 *South African Yearbook of International Law* 161. In Nigeria, whether self-executing or not, the constitutional position is rigid as such treaties as a matter of compulsion have to be first incorporated into the Nigerian legal system by the legislative arm of government.

<sup>36</sup> Sec 39(1)(b) SA Constitution 1996.

<sup>37</sup> Preamble, *Fundamental Rights Enforcement Procedures Rules* 2009. The FREPR was made pursuant to Section 46(3) of the 1999 Constitution of the Federal Republic of Nigeria. See also E Durojaye 'Litigating the right to health in Nigeria: Challenges & prospects' in M Killander (ed) *International law and domestic human rights litigation in Africa* (2009) 161-162.

<sup>38</sup> The UDHR together with the ICCPR & its twin, the ICESCR make up the International Bill of Human Rights.

<sup>39</sup> J Oraa Oraa 'The Universal Declaration of Human Rights' in I Gomez *et al* (eds) *International human rights law in a global context* (2009)163.

peoples.<sup>40</sup> Though non-binding, the declaration has gained recognition as constituting customary international law<sup>41</sup> that is enforced through the various international human rights treaties: foremost among which are the ICCPR and the ICESCR.<sup>42</sup> In the words of Singh *et al*, the UDHR, in giving hope to the most vulnerable and oppressed people worldwide, heralded a dawn, where a commitment based on the culture of respect and protection for the human rights of all peoples throughout the world was the norm.<sup>43</sup>

Apart from recognising that the inherent dignity and inalienable rights of all members of the human race are the foundation of freedom, justice and peace in the world<sup>44</sup> and that all humans are born free and equal in dignity and rights,<sup>45</sup> the UDHR recognises the protection of numerous rights, including the right to life, liberty and security of person, the right to non-discrimination, the right to dignity, the right to equality, the right to privacy, the right to information, and the right to education.<sup>46</sup>

The UDHR provides for the right to health by stating that ‘everyone has the right to a standard of living adequate for the health, and wellbeing of himself and his family’.<sup>47</sup> For the effective realisation of the right to health of female adolescents, generally, and their right to contraceptive information and services, in particular, it is paramount that their rights to privacy, dignity, information and education, already recognised under the UDHR, are not only protected but fulfilled by state parties.

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<sup>40</sup> Arts 19, 25 & 26 UDHR.

<sup>41</sup> V A Leary ‘The right to health in international human rights law’ (1994) 1 *Health and Human Rights* 32.

<sup>42</sup> As at today, the UDHR is used to measure the adherence by states to human rights provisions, the failure of which is regarded as violation under international law. See R Smith *Textbook on international human rights* (2005) 40; N I Aniekwu ‘Gender & human rights dimensions of HIV/AIDS in Nigeria’ (2002) 6 *African Journal of Reproductive Health* 30-37.

<sup>43</sup> J A Singh *et al* ‘Health & human rights 2: Do human rights matter to health?’ (2007) 370 *The Lancet* 521.

<sup>44</sup> Preamble UDHR (n 4 above).

<sup>45</sup> Art 1 UDHR.

<sup>46</sup> Arts 2, 5, 3, 7, 12, 19 & 26 UDHR. It should be noted that the ICCPR also recognises this right to privacy in art 17. Surprisingly, the African Charter does not contain a provision dealing with the right to privacy.

<sup>47</sup> Art 25 UDHR.

## 2.2 International Covenant on Civil and Political Rights (ICCPR)

The need to ensure that the various human rights recognised in the UDHR effectively protect individuals and that it is not merely a political declaration led to the adoption of the ICCPR and its twin the ICESCR.<sup>48</sup> The ICCPR recognises the protection of rights which can be regarded as ‘traditional’, such as the right to life,<sup>49</sup> dignity,<sup>50</sup> privacy,<sup>51</sup> information<sup>52</sup> and non-discrimination.<sup>53</sup> The above rights are inter-related with the right to health recognised in its counterpart, the ICESCR, and can be employed to influence and force state parties to remove barriers as well as to meet their duty to respect, protect and fulfil the reproductive and sexual health<sup>54</sup> rights of female adolescents. For example, the constant violation of the right to contraceptive information tends to engender negative and disastrous consequences to the SRH of adolescent girls. The Human Rights Committee<sup>55</sup> has interpreted that the right to

<sup>48</sup> The two international treaties (ICCPR and ICESCR) were adopted to legitimise the provisions of the Universal Declaration of Human Rights (UDHR). All together, the three international human rights documents make up the international bill of human rights.

<sup>49</sup> Art 6 ICCPR.

<sup>50</sup> Art 7 ICCPR. The right to dignity is one of the underlying concepts of modern human rights law which seeks the prevention of inhuman and degrading treatments on all humans and implies respect for the autonomy of individuals. E Wicks *Human rights and healthcare* (2007) 14.

<sup>51</sup> Art 17 ICCPR

<sup>52</sup> Art 19(2) ICCPR. The right to information is one of the most important rights necessary for the advancement of female adolescents’ reproductive health. The enjoyment of the right to information has evolved to create and impose concrete and immediate obligations on state parties to provide access to or refrain from interfering with information that is crucial for the promotion and protection of reproductive health choices See E Durojaye *Realising access to contraception for adolescents in Nigeria: A human right analysis* University of Free State (2010)162; S Coliver ‘The right to information necessary for reproductive health and choice under international law’ in Coliver (ed) *The right to know: Human rights and access to reproductive health information* (1995) 39; E Durojaye ‘Access to contraception for adolescents in Africa: a human rights challenge’ (2011) XLIV *The Comparative and International Law Journal of South Africa* 13.

<sup>53</sup> Arts 2(1), 3 & 26 ICCPR.

<sup>54</sup> Preamble - ICCPR para 4 specifically declares that for human beings to enjoy true freedom, especially from fear and want, conditions must be created where everyone enjoys not only their civil and political rights, but also their economic, social and cultural rights. The principle of the inter-dependence and inter-relatedness of all human rights connotes human rights as being part of a structure whereby the infringement or violation of one right automatically affects the enjoyment of other rights as well. See also R J Cook *et al Reproductive health and human rights: Integrating medicine, ethics and law* (2003) 159.

<sup>55</sup> The Human Rights Committee is the body of experts charged with the monitoring of the ICCPR by state parties. State parties are to submit reports at intervals to the Human Rights Committee, which examines them and give reports based upon the prevailing situation in the member states. See C

life<sup>56</sup> as enunciated in article six, as a 'supreme right from which no derogation is permitted even in times of public emergency which threatens the life of the nation'.<sup>57</sup>

In relation to other rights, including the right to health, the Human Rights Committee stated that the right to life is often narrowly interpreted in a restrictive manner and urged state parties to ensure that their legislation is in line with the provisions of the ICCPR and to adopt measures that will increase life expectancy.<sup>58</sup> The failure to access contraceptive services and other reproductive health information accounts for high maternal mortality rates and is a violation of the right to life. Where a state fails to guarantee its female adolescents access to contraceptive information and services or other reproductive health services needed by women generally, the right to life is violated. In the words of the Indian Supreme Court in *Paschim Banga Khet Mazdoor Samity & Ors v State of West Bengal & Another*,<sup>59</sup> the obligation imposed on the state by the right to life stands irrespective of constraints in financial resources.<sup>60</sup> The court further stated that the denial of timely medical treatment

Tomuschat *International Covenant on Civil and Political Rights* available at <http://untreaty.un.org/cod/avl/ha/iccpr/iccpr.html> (20 January 2013).

<sup>56</sup> The right to life has been described as the most fundamental of all human rights without which none of the other rights is of any use. See L Chenwi *Towards the abolition of the death penalty in Africa: A human rights perspective* (2007) 57; C Hoexter 'The right to life, liberty and security' in M Robertson (ed) *Human rights for South Africans* (1990) 31; *Villagram-Morales et al v Guatemala* -The "Street Children" Case, Judgment of November 19, 1999, Inter-Am. Ct. H.R. (Ser. C) No 63 (1999) para 144. The Constitutions of Nigeria (sec 33) & South Africa (sec 11) recognise the right to life. However, unlike the situation in Nigeria where the right to life can be derogated from based upon the orders of a competent court of law, the right to life under the Constitution of the Republic of South Africa is unqualified. See *S v Makwanyane* (1995) (3) SA 391 (CC); 1995 (6) BCLR 665 (CC) para 137.

<sup>57</sup> Para 1 general comment 6 Human Rights Committee, *Compilations of general comments and recommendations adopted by human rights treaty bodies Vols I* available at [http://www.amnesty.nl/sites/default/files/public/generalcomments\\_0.pdf](http://www.amnesty.nl/sites/default/files/public/generalcomments_0.pdf). (24 October, 2012). In the view of some others, the right to life can be derogated from in situations of self-defence where according to William Schabas, the right to life will only cover the innocent party. See also J Yorke *Introduction: the right to life and the value of life: Orientations in law, politics and ethics* (2010) 4-5.

<sup>58</sup> Para 5 general comment 6 Human Rights Committee; A R Chapman 'Monitoring women's rights to health under the International Covenant on Economic, Social and Cultural Rights' (1995) 44 *American University Law Review* 1171; concluding observations of the Human Rights Committee to El Salvador, UN Doc CCPR/CO/78/SLV 14; concluding observations of the Human Rights Committee to Mali, UN Doc. CCPR/CO/77/MLI, 14.

<sup>59</sup> *Paschim Banga Khet Mazdoor Samity & Ors v State of West Bengal & Anor* (1996) AIR SC 2426, (1996) 4 SCC 37.

<sup>60</sup> As above, para 9.

necessary to preserve human life in government-owned hospitals is a violation of this right.<sup>61</sup>

Taking into cognisance the comment of the Human Rights Committee that effort should be made to avoid the narrow interpretation of the right to life, it can be argued that the protection of the right to life imposes a duty upon the Nigerian and South African States to provide access to adolescent-friendly health services through which adolescent girls can access information and services relating to contraception so as not to place their lives in jeopardy.<sup>62</sup> Despite the fact that South Africa recognises the unqualified nature of the right to life and has put in place the necessary legislative framework which allows adolescent girls easy access to contraception and other needed reproductive health care services, reports show that few teenagers use the facilities.<sup>63</sup>

Apart from the right to life, the right to privacy<sup>64</sup> is of paramount importance in assuring the protection of the reproductive health of adolescent girls. Today,

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<sup>61</sup> As above, para 9.

<sup>62</sup> Currently, the Nigerian state is failing in this duty as the lives of adolescent girls are constantly jeopardised as a result of SRH issues related to teenage pregnancies, unsafe abortions and STIs occasioned by lack of access to contraceptives information and services. A Attahir *et al* 'Knowledge, perception and practice of emergency contraception among female adolescent hawkers in Rigasa sub-urban community of Kaduna State Nigeria' (2010) 4 *Journal of Family and Reproductive Health* 15-20; C I Akani *et al* 'Emergency contraception: knowledge and perception of female undergraduates in the Niger-Delta of Nigeria' (2008) 42 *Ghana Medical Journal* 68-70; B O Idonije *et al* 'A study on knowledge, attitude and practice of contraception among secondary school students in Ekpoma, Nigeria' (2011) 2 *Journal of Pharmacy and Clinical Sciences (JPCS)* 22-27; A Bankole *et al* *Unwanted pregnancy & induced abortion in Nigeria: Causes and consequences* (2006) 12-13, available at <http://www.guttmacher.org/pubs/2006/08/08/Nigeria-UP-IA.pdf> (23 October, 2012).

<sup>63</sup> Reasons adduced for this shortcoming include inaccessibility of services due to inconvenient operating hours, inadequate information about contraception and lack of knowledge about the availability of free sexual and reproductive health care services, unfriendly attitude of health providers, and so on. See V J Ehlers 'Adolescent mother's knowledge and perceptions of contraceptives in Tshwane, South Africa' (2003) 8 *Health SA Gesondheid* 19-20; A Skelton 'Girls' Socio-economic rights in South Africa' (2010) 26 *South African Journal of Human Rights* 151; T M M Maja 'Factors impacting on contraceptive use among youths in Northern Tshwane: Part two' (2007) 12 *Health SA Gesondheid* 43-44; K Wood *et al* 'Blood blockages and scolding nurses: Barriers to adolescent contraceptive use in South Africa' (2006) 14 *Reproductive Health Matters* 109-118.

<sup>64</sup> The right to privacy is guaranteed under sec 37 and sec 14 of the Nigerian and South African Constitutions respectively.

adolescents all over the world initiate sexual relations early,<sup>65</sup> under-lining their need to possess the capability to make decisions on matters relating to their SRH needs.<sup>66</sup> This need is coupled with a concurrent need for privacy<sup>67</sup> which determines whether adolescents will be willing to access available services or not.<sup>68</sup>

Despite the debate on whether adolescents require privacy rights or not, it is evident that there is a necessity to protect the privacy rights of adolescents generally and adolescent girls, in particular, especially in relation to access to SRH care services.<sup>69</sup> This is because neglect in this crucial area may lead to unsavoury consequences. The right of adolescents to medical confidentiality was recognised in *Gillick v. West Norfolk and Wisbech Area Health Authority and Another*,<sup>70</sup> where the court, in allowing the access of adolescents under sixteen to contraception, was of the view that once the adolescent is able to understand the nature of the treatment requested and there is a likelihood that she will engage in sexual activities with or

<sup>65</sup> Sometimes female adolescents engage in sexual relations voluntarily, in a majority of cases however engagement in the sexual act for the first time is non-consensual and an exploitation of their dependency. See R J Cook *et al* 'Respecting adolescents' confidentiality and reproductive and sexual choices' (2007) 98 *International Journal of Gynaecology and Obstetrics* 183; S Jejeebhoy *Sexual and reproductive health of young people: expanding the research and program agenda* (2006) 5, available at [http://hivaidsclearinghouse.unesco.org/search/resources/bie\\_pop\\_rev\\_jejeebhoy.pdf](http://hivaidsclearinghouse.unesco.org/search/resources/bie_pop_rev_jejeebhoy.pdf) (25 October 2012).

<sup>66</sup> K Scheiwe 'Between autonomy and dependency: minors' rights to decide on matters of sexuality, reproduction, marriage and parenthood. Problems and state of the debate – An introduction' (2004) 18 *International Journal of Law, Policy & the Family* 262-282; Cook *et al* 'Respecting adolescents' confidentiality and reproductive and sexual choices' (as above) 183.

<sup>67</sup> Various discussions have arisen as to whether children actually need privacy rights. Some scholars object to children being vested with privacy rights on the reasoning that they are incapable of making important decisions, others are of the view that granting adolescents privacy rights in relation to SRH needs will allow for willingness to access such services so as to prevent unsavoury consequences. See K Hughes 'The child's right to privacy and article 8 European Convention on Human Rights' in Freeman (ed) *Law and childhood studies: current legal issues 2011* (2012) 458-460; R J Cook and B M Dickens 'Recognizing adolescents' 'evolving capacities' to exercise choice in reproductive healthcare' (2000) 70 *International Journal of Gynaecology & Obstetrics* 17.

<sup>68</sup> Female adolescents will not endeavour to access needed contraceptive health care services if their right to privacy and confidentiality is not assured. Cook *et al* 'Respecting adolescents' confidentiality and reproductive and sexual choices' (n 65 above) 186; Cook & Dickens (as above) 17.

<sup>69</sup> In relation to the sexual and reproductive health, the right to privacy entails the freedom to take decisions on matters relating to the reproductive health needs of women and girls. It is the right of adolescent girls to access needed contraceptive services independently, privately and confidentially without interference from anyone.

<sup>70</sup> *Gillick v. West Norfolk and Wisbech Area Health Authority and Another* (1986) 1 AC 112, available at [http://www.hrcr.org/safrica/childrens\\_rights/Gillick\\_WestNorfolk.htm](http://www.hrcr.org/safrica/childrens_rights/Gillick_WestNorfolk.htm) (20 October 2012).

without protection, then it will be in her best interests to have access to the contraceptives without parental consent.<sup>71</sup>

Currently, in a majority of African countries, Nigeria and South Africa inclusive, access to contraception by female adolescents is affected by the existence of cultural, traditional and religious beliefs which make it offensive for young girls to require contraception or family planning services, a preserve only accessible by married adults. In the few instances where contraceptive services are available, issues relating to privacy and confidentiality arise and are coupled with the reluctance of health providers to allow adolescent girls to access the services.<sup>72</sup> Recently, the WHO issued guidelines in relation to the provision of contraceptive information and services to women and adolescent girls in which it recommended that states are to ensure that the services provided are not only sensitive to individual needs but also respect their right to dignity, autonomy and confidentiality.<sup>73</sup>

In addition to the necessity for privacy, the effective protection of the SRH of adolescent girls requires the fulfilment and respect of their right to information.<sup>74</sup> The reason for the right to information is not far-fetched. Apart from the fact that access to appropriate reproductive health information on contraception will assist in living a dignified life,<sup>75</sup> the possession of information on where contraceptive services

<sup>71</sup> (as above) 174. The decision of the House of Lords in the *Gillick's case* was again affirmed in *R (Axon) v Secretary of State for Health* (2006) EWHC 37 (Admin) para 62, available at <http://www.bailii.org/ew/cases/EWHC/Admin/2006/37.html> (25 October 2012).

<sup>72</sup> Apart from the above, it is felt that since female adolescents are still under parental guidance; access to contraception should only be based on the consent of their parents. See generally, Wood *et al* (n 63 above) 109-118; Durojaye 'Access to contraception for adolescents in Africa' (n 52 above) 22.

<sup>73</sup> WHO *Ensuring human rights in the provision of contraceptive information and services: Guidance and recommendations* (2014) 19-21 [http://apps.who.int/iris/bitstream/10665/102539/1/9789241506748\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/102539/1/9789241506748_eng.pdf) (10 March 2014).

<sup>74</sup> Nigeria and South Africa recognises the right to receive and impart information. See secs 39 & 16(1)(b) of the Nigerian and South African Constitutions respectively.

<sup>75</sup> The right to dignity is associated with other fundamental rights recognised under international human rights law, such as the right to equality, physical, mental and moral integrity and personality rights. However, while the other rights may be the subject of limitations in exceptional situations, the right to dignity cannot be limited. N Haysom *Dignity' in South African Constitutional Law: Bill of Rights (Issue 12)* (2012) 5-3. The right to dignity is protected in secs 10 & 34 of the South African and Nigerian Constitutions respectively.

can be obtained is a major means through which the need for contraception among female adolescents can be met, thereby allowing them to control their fertility and also protect themselves against STIs.

At a minimum, the duty to fulfil the right of adolescent girls to information places an obligation on state parties not to discriminate in the provision of contraceptive information on the basis of youth or to prohibit or illegalise efforts to disseminate such information. Instead, state parties are to create an environment in which relevant and necessary information on contraception can be disseminated to adolescent girls in a factual and easy-to-understand manner, while prohibiting cultural and religious gate keepers from interfering with the dissemination of contraceptive information.<sup>76</sup> It is important to highlight that South Africa especially recognises the right of children to have access to SRH information.<sup>77</sup> While there is no corresponding provision in the Nigerian Child Rights Act, it is the opinion that adolescent girls in the country have the right to access information relating to contraception due to the country's ratification of international and regional human rights instruments.

Nigeria and South Africa owe a paramount duty to make certain that female adolescents have access to contraceptive services and information and to ensure that laws and policies protecting their right to privacy and confidentiality are in order. Although the Nigerian Child Rights Act 2003<sup>78</sup> guarantees the right of children to privacy, which can be used in furthering their access to confidential contraceptive health care services, the section qualifies their enjoyment of the right as it allows parents and guardians to exercise reasonable supervision and control over their wards' conduct.<sup>79</sup> The insertion of this provision in the Child Rights Act will automatically discourage adolescent girls from accessing the required contraceptive

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<sup>76</sup> *Open Door Counselling and Dublin Well Woman v Ireland* (1992) 15 E.H.R.R 244; Coliver (n 52 above) 40-41.

<sup>77</sup> Sec 13(1)(a) South African Children's Act 2005.

<sup>78</sup> Sec 8(1) Child's Rights Act 26 2003.

<sup>79</sup> Sec 8(3) above.

services and encourage their engagement in unprotected sex.<sup>80</sup> South Africa guarantees the right of children to privacy from several angles. Apart from specifically providing that the rights contained in the Children's Act are meant to supplement the rights contained in the constitution,<sup>81</sup> the Children's Act not only upholds the right of adolescent girls to privacy and confidentiality when accessing contraception<sup>82</sup> but guarantees keeping their health records confidential.<sup>83</sup>

In addition, the Constitution of the Republic of South Africa respects the right of individuals (including girls) to take decisions on reproduction and have control of their body<sup>84</sup> thereby creating an environment where adolescent girls can make decisions privately on whether to access contraception or not. In *Christian Lawyers Association v Minister of Health & Others (Reproductive Health Alliance as Amicus Curaie)*,<sup>85</sup> the court refused to declare unconstitutional the provisions of the Choice on Termination of Pregnancy Act which allowed adolescent girls' to access abortion services without parental knowledge or consent, thereby guaranteeing the right of adolescent girls in the country to access reproductive health care services in a private and confidential manner.

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<sup>80</sup> Cook *et al* *Reproductive health and human rights* (n 54 above) 167; Centre for Reproductive Rights & UNFPA *The Right to Contraceptive Information and Services for Women and Adolescents* (2010) available at <http://www.unfpa.org/webdav/site/global/shared/documents/publications/2011/Contraception.pdf> (26 October 2012).

<sup>81</sup> Sec 8(1) Children's Act 2005. The section automatically infers that female adolescent's privacy rights are generally guaranteed under section 14 of the Constitution of the Republic of South Africa 1996.

<sup>82</sup> Sec 134(3) above.

<sup>83</sup> Sec 13 above. This can only be breached where maintaining such confidentiality is not in the best interests of the child such as where the child has been a victim of rape or other incestuous acts. This provision can be used in supporting the right to privacy and confidentiality when adolescent girls access contraceptive services.

<sup>84</sup> Secs 12(2)(a) & (b) Constitution of the Republic of South Africa 1996.

<sup>85</sup> *Christian Lawyers Association v Minister of Health & Others (Reproductive Health Alliance as Amicus Curaie)* 2005 (1) SA 509 (T)

### 2.3 International Covenant on Economic, Social and Cultural Rights (ICESCR)

The ICESCR is the treaty which converted the socio economic rights provisions of the UDHR into binding obligations.<sup>86</sup> In relation to the right to health, the ICESCR recognises the right of ‘everyone to the enjoyment of the highest attainable standard of physical and mental health’<sup>87</sup> and provides that state parties are to take steps<sup>88</sup> that will enable the achievement of its full realisation.<sup>89</sup>

However, unlike the ICCPR, the ICESCR allows for the gradual realisation of rights recognised in the treaty.<sup>90</sup> Article 2(1) provides:

Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.

It has been argued that the provision contained in Article 2(1) allows for the exercise of discretion by state parties on how and when the rights contained in the covenant are to be implemented.<sup>91</sup> Gaining inspiration from the interpretation of state

<sup>86</sup> Rights protected under the covenant include the right to an adequate standard of living (art11), the right to education (art13), the right to benefit from scientific progress (art15 (1)(b)), the right to work (art6) and the right to health (art12) among others. The other treaty that transformed the provisions of the UDHR into a binding form is the International Covenant on Civil and Political Rights 1966. See F Viljoen *International human rights law in Africa* (2012) 114.

<sup>87</sup> Article 12(1) ICESCR. The ICESCR has been criticised as being gender insensitive and male oriented because it makes no mention of the right of women to reproductive health in its provisions. See Chapman (n 58 above) 1165- 1166.

<sup>88</sup> The steps to be taken include ensuring access to contraceptive information and services for adolescent girls, ensuring reduction in stillbirth and infant mortality rates, improving all aspects of environmental and industrial hygiene, preventing, treating and controlling epidemic and other occupational diseases and creating an enabling environment that will assure access to medical attention in the event of sickness.

<sup>89</sup> Article 12(2) ICESCR.

<sup>90</sup> Article 2(1) above.

<sup>91</sup> Alston *et al* (n 8 above) 166; S Verma *Justiciability of economic, social and cultural rights: Relevant case law* available at [http://www.ichrp.org/files/papers/96/108\\_Justiciability\\_of\\_Economic\\_Social\\_and\\_Cultural\\_Rights\\_-\\_Relevant\\_Case\\_Law\\_Verma\\_\\_Shivani\\_\\_2005\\_\\_background.pdf](http://www.ichrp.org/files/papers/96/108_Justiciability_of_Economic_Social_and_Cultural_Rights_-_Relevant_Case_Law_Verma__Shivani__2005__background.pdf) (24 October 2012); M Craven ‘The Justiciability of economic, social and cultural rights’ in R Burchill *et al* (eds) *Economic, social and cultural rights: Their implementation in United Kingdom Law* (1999) 5, quoted by M Ssenyonjo ‘Economic, social and cultural rights: An examination of state obligations’ in S Joseph & A McBeth (eds) *Research Handbook on International Human Rights Law* (2010) 40.

parties' obligation in the Limburg Principles,<sup>92</sup> the Committee on Economic, Social and Rights<sup>93</sup> in its general comment on the nature of states parties' obligations, specified, while noting problems encountered as a result of the limitation of available resources, that the ICESCR Covenant imposed two immediate obligations on state parties: first, the obligation to exercise the rights in the ICESCR without discrimination and second, the obligation to take steps. On the obligation to take steps, the committee explained that, state parties are to take concrete, deliberate and targeted steps<sup>94</sup> that are consistent with the nature of the rights involved with the view of achieving full realisation of their obligations under the Covenant.<sup>95</sup>

Apart from the above, the CESCR Committee introduced minimum core essentials that must be guaranteed by state parties. Pertaining to the right to health, essentials<sup>96</sup> to be assured include those of availability,<sup>97</sup> accessibility,<sup>98</sup> acceptability<sup>99</sup>

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<sup>92</sup> The Limburg Principles were drafted by a group of experts in international law in 1986 to consider the nature and scope of the obligations of States parties to the International Covenant on Economic, Social and Cultural Rights.

<sup>93</sup> Hereafter referred to as the ICESCR Committee. The Committee on the ESCR was created in 1985 as a subsidiary of the Economic and Social Council of the United Nations by virtue of ECOSOC Resolution 1985/17. It is vested with the mandate of performing monitoring functions over the ICESCR and state parties are to submit periodic reports on the measures adopted and progress achieved in implementing the right contained in the Covenant. Recently, an Optional Protocol to the ICESCR was adopted by the UN General Assembly to pave way for the lodging of individual complaints to the ICESCR Committee on violations by state parties after local remedies have been exhausted. The OP-ICESCR recently entered into force in May 2013. Currently, 14 states have ratified the protocol. See [http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtmsg\\_no=IV-3-a&chapter=4&lang=en](http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtmsg_no=IV-3-a&chapter=4&lang=en) (10 June 2014).

<sup>94</sup> Through the adoption of necessary legislative, administrative, judicial and educational measures.

<sup>95</sup> Paras 1, 2 & 3 general comment 3 ICESCR Committee; F Coomans 'The International Covenant on Economic, Social and Cultural Rights: From step child to full member of the human rights family' in G I Felipe & K de Feyter (eds) *International human rights law in a Global Context* (2009) 295-296; V Jaichand 'An introduction to economic, social and cultural rights: Overcoming the constraints of categorization through implementation' in A R Chowdhury & J H Bhuiyan (eds) *An introduction to international human rights law* (2010) 59-60.

<sup>96</sup> Para 12 general comment 14 of the ICESCR Committee.

<sup>97</sup> This means that health care facilities, drugs, health personnel and services must be available in sufficient quantity.

<sup>98</sup> Requires that health facilities must be physically and economically accessible without discrimination to all women (including adolescent girls) and without distinction between those living in rural and urban areas. It also includes informational accessibility which means that individuals who need the services must receive or have access to all required information pertaining to the treatment or service.

<sup>99</sup> This means that the health care services and facilities provided must be take note of all medical ethics, be culturally appropriate and must respect the right to confidentiality of the clients it serves.

and quality.<sup>100</sup> The observance of the core minimum content in relation to female adolescents' access to contraceptive information and services requires that state parties establish sufficient adolescent-friendly clinics in both rural and urban areas,<sup>101</sup> employ health providers with a positive attitude,<sup>102</sup> introduce comprehensive sexual and family life education in schools,<sup>103</sup> enact laws that proscribe stereotypes and discrimination, ensure that the confidentiality and privacy of adolescent patients are maintained when accessing contraception services except where it will not be in the child's best interests.

Perhaps understanding the important role of the right to non-discrimination in ensuring that rights guaranteed in the ICESCR are enjoyed by all, the CESCR Committee clarified in General Comment 20<sup>104</sup> that states parties should endeavour to eliminate discrimination in all 'guises', both formally and substantively, in order to ensure that the Covenant rights are enjoyed equally.<sup>105</sup> Explaining that while article 2(2) of the ICESCR lists prohibited grounds of discrimination, including race, colour, sex, birth, it also includes 'other status' which denotes that the list is not exhaustive as other grounds such as age and marital status, prominent grounds upon which

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<sup>100</sup> This means that all the facilities and services rendered must be of good quality and the medical personnel must be skilled in their various fields.

<sup>101</sup> In its concluding observations to Russia in 2011, the ICESCR Committee recommended that the Russian government should ensure that family planning information and services are available to everyone, including people residing in rural areas, and that the teaching of sex education to adolescents should be included in the school curriculum so as to prevent early pregnancy and STIs. See para 30 ICESCR Committee concluding observations on Russia 2011 E/C.12/RUS/CO/5.

<sup>102</sup> Positive attitude here means health providers who don't have issues with prescribing contraception or other reproductive health services to adolescent girls.

<sup>103</sup> In its concluding observations to the Republic of Moldova in 2011, the ICESCR committee expressed concern at the withdrawal of the teaching of the Life Skills course in public schools and recommended that the teaching of sexual and reproductive rights should be reintroduced in curriculum of schools. See para 27 ICESCR committee concluding observation on Moldova E/C.12/MDA/CO/2.

<sup>104</sup> General Comment 20 on Non-discrimination in economic, social and cultural rights issued by the ICESCR Committee at its forty-second session in 2009. E/C.12/GC/20.

<sup>105</sup> Para 8 General Comment 20 ICESCR Committee. According to the Committee, eliminating formal discrimination requires state parties to ensure that their constitutions do not discriminate on prohibited grounds such as age or marital status. However, admitting that eliminating formal discrimination will not ensure substantive equality, the Committee explains that eliminating discrimination in practice requires governments to not only pay specific attention to groups of individuals who suffer historical or persistent prejudice but also adopt necessary measures that will eliminate the conditions and attitudes which cause and perpetuate substantive discrimination. See also para 9 General comment 20 ICESCR Committee.

adolescent girls are denied access to contraceptive information and services, can be added to it.<sup>106</sup>

In line with the CESCR Committee's interpretation in its General Comment 14,<sup>107</sup> female adolescents' right to access contraception is violated<sup>108</sup> if state parties adopt policies and laws that bar them from accessing necessary information on the availability of contraceptive services and other reproductive health services.<sup>109</sup> Also, state parties violate the right to health if their agents deliberately withhold information from adolescent girls that the use of family planning assists in the prevention of teenage pregnancies and infection by STIs or their accessibility to contraceptives is impeded due to the privatisation of health care services without providing alternatives where required information and services can be obtained.<sup>110</sup>

Apart from using the right to information to further the campaign for adolescent girls' access to contraception, the right to education, as well, can be interpreted as recognising the right of adolescent girls to obtain information on contraceptive services through the acquisition of life skills and other educative programmes. In *Kjeldsen, Busk Madsen, and Pedersen v Denmark*, the objection by some parents to the teaching of compulsory sex education in state schools based on the reasoning that it violated their rights and duty to ensure that the education of their wards was in conformity with their religious convictions and private and family life was overruled by the European Court on Human Rights. The Court held that none of the duties or rights alleged was violated since the teaching was principally intended to

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<sup>106</sup> Paras 15, 27, 29 & 31 General Comment 20 ICESCR Committee.

<sup>107</sup> Paras 47-52 General Comment 14 ICESCR Committee.

<sup>108</sup> Violation occurs where a state party is unwilling to invest the maximum available resources to ensure the realisation of the right to health in fulfilment of its obligations under article 12. In cases where violation is a result of inability to comply, it is mandatory that the state party justify that it has expediently invested all available resources to satisfy its obligations.

<sup>109</sup> As above.

<sup>110</sup> Para 35 General Comment 14 ICESCR Committee.

convey useful information that was necessary for the protection of the public interest.<sup>111</sup>

Concurring with the above view, the benefits of properly educating adolescent girls in Nigeria and South Africa cannot be quantified as the acquisition of family life and sex education promotes not only their understanding of the significance of engaging in safe sexual activities but also creates awareness of the negative effects occasioned by teenage pregnancy and risky sexual relations.<sup>112</sup> Hence, the right of adolescent girls' to access contraception services and information is a basic right which the governments of Nigeria and South Africa cannot leave unfulfilled or make subject to the availability of resources as the two countries, being signatories to the ICESCR,<sup>113</sup> are bound to respect, protect and fulfil their obligations under the Covenant.

South Africa, apart from the provision of section 27(1)(a) of its Bill of Rights which generally guarantees everyone the right to health care services, including services relating to reproductive health care, section 28(1)(c) specifically assures children a right to basic health care services from which access to contraceptive services and information by female adolescents can be inferred. Furthermore, sections 13 and 134 of the Children's Act,<sup>114</sup> specifically promises adolescents' access to contraception from the age of twelve and necessary information on health

<sup>111</sup> *Kjeldsen, Busk Madsen, and Pedersen v Denmark* (1976) 1 *European Human Rights Report* 711.

<sup>112</sup> When adolescents are properly educated on the disastrous effects of engaging in unsafe sex, they will try to ensure that they access (where there are no barriers) necessary contraception and family planning services in order to maintain good sexual and reproductive health. The right to education is recognized in arts 13 ICESCR, 10 CEDAW, 28 CRC, 17 African Charter and 11 ACRWC. Nigeria recognises the right of children to education under sec 15 2003 Child Rights Act from which the right to access to contraception can be inferred while South Africa recognises the right to education in sec 29 Constitution of the Republic of South Africa 1996.

<sup>113</sup> Nigeria ratified the ICESCR in July 1993. South Africa is yet to do so. The non-ratification of the ICESCR by South Africa is an aberration as it is a country that is foremost in the protection of the socio-economic rights of its citizens. This position is accentuated by the fact that the Constitution of the Republic of South Africa 1996 specifically guarantees in sec 7(2) to respect, protect and fulfil the rights contained in the Constitution. In 2012, the South African Government signified its intention to ratify the ICESCR which it signed on 3 October 1994. However, it is yet to do so. See <http://www.ngopulse.org/press-release/south-africa-ratify-international-socio-economic-rights-covenant-28-September-2014>).

<sup>114</sup> Children's Act No. 38 of 2005.

promotion, including information on the prevention and treatment of ill-health relating to sexuality and reproduction.<sup>115</sup>

Liebenberg explains that rights classified as ‘basic’ cannot be left unfulfilled for whatever reason, including that of the limitation of resources. According to her, in catering to the socio-economic needs of children, the South African state has a duty to take into account the special needs of children, including the severe impact that a denial of their socio-economic rights will entail.<sup>116</sup> As a result, it is felt that the guarantee of female adolescents’ access to contraceptive services and information is one that must be fulfilled immediately irrespective of resource constraints or impediments posed by non-state actors. In *Minister of Health and Others v Treatment Action Campaign and Others*,<sup>117</sup> the Constitutional Court, denouncing the failure to provide access to a drug in the prevention of mother to child HIV transmission as a result of government policy, held that the policy was unreasonable and ordered the immediate availability of the drug in government hospitals.

Even though Nigeria has ratified the ICESR, the Constitution does not recognise the right to health but instead acknowledges the state’s duty to protect the health and safety of citizens in its directive principles.<sup>118</sup> However, matters relating to the directive principles have been rendered non-justiciable by section 6(6) (c).<sup>119</sup> Despite the above, the mere reason that the right to health is not expressly recognised in the Constitution cannot be regarded as an impediment as the Nigerian courts, through

<sup>115</sup> This is apart from the provisions of the Choice on Termination of Pregnancy Act 92 of 1996 which allows girls of any age to access abortion services on confidential basis.

<sup>116</sup> S Liebenberg ‘Taking stock: The jurisprudence on children’s socio economic rights and its implications for government policy’ (2004) 5 *ESR Review* 3-5.

<sup>117</sup> *Minister of Health and Others v Treatment Action Campaign and Others* 2002 (5) SA 703; 2002 (10) BCLR 1075.

<sup>118</sup> Sec 17(3)(c) & (d) Nigerian Constitution 1999 provides that the Nigerian state is to ensure that: there are adequate medical and health facilities for all persons and that the health, safety and welfare of all persons are safeguarded and not endangered or abused.

<sup>119</sup> Sec 6(6)(c) Nigerian Constitution 1999 ousts the jurisdiction of the courts’ on matters relating to a failure to fulfil objectives contained in the directive principles. However, the court’s interpretation in *Nwankwo v Yar Adua* (2013) 13 NWLR (Pt 1263) 81 CA that the use of the word ‘shall’ in sec 13 of the Constitution implies that the mandate to achieve the fundamental objectives and directive principles is one that must be done, places a responsibility on the government to take every step to ensure that the objectives contained in sec 17(3)(d) are guaranteed and fulfilled.

the inter-related nature of rights, can link a failure to make access to contraceptive information and services available and accessible to adolescent girls to a violation of their right to life. This practice is adopted by the Indian courts.<sup>120</sup>

Apart from the foregoing, section 13 of the CRA<sup>121</sup> recognises the right to health of children. Adolescent girls make up a significant proportion of people protected by the Act and, therefore, have a right to access necessary contraception information and services. In fact, reading from the provisions of section 13(3)(b) which provides that the Nigerian state has a duty to ‘ensure the provision of necessary medical assistance and health care services to all children with emphasis on the development of primary health care’,<sup>122</sup> it can be inferred that the law courts can intervene by dismantling all regulatory, administrative or legal blockades which prevent adolescent girls from accessing contraception.

## 2.4 Convention on the Rights of the Child (CRC)

The CRC, which entered into force in less than a year after its adoption,<sup>123</sup> is the most widely ratified human rights treaty in history.<sup>124</sup> Its adoption was the result of several years of struggle for the recognition that children were full-fledged humans who required the protection of their rights as autonomous beings.<sup>125</sup> Despite near universal ratification, the CRC was condemned for the limited involvement of African states in its drafting process as only few states participated in the working groups’

<sup>120</sup> The Indian Courts have been consistent in interpreting the provision of socio economic rights as a basic requirement for the right to life recognized under Article 21 of its Constitution. See *Paschim Banga Khet Mazdoor Samity & Ors v State of West Bengal & Anor.* (1996) AIR SC 2426, (1996) 4 SCC 37.

<sup>121</sup> Child Rights Act 2003.

<sup>122</sup> Section 13(3)(b) above. According to the provisions of the Declaration of Alma-Ata 1978, primary Health care includes the provision of services and information on family planning, available at [http://www.paho.org/english/dd/pin/alma-ata\\_declaration.htm](http://www.paho.org/english/dd/pin/alma-ata_declaration.htm) (1 November 2012).

<sup>123</sup> The Convention on the Rights of the Child was adopted via resolution 44/25 of 20<sup>th</sup> November, 1989 and entered into force on the 2<sup>nd</sup> of September, 1990.

<sup>124</sup> Currently, only Somalia and the United States of America are not parties to the CRC, available at [http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg\\_no=IV-11&chapter=4&lang=en](http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-11&chapter=4&lang=en) (3 November 2012).

<sup>125</sup> W Vandenhoele ‘The Convention on the Rights of the Child’ in G I Felipe & K de Feyter (eds) *International Human Rights Law in a Global Context* (2009) 452-454.

efforts to draft the proposal that was accepted for adoption by the United Nations General Assembly.<sup>126</sup>

The CRC defines a child as ‘every human being below the age of eighteen years unless, under the law applicable to the child, majority is attained earlier’<sup>127</sup> and creates an obligation for state parties to recognise and protect the rights of children guaranteed under it.<sup>128</sup> Apart from the above, the CRC provides that the best interests of children should always be a primary consideration when determining issues relating to the child<sup>129</sup> and urges state parties to take every necessary measure in protecting them from mental or physical violence, including sexual abuse.<sup>130</sup>

Also, the convention, while recognising the rights and duties of parents and persons in *loco parentis*, urges the giving of guidance and direction to children according to their evolving capacities and asks that their views are respected according to their age and maturity.<sup>131</sup> As McGeeney and Blake note, the use of the evolving capacity principle in giving direction to children has far-reaching implications, especially in relation to the delivery of services to adolescent girls who are in special need of information and services relating to contraception and other reproductive health

<sup>126</sup> Viljoen (n 86 above) 133. This was a major reason for the subsequent adoption of the African Charter on the Rights and welfare of the Child. It was felt that due to the low participation of African states in the drafting process, the CRC did not take cognisance of the particular problems affecting children in the region.

<sup>127</sup> Art 1 CRC. This definition of the child has also been criticised as it allows for different states to fix different ages of majority for children, thereby failing a paramount duty of protecting children (especially girls) from child marriages and other harmful vices to which children are usually subjected. The African Children’s Charter corrected this problem in its art 2 by defining in strict terms that a child is someone less than 18 years.

<sup>128</sup> The CRC protects the rights of children to non-discrimination (art.2), life (art.6), nationality and registration of birth (art 7), identity (art 8), expression (art 13), privacy (art 16), access to information (art 17), standard of living adequate for physical and mental development (art 27), health (art 24) and education (art 28).

<sup>129</sup> Art 3(1) CRC.

<sup>130</sup> Art 19(1) above.

<sup>131</sup> Arts 5 & 12 CRC. The concept of evolving capacities is one that recognises that as children develop and acquire enhanced skills, parents and guardians are to adjust their levels of direction and allow the child to become responsible for taking decisions on issues affecting their lives. See also para 4 CRC Committee general comment 4; G Lansdown *The evolving capacities of the child* (2005) available at <http://www.unicef-irc.org/publications/pdf/evolving-eng.pdf> (3 November 2012).

care services.<sup>132</sup> Accordingly, the ‘evolving capacity’ principle supports the gradual relaxation of parental guidance/protection rules in so far as female adolescents possess the relevant levels of maturity needed to access contraception and other reproductive health care services.

In relation to the right of the child to health, the CRC provides for the recognition of the right of children to the enjoyment of the highest attainable standard of health and orders state parties to assure preventive health care, including that which relates to family planning education and services.<sup>133</sup> The provision on the right to the highest attainable standard of health ordered in the CRC corresponds with the provision in the ICESCR on the right to health<sup>134</sup> and is dependent upon the realisation of the rights of children to life, education and non-discrimination, among others.<sup>135</sup>

Noting the effect of the HIV and AIDS epidemics<sup>136</sup> and the fact that state parties have been neglectful in protecting the rights of children to access reproductive health care information and services, thereby exposing them to sexual and reproductive ill health, the Committee on the CRC issued its general comments 3<sup>137</sup> and 4<sup>138</sup> in order to provide guidance that state parties can utilise in furthering efforts to guarantee the realisation of the right to health of adolescents. In its general comments on HIV and AIDS and adolescent health and development,<sup>139</sup> the committee, urging states to ensure that appropriate services and information for the

<sup>132</sup> E McGeeney & S S Blake ‘How do we assess the capacity of young people to make autonomous decisions?’ in IPPF (ed) *Understanding young people’s right to decide* (2012) 1, available at [http://www.ippf.org/sites/default/files/ippf\\_right\\_to\\_decide\\_05.pdf](http://www.ippf.org/sites/default/files/ippf_right_to_decide_05.pdf) (12 June 2013).

<sup>133</sup> Arts 24(1) & 24(2)(f) CRC.

<sup>134</sup> Art 12 ICESCR.

<sup>135</sup> Para 11 general comment 14 ICESCR Committee.

<sup>136</sup> Para 1 CRC Committee General Comment 3 *Compilations of General Comments and Recommendations adopted by human rights treaty bodies Vol. II*, available at [http://www.bayefsky.com/general/hri\\_gen\\_1\\_rev9\\_vol\\_ii.pdf](http://www.bayefsky.com/general/hri_gen_1_rev9_vol_ii.pdf) 27 October, 2012); Lansdown (n 131 above).

<sup>137</sup> General comment 3 on HIV/AIDS and the rights of the child issued at its thirty-second session in 2003.

<sup>138</sup> General comment 4 on adolescent health and development in the context of the Convention on the Rights of the Child issued at its thirty-third session (2003).

<sup>139</sup> (n 133 & 134 above).

prevention and treatment of STIs, HIV and AIDS are available and accessible to adolescents, asked for the removal of other barriers which hinder their access to SRH information.<sup>140</sup> In addition, taking into account the evolving capacities of children, states parties are encouraged to ensure that only trained providers who fully respect the rights of children to privacy are employed to render services to adolescents who require contraceptive information and services.<sup>141</sup>

Recognition of the right of female adolescents to contraceptive information and services, entails their having access to private and confidential<sup>142</sup> consultations with health providers once it has been ascertained that they are *Gillick*<sup>143</sup> competent. Also, state parties must enact laws and policies that ensure privacy and confidentiality when adolescent girls are accessing contraception and other reproductive health treatments.<sup>144</sup> However it is emphasised that the enactment of laws is not enough as states are to make sure that the provisions of the laws are implemented.<sup>145</sup> Emphasising the need for privacy in relation to adolescent health, the Committee on the CRC states:

In order to promote the health and development of adolescents, States parties are also encouraged to respect strictly their right to privacy and confidentiality, including with respect to advice and counselling on health matters (art. 16). Health care providers have an obligation to keep confidential medical information concerning adolescents, bearing in mind the basic principles of the Convention. Such information may only be disclosed with the consent of the adolescent, or in the same situations applying to the violation of an adult's confidentiality. Adolescents deemed mature enough to receive counselling without the presence of a parent or other person are entitled to privacy and may request confidential services, including treatment.<sup>146</sup>

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<sup>140</sup> Paras 24 & 26 general comment 4 CRC Committee.

<sup>141</sup> Para 17 general comment 3 CRC Committee.

<sup>142</sup> The right to privacy of children is guaranteed in art 16 CRC.

<sup>143</sup> *Gillick v. West Norfolk and Wisbech Area Health Authority and Another* (1986) 1 AC 112.

<sup>144</sup> Para 24 general comment 3 CRC Committee & para 29 general comment 4 CRC Committee.

<sup>145</sup> Concluding observation of the CRC Committee to Nicaragua 1999 CRC/C/15/Add.108, available at [http://www.unhcr.ch/tbs/doc.nsf/\(Symbol\)/a60af0697af839428025679700483778?Opendocument](http://www.unhcr.ch/tbs/doc.nsf/(Symbol)/a60af0697af839428025679700483778?Opendocument). (25 October 2012).

<sup>146</sup> Para 7 general comment No. 3 CRC Committee.

Apart from imposing strict obligations on state parties to ensure that adolescent girls are not deprived of access to reproductive health care services including those relating to contraceptive information, education and services,<sup>147</sup> article 24<sup>148</sup> creates a duty on state parties to fulfil minimum core obligations for the enjoyment of the right to health. These obligations include providing financial and physical accessibility so that female adolescents will not be barred from having access to required services due to poverty or the inconvenience in location of health facilities.<sup>149</sup> As a matter of priority irrespective of their marital status or parental consent, the right of adolescent girls to access contraceptive information and services should be assured. Additionally, information relating to the physical accessibility of reproductive health facilities should generally be made available through awareness-raising programmes in venues where adolescents can easily be reached.<sup>150</sup>

Recently, the Committee on the CRC issued its general comment 14 on the ‘best interests’ of children<sup>151</sup> and identified the principle as one of the four general principles<sup>152</sup> of the Convention that are important for interpreting and implementing children’s rights.<sup>153</sup> While the Committee emphasises that the judgement of adults on what is perceived to be in a child’s best interests should not override the obligation to respect all the rights of children under the Convention, it explains that

<sup>147</sup> According to the CRC Committee, adolescent girls and children generally can only be adequately protected from STIs and HIV/AIDs if their rights, including their right to preventive health care, sex education and family planning education and services are fully respected. See para 4 general comment 3 CRC Committee.

<sup>148</sup> Art 24 CRC.

<sup>149</sup> Paras 17 & 18 general comment 3 CRC Committee.

<sup>150</sup> Paras 22, 24 & 26 general comment 4 CRC Committee.

<sup>151</sup> General comment No. 14 on the right of the child to have his or her best interests taken as a primary consideration issued at its sixty-second session (2013).

<sup>152</sup> Other principles include the obligation of States to respect and ensure the rights of the child to non-discrimination in art 2, the right of the child to life, survival and development in art 6 and the right of the child to be heard and to express his or her views freely in ‘all matter affecting the child’ in art 12. See generally para 12 general comment 5 CRC Committee’s (2003) available at [http://www.bayefsky.com/general/hri\\_gen\\_1\\_rev9\\_vol\\_ii.pdf](http://www.bayefsky.com/general/hri_gen_1_rev9_vol_ii.pdf) (27 October 2012) & para 2 general comment 12 CRC Committee (2009) <http://www.refworld.org/docid/4ae562c52.html> (4 June 2013).

<sup>153</sup> Para 1 general comment 14 CRC Committee.

all rights guaranteed in the CRC are in the 'child's best interests' and none of the rights should be negatively construed as not being in the child's best interests.<sup>154</sup>

Underlying that the child's 'best interests' is a threefold concept, the Committee explain that in the first instance, it is a substantive right that has to be considered in all situations relating to the child. Second, it is a fundamental interpretative legal principle and in situations where a provision has more than one interpretation, the interpretation that 'most' effectively serves the child's best interests should be chosen. Finally, it is a rule of procedure that expects when taking decisions on issues relating to children, that the decision-making process must automatically include an evaluation of the possible impacts of the decision on the children concerned. In all situations before adopting decisions on children, state parties are to justify that their best interests has been taken into consideration.<sup>155</sup>

In addition, the Committee explained while not attempting to prescribe 'what is best for the child in any given situation', that its reason for developing the general comment is based upon the necessity to strengthen the understanding and application of the right of children to have their best interests assessed and taken as a primary consideration so as to promote a 'real change' in attitudes that will eventually lead to the full respect of children as rights holders.<sup>156</sup>

In order to achieve its objective, the Committee recommends that state parties are to review and amend, where necessary, domestic legislation and other sources of law so as to incorporate the 'best interests' of children principle in them and to always consider the principle when implementing policies that affect children at all levels of government.<sup>157</sup> Other recommendations include that state parties are to combat all negative perceptions which impede the full achievement of the right of the child to have her best interests assessed and taken as a primary consideration in

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<sup>154</sup> Para 4 General comment 14 CRC Committee.

<sup>155</sup> Para 6 General comment 14 CRC Committee.

<sup>156</sup> Paras 11 & 12 General comment 14 CRC Committee.

<sup>157</sup> Para 15(a) & (b) General comment 14 CRC Committee.

all instances and establish mechanisms for complaints and redress so that the ‘best interests’ principle can be appropriately integrated and consistently applied in implementation of administrative and judicial proceedings.<sup>158</sup>

Additionally, in relation to the right of the child to the enjoyment of the highest attainable standard of health guaranteed under article 24 of the CRC, the Committee in its general comment 15<sup>159</sup> specifically explained that the right to health guaranteed to children is made up of freedoms and entitlements.<sup>160</sup> According to the Committee, while the ‘entitlements’ grant to children (in this situation female adolescents) the right to access services that allow them to enjoy the highest attainable standard of health, the freedoms, which increase gradually according to the child’s evolving capacity and maturity, include the child’s freedom to control her health and make responsible SRH choices, including on whether to use contraceptives or not.<sup>161</sup>

Likewise, the Committee illuminated on the fact that health care services must not only be functional and of sufficient quantity and quality, but that the services must be physically and financially assessable.<sup>162</sup> Also, state parties are enjoined to ensure that properly trained providers are employed to provide and deliver health services to children, including preventive primary health care services.<sup>163</sup> Taking notice of the limitations which prevent access to health care services, the Committee expressly declared that barriers which affect access to health care services should be identified and eliminated while according to their evolving capacities, children (including adolescent girls) should be permitted to access confidential health care services

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<sup>158</sup> Para 15(c) & (h) General comment 14 CRC Committee.

<sup>159</sup> General comment 15 on right of the child to the enjoyment of the highest attainable standard of health issued by the CRC Committee in 2013 (CRC/C/GC/15).

<sup>160</sup> Para 24 General comment 15 CRC Committee.

<sup>161</sup> Para 24 General Comment 15 CRC Committee.

<sup>162</sup> Para 25 General Comment 15 CRC Committee.

<sup>163</sup> Paras 26 & 27 General Comment 15 CRC Committee.

without parental or legal guardian consent, where it is in their best interests to do so.<sup>164</sup>

As parties to the CRC the Nigerian and South African<sup>165</sup> governments have a duty to protect, respect and fulfil the obligations necessary to ensure that female adolescents within their jurisdictions have access to contraceptive information and services. This duty is in line with the general comments of the CRC Committee and other treaty monitoring bodies relevant to the protection and recognition of adolescent access to reproductive health care services and information. Both governments are to submit reports to the CRC Committee<sup>166</sup> on the measures that have been adopted to give effect to the rights recognised in the CRC, including progress achieved in ensuring the enjoyment of the rights by children generally.

In its concluding observation to Pakistan, the CRC Committee recommended the strengthening of efforts by the government to address various adolescent health concerns and develop policies that will allow them to access in both urban and rural areas, reproductive health education, counselling and services on family planning and HIV among other issues.<sup>167</sup> In relation to Nigeria<sup>168</sup> the CRC Committee took note of the contradictory definition of the child in the various child rights laws adopted by states in the country and urged the Nigerian government to ensure that the offending portions are amended.<sup>169</sup> Apart from advocating that the right of the child to the best attainable state of physical and mental health is constitutionally recognised,<sup>170</sup> the CRC Committee recommended the abolishment of user fees and

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<sup>164</sup> Paras 29 & 31 General Comment 15 CRC Committee.

<sup>165</sup> Nigeria adopted the CRC on 19 April 1991 while South Africa adopted it on 16 June 1995. The CRC has been domesticated with the enactment of the Child Rights Act 2003 and the Children's Act 2005 in Nigeria and South Africa respectively.

<sup>166</sup> Art 44 CRC. The CRC Committee was established in art 43 of the Children's Convention to oversee and monitor the implementation of the provisions of the Children's Convention.

<sup>167</sup> Para 55 concluding observations of the CRC Committee on Pakistan, UN Doc CRC/C/15/Add.217 (2003).

<sup>168</sup> Concluding observations of the CRC Committee on Nigeria 2010 UN Doc CRC/C/NGA/CO/3-4, available at <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G10/431/92/PDF/G1043192.pdf?OpenElement> (25 October 2012).

<sup>169</sup> As above, para 27 .

<sup>170</sup> As above, para 60(e)&(f).

the implementation of child friendly awareness programmes on the use of contraception. Also, Nigeria was urged to review its abortion laws and introduce the teaching of sex education into the curriculum of schools.<sup>171</sup>

In the concluding observations on South Africa's initial report,<sup>172</sup> the CRC Committee recommended that the South African government reinforce its adolescent health policies and ensure that adolescent without parental consent have access to youth friendly reproductive health care services where it is in the best interests of the child.<sup>173</sup> Since 1997 when the initial report was submitted, South Africa has adopted the Children's Act<sup>174</sup> and a National Youth Policy<sup>175</sup> that extensively guarantee the rights of female adolescents to access adolescent-friendly and comprehensive reproductive health care services, including those relating to contraceptive information and services. This is in addition to already guaranteed constitutional provisions contained in sections 27(1) (a) and 28 (1) (c)<sup>176</sup> which protect the right to health care services generally for children, including reproductive health.

## 2.5 Convention for the Elimination of All Forms of Discrimination Against Women (CEDAW)

The CEDAW<sup>177</sup> was adopted by the United Nations General Assembly (UNGA) to provide a legal framework to end discrimination<sup>178</sup> against women on the basis of gender in the civil, political, economic, social and cultural fields.<sup>179</sup>

<sup>171</sup> As above, para 62.

<sup>172</sup> South Africa submitted its initial report in 1997 and it was considered by the CRC Committee in 2000. However, subsequent periodic reports have not been submitted.

<sup>173</sup> Para 31 concluding observations of the CRC Committee on South Africa 2000 CRC/C/15/Add.122 [http://www.unhcr.ch/tbs/doc.nsf/\(Symbol\)/CRC.C.15.Add.122.En?Opendocument](http://www.unhcr.ch/tbs/doc.nsf/(Symbol)/CRC.C.15.Add.122.En?Opendocument) (25 October 2012). It can be stated that South Africa has tried to fulfil this obligation by virtue of the provisions on consent and confidentiality contained in the Children's Act 2005.

<sup>174</sup> Secs 13 & 134 Children's Act 2005.

<sup>175</sup> National Youth Policy 2009 – 2014 <http://www.thepresidency.gov.za/MediaLib/Downloads/Home/Publications/YouthPublications/NationalYouthPolicyPDF/NYP.pdf> (23 October 2012).

<sup>176</sup> Secs 27(1)(a) & 28 (1)(c) Constitution of the Republic of South Africa 1996.

<sup>177</sup> The CEDAW reinforces the rights of women to the human rights already recognised in the ICCPR and ICESCR from the perspective of non-discrimination.

Unlike previous human rights treaties, the CEDAW framed its objective as prohibiting every form of discrimination against women and campaigns for the right of women to be treated as equals with their male counterparts through the removal of all female stereotypes.<sup>180</sup>

Article 1 defines discrimination as:

any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.

Apart from providing for the right of women not to be the subject of discrimination in the work place<sup>181</sup> and the family,<sup>182</sup> the right of women (including adolescent girls) not to be discriminated against in the field of health is recognised.<sup>183</sup> This places a duty on state parties to adopt all ‘*appropriate measures*’ in eliminating discrimination against women when accessing health care services and contraception

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<sup>178</sup> The right to non-discrimination or the right to equality is a fundamental principle of human rights law that runs through all the international human rights treaties. The right to equality, which can be either formal or substantive, depending on the particular view adopted, means the treatment of ‘like things in a like manner’. Formal equality is based upon the assumption that all persons are equal bearers of rights within a just social order in which inequality is eliminated by conferring the same rights and entitlements to all using a ‘neutral’ norm or standard of measurement. Substantive equality agrees that while individuals are being treated similarly, note should be taken of their particular situations so as to achieve actual and true equality. See generally C Albertyn & J Kentridge ‘Introducing the right to equality in the interim constitution’ (1994) 10 *South African Journal on Human Rights* 152.

<sup>179</sup> The need for the adoption of a Women’s Convention to eliminate discrimination arose as a result of the fact that women continued to be the subjects of intense discrimination despite the existence of international instruments proclaiming the ‘equality of all persons’. See M Plattner ‘The status of women under international human rights law and the 1995 UN World Conference on Women, Beijing, China’ (1995-1996) 84 *Kentucky Law Journal* 1254; Economic Commission for Africa ‘A fifteen-year review of the implementation of the Beijing Platform for Action in Africa (BPfA) +15: from 1995–2009’ (2010) 13, available at <http://new.uneca.org/Portals/ngm/CrossArticle/1/Documents/15YearReviewofBPfA.pdf> (23 September 2012).

<sup>180</sup> R J Cook ‘International human rights and women’s reproductive health’ (1993) 24(2) *Studies in Family Planning* 73-86; A Hendrks ‘Promotion & protection of women’s right to sexual & reproductive health under international law: The economic covenant and the women’s convention’ (1995) 44 *American University Law Review* 1123.

<sup>181</sup> Art 11 CEDAW.

<sup>182</sup> Art 16 CEDAW.

<sup>183</sup> The CEDAW provides for the right to health in the form of prohibiting the discrimination of women in accessing health care services needed by them.

on a basis of equality of men and women.<sup>184</sup> The taking of all appropriate measures automatically includes guaranteeing female adolescents' access to appropriate sex and reproductive health-related information and services without discrimination.

The need to grant adolescent girls protection and access to contraceptive information/education<sup>185</sup> and services as a matter of necessity is not unrelated to the fact that the practice of unsafe sex is a factor responsible for the disability and death of women and adolescent girls in Africa.<sup>186</sup> In the words of Glasier, 'sexually transmitted diseases are infections of the young due to the reason that their sexual relations are often unplanned and, sometimes, as a result of pressure or force, before they have the experience or skills to protect themselves'.<sup>187</sup> The CEDAW Committee also affirmed this need in its General Recommendation 24, in which it states that state parties should give special attention to the health needs of the vulnerable and disadvantaged which, inevitably, includes the girl child.<sup>188</sup>

To achieve this aim, the CEDAW has mandated state parties to take necessary steps in ensuring that adolescent girls and women have access to adequate health care facilities, including information, counselling and services in family planning.<sup>189</sup> The CEDAW Committee<sup>190</sup> for its part implores states to ensure that women (and

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<sup>184</sup> Art 12 CEDAW.

<sup>185</sup> Arts 10 (h) & 16(1)(e) CEDAW.

<sup>186</sup> A Glasier *et al Sexual & reproductive health: A matter of life & death* (2006) 1, available at [http://www.who.int/reproductivehealth/publications/general/lancet\\_1.pdf](http://www.who.int/reproductivehealth/publications/general/lancet_1.pdf). ( 31 October 2012).

<sup>187</sup> Glasier (as above) 6.

<sup>188</sup> Para 6 General recommendation 24 CEDAW Committee.

<sup>189</sup> Art 14(2)(b) CEDAW.

<sup>190</sup> The CEDAW Committee is the body of experts established to monitor progress achieved by member states in eliminating discrimination against women. Also, state parties are to submit reports on measures adopted to give effect to the provisions of the Convention, including progress achieved. See art 18 CEDAW. Recently, the Optional Protocol to the Convention on the Elimination of Discrimination against Women (OP-CEDAW) which provides for the creation of a complaints and inquiry mechanism was adopted. The optional protocol was adopted by resolution A/RES/54/4 of 6 October 1999 and entered into force on December 2000. The OP-CEDAW expressly disallows the entering of reservations to the protocol upon ratification by state parties. See arts 1, 2 ,4, 8, 9, 10 & 17 OP-CEDAW.

adolescent girls) have access to health services delivered in a manner that is sensitive to their human rights and respects their dignity and need for confidentiality.<sup>191</sup>

Also, acknowledging the basis of inequality from which women and girls operate (especially those residing in rural areas) and the problems encountered in accessing needed reproductive health care services, the CEDAW recognises the use of temporary special measures by state parties to accelerate substantive equality and provides that the use of the measures shall not be regarded as discrimination if discontinued immediately 'true' equality has been achieved.<sup>192</sup> In line with the above, Ngwena and Cook<sup>193</sup> stress the need for the adoption of temporary special measures where health services indicators show unreasonable disparities among groups in accessing health care services.

In Nigeria and South Africa, a major problem affecting access to contraception is the existence of disparities in the location of health facilities providing contraceptive information and services. In a majority of cases, the facilities are concentrated in cities to the detriment of female adolescents residing in rural areas.<sup>194</sup>

Apart from the above, regressive laws and legislation which bar women and girls from accessing required services should be expunged from national legal systems as their retention act as a major obstacle denying women and girls access to SRH services. In the words of Cook *et al*,<sup>195</sup> state parties have a duty to eradicate discrimination in health by taking essential steps to ensure that women have

<sup>191</sup> Paras 22 & 31(e) General recommendation 24 CEDAW Committee.

<sup>192</sup> Art 4 CEDAW.

<sup>193</sup> C Ngwena & R J Cook 'Rights concerning health' in D Brand & C Heyns (eds) *Socio-economic rights in South Africa* (2005) 121-122.

<sup>194</sup> A Ankomah *et al* 'Barriers to contraceptive use among married young adults in Nigeria: A qualitative study' (2013) 3 *International Journal of Tropical Disease & Health* 278; National Population Commission (NPC) & ICF Macro *Nigeria Demographic and Health Survey 2008* (2009) 69 & 75, available at <http://www.measuredhs.com/pubs/pdf/SR173/SR173.pdf> (21 October 2013); Department of Health & Medical Research Council *South Africa Demographic and Health Survey* (2003) 160 & 161, available at <http://www.measuredhs.com/pubs/pdf/FR206/FR206.pdf> (3 November 2013); O Onwujekwe *et al* 'Are modern contraceptives acceptable to people and where do they source them from across Nigeria?' (2013) 13 *International Health and Human Rights* available at <http://www.biomedcentral.com/1472-698X/13/7> (23 October 2013).

<sup>195</sup> Cook *et al* 'Reproductive health and human rights' (n 54 above) 197.

adequate protection and access to health facilities on a basis of equality with men and to amend laws and policies which have discriminatory effects on women, either openly or based on the effects occasioned as a result of their implementation.

The provisions of the CEDAW on access to contraception and family planning education has been recognised as among the broadest in guaranteeing and protecting the rights of women and adolescent girls to SRH care.<sup>196</sup> The CEDAW Committee recommends that states are to recognise the right of adolescent girls to educational information as including those relating to contraception and family planning.<sup>197</sup> In its concluding recommendation on Vietnam, the CEDAW Committee advised on the provision of sexual education generally for adolescents.<sup>198</sup> Also, in *LC v Peru*, the committee, in holding Peru liable for the violation of the applicant adolescent's right to reproductive health, recommended that the state party should undertake measures to assure access to reproductive health services for women and train health providers to change their negative attitudes to adolescent women seeking SRH services.<sup>199</sup>

Furthermore, the need to interpret health related rights from the perspective of women has been emphasised by the CEDAW Committee as this will go a long way in guaranteeing women, generally, and adolescent girls, in particular, the required access to contraceptives services and information.<sup>200</sup> Interpreting health related rights from the women's perspective requires an understanding of the gender and sexual dimensions of health. In relation to the sexual dimension of health, concern should focus on the biological and reproductive health needs of women while interpreting gender issues should involve examining how social construction of

<sup>196</sup> Art 10(h) CEDAW. See also E Durojaye 'Access to contraception for adolescents in Africa' (n 52 above) 26.

<sup>197</sup> Paras 18 & 23 General recommendation 24 CEDAW Committee.

<sup>198</sup> Para 267 CEDAW concluding observations on Vietnam 2001- CEDAW/C/2001/II/Add.8, available at [http://sim.law.uu.nl/SIM/CaseLaw/uncom.nsf/fe\\_005fcb50d8277\\_cc12569d5003e4aaa/f72f034302f9cf01c1256\\_ada0032cb47?](http://sim.law.uu.nl/SIM/CaseLaw/uncom.nsf/fe_005fcb50d8277_cc12569d5003e4aaa/f72f034302f9cf01c1256_ada0032cb47?) (14 November 2012).

<sup>199</sup> *L.C v Peru* Communication No. 22/2009, UN Doc. CEDAW/C/50/D/22/2009 (25 November 2011).

<sup>200</sup> Para 12 general recommendation 24 CEDAW Committee.

identity affects women and their capacity to take reproductive health care decisions on their own.<sup>201</sup>

Nigeria<sup>202</sup> and South Africa<sup>203</sup> are both signatories to the CEDAW and have duties to ensure that women and adolescent girls within their jurisdiction enjoy adequate protection of their reproductive health through access to education, information and counselling services relating to contraception and other reproductive health issues.<sup>204</sup> Current high levels of teenage pregnancies and the feminisation of HIV and AIDS, especially among adolescents, reflect the need for increased efforts to ensure access to contraception and awareness in maintaining good SRH.<sup>205</sup>

Accomplishing the above, requires that the governments act sincerely to fulfil their obligations under the CEDAW through the adoption of proactive measures to prohibit and remove regulatory, legal and administrative barriers preventing information, educational and physical accessibility to contraception services and information. In this regard, the interpretation by the governments of the right of female adolescents to contraception from the women's or adolescent girls'<sup>206</sup> perspective will assist in ensuring that essential measures needed to guarantee access to contraceptive information and services are put in place so that female adolescents will be free to achieve their full developmental potentials.

Specifically in relation to Nigeria, the CEDAW Committee has called upon the government to increase information and introduce sexual awareness education on

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<sup>201</sup> 'Article 12' in M A Freeman *et al* *The UN Convention on the Elimination of All Forms of Discrimination Against Women: A commentary* (2011) 316.

<sup>202</sup> Nigeria ratified the CEDAW Convention on the 13<sup>th</sup> of July, 1985.

<sup>203</sup> South Africa ratified the CEDAW treaty on 15<sup>th</sup> December 1995.

<sup>204</sup> Para 23 general recommendation 24 CEDAW Committee.

<sup>205</sup> B O Nwankwo & E A Nwoke 'Risky sexual behaviours among adolescents in Owerri municipal: Predictors of unmet family health needs' (2009) 13 *African Journal on Reproductive Health* 135-145; T Kanku & R Mash 'Attitudes, perceptions and understanding amongst teenagers regarding teenage pregnancy, sexuality and contraception in Taung' (2010) 52 *South African Family Practice* 563-572.

<sup>206</sup> Durojaye advocates asking the 'female adolescent' question to challenge the gender blindness of laws and policies relating to female adolescents' access to contraception. See Durojaye '*Realising access to contraception for adolescents in Nigeria*' (n 52 above) 13.

issues relating to adolescent girls' health and make an effort to improve the availability, affordability and accessibility of contraception and other reproductive health care services, particularly at the primary level and in rural areas.<sup>207</sup> South Africa submitted a combined report in 2010. In its concluding observation on the report, the committee expressed concern about the extent of HIV epidemic, including the fact that women and girls were disproportionately affected. The necessity for the South African government to increase awareness-raising campaigns and education that will be of benefit to women (including adolescent girls) and improve access to health care services was also noted.<sup>208</sup>

It is necessary to point out that, despite being frequently ratified, CEDAW has the highest number of reservations<sup>209</sup> in the United Nations human rights system, with major reservations relating to its provisions on the nature of steps to be taken to eliminate discrimination, the supremacy of existing family law in the reserving states

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<sup>207</sup> Though there are currently various adolescent and youth health policies in existence in the country guaranteeing accessibility to contraception, adolescent girls do not have access to the services due to poor educational and informational awareness coupled with cultural and religious impediments. Apart from the above, the Committee took note of the problem being encountered in the bid to ensure that the CEDAW is domesticated in the country as part of its local legislation so as to ensure the justiciability of the rights contained therein See generally Paras 335-337 concluding observation of the CEDAW Committee on Nigeria 2008 CEDAW/C/NGA/CO/6, available at <http://www2.ohchr.org/english/bodies/cedaw/docs/co/CEDAW-C-NGA-CO-6.pdf> (28 February 2013).

<sup>208</sup> Paras 36 & 38 concluding observation of the CEDAW Committee on South Africa 2011 CEDAW/C/ZAF/CO/4, available at [http://www.iwraw-ap.org/committee/pdf/48\\_concluding\\_observations/southafrica.pdf](http://www.iwraw-ap.org/committee/pdf/48_concluding_observations/southafrica.pdf) (28 February 2013).

<sup>209</sup> As legal persons under international law, state parties have different social, economic and political systems and practices which make it difficult to achieve absolute consensus when adopting international human right instruments. Hence, the practice by dualist states of authorising their legislatures to carefully scrutinise international agreements and instrument before ratification. In order to prevent situations where human rights instruments fail enter into force as a result of the inability to get the required number of ratifications, the practice of allowing state parties to enter reservations to particular provisions of treaties to which they do not give their consent and will therefore not be bound is recognised. The Vienna Convention on the Law of Treaties, 1969, (VCLT) regulates the procedure regarding the formulation, acceptance, objections, effects and withdrawal of reservations. As a general rule, the reservation entered by a state party should not defeat the purpose and objects of the human rights instrument being acceded to. See arts 19, 20, 21, 22 and 23 VCLT. See also N Yamali *How adequate is the law governing reservations to human rights treaties?* 4-8, available at <http://www.justice.gov.tr/e-journal/pdf/LW7090.pdf> (28 September 2014).

and a refusal to submit to the jurisdiction of the International Court of Justice (ICJ) in resolving differences on the interpretation or application of the CEDAW.<sup>210</sup>

Even though the foremost reason for the adoption human rights instruments is to ensure the provision of a high standard of protection of human rights, allowing states to enter reservations to provisions in human rights treaties encourages the ratification and acceptance of the generality of obligations in a treaty even where the state is of the belief that it may experience difficulties in guaranteeing all the rights in an instrument.<sup>211</sup> In other words, the procedure of permitting state parties to enter reservations to certain provisions in ratified instruments is such that allows states to remain in technical ‘compliance’ while flouting and engaging in practices which the instrument condemns at the same time.<sup>212</sup>

CEDAW, like other human rights treaties, allows for the expression of reservations as long as the reservation does not go against the purpose and objectives of the treaty,<sup>213</sup> it is, however, felt that the grounds on which reservations in CEDAW were made are fundamental grounds that affect the access of women and adolescent girls to health care services, including contraceptive information and services,<sup>214</sup> and that,

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<sup>210</sup> Articles of CEDAW to which reservations were made are arts 2, 5, 16, 28(1), 28(2) & 29 CEDAW. African countries that entered reservations to CEDAW include Algeria, Ethiopia, Lesotho, Niger, Morocco, and so on; Viljoen (n 86 above) 120-122.

<sup>211</sup> Para 4 General comment 24 (52) Human Rights Committee.

<sup>212</sup> Yamali (n 209 above) 7; E A Baylis ‘General comment 24: Confronting the problem of reservations to human rights treaties’ (1999) 17 *Berkeley Journal of International Law* 277.

<sup>213</sup> Art 28(2) CEDAW. The provision of this article is in agreement with the provisions of article 19(c) of the VCLT which allows for the formulation of reservations except if it is incompatible with the objects and purpose of the treaty.

<sup>214</sup> A considerable number of the reservations relate the issue of the accountability of states for their obligation to eliminate discrimination against women. Not only are female adolescents and women affected by customary and religious practices which discriminate along gender lines, but they also suffer from preconceived beliefs based upon the assumption that females are not only inferior to males but are incapable of making rational and autonomous decisions. It is worthy to point out that the CEDAW Committee has not only expressed concern over the number and scope of reservations, but encouraged states parties to re-examine their reservations with the view of withdrawing or narrowing them. According to the Committee, articles 2, 9, 15 and 16 are interrelated to other Convention articles which are fundamental to the objects and purpose of the CEDAW and that state parties in their periodic reports include discussions on their reservations and the rationale for entering them. Since 2008, the Committee has pointed out that state parties in their reports are to go further by not only explaining their reservations, but ‘clarifying’ reasons for their continued maintenance. See CEDAW General Recommendation No. 4 (U.N. Doc. A/42/38); CEDAW General Recommendation No. 20 (U.N. Doc.

therefore, they need to be decisively addressed. To this end, the CEDAW Committee's recommendation that state parties are to give clarifying and cogent reasons in their state reports for the continued retention of reservations to particular treaty provisions is commendable.<sup>215</sup>

## 2.6 Conclusion

In this section, a review of the international human rights instruments at the universal level which guarantee female adolescents right to health care, from which their right to access contraceptive information and services is inferred was undertaken. In view of the interrelatedness of human rights, other rights which contribute towards realising access to contraception were also briefly discussed in order to reveal how their non-protection affects the right to access contraception by female adolescents.

Generally, state parties are to adhere to set standards in fulfilment of the human rights of individuals within their territories. A refusal or failure to comply with agreed obligations results in the member state being in violation of international law. The right to health is no exception as parties have obligation to guarantee minimum essentials<sup>216</sup> which will allow women and adolescent girls to enjoy the highest attainable standard of physical and mental health.

Regardless of the fact that Nigeria and South Africa have signed and ratified similar international human rights instruments, the effect of the ratified treaties domestically in the two countries differs. South Africa allows its courts to apply self-

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A/47/38); M A Freeman *Reservations to CEDAW: An analysis for UNICEF* (2009) 3-21, available at [http://www.unicef.org/gender/files/Reservations\\_to\\_CEDAW-an\\_Analysis\\_for\\_UNICEF.pdf](http://www.unicef.org/gender/files/Reservations_to_CEDAW-an_Analysis_for_UNICEF.pdf) (29 September 2014).

<sup>215</sup> For its part the Human Rights Committee in charge of the ICCPR has decisively settled the problems occasioned by the entering of reservations in its General comment 24(52) on Reservations (CCPR/C/21/Rev.1/Add.6). The effect of the General comment is to show that while the Covenant does not prohibit reservations, it does not mean that any kind of reservation is permitted. Accordingly, the Committee notes that reservations which offend peremptory norms such as the right against discrimination would not be compatible with the object and purpose of the Covenant. See paras 6, 8,9 and 10 General comment 24 Human Rights Committee.

<sup>216</sup> Para 12 general comment 14 ICESCR Committee.

executory human rights provisions that are approved by parliament without the need for domestication, Nigerian courts cannot as human rights treaties need to be first domesticated by the National Assembly. Despite this situation, it is submitted that the non-domestication of a human right instrument by Nigeria should not prevent the courts from relying on its principles in appropriate circumstances.

Proceeding from this section, the focus shifts to examining regional treaties which guarantee adolescent girls' access to contraceptive information and services.

### 3 Regional treaties relating to adolescents right to access to contraception

The African human rights system originated with the launch of the Organisation of African Unity<sup>217</sup> whose establishment was the product of the struggle for the decolonisation of the region and the right to independence.<sup>218</sup> Due to the principle of non-interference, sovereignty and territorial integrity however, the OAU was not effective in the protection of human rights. The consequence of the ineffectiveness of the OAU was the subsequent adoption of the African Charter on Human and Peoples Right.<sup>219</sup> In later years, the African Commission<sup>220</sup> and the African Court on

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<sup>217</sup> Hereafter referred as the OAU. The Charter which established the OAU was adopted in 1963 in Addis Ababa, Ethiopia.

<sup>218</sup> See the Preamble to the OAU Charter. B Gawanas *The African Union: Concepts and implementation mechanisms relating to human rights* available at [http://www.kas.de/upload/auslandshomepages/namibia/Human\\_Rights\\_in\\_Africa/6\\_Gawanas.pdf](http://www.kas.de/upload/auslandshomepages/namibia/Human_Rights_in_Africa/6_Gawanas.pdf) (4 October 2012).

<sup>219</sup> The African Charter which is also referred to as the Banjul charter was adopted in 1981 and currently has 53 member states. See Viljoen (n 86 above) 156; O U Umozurike 'The African Charter on Human and Peoples' Rights' (1983) 77 *American Journal of International Law* 902-912; M Mutua *The African human rights system: A critical evaluation*, available at <http://hdr.undp.org/en/reports/global/hdr2000/papers/MUTUA.pdf> (4th October 2012).

<sup>220</sup> The African Commission on Human and Peoples Rights established in 1987 became fully operational in 1989. Apart from the mandate of promoting and protecting human rights in the African region, the commission also examines the reports of states on measures that have been adopted to give effect to the rights contained in the Charter. Arts 30-32, 36, 45 & 62 African Charter.

Human and Peoples' Rights<sup>221</sup> were established to assist in the implementation of the African Charter.

To differentiate the African Charter from the international human rights instruments that were already in existence, the committee of experts, who drafted the Charter, was principally guided by the belief that the African Charter should be a reflection of the African conception of human rights law.<sup>222</sup> To this end, the Charter, endorsing civil and political rights<sup>223</sup> also recognises the protection of socio economic rights<sup>224</sup> and the rights of 'peoples'<sup>225</sup> an hitherto unknown concept in international human rights, and the duties of individuals.<sup>226</sup> In the words of Viljoen, through its act of combining three different groups of rights in a single document, the African Charter discredited the tripartite division of rights into 'generations' making all rights to be equally justiciable.<sup>227</sup>

In 2001, African Union Constitutive Act entered into force transforming the OAU into the African Union. Unlike the OAU Charter, which cursorily referred to the concept of human rights, the African Union Constitutive Act provides considerably for human

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<sup>221</sup> The Protocol on the Establishment of the African Court was adopted by the OAU in 1998 but it entered into force in January 2004. Afterwards, the AU established the African Court of Justice through a protocol adopted in 2003 and which entered into force in 2009. However before 2009, another protocol creating the African Court of Justice and Human Rights which incorporates both the African Court on Human and Peoples' Rights and the African Court of Justice had been adopted in 2008. For now, only the African Court on Human and Peoples' Rights is in operation. See generally Viljoen (n 86 above) 410.

<sup>222</sup> See Preamble to the African Charter, available at <http://www.africa-union.org/root/au/Documents/Treaties/Text/Banjul%20Charter.pdf> (5 October 2012); O Okere 'The protection of human rights in Africa and the African Charter on Human and Peoples' Rights: A comparative analysis with the European and American systems' (1984) 6 *Human Rights Quarterly* 145.

<sup>223</sup> Arts 2-14 African Charter.

<sup>224</sup> Arts 15-18 African Charter.

<sup>225</sup> Arts 19-24 African Charter. The rights of 'peoples' listed here include the equal rights of all peoples to equality without domination of a people by another, the right to existence, the right to freely dispose wealth and natural resources, the right to development etc.

<sup>226</sup> Arts 27-29 African Charter. Duties listed here include the duty of the individual to his family and the society including those related to the common interest of all in the national community.

<sup>227</sup> Some scholars are of the view that the insertion of socio-economic rights in the African Charter was purely exhortatory, others view its insertion as a response to the prevailing situation of extreme poverty and corruption and an acknowledgement that accountability through the law process was a necessary solution with the provisions placing obligations on state parties to respect, protect and fulfill them. See Viljoen (n 86 above) 214-215; Okere (n 222 above) 147-148; De Schutter (n 8 above) 740-741.

rights with the right to socio economic well-being of the people accorded prominence.<sup>228</sup>

The focus in this section is specifically to scrutinise regional human rights instruments which are relevant for the protection and access of adolescent girls' to contraceptive information and services.

### 3.1 African Charter on Human and People's Rights (ACHPR)

The major instrument for the protection of human rights in the African region, the ACHPR acknowledges the protection of rights which, as a matter of necessity, guarantees to female adolescents access to contraceptive health care information, education and services.<sup>229</sup> Article 16 specifically recognises the protection of the right to health by guaranteeing every individual 'the right to enjoy the best attainable state of physical and mental health' and urges state parties to take the necessary measures to protect the health of their people and ensure their access to medical attention.<sup>230</sup>

Unlike the ICESCR, the ACHPR contains no provision for the recognition of the concept of progressive realisation, leading to a presumption that the right to health as obtainable under the charter has immediate realisation.<sup>231</sup> In line with Kiapi's view, although the provision of health care facilities and services may result in huge financial burdens for states, it is still possible for minimum obligations which will

<sup>228</sup> See generally article 2(1)(e) OAU Charter; G J Naldi 'The African Union and the regional human rights system' in M Evans & R Murray (eds) *The African Charter on Human and Peoples' Rights: The system in practice 1986-2006* (2008) 20-21; Viljoen (n 86 above) 164-166; C Heyns & M Killander 'The African Regional Human Rights System' in FG Isa & K de Feyer (eds) *International protection of human rights: Achievements and challenges* (2006) 510; Sirte Declaration adopted by the OAU in 1999, available at [http://www.iag-agi.org/bdf/docs/sirte\\_declaration.pdf](http://www.iag-agi.org/bdf/docs/sirte_declaration.pdf) accessed (5 October 2012).

<sup>229</sup> The African Charter has been ratified by all member states of the African Union, available at <http://www.africa-union.org/root/au/Documents/Treaties/List/African%20Charter%20on%20Human%20and%20Peoples%20Rights.pdf> (5 October 2012).

<sup>230</sup> Arts 16(1) & (2) African Charter.

<sup>231</sup> Various arguments have been posited for and against the issue of immediate realization of the right to health under the African Charter. See S Kiapi 'Interpreting the right to health under the African Charter' (2005) 11(1) *East African Journal of Peace and Human Rights* 11.

assure the right to health as recognised in the Charter exist without it being at variance with other international human rights provisions.<sup>232</sup> Even though specific mention of the right to contraception is not made in article 16, it is considered that the provision of the article is expansive so as to accommodate the access by all women, including female adolescents, to contraception and other reproductive and sexual health care services, as a subset of the right to health.

Apart from the right to health, the ACHPR protects the rights to non-discrimination and equality,<sup>233</sup> life,<sup>234</sup> dignity,<sup>235</sup> the right to information<sup>236</sup> and education.<sup>237</sup> In relation to the right to equality and non-discrimination the ACHPR not only provides that individuals are entitled to equal treatment and protection but also maintains that everyone is entitled to enjoy the rights and freedoms recognised in the Charter without distinction.<sup>238</sup> Though not specifically stated, it is believed that the provision automatically includes a prohibition of discrimination on the grounds of age, a ground upon which adolescent girls are discriminated when accessing contraceptives and other SRH care services.

In *Purohit and Anor v The Gambia*,<sup>239</sup> the African Commission reiterated the importance of the right to health and its significance for the enjoyment of other human rights, especially the right not to be discriminated against held:

the enjoyment of the right to health as it is widely known is vital to all aspects of a person's life and well-being, and is crucial to the realisation of all the other fundamental human rights and freedoms. This right includes

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<sup>232</sup> Kaipi (as above) 11.

<sup>233</sup> Arts 2 & 3 African Charter.

<sup>234</sup> Art 4 African Charter.

<sup>235</sup> Art 5 African Charter.

<sup>236</sup> Art 9 African Charter.

<sup>237</sup> Art 17 African Charter.

<sup>238</sup> Distinction in relation to this refers to differences on the basis of race, ethnic group, colour, sex, language, religion, political or any other opinion, national and social origin, fortune, birth or other status.

<sup>239</sup> (2003) AHRLR 96 (ACHPR 2003).

the right to health facilities, access to goods and services to be guaranteed to all without discrimination of any kind.<sup>240</sup>

In *Constitutional Rights Project and Others v Nigeria*<sup>241</sup> the commission succinctly explained that ‘the freedom of expression is a basic human right, vital to an individual’s personal development and comprised the right to receive information and express opinions’.<sup>242</sup> It can be argued that the decision of the commission lends support to the campaign for the right of adolescent girls to receive information on contraceptive information and services irrespective of age or marital status and also their right to receive education on SRH which is essential for their personal development.<sup>243</sup>

Allowing adolescent girls access to adequate and factual information on SRH is a major means of addressing the needs of adolescents in the African region and state parties violate their duty to protect the right to information when they impose legal, ethical and administrative barriers to girls receiving contraceptive information. In agreement with Ingwersen,<sup>244</sup> allowing adolescent girls’ access to educational SRH programmes apart from assisting in effectively addressing their SRH needs, also assists them in delaying sexual activity and reducing incidences of teenage pregnancies and sexually transmitted diseases. The Maputo Plan of Action<sup>245</sup> in its guidelines calls for cooperation amongst stakeholders in the bid to reposition family planning services as an integral part necessary in the attainment of health.<sup>246</sup> The

<sup>240</sup> *Purohit and Anor v The Gambia* (as above) para 80; *Social and Economic Rights Action Centre (SERAC) and Anor v Nigeria* (2001) AHRLR 60 (ACHPR 2001) para 52; *Legal Resources Foundation v Zambia* (2001) AHRLR 84 (ACHPR 2001) para 63 & *Free Legal Assistance Group & Ors v Zaire* (2000) AHRLR 74 (ACHPR 1995).

<sup>241</sup> (2000) AHRLR 227 (ACHPR 1999)

<sup>242</sup> *Constitutional Rights Project and Others v Nigeria* (as above) para 36.

<sup>243</sup> Durojaye ‘Access to contraception for adolescents in Africa’ (n 52 above) 19.

<sup>244</sup> R Ingwersen ‘Adolescent reproductive and sexual health in the developing world’ (2001) 56 *Development Bulletin* available at <http://www.arha.org.au/papersandarticles/OP%204.pdf> (24 September 2012).

<sup>245</sup> The Maputo Plan of Action was drafted and agreed by African Union Ministers of Health in 2006 as a Continental Policy Framework on Sexual and Reproductive Health and Rights to address the reproductive health challenges faced in Africa.

<sup>246</sup> Paras 16 & 17 Maputo Plan of Action, available at [http://www.unfpa.org/africa/newdocs/maputo\\_eng.pdf](http://www.unfpa.org/africa/newdocs/maputo_eng.pdf) (29 October 2012).

need for cooperation is *sine qua non* if general access to SRH is to be achieved. As noted by Durojaye, the observance of the policies contained in the Plan of Action will guarantee access to contraception and other health-related information so that female adolescents will be able to effectively protect themselves from HIV and other sexually transmitted diseases.<sup>247</sup>

Due to the reason that Nigeria<sup>248</sup> and South Africa<sup>249</sup> are parties to the ACHPR, the necessity to submit state reports arises.<sup>250</sup> Nigeria has submitted four reports to the commission.<sup>251</sup> In the last report, the Nigerian government alluded to the passage of a National Health Bill which will promote access to affordable and qualitative health care services in the country and though not justiciable, that constitutional provisions indirectly provide for the right to health care facilities and services, especially those relating to women's reproductive health rights without any discrimination.<sup>252</sup> In its concluding observation on Nigeria's third report, the African Commission, expressing worry at the high incidence of maternal mortality, requested information on whether the National HIV and AIDS Policy provides the necessary medical care in preventing mother to child transmission of HIV.<sup>253</sup> The two issues raised by the African Commission are a focal point in relation to the health of adolescent girls who are also

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<sup>247</sup> Durojaye 'Access to contraception for adolescents in Africa' (n 52 above) 14.

<sup>248</sup> Nigeria ratified the African Charter on 22 June 1983 and has domesticated the ACHPR through the African Charter on Human and Peoples Rights (Ratification and Enforcement) Act Cap A9, LFN 2004, available at [http://www.aidh.org/Biblio/Txt\\_Afr/Images/Charte%20A%20Ratifications.pdf](http://www.aidh.org/Biblio/Txt_Afr/Images/Charte%20A%20Ratifications.pdf) (8<sup>th</sup> October, 2012).

<sup>249</sup> South Africa ratified the Charter on the 9 July 1996.

<sup>250</sup> Art 62 African Charter.

<sup>251</sup> The last report was submitted during the 50th Ordinary Session of the Commission which took place between 24th October and 5 November 2011.

<sup>252</sup> See *Nigeria's 4th Periodic Country Report:- 2008-2010 on the Implementation of the African Charter on Human and Peoples' Rights in Nigeria* 58, available at [http://www.achpr.org/files/sessions/50th/state-reports/4th-2008-2010/staterep4\\_nigeria\\_2011\\_eng.pdf](http://www.achpr.org/files/sessions/50th/state-reports/4th-2008-2010/staterep4_nigeria_2011_eng.pdf) (8th October 2012). It has not been possible to view the concluding observation of the Commission for the 4<sup>th</sup> periodic report. As stated by Viljoen, allowing access to these observations enables members of the public and civil society to monitor whether state parties have taken the required steps to effect the Commission's recommendations. Viljoen (n 86 above) 365.

<sup>253</sup> Para 24 concluding observations and Recommendations on the Third Periodic Report of the Federal Republic of Nigeria 2008, available at [http://www.achpr.org/files/sessions/44th/conc-obs/3rd-2005-2008/achpr44\\_conc\\_staterep3\\_nigeria\\_2008\\_eng.pdf](http://www.achpr.org/files/sessions/44th/conc-obs/3rd-2005-2008/achpr44_conc_staterep3_nigeria_2008_eng.pdf) (8<sup>th</sup> October 2012).

affected by the AIDS epidemic and maternal mortality.<sup>254</sup> Unfortunately, due to various controversies the health bill mentioned in the report has not been signed into law.<sup>255</sup> South Africa has submitted just two reports to the African Commission, the last submission occurring in 2005.<sup>256</sup>

### 3.2 African Charter on the Rights and Welfare of the Child (ACRWC)

Before the adoption of the ACRWC, there had been attempts aimed at protecting children's rights in the African region. Previously, the OAU had adopted the Declaration on the Rights and Welfare of the African Child<sup>257</sup> which ensured that the protection of children's rights was firmly placed in the OAU agenda. In the Declaration, state parties were asked to formulate programmes on health and

<sup>254</sup> In calculating maternal mortality rates, deaths resulting from abortion of unwanted pregnancies and teenage pregnancies are also factored in.

<sup>255</sup> The Bill has not been passed into law as a result of bureaucratic bottlenecks and in-fighting among the various stakeholders in the health sector. Points of argument include: the perceived increase of power awarded to the Health Minister, the favourable position given to doctors over other health workers, the funding of the bill, and the 'vague' drafting of section 51 of the bill, among other issues. See U Uduma *National Health Bill: Not rosy yet* available at [http://leadership.ng/nga/articles/48473/2013/02/24/national\\_health\\_bill\\_not\\_rosy\\_yet.html](http://leadership.ng/nga/articles/48473/2013/02/24/national_health_bill_not_rosy_yet.html) (26 February 2013); L Akinloye *Nigeria's National Health Bill: Delayed, disputed and desperately needed* available at <http://thinkafricapress.com/nigeria/nigerias-national-health-bill-brave-new-world> (26 September 2014).

<sup>256</sup> The report submitted in 2005 was a compilation of the 2<sup>nd</sup>, 3<sup>rd</sup> & 4<sup>th</sup> periodic report. The report was considered in December 2005, available at <http://www.achpr.org/states/reports-and-concluding-observations/?s=overdue> (8<sup>th</sup> October 2012). In the concluding observation to the 1<sup>st</sup> report, the Commission voiced its distress at the fact that South Africa submitted the report four years after it was initially prepared, thereby making most of the information and statistics outdated. It thereafter recommended that the country should take steps to present its next periodic report in conformity with Article 62 of the African Charter. Unfortunately, further periodic reports have not been presented to the Commission. Also, in line with the provisions of art 62 of the Charter, South Africa was urged to ensure that state institutions dealing with issues of lack of involvement of various state institutions involved in the promotion and protection of civil, political and socio-economic rights contribute in the drafting and preparation of the report. See Paras 18, 19 & 37 concluding observations and recommendations on the first periodic report of the Republic of South Africa 2005, available at [http://www.achpr.org/files/sessions/38th/conc-obs/1st-1999-2001/achpr38\\_conc\\_staterep1\\_southafrica\\_2005\\_eng.pdf](http://www.achpr.org/files/sessions/38th/conc-obs/1st-1999-2001/achpr38_conc_staterep1_southafrica_2005_eng.pdf) (8 October 2012).

<sup>257</sup> The Declaration was adopted by the OAU Assembly of Heads of State and Government in July, 1979 at its Sixteenth Ordinary Session in Monrovia, Liberia. Though merely a declaration and non-binding, the African Children's Declaration eventually paved way for the adoption of the ACRWC as it admitted the need for states to concentrate on the problems of children and ensure their protection through a review of legal codes and laws. See paras 1 & 2 African Children's Declaration 1979, available at <http://www.africa-union.org/root/au/Documents/Decisions/hog/pHoGAssembly1979.pdf> (12 October 2012).

education with a view to making them universally accessible to all children within a short period of time.<sup>258</sup>

The eventual adoption of the ACRWC,<sup>259</sup> which gives legal backing for the protection children's rights, was predicated, among other reasons,<sup>260</sup> on a belief that the CRC did not take cognisance of the cultural and religious peculiarities in the region because the region was marginalised and under-represented while it was being drafted<sup>261</sup> thereby giving rise to a need to adopt a treaty that will address the particular experience of children in the region.<sup>262</sup>

In addition to placing an obligation on state parties to take the necessary steps that will give effect to the provisions of the charter<sup>263</sup> the ACRWC, by adopting the child as the bearer of rights approach,<sup>264</sup> recognises the 'best interests' of the child principle as done by its international counterpart. The Charter states that in all actions concerning the child the best interests of the child shall be the primary

<sup>258</sup> Para 6(a) African Children's Declaration; G Bekker 'The African Committee of Experts on the Rights and Welfare of the Child' in M Ssenyonjo (ed) *The African Regional Human Rights System: 30 Years after the African Charter on Human and Peoples' Rights* (2012) 249.

<sup>259</sup> Adopted by the OAU in 1990 vide OAU Doc. CAB/LEG/24.9/49 (1990) but entered into operation on the 29<sup>th</sup> of November, 1999. As of today only 46 out of the 53 member states have ratified the African Children's Charter.

<sup>260</sup> Bekker (n 258 above) 250; Naldi (n 228 above) 14.

<sup>261</sup> ACRWC was adopted in 1990, the year in which the CRC became operational (Viljoen (n 86 above) 391-392). The controversies that led to the drafting and adoption of a regional instrument guaranteeing the rights of children in Africa include the conviction by experts on the protection of the right of children in Africa that the problems of children in Africa were not adequately addressed, both in the drafting stage and in the final version of the CRC. Another point relates to the argument that because only a few African countries were involved in the drafting process, issues important to the African child were not sufficiently argued. R E Adegbola 'Children's Rights in Africa: An appraisal of the African Committee of Experts on the Rights and Welfare of the Child' University of Pretoria (2007) 11-12.

<sup>262</sup> T Kaime *The African Charter on the Rights and Welfare of the Child: A socio-legal perspective* (2009) 2; E N Njungwe 'International protection of children's rights: An analysis of African attributes in the African Charter on the Rights and Welfare of the Child' (2009) 3 *Cameroon Journal on Democracy and Human Rights* 5 & 11, available at <http://www.cjdh.org/2009-06/Eric-Njungwe.pdf> (11<sup>th</sup> October 2012); A Getachew *The contribution of the African Children's Charter and its monitoring committee in the advancement of children's rights in Africa: A critical reflection* (2011) available at [http://www.academia.edu/996820/The\\_contribution\\_of\\_the\\_African\\_Childrens\\_Charter\\_and\\_its\\_monitoring](http://www.academia.edu/996820/The_contribution_of_the_African_Childrens_Charter_and_its_monitoring) (11<sup>th</sup> October 2012).

<sup>263</sup> Art 1(1) ACRWC.

<sup>264</sup> This approach involves the specific allocation of rights to every child. Getachew (n 262 above) 6-7.

consideration.<sup>265</sup> As well, the ACRWC gives a definite definition of the child, prohibits child marriages and places an obligation on state parties to allow pregnant girls to continue with their education on basis of their individual capacities.<sup>266</sup> As Viljoen states, by inserting salient provisions of particular relevance to the African region, the ACRWC succeeds in complementing the CRC with regional specifics without eroding the universality of human rights principle.<sup>267</sup>

In relation to the right of female adolescents to access contraceptive information and services, the ACRWC recognises the right to non-discrimination, education, health care services and protection from harmful cultural practices.<sup>268</sup> Article 14 recognises the right to the best attainable state of physical, mental and spiritual health and instructs state parties to take action to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care. Apart from the forgoing, the Charter implores state parties to develop preventive health care, family life education and services for children.<sup>269</sup>

The provision of Article 14(f) of the ACRWC is relieving, in the sense that it clearly highlights the need for children to have access to family life education and preventive health care and it can be interpreted to mean that state parties are to develop educational programmes that will be conveyed in an objective, critical and pluralistic manner and enable adolescent girls to have adequate knowledge on SRH issues including contraception and methods of prevention of STIs and HIV.

Also, Article 11(2)(h) makes provision for the 'direction of the education of children towards their understanding of primary health care'. This provision can be interpreted to accommodate receiving information on contraceptive services and

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<sup>265</sup> Art 4 ACRWC.

<sup>266</sup> Arts 2, 11 (6), 21(2) & 22(2) ACRWC.

<sup>267</sup> Viljoen (n 86 above) 393.

<sup>268</sup> Arts 3, 11, 14 & 21 ACRWC.

<sup>269</sup> Arts 14(1), 14(2)(b) & 14(2)(f) ACRWC.

information since the provision of family planning and contraception constitutes a part of primary health care services.

Specifically, in relation to the right of adolescent girls to receive information, though this right is not guaranteed in the Children's Charter, it is felt that being individuals, the right can still be inferred from the African Charter which includes children in the 'every individual' it provides protection for.<sup>270</sup>

For effective protection, the ACRWC also provides for the subjection of state parties to periodic review by the African Committee of Experts on the Rights and Welfare of the Child<sup>271</sup> with state parties instructed to submit to the committee, reports of the actions and progress achieved in their bid to give effect to the provisions of the Charter.<sup>272</sup>

As state parties,<sup>273</sup> the Nigerian and South African governments are included in the mandate to furnish state reports on their progress. Nigeria submitted its initial report in 2006 and in the concluding recommendations, the Committee of Experts, noting the fact that the Child Right Act was not applicable throughout the country,<sup>274</sup> maintained that the Federal Government had a major responsibility to ensure consistent implementation of the Act in all states. Apart from the above, the Committee highlighted inconsistencies and contradictions occasioned by the concurrent application of laws, policies and customary law. A situation detrimental to children and which contributes to their reproductive ill health.<sup>275</sup> Even though

<sup>270</sup> Art 9(1) African Charter. It would have been thoughtful for the drafters of the Charter to include this right specifically in the ACRWC itself. Also, the provision on non-re-election of committee members has also been criticized. See generally Viljoen (n 86 above) 395- 398; Bekker (n 258 above) 253-254.

<sup>271</sup> The Committee was formally established in July 2001 during the 37th Session of the Assembly of Heads of State and Government of the African Union in Lusaka Zambia. Arts 32, 42 & 44 ACRWC.

<sup>272</sup> Art 43 ACRWC.

<sup>273</sup> Nigeria ratified the Children's Charter on 23 July 2001 while South Africa ratified it on 7 January 2000.

<sup>274</sup> Out of 36 states, only 24 states in the country have passed Child Rights Laws. Sokoto, Kebbi, Zamfara, Katsina, Kano, Kaduna, Bauchi, Gombe, Enugu, Yobe, Borno and Adamawa states are yet to pass corresponding laws. UNICEF Nigeria –Fact sheet on Child rights legislation in Nigeria, available at [http://www.unicef.org/nigeria/Child\\_rights\\_legislation\\_in\\_Nigeria.pdf](http://www.unicef.org/nigeria/Child_rights_legislation_in_Nigeria.pdf) (23 September 2014).

<sup>275</sup> The Committee was specifically concerned about the discrepancies in the age of majority and the issue of child marriage. See paras 1 & 2 concluding recommendations by the African Committee of Experts on

South Africa ratified the Charter in 2000, it is yet to submit any report in line with its reporting obligations.<sup>276</sup>

### 3.3 The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Women Protocol)

The Women Protocol<sup>277</sup> which entered into force on November 2005 came about as a result of the appeals by various African non-governmental organisations desirous of experiencing progress in the level of protection afforded women in the African region.<sup>278</sup> Prior to this, there was a lot of controversy relating to the manner of protection and security the African Charter afforded women.<sup>279</sup> This concern was coupled with the insincerity of African governments who lacked the political will to guarantee the rights of women in their respective states.<sup>280</sup>

In addition to highlighting rights already contained in the CEDAW and the African Charter, the Women Protocol focuses on issues which hitherto had not been

the Rights and Welfare of the Child (ACERWC) on the Nigeria report on the status of implementation of the African Charter on the Rights and Welfare of the Child <http://www.african-union.org/root/ar/index/Nigeria.pdf> (15th October 2012).

<sup>276</sup> It is felt that this is a worrisome situation as the submission of state report allows a state to know areas of concern which it still needs to work on.

<sup>277</sup> Also known as the Maputo Protocol. The protocol was adopted in July 2003 by the AU Assembly of Heads of State and Government vide resolution AHG/RES.240 (XXXI), after it had been merged with the OAU Draft Convention on Harmful Traditional Practices. As of today, 36 countries out of the 54 member states of the AU have ratified the Women Protocol. See 'Women's rights in Africa: 18 countries are yet to ratify the Maputo Protocol', available at <http://www.fidh.org/en/africa/african-union/13644-women-s-rights-in-africa-18-countries-are-yet-to-ratify-the-maputo> (13 July 2013). See also Viljoen (n 86 above) 250 – 251.

<sup>278</sup> Viljoen (as above) 250.

<sup>279</sup> Apart from the reasoning that the Charter was silent on issues affecting women such as the practice of FGM and forced/child marriages; It was felt that the provisions contained in article 18(3) of the African Charter only protected women within the context of the family and even, in this instance, women where lumped together with children, thereby strengthening the belief that the Charter was in tacit support of the stereotyping of women. See Heyns & Killander (n 228 above) 865.

<sup>280</sup> Despite having signed and ratified the CEDAW, African Charter, the ICESCR and the ICCPR. Even in the preamble to the Women Protocol, state parties observed that despite the reality that the African Charter, which had been ratified by member states, provides protection for women against discrimination in line with obligations recognized in international human right treaties, women in the region continued to be victims of discrimination and harmful practices. See F Banda 'Blazing a Trail: The African Protocol on Women's Rights comes into force' (2006) 50(1) *Journal of African Law* 73; M Ssenyonjo 'Culture and the human rights of women in Africa: Between light and shadow' (2007) 51 *Journal of African Law* 45. For the Women's Protocol drafting history, see M S Nsibirwa 'A brief analysis of the draft protocol to the African Charter on Human and Peoples' Rights on the Rights of Women' (2001) 1 *African Human Rights Law Journal* 41.

addressed.<sup>281</sup> In agreement with Banda, even though the Women Protocol used the CEDAW as a model, the document that was eventually adopted by the African Union was more radical than its predecessors as it indirectly domesticated the Beijing Declaration and the ICPD Programme of Action in the African region.<sup>282</sup>

In recognising the right to health, article 14 provides that state parties should safeguard and promote the right of women (including that of adolescent girls)<sup>283</sup> to control their fertility,<sup>284</sup> choose appropriate methods of contraception,<sup>285</sup> ensure self-protection against STIs and HIV and have access to family planning education.<sup>286</sup> The Protocol also creates an obligation on the part of states to take necessary measures in providing adequate, affordable and accessible health care services including the provision of appropriate information and education to women.<sup>287</sup>

By expressly providing for a right to choose appropriate methods of contraception, the Women Protocol not only understands the particular needs of women in Africa in relation to good reproductive health but seeks to ensure their protection in this regard so that adolescent girls can achieve their full development potential. In its general comment on article 14(1)(d) and (e) of the Women Protocol,<sup>288</sup> the African

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<sup>281</sup> Such as its reference to HIV/AIDs in relation to the protection of the sexual and reproductive rights of African women.

<sup>282</sup> Banda (n 280 above) 72-73; M Wandia *Not Yet a Force for Freedom: The Protocol on the Rights of Women in Africa*, available at [http://www.pambazuka.org/en/publications/africanvoices\\_chap04.pdf](http://www.pambazuka.org/en/publications/africanvoices_chap04.pdf) (18 October 2012). In the form of criticisms, the protocol has been criticized for its drafting flaws, failure to link the rights protected with the effect that their violations have on women and adolescent girls as the bearers of rights etc. R Rebouche 'Health and reproductive rights in the Protocol to the African Charter: Competing influences and unsettling questions' (2009-2010) 16 *Washington and Lee Journal of Civil Rights and Social Justice* 81, 90, 94, 102 & 105-107; Viljoen (n 86 above) 255.

<sup>283</sup> The Women Protocol in Art 1(k) defines women as persons of the female gender, including girls.

<sup>284</sup> Art 14(1)(a) Women Protocol.

<sup>285</sup> Art 14(1) (c) Women Protocol.

<sup>286</sup> Arts 14(1)(d) & (g) Women Protocol.

<sup>287</sup> Art 14(2)(a) Women Protocol. In this article, special mention is made of women and adolescent girls residing in rural areas who are in special need of sexual and reproductive health care services. Other rights provided for in the section include the right to medical abortion and duty for states to establish and strengthen maternal health care services. See Arts 14(2)(b) & (c) Women Protocol.

<sup>288</sup> The general comment on article 14(1)(d) and (e) of the Women Protocol was adopted by the African Commission at its 52nd session in October 2012 after a working group of experts had assisted in developing necessary guidelines on the obligations of state parties in relation to women's health and

Commission interpreted that the right to self-protection and to be protected includes the right of women and adolescent girls to access relevant information, education and SRH services.<sup>289</sup> State parties are mandated to create an enabling environment that will empower women to fully and freely realise their right to self-protection and to be protected.<sup>290</sup>

Apart from the above, the Protocol protects the right to dignity of every woman.<sup>291</sup> This can be interpreted as the right of women and adolescent girls to live respected, fulfilled and dignified lives made possible by access to needed contraceptives and other SRH care services. In relation to the right to non-discrimination, the Women Protocol defines discrimination as:

any distinction, exclusion or restriction or any differential treatment based on sex and whose objectives or effects compromise or destroy the recognition, enjoyment or the exercise by women, regardless of their marital status, of human rights and fundamental freedoms in all spheres of life.<sup>292</sup>

For adolescent girls to control their fertility and choose methods of contraception there is a necessity to avoid discrimination in whatever guise. Also, the need to possess the competence to take decisions regarding their reproductive health is paramount. As suggested by Durojaye, instead of generalising the assumption that adolescent girls are not competent to take reproductive health decisions, the competence of the particular adolescent seeking contraception and other reproductive health care service should be determined on the basis of her individuality. Such a determination rests on carrying out individual examinations to

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reproductive rights and HIV with particular reference to the provisions of Art 14 (1)(d) & (e) of the Women Protocol.

<sup>289</sup> Para 11 General comment on article 14(1)(d) and (e) of the Women Protocol available at [http://www1.chr.up.ac.za/images/files/news/news\\_2013/English%20General%20comments%20booklet.PDF](http://www1.chr.up.ac.za/images/files/news/news_2013/English%20General%20comments%20booklet.PDF) (3 May 2013).

<sup>290</sup> Para 10 General comment on article 14(1)(d) and (e) of the Women Protocol.

<sup>291</sup> Art 3.

<sup>292</sup> Art 1(f) Women Protocol.

determine whether an adolescent possesses sufficient understanding and intelligence to understand the nature and relevance of service demanded.<sup>293</sup>

Despite the adoption of guidelines for reporting under the protocol,<sup>294</sup> Nigeria and South Africa have not complied with the provisions on state reporting in relation to the Women Protocol.<sup>295</sup>

### 3.4 African Youth Charter (AYC)

The African Youth Charter<sup>296</sup> adopted in 2006 provides a legal framework for governments to develop policies and programmes that support young people in asserting their rights and contribute to the continent's development.<sup>297</sup> State

<sup>293</sup> Durojaye 'Realising access to contraception for adolescents in Nigeria' (n 52 above) 41. This can be done through evaluation and questioning that will allow the medical/health officer to arrive at the conclusion of whether the girl possesses the required competence to understand the nature of the service or not. See also *Gillick's case* (n 70 above); *R (Axon) v Secretary of State for Health* (n 71 above) *Cook et al* 'Reproductive health and human rights' (n 54 above) 117.

<sup>294</sup> Guidelines for State Reporting under the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, available at [http://www.chr.up.ac.za/images/files/research/gender/documents/gender\\_expert\\_meeting\\_state\\_reporting\\_guidelines.pdf](http://www.chr.up.ac.za/images/files/research/gender/documents/gender_expert_meeting_state_reporting_guidelines.pdf) (20 October 2012).

<sup>295</sup> Nigeria & South Africa ratified the Women Protocol in December, 2004 but the protocol entered into force on 25 November 2005 thirty days after the deposit of the fifteenth instrument of ratification. Even though Nigeria submitted its 4<sup>th</sup> country report on implementation of the African Charter in 2011, the report made no mention of the Women Protocol as required by the Guidelines for State Reporting. On the other hand, the protocol came into operation after South Africa had submitted its 2<sup>nd</sup> periodic report in 2005. The country has not submitted a subsequent report since then. See the 4<sup>th</sup> Nigeria's Periodic Country Report on implementation of the African Charter available at [http://www.achpr.org/files/sessions/50th/state-reports/4th-2008-2010/staterep4\\_nigeria\\_2011\\_eng.pdf](http://www.achpr.org/files/sessions/50th/state-reports/4th-2008-2010/staterep4_nigeria_2011_eng.pdf) (20 October 2012) & L Chenwi *South Africa: State of state reporting under international human rights law* (2010) 54-55 available at <http://www.communitylawcentre.org.za/projects/childrens-rights-project/Research/Research%20Reports/South%20Africa%20-%20State%20of%20state%20reporting%20under%20international%20human%20rights%20law.pdf> (20 October 2012).

<sup>296</sup> The Youth Charter came into operation in 2009 to improve the state of affairs of youths (defines youth as people between ages 15 and 35 years) who are seriously affected by the HIV/AIDS epidemic and have restricted access to necessary health services and information. Although the age bracket extends beyond the scope of this research, adolescent girls within the ages of 15-18 are covered by the AYC. See 'African Youth Charter' (2006) 4 *Human Sciences Research Council Review*, available at [http://www.hsrb.ac.za/HSRC\\_Review\\_Article-34.phtml](http://www.hsrb.ac.za/HSRC_Review_Article-34.phtml) (23 October 2012); D Mac-Ikemenjima *Beyond Banjul: It's time to implement the African Youth Charter* available at <http://www.afri-map.org/english/images/paper/AfriMAP-AYC-MacIkemenjima-EN.pdf> (23 October 2012).

<sup>297</sup> Art 12 AYC. For implementation purposes, the provisions of the Youth Charter is to be incorporated within the framework of existing policies in a state party while keeping in mind the need to create

parties<sup>298</sup> are to recognise and take the necessary steps to give effect to the provisions of the charter<sup>299</sup> and ensure that youths have access to information and education which will enable them acquire the decision-making skills needed for their development.<sup>300</sup> Apart from the above, the AYC recognises the right of youth to non-discrimination,<sup>301</sup> the freedom to seek and receive information,<sup>302</sup> the right to education, including that directed at the acquisition of life skills on issues relating to reproductive health, HIV and AIDS and cultural practices that are harmful to the health of young girls and women.<sup>303</sup>

In relation to the right to health, the AYC<sup>304</sup> urges states to ensure that youths (adolescent girls) in rural and poor urban areas have access to available and equitable health care services.<sup>305</sup> Also, state parties are to assist youths in identifying their reproductive health needs and how to respond to them,<sup>306</sup> provide access to youth-friendly reproductive health care services including those relating to contraception,<sup>307</sup> provide education, information and awareness on STIs and HIV<sup>308</sup> and take steps to ensure that girls and young women have equal access to health care services.<sup>309</sup>

### 3.5 Conclusion

Like their international or ‘universal’ counterparts, the human rights instruments examined in this section provide for the right of adolescent girls in the African region

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specific services for people in the age group protected under the Charter. See Mac-Ikemenjima (as above).

<sup>298</sup> Nigeria ratified the AYC on April 21 2009 while South Africa ratified it on 28 May 2009.

<sup>299</sup> Art 1 AYC.

<sup>300</sup> Arts 10(3)(d) & 11(2)(i) AYC.

<sup>301</sup> Art 2 AYC.

<sup>302</sup> Art 4(2) AYC.

<sup>303</sup> Art 13(3)(f)AYC.

<sup>304</sup> Art 16 AYC.

<sup>305</sup> Art 16(2)(a)AYC.

<sup>306</sup> Art 16(2)(b)AYC.

<sup>307</sup> Art 16(2)(c)AYC.

<sup>308</sup> Art 16(2)(e) AYC.

<sup>309</sup> Art 23(h) AYC.

to access health care services including those relating to contraceptive services and information.

The provisions of the African Charter on the Rights and Welfare of the Child takes cognisance of the cultural and religious peculiarities existing in the region and gives a categorical definition of the child, unlike its international counterpart. Also, of special note is the provision of the African Women Protocol which noted that the subject of women' (and adolescent girls') sexual and reproductive autonomy is problematic in Africa and followed the lead of the Cairo and Beijing declarations by recognising the right of women and girls to reproductive health. The inclusion of specific provisions relating to the right to choose appropriate methods of contraception, have access to family planning education and ensure self-protection against STIs and HIV is illustrative of a document that recognises and seeks to curb problems that prevent access to contraception for girls in Nigeria and South Africa, as discussed in Chapter six below.

Focus in the next section shifts to other international documents that support the protection of adolescent girls' access to contraceptive information and services.

#### **4 Other international documents on female adolescents right to access contraceptive information and services**

The use of the terms 'soft' and 'hard' law to differentiate the legal effect of the United Nations instruments on state parties has gained notoriety in recent years. In most cases human rights treaties ratified and signed by member states are regarded as hard law as a result of their binding nature which gives rise naturally to the fulfilment of rights.<sup>310</sup> Soft law is used to describe international agreements and declarations that do not have any legally binding force.<sup>311</sup>

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<sup>310</sup> Hard law refers to binding and legally enforceable instruments and laws which impose commitments on state parties and other international subjects.

<sup>311</sup> Soft law usually comes in the form of declarations, resolutions or recommendations. In the UN parlance, a declaration is a 'formal and solemn instrument made on occasions when principles considered to be of special importance are being enunciated' (memo from the Legal Affairs Office, UN

Even though it is generally accepted that declarations or soft laws cannot bind parties legally, however, they have the potential of transforming into hard law as state parties might eventually not mind being bound by commitments that they would have initially rejected. Soft laws are usually good faith commitments which influence the practice of states.<sup>312</sup> In fact, it has been stated that often, hard and soft law complement each other to progressively develop international law and lead to the generation of customary international law norms.<sup>313</sup> Apart from being proof of the importance of the issues they relate to, it has now become a norm to table matters of international concern at discussions of the UN and thereafter issue declarations which are expressions of common interest and collective agreements.<sup>314</sup>

Unlike the international treaties discussed in the second section which legally bind ratifying state parties and guarantees female adolescents the right to access contraceptive information and services,<sup>315</sup> the human right declarations<sup>316</sup> to be

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Secretariat 34 UN ESCOR Supp. (No. 8) 15 UN Doc. E/CN/4/610 (1964). Although countries come together to adopt soft laws, they cannot be held accountable for refusal to fulfil agreed recommendations or violations arising from them due to their non-binding nature. Increase in the use of soft laws in international law can be partly attributed to the difficulty experienced in getting enough ratification to enable new treaties enter into force. Another reason is due to the fact that in some countries, like Nigeria, human right treaties cannot be invoked in the national courts as a result of non-domestication by the legislature thereby making them ineffective. On the other hand, the mere fact that soft laws are non-binding sometimes makes state parties more willing to compromise and fulfil agreements reached in good faith.

<sup>312</sup> A E Boyle 'Some reflections on the relationship of treaties and soft law' (1999) 48 *International and Comparative Law Quarterly* 902.

<sup>313</sup> Customary international law norms are as a rule formed gradually. Their formation is based on the repeated actions of states on a particular issue or state actions regarding similar situations which lead to such practices becoming an accepted rule of conduct. Like international treaty law, customary international law norms rests on the consent of states, ie only states that accept and practice a particular norm are bound by it. A state that persistently objects to a norm of customary international law that other states accept is not bound by that norm. See, generally, G Shaffer and M A Pollack *Hard and soft law: What have we learned?* 10-11, available at <http://ssrn.com/abstract=2044800> (25 February 2013); G I Tunkin 'Remarks on the juridical nature of customary norms of international law' (1961) 49 *California Law Review* 419; Jus Cogens Legal Definition available at <http://www.duhaime.org/LegalDictionary/J/JusCogens.aspx> (28 September 2014).

<sup>314</sup> E Okon *Diplomatic protection of human rights as practised by South Africa* and Nigeria University of Pretoria (2010) 187.

<sup>315</sup> Reference is specifically made to the ICCPR, ICESCR, CEDAW and CRC. These treaties are referred to as 'hard law' due to their strictly binding nature.

<sup>316</sup> Specifically reference is made to the ICPD Programme of Action and the Beijing Declaration.

discussed in this part though legally non-binding, affirm support for the recognition of the right of adolescent girls to reproductive health.

#### 4.1 International Conference on Population and Development (ICPD) Programme of Action

The ICPD Programme of Action is the first international declaration<sup>317</sup> that specifically focuses on the rights of women to access reproductive health care and family planning services without discrimination on the basis of age, status, or any other condition.<sup>318</sup> The conference, which took place in 1994, led to the endorsement of a new vision and strategy for addressing the link between population, development and the well-being of women by shifting focus from achieving demographic targets to meeting the reproductive health needs of women.<sup>319</sup> By moving from a need to control population numbers to the recognition of the right of women to reproductive health care, the ICPD succeeded in pinpointing, where the needs of women to access family planning and other reproductive health services are assured, that the goal of development and population stabilisation will naturally occur without the use of coercive force.<sup>320</sup>

Apart from recognising the right of women and girls to equality, dignity and development and making the protection of women's health the focus of

<sup>317</sup> 179 countries signed the ICPD Programme of Action in Cairo in 1994. See ICPD - Programme of Action - A/CONF.171/13/Rev.1.

<sup>318</sup> M Raguz 'Adolescent sexual and reproductive health in Latin America' (2001) 5 *Health and Human Rights* 49.

<sup>319</sup> Unlike previous international agreements which usually were concerned only about population size and ways to control it, the ICPD set out to ensure that women and girls had universal access to family planning and other sexual and reproductive health services. The shifting of focus on these issues was due to the recognition that maintenance of good reproductive health by women is a key component for development. See R J Cook & M Fathalla 'Advancing reproductive rights beyond Cairo and Beijing' (1996) 22 *International Family Planning Perspectives* 115; Raguz (as above) 50; UNFPA *Investing in People: National Progress in Implementing the ICPD Programme of Action 1994-2004* (2004) IX available at [http://www.unfpa.org/webdav/site/global/shared/documents/publications/2004/icpd\\_globalsurvey04.pdf](http://www.unfpa.org/webdav/site/global/shared/documents/publications/2004/icpd_globalsurvey04.pdf). (5 October 2012).

<sup>320</sup> Women and girls also naturally want to develop themselves and will make the right decisions once access to appropriate reproductive health care services and information are guaranteed. Gender stereotyping and culture are the root cause of women's low status in society. See generally principles 1-4 of the ICPD Programme of Action, 1994.

contraception and family planning programmes, the ICPD programme of action, in defining reproductive health, enunciated that the protection of reproductive health comprises of the right of women to be informed and have access to safe, effective, acceptable and affordable methods of contraception of their choice to regulate their fertility. It further includes their right to access appropriate health care services that will enable them undergo pregnancy and child birth safely.<sup>321</sup>

In relation to the right of adolescent girls to contraceptive information and services, the ICPD's objective is to comprehensively address adolescents' SRH issues and substantially reduce teenage pregnancies.<sup>322</sup> Taking note that adolescents, a critical group with SRH needs, have been totally ignored by society, the ICPD reminded governments of their obligation to promote and protect the rights of adolescents and make accessible to them requisite information, education and services on reproductive health including those related to contraception so as to create awareness of protection and the prevention of unwanted pregnancies, HIV and other sexually transmitted infections.<sup>323</sup>

Also, governments were advised on the need to involve adolescents in the designing of programmes that will assist in ensuring that their access to contraception and other reproductive health is guaranteed. The involvement of adolescents in designing the programmes allows for the effective realisation of intended goals since they will be able to identify their particular needs.<sup>324</sup>

Accentuating the need of adolescent girls to access adequate reproductive health care services, the Key Actions for the Further Implementation of the Programme of

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<sup>321</sup> Para 7.2 ICPD Programme of Action, 1994 for full definition of reproductive health, available at [http://www.unfpa.org/webdav/site/global/shared/documents/publications/2004/icpd\\_eng.pdf](http://www.unfpa.org/webdav/site/global/shared/documents/publications/2004/icpd_eng.pdf) (5 October 2012).

<sup>322</sup> Para 7.44 ICPD Programme of Action.

<sup>323</sup> Paras 7.41, 7.46 & 7.47 ICPD Programme of Action.

<sup>324</sup> Para 7.43 ICPD Programme of Action.

Action of the International Conference on Population and Development (ICPD + 5)<sup>325</sup> adopted at the review of the ICPD, apart from repeating the provisions of the ICPD, urged governments to protect adolescent girls from discrimination by curtailing the negative attitudes usually exhibited by health care providers which prevent access to contraception and other appropriate services. Also, governments were urged to promote adolescents' right to the enjoyment of the highest attainable standard of health through their access to adolescent-friendly reproductive and sexual healthcare information, services and counselling in an environment which safeguards their right to privacy, confidentiality and informed consent.<sup>326</sup>

#### 4.2 Beijing Declaration and Platform for Action

The Fourth United Nations World Conference on Women 1995<sup>327</sup> presented an opportunity for countries to reaffirm their support for the recognition of women's rights as human rights.<sup>328</sup> Apart from allowing for the recognition of the right of women to reproductive health, which had previously been recognised under the ICPD conference as an important component of the right to health, the Beijing conference went further in advancing the equality of women and men in sexual

<sup>325</sup> The ICPD +5 Key Actions document was adopted at the twenty-first special session of the United Nations General Assembly in November, 1999 via resolution A/RES/S-21/2. Recently, the UNGA instructed the UNFPA to undertake an operational review of the implementation of the International Conference on Population (ICPD) Programme of Action so as to reveal progress that has been achieved, best practices and note new challenges at both national and regional levels and how to respond to them with a view to extending the ICPD Programme of Action and the Key Actions for the Further Implementation of the Programme of Action beyond 2014, the initial target date set by the programme in 1994. See para 5 UN Resolution 65/234 of December 2010, available at <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N10/526/58/PDF/N1052658.pdf?OpenElement> (5 October 2012).

<sup>326</sup> Para 73 ICPD +5 Key Actions Document, available at <http://www.un.org/documents/ga/res/21sp/a21spr02.htm> (5 October 2012). The need for privacy and confidentiality when accessing reproductive health services had been previously stressed in para 7.45 of the ICPD Programme of Action 1994.

<sup>327</sup> The Beijing Declaration and Platform of Action - A/CONF.177/20 adopted at the 4<sup>th</sup> World Conference on Women. The Fourth World Conference on Women took place in Beijing, China between the 4–15 September 1995. Though non-binding, the Beijing Declaration, like its ICPD counterpart, aided the advancement of the right of women to reproductive health. See B Sadasivam 'The rights framework in reproductive health advocacy: A reappraisal' (1997) 8 *Hastings Women's Law Journal* 323.

<sup>328</sup> Plattner (n 179 above) 1250.

relations based on mutual respect, consent and shared responsibility.<sup>329</sup> Taking note of the fact that even though women and adolescent girls, like their male counterparts, have the right to enjoy the highest attainable standard of physical and mental health, health and well-being continue to elude them due to inequality and gender stereotyping which promote inadequacy and the inaccessibility of reproductive health services required by women alone.<sup>330</sup>

As in the ICPD Programme of Action, the Beijing Declaration supports the view that there is a need for adolescent girls to have access to quality contraceptive information and health services which respect their rights to privacy and confidentiality. Non-access to this essential service is responsible for the increase in unwanted teenage pregnancies, unsafe abortions, HIV and other STIs.<sup>331</sup>

In order to address the shortcomings responsible for the sexual and reproductive ill health of adolescent girls, governments are urged to support and implement their commitments to the ICPD Programme of Action,<sup>332</sup> promote policies which take cognisance of the views and needs of adolescent girls, including the effect which the passage of retrogressive laws has on them.<sup>333</sup> Also, the Beijing Declaration urged not only the training of health providers so as to improve their communication and interpersonal skills with a view to making them sensitive to the needs of female adolescents but also that a review of existing legislations and policies be made so as to bring them in line with international and regional standards assuring access to

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<sup>329</sup> Cook & Fathalla 'Advancing reproductive rights' (n 319 above) 115. The Beijing Declaration and Platform for Action apart from adopting the ICPD definition of reproductive health in para 94, went further stating that the right of women to have control and decide on their reproductive health includes their right to take decisions free of coercion, discrimination and violence. It also involves the observance of equal relationships between women and men in sexual relations and reproduction based upon mutual respect, consent and shared responsibility for sexual behaviour and its consequences. See para 96 Beijing Declaration and Platform for Action.

<sup>330</sup> Paras 89 & 90 Beijing Declaration and Platform for Action.

<sup>331</sup> Para 93 Beijing Declaration and Platform for Action.

<sup>332</sup> Para 106(a) Beijing Declaration and Platform for Action

<sup>333</sup> Para 105 Beijing Declaration and Platform for Action.

available, accessible, acceptable and quality family planning education, information and services.<sup>334</sup>

### 4.3 Conclusion

Earlier, the regional human rights instruments which support the recognition of adolescent girls' right to access contraceptive information and services in the African region had been analysed. The endorsement of the ICPD Programme of Action in 1994, led to a shift of focus from population control to the recognition of the fact that the protection of the rights of women and their subsequent empowerment are essential for poverty eradication and the stabilisation of population growth.

Affirming recognition of women's rights as human rights, an overview of the Cairo Programme of Action and the Beijing Platform of Action revealed particular support for the protection of the rights of girls to access safe methods of contraception to regulate their fertility and confidential information to assist them to take responsible decisions in relation to their sexuality.

Also, similar to the duties imposed under human rights instruments, the documents describe actions to be carried out by countries in fulfilment of their pledge. It is submitted due to their strong persuasive nature, despite being soft law, that the ICPD and Beijing documents can be used to 'encourage' both Nigeria and South Africa to live up to their obligation of guaranteeing access to contraceptive information and services for female adolescents.

## 5 Chapter conclusion

In this chapter, the focus has been on the various international and regional instruments that guarantee rights from which the right of female adolescents to access contraceptive information and services can be inferred. Apart from the right to health, the relevance of respecting the rights of adolescent girls to life, privacy,

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<sup>334</sup> Para 106 (b), (e) & (f) Beijing Declaration and Platform for Action.

dignity and information was noted as, in varying degrees, these rights allow for the promotion of access to contraception information and services. Respecting these rights is a necessity in the face of the obvious consequences of engaging in unprotected sexual relations.

It is noted, although the international and regional instruments discussed in the chapter assure the protection of the right to contraceptive information and services, and, Nigeria and South Africa are parties to the instruments,<sup>335</sup> this has not automatically translated to a guarantee of female adolescents' access to contraceptive information and services as several other factors, including the domestication of treaties by the legislative arm of government, the level of awareness and access to domestic courts play important roles as well.

The chapter evaluated the tension created as a result of the application of monist and dualist approaches by ratifying states which tends to make the protection afforded by human right instruments ineffective. Although South Africa is a dualist state, it allows for the direct application by South African courts of human rights treaties approved by Parliament<sup>336</sup> and mandates that cognisance of international law should be taken when interpreting its Bill of Rights.<sup>337</sup> In addition, there is a constitutional recognition of the right to health care, including reproductive health care services, thereby putting in place mechanisms that not only allow adolescent girls to have access to contraceptive information and services but also makes them have suitable recourse to the judiciary in case of violation. In Nigeria, the situation is different as the legislative arm of government has to domesticate ratified treaties<sup>338</sup> before they can be applied by domestic courts, thereby resulting in reluctance on the part of the judiciary to adjudicate on issues relating to violations.

<sup>335</sup> South Africa is not yet a party to the International Covenant on Economic Social and Cultural Rights.

<sup>336</sup> In South Africa, human right treaties are generally self-executing once they have been approved and ratified by Parliament. See sec 231(4) Constitution of the Republic of South Africa 1996; Ngolele (n 35 above) 161; J Dugard 'South Africa' in D Sloss & D Jinks (eds) *The role of domestic courts in treaty enforcement: A comparative study* (2009) 9.

<sup>337</sup> Sec 39(1)(b) SA Constitution.

<sup>338</sup> Sec 12 Nigerian Constitution 1999.

The domestication of the ACHPR in Nigeria should be an advantage as the provisions of the Charter in relation to the right to health can be used by the courts to make the government live up to its obligations. Since the ratification of human rights treaties presupposes an intention to abide by and fulfil obligations arising out of membership, it is opined that there is a need for the Nigerian legislature to act proactively, either by domesticating ratified instruments timeously so as to make them effective in the national arena or directly incorporating the protection of the right to health care in the Nigerian Constitution, as has been done in South Africa.

As rights bearers<sup>339</sup> the necessity of allowing female adolescents to have access to confidential adolescent-friendly services, information and education on contraception on a non-discriminatory basis is paramount. As pointed out by Cook *et al*,<sup>340</sup> female adolescents will not attempt to access contraceptive services if their right to privacy is not assured. In line with the above, the Nigerian and South African governments, in fulfilment of their obligations under international human rights law, need to endeavour that female adolescents' have access to private and confidential reproductive health care services in adolescent-friendly environments with qualified health personnel in attendance, as this protect their dignity.

As a matter of priority, information on the physical and economic accessibility of family planning services should be made available to adolescent girls through awareness-raising programmes in venues where they can easily be reached. In this regard, the adoption of the general comment on article 14(1)(d) and (e) of the Women Protocol by the African Commission is a welcome development, as, importantly, it sheds light on the interpretation of the provisions of the protocol through its explanation that the right to self-protection includes providing adolescent girls access to information, education and related SRH services. Also, programmes to change negative attitudes among health providers towards adolescent girls who

<sup>339</sup> Getachew (n 262 above) 6-7.

<sup>340</sup> Cook *et al* 'Respecting adolescents' confidentiality and reproductive and sexual choices' (n 65 above) 186.

attempt to access contraception should be developed so that impediments experienced in this quarter can be removed.

Additionally welcome are the general comments and recommendations of the various international human rights committees which seek to advance and ensure that state parties live up to their responsibility of guaranteeing the rights of female adolescents to SRH care rights, most especially their right to access contraceptive services and information. Assuring girls' access to this important health care service is of urgent and paramount importance, especially in the sub-Saharan African region where the devastating effects of the HIV and AIDS epidemic are currently being greatly felt.

In relation to this, the general comments by the CRC Committee on 'best interests' and right of the child to enjoy the highest attainable standard of health are appropriate, as they reiterate the importance of adopting the 'best interests' principle in all matters relating to children and also the need to recognise their freedom to control their health and make responsible SRH choices according to their evolving capacity. It is submitted that these general comments can be used to support the campaign that granting adolescent girls in Nigeria and South Africa access to full contraceptive information, education and services is in their best interests as it enables them to achieve their future socio-economic development.

In view of the inter-relatedness of all rights, it is advanced that the right to life recognised under the international and regional instruments examined in the chapter, be used in demanding protection of the right to reproductive health for female adolescents. This link is especially valuable in Nigeria where the right to health care is not assured. As Durojaye<sup>341</sup> points out, Nigerian courts can use the provisions of the section recognising the right to life to hold government accountable for the loss of life of adolescent girls that is the result of a failure to provide

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<sup>341</sup> Durojaye 'Realising access to contraception for adolescents in Nigeria' (n 52 above) 155.

affordable and adequate access to contraception and other SRH care services. Also, it is felt, although the ICPD Programme of Action and the Beijing Declaration are non-binding that focusing on their provisions by non-governmental organisations can influence the Nigerian and South African governments to establish appropriate mechanisms to respond to the special needs of adolescent girls. A subsequent domestication of the CEDAW and, most especially, the Women Protocol in Nigeria will be an added advantage as not only will it assist in the guarantee and enjoyment of the right of adolescent girls to access contraceptive information and services but also help in the realisation of the right to self-protection from STIs and HIV.

With regard to the submission of state reports, the need for both countries to take their reporting obligations seriously is noted. This practice will illuminate specific areas of deficiency in relation to the fulfilment of their obligations in respect of female adolescents' access to contraceptive information and services.

Having examined the international and regional human rights instruments guaranteeing female adolescents' right to contraceptive information and services, in the next chapter the focus will turn to an examination of the Constitutions and other national laws and policies of Nigeria and South Africa which contribute to the protection of the right of adolescent girls to access contraceptive information and services in the two jurisdictions.

## CHAPTER 3

# NATIONAL LAWS AND POLICIES ON ADOLESCENTS' REPRODUCTIVE HEALTH

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## 1 Introduction

As discussed in the previous chapter, the ratification of the relevant international and regional human rights treaties protecting the right to reproductive health is merely an initial stage in the process of ensuring social and attitudinal change in order to guarantee female adolescents access to contraceptive information and services. After ratification, state parties need to adopt legislative and other measures to give effect to the provisions of ratified instruments through domestication (as applicable in Nigeria and South Africa)<sup>1</sup> in order to make local laws compatible with the ratified treaties. Also, policies that guide the government in its developmental efforts to effectively address adolescent reproductive health needs are also adopted.<sup>2</sup>

This chapter examines briefly, the historical background of the Nigerian and South African legal systems, especially in the context of the development of children protection laws in the two countries. Also, the sources of laws and relevant national laws on reproductive health in the two jurisdictions will be noted and highlighted to discover whether legal recognition to enjoy the right to reproductive health and contraception is granted female adolescents in the nation's statute books. Where relevant, the role of domestic courts in assisting governmental efforts in guaranteeing the rights of adolescent girls will be noted.

Finally, the various health policies that have been adopted by government to assist in their developmental efforts to ensure that female adolescents have access to

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<sup>1</sup> Nigeria requires the domestication of international and regional treaties by virtue of the provisions contained in sec 12 of the Nigerian Constitution 1999. For South Africa, while domestication of human rights provisions is not necessary, the instruments must be approved by the country's parliament. See 231(4) Constitution of the Republic of South Africa, 1996. In some other jurisdictions, international treaties are automatically incorporated into the domestic legal system. Examples of monist states include francophone countries such Benin and Senegal. Also, Portuguese-speaking African countries like Mozambique and Angola are monist states.

<sup>2</sup> F Viljoen 'Application of the African Charter on Human and Peoples' Rights by domestic courts in Africa' (1999) 43 *Journal of African Law* 1; CRR 'Using legal advocacy to advance reproductive rights' in *Gaining ground: A tool for advancing reproductive rights law reform* 18, available at [http://www.k4health.org/sites/default/files/pub\\_bo\\_GG\\_advocacy.pdf](http://www.k4health.org/sites/default/files/pub_bo_GG_advocacy.pdf) (accessed 5 March 2013).

contraceptive information and services will be examined to determine if the policies have been effective or whether there is a need to increase efforts in particular areas.

## 2 NIGERIA

### 2.1 Brief historical background of the Nigerian legal system

Nigeria, the most populous country in the African continent, has a total population of over 170 million people,<sup>3</sup> with three major ethnic groups representing over 60%<sup>4</sup> of the population. Currently adolescents represent 22%<sup>5</sup> of its total population.

During the period of colonial rule, initially, the northern and southern protectorates together with the colony of Lagos were separately administered for several years. In 1914 an amalgamation of the protectorates<sup>6</sup> occurred to form the present-day Nigeria.<sup>7</sup> After becoming independent on 1 October 1960, Nigeria spent almost 30 years under military rule<sup>8</sup> with civilian regime intervening briefly in between.<sup>9</sup> Currently, Nigeria operates a federal system of government made up of the executive, legislature and judiciary with the 1999 Constitution as its highest source of law. As a result of the colonisation of Nigeria by the British, the Nigeria's legal system is largely influenced by English law.<sup>10</sup>

Durojaye and Iguh explain that because the British was more concerned with maintaining a strong hold over the territories, the protection of the welfare of Nigerian children and adolescents was not a major cause of concern as such matters

<sup>3</sup> Nigeria Demographics Profile 2012, available at [http://www.indexmundi.com/nigeria/demographics\\_profile.html](http://www.indexmundi.com/nigeria/demographics_profile.html) (accessed 6 March 2013).

<sup>4</sup> The three major ethnic groups consists of the Yoruba 21%, Hausa and Fulani 29% and Igbo 18%. See Nigeria Demographics Profile 2012 (as above).

<sup>5</sup> Unicef 'At a glance: Nigeria statistics', available at [http://www.unicef.org/infobycountry/nigeria\\_statistics.html#91](http://www.unicef.org/infobycountry/nigeria_statistics.html#91)(6 March 2013).

<sup>6</sup> Before this period in 1906, the Lagos colony and the southern protectorate had been merged together.

<sup>7</sup> For a comprehensive history of Nigeria, see T Falola *The history of Nigeria* (1999), especially chaps 2, 3 & 4.

<sup>8</sup> Falola (as above) 5.

<sup>9</sup> The first republic (1960-1965) and the second republic (1979-1983). The third republic began in 1999.

<sup>10</sup> E Durojaye 'Realising access to contraception for adolescents in Nigeria: A human right analysis' University of Free State (2010) 111.

were deemed virtually inconsequential.<sup>11</sup> The only major piece of legislation enacted during the colonial period was the Children and Young Persons Ordinance of 1943,<sup>12</sup> which was modelled on the English Children and Young Persons Act (CYPA) of 1933 to deal with issues pertaining to the juvenile justice system. Central to the system was the idea that rehabilitation was the only effective strategy that could be used to address the problems of juvenile delinquents and children in need of care.<sup>13</sup>

Numerous constitutions<sup>14</sup> regulated the affairs of the Nigerian state during the colonial era. However, none of the constitutions contained a bill of rights guaranteeing its citizen's rights - whether children or adults. The position on the insertion of a bill of rights to guarantee the human rights of citizens in the constitution changed with the adoption of the 1960 Independence Constitution,<sup>15</sup> which made provision for the recognition of the fundamental human rights of Nigerian citizens in chapter three.<sup>16</sup> According to Durojaye, apart from the rights to life, dignity, liberty, privacy and information<sup>17</sup> protected under the 1960 Constitution, there were no provisions for the special protection and guarantee of children's and

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<sup>11</sup> Durojaye (as above) 111; N A Iguh *An examination of the child rights protection and corporal punishment in Nigeria* (2011) 99, available at [www.ajol.info/index.php/naujilj/article/download/82391/72546](http://www.ajol.info/index.php/naujilj/article/download/82391/72546) (7 March 2013).

<sup>12</sup> The Children and Young Persons Ordinance 1943 was subsequently variously amended by the Children and Young Persons Ordinance 44 of 1945, 27 of 1947, 16 of 1950. It was changed to the Children and Young Persons Act Cap 32, Laws of the Federation of Nigeria and Lagos, 1958. As a national legislation, the Children and Young Persons Act was extended to the Eastern and Western Regions in 1946 by Order in Council, No. 22 of 1946 while in 1958, it was enacted in the Northern Region as the Children and Young Persons' Law (CYPL) Cap 21 of the Laws of Northern Nigeria 1963. See Iguh (as above) 101.

<sup>13</sup> L Fourchard 'The Limits of Penal Reform: Punishing children and young offenders in South Africa and Nigeria (1930s to 1960)' (2011) 37 *Journal of Southern African Studies* 517.

<sup>14</sup> After the 1914 constitution, subsequent constitutions were enacted in 1922, 1946 (the Richards Constitution, 1951 (the Macpherson constitution), and 1954 (the Lyttelton Constitution). The 1946 Richards Constitution divided the country into three regions (north, east and west); the 1951 Macpherson Constitution devolved granted the 3 regions autonomy through the creation of regional Houses of Assembly while the 1954 Lyttelton Constitution officially transformed Nigeria into a federal state. See C Mwalimu *The Nigerian Legal System* (2007) 20.

<sup>15</sup> The introduction of a bill of rights into the 1960 Constitution was based upon the recommendations of the Willink Commission of Inquiry into minority fears.

<sup>16</sup> See Nigerian Independence Constitution 1960, available at [http://www.waado.org/nigerdelta/ConstitutionalMatters/1960\\_constitution/1960\\_constitution.html](http://www.waado.org/nigerdelta/ConstitutionalMatters/1960_constitution/1960_constitution.html) (7 March 2013).

<sup>17</sup> Sections 17, 18, 20, 22 & 24 of the 1960 Nigerian Independence Constitution.

adolescents' rights.<sup>18</sup> The example laid down in the independence Constitution has been repeatedly followed by subsequent Nigerian constitutions.<sup>19</sup>

As a result of the fusing together of numerous ethnic groups and the introduction of the English system of governance during the colonial period, currently, the Nigerian legal system is not only multifaceted, but is also a reflection of a variety of jurisdictions and different systems of law.<sup>20</sup> As of today, the major sources of Nigerian law are national legislation,<sup>21</sup> the received English law (made up of common law, doctrines of equity and statutes of general application in force in England up to 1900), customary law (including Islamic law), and judicial precedent.

## 2.2. Nigerian Constitution, 1999

The 1999 Nigerian Constitution promulgated by the Military government<sup>22</sup> became operative on 29 May 1999 when a democratic regime was instituted after several years of Military rule.<sup>23</sup> Like previous constitutions, the 1999 Constitution is made up of eight chapters which sets out the necessary political, legal and social structures essential for the smooth governance of the Nigerian state. Section 1(1)<sup>24</sup> declares the supremacy of the Constitution over all other laws and provides that its provisions are binding on all authorities and persons throughout the Federal Republic of Nigeria.<sup>25</sup> Chapter two of the Constitution makes provision for the fundamental

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<sup>18</sup> Durojaye 'Realising access to contraception for adolescents in Nigeria' (n 10 above) 113.

<sup>19</sup> See the 1963, 1979 and 1999 Nigerian Constitutions.

<sup>20</sup> Mwalimu (n 14 above) 18.

<sup>21</sup> The Nigerian Constitution is an important part of Nigerian legislations which make up the Nigerian legal system.

<sup>22</sup> The Nigerian Constitution was passed via Decree No. 24 1999. The Constitution is contained in Cap 24 LFN 2004, available at <http://www.nigeria-law.org/ConstitutionOfTheFederalRepublicOfNigeria.html> (5 March 2013).

<sup>23</sup> Previously Nigeria had operated three democratic regimes which were truncated by the military in 1966, 1983 and 1993. The 1993 3<sup>rd</sup> republic did not fully take off as the election to usher in the democratic government was annulled.

<sup>24</sup> Sec 1(1) Nigerian Constitution 1999.

<sup>25</sup> In situations where the provisions of the constitution clash with those of other laws, such other law would be automatically void to the extent of its inconsistency. See sec 1(3) Nigerian Constitution 1999.

objectives and directive principles of state policy;<sup>26</sup> chapter four provides for the recognition and protection of the fundamental human rights of its citizens.<sup>27</sup>

In relation to the recognition and protection of the rights of female adolescents to contraceptive information and services, the 1999 Nigerian Constitution recognises the right to life,<sup>28</sup> dignity,<sup>29</sup> privacy,<sup>30</sup> non-discrimination<sup>31</sup> and the right to freedom of expression and information.<sup>32</sup>

However, it is worth noting that, although the Constitution provides for the above rights from which the right of adolescent girls to contraception can be inferred, it does not contain any specific provision granting recognition of the protection of the right to health, nor does it guarantee the right to reproductive health, which is of paramount importance to Nigerian women and girls. As pointed out above, Nigerian women and girls specifically require a guarantee of their right to SRH so that they can achieve their social and developmental potential on one hand, and also be protected on the other, as they are often victimised in society – specifically by men. According to Aniekwu, the Nigerian Constitution actively protects international human rights, but it is “*passive*” on the protection of gender-specific human rights obligations.<sup>33</sup>

In the Constitution, health is mentioned only under the fundamental objectives and directive principles of state policy provided for in chapter 2.<sup>34</sup> Section 17(3)(d) provides that the government of Nigeria ‘shall direct its policy towards

<sup>26</sup> Secs 13-24 Nigerian Constitution 1999. Recognition of the fundamental objectives and directive principles refers to the identification of the ultimate goals/ideals of the Nigerian nation including recognition of the policies and steps which the government has to take to achieve the goals. See B O Okere ‘Fundamental objectives and directive principles of state policy under the Nigerian Constitution’ (1983)<sup>32</sup> *International & Comparative Law Quarterly* 214.

<sup>27</sup> Secs 33-46 Nigerian Constitution 1999.

<sup>28</sup> Sec 33 Nigerian Constitution 1999.

<sup>29</sup> Sec 34 Nigerian Constitution 1999.

<sup>30</sup> Sec 37 Nigerian Constitution 1999.

<sup>31</sup> Sec 42 Nigerian Constitution 1999.

<sup>32</sup> Sec 39 Nigerian Constitution 1999.

<sup>33</sup> N I Aniekwu *Engendering sexuality: Human rights issues in reproductive and sexual health* (2006) 41, available at <http://www.arsrc.org/downloads/features/aniekwu.pdf> (4 March 2013).

<sup>34</sup> Sec 17(3)(d) Nigerian Constitution 1999.

ensuring that there are adequate medical and health facilities for all persons'. The contents of the above provision, however, are not helpful, as the provisions of section 6(6)(c) of the same constitution purportedly ousts the jurisdiction of domestic courts from adjudicating on matters relating to the non-performance by government of its obligations under chapter 2, making the provisions merely declaratory.<sup>35</sup>

As noted by Okeke and Okeke,<sup>36</sup> it is unlikely that the provisions contained in chapter 2 of the Constitution were intended to make all the organs of government assume responsibility since the jurisdiction of the major organ (the judiciary), that should naturally assist in ensuring compliance and effectiveness, has been ousted as a result of the non-justiciability clause.<sup>37</sup>

Irrespective of the above, it is opined that neither the failure to provide a constitutional guarantee for the protection of the right to health nor the making of the provisions of section 17(3)(d) non-justiciable, discharges the Nigerian government from its international and regional obligation to ensure that adolescent girls are guaranteed access to contraceptive information and services. This view is based on several grounds:

To begin with, despite the fact that the International Covenant for Economic, Social and Cultural Rights (ICESCR),<sup>38</sup> the principal human rights instrument that assures the protection of the right to health,<sup>39</sup> does not have legal force in Nigeria,<sup>40</sup> the African

<sup>35</sup> *AG Ondo v A G Federation* (2002) 9 NWLR (Pt 772) 272. The rights contained in chapter two require affirmative action from the government for their enjoyment.

<sup>36</sup> G N Okeke & C Okeke 'The justiciability of the non-justiciable constitutional policy of governance in Nigeria' (2013) 7(6) *IOSR Journal of Humanities and Social Science* 9, available at <http://www.iosrjournals.org/iosr-jhss/papers/Vol7-issue6/B0760914.pdf> (7 March 2013).

<sup>37</sup> Sec 6(6)(c) Nigerian Constitution 1999.

<sup>38</sup> Adopted by resolution 2200A (XXI) of 16 December 1966, available at <http://www2.ohchr.org/english/law/pdf/cescr.pdf> (20 September 2012). Nigeria ratified the ICESCR in July 1993.

<sup>39</sup> Art 12 ICESCR.

<sup>40</sup> The steps to be undertaken for domestication and application of treaties locally are provided in the constitution. See sec 12 Nigerian Constitution 1999.

Charter on Human and Peoples' Right,<sup>41</sup> particularly article 16 which also guarantees the right to health, has been domesticated as a national legislation.<sup>42</sup> As a result it is possible for Nigerian courts to rely on its provisions to ensure that the government meets its obligation to respect, protect and fulfil the right of female adolescents to reproductive health.

Also, even though the objectives and principles on health, like other contents of chapter two of the Constitution have been declared unenforceable by virtue of section 6(6)(c), it is believed that going by the provisions of section 13 of the Constitution, which expressly declares that 'it shall be the duty and responsibility of all organs of government to conform, observe and apply the provisions contained in the fundamental objectives and directive principles',<sup>43</sup> the requisite organs of government have a responsibility to act in good faith in performing their duties in order for the ideals expressed in Chapter 2 of the Constitution to be achieved.

Going by the court's interpretation in *Nwankwo v Yar Adua*<sup>44</sup> that the word 'shall' imports a command or mandate that must be done,<sup>45</sup> it may be argued that the mere fact that there are in existence various health policies<sup>46</sup> relating to the right to access health care, including contraceptive information and services, creates a duty for the government to ensure that the contents of the policies become achievable, thereby

<sup>41</sup> Adopted in 1981 vide OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982) and entered into force in October, 1986 <http://www1.umn.edu/humanrts/instreet/z1afchar.htm> (20 September 2012). Nigeria ratified the African Charter in 22 June 1983.

<sup>42</sup> Nigeria domesticated the contents of the ACHPR through the African Charter on Human and Peoples, Rights (Ratification and Enforcement) Act Cap A9, LFN 2004. The power to domesticate international treaties is also preserved in sec 315 of the Nigerian Constitution 1999. In *Abacha v Fawehinmi* (2000) 6 NWLR (Pt 660) 228, the Supreme Court explained that the provisions contained in the African Charter on Human and Peoples' Rights Act are: provisions in a class of their own, protected by International law and cannot be overridden by other municipal laws.

<sup>43</sup> Sec 13 Nigerian Constitution 1999.

<sup>44</sup> (2013) 13 NWLR (Pt 1263) 81 CA.

<sup>45</sup> See also *Enwezor v INEC* (2009) 8NWLR (Pt 1143) 223 CA; *Ngige v. Obi* (2006) 14 NWLR (Pt 991) 1.

<sup>46</sup> Examples of policies in existence in Nigeria relating to health care services include the National Health Policy 2004, National Reproductive Health Policy 2001, National Youth Policy 2007 and the National Youth Policy, among others.

realising its obligation to respect, protect and fulfil the right of adolescent girls to access contraceptives.<sup>47</sup>

Instead of Nigerian courts standing back and declaring that they cannot enforce any of the contents of Chapter 2 due to the provisions of section 6(6)(c) of the Constitution, they should act proactively and use every opportunity to give 'judicial support' by dissecting and analysing Nigerian laws which relate to the right to health or have an impact on it in order to declare government actions or inactions incompatible with the right to health where applicable.<sup>48</sup> It is submitted that courts should take judicial notice of international and regional human rights instruments brought to the courts' attention, as well as enforce provisions contained in the African Charter, which is domestic law.

Although the right to health - a socio-economic right - is a non-justiciable right in the 1999 Constitution, thereby making it challenging to force the government<sup>49</sup> to perform its obligation to protect female adolescents' right to contraceptive information and services, the rights to life, dignity, privacy, information and non-discrimination already granted recognition<sup>50</sup> are good grounds by which the aim of ensuring protection for the SRH of adolescent girls can be achieved.

On the protection of the right to life, section 33(1) of the 1999 Constitution provides:

Every person has a right to life, and no one shall be deprived intentionally of his life, save in execution of the sentence of a court in respect of a criminal offence of which he has been found guilty in Nigeria.

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<sup>47</sup> It is necessary to point out that to back up the provisions of sec 13, item 60(a) of the exclusive legislative list in the 2<sup>nd</sup> Schedule to the Constitution allows the Federal government to establish and regulate authorities vested with the duty of promoting and enforcing observance of the contents of chapter two of the Constitution. It should be noted that if the National Health Bill is eventually enacted as a national law, the ability to enforce protection of the right to health will become easier.

<sup>48</sup> *AG Ondo v A G Federation* (2002) 9 NWLR (Pt 772) 222 at 272; (2002) 6 S.C (Pt 1) 1.

<sup>49</sup> According to the Supreme Court in *AG Ondo v A G Federation*, the contents of the Fundamental Objectives and Directive Principles remain merely declaratory and cannot be enforced by legal process, they can only become justiciable by means of legislation. See *AG Ondo v A G Federation* (2002) 9 NWLR (Pt 772) 222 at 272 & 276.

<sup>50</sup> Secs 33, 34, 37 and 39 Nigerian Constitution 1999.

This provision, at face value, seems only a limited guarantee of the protection of the right to life of people accused of committing criminal acts. However, it has been determined that the protection of the right to life applies in all circumstances. The Indian courts have successfully used the constitutional provision contained in article 21<sup>51</sup> of the Constitution on the protection of the right to life to canvas for the protection of the rights to food,<sup>52</sup> education,<sup>53</sup> and even health.<sup>54</sup> As Durojaye observes, regardless of the fact that section 33 of the Nigerian Constitution 1999 is framed negatively, it can be invoked by the Nigerian courts (in the same way as their counterparts in India)<sup>55</sup> to hold the Nigerian government responsible for the unnecessary loss of lives of female adolescents<sup>56</sup> that occur as a result of their lack of access to either contraceptive services or to information which would have enabled them know where to access the services.

The traditional understanding of the right to life contained in the Nigerian Constitution does not contemplate violations of the right to health and life which are occasioned as a result of either the action or inaction of the state and its officials to provide adolescent girls access to contraceptive information and services. As noted by Umukoro,<sup>57</sup> a strict interpretation of the right to life which does not contemplate violations that are not the result of force will make the realisation of the objective behind section 33 impossible and, therefore, unachieved. This position was also confirmed by Uwaifo JCA in *Nemi v AG Lagos State*.<sup>58</sup> The learned Justice explained, in order to meaningfully guarantee the rights recognised in Chapter four of the

<sup>51</sup> Art 21 Indian Constitution 1949.

<sup>52</sup> *People's Union for Civil Liberties (PUCL) v Union of India and Others* Writ Petition (Civil) No. 196/2001, (S.C. 2001).

<sup>53</sup> *Mohini Jain v Union of India* (1992) 3 SCC 666; *JP Unnikrishnan v State of Andhra Pradesh* (1993) SCC (1) 645.

<sup>54</sup> *Parmanand Katara v Union Of India & Others* (1989) AIR 2039, (1989) SCR (3) 997; *Paschim Banga Khet Mazdoorsamity v State Of West Bengal & Another* (1996) SCC (4) 37.

<sup>55</sup> As above.

<sup>56</sup> Durojaye 'Realising access to contraception for adolescents in Nigeria' (n 10 above) 155.

<sup>57</sup> B E Umukoro 'Gas flaring, environmental corporate responsibility and the right to a healthy environment: The case study of the Niger-Delta' in F Emiri & G Deinduomo (eds) *Law and the petroleum industry in Nigeria: Current Challenges* (2009) 56.

<sup>58</sup> Uwaifo JCA in *Nemi v AG Lagos State* (1996) 6 NWLR (pt 452) 42.

Constitution, it is not enough that Nigeria has ratified the African Charter on Human and Peoples' Rights and other international human rights instruments. Instead, there is a necessity to ensure that every possible violation relating to the rights are meaningfully addressed as soon as possible.<sup>59</sup>

The argument that a broad interpretation of the rights recognised in the Constitution should be adopted when adjudicating on matters relating to violation of rights was supported in the case of *C.P.C v Nyako*<sup>60</sup> where the Supreme Court explained:

Where a matter touches constitutional interpretation of the legal right of applicants, a broad interpretation which entails a liberal approach or global view should be employed.<sup>61</sup>

Interpreting the provisions of section 33 broadly would consequently mean that the Nigerian state has the duty of ensuring that its citizens have access to health facilities that will not only ensure the preservation of life but also prevent death. Thus, in *Gbemre v Shell Petroleum Development Company and Others*,<sup>62</sup> a Nigerian court indicated that by endangering the health of citizens in Iwherekan community of Delta State, the government was in violation of not only the right to life protected under section 33 of the Constitution but also of the right to health recognised under article 16 of the African Charter. Considering that inaccessibility to contraceptive information and services results in greater negative consequences for female adolescents than for their male counter-parts, the courts are enjoined to note and reflect on this factor in actions relating to the violation of the right to life as a result of non-access to reproductive health care.<sup>63</sup>

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<sup>59</sup> (as above) 58.

<sup>60</sup> (2011) 17NWLR ( Pt 1277) 458.

<sup>61</sup> See also *Rabiu v State* (1980) 2NCLR 293.

<sup>62</sup> (2005) Suit No. FHC/B/CS/53/05 (unreported) available at <http://www.chr.up.ac.za/index.php/browse-by-subject/418-nigeria-gbemre-v-shell-petroleum-development-company-nigeria-limited-and-others-2005-ahrlr-151-nghc-2005.html> (7 March, 2013). See also *Georgina Ahamefule v Imperial Medical Center & Alex Molokwu* (unreported) Suit NO. ID/1627/2000 – where it was held that denial of treatment was a violation of the provisions of article 16 of the African Charter, available at [www.scribd.com/doc/126185950/Georgiana-Ahamefule-vs-Imperial-Medical-Centre-Dr-Alex-Molokwu-ID-1627-2000-Judgement](http://www.scribd.com/doc/126185950/Georgiana-Ahamefule-vs-Imperial-Medical-Centre-Dr-Alex-Molokwu-ID-1627-2000-Judgement) (8 March 2013).

<sup>63</sup> Durojaye 'Realising access to contraception for adolescents in Nigeria' (n 10 above) 158.

On the right to dignity, section 34(1) (a), in providing for the protection of the right to dignity, prohibits the subjection of individuals to inhuman or degrading treatment. The content of this constitutional provision can be used in campaigns favouring the access of adolescent girls to contraceptive information and services. As already advanced, access to contraceptives and information on its proper use by adolescent girls prevents the transmission of STIs and the occurrence of teenage pregnancies.

The Nigerian government, in safeguarding the SRH of female adolescents in line with the constitutional provision of section 34(1)(a), has a duty to ensure that the girls have the requisite access to contraceptive services and information and that these services, counselling and information are provided in adolescent-friendly facilities. Such facilities should be staffed by qualified health professionals who will treat adolescent girls who come to access the services in a dignified manner so that they feel comfortable, and are willing to access follow-up services.

Section 37 of the Nigerian Constitution 1999 provides:

‘The privacy of citizens, their homes, correspondence, telephone conversations and telegraphic communications is hereby protected and guaranteed’.<sup>64</sup>

The right to privacy imposes on the government the right to respect the privacy of its citizens. This obligation includes the right to protect the privacy of information and respect the confidentiality to all persons. By guaranteeing every one (adolescent girls inclusive) the right to privacy in section 37, the 1999 Nigerian Constitution provides ample grounds upon which the right of female adolescents to privately access confidential contraceptive services can be inferred. As noted in the preceding chapter, guaranteeing female adolescents in Nigeria access to contraception in private and confidential environments assists in the maintenance of good reproductive health. Adolescents, generally, will only access such intimate services where their privacy is assured.<sup>65</sup> In line with the decisions in *Gillick v West Norfolk*

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<sup>64</sup> The marginal note of the section reads the right to private and family life.

<sup>65</sup> R J Cook *et al* ‘Respecting adolescents’ confidentiality and reproductive and sexual choices’ (2007) 98 *International Journal of Gynaecology and Obstetrics* 183; R J Cook and BM Dickens ‘Recognizing

and *Wisbech Area Health Authority and Another*<sup>66</sup> and also *R (Axon) v Secretary of State for Health*,<sup>67</sup> once it has been confirmed that the female adolescent has the competence to understand the nature of service she has requested by responding to questions in an intelligent manner and she cannot be convinced to inform her parents, it will be in her best interests for the health provider to avail her of the requested service without discrimination since adolescents will engage in sexual relations with or without adequate protection.<sup>68</sup>

Currently, as a result of the high rate in which adolescents engage in sexual activity,<sup>69</sup> it is unrealistic to insist on African belief that female adolescents are either too young to know about sex or that they require parental consent before having access to contraceptives.<sup>70</sup> Like the CRC Committee stated in its general comment on adolescent health and development in the context of the CRC,<sup>71</sup> the Nigerian government has an obligation to guarantee the access of adolescent girls to contraception and to respect their rights to privacy and counselling when accessing health care services generally, and reproductive health care services in particular. In addition, there is a need for the government to caution its agents on their obligation

adolescents' 'evolving capacities' to exercise choice in reproductive healthcare' (2000) 70 *International Journal of Gynaecology & Obstetrics* 17; S Jejeebhoy *Sexual and reproductive health of young people: Expanding the research and program agenda* (2006) 5, available at [http://hivaidsclearinghouse.unesco.org/search/resources/bie\\_pop\\_rev\\_jejeebhoy.pdf](http://hivaidsclearinghouse.unesco.org/search/resources/bie_pop_rev_jejeebhoy.pdf) ( 15 September 2013).

<sup>66</sup> *Gillick v West Norfolk and Wisbech Area Health Authority and Another* [1985] 3 All ER 402, available at [http://www.hrcr.org/safrica/childrens\\_rights/Gillick\\_WestNorfolk.htm](http://www.hrcr.org/safrica/childrens_rights/Gillick_WestNorfolk.htm) (20 October 2012).

<sup>67</sup> *R (Axon) v Secretary of State for Health* [2006] EWHC 37 (Admin) para 62, available at <http://www.bailii.org/ew/cases/EWHC/Admin/2006/37.html> (25 October 2012).

<sup>68</sup> *Gillick's case* (n 66 above) 413.

<sup>69</sup> In this instance, whether the girls initially engaged in sexual activity voluntarily or they were coerced into doing so by their peers, it is important to ensure that their autonomy and right to privacy in accessing contraceptive information and services is guaranteed so as to avoid disastrous consequences. See A O Arowojolu *et al* 'Sexuality, contraceptive choice and AIDS awareness among Nigerian undergraduates' (2002) 6 *African Journal of Reproductive Health* 60-70.

<sup>70</sup> A S Erulkar *et al* 'What is youth-friendly? Adolescents' preferences for reproductive health services in Kenya and Zimbabwe' (2005) 9 *African Journal of Reproductive Health* 52; K Wood *et al* 'Blood Blockages and Scolding Nurses: Barriers to Adolescent Contraceptive Use in South Africa' (2006) 14 *Reproductive Health Matters* 109-118.

<sup>71</sup> Para 7 general comment 4 CRC Committee *Compilations of General Comments and Recommendations Adopted by Human rights Treaty Bodies, Vol. II*, available at [http://www.bayefsky.com/general/hri\\_gen\\_1\\_rev9\\_vol\\_ii.pdf](http://www.bayefsky.com/general/hri_gen_1_rev9_vol_ii.pdf) (27 October 2012).

to keep medical information concerning adolescents confidential, except in situations where it is not in the adolescent's best interests to do so.

The right to information is one of the most important rights necessary for the advancement of female adolescents' reproductive health especially in relation to access to contraceptives.<sup>72</sup> Constitutionally, the right of female adolescents to information is recognised under section 39(1) which protects the right to freedom of expression and information.<sup>73</sup> In the past, the right to freedom of expression and information related only to the freedom to seek and receive information on ideas without government interference. Today, however, the right has evolved to create and impose concrete and immediate obligations on state parties to provide access and refrain from interfering with information that is crucial for the promotion and protection of the reproductive health choices of adolescent girls.<sup>74</sup>

It should be noted that the motive for advocating the access of adolescent girls to essential information is based upon the certainty that the possession of factual education and information on their sexuality will cause female adolescents not only to appreciate the reason to exercise caution and delay sex until they are mature, but also will enable them exercise their right to sexual and reproductive autonomy by taking precautions if they already engage in sex. Apart from the above, granting female adolescents in Nigeria access to available, acceptable and quality information and education on their SRH without bias or discrimination by health providers and other gate keepers, allows for their socio-economic development and empowerment as members of society. It is necessary, irrespective of the outcome that occurs, to highlight that the benefit that accrues from adolescent girls having adequate

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<sup>72</sup> Durojaye 'Realising access to contraception for adolescents in Nigeria' (n 10 above) 162.

<sup>73</sup> Sec 39(1) Nigerian Constitution provides: Every person shall be entitled to freedom of expression, including freedom to hold opinions and to receive and impart ideas and information without interference.

<sup>74</sup> S Coliver 'The right to information necessary for reproductive health and choice under international law' in S Coliver (ed) *The Right to Know: Human Rights and Access to Reproductive Health Information* (1995) 39; E Durojaye 'Access to contraception for adolescents in Africa: a human rights challenge' (2011) XLIV *The Comparative and International Law Journal of South Africa* 13; *Olubunmi Okogie v Attorney General Lagos State* (1981) 1 NCLR 218.

information on the protection of their SRH in general and access to contraception in particular works for the public good.<sup>75</sup>

Generally, discrimination has been defined to mean any distinction, exclusion or restriction made on any ground which has the effect of impairing or nullifying the enjoyment of human rights and fundamental freedoms.<sup>76</sup> In relation to adolescent girls and their right to access contraceptive services and information, discrimination entails restricting and prohibiting them from accessing the required services either through the enactment of laws and the adoption of policies that prevent granting access to contraceptive information and services to adolescent girls on account of their age<sup>77</sup> or by encouraging cultural, religious and societal beliefs which entrench patriarchy by its insistence on the ignorance of girls in SRH matters or the prevention of their seeking SRH information, counselling and services with the same confidentiality as their male counterparts and adults.<sup>78</sup>

Section 42 of the Nigerian Constitution 1999 guarantees the right not to be subjected to discrimination on the grounds of sex, religion, ethnic group, place of origin and political opinion. Unlike under the Constitution of the Republic of South Africa<sup>79</sup> where discrimination is prohibited on wider grounds, including those of pregnancy, age, marital status and sexual orientation, the Nigerian Constitution has been criticised for its oversight in prohibiting discrimination on the grounds of age and marital status: two important grounds upon which female adolescents are usually

<sup>75</sup> A M Sunmola *et al* 'Reproductive, sexual and contraceptive behaviour of adolescents in Niger State, Nigeria' (2002) 6 *African Journal of Reproductive Health* 82-92; D Shaw 'Access to sexual and reproductive health for young people: Bridging the disconnect between rights and reality' (2009) 106 *International Journal of Gynaecology and Obstetrics* 133-134; Kjeldsen, Busk Madsen, and Pedersen v. Denmark (1976) 1 European Human Rights Report 711.

<sup>76</sup> United Nations High Commissioner for Human Rights 'The right to health: Fact sheet No. 31' 7, available at <http://www.ohchr.org/Documents/Publications/Factsheet31.pdf> (12 March 2013).

<sup>77</sup> E Durojaye 'Realising access to sexual health information and services for adolescents through the Protocol to the African Charter on the Rights of Women' (2009) 16 *Washington and Lee Journal of Civil Rights and Social Justice* 165.

<sup>78</sup> R J Cook 'Human rights and reproductive self-determination' (1994-1995) 44 *American University Law Review* 1009.

<sup>79</sup> Sec 9(3) Constitution of the Republic of South Africa 1996.

subjected to discrimination when seeking contraceptive services and information in Nigeria.<sup>80</sup>

Even though the Nigerian constitution does not recognise discrimination on the grounds of age, marital status or pregnancy, as a party to various international and regional human rights treaties which generally prohibit discrimination, the government has an obligation to ensure that female adolescents enjoy their right to access contraception by proscribing, repealing or amending laws and policies that discriminate against them and deny them access to this crucial service *prima facie* or based on effects occasioned as a result of the implementation of the laws.<sup>81</sup>

Apart from the government amending or repealing laws which are discriminatory and prevent access to contraception, domestic courts in the country must also purposefully and widely interpret the provisions of section 42 to include grounds not expressly included in the Constitution and declare as illegal and discriminatory laws, policies, customs, traditions and acts of third parties which expressly or indirectly restrict access to contraception by female adolescents as was recently the case, when a Nigerian court awarded damages for discrimination against a HIV- positive woman on account of her health status.<sup>82</sup>

### 2.3 Nigerian legislation

In addition to the 1999 Constitution<sup>83</sup> which lays down the basic structures necessary for efficient governance, the Nigerian state is also administered through statutes and subsidiary legislation which aim to establish and sustain the maintenance of an orderly society. In Nigeria the legislature is made up of the national assembly (federal legislative arm of government) and the houses of assemblies of the various states (state legislature). Laws passed by the federal legislature are referred to as

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<sup>80</sup> Durojaye 'Realising access to contraception for adolescents in Nigeria' (n 10 above) 166.

<sup>81</sup> R J Cook *et al Reproductive health and human rights: Integrating medicine, ethics and law* (2003) 197.

<sup>82</sup> *Georgina Ahamefule v Imperial Medical Center* (n 62 above).

<sup>83</sup> It should be noted that the various constitutions of the Federal Republic of Nigeria also forms part of Nigerian legislation.

Acts;<sup>84</sup> those passed by their state counterparts are called Laws.<sup>85</sup> Subsidiary legislation is in the form of laws enacted by the executive arm of government in exercise of powers conferred on them by statute.

Apart from the Constitution, a principal legislation which can be used to further the advancement of the right of adolescent girls in Nigeria to contraceptive information and services is the Child Rights Act (CRA)<sup>86</sup> adopted in 2003. Relevant portions of the CRA will be discussed in section 3 of this chapter.

## 2.4 English law

English law was introduced into Nigeria as part of the Nigerian legal system in 1863 when Ordinance No 3<sup>87</sup> was introduced in the Colony of Lagos. Received English law is made up of the common laws of England, the doctrines of equity and statutes of general application which were in force in England on 1 January 1900. Apart from the above, English law adopted in England before 1 October 1960 and law made by the colonial legislature remain law in Nigeria and are part of the country's legal system unless they have been repealed by local legislation.<sup>88</sup>

Common law became applicable in Nigeria as case precedents derived from the decisions of various English courts. English judges developed the doctrines of equity through the application of fair and just rules in order to mitigate the harshness of common law.<sup>89</sup>

Generally, where a court is authorised to administer English law in civil or criminal proceedings, the provisions granting their powers are normally contained in the main

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<sup>84</sup> During military regime, federal acts are referred to as decrees. Before 1 October 1954, laws passed by the Nigerian central legislature were known as ordinances.

<sup>85</sup> State laws are referred to as edicts during military governance.

<sup>86</sup> Child Rights Act cap C50 Laws of the Federation of Nigeria 2004.

<sup>87</sup> This was the law that was officially used to introduce English law into Nigeria.

<sup>88</sup> Mwalimu (n 14 above) 22-23.

<sup>89</sup> A M Olong *The Nigerian legal system: An introduction* (2007)12-14. In situations of conflict between the common law and doctrines of equity, the doctrine of equity prevails.

and subsidiary enactments of the legislation creating the courts. Laws creating the magistrate and high courts in Lagos,<sup>90</sup> former western states, northern states and some part of the eastern states contain provisions which allow for the resort to English law where applicable.

Currently, although a source of the Nigerian legal system, the received English law generally applies subject to Nigerian legislation while decisions of English courts, whether based on common law or equity, merely serve as a guide to the Nigerian courts.<sup>91</sup> In situations where a rule recognised under English law is contained in local legislation, the local legislation is regarded as the applicable law.<sup>92</sup>

Nigeria continues to apply some received English laws even though the laws have been repealed or relaxed in England<sup>93</sup> in order to pave the way for newer and more humane laws. For example, in relation to the rights of adolescent girls to reproductive health, requirements restricting access to medical treatment (including those related to contraception and other reproductive health services) by minors subject to parental consent have been relaxed in the United Kingdom in line with current human right practices, as evidenced by the decisions of the House of Lords in the *Gillick*<sup>94</sup> and *R (Axon)* cases.<sup>95</sup> This is not the case in Nigeria as the consent of parents still has to be obtained before minors and adolescents can be treated,<sup>96</sup> leading to situations where adolescent girls refuse to use contraception and shun health care facilities because their confidentiality and privacy are not assured.

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<sup>90</sup> High Court of Lagos State Law 1973 amended in 2012.

<sup>91</sup> A O Obilade *The Nigerian legal system* (1979) 71 & 77. Nigerian courts can hold that the common law or doctrines of equity by the highest court in England are neither English law nor the applicable doctrine on an issue.

<sup>92</sup> It is only in situations where Nigerian legislation is silent on an issue that recourse can be had to English law. See *Apampa v The State* (1982) 6 S.C. 22 paras C-A; *Salisu Yahaya v The State* (2002) 3 NWLR (Pt.754) 289 paras B-C.

<sup>93</sup> A prominent example relates to the protection of the rights of children. The Children and Young Persons Act Cap 32 LFN 1958 was applied in the country until 2003 when the Child Rights Act repealed it.

<sup>94</sup> *Gillick's case* (n 66 above).

<sup>95</sup> *R (Axon)* (n 67 above).

<sup>96</sup> Durojaye 'Realising access to contraception for adolescents in Nigeria' (n 10 above) 117.

## 2.5 Customary law

Traditionally, customary law is classified into 2 distinct categories: Ethnic/Non-Muslim Customary law and Islamic/Sharia law.<sup>97</sup> While indigenous customary law is largely unwritten and varies from locality to locality depending on the practices of the inhabitants of a community, Islamic law is written, based on the holy Quran and applied in the northern part of Nigeria as Muslim law. With the introduction of the sharia legal system in some states in Northern Nigeria, the scope of operation of Islamic law has become broader.<sup>98</sup> Indigenous customary law is generally regarded as a mirror of accepted usage due to the fact that it is flexible and adapts to changing circumstances and society.<sup>99</sup> As a result of continual practice, indigenous customary law has acquired the force of law. Law courts take judicial notice of customary law in relation to various practices, including the celebration of births and marriages and the administration of estates and succession rules among others as long as the customs are not repugnant to natural justice, equity and good conscience.<sup>100</sup>

As noted by Durojaye, even though under customary law, the arrival of a child is welcomed with celebration and fanfare, it does not lead to the presumption that children are rights holders nor does it result in the belief that they can make private

<sup>97</sup> Ethnic/ non-Muslim customary law is also known as indigenous law. See B C Uweru 'Repugnancy doctrine and customary law in Nigeria: A positive aspect of British colonialism' (2008) 2 *African Research Review* 293; Obilade (n 91 above) 83; Mwalimu (n 14 above) 37; J Lokulo-Sodipe *et al Legal Basis for research ethics governance in Nigeria*, available at <http://elearning.trree.org/mod/page/view.php?id=142> (28 September 2014).

<sup>98</sup> In some parts of Nigeria (Northern Nigeria), Islamic law has completely supplanted the pre-existing system of customary laws, whereas in other states in Southern Nigeria it is incorporated with customary law and the two systems are fused and jointly administered. Islamic law is enforced as a separate source of law in Northern Nigeria where members of the population are predominantly Moslems. States where Sharia has been introduced include Zamfara, Kano, Kaduna and Sokoto. See *Y Dina et al Guide to Nigerian legal information* (2013) available at <http://www.nyulawglobal.org/globalex/Nigeria1.htm> (29 October 2014). While customary law is enforced in Customary Courts, Islamic law is enforced by the Sharia Courts. See secs 6, 275, 277, 280 and 282 Nigerian Constitution 1999.

<sup>99</sup> Customary law changes from time to time without losing its individual character. *Lewis v Bankole* (1908) 1 NLR 81.

<sup>100</sup> This is called the validity test as laid down in *Eshugbayi Eleko v Government of Nigeria* (1931) AC 262 at 273, where Lord Atkin stated:

The court cannot itself transform a barbarous custom into a milder one. If it stands in its barbarous character it must be rejected as repugnant to natural justice, equity and good conscience.

decisions.<sup>101</sup> Under a majority of customs in Nigeria, Islamic customary law inclusive, it is felt that children and adolescents are under parental guidance and tutelage until marriage when they acquire the status of adults as full members of society. For females however, autonomy and decision-making powers are merely transferred to their spouses. The reason for this is that females are still considered the ‘property’ of their husbands and cannot access modern contraceptive methods without their spouses’ authorisation.<sup>102</sup> The above position also applies under Islamic customary law as parents (especially the girl’s father) have the right (*ijbar*) not only to arrange marriages for their daughters but can do so without her consent.<sup>103</sup>

In line with the fact that Nigerian courts take judicial notice of customary laws as practiced among the various ethnic groups, it is important that the courts should be quick to strike down customary laws and traditions which are discriminatory against women and girls generally, as done in *Mojekwu and others v Ejikeme and others*,<sup>104</sup> as well as customs which encourage patriarchy and prevent access to contraception and other needed reproductive health care services.

<sup>101</sup> Durojaye ‘Realising access to contraception for adolescents in Nigeria’ (n 10 above) 118.

<sup>102</sup> N I Aniekwu *The Convention on the Elimination of All Forms of Discrimination Against Women and the status of implementation on the right to health care in Nigeria* (2006) 35, available at <http://www.wcl.american.edu/hrbrief/13/3ijeoma.pdf> (19 March 2013).

<sup>103</sup> A S Erulkar & M Bello *The experience of married adolescent girls in northern Nigeria* (2007) 6 [http://www.popcouncil.org/pdfs/Nigeria\\_MarriedAdol.pdf](http://www.popcouncil.org/pdfs/Nigeria_MarriedAdol.pdf) (20 June 2013), P Makinwa-Adebusoye *Hidden: A profile of married adolescents in Northern Nigeria* (2006) 16, available at <http://www.actionhealthinc.org/publications/docs/hidden.pdf> (20 June 2013); Center for Reproductive Law and Policy *Women’s reproductive rights in Nigeria: A shadow report* (1998) 10 & 13, available at [http://reproductiverights.org/sites/default/files/documents/sr\\_nig\\_0698\\_eng.pdf](http://reproductiverights.org/sites/default/files/documents/sr_nig_0698_eng.pdf) (3 May 2013). It should be known that the practice of forced marriage occur despite that Islam is emphatically against the celebration of marriage without the mutual consent of the parties.

<sup>104</sup> *Mojekwu and others v Ejikeme and others* (2000) 5 NWLR 402, available at [http://www.equalrightstrust.org/ertdocumentbank/Mojekwu%20&%20others%20v%20Ejikeme%20&%20others%20\\_2000\\_%205%20NWLR%20402.pdf](http://www.equalrightstrust.org/ertdocumentbank/Mojekwu%20&%20others%20v%20Ejikeme%20&%20others%20_2000_%205%20NWLR%20402.pdf) (14 March 2013). Before this case, Nigerian courts were quick to support or defend customary laws which denied women and girls inheritance rights as seen in *Nezianya v Okagbue* (1963) 1All NLR 352; *Onwuchekwa v Onwuchekwa* (1991) 5 NWLR 739. See F O Anaeme *Reducing Gender Discrimination and Violence against Women through Library and Information Services* (2012) 3, available at <http://www.webpages.uidaho.edu/~mbolin/anaeme.pdf> (17 March 2013).

## 2.6 Judicial precedents

Judicial precedents in Nigeria are principles of law that have been laid down by the courts in previous cases as *ratio decidendi* (reason for a decision) upon which similar decisions are to be premised. As a matter of necessity, based on the doctrine of *stare decisis* and the hierarchy of courts, precedents laid down by superior courts in relation to material facts of a similar case are binding and must be followed by lower courts,<sup>105</sup> except if such decisions have been overruled by another court higher than the court which previously laid down the principle.<sup>106</sup>

On the other hand, principles of law laid down in similar cases serve only as persuasive authority to superior courts and courts with concurrent jurisdiction. If two courts of the same hierarchical status make conflicting decisions on the same issue, the lower court is at liberty to follow the precedent laid down by either of the courts.<sup>107</sup> Also, decisions reached by the law courts in other commonwealth jurisdictions can be of persuasive authority to Nigerian courts where the matter involved have not been adjudicated before.<sup>108</sup>

## 2.7 Conclusion

This section presented a brief examination of the historical development of laws protecting children's rights in Nigeria, although during the colonial period the protection of children and adolescents' welfare rights was not of special concern. In tracing the country's constitutional development, a section guaranteeing the protection of human rights does not occur until the enactment of the 1960 Independence Constitution. Even when provision protecting human rights was inserted in the Constitution, there was no provision protecting the right to health

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<sup>105</sup> Obilade (n 91 above) 111.

<sup>106</sup> Obilade (as above) 115.

<sup>107</sup> Obilade (as above) 115.

<sup>108</sup> Since Nigerian courts have not specifically adjudicated on matters relating to the rights of adolescents to seek contraception and other reproductive health care services, references can be made to the enlightening decisions of the English House of Lords in *Gillick's* case and *R (Axon)* case as persuasive authorities.

care. This position continues to apply in relation to the constitutional protection of socio-economic rights in Nigeria as the provisions relating to socio-economic rights are mentioned only under chapter two on directive principles of state policy that are not justiciable.

Since international laws protecting adolescent girls' access to contraceptive information and services cannot stand on their own without support from domestic quarters, other sources of Nigerian law, including domestic legislation and customary law are examined. As a source of Nigerian law, the doctrine of judicial precedents discussed in the section offers a basis for domestic courts to take notice of decisions by courts in other Commonwealth jurisdictions. This doctrine provides a ready avenue through which judgements protecting the right to health care contained in human rights instruments ratified by Nigeria can serve as persuasive authorities. National laws and policies relating to female adolescents' access to contraceptive information and services will be analysed in the next section.

### 3 Adolescent reproductive health laws and policies in Nigeria

The provision of health care in Nigeria is the concurrent responsibility of the three tiers of government which are primarily responsible for the dispensation of health care services in one of three (primary,<sup>109</sup> secondary<sup>110</sup> and tertiary<sup>111</sup>) levels of health care systems in operation in the country. Although the three levels of government have principal responsibility for a particular level of health care, they are not precluded from providing services in either of the other two levels of care.<sup>112</sup>

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<sup>109</sup> The local government councils have responsibility for the primary health care centres (PHC) in the various communities with support from their respective state ministries of health. The PHC are responsible for the provision of first level of care, immunisations and family planning services.

<sup>110</sup> The state government is responsible for the provision of secondary health care services at general hospitals with assistance from respective state ministries of health.

<sup>111</sup> The Federal Government is responsible for the provision of tertiary health care at teaching hospitals with assistance from the Federal Ministry of Health.

<sup>112</sup> M C Asuzu 'The necessity for a health systems reform in Nigeria' (2004) 16 *Journal of Community Medicine & Primary Health Care* 1; WHO - *The Nigerian health system* 21-23, available at <http://www.who.int/pmnch/countries/nigeria-plan-chapter-3.pdf> (15 March 2013). On the face of it,

The intention in this section is to examine the legislation and reproductive health policies which have a direct influence and impact on the guarantee of female adolescents' access to contraceptive information and services. Despite the fact that the provision of health care is on the concurrent legislative list,<sup>113</sup> the focus is on the Child Rights Act (CRA) and selected policies adopted at the Federal level which automatically govern the entire country. It will be impossible to discuss the various laws and policies (if any) existing in all the thirty six states of the Federation.

### 3.1 Child Rights Act (CRA) 2003

In 2003, the Nigerian government finally succeeded in domesticating provisions for the protection of the rights of children contained in the International Convention on the Rights of the Child (CRC)<sup>114</sup> and its regional counterpart, the African Charter on the Rights and Welfare of the Child (ACRWC),<sup>115</sup> through the adoption of the Child Rights Act (CRA)<sup>116</sup> after numerous attempts and debates in the legislative arm of government.<sup>117</sup>

As mentioned earlier, before the adoption of the CRA, the only piece of legislation enacted during the colonial period to protect the welfare of Nigerian children and

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while the fact that both the state and federal governments can assist in the provision of services at other levels of care looks good due to a belief that this will lead to better services, this is not the case as there is often a confusion of roles with duplication of efforts.

<sup>113</sup> This makes it possible for both federal and state legislatures to regulate and pass laws on health care but in situations of conflict arising from laws passed by the two levels of legislatures, the laws made by the Federal Legislature supersede those of the State Legislatures. See sec 4(5) Nigerian Constitution 1999. Also, while the ministries of health at the two levels are empowered to develop and implement policies necessary for the delivery of efficient and affordable health services, the Federal Ministry of Health maintains the paramount position of overseeing efficient and proper coordination of activities in the sector.

<sup>114</sup> Adopted by the United Nations General Assembly in 1989 and became operative on 2 September 1990, available at <http://www2.ohchr.org/english/law/pdf/crc.pdf>. (20 September 2012). Nigerian ratified the CRC on 19 April 1991.

<sup>115</sup> Adopted in 1990 vide OAU Doc. CAB/LEG/24.9/49 and entered into force in 1999. Nigeria ratified the Children's Charter on 23 July 2001.

<sup>116</sup> Child's Right Act 2003.

<sup>117</sup> Unicef - *The Child's Rights Act (August 2007)* available at [http://www.unicef.org/wcaro/WCARO\\_Nigeria\\_Factsheets\\_CRA.pdf](http://www.unicef.org/wcaro/WCARO_Nigeria_Factsheets_CRA.pdf) (15 March 2013).

adolescents was the Children and Young Persons Ordinance of 1943<sup>118</sup> (which later became the Children and Young Persons Act - CYPA).<sup>119</sup> This Act primarily, was adopted to address the problems associated with the issues of juvenile delinquency and children that were in need of care.<sup>120</sup> CYPA, which was subsequently adopted as state law,<sup>121</sup> lacked the provisions of the ACRWC and CRC that recognise children as right holders.<sup>122</sup> This lack led to agitation for the domestication of international and regional human rights instruments protecting children in the country through the creation of a statute that will incorporate both the rights of children and the obligations of government in a single document.

The CRA, which repealed the CYPA, enlarged the scope of the law in relation to the protection of children's rights in various areas, including those related to adoption, guardianship, custody, supervision and care of children. Apart from creating obligations for the Nigerian government in relation to children, the CRA specifically provides for the duties of guardians and people in *loco parentis*.<sup>123</sup>

Conforming to international standards, the CRA categorically defines a child as a person under the age of 18<sup>124</sup> and provides, in all matters concerning the child, that the best interests of the child should be the primary consideration<sup>125</sup> with guidance and direction provided to the child according to her evolving capacities.<sup>126</sup> By inserting the provision on the protection of children according to the 'best interests'

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<sup>118</sup> Cap 31 of 1948.

<sup>119</sup> Children and Young Persons Act Cap 32 LFN 1958 and the Children and Young Persons Act Cap 25 LFN 2004.

<sup>120</sup> Fourchard (n 13 above) 517.

<sup>121</sup> Children and Young Persons Law Cap 21 Laws of Northern Nigeria and Children and Young Persons Law Cap C10 Laws of Lagos State 2003.

<sup>122</sup> Other laws which made provisions in passing for the protection of children's welfare before the CRA include the Labour Act (sec 59 (a) & (b)), Criminal Code (secs 295 & 301) and so on.

<sup>123</sup> Secs 7(2) & 20 Child Rights Act.

<sup>124</sup> Sec 277 Child Rights Act. This position is in line with the definition contained the ACRWC, unlike the CRC, which, in Art 1, defined a child as an individual below the age of eighteen years unless, under the law applicable to the child, majority is attained earlier, or the repealed Children and Young Person's Act 1958 which defined a child as someone under 14 years and a young person as someone that had not reached the age of 18.

<sup>125</sup> Sec 1 Child Rights Act.

<sup>126</sup> Sec 7(2) Child Rights Act.

principle in the CRA, an obligation is automatically created that people dealing with children, in all circumstances, should make decisions only after extensively weighing the potential effect and outcome of such decisions on children.

In relation to the rights of female adolescents to contraception, the Nigerian government, health care providers and other gate keepers have a responsibility to note the disastrous consequences that are occasioned by the inaccessibility of contraception to adolescent girls. It is argued that these adverse effects outweigh whatever cultural/traditional reservations that are the reason for refusing young girls access to this important health care service. Instead of generally denying female adolescent's access to contraception, it is felt, acting in accordance with the 'best interests' of children principle, will create opportunity for properly trained health care providers in the field of adolescent SRH care to carry out the necessary medical examinations in order to determine the maturity and mental capacity of the adolescent requesting contraception so as to establish whether the girl understands the nature of the services she has requested.<sup>127</sup>

Although the provision on the evolving capacities of the child recognised in the CRA is mentioned in section 7 in relation to the right of the child to freedom of thought, conscience and religion,<sup>128</sup> it is argued that the necessity to 'take note' of the evolving capacities of children goes further to include situations where adolescent girls need to take decisions on whether or not to access contraception and other reproductive health services. In this situation, it is felt, in accordance with the obligations created under international and regional human rights provisions,<sup>129</sup> that parents and guardians, in performance of their duty of giving 'direction and guidance' according to the evolving capacities and best interests of female adolescents, are to ensure their access to contraception. Such response should be in

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<sup>127</sup> *Gillick's case* (n 66 above).

<sup>128</sup> Sec 7(2) Child Rights Act.

<sup>129</sup> Art 5 CRC & Art 4(1) ACRWC.

line with the adolescent girls' level of maturity, and is preferable to idealistic arguments which generally deny them access to contraception.

In addition to the rights contained in Chapter four of the 1999 Constitution to which Nigerian children are entitled,<sup>130</sup> various rights accruable to the Nigerian child are provided for in sections 4 to 18 of CRA. In connection with the right of adolescent girls to reproductive health, the rights include the right to survival and development,<sup>131</sup> the right to privacy,<sup>132</sup> the right to equality and non-discrimination,<sup>133</sup> the right to dignity,<sup>134</sup> the right to enjoy the best attainable state of physical, mental and spiritual health<sup>135</sup> and the right to education.<sup>136</sup> Each of these is discussed below.

The right to life is assured in the Nigerian Constitution, however, the further restatement of the guarantee of this right through the protection of the right of children to survival and development in the CRA is gratifying. Adolescent girls, not only deserve the adoption of extra precautionary measures but, as a matter of great importance, require adequate and continual access to contraceptive information and services for their survival as well as socio economic development. The death or permanent disability of female adolescents which results from illegal and back street abortions<sup>137</sup> is a major contributor to high mortality and morbidity rates in the country.<sup>138</sup>

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<sup>130</sup> Sec 3 Child Rights Act provides that the rights guaranteed in Chap IV of the Nigerian Constitution 1999 automatically apply to children as if expressly stated in the Act.

<sup>131</sup> Sec 4 Child Rights Act.

<sup>132</sup> Sec 8(1) Child Rights Act.

<sup>133</sup> Sec 10 Child Rights Act.

<sup>134</sup> Sec 11 Child Rights Act.

<sup>135</sup> Sec 13 Child Rights Act.

<sup>136</sup> Sec 15 Child Rights Act.

<sup>137</sup> Nigeria currently has in place highly restrictive abortion laws which permit access to legal and safe abortion only to save the life of a pregnant woman thereby leading to a situation where adolescent girls resort to engaging in risky abortion methods, either by adopting various 'traditional methods' or engaging the services of unqualified charlatans. See, generally, S A Aderibigbe *et al* 'Teenage pregnancy and prevalence of abortion among in-school adolescents in North Central, Nigeria' (2011) 7 *Asian Social Science* 122-127; A Attahir *et al* 'Knowledge, perception and practice of emergency contraception among female adolescent hawkers in Rigasa suburban community of Kaduna State Nigeria (2010) 4

The guarantee of the rights of children to privacy<sup>139</sup> in the CRA is welcome and can be used in furthering the access of adolescent girls to confidential contraceptive health care services. However, the insertion of a limitation clause in the form of the provision contained in sub-section 3, which provides that ‘nothing in the provision of subsections (1) and (2) of this section shall affect the rights of parents and, where applicable, legal guardians, to exercise reasonable supervision and control over the conduct of their children and wards’, is a shortcoming. This clause may dissuade adolescent girls from accessing the required reproductive and contraceptive services thereby exposing them to the risks occasioned by engaging in unprotected sex.<sup>140</sup>

In the opinion of Durojaye, it is necessary for domestic courts to positively contribute to the advancement of adolescents’ access to reproductive health care services by ‘overriding’ negative interpretations related to the access to contraception by female adolescents and by instructing the Nigerian government, to modify its laws with the aim of removing obstacles to private and confidential access to reproductive health services by young girls.<sup>141</sup>

In line with the provisions of the CRA on the right of children to non-discrimination<sup>142</sup> and dignity,<sup>143</sup> adolescent girls are to be treated with dignity when accessing contraceptive services, most especially by health providers, who must be sensitive to adolescents’ particular needs without exhibiting critical or judgmental attitudes. Adopting these practices will increase the confidence of adolescent girls to access

*Journal of Family and Reproductive Health* 15-20; V O Otoide *et al* ‘Why Nigerian adolescents seek abortion rather than contraception: Evidence from focus group discussions’ (2001) 27 *International Family Planning Perspectives* 77-81.

<sup>138</sup> K Graczyk *Adolescent maternal mortality: An overlooked crisis* (2007) available at <http://www.advocatesforyouth.org/storage/advfy/documents/fsmaternal.pdf> (19 March 2013).

<sup>139</sup> Sec 8 Child Rights Act.

<sup>140</sup> Cook *et al* *Reproductive health and human rights* (n 81 above) 167; Cook & Dickens (n 65 above); CRR and UNFPA ‘The Right to Contraceptive Information and Services for Women and Adolescents’ (2010) available at <http://www.unfpa.org/webdav/site/global/shared/documents/publications/2011/Contraception.pdf> (26 October 2012).

<sup>141</sup> Durojaye ‘Realising access to contraception for adolescents in Nigeria’ (n 10 above) 161.

<sup>142</sup> Sec 10 Child Rights Act.

<sup>143</sup> Sec 11 Child Rights Act.

family planning services. As in the argument advanced in the section discussing the right to be free from discrimination contained in the 1999 Constitution,<sup>144</sup> though the CRA recognises the right to be free from discrimination only on limited grounds,<sup>145</sup> the provision can be used to cover the right of adolescent girls not to be discriminated against on the grounds of age or marital status when accessing or seeking contraceptive information and services as Nigeria is a party to numerous human rights treaties which prohibit discrimination in every form.

Section 13 of the Act recognises the right of children to health and advocates that all levels of government and bodies responsible for the care of children, including parents, should endeavour to guarantee their access to the best attainable state of health care services.<sup>146</sup> In Nigeria, the provision of family planning services is part of the primary health care services provided by local and community health care centres. It is felt that the provision of the CRA that children are to be given necessary medical assistance, especially those related to the development of primary health care,<sup>147</sup> can be interpreted to grant female adolescents access to needed contraceptive services and information at available primary health care centres in their respective communities without discrimination and in an adolescent-friendly environment and manner.

Although the disciplinary measures introduced in section 13(5) of the Act seem to relate only to people in charge of children who fail in the duty imposed on them under sub section (4) of the Act,<sup>148</sup> it is felt that the domestic courts can take the initiative and extend its interpretation to include the award of punishment to people who generally bar and prevent female adolescents from having access to need

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<sup>144</sup> Sec 42 Nigerian Constitution 1999.

<sup>145</sup> Sec 10(1) Child Rights Act provides: 'A child shall not be subjected to any form of discrimination merely by reason of his belonging to a particular community or ethnic group or by reason of his place of origin, sex, religion or political opinion'.

<sup>146</sup> Sec 13(2) Child Rights Act.

<sup>147</sup> Sec 13(3)(b) Child Rights Act.

<sup>148</sup> Sec 13(4) Child Rights Act provides: 'Every parent, guardian or person having the care and custody or a child under the age of two years shall ensure that the child is provided with full immunisation'.

contraceptive services and information, thereby infringing their right to health care as recognised in the Act.

In addition, the right to education is guaranteed and recognised in section 15 of the CRA. While the provision contained in the section is worded in a manner that can be restrictively interpreted as only granting children access to basic education services and not related precisely to their having access to reproductive health education, the application of such a narrow interpretation would be catastrophic due to the necessity and importance of sexual and reproductive education in the lives of adolescent girls. A major reason which has been attributed for the feminisation of the HIV epidemic in Africa is the lack of access of women and girls to reproductive health education. Such access is a means to eliminate the occurrence of teenage pregnancies, encourage safer sexual relations and reduce the transmission of HIV and other STIs.<sup>149</sup>

The right of adolescent girls to information is not specifically included in CRA but based on the provision of section 3(1) of the Act which expressly provides that ‘the provisions contained in Chapter IV of the Nigerian Constitution 1999 shall apply as if those provisions are expressly stated in the Act’, it is felt that adolescent girls have a right to access important information on contraception not only as a result of constitutional provision on the right to information but also due to Nigeria’s ratification of international and regional human rights instruments guaranteeing the right.

Major downsides of the Act, however, is that apart from the fact that it does not specifically recognise the rights of children to participate or give consent in the decision-making process in issues that affect them or guarantee them ‘full privacy’ rights, the Child Rights Act is not applicable to the entire country. In line with the

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<sup>149</sup> S L Dworkin & A A Ehrhardt ‘Going beyond “ABC” to include “GEM”’: Critical reflections on progress in the HIV/AIDS epidemic’ (2007) 97 *American Journal of Public Health* 13-15.

country's federal structure, the various state legislatures need to pass corresponding laws in relation to child rights protection.<sup>150</sup>

### 3.2 National Health Policy 2004

In order to reflect current trends in the state of the country's health with a view to laying a genuine foundation necessary for the management of Nigeria's overall health system, the adoption of a new National Health Policy in 2004 to replace the National Health Policy 1988<sup>151</sup> was necessary. Formulated in the context of the health strategy of NEPAD,<sup>152</sup> the achievement of the Millennium Development Goals (MDG) and the development of a health sector reform programme that is an integral part of the New Economic Empowerment and Development Strategy (NEEDS),<sup>153</sup> the basis of the National Health Policy are: the underlying principles of social justice, equity and the ideals of freedom affirmed in the Nigerian Constitution, the recognition that health and access to quality and affordable health care is a human right, that primary health care (PHC) is a veritable strategy for national health development and that the attainment of equity in health care for all Nigerians is an ideal to be achieved.<sup>154</sup>

Major targets of the health policy that are relevant to the right of female adolescents to contraceptive services include: to have reduced by three-quarters between 1990

<sup>150</sup> Issues relating to child rights protection are on the residual list of the Nigerian Constitution, thereby giving states exclusive responsibility and jurisdiction to make laws relevant to their specific situations. 24 states of the federation have passed corresponding Child Rights Laws while Sokoto, Kebbi, Zamfara, Katsina, Kano, Kaduna, Bauchi, Gombe, Enugu, Yobe, Borno and Adamawa states are yet to pass the laws. UNICEF Nigeria–Fact sheet on Child rights legislation in Nigeria, available at [http://www.unicef.org/nigeria/Child\\_rights\\_legislation\\_in\\_Nigeria.pdf](http://www.unicef.org/nigeria/Child_rights_legislation_in_Nigeria.pdf) (23 September 2014).

<sup>151</sup> The 1988 national health policy which was coined the National Health Policy and Strategy to Achieve Health for all Nigerians was the first comprehensive health policy in the country.

<sup>152</sup> The New Partnership for Africa's Development (NEPAD) is a pledge made by African leaders on a common vision and conviction that they have a duty to wipe out poverty by placing their countries on the path of sustainable growth and development.

<sup>153</sup> The NEEDS is aimed at re-orienting the values of Nigerians, reforming governance, increasing the role played by the private sector and enshrining a social charter on human development. See generally para 3.1 Nigerian National Health Policy 2004, available at <http://cheld.org/wp-content/uploads/2012/04/Nigeria-Revised-National-Health-Policy-2004.pdf> (20 March 2013).

<sup>154</sup> Para 3.2 National Health Policy.

and 2015 high maternal mortality rates and to have halted the spread of HIV and commenced its reversal by 2015.<sup>155</sup> Strategies for the achievement of the goals include ensuring the capacity building of reproductive health providers and the availability of materials needed for the provision of efficient reproductive health services. Even though it is doubtful that the Nigerian government will achieve its targets on the reduction of maternal mortality and halting the spread of HIV by 2015,<sup>156</sup> there is an urgent need to double current efforts in this regard by granting unfettered access of female adolescents to contraceptive information and services. Adolescents constitute a major block of people affected by the HIV epidemic in Nigeria because they are unable to access contraceptive information and services,<sup>157</sup> thereby contributing to the high maternal mortality rates recorded against the country.<sup>158</sup>

Policy declarations in the Health Policy include the commitment of the three levels of government and the co-operation of the private health sector to attaining the goal of

<sup>155</sup> Para 3.4 National Health Policy. Other intentions include reducing gender imbalance in SRH matters and promoting the undertaking of comprehensive research on reproductive health issues.

<sup>156</sup> As at 1990 Nigeria's maternal mortality ratio was 1200 per 100,000 live births. Current estimates for 2013 put the MMR at 560 per 100,000 live births. While the country has made significant progress in its efforts to reduce the number of maternal deaths in the country, it is still behind achieving the MDG target of 300 per 100,000 by 2015. See WHO, UNICEF, UNFPA, World Bank & the United Nations Population Division *Maternal mortality in 1990-2013: Nigeria* (2014) available at <http://www.mamaye.org.ng/en/evidence/maternal-mortality-1990-2013-nigeria> (24 September 2014); 'Nigeria accounts for 13% global maternal mortality rates' *This Day* 12 July 2014 available at <http://www.thisdaylive.com/articles/nigeria-accounts-for-13-global-maternal-mortality-rates/183394/> (24 September 2014). In the case of HIV, according to National Agency for the Control of AIDS (NACA), based on 2012 national survey, the HIV prevalence rate in Nigeria has reduced from 3.6% to 3.4%. According to reports, 3.5 million people are infected with the virus and 1.5 million are in need of treatment. See 'HIV/AIDS remains serious challenge – NACA' *The Punch* 26 November 2013 available at <http://www.punchng.com/news/hivaids-remains-serious-challenge-naca/> (24 September 2014); '12 Nigerian states, Abuja are HIV endemic –NACA' *The Eagle Online* 23 September 2014 available at <http://theeagleonline.com.ng/12-nigerian-states-abuja-are-hiv-endemic-naca/> (24 September 2014).

<sup>157</sup> Unicef *Nigeria: HIV/AIDS* [http://www.unicef.org/nigeria/children\\_1940.html](http://www.unicef.org/nigeria/children_1940.html) (20 March 2013); S T Omoniye *et al* 'Adolescents and HIV-related behaviour in Nigeria: Does knowledge of HIV/AIDS promote protective sexual behaviour among sexually active adolescents?' (2012) available at <http://paa2012.princeton.edu/papers/120500> (20 March 2013).

<sup>158</sup> A Tayo *et al* 'Contraceptive knowledge and usage amongst female secondary school students in Lagos, Southwest Nigeria' (2011) 3 *Journal of Public Health and Epidemiology* 34-37; A Bankole *et al* *Barriers to Safe Motherhood in Nigeria* (2009) 3, available at <http://www.gutmacher.org/pubs/2009/05/28/MotherhoodNigeria.pdf> (20 March 2013); I A O Ujah *et al* 'Factors Contributing to Maternal Mortality in North-Central Nigeria: A Seventeen-year Review' (2005) 9 *African Journal of Reproductive Health* 28-40; Aderibigbe *et al* (n 137 above).

health for all citizens with a view to enable them to lead socially and economically productive lives at the highest possible level.<sup>159</sup> Also, the policy emphasizes the right of individuals to participate in the planning and implementation of their health care<sup>160</sup> and restates that the practice of a primary health care (PHC) that is universally accessible to individuals and based on practical, scientifically sound and socially acceptable methods is essential to the achievement of health for all.<sup>161</sup> In addition, the government is to exercise its political will to mobilise and use all available health resources to achieve the objectives contained in the health policy.<sup>162</sup>

As laudable as the provisions of the health policy are, as a result of constitutional provisions<sup>163</sup> which remove the powers of domestic courts from deciding matters related to the fundamental objectives and directive principles of state policy,<sup>164</sup> a major shortcoming is the fact that the failure of government to use available resources to achieve the health policy objectives cannot be the subject of litigation. However, despite the above, the fact that the policy recognises health and access to quality and affordable health care as a human right<sup>165</sup> can be used to canvass for the access of adolescents, generally, and female adolescents, in particular, to contraception services and information. Also, instead of domestic courts doing nothing, in actions relating to the violation of the right to health<sup>166</sup> they can use the health policy as a guide to determine whether government's action in relation to a particular health issue is reasonable or not.<sup>167</sup>

<sup>159</sup> Para 3.5 (i) National Health Policy.

<sup>160</sup> Para 3.5 (iii) National Health Policy.

<sup>161</sup> Para 3.5 (iv) National Health Policy.

<sup>162</sup> Para 3.5(v-viii) National Health Policy.

<sup>163</sup> Sec 6(6) (c) Nigerian Constitution 1999.

<sup>164</sup> Fundamental objectives and directive principles of state policy is contained in chapter two of the Nigerian Constitution 1999.

<sup>165</sup> This can either be regarded as a contradiction since the Nigerian Constitution does not recognise the right to health care or a step in the right direction towards the fulfilment of the provisions on health contained in the various human rights treaties to which Nigeria is a party.

<sup>166</sup> Nigeria domesticated the contents of the African Charter through the African Charter on Human and Peoples Rights (Ratification and Enforcement) Act Cap A9, LFN 2004.

<sup>167</sup> *Minister of Health v Treatment Action Campaign* (TAC) (2002) 5 SA 721 (CC).

### 3.3 National Reproductive Health Policy 2001

In response to Nigeria's adoption of the ICPD Programme of Action in 1994 at the international level and the African regional strategy on reproductive health in 1997, the Federal Government in 2001 adopted the National Reproductive Health Policy to replace the previous Maternal and Child Health Policy. The revision, which became necessary, as a result of the paradigm shift from the concept of the protection of maternal, child health and family planning to reproductive health, was made to enable the country address and reverse the trend of reproductive health challenges affecting Nigerian citizens.<sup>168</sup> In acknowledgment of the generally poor reproductive health situation in Nigeria, the Reproductive Health Policy sought to provide a framework which, on one hand, will tackle the problems facing the health sector and on the other, will lead to the implementation of programmes that will result not only in the creation of a functioning health care delivery system but also ensure access to affordable good quality care at all levels.<sup>169</sup>

The Reproductive Health Policy specifically refers to the intention to promote adolescent reproductive health by noting the 'increasing high-risk behaviour of adolescents which led to their engagement in premarital sexual encounters, unsafe abortions and unintended pregnancies with its attendant social consequences including early marriages and school dropout'. In addition, the policy notes the low level of awareness and utilisation of family planning services, the fragmentation of existing reproductive health care activities and the limited impact which existing programmes have in reducing sexual and reproductive ill health.<sup>170</sup>

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<sup>168</sup> Para 1.1 Nigerian National Reproductive Health Policy (2001) available at <http://www.youth-policy.com/Policies/Nigeria%20National%20Reproductive%20Health%20Policy%20and%20Strategy.pdf> (20 March 2013); N I Aniekwu 'Gender and reproductive health: Towards advancing judicial reform in Nigerian law' in E Azinge & C J Dakas (eds) *Judicial reform and transformation in Nigeria: A tribute to Hon. Justice Dahiru Musdapher* (2012) 437.

<sup>169</sup> Para 1.2.2 Nigerian National Reproductive Health Policy.

<sup>170</sup> Para 1.3 Nigerian National Reproductive Health Policy.

To improve the reproductive health of adolescents, in particular, the Nigerian government, through the Reproductive Health Policy, set targets to increase access to reproductive health information/counselling and contraceptive services to all in- and out-of-school adolescents in youth-friendly environments, so as to reduce the number of unwanted pregnancies and maternal morbidity and mortality rates due to pregnancy.<sup>171</sup>

Also, the policy seeks the introduction of sexuality and family life education in school curricula, calls for the removal of barriers which limit access to qualitative reproductive health care and supports the enactment and review of laws relevant to adolescent health.<sup>172</sup> However, like all Nigerian health policies, a major limitation of the Reproductive Health Policy, apart from not being enforceable under Nigerian law,<sup>173</sup> is that it is a policy document which proposes merely to serve as guide to the Nigerian government, who possess the power to change policy direction at a whim.<sup>174</sup>

### **3.4 National Policy on Health and Development of Adolescents and Young People 2007**

Adopted in 2007, the National Policy on Health and Development of Adolescents and Young People,<sup>175</sup> which replaced the 1995 Adolescent Health Policy, defines adolescents and young people as people in the age group of 10-24 years. Recognising the importance of protecting the reproductive health of adolescents and young people in the country who engage in sexual relations at an early age without adequate information about the effects occasioned by such early induction, the

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<sup>171</sup> Para 3.2.8 Nigerian National Reproductive Health Policy.

<sup>172</sup> As above.

<sup>173</sup> Sec 6(6)(c) Nigerian Constitution 1999.

<sup>174</sup> Durojaye 'Realising access to contraception for adolescents in Nigeria' (n 10 above) 201.

<sup>175</sup> Generally referred to as the National Adolescent Policy 2007.

policy states the intention of the Nigerian government to design programmes of action that will effectively address the problem.<sup>176</sup>

Taking note of the fact that adolescents have inadequate access to SRH information and services,<sup>177</sup> the policy which has the goal of promoting the development and optimal health of adolescents, aims to stimulate advocacy efforts in order to increase political will in allocating resources towards young people's health and development programmes on one hand, and, increase the access of adolescents and young people to quality information, education and adolescent-friendly services on the other.<sup>178</sup> As well, the policy sets health targets that include the reduction of the maternal mortality ratio by 75%, lowering the incidence of unwanted pregnancies by 50% and increasing the access of adolescents and young people to reproductive health information and services by 50% by 2015.<sup>179</sup>

The strategies highlighted for the achievement of the targets include the training and capacity building of health providers, involved in the provision of adolescent health care services, engaging in advocacy so as to effect behavioural changes among adolescents and establishing systems that will efficiently monitor the implementation of the policy.<sup>180</sup> According to Aniekwu, the significance of satisfying the reproductive health needs of adolescents cannot be overemphasised as research and health surveys reveal the large number of female adolescents who are married, pregnant or have given birth.<sup>181</sup>

Policy declarations include the commitment of the Federal, State and Local governments and other stakeholders (including the private health sector) to assist in

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<sup>176</sup> Para 1 National Adolescent Policy.

<sup>177</sup> Especially female adolescents both married and unmarried, who as a result of cultural and religious barriers are denied access to adequate sexual and reproductive health care services including those related to contraception. Para 2.1.1 National Adolescent Policy.

<sup>178</sup> Paras 4.1.1 & 4.1.2 National Adolescent Policy.

<sup>179</sup> Para 4.2 National Adolescent Policy.

<sup>180</sup> Para 4.3.1 National Adolescent Policy.

<sup>181</sup> Aniekwu 'Gender and reproductive health' (n 168 above) 441.

the successful implementation of the policy. In addition, it restates that adolescents and young people themselves have a duty to participate in the planning and implementation of the programmes that will enable the realisation of their reproductive health needs.<sup>182</sup>

While appreciating the impressive contents of the policy which, if implemented will assist in the guarantee of female adolescents right to access reproductive health care services and information, it is felt that the Nigerian government has a duty to carry out of active advocacy and awareness-raising campaigns especially at community levels where female adolescents mostly encounter cultural and religious barriers and initially have contact when attempting to access contraceptive SRH care services and information. The achievement of a successful campaign at the communal level will go a long way not only to ensure the success of policy but also effectively address the reproductive health needs of adolescents generally.

### 3.5 National Youth Policy 2009<sup>183</sup>

In 2009, Nigeria drafted a new National Youth Policy: an indication of the government's willingness to meet the numerous problems, needs and aspirations of youth. The Youth Policy, which sets out necessary guidelines and framework to be adopted by stakeholders, seeks to promote and protect the enjoyment of the fundamental human rights of youth and empower them to take advantage of available opportunities with the view to realising their potential and making a positive contribution to society.

Taking note that youths have different needs, the policy contains provisions that address the specific needs of severally identified target groups.<sup>184</sup> The Policy is reflective of previously formulated laws, national policies and international

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<sup>182</sup> Para 5.1 National Adolescent Policy.

<sup>183</sup> Second National Youth Policy Document of the Federal Republic of Nigeria' 2009 [http://planipolis.iiep.unesco.org/upload/Youth/Nigeria/Nigeria\\_YouthPolicy.pdf](http://planipolis.iiep.unesco.org/upload/Youth/Nigeria/Nigeria_YouthPolicy.pdf) (23 October 2012).

<sup>184</sup> Examples of the policy's target groups include Students in secondary and tertiary institutions, Out of school Youths, female youths and youths residing in rural areas among others.

programmes, including the Nigerian Constitution, National Adolescent Health Policy, National Health Policy, the Millennium Development Goals (MDGs) and African Youth Charter among others.<sup>185</sup>

Unlike the African Youth Charter however,<sup>186</sup> the Nigerian Youth charter defines youth as people between the ages of 18 and 35 years. Restating the commitment that the Youth Policy shall be youth driven and centred, the policy seeks to promote the development of programmes that will address the needs of youth especially those in rural communities, at the same time ‘respecting the role of tradition, religion, and culture in the development of young men and women’. It is doubtful how the policy will achieve balance its commitment to addressing youth needs while ‘recognising and respecting’ the role of tradition, culture and religion in relation to youth needs since it is the opinion that these are major factors that inhibit the access of adolescents to contraceptives and other reproductive health care services.

To generally fulfil its objectives on the health of youth, the policy has, as goals, the training of health providers to provide access to youth-friendly services in a considerate and non-judgmental manner, introduce health education and life skills into the curricula of schools and programmes designed for out-of-school youths, design and implement health services that will promote and maintain a healthy youth population and provide appropriate contraceptive education and services in accordance with recommendations decided at the International Conference on Population and Development 1994.<sup>187</sup>

### 3.6 Family Life and HIV Education (FLHE) Curriculum<sup>188</sup>

Before the Family Life and HIV Education (FLHE) Curriculum was introduced in 2001, the debate over granting adolescents access to essential information that will allow

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<sup>185</sup> Para 1.2 National Youth Policy. Nigeria ratified the African Youth Charter on 21 April 2009.

<sup>186</sup> The African Youth Charter defines youths as people between ages 15 and 35 years.

<sup>187</sup> Para 5.3 National Youth Policy.

<sup>188</sup> *National family life and HIV education curriculum for junior secondary schools* (2003) available at <http://www.actionhealthinc.org/publications/docs/jnrcurriculum.pdf> (15 August 2013)

for a positive response to their SRH needs had been on-going since the 1980s. The initial response was the adoption of two national efforts based on a curricular approach that primarily focused on the biology of reproduction and emphasised fertility reduction.<sup>189</sup>

The spread of HIV and other STIs among Nigerian adolescents (particularly adolescent girls)<sup>190</sup> due to their involvement in unsafe sexual practices and regardless of widespread disapproval of adolescent sexual relations, forced the realisation of the necessity to streamline the teaching of HIV prevention with family life education in the school curriculum thereby resulting in the redesign/review of the entire family life education curriculum. The review of the curriculum was to ensure the addition and teaching of sexuality education at the different educational levels in the country, to provide knowledge and develop skills and attitudes that will assist in ensuring not only the reduction of the spread of HIV but also lessen its impact on national development.<sup>191</sup> This paradigm shift led to the introduction of the FLHE curriculum.<sup>192</sup>

Its introduction is a victory for civil society organisations advocating the protection of the rights of children, generally, and their right to access SRH care information, education and services in particular, based on the belief that the effective teaching of sexuality education to young people will reduce misinformation, clarify and

<sup>189</sup> Previous population and sexual education programmes that were adopted before 2002 when the Family Life and HIV Education (FLHE) was introduced include the Population Education Programme (POP-ED) and the Population Family Life Education Programme (POP/FLE). It is however necessary to state that the two programmes were unsuccessful. See AHI *Building consensus for family life & HIV/AIDS education in schools: Report of the national consultative forum with religious leaders on education sector response to adolescent sexual and reproductive health and rights* (2004) 4, available at [http://www.actionhealthinc.org/publications/docs/building\\_consensus.pdf](http://www.actionhealthinc.org/publications/docs/building_consensus.pdf) (4 June 2013).

<sup>190</sup> A Ajuwon & W Brieger 'Evaluation of a school-based reproductive health education program in rural South Western, Nigeria' (2007) 11 *African Journal of Reproductive Health* 48.

<sup>191</sup> National family life and HIV education curriculum (n 188 above) i; AHI *Family life and emerging health issues curriculum: Training guide for colleges of education in Nigeria* (2009) iv, available at <http://www.actionhealthinc.org/publications/docs/FLEHICurriculum-TrainingGuideForCollegesOfEducation2009.pdf> (17 August 2013).

<sup>192</sup> The FLHE was initially known as the National Sexuality Education Curriculum. The name and content of the curriculum had to be changed due to concerns from various stakeholders thereby leading the National Council on Education (NCE) to allow states implement the FLHE in a culturally-acceptable manner based upon their socio-cultural peculiarities. See AHI -Building consensus (n 189 above) 4.

strengthen positive attitudes and values and also increase adolescent skills to take informed decisions and act upon them.<sup>193</sup> The major goal of the FLHE curriculum is to promote awareness and prevention against HIV and AIDS from primary to tertiary levels of education by providing learners with opportunities to:

- (i) develop a positive and factual view of their selves;
- (ii) acquire information and skills needed to take care of their health including preventing HIV;
- (iii) respect and value themselves and others; and
- (iv) acquire the skills needed to make healthy decisions about their sexual health and behaviour.<sup>194</sup>

The FLHE curriculum is organised around the themes of enhancing human development, personal skills, sexual behaviour, health and relationships of adolescents generally, and covers a variety of topics that allow for imparting information on issues relating to puberty, decision-making, values, communication skills, STIs, HIV and AIDS, abstinence, body abuse, gender including factors which influence/perpetuate gender roles and laws protecting children from abuse among others.<sup>195</sup>

Despite efforts to appease religious groups and other gatekeepers by allowing for the consideration of socio-cultural factors when implementing the FLHE Curriculum in states, there was continued resistance to the teaching of the curriculum giving rise to the need to embark on further consultation with various groups so as get an insight into their views on the curriculum.<sup>196</sup> At the end of the consultations, a FLHE curriculum was reluctantly adopted by the stakeholders based upon a major dilution of its contents with the removal of words perceived to be offensive.<sup>197</sup>

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<sup>193</sup> Durojaye 'Realising access to contraception for adolescents in Nigeria' (n 10 above) 203-204.

<sup>194</sup> National family life and HIV education curriculum (n 188 above) iii.

<sup>195</sup> National family life and HIV education curriculum (n 188 above) 1-47.

<sup>196</sup> The 2003 World Population Day with a theme on adolescent sexual and reproductive health and rights provided the chance to begin consultations on the curriculum. See AHI -Building consensus (n 189 above) 4.

<sup>197</sup> Like Durojaye notes: throughout the FLHE Curriculum, words like masturbation, vagina, genitals, homosexuality, contraception, condom, unprotected sex etc. perceived as 'offensive' were deliberately

While understanding to some extent the reason for the compromise which led to the ‘watering-down’ of the curriculum,<sup>198</sup> the importance of allowing adolescents (female adolescents in particular) to have access to realistic and factual information about their sexuality and reproductive health without restriction by cultural or religious beliefs cannot be over-emphasised. According to Jejeebhoy, five million adolescents and youths between 15 to 24 live with HIV and nine million young women between the ages of 15 and 24 undergo unsafe abortions yearly,<sup>199</sup> so denying adolescents and young people access to life-saving and health-promoting information and education on SRH care on the basis of protecting them from the ‘dangers of the modern world’ amounts to living in a fool’s paradise.<sup>200</sup>

Ensuring that adolescents have access to sexuality and reproductive health information is a major strategy to promote the practice of safer sexual behaviour.<sup>201</sup> As a result, there is the need for the content of the family life and HIV education curriculum to be as practical as possible and to also cover a wide range of issues, including pregnancy, anatomy, pregnancy and STIs among others. As Durojaye and other writers stress, the teaching of sexuality education, in addition to the topics highlighted above, should promote gender equality, decision-making and negotiation

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omitted and removed from the curriculum. See Durojaye ‘Realising access to contraception for adolescents in Nigeria’ (n 10 above) 206; AHI -Building consensus (as above).

<sup>198</sup> Due to the various cultural and religious impediments which contributed to the failure of previous national efforts to introduce sexuality education in schools and the disastrous impact of the HIV epidemic on the adolescent population, it is felt that the Nigerian government was pressed to make every effort to ensure that the FLHE Curriculum was at least initially introduced in schools. This led to the dilution of the curriculum from the original contents proposed by civil society organisations. Durojaye ‘Realising access to contraception for adolescents in Nigeria’ (n 10 above) 206.

<sup>199</sup> A majority of the affected adolescents and youths from this worldwide statistics live in Asia and sub-Saharan Africa. See Economic and Social Council - *Fool’s Paradise’ to Think Denying Adolescents Health-Promoting, Life-Saving Services Shielded Them, Prevented Promiscuity, Population Commission Told*, available at <http://www.un.org/News/Press/docs/2012/pop1003.doc.htm> (6 May 2013).

<sup>200</sup> Economic and Social Council - *Fool’s Paradise’ to Think* (as above).

<sup>201</sup> L Lindberg & I Maddow-Zimet ‘Consequences of sex education on teen and young adult sexual behaviours and outcomes’ (2012) 51 *Journal of Adolescent Health* 332.

and provide information on contraception, including the various methods available and where the services can be accessed.<sup>202</sup>

### 3.7 National Health Bill<sup>203</sup>

The proposed National Health Bill is based upon the move to adopt comprehensive health legislation that will assure access to basic health care services by Nigerians. Apart from defining clear roles and responsibilities for all the levels of government, the Health Bill seeks to provide a framework and strategies necessary for the effective planning, financing, monitoring and general evaluation of health care services.

Apart from stipulating that no health care provider should refuse to render emergency treatment for any reason,<sup>204</sup> the Health Bill includes provisions for making accessible to patients relevant information on their health status<sup>205</sup> and assuring that their privacy and confidentiality is maintained. Except in a situation where the patient consents to disclosure, disclosure should only be made based on a court order or where the maintenance of such confidentiality will amount to a serious public threat.<sup>206</sup>

Generally, based on its contents, the adoption and subsequent enactment of the proposed bill will amount to a step in the right direction, especially for female adolescents who suffer hardship in obtaining access to SRH care services including those related to contraceptive information and services; a situation which will be

<sup>202</sup> Durojaye 'Realising access to contraception for adolescents in Nigeria' (n 10 above) 206; F Alli 'Comprehensive sexual and reproductive health care services for youth: A health sector priority' University of KwaZulu-Natal (2011) 31-32; A Ajuwon *Benefits of Sexuality Education for Young People in Nigeria* (2005) available at <http://www.arsrc.org/downloads/uhsss/ajuwon.pdf> (15 July 2013).

<sup>203</sup> Nigerian National Health Bill 2012, available at [http://www.google.co.za/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&cad=rja&ved=0CCkQFjAA&url=http%3A%2F%2Fwww.nassnig.org%2F%2Fnass%2Flegislation.php%3Fid%3D1300&ei=3\\_FSUseYN4m-OQWt\\_YCwBg&usg=AFQjCNFicWbyQBiu11RQNZ7lgyEO31scww](http://www.google.co.za/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&cad=rja&ved=0CCkQFjAA&url=http%3A%2F%2Fwww.nassnig.org%2F%2Fnass%2Flegislation.php%3Fid%3D1300&ei=3_FSUseYN4m-OQWt_YCwBg&usg=AFQjCNFicWbyQBiu11RQNZ7lgyEO31scww) (15 August 2013).

<sup>204</sup> Sec 20 National Health Bill.

<sup>205</sup> Sec 23(1) National Health Bill.

<sup>206</sup> Sec 26 National Health Bill.

relieved by the provisions relating to the keeping of confidential records and the express prohibition of refusal by health officials to provide emergency health care services.

Accessing contraceptive services and information in an adolescent-friendly environment by adolescent girls is vital since refusal/non access can have disastrous consequences, including teenage pregnancy, which may lead to the loss of life as a result of illegal abortion, as well as infection with HIV and other STIs. Also, by guaranteeing access to needed health care services in private and confidential settings, adolescents, generally, and female adolescents, in particular, will be encouraged to access needed reproductive health care services. However, it is sad that attempts to pass the Nigerian National Health Bill have been the subject of various controversies since 2008 when moves towards its adoption were initiated.<sup>207</sup>

### 3.8 Conclusion

This section examines legislation and policies relating to adolescent reproductive health in Nigeria. As noted in the previous section, in addition to the African Charter which recognises the right to health and has been domesticated verbatim in Nigeria, the CRA 2003 is the major national law protecting children's rights, including their right to health care in Nigeria. The existence of various deficiencies in the CRA, such as its general limitation of children privacy rights, non-recognition of age and marital status as the basis of discrimination and the omission of children's right to access information, especially to contraceptive information and services are major shortcomings which require review.

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<sup>207</sup> Different groups have continued to oppose the passage of the bill into law due to varying reasons. See S Ayo-Aderele *'Rid proposed Health Bill of contentious items —CSOs'* (2013) available at <http://www.punchng.com/health/rid-proposed-health-bill-of-contentious-items-csos/> (21 March 2013); NIMASA *'NIGERIA: National Health Bill 2013'*, available at <http://nimsanigeria.wordpress.com/2013/02/13/nigeria-national-health-bill-2013/> (21 March 2013); Nigeria rivalry between Doctors & Health Workers spills into streets of Abuja over Health Bill, available at <http://battabox.com/2013/02/11/nigeria-health-rivalry-between-doctor-health-workers-spills-streets-abuja-health-bill/> (21 March 2013).

Also, although numerous health care policies that seek to improve the reproductive health of female adolescents exist in Nigeria, the fact that they serve merely as guidelines for the implementation and provision of health care services and are not justiciable is a shortcoming. However, it is suggested that as a result of the domestication of the African Charter and CRC in Nigeria, the court, in upholding the duties of the government to protect and respect the right to health care, can enquire into the reasonability of the policy implementation approaches. The deliberate dilution of the contents of the FLHE curriculum is a deficiency that reveals the unrealistic posture adopted by socio-cultural and religious gatekeepers, on one hand, and the Nigerian government, on the other, to effectively tackle problems associated with female adolescents' access to contraceptive information. The intent in the next section is to review the situation South Africa.

## 4 SOUTH AFRICA

### 4.1 Brief historical background of the South African legal system

The population of South Africa comprises several ethnic groups. It has a rich history, a prominent position in the African region,<sup>208</sup> almost 52 million citizens, nine provinces and an adolescent population that is 20% of its total populace.<sup>209</sup>

Because of both Dutch and British influence its legal system is peculiarly rich.<sup>210</sup> The country's legal system has a supreme Constitution and any law which is inconsistent

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<sup>208</sup> For a comprehensive history of South Africa, see G W Mukundi *South Africa: Constitutional, legislative and administrative provisions concerning indigenous peoples* (2009) available at [http://www1.chr.up.ac.za/chr\\_old/indigenous/country\\_reports/Country\\_reports\\_SouthAfrica.pdf](http://www1.chr.up.ac.za/chr_old/indigenous/country_reports/Country_reports_SouthAfrica.pdf) (26 September 2013); F T Abioye 'Rule of law in English speaking African countries: The case of Nigeria and South Africa' University of Pretoria (2011) 252-296.

<sup>209</sup> Statistics South Africa *Census 2011: Methodology and highlights of key results* (2012) 10, available at [http://www.statssa.gov.za/Census2011/Products/Census\\_2011\\_Methodology\\_and\\_Highlights\\_of\\_key\\_results.pdf](http://www.statssa.gov.za/Census2011/Products/Census_2011_Methodology_and_Highlights_of_key_results.pdf) (21 March 2013).

<sup>210</sup> In 1652 the Dutch created a settlement at the Cape of Good Hope. In 1910 the Union of South Africa was formed. The British and Dutch, at various times, 'colonised' the country thereby resulting in the hybrid nature of its laws. See Mukundi (n 208 above); J C Bekker *et al Introduction to legal pluralism in South Africa* (2006) 7.

with the Constitution is null and void to the extent of such inconsistency.<sup>211</sup> Apart from the Constitution, the country derives its legal roots from an amalgam of Roman Dutch law and common law and, in addition, African customary law, which jointly make up South Africa's legal system.<sup>212</sup>

In 1910, the Union of South Africa was formed with the promulgation of the South Africa Act of 1909 which also served as the Constitution of the Republic of South Africa.<sup>213</sup> According to the Act, the powers of the British monarch were vested in his representative, the governor general.<sup>214</sup>

In 1948 the Nationalist Party won a majority in Parliament and introduced the 'Apartheid' system.<sup>215</sup> The policy of separate development enabled them to control the country's socio-economic system and exclude black people from political power.<sup>216</sup> In 1961, South Africa became a republic with the formal severing of ties with Britain through the passage of the Republic of South Africa Constitution Act.<sup>217</sup> Several decades of struggle to be free from apartheid and its' policies followed.<sup>218</sup> In 1990 President De Klerk<sup>219</sup> announced the unbanning of certain opposition parties,

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<sup>211</sup> Sec 2 Constitution of the Republic of South Africa 1996.

<sup>212</sup> For example, the crime of 'abortion', before 1996 when the Choice on Termination of Pregnancy Act No. 92 of 1996 was passed, originated, from both the Common law and Roman-Dutch law. Also the law of contract has its roots in the Roman-Dutch law while Company law has its roots in English common law. See F A R Adeleke. 'Reproductive right or reproductive fallacy? The extreme provisions of the Choice of Termination of Pregnancy (CTOP) Act 1996 in South Africa' (2010) 16 *Fort Hare Papers* 31; Mukundi (n 208 above) 14.

<sup>213</sup> Under the provisions of the South Africa Act, the Union of South Africa remained a British territory. In 1934, South Africa gained dominion status. For a fuller history of South Africa, see Mukundi (n 208 above); Abioye (n 208 above).

<sup>214</sup> See generally Abioye (as above) 273-274.

<sup>215</sup> The term 'Apartheid' means 'apartness', a system of white political domination and racial discrimination. The entire population was divided along racial lines of whites, coloureds and blacks to determine access to education, health care services and voting rights among others. The Apartheid system was in operation in South Africa until 1994.

<sup>216</sup> Mukundi (n208 above) 11.

<sup>217</sup> The Republic of South Africa Constitution Act 32 of 1961. Blacks, who make up a majority, had no share in the 1909 and 1961 Constitutions.

<sup>218</sup> For the history of the series of events that occurred during Apartheid, see generally Abioye (n 194 above) 275- 296.

<sup>219</sup> Address by President FW De Klerk at the opening of the second session of the ninth parliament of the Republic of South Africa in Cape Town on 2 February 1990, available at <http://www.info.gov.za/speeches/1996/101348690.htm> (24 March 2013). Nelson Mandela, a

freeing political prisoners and the abolition of capital punishment. These moves signified the beginning of the end of 'apartheid'. The present Constitution of South Africa was drafted after a series of negotiations among various interest groups.<sup>220</sup>

The Children's Act of 1937<sup>221</sup> - as noted by Fourchard<sup>222</sup> - was passed to address the problems associated with juvenile delinquency and the welfare of children who were in need of attention. During the struggle against the separatist policies, children had been held in custody for participating in political activities and their rights were violated.<sup>223</sup>

The protection of South African children was similar to the position in Nigeria, in the sense that before the adoption of the present children's legislation,<sup>224</sup> previous legislation focused on the issue of juvenile offenders and children in need of care to the detriment of ensuring the overall protection of children's rights.<sup>225</sup> As a result of the precarious situation of South African children generally, a large number of non-governmental organisations sprang up to advocate the promotion of the rights of children.<sup>226</sup> Numerous conferences focused on the impact of the apartheid system on the lives of children and women in South African society.<sup>227</sup>

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prominent political prisoner who later became the President of a newly democratic South African Republic, was released nine days after the speech.

<sup>220</sup> The negotiation for a democratic constitution began with the convening of the Convention for a Democratic South Africa (CODESA) in 1991 and culminated with the draft of an interim constitution in 1993 that came into force in 1994. See, generally, South Africa History online: The drafting and acceptance of the Constitution, available at <http://www.sahistory.org.za/drafting-and-acceptance-constitution> (24 March 2013).

<sup>221</sup> The Children's Act No. 31 of 1937 was later repealed by the Children's Act No. 33 of 1960. Some of the other laws relating to children include the Child Care Act No. 74 of 1983, Child Care Amendment Act No. 86 of 1991 etc. These laws were repealed by the Children Act No. 38 of 2005.

<sup>222</sup> Fourchard (n 13 above) 517.

<sup>223</sup> K Abrahams & T Matthews 'Child Rights Manual: Handbook for Parliamentarians' (2011) 10, available at [http://www.unicef.org/southafrica/SAF\\_resources\\_promoterights.pdf](http://www.unicef.org/southafrica/SAF_resources_promoterights.pdf) (24 March, 2013).

<sup>224</sup> Children's Act 2005 and Child Rights Act 2003.

<sup>225</sup> Fourchard (n 13 above) 517.

<sup>226</sup> In 1990, a National Committee on the Rights of the Child (NCRC) comprising over 200 NGOs working on children's rights, was established to ensure the effective coordination of their activities in the general interest of children. South Africa History online (n 206 above) 12.

<sup>227</sup> South Africa History online (n 206 above) 10.

Further efforts to guarantee children's rights include the submission of a Children's Charter at CODESA and an invitation to child rights experts to have an input in the promotion of children's rights in the draft constitution. The numerous efforts<sup>228</sup> yielded fruit, in addition to the general rights afforded all South African citizens, a specific section protecting children's rights (both civil and socio-economic rights) was inserted into both the Interim Constitution of 1993<sup>229</sup> and its final version in 1996.<sup>230</sup>

The South African legal system is hybrid in nature and largely un-codified. The sources of law are the Constitution, national legislation, customary law, judicial precedents and the writings of modern authors: all of which will be discussed in the subsequent sub-sections.

#### 4.2 Constitution of the Republic of South Africa, 1996

With the emergence of constitutional democracy in South Africa in 1994, the Constituent Assembly had the important duty of preparing a final constitution that would tally with the aspirations of South Africans noted during the process of drafting of the Interim Constitution. After a number of painstaking efforts, that included a certification process by the Constitutional Court, the Constitution of the Republic of South Africa was signed into law in 1996, becoming the country's supreme law.

Consisting of thirteen chapters and 243 sections, the Constitution of the Republic of South Africa introduces standards and principles grounded upon the realisation and need to assure the human rights of all South African citizens. In its preamble, the Constitution, which acknowledges the infliction of past injustices and believes in the

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<sup>228</sup> In December 1993, South Africa through President De Klerk and Nelson Mandela signed the 1990 Declaration and Plan of Action of the World Summit for Children and the international Convention on the Rights of the Child while work began on the drafting of a National Programme of Action for South African children.

<sup>229</sup> Sec 30 Constitution of the Republic of South Africa Act No. 200 of 1993, available at <http://www.info.gov.za/documents/constitution/93cons.htm> (24 March 2013).

<sup>230</sup> Sec 28 Constitution of the Republic of South Africa Act No. 108 of 1996, available at <http://www.info.gov.za/documents/constitution/1996/a108-96.pdf> (24 March 2013).

unity of all despite diversity, lays the foundation for the creation of a democratic and open society in which governance is based on the will of the people.<sup>231</sup> Section one states that the South African nation is a sovereign democratic state founded upon the values of respect for human dignity, equality, non- discrimination and the supremacy of the constitution and the rule of law. Section two reiterates the declaration that the Constitution is the supreme law of the republic and laws or conducts which are inconsistent with its provisions are invalid.

Chapter two<sup>232</sup> of the Constitution contains the Bill of Rights, a cornerstone of South African democracy, which, apart from enshrining the rights of all peoples, importantly affirms democratic values relating to dignity, freedom and equality that must be respected, protected and fulfilled by the South African state and which binds all the organs of government.<sup>233</sup>

As in the examination of the Nigerian 1999 Constitution, rights that are relevant to guarantee female adolescents access to contraceptive information and services will be examined. Such rights include the rights to equality,<sup>234</sup> dignity,<sup>235</sup> life,<sup>236</sup> freedom and security of the person<sup>237</sup> privacy,<sup>238</sup> freedom of expression,<sup>239</sup> health care, including reproductive health care,<sup>240</sup> children's right to basic health care services,<sup>241</sup> to education<sup>242</sup> and access to information.<sup>243</sup>

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<sup>231</sup> Preamble, Constitution of the Republic of South Africa 1996.

<sup>232</sup> Secs 7-39 Constitution of the Republic of South Africa 1996.

<sup>233</sup> Sec 7 & 8 Constitution of the Republic of South Africa 1996.

<sup>234</sup> Sec 9 Constitution of the Republic of South Africa 1996.

<sup>235</sup> Sec 10 Constitution of the Republic of South Africa 1996.

<sup>236</sup> Sec 11 Constitution of the Republic of South Africa 1996.

<sup>237</sup> Sec 12 Constitution of the Republic of South Africa 1996. Especially the right to bodily and psychological integrity which includes the right to make decisions on reproduction guaranteed in sec 12(2)(a).

<sup>238</sup> Sec 14 Constitution of the Republic of South Africa 1996.

<sup>239</sup> Sec 16 Constitution of the Republic of South Africa 1996. Especially the freedom to receive and impart information recognised in sec 16(1)(b).

<sup>240</sup> Sec 27(1)(a) Constitution of the Republic of South Africa 1996.

<sup>241</sup> Sec 28(1)(c) Constitution of the Republic of South Africa 1996.

<sup>242</sup> Sec 29 Constitution of the Republic of South Africa 1996.

<sup>243</sup> Sec 32 Constitution of the Republic of South Africa 1996.

As the first right guaranteed in the Bill of Rights, the importance attached to the protection of the right to equality of all people by the South African state is obvious. The section which unequivocally states that everyone is equal before the law and has a right to equal protection of the law declares that the right to equality not only includes full and equal enjoyment of all rights and freedoms, but also includes the promotion of affirmative actions that will result in the advancement of people in positions of disadvantage as a result of unfair discrimination.<sup>244</sup> In other words, the equality provision contained in the constitution recognises the need for people to be treated equally and it encourages the practice of substantive equality which operates from a position that although individuals are to be treated similarly, in the bid to achieve actual and true equality, notice of their particular situations should be put into consideration.

In the words of Devenish,<sup>245</sup> the insertion of the affirmative action provision in the Constitution of the Republic of South Africa is understandable in light of the country's history and political experience and the objective of the equality jurisprudence is to thoroughly examine differentiations that impact on human dignity. Also, according to Abertyn and Kentridge, the use of a substantive equality principle requires a careful examination of the actual socio-economic conditions of groups and individuals so as to determine whether constitutional commitments to equality are being upheld.<sup>246</sup>

Additionally, the Constitution<sup>247</sup> expressly prohibits unfair discrimination on the grounds of race, gender, sex, pregnancy, marital status, colour, sexual orientation and age among others. The insertion of extensive grounds upon which discrimination is prohibited is encouraging as it specifically includes grounds such as age, pregnancy, gender and marital status, areas in which female adolescents generally experience

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<sup>244</sup> Sec 9(2) Constitution of the Republic of South Africa 1996.

<sup>245</sup> G E Devenish *The South African Constitution* (2005) 47.

<sup>246</sup> C Abertyn & J Kentridge 'Introducing The Right to Equality in the Interim Constitution' (1994) 10 *South African Journal on Human Rights* 152.

<sup>247</sup> Sec 9(3) Constitution of the Republic of South Africa 1996.

unfair discrimination when attempting to access contraceptive information and services. This is unlike the position in the Nigerian Constitution which has been extensively criticised as a result of its omission to prohibit discrimination on the important grounds on which adolescent girls suffer inequality.<sup>248</sup>

The importance and need to treat adolescent girls with dignity when accessing contraception and other SRH care services cannot be over emphasised. Unlike other rights recognised under international human rights law, such as the rights to equality, privacy and information, which may be the subject of limitations in exceptional situations, the right to dignity cannot be limited as it is the ‘characteristic that gives a person intrinsic worth’.<sup>249</sup> In *S v Makwanyane and Another*,<sup>250</sup> the South African Constitutional Court reaffirmed the importance of the right to dignity when it stated:

[T]he importance of dignity as a founding value of the new constitution cannot be over-emphasised. Recognising a right to dignity is the acknowledgement of the intrinsic worth of human beings: human beings are entitled to be treated as worthy of respect and concern. This right therefore, is the foundation of many of the other rights that are specifically entrenched.<sup>251</sup>

A major obstacle to the right of adolescents generally (adolescent girls in particular) in Nigeria and South Africa to reproductive health care is the refusal of health providers, as a result of their cultural or religious bias<sup>252</sup> to treat them with dignity

<sup>248</sup> Durojaye ‘Realising access to contraception for adolescents in Nigeria’ (n 10 above) 166.

<sup>249</sup> Devenish (n 245 above) 61.

<sup>250</sup> *S v Makwanyane and Another* (1995) (3) SA 391 (CC), 1995 (6) BCLR 665 (CC).

<sup>251</sup> As above, para 328.

<sup>252</sup> As a result of cultural and religious beliefs, adolescent girls are prevented from accessing contraceptives services and information. In South Africa, especially in relation to abortion services, health care providers use contentious objection to refuse to participate in abortion procedures. However, such providers are under the obligation to refer the woman or adolescent to another provider or facility where the procedure can be carried out. See J Harries *et al* ‘Conscientious objection and its impact on abortion service provision in South Africa: A qualitative study’ (2014)11 *Reproductive Health* 3 & 4; J Harries *et al* ‘Health care providers’ attitudes towards termination of pregnancy: A qualitative study in South Africa’ (2009) 9 *BMC Public Health* 2 available at <http://www.biomedcentral.com/content/pdf/1471-2458-9-296.pdf> (2 October 2014). Conscientious objection is the refusal to perform a legal role or responsibility as a result of personal beliefs. In health care, conscientious objection involves health care providers’ refusal to carry out certain treatment on patients as a result of their moral or religious beliefs.

when they access contraception. Female adolescents will endeavour to access contraceptive services and information only in a situation in which they are assured of receiving dignified treatment in adolescent-friendly environments. In light of the high rates of STIs and HIV which disproportionately affect female adolescents, there is an urgent need to overcome these prejudice so that various international, regional and national efforts to curb the spread of the epidemic can yield fruit.

Like the right to dignity, the right to life is unqualified under the South African Constitution: section 11 simply provides that ‘Everyone has the right to life’. As explained by Devenish,<sup>253</sup> although the broad protection of the right to life guaranteed in the constitution is abstract and can lead to various interpretations, especially in relation to contentious issues of the right to life in euthanasia and abortion<sup>254</sup> cases, the unqualified nature of the right to life under the Constitution is a personal one that exists in human beings only. In relation to the right of South African adolescent girls, the right to life would be encroached upon and violated if the government fails to ensure that its female adolescents have access to contraceptive information and services and other reproductive health services guaranteed under its Constitution<sup>255</sup> and the Children’s Act.<sup>256</sup> Its responsibilities include curtailing health care providers and other morality gate keepers who, by their actions, may discourage adolescents generally from accessing contraception.<sup>257</sup>

In relation to the rights to security of the person, privacy and information, the Constitution recognises the right of citizens (including adolescent girls) to privacy and acknowledges their freedom to make decisions on reproduction and receive relevant information thereto. This recognition is in addition to the fact that the Children’s Act

<sup>253</sup> Devenish (n 245 above) 65.

<sup>254</sup> In *Christian Lawyers Association of South Africa v Minister of Health* (1998) (4) SA 1113 (T) – the plaintiffs argued that the provision of section 11 of the 1996 SA Constitution that guarantees the right to life to everyone, also includes the unborn child as a result of which the Choice on Termination of Pregnancy Act should be struck down. The court decided, however, though the right to life applied to everyone, that it does not confer legal personality on a foetus.

<sup>255</sup> Secs 16(1)(b), ) 27(1)(a) & 28(1)(c) Constitution of the Republic of South Africa 1996.

<sup>256</sup> Sec 134 Children’s Act.

<sup>257</sup> Wood (n 70 above) 113 - 114.

specifically allows children to personally consent to medical procedures,<sup>258</sup> receive information on SRH<sup>259</sup> and access private and confidential contraception<sup>260</sup> and pregnancy termination services without parental consent.<sup>261</sup> As reiterated, granting adolescent girls access to contraceptive information and services in private and confidential settings not only allows for their exercise of autonomy and freedom but also encourages their predisposition to access protective SRH care services generally. Over time, this achievement translates to a country reaping dividends by the reduction in the number of teenage pregnancies and of adolescent sexual ill health.

By allowing the provisions dealing with the protection of the reproductive health of its citizens to apply to children, the South African government has been progressive in enhancing the rights of children in relation to their access to contraception and reproductive health care. This is a more realistic and practical approach in dealing with adolescent SRH issues, unlike in Nigeria, where the laws and policies do not outright grant female adolescents access to contraception. However, the setting of 12 years as the age at which access to contraception can be granted on request may, as rightly observed by Dickens and Cook, prejudice adolescent health and well-being and create a barrier to care as adolescents, generally, do not mature at the same pace.<sup>262</sup>

For adolescent girls to enjoy reproductive health rights, it is vital that their access to contraceptive information and services is guaranteed by government which are duty

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<sup>258</sup> Sec 129 Children's Act. Children from the age of 12 can consent to medical procedures in certain situations.

<sup>259</sup> Sec 13(1)(a) Children's Act.

<sup>260</sup> Sec 134 (3) Children's Act. In relation to access to contraception, the Act allows access for children from 12 years after proper medical advice has been given and relevant and necessary medical examinations have been conducted to determine whether there is a specific reason not to grant a particular type of contraception to the child.

<sup>261</sup> Sec 5(2) & (3) Choice on Termination of Pregnancy Act 92 of 1996.

<sup>262</sup> B M Dickens & R J Cook 'Adolescents and consent to treatment' (2005) 89 *International Journal of Gynaecology and Obstetrics* 182 -183. According to the authors, since adolescents do not mature at the same pace fixing 'ages of medical consent' instead of 'conditions of consent' may result in barriers to adolescent sexual and reproductive health being imposed unintentionally as sometimes, there may be mature minors, who though below 12 years, already understand the reason for their need of actual contraceptive services and information.

bound to ensure that female adolescents have access to the required services and information free of charge at government hospitals. Currently, this is the position in South Africa where the right to reproductive health care is constitutionally assured.<sup>263</sup> In Nigeria, the right to health care is not acknowledged constitutionally nor are adolescent girls given the express right in its laws, to access contraceptive information and services.

By guaranteeing the right to reproductive health care constitutionally, the South African government specifically takes note of the special needs of women (including adolescent girls'), who in order to live dignified lives, require access to essential information and services in this field of health care as a result of their biological makeup and the huge burden of disease related to the performance of their reproductive functions.<sup>264</sup> Ngwena states, the provision of section 27 of the Constitution of the Republic of South Africa, which confers a positive right to receive reproductive health care from the state, is egalitarian since it strives to secure not only formal equality,<sup>265</sup> so that factors like gender, age, marital status and race cease being issues that affect access to health care services, but also substantive equality so that other social disadvantages that prevent access to health care<sup>266</sup> are eliminated or reduced to a minimum.<sup>267</sup>

An outstanding distinction which separates the Constitution of the Republic of South Africa from its Nigerian counterpart is its specific inclusion of children rights in its provisions. According to Sloth-Nielsen, the inclusion of a detailed provision on the

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<sup>263</sup> Sec 27(1)(a) Constitution of the Republic of South Africa 1996.

<sup>264</sup> Women play a major role in reproduction and have an elaborate reproductive system that is vulnerable to diseases. See Cook et al 'Reproductive health and human rights' (n 81 above) 8-9.

<sup>265</sup> Formal equality involves the treatment of 'like things in a like manner'. This mode of equality promotes the recognition of the equal treatment of individuals without consideration of the existence of extraneous factors or vulnerability.

<sup>266</sup> Social impediments which affect adolescent girls' access to contraception include those related to income, culture, religion and geographical location as girls living in rural areas in a majority of situations don't have access to reproductive health care due to the reason that either the facilities are far away or they cannot afford paying user fees.

<sup>267</sup> C Ngwena 'The recognition of access to health care as a human right in South Africa: Is it enough?' (2000) 5 *Health and human rights* 29.

protection of the right of children in section 28 of the Constitution of the Republic of South Africa can be traced to international law which advocates in various human rights instruments<sup>268</sup> the protection of children's rights.<sup>269</sup>

In recognition of the vulnerable situation of children, apart from the specific protection provided children in section 28, the Constitution recognises the right of children to enjoy all other rights guaranteed to adults in the Bill of Rights.<sup>270</sup> Although various rights pertaining to children are specifically guaranteed in section 28,<sup>271</sup> attention will be given to the right of children to basic health care provided in section 28(1) (c).<sup>272</sup> It is important to highlight from the outset that the rights recognised in section 28(1) (c) are socio-economic rights which have already been guaranteed to 'everyone' in the Constitution. As Robinson notes,<sup>273</sup> the inclusion of socio-economic rights in the rights guaranteed in section 28 is to give a qualitative content to the child's right to care and protection as it provides baseline necessities which children are entitled to in order to live dignified lives.

It is also important to emphasise that whereas the right of everyone to the socio-economic rights assured in sections 26(1) and 27(1) is subject to the availability of resources,<sup>274</sup> the entitlement of children with regard to the rights contained in

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<sup>268</sup> Human rights instruments like the International Covenant on Civil and Political Rights, International Covenant on Economic, Social and Cultural Rights, African Charter on Human and Peoples' Rights, Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa generally advocate the protection of the rights of people generally while the Convention on the Rights of the Child and its African counterpart, the African Charter on the Rights and Welfare of the Child, specifically guarantee the rights children generally.

<sup>269</sup> J Sloth-Nielsen 'Children' in *South African Constitutional Law: Bill of rights* (2012) 23-2. See also *Government of the Republic of South Africa v Grootboom* 2001(1) SA 46 (CC) para 75.

<sup>270</sup> J A Robinson 'Children's rights in the South African Constitution' (2003) 6 *Potchefstroom Electronic Law Journal* 16. An exception in this regard relates to the right to vote which is only accorded to adult citizens – Sec 19(3) (a) Constitution of the Republic of South Africa 1996.

<sup>271</sup> Apart from children's rights protected under sec 28(1)(c), other rights recognized in the section include the right of children to family care or parental care – 28 (1) (b); the right of children to be protected from maltreatment, abuse or degradation-28 (1) (d); children's right to be protected from exploitative labour practices - 28 (1) (e) among others.

<sup>272</sup> Sec 28(1) (c) Constitution of the Republic of South Africa recognises the right of children to basic nutrition, shelter, basic health care services and social services.

<sup>273</sup> Robinson (n 270 above) 41.

<sup>274</sup> Secs 26(2) & 27(2) Constitution of the Republic of South Africa 1996.

section 28(1) (c) is unqualified and not subject to the availability of resources.<sup>275</sup> The above will be the basic interpretation of the provision of the section, however, in *Government of the Republic of South Africa v Grootboom*,<sup>276</sup> the Constitutional Court rejected the application of the right under section 28(1)(c), unqualifiedly, on the basis that it produces anomalous results in the sense that people who have children would have direct and enforceable right to housing under s 28(1)(c), whereas others who have none or whose children are adult are not entitled to housing under the section, no matter how old, disabled or otherwise deserving they may be.<sup>277</sup> In addition, there is the danger of children being used as ‘stepping stones’ to housing for their parents instead of being valued for who they are.<sup>278</sup>

In *Minister of Health v Treatment Action Campaign (TAC)*,<sup>279</sup> a case was instituted as a result of the government’s refusal to expand its pilot programme on the provision of Nevirapine a drug administered to prevent the transmission of HIV from pregnant women to their unborn children. The Constitutional Court attempted to clarify its earlier decision in *Grootboom* by declaring that the state’s duty to guarantee and provide children’s socio-economic rights under section 28(1) (c) is triggered not only when children are physically separated from their parents but also in situations in which, though the children reside with their parents, the parents are indigent and unable to effectively provide basic necessities for their children.<sup>280</sup> Despite the clarification, however, the court did not base its decision on section 28(1) (c) by concluding that children directly had individual rights to health care if they had

<sup>275</sup> Robinson (n 270 above) 42.

<sup>276</sup> *Government of the Republic of South Africa v Grootboom* (n 269 above). At the high court, the judge had reached a decision that considering section 28(1)(c) which guarantees children the right to basic nutrition, shelter, basic health care services and social services unqualifiedly, the right in sec 28(1)(c) had been violated.

<sup>277</sup> *Government of the Republic of South Africa v Grootboom* (n 269 above) para 71.

<sup>278</sup> (as above) para 71. To ‘cure’ the perceived defect, the Constitutional Court reached a decision that the provisions of section 28(1)(c) creates an obligation on the state to provide shelter to those children who are removed from their families but for children being cared for by their parents or families, sec 28(1)(c) does not create any primary state obligation to provide them shelter on demand – para 77.

<sup>279</sup> *Minister of Health v Treatment Action Campaign (TAC)* 2002 (5) SA 721 (CC).

<sup>280</sup> (as above) para 79. See also S Liebenberg ‘Taking stock: The jurisprudence on children’s socio economic rights and its implications for government policy’ (2004) 5 *ESR Review* 4.

indigent parents but, instead, declared that a violation of sections 27(1) and (2) of the Constitution had occurred and required the government to devise and implement within its available resources a comprehensive and co-ordinated programme to realise progressively the right to health care.<sup>281</sup>

Notwithstanding the fact that the Constitutional Court did not centre its decision on the provisions contained in section 28(1)(c), it is argued that the constitutional obligation imposed on the South African government to ensure the guarantee of the right of children to basic health care services obviously will include female adolescents being entitled, at the minimum, to basic reproductive health care services of which their access to contraceptive information and services is an integral part. It is also argued that the interpretation which afford South African female adolescents access to contraceptive information and services as part of their right to basic health care services can be applied to Nigerian female adolescents who, despite the fact that their right to health care is not constitutionally guaranteed, are entitled to the best attainable state of health services, including primary health care,<sup>282</sup> under which family planning and contraception services are offered in the country.

Apart from the specific guarantee of the rights of children in section 28(1), the Constitution in section 28(2) provides that the best interests of children are of paramount importance in every matter concerning them. In interpreting the 'best interests' of children principle, the Constitutional Court, in *Minister of Welfare and Population Development v Fitzpatrick*,<sup>283</sup> explained that the 'best interests' of children principle recognised as paramount in sec 28(2) of the Constitution extends

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<sup>281</sup> *Treatment Action Campaign's case* (n 279 above) para 135. Instead the court used the provision of section 28(1)(c) to support its findings that the government's rigid and restrictive policy on Nevirapine was 'unreasonable' as it excluded and harmed a particularly vulnerable group. See Liebenberg (as above) 5. Probably to highlight the fact that the rights of children contained in section 28(1)(c) is not unqualified but in fact subject to the availability of resources, sec 4(2) of the Children's Act which came in to effect on 1 July, 2007 specifically notes that in achieving the realisation of the objects of the Act, all arms of government must take reasonable measures to the maximum extent of available resources.

<sup>282</sup> Sec 13 (1) & (3) (b) Child Rights Act.

<sup>283</sup> *Minister of Welfare and Population Development v Fitzpatrick* 2000 (3) SA 422 (CC)

beyond the rights enumerated in section 28(1) to create a right on its own.<sup>284</sup> In addition, the courts have variously used the principle in reaching appropriate decisions in cases where determining the best interests of the child is an important factor.<sup>285</sup> Recently in the *Teddy Bear Clinic case*,<sup>286</sup> the Gauteng High Court, in declaring some portions of the of the Criminal Law (Sexual Offences and Related Matters) Amendment Act<sup>287</sup> unconstitutional, repeated the position adopted by South African courts in relation to the ‘best interests’ principle by declaring that the provisions of section 28(2) has a wide ambit and must be considered in all matters affecting children.<sup>288</sup>

Finally, in alignment with international and regional human rights instruments relating to children, it is necessary to highlight that the Constitution of the Republic of South Africa defines a child as ‘any person under 18 years’ and restates the ‘best interests’ of the child principle.<sup>289</sup> The insertion of section 39(1) in the constitution, which provides that South African courts are to consider international law and promote the values of human dignity, equality and freedom, serves as a further guarantee of South African adolescent girls’ right to contraceptive information and services. The courts have no choice but to take note of international human rights standards in actions relating to the interpretation or violation of adolescents’ right to reproductive health care.

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<sup>284</sup> As above, para 17.

<sup>285</sup> *Mfolo v Minister of Education, Bophuthatswana* 1992 (3) SA 181 (BG); *Minister of Welfare and Population Development v Fitzpatrick* (n 283 above) para 18; *Director of Public Prosecutions, KwaZulu-Natal v P* 2006 (1) SACR 243(SCA) para 18; *S v M (Centre for Child Law as Amicus Curiae)* 2008 (3) SA 232 (CC) para 22.

<sup>286</sup> *Teddy Bear Clinic for Abused Children and RAPCAN v Minister of Justice and Constitutional Development and Another* Case No: 73300/10.

<sup>287</sup> Secs 15, 16, 56(2)(b) Criminal Law (Sexual Offences and Related Matters) Amendment Act No. 32 of 2007. See also the definition of ‘sexual penetration’ in sec 1 of the Act.

<sup>288</sup> *Teddy Bear Clinic case* (n 286 above) para 72. The best interest principle under the South African jurisdiction is further discussed below in relation to the provision of sec 9 of the Children’s Act 2005.

<sup>289</sup> Sec 28(2) & (3) Constitution of the Republic of South Africa 1996.

### 4.3 South African legislation

Apart from the Constitution of the Republic of South Africa, legislation laid down by Parliament (the legislative arm of the South African government) is an important source of law. Legislation is usually expressed in writing as ‘statutes’ or ‘Acts’. Apart from parliament, organs of government at other levels, such as the provincial legislatures, are able to pass subordinate legislation in the form of provincial acts or municipal by-laws.<sup>290</sup>

As a powerful source of law, legislation is usually the source of choice in the interpretation and examination of the contents of the law in any particular field.<sup>291</sup> The scope and powers of the legislative arm of government in the South African Republic are generally contained in chapter 4 of the 1996 Constitution and include the powers to pass legislation with regard to any matter and to amend the Constitution as necessary.<sup>292</sup> Currently, apart from the Constitution, the principal legislations which protect the right of adolescent girls in South Africa to contraceptive information and services are the Children’s Act,<sup>293</sup> the Choice on Termination of Pregnancy Act<sup>294</sup> and the National Health Act that was adopted in 2003.<sup>295</sup> Relevant portions of these legislations will be discussed in section 5 on adolescent reproductive health laws and policies in South Africa.

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<sup>290</sup> It should be noted that the municipal council is also empowered to pass by laws that regulate affairs in a municipality.

<sup>291</sup> Department of Justice *African Charter on Human and Peoples’ Rights: Introduction into the South African legal system*, available at <http://www.justice.gov.za/policy/african%20charter/african-charter02.html> (24 March 2013).

<sup>292</sup> Sec 44 Constitution of the Republic of South Africa 1996.

<sup>293</sup> Children’s Act No. 38 of 2005.

<sup>294</sup> Choice on Termination of Pregnancy Act No. 92 of 1996.

<sup>295</sup> Sec 2(c) (i) & (iii) National Health Act.

#### 4.4 Customary law

Another source of law in South Africa is customary law, which includes indigenous law. Indigenous signifies law which originates in the culture of a particular African tribe and society as a result of continued usage. Customary law is generally unwritten, indigenous law on the other hand can be in written or unwritten form.<sup>296</sup> It should be noted that for customary law to be recognised, it must be reasonable, long-established and clear.<sup>297</sup>

Many black communities live according to the dictates of indigenous and customary laws, so indigenous law is taken note of and applied in South African courts by virtue of the provisions of section 211(3) of the Constitution 1996 which state that the courts must apply customary law when it is applicable, albeit subject to the provisions of the Constitution<sup>298</sup> and any legislation that specifically deals with customary law. Also, the Evidence Amendment Act<sup>299</sup> stipulates that a court can take judicial notice of indigenous law provided such law does not conflict with the principles of public policy or natural justice.

#### 4.5 Common law

In South Africa, common law as a source of law is mainly Roman Dutch law that was introduced into the South African Republic in the 17th and 18th centuries as a result of colonisation by the Dutch. English law has had a lesser influence. South Africa has an uncodified legal system, so a majority of its laws in different areas are still dictated by common law rules as a result of the fact that the fundamental principles which provide a framework for the laws are not contained in any legislation. Even

<sup>296</sup> Department of Justice (n 291 above).

<sup>297</sup> As above.

<sup>298</sup> *Mabuza v Mbatha* (1939/01) [2002] ZAWCHC 11; (2003) (7) BCLR 743; (2003) (4) SA 218 (C) para 32. In *Bhe v. Magistrate Khayelitsha & Others* 2005 (1) BCLR 1 (CC), the Constitutional Court declared section 23 of the Black Administration Act invalid and unconstitutional as it discriminates unfairly against women and illegitimate children on the grounds of race, gender and birth. See also *Shilubana and Others v Nwamitwa* (2008) ZACC 9; 2008 (9) BCLR 914 (CC); 2009 (2) SA 66 (CC).

<sup>299</sup> Evidence Amendment Act 45 of 1988.

where legislation exists, recourse is still made to common law concepts and principles for clarity,<sup>300</sup> especially in situations in which there is a *lacuna* in legislation or where existing legislation fails to provide needed answers.<sup>301</sup>

To this extent it can be rightly stated that the South African courts, apart from interpreting legislation, also interpret the common law.<sup>302</sup> Acknowledging the important role which common law plays in the country's legal system, the Constitution recognises the inherent powers of the court to protect and regulate their processes, while taking into cognisance the interests of justice.<sup>303</sup>

#### 4.6 Judicial precedents

As in Nigeria, judicial precedents are also a source of law under South Africa's legal system with decisions emanating from superior courts in the country serving as guide and precedent for lower courts to follow.<sup>304</sup>

#### 4.7 Conclusion

Taking its legal roots from an amalgam of common law and Roman-Dutch law, South Africa's legal system is based on its Constitution, which is the supreme law in the country. Like in Nigeria, other sources of the country's legal system include national legislation, customary law and judicial precedents.

Affirming underlying values of respect for human dignity, equality and freedom, the Constitution of the Republic of South Africa directly domesticates provisions contained in human rights instruments, enshrining the protection of socio-economic rights alongside civil and political rights in its Bill of Rights. In relation to the right of female adolescents' to access contraceptive information and services, and differing

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<sup>300</sup> Examples of areas where common law dictates include the laws of contract (obligations) and property law. F du Bois 'Introduction: History, system and sources' in C G Van Der Merwe & JE Du Plessis (eds) *Introduction to the law of South Africa* (2004) 40.

<sup>301</sup> W J Hosten *et al Introduction to South African Law and Legal Theory* (1995)385.

<sup>302</sup> D Kleyn & F Viljoen *Beginners guide for law students* (2002) 82-83.

<sup>303</sup> Sec 173 Constitution of the Republic of South Africa 1996.

<sup>304</sup> R B Antoine *Commonwealth Caribbean law and legal systems* (2008) 118.

from Nigeria's constitutional position, the Constitution of the Republic of South Africa specifically enshrines protection for the right to health care, including reproductive health care, and the right of children to 'basic health care services'. Unlike the former, the right of children to basic health care services is not subject to the availability of funds. Also, noting the vulnerability of children, provisions relating to the definition of a child and the mandate to regard the 'best interests' of children as paramount are constitutionally assured.

As sources of law, legislations which protect the right of South African adolescents' to contraceptive information and services, including the Children's Act, will be reviewed in the next section.

## 5 Adolescents reproductive health laws and policies in South Africa

Before the institution of constitutional democracy in South Africa in 1994, the practice of apartheid had various negative effects on the health of black South Africans generally (including women and adolescent girls) as access to health care services, irrespective of whether rendered in the private or public sector, was based on race.<sup>305</sup> With the end of apartheid a new vision for the national health system premised on the primary health care approach was adopted to eliminate the fragmentation of health care services. This approach integrated all health services under a single Ministry of Health and ensures that all South Africans have access to comprehensive community-based health care through the establishment of primary health care centres which are the foundation of the national health system all over the country.<sup>306</sup>

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<sup>305</sup> During this period, whites enjoyed a greater access to effective and functioning health care services to the detriment of their black counterparts thereby leading to negative outcomes with respect to mortality rates, morbidity rates and life expectancy in general. See Ngwena 'The recognition of access to health care' (n 267 above) 29; D Cooper *et al* 'Ten years of democracy in South Africa: Documenting transformation in reproductive health policy and status' (2004) 12 *Reproductive Health Matters* 70-71.

<sup>306</sup> To ensure that people have greater access to primary health care, the payment of user fees in public hospitals was abolished and the country was divided into 53 health districts as part of the government's drive to ensure that citizens have access to a comprehensive primary health care and district hospital

The South African health care system is concurrently administered by both the national and provincial governments. The national government is responsible for setting policies used in managing activities in the health sector; the provincial government is vested with the duty of overseeing the implementation of the policies.<sup>307</sup>

As in the section on adolescents' reproductive health laws and policies in Nigeria, the intention here is to examine the legislation and reproductive health policies which directly protect and influence the access of adolescent girls in South Africa to contraceptive information and services.

### 5.1 Children's Act No. 38 of 2005

A major law that was in need of extensive reforms with the commencement of the constitutional dispensation in South Africa was the Child Care Act<sup>308</sup> which was drafted during the apartheid era and gave little or no recognition to the international rights of children or to the challenges faced by South African children.<sup>309</sup> However, in fulfilment of the human rights obligations owed children in line with internationally recognised recommendations for the protection of children's rights, a re-drafting process of the Child Care Act commenced in 1997 and culminated in the passing of the South African Children's Act in 2005.<sup>310</sup>

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services. See K Kautzky & S M Tollmani 'A perspective on primary health care in South Africa' *South African health review* 2008 23, available at [http://www.hst.org.za/uploads/files/chap2\\_08.pdf](http://www.hst.org.za/uploads/files/chap2_08.pdf) (5 March 2013); T Naledi *et al* 'Primary health care in South Africa since 1994 and implications of the new vision for PHC re-engineering' (2011) *South African Health Review* 18; K Cullinan *Health services in South Africa: A basic introduction* (2006) available at <http://www.health-e.org.za/uploaded/cb1f388f3b351708d915c12cfb4fc3cf.pdf> (13 April 2013).

<sup>307</sup> Cullinan (as above). The South African health sector is made up of a large overburdened public health sector run by the government which renders free basic primary health care and other specialised health services to a majority of the population and the smaller private health sector that renders primary health care and other health services subject to the payment of fees. See *Health care in South Africa*, available at <http://www.southafrica.info/about/health/health.htm> (6 April 2013).

<sup>308</sup> Child Care Act No. 74 of 1983.

<sup>309</sup> C J Davel & A M Skelton *Commentary on the Children's Act* (2007) 1-11.

<sup>310</sup> Further commitment for legal protection of the rights of the child was added through the Children's Amendment Act.

The Children's Act was adopted to give effect to children's rights already guaranteed in the Constitution of the Republic of South Africa and set out principles relating to their care.<sup>311</sup> Noting that actions or decisions pertaining to children must respect, protect and fulfil children's rights as set out in the Constitution,<sup>312</sup> the Act provides that all organs of government at the national, provincial and local levels must take reasonable measures to the 'maximum extent of available resources' to achieve the realisation of its provisions. Furthermore, it advocates that a uniform approach aimed at integrating the services delivered to children must be adopted.<sup>313</sup>

While the South African's government's duty to fulfil the socio-economic rights of children including adolescent girls' right to access contraceptives and other health care services without being subjected to the availability of resources may be the preferable position and argument, it seems that the provision of section 4(2) of the Children's Act which came into operation in 2007 is in agreement with earlier decisions of the Constitutional Court in the *Republic of South Africa v Grootboom*<sup>314</sup> and *Minister of Health v Treatment Action Campaign*.<sup>315</sup>

Toeing the path adopted in human rights instruments recognising children rights and even going further, the Children's Act provides that the best interests of the child are paramount and must always be considered when taking decisions pertaining to children.<sup>316</sup> In addition, the Act recognises the right of children to be involved in the decision-making process on issues relating to them.<sup>317</sup>

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<sup>311</sup> Preamble Children's Act.

<sup>312</sup> Sec 6(2) Children's Act.

<sup>313</sup> Secs 4(1) and (2) & 5 Children's Act. As explained in n 281 above, the provision of sec 4(2) may have stemmed the argument that fulfilling children's rights was unqualified and not subjected to the availability of funds.

<sup>314</sup> *Republic of South Africa v Grootboom* 2001(1) SA 46 (CC) para 71.

<sup>315</sup> *Minister of Health v Treatment Action Campaign (TAC)* 2002 (5) SA 721 (CC) para 135.

<sup>316</sup> Secs 7 & 9 Children's Act. This is in line with provisions on the best interest of children already contained in the Constitution of the Republic of South Africa.

<sup>317</sup> Sec 10 Children's Act.

The ‘best interests’ of children principle which the Children’s Act declared as ‘paramount’, apart from having been entrenched in the Constitution of the Republic of South Africa<sup>318</sup> in recognition of the international law obligation that state parties are to adhere to the best interests of children standard in determining issues involving children, has also been variously used by South African courts in reaching decisions on matters where the interests of children will be affected.<sup>319</sup>

In reaction to criticisms that the ‘best interests’ of children’s principle is vague and indeterminate, and its interpretation subject to different influences thereby creating room for prejudice and discrimination,<sup>320</sup> the South African courts, over the years, have endeavoured to develop guidelines which will assist in interpreting the principle. In *Van Deijl v Van Deijl*,<sup>321</sup> the court, in reaching a decision on the best interests of the child in a case of custody and guardianship, stated:

‘the interest of the minor means the welfare of the minor and the term welfare must be taken in its widest sense to include economic, social, moral and religious considerations. Emotional needs and ties of affection must also be taken into account and in the case of older children; their wishes in the matter cannot be ignored’.<sup>322</sup>

<sup>318</sup> Sec 28(2) Constitution of the Republic of South Africa 1996. It should however be noted that while the Convention on the Rights of the Child declared the ‘best interest of children’ principle as a ‘primary consideration’ in art 3(1) CRC and the African Charter on the Rights and Welfare of the Child declared it (the best interest principle’) as ‘the primary consideration’ in art 4(1) ACRWC, the Constitution of the Republic of South Africa had already raised the bar of the ‘best interest’ principle by declaring it as being of ‘paramount importance’ in any matter concerning the child. See Davel & Skelton (n 309 above) 2-6 & 2-7 & *Minister of Welfare and Population Development v Fitzpatrick* (n 283 above) para 17, where the Constitutional Court declared the provision of sec 28(2) as a right on its own apart from it being used to support other rights protected in sec 28(1).

<sup>319</sup> *Mfolo v Minister of Education* (n 285 above); *Minister of Welfare and Population Development v Fitzpatrick* (as above) para 18; *Director of Public Prosecutions, KwaZulu-Natal v P* (n 285 above); *S v M (Centre for Child Law as Amicus Curiae)* (n 285 above) para 22; *Teddy Bear Clinic’s case* (n 286 above) para 72.

<sup>320</sup> The arguments against the application of the principle includes the fact that decisions can be made subject to factors like the cultural, historical, political, economic and social views of the decision maker. See Davel & Skelton (n 309 above) 2-7; J Heaton ‘Some general remarks on the concept “Best Interest of the Child”’ (1990) 53 *Journal of Contemporary Roman-Dutch Law (THRHR)* 95.

<sup>321</sup> *Van Deijl v Van Deijl* 1966(4) SA 260 (R); E Bonthuys ‘The best interests of children in the South African Constitution’ (2006) 20 *International Journal of Law, Policy and the Family* 23.

<sup>322</sup> *Van Deijl’s case* (as above) 261 H. See also *McCall v McCall* 1994 (3) SA 201 (C) where King J set out factors to be borne in mind when determining children’s best interest - 205 B-G; *Krasin v Ogle* [1997] 1 All SA 557 (W) 567i -569e.

As Davel and Skelton explain, the factors to be considered in determining the best interests of children would vary depending on the different cases and issues that need to be resolved. According to them, the court is not only under a duty to carefully weigh and balance the factors highlighted in the cases so as to reach a conclusion that can be regarded as being in the best interests of the child in the particular case but it also has an obligation to ensure that a child-centred approach which is based on constitutional values and sensitive to culture and religion is adopted in reaching its decision.<sup>323</sup> Also, while applying the best interests of children principle does not mean that the rights of children will ‘always’ outweigh the rights of other parties involved; it means that a careful weighing and balancing of the varied interests involved must be done so as not to obliterate other valuable constitutionally protected interest.<sup>324</sup>

By recognising the right of children to participate in taking decisions,<sup>325</sup> the Children’s Act is in line with international and regional children’s rights instruments,<sup>326</sup> which recognises children as specific bearers of human rights who can participate in issues affecting them according to their level of maturity and understanding.

In relation to the right of female adolescents to reproductive health and contraceptive information and services, a progressive step adopted in the Children’s Act relates to the right of children to be granted access to information on health care, including, specifically, that associated with the promotion of reproductive health and the prevention of ill health, in a format that will be easily accessible and

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<sup>323</sup> Like all other rights, the right to have the best interest of children protected has to be balanced with the rights of other persons or groups. See Davel & Skelton (n 309 above) 2-9 & 2-12; *Christian Education South Africa v Minister of Education* 2000(4) SA 757 (CC) paras 15 & 30-31.

<sup>324</sup> Davel & Skelton (as above) 2-14.

<sup>325</sup> Sec 10 Children’s Act.

<sup>326</sup> Art 12(1) Convention on the Rights of the Child and art 4(2) African Charter on the Rights and Welfare of the Child. Protecting children’s best interest includes guaranteeing their right to express their views which should be given weight according to their levels of maturity and understanding. See D Archard & M Skivenes ‘Balancing a Child’s Best Interests and a Child’s Views’ (2009) 17 *International Journal of Children’s Rights* 1.

understandable by them.<sup>327</sup> The inclusion of this provision in the Children's Act shows the realistic step that needs to be adopted to prevent the further spread of STIs and HIV which are particularly widespread among the adolescent population due to ignorance and the lack of relevant and factual information on safe sexual practices, including the media through which preventive SRH care services can be accessed.

While the Act recognises the age of eighteen as the age of majority,<sup>328</sup> it sets the age of twelve as the threshold for medical consent by children based on their maturity and ability to understand the risks and benefits attached to medical treatment.<sup>329</sup> Apart from the above, the Act specifically guarantees children access to contraceptives on request without parental consent from the age of twelve and provides that 'no person may refuse to grant a child's request to access contraception'.<sup>330</sup> In suitable circumstances, proper medical advice is to be given to the child, as well as a medical examination in order to determine the appropriate type of contraception to be provided.<sup>331</sup> It should also be noted that the refusal by adults and other gate-keepers to sell or provide contraception to adolescents where it is meant to be made available, is a criminal offence under the Children's Act.<sup>332</sup>

Furthermore, like adults, children are entitled to confidentiality when accessing health care services with information relating to their health status remaining confidential unless consent to disclose information is granted by the child.<sup>333</sup> The same position on confidentiality applies where female adolescents access contraceptive services and information,<sup>334</sup> except if the health provider has reason to

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<sup>327</sup> Sec 13(1)(a) & 13(2) Children's Act.

<sup>328</sup> Sec 17 Children's Act.

<sup>329</sup> Sec 129 Children's Act. It should however be noted that in relation to termination of pregnancy, the age of twelve does not apply as sec 5 Choice on Termination of Pregnancy Act 92 of 1996 allows a woman of any age to consent to the termination of her pregnancy.

<sup>330</sup> Sec 134(1) Children's Act.

<sup>331</sup> Sec 134(2) Children's Act.

<sup>332</sup> Sec 305(1) (c) Children's Act. This particular sub-section came into effect in July 2007.

<sup>333</sup> Secs 13(1) (d) and 133 Children's Act.

<sup>334</sup> Sec 134(3) Children's Act.

believe that the adolescent girl or child has been a victim of sexual abuse, or if maintaining confidentiality will not be in the child's best interests, in which case report is to be made to the appropriate authorities.<sup>335</sup>

Finally, it can be concluded that South Africa's Children's Act, apart from being progressive, is realistic as it takes note of current trends relating to adolescent sexuality and takes steps to ensure their effective protection by allowing them to exercise their autonomy while engaging in sexual relations. Davel & Skelton declare that the provisions of the Children's Act go further than other legislative enactments on the protection of children's rights in the African region and beyond in the recognition to the right of children to autonomy in the reproductive health care context.<sup>336</sup>

## 5.2 National Health Act No. 61 of 2003

The National Health Act<sup>337</sup> came into operation in 2005 and provides a framework for the progressive realisation of the constitutional guarantee of the right to access health care services, including reproductive health care in South Africa.<sup>338</sup> The Act seeks to regulate national health and provide uniformity in respect of health services across the nation. It establishes a national health system made up of both the public and private health sector, highlights the rights and duties of health providers and users and strives to protect, respect, promote and fulfil the rights of South Africans to health care.<sup>339</sup>

Apart from providing that health users must have full information about their health status,<sup>340</sup> the Act, recognising the importance of consent and participation in medical

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<sup>335</sup> Sec 110(1) Children's Act.

<sup>336</sup> Davel & Skelton (n 309 above) 7-41.

<sup>337</sup> The National Health Act No. 61 of 2003.

<sup>338</sup> Preamble National Health Act.

<sup>339</sup> Sec 2 National Health Act.

<sup>340</sup> Sec 6 National Health Act. Disclosure of health status must be provided to the patient in a language the patient understands except there is evidence to show that such disclosure will be contrary to the best interest of the patient.

decisions, provides that the informed consent of a patient must be obtained before the commencement of medical treatment and also that health users must participate in decisions affecting their health.<sup>341</sup> Also recognising the role confidentiality plays in guaranteeing access to health care services generally, the Act provides for the confidential keeping of health records, except if disclosure is needed to protect public health, is based on court orders or the user personally consents to the disclosure being made.<sup>342</sup> In addition to the above, the National Health Act takes a step further in protecting children and adolescents by providing, before medical experiments for therapeutic purposes involving a minor can be conducted, that the best interests and consent of children must be considered and obtained if they are capable of understanding the nature of the experiment.<sup>343</sup> Where the research is not for therapeutic purposes, in addition to the minor's consent being obtained the minister of health must also consent to the experimentation.<sup>344</sup>

The continued reiteration of provisions on informed consent, participation of children and adolescents in health decisions and confidentiality reinforces provisions already contained in the Children's Act and the Constitution on the rights to health care, information, dignity and privacy. These provisions will encourage adolescent girls to seek access to much-needed contraceptive information and services instead of relying on charlatans who constitute serious health risks to adolescents.

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<sup>341</sup> Secs 7 & 8 National Health Act. Informed consent must always be obtained except in circumstances provided under sec 7(1) (a-e).

<sup>342</sup> Sec 14 National Health Act.

<sup>343</sup> Sec 71(2) National Health Act. This section provides that consent of the minor is to be obtained, it also provides that the consent of parents or a child's guardian should be obtained. It is not clear whether the consent of both the minor and the parents is to be obtained or whether only the child's consent is sufficient if she is capable of giving informed consent.

<sup>344</sup> Sec 71(3) National Health Act. The minister can refuse to give his consent if he is of the opinion that the objects of the research can be achieved if conducted on an adult, is of the belief that the research or experiment is not likely to improve the minor's condition, where the proposed experimentation is contrary to public policy, the research poses significant risk to the health of the minor or where the risk involved outweigh the proposed benefits to be achieved.

### 5.3 Choice on Termination of Pregnancy Act No. 92 of 1996<sup>345</sup>

The Choice on Termination of Pregnancy Act (CTOP) which came into operation in 1996 was passed into law so as to put into effect, the Constitutional guarantee of the right of women (including adolescent girls) to exercise autonomy over their reproduction and bodies and to ensure that such choice is made without fear or harm.<sup>346</sup> Based upon the recognition that the termination of pregnancy is not a form of contraception nor birth control, the CTOP repealed the Abortion and Sterilization Act<sup>347</sup> and promotes the observance of female reproductive rights by seeking to create an environment in which women and female adolescents alike can choose to procure early, safe and legal termination of their pregnancies according to their individual beliefs.<sup>348</sup>

Stipulating the circumstances upon which a termination of pregnancy may be procured, the CTOP provides that termination services may be solely provided upon a woman's request within the first trimester of pregnancy,<sup>349</sup> after which termination will occur based on the obtaining of the progressive opinion of a medical practitioner or practitioners (in accordance with the level of pregnancy)<sup>350</sup> and the existence of several factors, including the opinion that continuing the pregnancy will have an adverse effect on the woman's (or adolescent girl as the case may be) physical or mental health or endanger her life,<sup>351</sup> among other factors.<sup>352</sup> In addition to providing that people who wish to access termination of pregnancy services are to be

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<sup>345</sup> Choice on Termination of Pregnancy Act 92 of 1996.

<sup>346</sup> Preamble CTOP Act.

<sup>347</sup> Abortion and Sterilization Act No. 2 of 1975. Under the Act, the procurement of legal abortion was unnecessarily difficult as a result of the stringent grounds laid down in the Act and even in situations where any of the conditions applied, the doctor who intended performing the procedure had to apply for permission from the hospital's management while certification from two other doctors had to be obtained. See secs 3-6 Abortion and Sterilization Act.

<sup>348</sup> Preamble CTOP Act.

<sup>349</sup> Sec 2(1)(a) CTOP Act (n 342 above)

<sup>350</sup> Sec 2(1)(b) & (c) CTOP Act.

<sup>351</sup> Secs 2(1)(b)(i) & 3(1)(c)(i) CTOP Act.

<sup>352</sup> Secs 2(1)(b)(iii) & (iv) CTOP Act.

provided with non-mandatory counselling services, the Act also stipulates the provision of counselling services after termination of pregnancy has occurred.<sup>353</sup>

In relation to the obtaining and provision of consent, the Act provides strictly that termination of pregnancy services should not occur unless the informed consent of the woman has been obtained.<sup>354</sup> In relation to female adolescents access of termination services, the Act, in agreement with the decision of the English courts in *Gillick v. West Norfolk and Wisbech Area Health Authority and Another* and *R (Axon) v Secretary of State for Health*,<sup>355</sup> provides that the only person whose consent is required for termination purposes is the adolescent<sup>356</sup> and the health care provider cannot refuse to perform the services even if the adolescent cannot be persuaded to inform her parents of her intent to procure a termination.<sup>357</sup>

In South Africa, an initial action was brought before the courts to declare the CTOP Act unconstitutional in *Christian Lawyers Association v. Minister of Health* (Christian Lawyers Case No. 1)<sup>358</sup> on the basis that it infringed on the right to life of the foetus. In *Christian Lawyers Association v Minister of Health* (Christian Lawyers Case No. 2),<sup>359</sup> the plaintiff's argument that the provisions in the CTOP Act,<sup>360</sup> which allows an adolescent under the age of 18 to procure an abortion without parental consent, is unconstitutional due to the reason that children are 'incapable of giving consent', was rejected by the courts who held that the legislature had put in place

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<sup>353</sup> Sec 4 CTOP Act.

<sup>354</sup> Sec 5(1) CTOP Act.

<sup>355</sup> *Gillick's case* (n 66 above); *R (Axon)* (n 67 above). In the first case, the principle of the *Gillick* competent child who can personally consent to medical services, including contraceptives, was laid down with the House of Lords agreeing that the competence of adolescents to consent to treatment has evolved to the extent that it is to be measured based on their level of maturity and not age. In the *R(Axon)* case, the courts adopting the decision in the *Gillick's* case, reached the decision that female adolescents (who are *Gillick* competent) were entitled to confidential health care services, just like adults, in order to forestall situations where the adolescents will be further exposed to SRH ills.

<sup>356</sup> According to the provision of the Act, a 'woman' means any female person of any age including children and adolescent girls. See secs 1(xi) & 5(2) CTOP Act.

<sup>357</sup> Sec 5(3) CTOP Act.

<sup>358</sup> *Christian Lawyers No. 1* (n 254 above).

<sup>359</sup> *Christian Lawyers Association v Minister of Health And Others* (Reproductive Health Alliance as Amicus Curaie) 2005 (1) SA 509 (T).

<sup>360</sup> Secs 5(2) & (3) CTOP Act.

requirements to be fulfilled in order to ensure that the informed consent of a girl is obtained before termination of pregnancy occurs and that no woman regardless of age can have her pregnancy terminated unless she is capable of giving informed consent.<sup>361</sup>

While the indiscriminate termination of pregnancy is not supported due to the reason that adolescent girls should instead be encouraged to visit facilities where they can access contraceptive services in youth-friendly environments in order to prevent the occurrence of unplanned pregnancies and STIs, it is felt that the progressive nature of the CTOP Act, which allows female adolescents access to confidential abortion services after giving informed consent, is welcomed. This reasoning is adopted because adolescent girls access to private abortion services ultimately serves a twofold advantageous purpose: first, the SRH rights of adolescent girls' are respected due to the reason that girls are guaranteed access to safe and legal termination of pregnancies and second, the ability to obtain safe and free abortion services will hopefully prevent the procurement of illegal and dangerous back-street abortions.

#### 5.4 National Youth Policy (NYP)<sup>362</sup>

From the time of instituting a constitutional democracy in South Africa,<sup>363</sup> various policies have been developed by the government to serve as developmental guides in the youth sector.<sup>364</sup> The current National Youth Policy, which builds upon previous policy foundations, seeks to close and address identified policy gaps and challenges that remained after the implementation of previous policies with a view to

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<sup>361</sup> *Christian Lawyers No. 2* (n 359 above) 515.

<sup>362</sup> National Youth Policy 2009 – 2014, available at <http://www.thepresidency.gov.za/MediaLib/Downloads/Home/Publications/YouthPublications/NationalYouthPolicyPDF/NYP.pdf> (6 April 2013).

<sup>363</sup> South Africa ratified the African Youth Charter on 28<sup>th</sup> May, 2009.

<sup>364</sup> Youth Policies that have been developed include the National Youth Policy (NYP) 2000 and the National Youth Development Policy Framework (NYDPF) 2002. Although the 2000 NYP was not adopted by the South African government, it served as a guide for subsequent policy developments. The NYDPF covered a five year period from 2002-2007.

recommend new measures that will be more beneficial to their development.<sup>365</sup> Objectives of the NYP include the integration of youth development into the mainstream of government policies, curbing the marginalisation of young people and strengthening the capacities of young people to personally take charge of their well-being so as that ultimately they can realise their potential.<sup>366</sup>

Although defining youth as young people in the age group of 14 to 35,<sup>367</sup> the National Youth Policy recognises that young people, a non-homogenous group, have different needs thereby bringing to the fore the necessity to design diverse solutions to meet their needs.<sup>368</sup> However, recognising the precarious situation of females generally, the policy acknowledges that based upon the impact of gender stereotyping and diseases especially HIV and AIDS<sup>369</sup> priority and immediate attention should to be accorded to addressing the needs of young women.<sup>370</sup>

Taking note of the various health challenges of South African youth, including those affecting their reproductive and sexual health, the policy also acknowledges, despite relevant stakeholders' efforts to address identified challenges, that campaigns for sexuality education have not led to desired outcomes<sup>371</sup> giving rise to a need to improve access to youth-friendly health related services and information and ensure that sexuality education forms part of life skills curriculums from an early age in order to prevent engaging in risky sexual behaviour which exposes adolescents and

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<sup>365</sup> Para 2 & 3 South Africa National Youth Policy.

<sup>366</sup> Para 6 South Africa National Youth Policy.

<sup>367</sup> This is more encompassing unlike the current Nigerian youth policy which restricts the definition of youth to people between the ages of 18 and 35 years and the African Youth Charter which sets the age of 15 years as the starting point for those protected under it. The widening of the scope of people protected in the Youth Policy is progressive due to the reason that there is a definite recognition that this group of people specifically are in need of youth and adolescent-friendly health services, including those relating to contraception. Also, it is noted that this provision is not out of place as sec 134 of the Children's Act 2005 already provides access to contraception from twelve years of age. This is apart from the Choice on Termination of Pregnancy Act 1996 which recognises the right to abortion of all women irrespective of their age.

<sup>368</sup> Para 12 South Africa National Youth Policy.

<sup>369</sup> Para 12.1 South Africa National Youth Policy.

<sup>370</sup> Including female youths residing in rural areas. Other special target groups include youths with disabilities, unemployed youths and school aged but out of school youths among others.

<sup>371</sup> Para 14.3 South Africa National Youth Policy.

youths to HIV and STIs.<sup>372</sup> While taking note of the progressive interventions recommended in the youth policy, it is opined that factors which inhibit female adolescents access to needed reproductive health care services and information, especially at the community level, should be tackled decisively through awareness-raising actions and through the imposition of sanctions, where necessary, so as to prevent repeated occurrences.

### 5.5 National Policy on HIV and AIDS for Learners and Educators in Public Schools and Students and Educators in Further Education and Training Institutions<sup>373</sup>

The *National Policy on HIV and AIDS for Learners and Educators in Public Schools and Students and Educators in Further Education and Training Institutions* was adopted in 1999<sup>374</sup> with the primary purpose of providing a framework/guideline that will be used by the various provinces and schools to develop strategies that will be embraced by learners in order to adopt behaviours, knowledge, skills, values and attitudes which will protect them from HIV infection.<sup>375</sup>

The policy acknowledges the high infection rates in the country and recognises that both students and educators already infected with the virus will gradually constitute part of the population in the various educational institutions. Based on the crucial aim of ensuring non-discrimination and equality among learners, the policy seeks to increase students' knowledge about HIV and AIDS and introduces general

<sup>372</sup> Para 14.3.1 South Africa National Youth Policy.

<sup>373</sup> National Policy on HIV and AIDS for Learners and Educators in Public Schools and Students and Educators in Further Education and Training Institutions (1999) available at [http://wced.pgwc.gov.za/branchIDC/special\\_ed/hiv\\_aids/National\\_policy\\_on\\_HIV-AIDS.pdf](http://wced.pgwc.gov.za/branchIDC/special_ed/hiv_aids/National_policy_on_HIV-AIDS.pdf) (16 August 2013).

<sup>374</sup> It should be noted that before the Life Skills and HIV/AIDS education program based on the contents of the National Policy on HIV and AIDS for Learners and Educators in Public Schools was introduced, previous HIV/AIDS education programs such as the *First AIDS Kit* aimed at educating students on sexuality had already been introduced in the schools.

<sup>375</sup> National Policy on HIV and AIDS for Learners and Educators (n 373 above).

precautions that will be adopted in order to ensure the safety of both learners and their educators in the schools.<sup>376</sup>

To achieve its aim of increasing students' knowledge about HIV and AIDS, the policy advocates the compulsory teaching of Life Skills and HIV/AIDS in both primary and secondary schools and its integration into the Life Orientation (LO) curriculum in a scientific and age appropriate manner that will be easily understandable by students.<sup>377</sup>

The contents of Life Skills and HIV/AIDS education, as merged to the Life Orientation programme, are based on four focus areas: personal well-being, citizenship education, recreation and physical activity and careers and career choices. Under the personal well-being topic, the issues to be discussed include teenage pregnancy, STI and HIV, including ways they are transmitted and appropriate prevention methods, alcohol and substance abuse, sexuality, decision-making, adoption of skills to resist peer pressure, the promotion of personal, community, and environmental health.<sup>378</sup> The expected outcomes from imparting Life Skills and HIV/AIDS education include to the ability of students to demonstrate clear understanding of sexuality, gender, STIs, and HIV and AIDS. Additionally, students are to comprehend and realise

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<sup>376</sup> Department of Basic Education *Draft Integrated Strategy on HIV and AIDS: 2011-2015* (2010) 32, available at <http://www.education.gov.za/LinkClick.aspx?fileticket=obmjS2dC%2BQM%3D&tabid=614&mid=1713> (15 August 2013).

<sup>377</sup> Initially, in 1999, learners in grades 4-9 were set apart as the primary group to begin the implementation of the programme with. However, in 2005, the teaching of preventive life skills and HIV/AIDS sexuality education was extended to pupils in grade R-3 and 10-12. See R I Mpangana 'Implementation of the life skills HIV and AIDs program in Manyeleti circuit schools' University of Stellenbosch (2012) 11.

<sup>378</sup> See G George *The Life Orientation project: Implementation, delivery and engagement with the Life Orientation Programme in South African schools* (2013) 4; Mpangana (as above) 13; Department of Education *National Curriculum Statement Grades 10-12: Life Orientation* (2003) available at <http://www.education.gov.za/LinkClick.aspx?fileticket=xY8RaCOWqTY%3D&> (23 September 2013); paras 2.10 and 3 National Policy on HIV and AIDS for Learners and Educators (n 373 above).

the reasons for delaying sexual intercourse or practising abstinence, including how to deal with pressures to engage in sexual relations.<sup>379</sup>

In addition, to further curb high infection rates, the policy advises that strict adherence to universal precautions be undertaken in schools and, apart from the sexuality and life skills education that is being provided by educators, that parents, as stakeholders, are to support the drive to reduce infection rates by imparting to their children sexuality education and guidance regarding sexual abstinence while already sexually-active adolescents are to be counselled to practice safe sex.<sup>380</sup> The specific provision of the involvement of parents as stakeholders in the provision of SRH information to their children as a means of supplementing Life Skills and HIV/AIDS education received in the school is a positive approach.<sup>381</sup>

### 5.6 National Contraception and Fertility Planning Policy and Service Delivery Guidelines 2012<sup>382</sup>

In a bid to ensure that the contraception policy in operation in South Africa is up to date so as to reflect changes which had occurred over the last decade in the field of reproductive and contraceptive technology and in order to ensure compliance with other related national and international policies/frameworks, the National Contraception and Fertility Planning Policy and Service Delivery Guidelines were adopted.<sup>383</sup> The revised policy, which replaced previous policies and guidelines on

<sup>379</sup> K Peltzer & S Promtussananon 'HIV education in South Africa: Teacher knowledge about HIV/AIDS: Teacher attitude about and control of HIV education' (2003) 31 *Social Behaviour and Personality* 350.

<sup>380</sup> Para 2.6.5 National Policy on HIV and AIDS for Learners and Educators (n 373 above).

<sup>381</sup> In Nigeria there is no provision for the participation of parents in the implementation of the curriculum. See Lagos State AIDS Control Agency *Family life HIV Education implementation: An assessment of the status of implementation of the Family Life HIV Education Curriculum in Lagos State* (2012) 8, available at

<http://www.google.com.ng/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=5&cad=rja&ved=0CFUQFjAE&url=http%3A%2F%2Fwww.lsaca.org%2Fwp-content%2Fuploads%2F2012%2F06%2FFLHE-Implementation-Report.doc&ei=IHcsUvrSCafL0AXopoCoAQ&usg=AFQjCNFxfhTX0g3JIHxKjfvstLrLjHjv-nQ&sig2=hwIHGp5PYXXVnNmVUWaSw&bvm=bv.51773540,d.d2k> (18 August 2013).

<sup>382</sup> National Contraception and Fertility Planning Policy and Service Delivery Guidelines, available at [http://www.doh.gov.za/docs/policy/2013/contraception\\_fertility\\_planning.pdf](http://www.doh.gov.za/docs/policy/2013/contraception_fertility_planning.pdf) (3 May 2013).

<sup>383</sup> Introduction 'National Contraception and Fertility Planning Policy and Service Delivery Guidelines' (as above).

contraception,<sup>384</sup> aims at the reprioritisation of contraception and fertility planning services in the country and places great emphasis on the need for dual protection through the prevention of unwanted pregnancy and the planning for a healthy pregnancy<sup>385</sup> so as to achieve the goal of providing comprehensive quality contraception and fertility management services to South Africans as part of a broader SRH package.<sup>386</sup>

Based upon the SRH and rights framework,<sup>387</sup> the guiding principles for the revised contraception policy and guidelines embrace the provision of strong and visible stewardship for the promotion of SRH and rights, the provision of integrated services at the district level, the adoption of a human rights approach in the provision of contraception and fertility planning services, as well as inter-sectoral collaboration to ensure effective provision of services, among others.<sup>388</sup>

Objectives of the policy include:<sup>389</sup>

- a. Ensuring that Contraception and fertility choices are expanded and actively promoted to enable clients to meet their reproductive intentions throughout their reproductive life.<sup>390</sup>
- b. Ensuring that contraceptive and fertility planning services are integrated into other health services as needed.

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<sup>384</sup> The National Contraception Policy Guidelines within a reproductive health framework 2001 and the National Contraception Service Delivery Guidelines 2003

<sup>385</sup> Forward 'National Contraception and Fertility Planning Policy and Service Delivery Guidelines' (n 382 above).

<sup>386</sup> Para 3.2.1 'National Contraception and Fertility Planning Policy and Service Delivery Guidelines' (as above).

<sup>387</sup> The sexual and reproductive health and rights framework was adopted by the Department of Health in 2011 as Sexual and Reproductive Health and Rights: Fulfilling our commitments, available at <http://www.agenda.org.za/wp-content/uploads/2012/09/SRHR-Fulfilling-our-Commitments.pdf> (3 May 2013).

<sup>388</sup> Para 3.1 'National Contraception and Fertility Planning Policy and Service Delivery Guidelines' (n 382 above).

<sup>389</sup> Para 3.2.2 'National Contraception and Fertility Planning Policy and Service Delivery Guidelines' (as above).

<sup>390</sup> Expand the current range of contraceptive methods available to include IUDs, single-rod progesterone implants, combined oestrogen and progestogen injections, etc.

- c. Training and building the capacity of health care providers so that they acquire appropriate knowledge, attitude and skills to provide holistic, quality contraceptive and fertility planning services in accordance with their scope of practice and level of care.
- d. Ensuring that the delivery of contraceptive and fertility planning services is backed by necessary regulatory, legislative and institutional framework for all levels of care.
- e. Adopting appropriate evidence guided communication methods that will assist in increasing the level of public awareness on contraceptive and fertility planning rights, choices and services
- f. Setting up appropriate monitoring and evaluation mechanisms to observe effectiveness of the policy and the development of a research agenda to inform subsequent policy formulation and programme planning based on future recommendations.

In addition to the above, the revised policy contains service delivery guidelines which explain and provide a list of the type of contraceptive and fertility planning services that are available at various health service points, including appropriate health care providers who are empowered to deliver contraception and family planning services.<sup>391</sup> To ensure effectiveness in contraceptive service delivery and quality of care, areas in the health systems which need improvement are identified and the necessary steps to be taken to improve them are recommended.<sup>392</sup>

The policy specifically seeks to address the problems encountered by adolescents in their bid to access contraception and protect their reproductive health. While acknowledging that abstinence is the ideal, practically, it recognises that a majority of young people are sexually active and that pregnancy and HIV can have dire consequences on their life and future. The policy advocates the provision of

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<sup>391</sup> Para 4.1 'National Contraception and Fertility Planning Policy and Service Delivery Guidelines' (n 382 above).

<sup>392</sup> Paras 5.1 & 5.2 'National Contraception and Fertility Planning Policy and Service Delivery Guidelines' (as above).

adolescent-friendly contraceptive services that are structured in ways that mitigate the barriers to access.<sup>393</sup>

### 5.7 Integrated School Health Policy 2012<sup>394</sup>

Recognising that support for school health services is a major way of strengthening the South African Department of Health's efforts of reengineering and strengthening primary health care service delivery, the Integrated School Health Policy (ISHP) was adopted to reinstate health care programmes in public schools and to ensure that schools become inclusive centres of learning, care and support that assist in the protection and realisation of the educational rights of all children<sup>395</sup> by addressing the immediate health problems of learners as well as implementing interventions which will assist in the promotion of their health and well-being from childhood to adulthood. In order to achieve these goals, the ISHP aims to build on existing school health services by making sure that the Departments of Health, Basic Education and Social Development collaborate so as to ensure that the provision of health education and health care services reach every learner in all schools, irrespective of age or grade levels.<sup>396</sup>

Adopting strategies which advocate health promotion, health education and the provision of essential health care services in schools, the ISHP seeks to achieve the objectives of providing preventive and promotive services that address the health needs of school-going children through the provision of support which not only facilitates learning by identifying existing barriers to learning but also enables learners to access health services, thus supporting the school community's bid to create safe and secure environments for teaching and learning.<sup>397</sup> At a minimum,

<sup>393</sup> Para 6.1.2 'National Contraception and Fertility Planning Policy and Service Delivery Guidelines' (as above).

<sup>394</sup> Integrated School Health Policy (2012) available at [http://www.doh.gov.za/docs/policy/2012/Integrated\\_School\\_Health\\_Policy.pdf](http://www.doh.gov.za/docs/policy/2012/Integrated_School_Health_Policy.pdf) (18 September, 2013).

<sup>395</sup> Forward Integrated School Health Policy (n 394 above)

<sup>396</sup> Foreword, introduction & para 2.5 Integrated School Health Policy (as above).

<sup>397</sup> Para 2.4 Integrated School Health Policy (as above).

according to the ISHP, health education, which is to be integrated into the school curriculum and Life Orientation programme, should fully address issues relating to SRH, menstruation, contraception, STIs, including HIV and AIDS, male circumcision, teenage pregnancy, termination of pregnancy, prevention of mother to child transmission, mental health, drug and substance abuse, depression and anxiety, among others.<sup>398</sup> Health care services to be provided according to policy in school clinics by school health nurses include counselling on sexual rights, dual protection and hormonal contraception for sexually active learners and screening for STIs. In order not to fall foul of the law by infringing the human rights of the learners, the consent of learners to these services has to be obtained.<sup>399</sup>

The objective behind the adoption of the ISHP is to be lauded. However, in relation to the provision of the policy on health education, it is felt that a tendency to confuse and duplicate efforts may arise leading to a situation where educators may not know which programme to adopt or teach as the Life Skills and HIV/AIDS education programme which has been integrated into the Life Orientation curriculum already exists. On the other hand, the department of education, in collaboration with other supervising departments can merge all the programmes into a single policy which should be taught uniformly in schools.

## 5.8 Conclusion

This section explored the laws and policies that support the Constitution in assuring adolescent girls' have access to contraceptive information and services in South Africa. Building on foundation laid in the Constitution, the Children's Act reaffirms the 'paramountcy' of the best interests of children, recognises their right to access contraceptive services and information, consent to medical treatment,

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<sup>398</sup> Para 2.6 Integrated School Health Policy (as above).

<sup>399</sup> Where necessary, the school health nurse is to refer such learner to a health facility where he/she should receive the service. For learners younger than 14 years, the consent of their parents is to be obtained, learners older than 14 years personally can give consent. See paras 2.6 & 2.7 Integrated School Health Policy (on 394 above).

confidentiality and also to participate in issues affecting them according to their levels of maturity and understanding.<sup>400</sup>

Apart from the Children's Act, the other laws and policies reviewed in the section reveals South Africa's recognition of the importance of guaranteeing adolescent girls' medical confidentiality when accessing contraceptive services and the necessity of allowing them to access sexuality information and education in adolescent-friendly environments so as to enhance their willingness to access the services in future. Also, the existence of constant monitoring mechanisms is evident. Recent policies cite a need to strengthen weakened contraceptive delivery services and give special attention to children's optimal health as reasons for a policy review.<sup>401</sup>

It is submitted, by trying to pre-empt the sexual health care needs of female adolescents and by incorporating their right to access contraceptive services and information in various legislation, South Africa demonstrates a genuine effort towards combating the spread of HIV and other STIs affecting adolescents.

## 6 Chapter conclusion

The focus in this chapter has been on an examination of the national laws and policies on adolescents' reproductive health in Nigeria and in South Africa. The backgrounds of the legal systems in the two jurisdictions have been examined and the various relevant national laws and policies which assure female adolescents access to contraceptive information and services have been scrutinised.

It is clear that both countries have taken steps to guarantee access to the required services, but that their levels of commitment to ensure this protection are different. Both Nigeria and South Africa have legislation and policies which specifically protect children's rights and domesticate international and regional human rights instruments on children. However, South Africa's Children's Act automatically applies

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<sup>400</sup> Secs 13(1)(a) &(d), 13(2), 129(2), 134(1) &134(3) Children's Act 2005.

<sup>401</sup> Integrated School Health Policy (n 394 above) 6.

to the whole country whereas the situation in Nigeria is different. State governments have to adapt and domesticate the Child Rights Act as state law,<sup>402</sup> thereby preventing the uniform application of the law throughout the country and constituting a setback to the protection of children's rights, including those of female adolescents.<sup>403</sup>

Ngwena correctly remarks that South Africa exhibits an understanding of the nature of human rights, and underscores that understanding by inserting concrete provisions that recognise, respect and protect all rights, inclusive of socio economic rights, in its Bill of Rights, rather than merely issuing directive principles.<sup>404</sup> The barrier of constitutionally-recognising the right to health care has been overcome in South Africa.<sup>405</sup> The same cannot be said of Nigeria as there is no constitutional recognition of the right to health, either in previous constitutions or the present 1999 Constitution. Provision for health care is made under Nigeria's fundamental objectives and directive principles of state policy<sup>406</sup> which are not justiciable by reason of the provisions of section 6(6)(c).<sup>407</sup> Section 6(6)(c) ousts the jurisdiction of domestic courts to adjudicate matters listed under chapter 2 of the Constitution, thereby making it difficult to ensure protection or enforce performance. Resort has to be made either to the provision on the right to health contained in the African Charter,<sup>408</sup> or by instituting action for the infringement of the constitutionally-recognised 'right to life'.

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<sup>402</sup> This is as a result of the federal system of government being practiced in the country. Moreover, issues related to the protection of children are not contained either in the exclusive or concurrent legislative lists. This means that these issues are specifically left on the residual list of the Nigerian Constitution.

<sup>403</sup> Currently only 24 states have domesticated the Child Rights Act. Due to the application of Sharia law in the northern part of the Country, a majority of the northern states have refused to pass the Child Right Act 2003 as state law. See UNICEF Nigeria –Fact sheet on Child rights legislation (n 150 above).

<sup>404</sup> Ngwena 'The recognition of access to health care' (n 267 above) 38.

<sup>405</sup> Secs 27(1)(a) Constitution of the Republic of South Africa 1996.

<sup>406</sup> Sec 17(3) (d) Nigerian Constitution 1999.

<sup>407</sup> 6(6)(c) Nigerian Constitution 1999.

<sup>408</sup> Art 16 African Charter on Human and Peoples Right.

Also, the Nigerian CRA provides that the best interests of children shall be the primary consideration but in South Africa, the best interests of children has been raised to the position of paramountcy; indicating the great importance attached to the protection of children's rights and that female adolescents have the right to access contraceptive information and services which is in their best interests in accordance with constitutional mandates.<sup>409</sup> In addition, South Africa's Children's Act recognises the necessity of children to participate in decisions affecting them unlike the Nigerian CRA which is silent on the issue. The position adopted by South Africa supports current international recommendations that age should not be used as a barrier to prevent children (and in this case, adolescent girls) from effectively participating in decision-making processes on matters affecting their health, most especially when the decision relates to their ability to consent to and exercise choice about their need for contraceptives and other relevant reproductive health care services.<sup>410</sup>

Another important observation made in the chapter relates to the fact that South Africa's Children's Act expressly provides for the right of children to access contraception in addition to the guarantee of confidentiality when accessing the services. Its Nigerian counterpart does not contain anything of the kind in its provisions. As already noted, providing adolescents in South Africa and Nigeria with access to contraceptive services and information in confidential environments is a necessity and in their best interests so that adolescent girls can be afforded the opportunity effectively to protect themselves from HIV and STIs while developing and achieving their full socio-economic potential.

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<sup>409</sup> Sec 9 Children's Act; Secs 12(2)(a), 27(1)(a) & 28(2) Constitution of the Republic of South Africa 1996. See also *Minister of Welfare and Population Development v Fitzpatrick* (n 283 above) para 17.

<sup>410</sup> Instead of age, the criteria of maturity and capability to understand are to be used in determining female adolescent's involvement in their sexual and reproductive health care. C Ngwenya 'Health care decision-making and the competent minor: The limits of self-determination' (1996) *Acta Juridica* 137; *Gillick's case* (n 66 above); *R (Axon)* (n 67 above).

In order to supplement the right to health care recognised under the Constitution of the Republic of South Africa, the right of children (which includes female adolescents) to basic health care services is constitutionally recognised. However, unlike the section 27 right, which is subject to availability of resources and progressive realisation, the right of children to basic health care is not.<sup>411</sup> Although the Nigeria's CRA recognises the right of children to health care,<sup>412</sup> it submitted, in addition to this provision, that at the most basic level the Nigerian government has a duty to constitutionally guarantee children's rights to basic health care, including contraceptive services and information. This recognition will go a long way to ensure their access to the services.

Moreover, unlike the African Youth Charter and its South African counterpart, the Nigerian Youth Policy narrows the range of protection to youths between the ages of 18- 35 years.<sup>413</sup> By this definition, the policy is in contravention of the age stipulations contained in the Youth Charter. This amounts to Nigeria burying its face in the sand as the country accounts for a high percentage of teenage pregnancies due to the reason that female adolescents not only engage in their first sexual relations between the ages of 12 and 16, but a majority of them have multiple sexual partners.<sup>414</sup> Furthermore, it is submitted that the contents of the Nigerian Youth Policy, especially those relating to health, fall below reasonable expectations in line with current global practice that advocates increased autonomy and access to confidential reproductive health care services, including those relating to contraception for female adolescents.

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<sup>411</sup> Robinson (n 270 above).

<sup>412</sup> Sec 13(2) Child Rights Act.

<sup>413</sup> Para 1.3 Nigerian Youth Policy. Female adolescents in the age group of 15-17 are among the group of people who are in need of youth-friendly SRH care services and information.

<sup>414</sup> Sunmola (n 75 above) 82-92; L A Adeokun 'Sexual and reproductive health knowledge, behaviour and education needs of in-school adolescents in Northern Nigeria (2009) 13 *African Journal of Reproductive Health* 37- 49; P I Okonta 'Adolescent Sexual and Reproductive Health in the Niger Delta Region of Nigeria-Issues and Challenges' (2007) 11(1) *African Journal of Reproductive Health* 113-124; and *Nigeria Demographic and Health Survey 2008*, available at <http://www.measuredhs.com/pubs/pdf/SR173/SR173.pdf>. (23 October 2012).

Although Nigeria has numerous policies in existence relating to the protection of the general health and reproductive well-being of all Nigerians, including adolescents generally, as highlighted by Aniekwu,<sup>415</sup> the various health policies do not provide a legal framework based upon the mandate to respect, protect and fulfil reproductive health rights as human rights as stipulated in ratified international Conventions. The fact that policies adopted have the tendency to be changed at the whim of government is further aggravated by the unenforceability of policy documents which makes it impossible to effectively monitor performance and sincerity. Additionally, the lack of coordination among health departments in the three tiers of government allows for the duplication of effort geared towards the fulfilment of the policy contents of the various health policies, resulting in non-performance.<sup>416</sup>

In South Africa, on the contrary, there are policies in existence which are adequately monitored and constantly reviewed to take cognisance of current national and international developments. In addition, they have the requisite constitutional and legal backing which makes them more effective. South African National Youth Policy, which is based on recognised principles related to the protection of human rights and the guarantee of social and economic justice, addresses the policy gaps that were identified after the implementation of previous policies on youths with the view of ensuring overall development of young people in the country. Also, the new National Contraception and Fertility Planning Policy and Service Delivery Guidelines, which advocate the adoption of a human rights-based approach in the provision of contraception in adolescent-friendly health care environments to adolescents, who constitute a major part of its target group, and the Integrated School Health Policy which seeks to ensure the provision of comprehensive SRH care services in schools, are a welcome development.

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<sup>415</sup> N I Aniekwu *The development of reproductive health laws: Considerations for the Nigerian legal system* 1, available at <http://www.nigerianlawguru.com/articles/general/THE%20DEVELOPMENT%20OF%20REPRODUCTIVE%20HEALTH%20LAWS,%20CONSIDERATIONS%20FOR%20THE%20NIGERIAN%20LEGAL%20SYSTEM.pdf> (24 September 2012).

<sup>416</sup> Aniekwu *'Engendering sexuality'* (n 33 above) 38.

## Chapter 3

## National Legislations and Policies

In the next chapter, the focus will shift to an examination of the need of adolescent girls in Nigeria and South Africa for autonomy and other important components including informed consent, confidentiality and best interests, and the relevance of these issues in the quest by female adolescents to access contraceptive information and services.

## CHAPTER 4

### THE MEANING OF AUTONOMY IN THE CONTEXT OF ADOLESCENT GIRLS' ACCESS TO CONTRACEPTIVES

#### Outline

- 1 Introduction**
- 2 Concept of autonomy**
- 3 Adolescents and the need for autonomy**
  - 3.1 Consent
  - 3.2 Confidentiality
  - 3.3 'Best interests' principle
  - 3.4 Conclusion
- 4 Chapter conclusion**

#### 1 Introduction

Haider correctly remarks:<sup>1</sup> '[A]s a matter of policy, the reproductive and sexual health of adolescents matter because they comprise almost one half of the world's population. As a matter of international human rights law, adolescents have reproductive and sexual health rights'.<sup>2</sup> Historically, there has been no recognition of children or adolescents as rights bearers with rational capabilities. Far from being accepted as autonomous beings, adolescents were regarded as a *species* of property, requiring adult protection and assistance in every decision-making process.<sup>3</sup> Today, adolescents are not only viewed as beings entitled to their own rights but also as having the capacity to arrive at independent decisions on issues affecting their future.

In spite of the above, however, the capacity of adolescents (female adolescents especially) to consent to and access confidential contraceptive and other SRH care

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<sup>1</sup> A Haider 'Adolescents under international law: Autonomy as the key to reproductive health' (2008) 14 *William & Mary Journal of Women and the Law* 605- 633.

<sup>2</sup> Haider (as above) 605.

<sup>3</sup> S R Arnott 'Autonomy, standing, and children's rights' (2007) 33 *William Mitchell Law Review* 809.

information and services has remained a ‘tug of war’ between the adolescents, on one hand, and their parents and various other stakeholders, concerned with promoting the health and well-being of adolescents, on the other.<sup>4</sup>

Proceeding from the previous chapter in which national laws and policies guaranteeing the right of female adolescents to access contraceptive information and services in Nigeria and South Africa were discussed, this chapter explores the concept of ‘autonomy’ and its relevance to adolescent girls’ need for freedom and privacy when making informed decisions on contraception in accordance with the ‘best interests’ principle. This principle is advanced not only in international<sup>5</sup> and regional<sup>6</sup> human rights instruments, but also in the child protection laws of both countries,<sup>7</sup> as well as in the Constitution of the Republic of South Africa.<sup>8</sup>

## 2 Concept of autonomy

The concept of ‘autonomy’, which can be defined as a state of independence and has become nearly synonymous with human dignity<sup>9</sup> and the respect for persons,<sup>10</sup> attained philosophical prominence through Immanuel Kant’s *Groundwork for the metaphysics of morals*,<sup>11</sup> in which Kant considered autonomy from the perspective of man's moral character and his ability to make rational decisions without subjugating himself to external factors or considerations.<sup>12</sup> According to Kant, man’s ability to do

<sup>4</sup> M Goodwin & N Duke ‘Capacity and autonomy: A thought experiment on minors’ access to assisted reproductive technology’ (2011) 34 *Harvard Journal of Law & Gender* 507.

<sup>5</sup> Art 3 Convention on the Rights of the Child, available at <http://www2.ohchr.org/english/law/pdf/crc.pdf> (20 September 2012).

<sup>6</sup> Art 4 AC RWC.

<sup>7</sup> Sec 1 Nigerian Child Rights Act 2003 & Secs 7 & 9 South African Children’s Act 2005.

<sup>8</sup> Sec 28(2) Constitution of the Republic of South Africa, 1996, available at <http://www.info.gov.za/documents/constitution/1996/a108-96.pdf> (24 March 2013).

<sup>9</sup> *Ferreira v Levin* 1996 (1) SA 984 (CC), 1996 (4) BCLR 1 (CC) para 49.

<sup>10</sup> T May ‘The concept of autonomy’ (1994) 31 *American Philosophical Quarterly* 133.

<sup>11</sup> I Kant *Groundwork for the metaphysics of morals* ed by AW Wood (2002).

<sup>12</sup> S Darwall ‘The value of autonomy and autonomy of the will’ (2006) 116 *Ethics* 263; Kant *Groundwork for the metaphysics of morals* in A W Wood (n 11 above) 16-17& 29; May (n 10 above) 136-137; C C Gauthier ‘Philosophical foundations of respect for autonomy’ (1993) 3 *Kennedy Institute of Ethics Journal* 23.

good should be based on the reasoning that he has a moral duty to do so (as an end itself) and not for the satisfaction of achieving an end.<sup>13</sup> In other words, respecting the autonomy of others should be not only because it is the proper thing to do but also because we accept, as free and rational beings, that they possess the capacity to morally choose for themselves and, therefore act on their belief of what is right.<sup>14</sup> Durojaye explains that Kant's view of the autonomous person is the person, who is able not only to act independently but is also capable of absorbing the consequences of his/her action. According to him, adopting this position means that a child or adolescent may not be able to access contraceptive services thereby resulting in disastrous results especially for children in African settings.<sup>15</sup>

There are additional meanings of the concept of 'autonomy'. Rawls view is that to effectively exercise one's rights one must be autonomous, J.S. Mill believed that autonomy involves individuals being rational enough to make decisions about their own good, and being respected and allowed to pursue their personal goals except where their actions will affect others.<sup>16</sup> in relation to the autonomy of children, however, Mill was of the opinion that children are too immature to be autonomous and, therefore, are in need of parental guidance.<sup>17</sup>

According to O'Neill, viewing autonomy separately from both an independence or rationality perspective is bound to create problems. Acts of autonomy based on independence, in her opinion, might be unlawful, dangerous and not necessarily valuable; while rationality theories which exclude independence will make acts of

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<sup>13</sup> R Gillon 'Autonomy and the principle of respect for autonomy' (1985)290 *British Medical Journal* 1807; Gauthier (n 12 above) 24.

<sup>14</sup> Gauthier (n 12 above) 21-37.

<sup>15</sup> In African settings, it is believed that adolescents or children are unable to act independently nor capable to making important decisions. Adopting Kant's reasoning may spell doom for adolescent girls from the African region; see E Durojaye, 'Realising access to contraception for adolescents in Nigeria: A human right analysis' University of Free State (2010) 30.

<sup>16</sup> J S Mill, who can be regarded as one of the earliest feminists, was of the view that the legal suppression of women through prejudice was wrong and responsible for hindering human progress. See V Ashley *Philosophical models of personal autonomy* 3 <http://autonomy.essex.ac.uk/philosophical-models-of-autonomy> (14 May 2013).

<sup>17</sup> Ashley (as above); J Fortin *Children's Rights and the developing law* (2009) 19-20.

servility and obedience not truly autonomous even if made by rational beings.<sup>18</sup> According to O'Neil, true autonomy requires the combination of independence and rationality.

Hill was of the opinion that respecting the autonomy of others should not be dependent on the characteristic capacity of humans to think rationally as rationality does not mean that humans will always act in a morally good way. Instead, respecting persons should be because they are human and not otherwise.<sup>19</sup> In other words, there is a minimum degree of respect owed to people that cannot be derogated from: respect for them as persons worthy of utmost respect.<sup>20</sup> In agreement with both O'Neill and Hill; it is believed that allowing female adolescents in Nigeria and South Africa, to independently, arrive at decisions on whether to access contraceptive services should not only be because they are 'Gillick' competent<sup>21</sup> but also because they are human beings deserving of dignity and respect.

Feminists have been particularly critical of the concept of 'autonomy' which is informed by liberalism. According to them, a depiction of the self-sufficient and independent individual without taking into consideration the inherent social nature of humans or values related to care; inter-dependency or friendship, thereby leading to the isolation of the individual is impractical.<sup>22</sup> Some feminists are of the view that the concept of 'autonomy' reflects masculine bias and are sceptical as to its benefits

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<sup>18</sup> B A Headley 'Feminist theories of autonomy and their implications for rape law reform' University of Montana (2007) 2 <http://etd.lib.umt.edu/theses/available/etd-04092007-143444/unrestricted/thesisPDF.pdf> (14 May 2013).

<sup>19</sup> T E Hill *Respect for humanity* 26-28, available at <http://tannerlectures.utah.edu/lectures/documents/Hill97.pdf> (22 May 2013).

<sup>20</sup> T E Hill *Autonomy and self-respect* (1991) 15; Durojaye (n 15 above) 30.

<sup>21</sup> Also referred to as the doctrine of the mature minor laid down in *Gillick v. West Norfolk and Wisbech Area Health Authority and Another* (1986) 1 AC 112, (1985) 3 All ER 402 in which the House of Lords were of the opinion that once an adolescent girl under the age of sixteen could understand the nature of sexual and reproductive health care services she requested and its implication, she should be granted access to the treatment in confidential settings without parental consent.

<sup>22</sup> J Nedelsky 'Reconceiving autonomy: Sources, thoughts and possibilities' (1989) 7 *Yale Journal of Law and Feminism* 12; May (n 10 above) 139

for females.<sup>23</sup> Others, like Sarah Hoagland, regard ‘autonomy’ as a thoroughly noxious concept that encourages the belief that connecting and engaging with others is a limitation.<sup>24</sup> Despite these criticisms, some feminist see autonomy as a valuable concept that will assist in the eradication of societal conditions that oppress women thereby seeking not only to retain the value of autonomy but to develop a new idea of the concept<sup>25</sup> which, not emphasising individualism, is based on the need for constructive relationships (relational autonomy). This idea, while encouraging interaction with others,<sup>26</sup> does not lead to the loss of oneself.<sup>27</sup>

Similar to the view expressed by relational autonomy, communitarian philosophers<sup>28</sup> believe that there is a link between the individual and the community which gives rise to the need to balance both individual rights and community interests. According to Lomelino,<sup>29</sup> under communitarianism individuals are granted the level of respect owed all persons as a result of their membership of the community but greater respect is achieved through their subsequent interaction with other community members. Nienaber explains that the utilitarian believes in the achievement of a common good for the maximum number of individuals with particular emphasis on the happiness of each individual, whereas communitarians are of the view that the promotion of shared societal values and ideals result in the

<sup>23</sup> B Rossler *The value of privacy* (2004) 103; M Friedman *Autonomy, Gender, Politics* (2003) vii.

<sup>24</sup> S Hoagland *Lesbian ethics: Toward new value* (1988) 144.

<sup>25</sup> The idea of relational autonomy seeks to address the challenge of balancing the need for self-determination with social interactions of inter-dependency and care without denying women the capacity required to change unfavourable situations.

<sup>26</sup> J Nedelsky *Law's relations: A relational theory of self, autonomy and law* (2011) 118; C Mackenzie & N Stoljar ‘Autonomy refigured’ in C Mackenzie & N Stoljar (eds) *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self* (2000) 3-4.

<sup>27</sup> Nedelsky *Law's relations* (as above) 123-124. As Durojaye notes, the total acceptance of Nedelsky's relational autonomy might be a potential source of ‘danger’ to female adolescents who will have to inform their parents and guardians of their need to access contraception services which will definitely not augur well for such adolescent, especially in African settings; see Durojaye (n 15 above) 55.

<sup>28</sup> Alasdair MacIntyre, Micheal Sandel, Charles Taylor and Micheal Walzer challenged the belief of liberals, who equate autonomy with individualism. See P Schaber & N Anwender ‘Communitarian values’ in R C Elliot (ed) *Institutional Issues Involving Ethics & Justice (Vol 1)* (2009) 144.

<sup>29</sup> P J Lomelino ‘Reconceptualizing autonomy to address cross cultural differences in informed consent’ (2009) 25 *Social Philosophy Today* 174-194, available at [https://www.academia.edu/930430/Reconceptualizing\\_Autonomy\\_to\\_Address\\_Cross\\_Cultural\\_Differences\\_in\\_Informed\\_Consent\\_Social\\_Philosophy\\_Today\\_25\\_2009\\_179-94](https://www.academia.edu/930430/Reconceptualizing_Autonomy_to_Address_Cross_Cultural_Differences_in_Informed_Consent_Social_Philosophy_Today_25_2009_179-94) (4 March 2014).

achievement of the common good. In other words, though community members may hold different opinions about what is good for the society they have common ideals which they seek to protect.<sup>30</sup>

The perception of 'autonomy' held by the communitarians fits with the African ideology of children as being incapable of making rational decisions and, therefore, requiring communal assistance to provide them with emotional and psychological support.<sup>31</sup> Thus, adopting communitarian principles of autonomy may not result in the achievement of the desired result in relation to the campaign for female adolescents' access to contraceptive services and information as supposed societal need to protect the morality of its young may be placed above the individual need of adolescent girls to access contraceptives.

Like other areas in life where the concept of 'autonomy' comes into play, in the medical profession the exercise of autonomy is understood in relation to the liberty to choose independently without controlling influences.<sup>32</sup> Apart from patients being able to exercise their right to medical autonomy, the necessity of respecting their views and choices, thereby respecting their autonomy, is paramount as there is a tendency for health care providers to perpetuate patient dependency instead of promoting their autonomy.<sup>33</sup>

Beauchamp & Childress believe that respecting the autonomy of patients requires the disclosure of information that will foster autonomous decision-making processes based on principles of telling the truth, respecting patient privacy, protecting

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<sup>30</sup> A G Nienaber 'Ethics and human rights in HIV-related clinical trials in Africa with specific reference to informed consent in preventive HIV vaccine efficacy trials in South Africa' University of Pretoria (2007) 90.

<sup>31</sup> Durojaye (n 15 above) 48.

<sup>32</sup> For medical autonomy to exist, three conditions must be satisfied; the medical choice must be made intentionally, based on understanding and be without external constraints. See T L Beauchamp & J F Childress *Principles of biomedical ethics* (2009) 100 - 101; A Slowther 'The concept of autonomy and its interpretation in health care' (2007) 2 *Clinical Ethics* 173; R R Faden & T L Beauchamp *A history and theory of informed consent* (1986) 242.

<sup>33</sup> Beauchamp & Childress (n 32 above) 104.

confidentiality and obtaining consent.<sup>34</sup> Others believe that respecting patient autonomy requires an acceptance of their choices without interference, no matter the decision reached.<sup>35</sup> It is felt once a patient has been provided with relevant information and has essential understanding of a medical procedure so as to be able to exercise a choice without undue pressure or inducement then the duty to respect the autonomy of such patient has been fulfilled.

It is necessary to emphasise that the principle of ‘autonomy’ which applies in general medical health situations also applies in relation to access to reproductive health care and currently is being used to support the right of women to make decisions to determine their family size through contraception.<sup>36</sup> Accordingly, respecting reproductive autonomy will involve women and adolescent girls being treated as individuals in their own right with the competence to make decisions and choices concerning their health. It will also include their right to take final decisions on issues relating to contraception and other reproductive/medical health care treatment after being provided with necessary and relevant information.<sup>37</sup>

Accordingly, the affirmation by Beauchamp & Childress that only a substantial degree of understanding is necessary to exercise autonomy conforms with judicial decisions on the ‘mature minor’,<sup>38</sup> which lean towards the view that adolescents who are deemed to be sufficiently intelligent and mature to understand the nature and

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<sup>34</sup> As above.

<sup>35</sup> Slowther (n 32 above) 173.

<sup>36</sup> R J Cook *et al* *Reproductive health and human rights: Integrating medicine, ethics and law* (2003) 70; L Gable *Reproductive health as a human right* (2009-2010) 60 *Case Western Reserve Law Review* 957-958.

<sup>37</sup> K Moodley *Medical Ethics, Law and Human Rights: A South African Perspective* (2011) 42.

<sup>38</sup> The mature minor rule is a Common law doctrine that allows children who though not yet of age statutorily but possess sufficient maturity to understand the nature of a medical treatment to exercise a choice in its acceptance or rejection. In the United States of America, apart from the mature minor doctrine, the position of the emancipated minor is also recognised. Emancipated minors are adolescents who, though below the legal age of majority, are free of parental control, as a result of marriage, living away from home or being a member of the armed forces. See Cook *et al* *Reproductive health and human rights* (n 36 above) 283.

consequences of the SRH treatment requested may consent to treatment without parental involvement.<sup>39</sup>

Finally, Mill's opinion on the right of children to autonomy and the communitarian view with respect to communal interest superseding individual wishes, are noted. However, it is submitted that there is still need to recognise the situation of some female adolescents, who though under the age of consent, are already 'mature' and possess the capacity to take decisions in relation to their SRH without interference. Hill's reasoning<sup>40</sup> that the autonomy of individuals rests on the view that as humans, they deserve the utmost respect, irrespective of their status, supports the position advocated that adolescents are not only human, but like adults, deserve to be treated with respect and dignity when attempting to access or actually accessing contraceptive and other SRH care services.

### 3 Adolescents and the need for autonomy

Adolescents constitute a large and growing segment of many societies.<sup>41</sup> During adolescence, young people encounter various transitions including their development of identity, the acquisition of skills and a move towards social and economic independence.<sup>42</sup> In addition, physical and sexual maturity takes place with a consequent commencement of sexual activity.<sup>43</sup> However, the initiation of sexual

<sup>39</sup> *Gillick 's Case* (n 21 above) 409-410; *R (Axon) v Secretary of State for Health* (2006) EWHC 37; *Christian Lawyers Association v Minister Of Health And Others (Reproductive Health Alliance As Amicus Curaie)* 2005 (1) SA 509 (T). See also Durojaye 'Realising access to contraception for adolescents in Nigeria' (n 15 above) 31.

<sup>40</sup> Hill 'Autonomy and self-respect' (n 20 above) 15; Durojaye 'Realising access to contraception for adolescents in Nigeria' (n 15 above) 30.

<sup>41</sup> Fortin (n 17 above) 81; A Bankole & S Malarcher 'Removing barriers to adolescents' access to contraceptive information and services' (2010) 41 *Studies in Family Planning* 117.

<sup>42</sup> WHO *Adolescent development: A critical transition* available at [http://www.who.int/maternal\\_child\\_adolescent/topics/adolescence/dev/en/index.html](http://www.who.int/maternal_child_adolescent/topics/adolescence/dev/en/index.html) (9 May 2013).

<sup>43</sup> Studies abound showing that sexual activities is usually initiated during the period of adolescence. See B O Nwankwo & E A Nwoke 'Risky sexual behaviours among adolescents in Owerri municipal: Predictors of unmet family health needs' (2009) 13 *African Journal of Reproductive Health* 135-145; S James *et al* 'Perceptions of pregnant teenagers with regard to the antenatal care clinic environment' (2012) 35 *Curationis* 2; O A Uthman 'Geographical variations and contextual effects on age of initiation of sexual intercourse among women in Nigeria: A multilevel and spatial analysis' (2008) 7 *International Journal of Health Geographics*, available at <http://www.ij-healthgeographics.com/content/7/1/27> (9 May 2013);

activity gives rise to problems associated with their access to SRH care services and information. Government, parents and other stake-holders tend to exercise of control and authority over the female adolescent's right to determine her sexual and reproductive needs.<sup>44</sup> The situation was summed by Haider:

Because adolescence is a borderline stage of life, it often becomes a legal battleground for control over provocative issues, such as sex, contraception, abortion, and sexually transmitted diseases. Despite the critical health issues at stake, discussing the sexuality of young persons' typically sparks controversy. Sometimes the issue is age or maturity level. The charge is that talking to teens about sex is tantamount to pushing them into sexual encounters. Sometimes the issue is the relativity of rights. Advocates in this scenario are confronted with the assertion of culture as a justification and a defence for violations of adolescents' rights.' Refuting the cultural relativist defence opens one up to charges of human rights imperialism and a lack of respect for local culture because of a refusal to accept the dictates of local authority.<sup>45</sup>

As Fortin observes, traditionally, the recognition of the rights of children including their right to autonomy, is one that has always been fraught with controversy, with 'children liberationists', on the one hand, and those who are of the view that children should be allowed to be 'children' on the other.<sup>46</sup> The liberationists argued that children, as persons and right-holders do not deserve to be discriminated against through their exclusion from the adult world. For them, children have greater abilities for self-determination than society cares to admit and there is no reason to prohibit them from enjoying the freedoms granted by the states to adults, including the right to control their private sexual lives.<sup>47</sup>

The views of the liberationists attract varied criticism, including from those which regard the liberationist's ideas not only as unrealistic but reckless due to their wrongful perception of children's capacities and ignorance of their slow rate of

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M Mantakana *Dynamic contextual analysis of adolescent sexual and reproductive health in Peddie, Eastern Cape* (2002) 7, available at [http://www.cadre.org.za/files/DCA\\_final\\_report.pdf](http://www.cadre.org.za/files/DCA_final_report.pdf) (9 May 2013).

<sup>44</sup> Autonomy in this instance refers to 'personal autonomy' - the right of individuals to self-determination and taking informed decisions about personal matters without any form of coercion or fear.

<sup>45</sup> Haider (n 1 above) 607.

<sup>46</sup> Fortin (n 17 above) 4- 5.

<sup>47</sup> Fortin (n 17 above) 4.

physical and mental development. In addition, it is felt that interfering with the parent-child relationship portends a danger of damaging the family unit as a whole.<sup>48</sup> According to Campbell,<sup>49</sup> children will be under constant stress if, like adults, they are to make rational decisions for themselves. For him, children have a right to be children and not adults and granting them autonomy rights would amount to redrawing the boundary lines between childhood and adulthood.<sup>50</sup> Furthermore, a recurring argument has been that allowing children autonomy rights will lead to an undermining of the rights, status and authority of parents.

Fortin argues that children have a whole range of rights, which include the right to care and protection, which have very little to do with decision-making, an acknowledgement of which is more important to younger children than autonomy related rights. However, as children develop, their capacity for taking responsibility for their lives needs to be encouraged.<sup>51</sup> Freeman has advocated for the right of children to autonomy and believes that to respect a child's autonomy is to treat that child as a person and as a rights-holder but he is of the belief that suggestions that the child's right to self-determination includes their right to sexual relationship with whomsoever they wish are dangerous and children should be protected from sexual exploitation and other vices which will prevent their maturation into independent adulthood.<sup>52</sup>

Although there is a growing view in developed nations that children are to be provided with greater opportunities for developing their decision-making capacities with parents promoting their children's capacity to reach important decisions about

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<sup>48</sup> Fortin (as above) 5.

<sup>49</sup> T D Campbell 'The rights of the minor: As person, as child, as juvenile, as future adult' (1992) 6 *International Journal of Law, Policy and the Family* 1-23.

<sup>50</sup> Fortin (n 17 above) 5. See also V Morrow 'We are people too': Children's and young people's perspectives on children's rights and decision-making in England' (1999) 7 *The International Journal of Children's Rights* 150.

<sup>51</sup> Fortin (n 17 above) 7.

<sup>52</sup> M Freeman 'Taking children's rights more seriously' (1992) 6 *International Journal of Law and the Family* 67-68.

their futures themselves,<sup>53</sup> the same cannot be said of African societies. In African societies, even though the general attitude towards children is warm and positive, the notion of children asserting their rights generally or exercising their autonomy by making decisions is unknown. Instead, emphasis is usually placed on ensuring their obedience to the power and control exercised by their parents and guardians.<sup>54</sup> Durojaye notes: the African adolescent's right to autonomy is limited due to beliefs that 'no matter how old a child is, a child is still a child' and is therefore 'unwise' or 'imprudent' to make serious decisions on issues affecting their lives'.<sup>55</sup> This position is similar to the situation that which existed in the past in societies such as ancient Greece. According to Arnott,<sup>56</sup> children were not owed any rights nor were they expected to act autonomously as their parents were responsible for their control and protection.<sup>57</sup>

The right of adolescent girls' to exercise their autonomy and, therefore, to access reproductive health services cannot be over emphasised.<sup>58</sup> This is especially important in African societies in which, as a result of cultural and religious subordination,<sup>59</sup> young girls occupy a vulnerable situation due to various belief systems. These beliefs proclaim the superiority of male children and nurture the idea that there is no need to educate females, who are to be contracted in marriage at

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<sup>53</sup> Fortin (n 17 above) 7.

<sup>54</sup> B Owasonoye 'Implementation of the United Nations Convention on the Rights of the Child in Nigeria' (2001) 2 & 3, available at <http://www.google.co.za/url?sa=t&rct=j&q=speaker+presentations++bolaji+owasonoye+&source=web&cd=1&cad=rja&ved=0CCoQFjAA&url=http%3A%2F%2Fwww.childjustice.org%2Findex.php%2Fcomponent%2Fedocman%2F%3Ftask%3Ddocument.download%26id%3D32%26Itemid%3D470&ei=82qjUZC8J8u2hAe0xlGwBg&usg=AFQjCNEcAgqHYvG5y1hEzTSPjz6bv6XIZw&bvm=bv.47008514,d.d2k> (27 May 2013).

<sup>55</sup> Durojaye (n 15 above) 37-38.

<sup>56</sup> Arnott (n 3 above) 809.

<sup>57</sup> Today, as Ngwena notes, 'the idea of absolute parental control with children as automaton at the direction of their parents until their attainment of legal majority is, in a majority of modern jurisdictions, only an historical curiosity'. See C Ngwena 'Health care decision-making and the competent minor: The limits of self-determination' (1996) *Acta Juridica* 132.

<sup>58</sup> The level of sexual activity among adolescent girls has been noted. See R J Cook & B M Dickens 'Recognizing adolescents' 'evolving capacities' to exercise choice in reproductive healthcare' (2000) 70 *International Journal of Gynaecology & Obstetrics* 13.

<sup>59</sup> F Adjetey 'Reclaiming the African woman's individuality: the struggle between women's reproductive autonomy and African society and culture' (1995) 44 *American University Law Review* 1353.

early age or circumcised early in life to avoid sexual promiscuity. Their male counterparts essentially are encouraged in these situations to bolster their masculinity.<sup>60</sup>

A careful consideration of the inequalities faced by the girl child in African societies (including Nigeria and South Africa) brings to fore the importance of using provisions contained in human rights instruments to advance the adolescent girls' need for autonomy. The use of human rights in advancing the autonomy of the girl-child arises out of the entrenchment of unequal gender relations between the sexes. Temin and Levine point out that this inequality continues to be a factor which allows for the coercion of girls into initiating sexual relations and prevents their access to SRH services, thereby exposing them to HIV and other STIs.<sup>61</sup>

As previously stated, female adolescents have a right to health care, including SRH care services, which are guaranteed and affirmed under various human rights instruments and declarations.<sup>62</sup> In addition, they possess the right to assert their sexual and reproductive autonomy by seeking health services in relation to contraception. It is important to state, until recently, the traditional approach, medically, was to ignore the capacity of children to choose as it was assumed that parents were the appropriate people who had the capacity to determine what happened to their children medically.<sup>63</sup> The judicial pronouncement from the House of Lords in the case of *Gillick v West Norfolk and Wisbech Area Health Authority and Another*,<sup>64</sup> in which the court held that a doctor would not be acting unlawfully if he gives advice or treatment to an adolescent who has the necessary understanding and

<sup>60</sup> C O Izugbara 'The Socio-Cultural Context of Adolescents' Notions of Sex and Sexuality in Rural South-Eastern Nigeria' (2005) 8 *Sexualities* 600–617.

<sup>61</sup> M Temin & R Levine Start with a girl: A new agenda for global health (2009) 22-24, available at [http://www.cgdev.org/files/1422899\\_file\\_Start\\_with\\_a\\_Girl\\_FINAL.pdf](http://www.cgdev.org/files/1422899_file_Start_with_a_Girl_FINAL.pdf) (6 March 2014).

<sup>62</sup> Art 25 UDHR, art 12 CEDAW, art 12 ICESCR, art 24(1) CRC, art 16 ACHPR, art 14 ACRWC, art 14 African Women's Protocol, paras 7.2 & 7.44 ICPD Programme of Action and paras 89, 90 & 93 Beijing Declaration and Platform for Action.

<sup>63</sup> Fortin (n 17 above) 147.

<sup>64</sup> *Gillick's* case (n 21 above).

intelligence to comprehend the nature of proposed treatment,<sup>65</sup> demonstrates the adoption of an open-minded approach that takes cognisance of an adolescents' decision-making capacities when accessing SRH care services in a confidential settings in so far as it is proved that they fully understand the nature of their request and its implications.

The above position was confirmed in *R (Axon) v Secretary of State for Health*.<sup>66</sup> The court refused to make a declaration that would allow doctors to break the confidentiality of their adolescent patients who seek to access sexual health care services without parental consent or involvement on the ground that such treatment without the parent's consent will interfere with the right to family life<sup>67</sup>

The above international position has been repeated in the South African case of *Christian Lawyers Association v Minister of Health and Others (Reproductive Health Alliance as Amicus Curiae)*.<sup>68</sup> Mojaelo J refused to grant the application of the plaintiffs that sections 5(2) and 5(3) of the Choice on Termination of Pregnancy Act 1996 be declared unconstitutional on the grounds that it allowed adolescents under the age of eighteen, who are 'incapable of giving consent', to terminate their pregnancies without parental consent, thereby acting against their best interests<sup>69</sup> and intruding on the children's rights to parental care and protection from abuse.<sup>70</sup>

In refusing the application, the judge took note of the fact that the legislature did not leave the area of the termination of pregnancy totally unregulated as it had put in place the requirement that the informed consent of a woman or girl is obtained before termination of pregnancy occurs and that no woman, regardless of age, can have her pregnancy terminated unless she is capable of giving informed consent and

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<sup>65</sup> *Gillick's case* (n 21 above) 413.

<sup>66</sup> *R (Axon)* (n 39 above).

<sup>67</sup> *R (Axon)* (n 39 above) para 156.

<sup>68</sup> *Christian Lawyers No 2* (n 39 above).

<sup>69</sup> Sec 28(2) Constitution of the Republic of South Africa 1996.

<sup>70</sup> Sec 28(1)(b) & (d) Constitution of the Republic of South Africa 1996.

actually does this.<sup>71</sup> According to the court, valid consent can only be given by a person who possesses the intellectual and emotional capacity to appreciate the nature of the medical treatment requested. Automatically, this requirement will dissuade or prevent 'immature' adolescents from assessing the services without parental knowledge.<sup>72</sup>

It is necessary to point out that the above judgements, which hinge upon the adolescent girl's ability to access contraceptive health care services based upon her level of maturity and intelligence are consistent with provisions on the evolving capacities of the child contained in human rights instruments providing for the protection of the rights of the child and with the common law 'mature minor' doctrine.<sup>73</sup>

As affirmed by the decisions of the courts and in the opinion of Ngwena, recognising the autonomy of adolescents is an explicit way of accepting that childhood is not a static condition but merely a period whereby the child matures in stages and acquires varying degrees of autonomy before attaining the designated 'age of majority', by which period she would have achieved a status that is comparable with that of adults.<sup>74</sup>

It is accepted that adolescents do not mature at the same age or pace and the period of adolescence is a phase in which adolescents typically engage in behaviour which can be detrimental to their health,<sup>75</sup> yet it amounts to a gross disservice if an age limit is fixed at which adolescents can access sexual or reproductive health care

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<sup>71</sup> *Christian Lawyers No 2* (n 39 above) 515.

<sup>72</sup> *Christian Lawyers No 2* (n 39 above) 516.

<sup>73</sup> Art 5 CRC & art 9(2) ACRWC. See also Durojaye (n 15 above) 289. A disadvantage however to the requirement that the health care provider carries out tests to determine the maturity and capability of adolescents understand the nature of treatment requested before accessing contraception is that the outcome is uncertain as it is based on the 'subjectiveness' of the health provider resulting in a situation where some adolescents' automatically have access to contraception while some will be automatically disqualified by the provider-gatekeeper. See L Kelly 'Why is it important to develop capacities for autonomous decision-making?' in IPPF (ed) *Understanding young people's right to decide* (2012) 4, available at [http://www.ippf.org/sites/default/files/ippf\\_right\\_to\\_decide\\_02.pdf](http://www.ippf.org/sites/default/files/ippf_right_to_decide_02.pdf) (12 June 2013).

<sup>74</sup> Ngwena (n 57 above) 133.

<sup>75</sup> Fortin (n 17 above) 85.

services.<sup>76</sup> Adolescent girls that are sufficiently mature to understand the nature of the SRH care treatment requested will be prevented from exercising their decision-making capabilities by accessing needed contraceptives information and services as a result of such a limitation. This action is contrary to the recommendation of the ICESCR Committee that health care facilities and services must be legally, factually and effectively accessible to all, especially the most vulnerable and marginalised sections of the population, without discrimination on any of the prohibited grounds.<sup>77</sup>

As Durojaye explains, instead of generally assuming that adolescents are immature and personally incapable of making informed decisions, the competence of such adolescents should be determined on an 'individual basis' when they seek to access contraceptive services.<sup>78</sup>

### 3.1 Consent

Although it is recent, the idea, of informed consent plays a central role in the regulation of medical ethics generally and the conduct of health providers in particular.<sup>79</sup> The shift to obtaining a patient's consent<sup>80</sup> is a reaction to the behaviour of health care practitioners and researchers<sup>81</sup> and based on the idea of patient autonomy which recognises the rights of patients to determine what happens to them medically.<sup>82</sup> In *Schloendorff v New York Hospital*, Cardozo J states: 'every human being of adult years and sound mind has a right to determine what shall be

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<sup>76</sup> *Centre for Child Law v Minister for Justice and Constitutional Development* 2009 (6) SA 632 (CC) para 39.

<sup>77</sup> Para 12(b) General comment 14 of the ICESCR Committee *Compilations of General Comments and Recommendations Adopted by Human rights Treaty Bodies, Vol I*, available at [http://www.amnesty.nl/sites/default/files/public/generalcomments\\_0.pdf](http://www.amnesty.nl/sites/default/files/public/generalcomments_0.pdf) (24 October 2012).

<sup>78</sup> Durojaye (n 15 above) 41.

<sup>79</sup> Z A Bhutta 'Beyond informed consent' (2004) 82 *Bulletin of the World Health Organisation* 771.

<sup>80</sup> It is necessary to explain that the patient may consent to treatment orally, in writing or impliedly by signifying her acquiescence. Any of the above options, however, must be taken with the knowledge and understanding of what the treatment involves and that there is an option to refuse treatment. See J Herring *Medical law and ethics* (2010) 159.

<sup>81</sup> Nienaber (n 30 above) 304.

<sup>82</sup> Herring (n 80 above) 192.

done to his own body; and a surgeon who performs an operation without his patient's consent, commits an assault'.<sup>83</sup>

The above judicial position supports the opinion of Van Oosten that 'between patient autonomy and medical paternalism, choosing the former is in conformity with contemporary notions of human rights and individual freedom unlike the latter which is based on outmoded patriarchal attitudes'.<sup>84</sup> The principle of self-determination squarely places on the patient and no one else<sup>85</sup> the decision of whether to undergo or refuse medical treatment.

Before the decision of the House of Lords in the *Gillick's case*,<sup>86</sup> the traditional approach adopted under common law in relation to adolescents' consent to medical treatment was paternalistic. Children could not consent to medical treatment until they had attained the age of 16<sup>87</sup> or 18,<sup>88</sup> the statutory age signifying the commencement of adulthood.<sup>89</sup> Exceptions to the general rule pertained to those

<sup>83</sup> *Schloendorff v New York Hospital* (1914) 105 NE 92. See also *Castell v De Greef* 1994 (4) SA 408 (C).

<sup>84</sup> Nienaber (n 30 above) 304; P de Cruz *Comparative healthcare law* (2000) 3.

<sup>85</sup> Moving away from the era of simple consent, the principle of informed consent is based upon a patient being adequately informed, in a manner that the patient substantially understands, about the ratio of risk and benefit involved in a particular procedure as compared to alternate procedures or none at all. See also Nienaber (n 30 above) 304; Herring (n 80 above) 198; Beauchamp & Childress (n 32 above) 117-119.

<sup>86</sup> *Gillick's Case* (n 21 above).

<sup>87</sup> Before the *Gillick case*, the age of sixteen was recognised under English law (sec 8(1) Family Law Reform Act 1969) as the threshold of adolescent consent as it was believed that, by then, adolescents could be assumed to have sufficient capacity to make choices over their health care. The *Gillick case* however extended the ability to consent to medical treatment to adolescents under sixteen in so far as they can adequately comprehend the nature of the treatment. See Fortin (n 17 above) 147-148; de Cruz (n 84 above) 117.

<sup>88</sup> Although adolescents' over sixteen are capable of consenting to general medical treatment, in the case of serious medical issues, including organ donation or blood transfusion where a matter of life and death is involved, the necessity of involving the adolescent's parent's ensues and, even in these instances, the procedure must be in the child's best interest. In these instances, the tendency has been for the courts to override the wishes of the child who refuses to consent to medical treatment. See Fortin (n 17 above) 151-152; de Cruz (n 84 above) 125-126.

<sup>89</sup> In this case, the Convention on the Rights of the Child (CRC) 1990 is not categorical on the exact definition of a child as it dances to the tune of some countries by providing in Art 1 that 'a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier'. The African Charter on the Rights and Welfare of the Child (ACRWC) is more assertive as it defined a child in Art 2 as 'every human being below the age of 18 years'. In South Africa, sec 17 of the Children's Act 2005 defines a child as someone younger than eighteen. The same position

minors who, though below the age of consent, were already emancipated from parental control due to marriage, involvement in military activities or the fact that they are economically self-sufficient.<sup>90</sup>

Apart from the liberation afforded adolescents to exercise their autonomy due to the favourable decisions of the courts in support of granting mature adolescents, who are *Gillick* competent,<sup>91</sup> the independence to access SRH care services without parental involvement, and the situation of emancipated minors, there is a further example to be considered. The current position regarding the high incidence of teenage pregnancy and the existence of child-headed households evident in sub-Saharan Africa due to the AIDS epidemic, have made it unavoidable for some children, though legally minors, to control their future by making autonomous decisions and giving consent on matters affecting their health, generally, and SRH, in particular.<sup>92</sup>

According to Beauchamp and Childress, writers have identified five elements establishing the validity of informed consent.<sup>93</sup> The elements are disclosure,<sup>94</sup> understanding, competence,<sup>95</sup> voluntariness<sup>96</sup> and consent<sup>97</sup> In *Christian Lawyers No.*

applies in Nigeria where a child is a person under the age of eighteen years - sec 277 of the Child Rights Act 2003.

<sup>90</sup> Cook *et al* *Reproductive health and human rights* (n 36 above) 283.

<sup>91</sup> Ngwenya (n 57 above) 137.

<sup>92</sup> A Roux-Kemp *Child-headed households in South Africa: The legal and ethical dilemmas when children are the primary caregivers in a therapeutic relationship* (2013) 1-13, available at <http://www.inter-disciplinary.net/probing-the-boundaries/wp-content/uploads/2013/02/Roux-Kemp.pdf> (31 May 2013); C E Kaufman *et al* 'Adolescent Pregnancy and parenthood in South Africa (2000) 4, available at <http://www.popcouncil.org/pdfs/wp/136.pdf> (15 July 2013).

<sup>93</sup> For their part, Beauchamp and Childress identified seven elements, viz, disclosure, understanding, competence, recommendation, decision, voluntariness and authorisation. Beauchamp & Childress (n 32 above) 120-121.

<sup>94</sup> This involves the health care provider giving the patient information on proposed treatment including the material inherent risks or complications associated with the treatment and possible alternatives.

<sup>95</sup> This involves the health care provider determining the intellectual competence and capacity of the adolescent patient to appreciate/understand the nature of the treatment requested. See Moodley (n 37 above) 44.

<sup>96</sup> This relates to the absence of coercion or manipulation of the adolescent patient to consent to treatment.

<sup>97</sup> It is only after the adolescent has been made to understand the nature of the treatment including attendant or possible risk that she can give an informed consent.

2,<sup>98</sup> the court explained that the requirement of informed consent relies on three principles, namely, knowledge, appreciation and consent.<sup>99</sup> According to the Judge, the requirement of knowledge means that the woman (adolescent girl) who consents to the termination of a pregnancy must have full knowledge of the nature and extent of the harm or risk. The requirement of ‘appreciation’ implies more than mere knowledge. In this instance, the woman who gives consent to the termination of her pregnancy must also ‘comprehend and understand the nature and extent of the harm or risk’. The last requirement of ‘consent’ means that the woman must subjectively consent to the harm or risk associated with the termination of her pregnancy and her consent must be comprehensive in that it must extend to the entire transaction inclusive of its consequences<sup>100</sup>

The provisions of the common law on consent have evolved to the extent that the competence of adolescents to consent to treatment is measured by their level of maturity and not their age.<sup>101</sup> The position laid down in the *Gillick case* is followed in other countries who give recognition to the rights of adolescents to assess contraceptive and other reproductive health care services. In the United States, for example, the legal ability of minors to give consent to SRH care has been dramatically expanded with a majority of states explicitly allowing competent minors to obtain contraceptive and other STD health care services without parental involvement.<sup>102</sup> The same view applies in Sweden where female adolescents can consent to contraception and other reproductive health care services without restrictions in terms of age or need for parental consent.<sup>103</sup> Recently, France passed a law which

<sup>98</sup> *Christian Lawyers No 2* (n 39 above).

<sup>99</sup> As above, 515.

<sup>100</sup> As above.

<sup>101</sup> *AC v Manitoba (Director of Child and Family Services)* 2009 SCC 30, (2009) 2 S.C.R. 181 para 111. See also O J Aniaka ‘Making informed consent work in Nigerian health care’ Dalhousie University (2012) 55.

<sup>102</sup> In most cases, the state consent laws apply to all minors from the age of 12. However, for abortion, parental involvement is required. See Guttmacher Institute *State policies in brief: An overview of minors’ consent law* (2013), available at [http://www.guttmacher.org/statecenter/spibs/spib\\_OMCL.pdf](http://www.guttmacher.org/statecenter/spibs/spib_OMCL.pdf) (4 June 2013); H Boonstra & E Nash, ‘Minors and the Right to Consent to Health Care’ (2000) *The Guttmacher Report on Public Policy* 4.

<sup>103</sup> M Danielsson *et al* ‘Teenage sexual and reproductive behavior in developed countries: Country report

allows adolescents between the ages of 15 and 18 to have access to contraceptive services without parental notification.<sup>104</sup>

At this stage, it is necessary to emphasise that although it is the intention in this study to advocate the unfettered access by female adolescents' in Nigeria and South Africa to contraceptive services and information in order to protect and fulfil their right to reproductive health care services as guaranteed under human rights instruments, it is important to stress that granting such access should be backed by the adolescent girl's ability to give informed consent as has been discussed.<sup>105</sup> In this situation female adolescents' individually, who wish to access contraceptive services should: voluntarily consent to the services, understand the nature of the services requested and also appreciate the risks associated with engaging in early sexual relations with the attendant effects (including the effects associated with the use of particular types of contraception). The importance of ensuring the fulfilment of these pre-conditions will naturally make the services inaccessible to mentally immature adolescent girls who may be victims of sexual abuse or victimisation.

In South Africa, the current threshold for children giving consent to medical treatment independently is 12 years. According to provisions contained in the Children's Act,<sup>106</sup> children can consent to their medical treatment or the medical treatment of their own children if they are above 12 years and of sufficient maturity and mental capacity to understand the benefits, risks, social and other implications associated with the treatment.<sup>107</sup> However, it is necessary to point out that in the

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for Sweden' (2001) 30, available at [http://www.guttmacher.org/pubs/summaries/sweden\\_teen.pdf](http://www.guttmacher.org/pubs/summaries/sweden_teen.pdf) (5 June 2013).

<sup>104</sup> 'France's Free Abortion Law Takes Effect', available at [http://www.huffingtonpost.com/2013/04/02/france-free-abortion-law\\_n\\_2998962.html](http://www.huffingtonpost.com/2013/04/02/france-free-abortion-law_n_2998962.html) (4 June 2013). The fact that an age limit was placed on adolescents' who can access contraception is not encouraging, but that there are provisions expressly allowing adolescents in the age group of 15 and 18 to access contraception is a welcome development.

<sup>105</sup> *Christian Lawyers No 2* (n 39 above) 515; *Gillick* case (n 21 above) *Beauchamp & Childress* (n 32 above) 120-121; *Moodley* (n 37 above) 44.

<sup>106</sup> Children's Act No. 38 of 2005 (as amended by the Children's Amendment Act No. 41 of 2007).

<sup>107</sup> Sec 129 Children's Act. This particular section came into force on 11 April 2010. See generally P Mahery *et al A guide to the Children's Act for health professionals* (2010) 9

case of a termination of pregnancy the adolescent girl's capacity to consent is not regulated by the provisions of the Children's Act but by the Choice on Termination of Pregnancy Act which allows a woman of 'any age' to give consent to the termination of her pregnancy.<sup>108</sup> Furthermore, apart from the Children's Act and the Choice on Termination of Pregnancy Act, the National Health Act<sup>109</sup> contains provisions requiring that the informed consent of health care services users is to be obtained before proceeding with treatment.<sup>110</sup>

In Nigeria, whereas the right of adults to give informed consent to medical treatment can be inferred from constitutional provisions on the rights contained in sections 34, 35, 37 and 38 of the Nigerian Constitution 1999,<sup>111</sup> the Code of Ethics of Medical and Dental Professionals<sup>112</sup> and the law of torts under the received English law<sup>113</sup> which places profound emphasis on the recognition of the right of patients to autonomy,<sup>114</sup> the position in relation to adolescents' consent to medical treatment is different. Children are regarded as incapable of consenting to medical treatment and the approval of their next of kin or, in special circumstances; an order of the court is to be first obtained.<sup>115</sup> It is necessary to state that the position adopted under the Code of Medical Ethics is also the same position adopted in the Constitution. Section

[http://www.ci.org.za/depts/ci/pubs/pdf/resources/general/ca\\_guide\\_health%20prof\\_2010.pdf](http://www.ci.org.za/depts/ci/pubs/pdf/resources/general/ca_guide_health%20prof_2010.pdf) (5 June 2013).

<sup>108</sup> Secs 1(xi) & 5(1)(2) & (3) Choice on Termination of Pregnancy 1996.

<sup>109</sup> The National Health Act No. 61 of 2003.

<sup>110</sup> Secs 6, 7 & 8 National Health Act.

<sup>111</sup> See sections providing for the right to dignity (34), liberty (35), privacy (37) and freedom of thought, conscience and religion (38) Nigerian Constitution 1999.

<sup>112</sup> Sec 19 Code of Ethics of Medical and Dental Professionals. The Code of Ethics of Medical and Dental Professionals in Nigeria was made by the Medical and Dental Council of Nigeria pursuant to its functions under the Medical and Dental Practitioners Act, Cap M8 LFN 2004.

<sup>113</sup> As already explained in the previous chapter, it is only in situations where Nigerian laws are silent on a particular issue that resort can be had to English law. See *Apampa v The State* (1982) 6 S.C. 22 at paras C-A; *Salisu Yahaya v The State* (2002) 3 NWLR (Pt. 754) 289 paras B-C.

<sup>114</sup> *MDPDT v Okonkwo* (2001) 7 NWLR (Pt. 711) 206 255.

<sup>115</sup> Sec 19 Code of Ethics of Medical and Dental Professionals. Special circumstances here includes where parents refuse to consent to the treatment of their children as a result of their religious beliefs. See *Esabunor v Fayewa* [2008] 12 NWLR (pt 1102) 794, available at [http://www.lawpavilionpersonal.com/lawreportsummary\\_ca.jsp?suite=olabisi@9thfloor&pk=CA/L/226/2003&apk=42587](http://www.lawpavilionpersonal.com/lawreportsummary_ca.jsp?suite=olabisi@9thfloor&pk=CA/L/226/2003&apk=42587) (7 June 2013).

35(1)(d) expressly limits the liberty of adolescents for their 'welfare purposes', which may be interpreted to include their accessing medical health care generally.

The position adopted in the Nigerian Constitution and the Code of Ethics, which restricts the autonomy of adolescents to consent to medical treatment by making their right to consent subject to parental rights, was also adopted in the Nigerian CRA.<sup>116</sup> Unlike its South African<sup>117</sup> counterpart, the CRA is silent on the right of children to consent to medical treatment and to participate in decisions that affect them as there are no provisions relating to these in the Act.

Apart from the fact that the lack of specific medical consent provisions in the CRA (which is fairly recent legislation) is a disappointment and disadvantage as it further entrenches cultural and paternalistic views that adolescents girls, in particular, and children generally have no say in their affairs or what course their health care treatment assumes, the lack of consent provision in the CRA is contrary to the position currently adopted in other jurisdictions that base the competence of adolescents to consent to health care treatment on their maturity and capacity to understand and comprehend the nature of treatment rather than on their age.

The lack of consent provision in the CRA automatically affects the right of female adolescents to access important contraceptive and other reproductive health care services without the knowledge and consent of their parents and as Durojaye opines 'considering the ever contentious issue regarding children's rights to seek sexual health treatment in Nigeria, one will not be wrong to say that the Child Rights Act scores an own goal in this regard'.<sup>118</sup>

The proposed National Health Bill<sup>119</sup> contains provisions specifying that health care providers are to make available to patients full information about their state of

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<sup>116</sup> Child's Right Act, Cap C50 LFN 2004.

<sup>117</sup> Sec 129 Children's Act (n 123 above)

<sup>118</sup> Durojaye (n 15 above) 181.

<sup>119</sup> Nigerian National Health Bill 2012.

health and the range of treatment options available to them, including the benefits, risks and consequences associated with each option, as well as their right to refuse treatment,<sup>120</sup> in a language that they understand while taking into consideration their level of literacy.<sup>121</sup> However, like its predecessors, the Bill, is silent on the issue of adolescents' consent to medical treatment thereby further affirming the position that adolescents do not have a right personally to consent to medical treatment.

### 3.2 Confidentiality

In addition to the issue of adolescents personally consenting to medical treatment generally and SRH care services in particular, another contentious issue relates to the issue of the right of adolescent girls to confidentiality when accessing contraceptive information and health care services. According to Dailard and Richardson, the debate over whether adolescents should be allowed to obtain reproductive health care services privately or with their parent's consent dates to the 1970s when teenage sexual activity became increasingly visible and the occurrence of adolescent pregnancy was recognised as a national social problem. As the age of marriage kept rising, pregnancies which normally would have occurred within marriage increasingly occurred before marriage.<sup>122</sup>

The entitlement of children to confidential health care services has been discussed.<sup>123</sup> Nevertheless, it is necessary to re-assert that the obligation of confidence owed by health care providers to their adult patients is automatically owed to their *Gillick* competent patients.<sup>124</sup> The issue of confidentiality of health care treatment is of particular importance to adolescent girls. Cook *et al* note, guaranteeing confidential health care services to female adolescents influences their

<sup>120</sup> Sec 23 (1)(b) , (c)& (d) Nigerian National Health Bill.

<sup>121</sup> Sec 23(2) National Health Bill.

<sup>122</sup> C Dailard & C T Richardson 'Teenagers' Access to Confidential Reproductive Health Services' (2005) *The Guttmacher Report on Public Policy* 6, available at <http://www.guttmacher.org/pubs/tgr/08/4/gr080406.pdf> (24 May 2013).

<sup>123</sup> The same arguments which have been advanced for female adolescents' entitlement to consent to contraceptive services also apply to their entitlement to access the services confidentially.

<sup>124</sup> J Montgomery *Health care law* (2003) 308.

willingness to access contraceptive information and services since young girls will not attempt to use sexual or reproductive services when their rights to privacy is not assured.<sup>125</sup>

In recognition of the correlation between confidentiality and adolescent girls' access to SRH care services, the courts in *Gillick*,<sup>126</sup> *R (Axon)*<sup>127</sup> and *Christian Lawyers No. 2*,<sup>128</sup> variously confirmed the need of adolescents to access these services confidentially. Lord Scarman,<sup>129</sup> in interpreting the memorandum of guidance issued by the United Kingdom Department of Health, stated:

In my judgment the guidance clearly implies that in exceptional cases the parental right to make decisions as to the care of their children, which derives from their right of custody, can lawfully be overridden, and that in such cases the doctor may without parental consultation or consent prescribe contraceptive treatment in the exercise of his clinical judgment and the guidance reminds the doctor that in such cases he owes the duty of confidentiality to his patient, by which is meant that the doctor would be in breach of his duty to her if he did communicate with her parents.<sup>130</sup>

Similarly, in *R (Axon)*,<sup>131</sup> the court, validating the position of the House of Lords in the *Gillick case*, stated:

... the very basis and nature of the information which a doctor or a medical professional receives relating to the SRH of any patient of whatever age deserves the highest degree of confidentiality and this factor undermines the existence of a limitation on the duty of disclosure...the doctor stands in a confidential relationship to every patient of whatever age but the purpose of the relationship is the welfare of the patient.<sup>132</sup>

Furthermore, the court also noted:

There is clear evidence that confidentiality increases the use of contraceptive and abortion services for those under the age of sixteen and that conclusion corresponds with common sense. The use of contraceptives will also reduce the risk of the need subsequently for

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<sup>125</sup> R J Cook *et al* 'Respecting adolescents' confidentiality and reproductive and sexual choices' (2007) 98 *International Journal of Gynaecology and Obstetrics* 183; Cook & Dickens (n 58 above) 17. See also para 31 General comment 15 CRC Committee.

<sup>126</sup> *Gillick's case* (n 21 above).

<sup>127</sup> *R (Axon)* (n 39 above).

<sup>128</sup> *Christian Lawyers No 2* (n 39 above).

<sup>129</sup> *Gillick's case* (n 21 above).

<sup>130</sup> *Gillick's case* (n 21 above) 417-418.

<sup>131</sup> *R (Axon)* (n 39 above).

<sup>132</sup> As above, para 62.

treatment for sexually transmitted diseases and for abortion. By the same token, in the case of sexually transmissible diseases, it is much more likely that a young person, who does not want his or her parents to know of his or her sexual activities, would go and obtain advice from a medical professional if that young person knew that his or her parents would not be notified of the advice or of the young person's condition by a medical professional. In other words, many young people, who need help on sexual matters from medical professionals, would be or might be deterred from obtaining such advice and treatment if their parents would have to be notified and this conclusion justifies the approach in the 2004 Guidance.<sup>133</sup>

In *Christian Lawyers No. 2*<sup>134</sup> the court observed that the provisions of the Choice on Termination of Pregnancy Act<sup>135</sup> provided that minors should be advised to consult with their parents before pregnancy termination, however, it noted that the termination of a pregnancy should not be denied because a minor refuses to seek parental consent<sup>136</sup> thereby securing the right of the adolescent girl to confidentiality in accordance with constitutional provisions contained in the Bill of Rights, which guarantees the rights to privacy<sup>137</sup> and the right to have access to reproductive health care among other rights.<sup>138</sup> In addition to the above, the South African National Health Act,<sup>139</sup> recognising the confidentiality of the information of health care users, expressly forbids the disclosure of information relating to the health status of patients except if the disclosure is within the ordinary scope of the health care provider's duties, in the interest of the health care user or based upon his/her consent.<sup>140</sup>

Furthermore, as stated in the previous chapter, apart from the protection of the right to confidential health care services granted in the Constitution of the Republic of South Africa, *viz*, the right to privacy and the provisions of the National Health Act,

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<sup>133</sup> As above, para 142.

<sup>134</sup> *Christian Lawyers No 2* (n 39 above).

<sup>135</sup> COTP Act.

<sup>136</sup> Sec 5(3) CTOP Act.

<sup>137</sup> Sec 14 Constitution of the Republic of South Africa 1996.

<sup>138</sup> Sec 27(1) (a) Constitution of the Republic of South Africa 1996. Other rights include the rights to equality (sec 9) & dignity (sec 10). In all, the assurance of these rights in the Constitution of the Republic of South Africa greatly assists in ensuring the enjoyment of the right to confidentiality which adolescent girls are expected to enjoy when accessing contraceptive health care services and information.

<sup>139</sup> National Health Act.

<sup>140</sup> Secs 14 & 15 National Health Act.

the Children's Act<sup>141</sup> allows contraceptive provision to children upon request from the age of 12 years without parental notification or consent<sup>142</sup> and requires that the confidentiality of children who access the services is assured.<sup>143</sup> These legal guarantees are in addition to the right of children to confidentiality in relation to their medical condition and health status as children are allowed to choose whether or not to disclose their health status.<sup>144</sup>

As was argued in relation to the right to consent to health care treatment, the right to ensure the confidentiality of children when accessing medical treatment in Nigeria can be inferred from the Constitution which assures every one (including adolescent girls) privacy rights.<sup>145</sup> This assurance offers sufficient grounds from which the right to the confidentiality of health records and services generally can be deduced. Specifically, in relation to adolescent girls, the CRA assures the right of children to privacy.<sup>146</sup>

The inclusion of the protection of this right in a legal document specifically created for ensuring that the rights of children are not trampled on is appropriate as it can be used to further the line of reasoning that female adolescents importantly need to have access to confidential contraceptive health care services so as to clear the bottleneck which usually occurs when young girls approach health care institutions for contraceptive counselling, information and services.<sup>147</sup> However, as noted in

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<sup>141</sup> Children's Act 2005.

<sup>142</sup> Sec 134(2) Children's Act.

<sup>143</sup> Sec 134(3) Children's Act.

<sup>144</sup> Sec 133 Children's Act.

<sup>145</sup> Sec 37 Nigerian Constitution 1999. While the right to privacy involves the right of a person to control information about herself from getting to third parties unnecessarily, the right to confidentiality is basically used in health care settings to refer to the duty of health care providers not to disclose information concerning a patient without the patient's consent. Even though these rights do not necessarily mean the same thing, it is believed that the right to confidentiality is subsumed under the privacy rights of patients, who are first of all humans before being patients.

<sup>146</sup> Sec 8(1) Child Rights Act 2003. Since the right of children to confidentiality is not specifically provided for in the Child Rights Act as it is in the South African counterpart, it can be interpreted that the recognition of the protection of right to privacy in the CRA naturally infers a concurrent right to access confidential health care services for female adolescents.

<sup>147</sup> K N Mmari *et al* 'STI treatment-seeking behaviours among youth in Nigeria: Are there gender differences?' (2010) 36 *International Perspectives on Sexual and Reproductive Health* 73. According to a

chapter three, inserting a limitation clause in section 8(3), which provides that the privacy rights of children shall not affect or limit the rights of parents to exercise reasonable supervision and control over the conduct of their children, is a shortcoming. This limitation will spontaneously discourage adolescent girls from accessing contraceptive health care services, thereby increasing their risk of exposure to STIs and HIV.<sup>148</sup>

In addition to the Nigerian Constitution and the CRA which recognises the right of people (including female adolescent girls) to confidential health care services through the guarantee of the right to privacy, the Code of Ethics<sup>149</sup> recognises the need for health care providers to maintain the confidentiality of their patients. The information which comes to the knowledge of the provider constitutes 'secret and privileged information' which must not be divulged to third parties except with the informed consent of the patient, which should be in writing.<sup>150</sup>

Apart from situations where patients specifically consent to the disclosure of confidential health care records, generally, exceptions to the confidentiality rule in both Nigeria and South Africa include situations where a court of law mandates the disclosure or where the disclosure is necessary to protect public health.<sup>151</sup> Other exceptions to the right to confidentiality, especially in relation to adolescent girls and their access to confidential contraceptive information and services include situations where the female adolescent has been a victim of sexual abuse or is currently being

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report, it was noted that adolescents expressed a preference of treating sexually transmitted diseases at traditional healing homes and patent medicine dealers as a result of the belief that they will be offered confidential treatment services. See M J Temin *et al* 'Perception of sexual behavior and knowledge about sexually transmitted diseases among adolescents in Benin-city, Nigeria' (1999) 25 *International Family Planning Perspectives* 188.

<sup>148</sup> Cook *et al* *Reproductive health and human rights* (n 36 above) 167; Cook and Dickens (n 58 above) 17; CRR and UNFPA 'The Right to Contraceptive Information and Services for Women and Adolescents' (2010) available at <http://www.unfpa.org/webdav/site/global/shared/documents/publications/2011/Contraception.pdf> (26 October 2012).

<sup>149</sup> Code of Ethics of Medical and Dental Professionals in Nigeria

<sup>150</sup> Sec 44 Code of Ethics of Medical and Dental Professionals in Nigeria.

<sup>151</sup> Sec 14(2) (b) & (c) National Health Act and sec 44 Code of Ethics of Medical and Dental Professionals in Nigeria.

sexually abused: in which case, a report is to be made to the appropriate authorities.<sup>152</sup> Additionally, the right to confidentiality of an adolescent's health care records can be overridden in South Africa is where the child either grants consent to disclose his/her medical information or where maintaining such confidence will not be in the child's best interests.<sup>153</sup>

Finally, as noted above, the assurance of confidential contraceptive health care services for female adolescents in Africa generally, and Nigeria and South Africa, in particular, not only increases the use of contraception but corresponds with common sense. Adolescents will continue having unprotected sexual relations rather than informing their parents of their need for contraception.<sup>154</sup> This observation coincides with Fortin's opinion that the decision in *Gillick* was a victory of realism over idealism. It not only was an exercise in pragmatism but also reflects an acceptance of the common sense advice that to abandon the principle of confidentiality for adolescent girls might lead to the increase of unintended pregnancies and STIs.<sup>155</sup> To prevent this, as Haider opines, the significance of continually fostering an open relationship between health care providers and female adolescents is vital, as this not only advances the adolescent's autonomy in relation to her reproductive life but

<sup>152</sup> Sec 110(1) Children's Act 2005. This portion of the Act recently took effect in 2007). See also sec 44 (f), (g) & (h) Code of Ethics of Medical and Dental Professionals in Nigeria. In relation to a situation involving sexual abuse, there should naturally be a differentiation between when an adolescent engages in consensual sexual activities with another adolescent and when the adolescent is a victim of sexual abuse, such as rape or incest or is involved in sexual relations with an adult, which gives rise to the criminal offence of statutory rape. See American Academy of Family Physicians *et al* 'Protecting adolescents: Ensuring access to care and reporting sexual activity and abuse: Position paper' (2004) 35 *Journal of Adolescent Health* 420-422.

<sup>153</sup> Sec 13(1)(d) & 133 Children's Act.

<sup>154</sup> K L Santoro *et al* *Protecting confidential health services for adolescents & young adults: Strategies & considerations for health plans* (2011) 2, available at <http://www.cicatelli.org/ipp/downloadable/NIHCM-Confidentiality-Final.pdf> (10 June 2013); CRR *Adolescents' Access to Reproductive Health Services and Information* (2010) available at <http://reproductiverights.org/en/project/adolescents-access-to-reproductive-health-services-and-information> (10 June 2013).

<sup>155</sup> Fortin (n 17 above) 164.

also allows her to determine personally, the course of action in life that suits her best.<sup>156</sup>

### 3.3 'Best interests' principle

The 'best interests' principle<sup>157</sup> is a fundamental principle that governs disputes affecting children and encompasses all the human rights of children.<sup>158</sup> The principle, which replaced the earlier notion of looking out for the 'the well-being of the child',<sup>159</sup> is a recent concept that is accorded immense importance and recognition in international and regional human rights instruments on the rights of children.<sup>160</sup> The principle which recognises children as potentially vulnerable members of the society who deserve the highest levels of protection by adults has been interpreted to mean the careful deliberation by state parties and other stakeholders (including judges) involved in the care of children to always consider in their actions, orders which best serves the interest of children in all situations.<sup>161</sup>

As noted in chapter three, a major criticism of the application of the 'best interests' principle has been because of its vagueness and indeterminacy<sup>162</sup> which is predicated

<sup>156</sup> Haider (n 1 above) 617.

<sup>157</sup> Art 3(1) CRC (n 5 above) & art 4 ACRWC (n 6 above).

<sup>158</sup> African Child Policy Forum *In the best interest of the child: Harmonising Laws on Children in West and Central Africa* (2011) 31, available at <http://www.acerwc.org/wp-content/uploads/2012/05/English-ACERWC-Harmonising-Laws-on-Children-in-west-and-central-Africa.pdf> (17 June 2013).

<sup>159</sup> The principle of the 'best interests' of the child has long been recognised in civil and common-law jurisdictions from the perspective of family law (especially in custody cases) and legislations on the protection of children welfare. See African Child Policy Forum (n 158 above) 31.

<sup>160</sup> J Zermatten *The Best Interests of the Child: Literal Analysis, Function and Implementation* (2010) 5-6, available at [http://www.childsrights.org/html/documents/wr/wr\\_best\\_interest\\_child09.pdf](http://www.childsrights.org/html/documents/wr/wr_best_interest_child09.pdf) (11 June 2013).

<sup>161</sup> J Karp 'Matching human dignity with the UN Convention on the Rights of the Child' in Y Ronen & C W Greenbaum (eds) *The case for the child: Towards a new agenda* (2008)121; Child Welfare Information Gateway *Determining the Best Interests of the Child 2*, available at [https://www.childwelfare.gov/systemwide/laws\\_policies/statutes/best\\_interest.cfm](https://www.childwelfare.gov/systemwide/laws_policies/statutes/best_interest.cfm) (11 June 2013). It is however necessary to point out that while applying the 'best interest' principle does not always mean that the rights of other people like parents and guardians will always be overridden; it means that a careful weighing and balancing of varied interest must be done to achieve the best interest of children in all situations. See C J Davel & A M Skelton *Commentary on the Children's Act* (2012) 2-14.

<sup>162</sup> The arguments against the application of the principle includes the fact that decisions can be made subject to factors like the cultural, historical, political, economic and social views of the decision maker.

on stake-holders and adults dealing with children's issues use of subjective reasoning to determine what is felt to be in children's best interests. In the view of some writers 'the best interests principle by being idealistic can lead to the delusion that its application is an achievement itself, the flaw is that what is regarded as best for any child or even children in general is often indeterminate, speculative and requires individualised choices between alternatives'.<sup>163</sup> Others have criticised the principle based on the understanding that 'in spite of the decision maker's best efforts, there still remain a wide variety of circumstances that cannot be accounted for both in the present and the future, which may distort the validity of the decision as being in the child's best interests. Consequently, according such ability to a decision-maker is to bestow upon him, shaman-like qualities for the prediction of future events'.<sup>164</sup>

This group feel that a practical decision, which might seem to be an excellent solution to a child's problem and in his/her best interests, might actually turn out otherwise. In response to these criticisms, Lansdown and Wernham explain that interpreting the best interests of children should always be centred in a rights-based approach which takes cognisance of all the rights to which children are generally entitled, including, but not limited to, their rights to survival, dignity, health, development, participation and non-discrimination.<sup>165</sup> Also, in this respect, the Committee on the CRC<sup>166</sup> has explained that the child's 'best interests' is a threefold concept. In the first instance it involves a substantive right that has to be considered in all situations relating to the child. Second, it is a fundamental interpretative legal principle which requires that the 'most' effective interpretation that furthers the best interests of children should be chosen in situations where a provision has more

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See Davel & Skelton (n 161 above) 2-7; J Heaton 'Some general remarks on the concept "Best Interest of the Child"' (1990) 53 *Journal of Contemporary Roman-Dutch Law (THRHR)* 95.

<sup>163</sup> S Elliston *The best interest of the child in healthcare* (2007) 17.

<sup>164</sup> As above, 17.

<sup>165</sup> G Lansdown & M Wernham 'Are protection and autonomy opposing concepts?' in IPPF (ed) *Understanding young people's right to decide* (2012) 7, available at [http://www.ippf.org/sites/default/files/ippf\\_right\\_to\\_decide\\_03.pdf](http://www.ippf.org/sites/default/files/ippf_right_to_decide_03.pdf) (12 June 2013).

<sup>166</sup> CRC Committee General comment No. 14 on the right of the child to have his or her best interests taken as a primary consideration issued at its sixty-second session (2013) available at [http://www2.ohchr.org/English/bodies/crc/docs/GC/CRC\\_C\\_GC\\_14\\_ENG.pdf](http://www2.ohchr.org/English/bodies/crc/docs/GC/CRC_C_GC_14_ENG.pdf) (15 August 2013).

than one interpretation. Finally, it is a rule of procedure that requires that when taking decisions on issues relating to children, the decision-making process must automatically include an evaluation of the possible impacts of the decision on the children concerned and state parties are to justify in all situations, before adopting decisions on children, that their best interests had been put into consideration.<sup>167</sup>

It is necessary to emphasise that the two major instruments guaranteeing the human rights of children globally and regionally, apart from recognising the obligation to protect the 'best interests' of children (adolescent girls inclusive) also guarantee the obligation to allow children to 'express their views' in respect of matters affecting their interests.<sup>168</sup> These two obligations, which 'seemingly' conflict, apply to all important areas in which the interests of children are involved, including health care and child protection.<sup>169</sup>

According to Archard and Skivenes<sup>170</sup> there is a tendency to instinctively respond to the obligation to protect the best interests of children in a paternalistic manner based on a natural reaction by adults that acting in the best interests of children means doing what is 'thought' to be in children's best interests. However, the obligation to respect the views of the children in matters affecting them, after taking into consideration their age and level of maturity/understanding according to their evolving capabilities,<sup>171</sup> may pull in a direction which adults have not envisaged.<sup>172</sup> This leads to a situation which according to Fortin is fraught with 'internal inconsistencies': the child protection instruments, on one hand, support the

<sup>167</sup> Para 6 General comment 14 CRC Committee.

<sup>168</sup> Art 12(1) CRC; art 4(2) ACRWC. Protecting the best interest of children includes their right to express their views which should be given due weight in accordance with their evolving capabilities based on their level of maturity, age and understanding. See D Archard & M Skivenes 'Balancing a Child's Best Interests and a Child's Views' (2009) 17 *International Journal of Children's Rights* 1.

<sup>169</sup> The obligation to act according to the best interest of children and allow them to express their views cuts across various areas of child law, ranging from issues relating to parental responsibilities, adoption, health care, criminal issues and court proceedings among others. Archard & Skivenes (as above) 1.

<sup>170</sup> Archard & Skivenes (as above) 2.

<sup>171</sup> Art 5 CRC & art 9(2) ACRWC.

<sup>172</sup> Archard & Skivenes (n 168 above) 3-4.

traditional role of the family and the authority of parents over their children and, on the other, simultaneously, emphasise the need to promote children's capacity for autonomy.<sup>173</sup>

The inconsistency created by parents exercising their powers of protection in observance of the 'best interests' of children principle and the need to respect their views, is particularly evident in the field of health care where female adolescents have to make decisions on whether or not to access contraception and other SRH care services. According to Lansdown and Wernham, while maintaining a balance between the protection of children, on one hand, and allowing them to exercise their autonomy in accordance with their evolving capacities and best interests, on the other, is difficult, the situation is still more complex in the field of SRH due to the extreme sensitivity of the issues involved and their various cultural implications.<sup>174</sup> However, no matter the inconsistencies, the necessity of protecting the best interests of children by taking their views into consideration in decision-making processes always is paramount.<sup>175</sup> This position agrees with the view of the Committee on the CRC in its recent general comment 14 on the best interests of children. The Committee emphasised that the judgement of adults about what is perceived to be in a child's best interests should not override the obligation to respect all the rights of children under the Convention.<sup>176</sup>

South Africa has provided for and guaranteed the 'best interests' of the child principle in its Constitution.<sup>177</sup> Also, it adopted the principle as the measure for all legal decisions relating to the protection, development and welfare of children in the

<sup>173</sup> Fortin (n 17 above) 43; Elliston (n 163 above) 10-11.

<sup>174</sup> Lansdown & Wernham (n 165 above) 3.

<sup>175</sup> Art 2 (1) CRC & art 3 ACRWC.

<sup>176</sup> Para 4 General comment 14 CRC Committee. The same point was reiterated by the same Committee in para 26 of its General Comment 8 *Compilations of General Comments and Recommendations adopted by human rights treaty bodies Vol. II*, available at [http://www.bayefsky.com/general/hri\\_gen\\_1\\_rev9\\_vol\\_ii.pdf](http://www.bayefsky.com/general/hri_gen_1_rev9_vol_ii.pdf) (27 October 2012).

<sup>177</sup> Sec 28(2) Constitution of the Republic of South Africa 1996. Apart from the Constitution, the best interest of the child principle is specifically incorporated into sec 9 of the Children's Act.

country.<sup>178</sup> The Constitutional Court in *Minister of Welfare and Population Development v Fitzpatrick*,<sup>179</sup> explained that the ‘best interests’ of children principle recognised in sec 28(2) of the Constitution extends beyond the rights enumerated in section 28(1) to create a right on its own<sup>180</sup> which as a matter of necessity must always be considered in issues involving children. In *Van Deijl v Van Deijl*,<sup>181</sup> the court explained, in making decisions on the best interests of children, that the economic, social, moral and religious interest of the minor must be considered, in addition to their wishes, emotional needs and ties of affection.<sup>182</sup>

In using the ‘best interests’ principle to determine cases before the courts, Davel & Skelton elucidate that the factors which need to be taken into consideration would vary depending on the facts of each case before the court.<sup>183</sup> In their opinion the court has a duty not only to carefully balance issues in reaching a conclusion that can be viewed as being in the best interests of children but must also ensure that child-centred approaches are adopted in reaching their decision.<sup>184</sup> In *Christian Education South Africa v Minister of Education*,<sup>185</sup> the Constitutional Court explained that the South African Schools Act<sup>186</sup> did not deprive parents of their general right and capacity to bring up their children according to their Christian beliefs but merely was acting in the ‘best interests’ of children by preventing the parents from authorising

<sup>178</sup> S Burman ‘The best interest of the South African child’ (2003) 17 *International Journal of Law, Policy and the Family* 28. Recently in *Teddy Bear Clinic for Abused Children and RA.PCAN v Minister of Justice and Constitutional Development and Another* Case No: 73300/10 – para 72, the Gauteng High Court restated the ‘best interest’ principle by declaring that the provisions of section 28(2) have a wide ambit and must be considered in all matters affecting children.

<sup>179</sup> *Minister of Welfare and Population Development v Fitzpatrick* 2000 (3) SA 422 (CC).

<sup>180</sup> As above, para 17.

<sup>181</sup> *Van Deijl v Van Deijl* 1966(4) SA 260 (R).

<sup>182</sup> As above, 261 H. See also *McCall v McCall* 1994 (3) SA 201 (C) where King J set out factors to be borne in mind when determining children’s best interest - at 205 B-G; *Krasin v Ogle* [1997] 1 All SA 557 (W) at 567i -569e.

<sup>183</sup> Davel & Skelton (n 161 above) 2-9.

<sup>184</sup> Like all other rights, the right to have the best interest of children protected has to be balanced with the rights of other persons or groups. See Davel & Skelton (n 161 above) 2-12 & 2-14; *Christian Education South Africa v Minister of Education* 2000 (4) SA 757 (CC) paras 30 & 31.

<sup>185</sup> *Christian Education South Africa v Minister of Education* (as above).

<sup>186</sup> South African Schools Act No. 84 of 1996.



the brunt of various traditional/cultural ills plaguing the Nigerian society without their best interests being adequately considered.<sup>194</sup> Peter-Odili JSC states that while the Nigerian government continually acknowledges the urgent need to protect the interest of children, it fails to make concrete investment geared towards putting in place the right policy and mechanism for determination of the best interests of the child in specific situations.<sup>195</sup> Her view tallies with the judgement concerning this deficiency made by the Committee on the Rights of the Child in its recent concluding report on Nigeria. The Committee urges the Nigerian state to:

formally incorporate the best interests of the child as a guiding principle in actions concerning children, particularly in decisions concerning children without parental care and in the juvenile justice system, and by harmonising this principle with the Sharia Penal Codes and enforcing it in practice.<sup>196</sup>

The major area where the ‘best interests’ of children principle can be said to be taken into consideration in Nigeria continues to be is in relation to the determination of custody and welfare of children in matrimonial proceedings.<sup>197</sup> In *Odogwu v Odogwu*,<sup>198</sup> the court expressed the opinion to the effect that in welfare cases, looking out for the fulfilment of the child’s happiness and psychological development was of greater importance than the material or financial comfort that a particular parent might offer. In these situations, the court was of the view that children should

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<sup>194</sup> Peter-Odili (n 193 above) 25; Oshio (n 193 above).

<sup>195</sup> Peter-Odili 25.

<sup>196</sup> Concluding Observations of the CRC Committee on Nigeria 2010 UN Doc CRC/C/NGA/CO/3-4 - para 31, available at <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G10/431/92/PDF/G1043192.pdf?OpenElement> (17 June 2013); Concluding Recommendations by the African Committee of Experts on the Rights and Welfare of the Child (ACERWC) on the Nigeria report on the status of implementation of the African Charter on the Rights and Welfare of the Child – para 4, available at <http://www.africa-union.org/root/ar/index/Nigeria.pdf> (15 October 2012).

<sup>197</sup> This is in fulfilment of the provision of sec 71(1) of the Matrimonial Causes Act 1970. The section provides:

In proceedings with respect to the custody guardianship, welfare, advancement or education of children of a marriage, the court shall regard the interests of those children as the paramount consideration; and subject thereto, the court may make such order in respect of those matters as it thinks proper.

<sup>198</sup> *Odogwu v Odogwu* 1992) 2 NWLR (pt. 225) 539.

be allowed to participate in order to determine their wishes.<sup>199</sup> Although not specifically pointing out that the court has a duty to take into consideration the best interests of the child in determining custody in divorce proceedings, it is apparent from the court's stance that this was its intention and is in line with provisions laid down in the CRC and other human rights instruments.

Irrespective of the fact that (except in custody cases) there is currently little or no jurisprudence on the application of the 'best interests' of children principle in relation to the numerous rights of children guaranteed under human rights instruments to which Nigeria is a party and has domesticated through the Child Rights Act, it is felt the Nigerian courts have a major role to play in developing jurisprudence in this area. The courts can ensure that the best interests of the child is always the guiding principle when actions concerning the protection of the right of children, including those in relation to the right of adolescent girls to contraceptive information and services, are brought before them. This suggestion corresponds with the explanation of the Committee on the CRC that its reason for developing the general comment on the 'best interests' principle is centred in the need to strengthen the understanding and application of the right of children to have their best interests assessed and taken as primary consideration so as to promote a 'real change' in attitudes that will eventually lead to the full respect of children as rights holders.<sup>200</sup>

### 3.4 Conclusion

This section has revealed the constant struggle to grant adolescents (especially adolescent girls) autonomy to consent to and gain access to confidential medical health care services generally and SRH care services in particular. As pointed out, in the section, the study supports developments by means of which female adolescents gain being granted access to confidential contraceptive information and services in

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<sup>199</sup> As above, 559-560. See also *Williams v Williams* (1987) NWLR ( pt. 54) 66 89.

<sup>200</sup> CRC Committee on General Comment 14 (n 188 above) paras 11 & 12.

Nigeria and South Africa. It also agrees with Freeman's view which opposes the proposal that the possession of autonomy by adolescents includes their right to have sexual relations with whomsoever they wish.<sup>201</sup> This position is based upon the reasoning that equating adolescent girls' possession of autonomy with the freedom to initiate sexual relations with whomsoever they want, might pave way for their becoming potential victims of sexual exploitation by unscrupulous adults.

However, female adolescents also engage in sexual activity with their peers, and therefore, require access to contraceptives and other reproductive health care services. In this regard, the WHO in its guidelines on the provision of contraceptive information and services recently recommended that states should assist in ensuring women (and adolescent girls) access to contraceptive services that are sensitive to their individual needs and also respect their right to dignity, autonomy and confidentiality is instructive.<sup>202</sup> Concurring with the opinions of Skelton<sup>203</sup> and Cook *et al*,<sup>204</sup> it is submitted that the capacity and willingness of adolescent girls' to access contraceptive services will depend not only on their competence to make informed SRH choices but also on the open-mindedness of adults to face current realities by assuring their access to the services in confidential settings as the fear of societal stigmatisation may be enough reason for female adolescents' not to use available contraceptive health care services.

Despite a tendency to want to over-protect female adolescents' through the creation of parameters which limit their access to harm generally, there is a necessity to ensure their empowerment developmentally access to appropriate comprehensive sexuality information so that they can acquire the necessary skills on decision-making and the confidence to negotiate consensual and safe sex. Such empowerment is of

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<sup>201</sup> Freeman (n 52 above) 67-68.

<sup>202</sup> WHO *Ensuring human rights in the provision of contraceptive information and services: Guidance and recommendations* (2014) 19-21, available at [http://apps.who.int/iris/bitstream/10665/102539/1/9789241506748\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/102539/1/9789241506748_eng.pdf) (10 March 2014).

<sup>203</sup> A Skelton 'Girls' socio-economic rights in South Africa (2010) 26 *South African Journal of Human Rights* 162.

<sup>204</sup> Cook *et al* 'Respecting adolescents' (125 above) 183; Cook & Dickens (n 58 above) 17.

greater value and in their best interests.<sup>205</sup> To this extent, there is the need for stakeholders and other interested parties to ensure that they strive to maintain an equilibrium between the duty of protecting children generally (female adolescents in particular) and allowing children to exercise their decision-making capabilities and autonomy as guided by their evolving capacities. The parties must act on the best interests principle without leaning either towards over-protection or under-protection.<sup>206</sup>

#### 4. Chapter conclusion

In this chapter, opinions in relation to adolescents' need for autonomy have been examined. Some writers are of the view that allowing children autonomy rights amounts to redrawing the boundary lines between childhood and adulthood, thereby putting them under constant stress as adults face when making important decisions.<sup>207</sup> Others are of the view that respecting the autonomy of individuals (including adolescents) should be because they are humans, deserving of utmost respect irrespective of their status.<sup>208</sup> Nevertheless, as pointed out by Fortin,<sup>209</sup> even though from childhood adolescents are entitled to a range of rights, including the right to care and protection, as they develop their capacity for taking responsibility for their lives, including making important decisions on their sexual and reproductive well-being, needs to be encouraged.

The African view of autonomy and of female adolescents' ability to consent and gain access to confidential contraceptive information and services tallies with the view of communitarians which according to Durojaye, applies to both Nigeria and South Africa.<sup>210</sup> However, the response by the governments in the two countries in

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<sup>205</sup> Lansdown & Wernham (n 165 above) 5.

<sup>206</sup> As above, 9.

<sup>207</sup> Campbell (n 49 above) 1-23; V Morrow (n 50 above) 150.

<sup>208</sup> Hill 'Autonomy and self-respect' (n 20 above) 15.

<sup>209</sup> Fortin (n 17 above) 7.

<sup>210</sup> Durojaye (n 15 above) 37-38.

recognising and granting adolescents autonomy, especially in relation to health care issues (SRH care inclusive), differs. In relation to the ability of adolescents to give consent to medical treatment independently, South Africa sets a threshold of 12 years, except in relation to the termination of pregnancies, where the CTOP Act allows a woman of 'any age' to give consent to the termination of her pregnancy.<sup>211</sup> Nigeria's position is different as adolescents cannot individually consent to medical treatment as the consent of parents and next of kin or in special situations, the law courts, has to be obtained.<sup>212</sup> In fact, the CRA, unlike its South African counterpart, is silent on the issue as there are no provisions relating to medical consent in the Act. Indirectly, this silence entrenches a paternalistic view point that adolescents have no say in their affairs nor over what course their health care treatment assumes, even if they are mature and can adequately understand and comprehend the nature of the treatment requested.

Additionally, as noted in Chapter 3 and severally in this chapter, the necessity to protect the best interests of adolescent girls by allowing them access contraceptives in confidential settings is important as this influences their willingness to access contraceptive information and services. As is the case concerning the issue of consent, the Constitution, Children's Act and National Health Act in South Africa specifically contain provisions which protect the right of its adolescents to confidential health care services, including contraceptive services. In addition, issues concerning the best interests of children have been upgraded to a position of paramountcy that must be carefully considered and applied in all circumstances relating to children (including female adolescents).<sup>213</sup> The situation is different in Nigeria. Even though the CRA provides that the best interests of children shall be the primary consideration, female adolescents' access to contraceptives information and

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<sup>211</sup> Sec 129 Children's Act (n 122 above); COTPA Act (n 124 above); secs 6, 7 & 8 National Health Act.

<sup>212</sup> Sec 19 Code of Ethics for Medical and Dental Practitioners; *Esabunor v Fayewa* (n 115 above) 794.

<sup>213</sup> Sec 28(2); Constitution of the Republic of South Africa; secs 9 & 134(3) Children's Act (n 123 above). See also *Van Deijl v Van Deijl* (n 181 above) 261 H.

services in private and confidential settings has to be generally inferred from privacy rights recognised in the Constitution and the CRA.<sup>214</sup>

As has been explained, though privacy rights are granted to children, the right is severely curtailed as a result of the inclusion of the provision of section 8(3) in the CRA which allows parents to exercise 'reasonable supervision and control' over the conduct of their children, thereby indirectly limiting privacy rights already assured adolescents. It is felt that the provision contained in section 8(3) is unnecessarily broad and is open to several interpretations which can be used specifically to limit female adolescents' access to contraception. The limitation needs to be corrected in such a way that it does not extend to adolescents' access to contraceptives, especially if the adolescent is sufficiently mature so as to understand the nature of the treatment requested.

Amending or redrafting this sub-section will be in accordance with the position adopted by the English and South African courts on adolescents' need for privacy when accessing SRH care services. In the *Gillicks* and *R (Axon)* cases, the learned justices were of the opinion that guaranteeing confidentiality to adolescents corresponds with common sense as not only does it increase their use of contraceptive services but also drastically reduces their need for subsequent abortion and STI treatments.<sup>215</sup> The above reasoning is practical as adolescent girls' will continue to have unprotected sexual relations rather than inform their parents of their need for contraceptives.<sup>216</sup> In the *Christian Lawyers No. 2* case, the court was of the opinion that access to SRH care services (in this case abortion) should not be denied because an adolescent refuses to seek parental consent.<sup>217</sup>

It is felt that the only situation in which the privacy and best interests of female adolescents in Nigeria and South Africa can be overruled should be a situation in

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<sup>214</sup> Sec 37 Nigerian Constitution; secs 1 & 8(1) Child Rights Act.

<sup>215</sup> *R (Axon)* (n 39 above) paras 62 & 142; *Gillick* case (n 21 above) 417-418.

<sup>216</sup> *Santoro et al* (n 154 above) 2.

<sup>217</sup> *Christian Lawyers No 2* (n 39 above) quoting the provision of sec 5(3) of the CTOP Act.

which the adolescent has been a victim of sexual assault and abuse or is currently being sexually abused. In which case, a report as a matter of urgency must be made to the appropriate authorities.<sup>218</sup>

Finally, in agreement with Skelton's position that the ability of female adolescents' to make effective and informed choices depends on their being properly informed and involved in decision-making processes relating to medical decisions, it is suggested that the Nigerian government needs to close the gap created by legislation regarding adolescent consent to treatment provisions either by amending the relevant sections or by inserting 'adolescent friendly' provision in laws which do not provide for such in the first place.<sup>219</sup> These actions are especially important if the treatment involves the provision of and access to SRH care services.

Having considered the meaning of autonomy in the context of adolescent girls' access to SHR, specifically female adolescents' need for autonomy, informed consent and confidentiality when accessing contraceptive information and services, in the following chapter the spotlight shifts to the access actually enjoyed by adolescent girls in Nigeria and South Africa to contraceptive information, education and services.

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<sup>218</sup> American Academy of Family Physicians *et al* (n 152 above) 420-422.

<sup>219</sup> For example, the Nigerian constitution and the Child Rights Act need to contain provisions where adolescents can personally give consent to medical treatment.

# CHAPTER 5

## TRANSLATING WORDS INTO ACTIONS: ACCESS TO CONTRACEPTIVE INFORMATION AND SERVICES IN NIGERIA AND SOUTH AFRICA

### Outline

- 1 Introduction**
- 2. Adolescent girls and contraception**
  - 2.1 Married adolescents and access to contraception**
    - 2.1.1 Married adolescents and access to contraception in Nigeria
    - 2.1.2 Married adolescents and access to contraception in South Africa
  - 2.2 Unmarried adolescents and access to contraception**
    - 2.2.1 Unmarried adolescents and access to contraception in Nigeria
    - 2.2.2 Unmarried adolescent and access to contraception in South Africa
  - 2.3 Conclusion
- 3 NIGERIA**
  - 3.1 Realising access to contraceptive information and services by adolescent girls in Nigeria
  - 3.2 Access to sexuality information and education
  - 3.3 Access to contraception through health care services
  - 3.4 Conclusion
- 4 SOUTH AFRICA**
  - 4.1 Realising access to contraceptive information and services by adolescent girls in South Africa
  - 4.2 Access to sexuality information and education
  - 4.3 Access to contraception through health care services
  - 4.4 Conclusion
- 5 International best practices relating to female adolescents' access to contraception**
  - 5.1 Introduction
  - 5.2 Denmark
  - 5.3 Mozambique
  - 5.4 Conclusion
- 6 Chapter conclusion**

## 1 Introduction

In sub-Saharan Africa, as in the rest of the world, the protection of adolescents' SRH through their access to contraceptive services and information not only generates numerous concerns among stakeholders, but also continues to be a constant subject of government policies and programmes as a result of the spread of HIV in many African countries.<sup>1</sup> These stakeholders either canvass for the restriction of adolescent girls' access to contraceptive and other SRH care information or services or champion the increase of their access to the life-saving information and services.<sup>2</sup> In addition to the problem of HIV, is the challenge of adolescent pregnancy which has been attributed as contributing to high maternal mortality rates in developing countries. According to Presler-Marshall & Jones quoting the World Bank statistics on adolescent birth rates, while the global fertility rate among 15-19 year olds in 2010 was 53 births per 1,000 adolescents, teenage fertility rates in sub-Saharan Africa amounted to an alarming 107.6 per 1,000 adolescents.<sup>3</sup>

As previously noted, apart from the realisation that it is in the best interests of female adolescents to recognise their autonomy and need to access confidential SRH care services in order to guarantee good health outcomes, another method of achieving adolescent girls' access to contraceptives involves the adoption of strategies that

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<sup>1</sup> A Bankole *et al* 'Sexual behaviour, knowledge and information sources of very young adolescents in four sub-Saharan African countries' (2007(11) *African Journal of Reproductive Health* 29.

<sup>2</sup> L L Wynn *et al* 'Harm reduction or women's rights? Debating access to emergency contraceptive pills in Canada and the United States' (2007) 38 *Studies in Family Planning* 253-267; V Schiappacasse & S Diaz 'Access to emergency contraception' (2006) 94 *International Journal of Gynecology and Obstetrics* 302; B Grundfest Schoepf 'Uganda: Lessons for AIDS control in Africa' (2003) *Review of African Political Economy* 554-556; N N Sarkar 'Barriers to emergency contraception (EC): Does promoting EC increase risk for contacting sexually transmitted infections, HIV/AIDS?(2008) 62 *International Journal of Clinical Practice* 1772.

<sup>3</sup> E Presler-Marshall & N Jones *Charting the future: Empowering girls to prevent early pregnancy* (2012) iii & 4, available at <http://www.odi.org.uk/sites/odi.org.uk/files/odi-assets/publications-opinion-files/7724.pdf> (23 September 2013).

guarantee factual sexuality education/information coupled with accessible, affordable and age appropriate contraceptive services.<sup>4</sup>

To this end, the purpose of this chapter is: First, to scrutinise the issue of adolescent girls (both married and unmarried) and contraception. Second, to examine the particular access that is available to adolescent girls in Nigeria and South Africa presently to contraception through information, education and health care services. This examination is in order to determine whether strategies to ensure access to contraceptive information through sexuality education actually translate into these services being available, accessible and acceptable to the targeted group in line with international recommendations. Third, international best practices relating to female adolescents' access to contraceptive education, information and services are examined (where available) so as to determine whether there is anything Nigeria and South Africa may learn from such practices to improve the access of their adolescent girls to contraceptive information and services.

## 2. Adolescent girls and contraception

The occurrence of unintended pregnancies among adolescents is a common public health problem worldwide.<sup>5</sup> Especially in the developing world, early pregnancy is not only a major cause of death among adolescent girls between the ages of 15-19, but a large number of girls also suffer from chronic illnesses and disability as a result of early

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<sup>4</sup> WHO *Cutting-edge global research on family planning and improving adolescent sexual and reproductive health* (2012) 2, available at [http://apps.who.int/iris/bitstream/10665/76235/1/WHO\\_RHR\\_HRP\\_12.30\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/76235/1/WHO_RHR_HRP_12.30_eng.pdf) (23 September 2013); UNFPA *Community pathways to improved adolescent sexual and reproductive health: A conceptual framework and suggested outcome indicators* (2007) 2, available at [http://www.unfpa.org/webdav/site/global/shared/documents/publications/2007/asrh\\_pathways.pdf](http://www.unfpa.org/webdav/site/global/shared/documents/publications/2007/asrh_pathways.pdf) (22 September 2013); Para 107(e) - Beijing Declaration and Platform of Action (1995) available at [http://www.unesco.org/education/information/nfsunesco/pdf/BEIJIN\\_E.PDF](http://www.unesco.org/education/information/nfsunesco/pdf/BEIJIN_E.PDF) (20 September 2012).

<sup>5</sup> S Ramos 'Interventions for preventing unintended pregnancies among adolescents' (2011) *WHO Reproductive Health Library Commentary* available at [http://apps.who.int/rhl/adolescent/cd005215\\_ramoss\\_com/en/index.html](http://apps.who.int/rhl/adolescent/cd005215_ramoss_com/en/index.html) (10 March 2014).

sexual initiation, pregnancy and childbirth;<sup>6</sup> hence the urgency to guarantee their access to factual contraceptive information and services.

Current demographic data puts the world adolescent population at 1.2 billion, the majority of whom reside in developing countries.<sup>7</sup> In sub-Saharan Africa, adolescents account for more than one in every five inhabitants.<sup>8</sup> The large population of adolescents currently presents an opportunity to hasten economic development and minimise poverty, thus an investment in the SRH of this group constitutes the foundation for remodelling the future of countries in the Sub-Saharan African region.<sup>9</sup>

Several reasons exist for investing in adolescent health. Apart from the fact that there are over a billion adolescents in the world and an investment in them is an investment in a better future<sup>10</sup> or that the choices made during adolescence have lasting implications for individual health, a prominent reason is that adolescents who engage in sexual relations early face various SRH risks about which they lack the knowledge to

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<sup>6</sup> As above.

<sup>7</sup> UNICEF *Demographic trends for adolescents: Ten key facts* available at <http://www.unicef.org/sowc2011/pdfs/Demographic-Trends.pdf> (8 May 2013). Current statistics shows that over 88 per cent of adolescents reside in the developing world with the African region being home over 220 million of them.

<sup>8</sup> UNICEF *Demographic trends for adolescents* (as above).

<sup>9</sup> Programmes to ensure a greater number of enrolments in schools and higher schooling completion rates should also apply to the girl child and not only male children. See Population Reference Bureau *The time is now: Invest in sexual and reproductive health for young people* (2012) available at <http://www.prb.org/pdf12/engage-youth-key-messages.pdf> (20 June 2013); J Chaaban & W Cunningham *Measuring the economic gain of investing in girls: The girl effect dividend* (2011) 3, available at [http://www-wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/2011/08/08/000158349\\_20110808092702/Rendred/PDF/WPS5753.pdf](http://www-wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/2011/08/08/000158349_20110808092702/Rendred/PDF/WPS5753.pdf) (20 June 2013); A Bankole & S Malarcher 'Removing barriers to adolescents' access to contraceptive information and services' (2010) 41 *Studies in Family Planning* 117; E Y Jimenez *et al* *World Development Report 2007: Development and the Next Generation* (2006) 26-28, available at [http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2006/09/13/000112742\\_20060913111024/Rendered/PDF/359990WDR0complete.pdf](http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2006/09/13/000112742_20060913111024/Rendered/PDF/359990WDR0complete.pdf) (19 June 2013).

<sup>10</sup> UNICEF *The state of the world's children 2011: Adolescence an Age of Opportunity* (2011) 4-5, available at [http://www.unicef.org/sowc2011/pdfs/SOWC-2011-Main-Report\\_EN\\_02092011.pdf](http://www.unicef.org/sowc2011/pdfs/SOWC-2011-Main-Report_EN_02092011.pdf) (9 May 2013).

make informed choices.<sup>11</sup> These factors are not limited to being the consequence of the process of urbanisation.

As a critical stage when adolescents' transit from being dependents to being providers, the period of adolescence requires careful managing because the health and sexual choices made during the phase to a large extent shape the adolescent's future. The situation is more tendentious in the case of adolescent girls. They, (like their male counterparts) are not only constantly being faced with peer pressure to engage in early sexual relations,<sup>12</sup> but, also, they are often victims of sexual violence.<sup>13</sup> In addition, achieving socio-economic growth and breaking the shackles of poverty is more taxing experience for adolescent girls in developing countries than it is for their male counterparts as a result of gender inequality which allows for their being stereotyped as natural subordinates who are available to satisfy the sexual needs of men and for whom 'motherhood is their ultimate and ideal role', making them victims of sexual and reproductive ill-health.<sup>14</sup>

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<sup>11</sup> S J Jejeebhoy *Sexual and reproductive health of young people: Expanding the research and program agenda* (2006) 1, available at [http://hivaidsclearinghouse.unesco.org/search/resources/bie\\_pop\\_rev\\_jejeebhoy.pdf](http://hivaidsclearinghouse.unesco.org/search/resources/bie_pop_rev_jejeebhoy.pdf) (9 May 2013).

<sup>12</sup> A Ankomah *et al* 'Reasons for delaying or engaging in early sexual initiation among adolescents in Nigeria' (2011) 2 *Adolescent Health, Medicine and Therapeutics* 78-80, available at <http://www.pathfinder.org/publications-tools/pdfs/Reasons-for-delaying-or-engaging-in-early-sexual-initiation-among-adolescents-in-Nigeria.pdf> (8 May 2013); T Selikow *et al* 'I am not "umqwayito": A qualitative study of peer pressure and sexual risk behaviour among young adolescents in Cape Town, South Africa' (2009) 37 *Scandinavian Journal of Public Health* 109-110; J B Bingenheimer *et al* 'The peer group context of sexual behaviors among Ghanaian youth' available at <http://paa2013.princeton.edu/papers/131537> (8 May 2013).

<sup>13</sup> R Jewkes 'Non-consensual sex among South African youth: Prevalence of coerced sex and discourses of control and desire' in S J Jejeebhoy *et al* (eds) *Sex without consent: Young people in developing countries* (2005) 88; F F Akanle 'Sexual Coercion of Adolescent Girls in Yoruba Land of Nigeria' (2011) 3(2) *Current Research Journal of Social Sciences* 132-138; Family Health International 'Non Consensual sex' (2005) 23(4) *Network* 3-4, available at [http://lastradainternational.org/lsidocs/583%20fhi\\_05\\_nonconsensual\\_sex\\_070402.pdf](http://lastradainternational.org/lsidocs/583%20fhi_05_nonconsensual_sex_070402.pdf) (8 May 2013); Ankomah *et al* (n 12 above) 81-82.

<sup>14</sup> Human Rights Watch *This old man can feed us, you will marry him: Child and forced marriage in South Sudan* (2013) 48-49, available at [http://www.hrw.org/sites/default/files/reports/southSudan0313\\_forinsertWebVersion\\_0.pdf](http://www.hrw.org/sites/default/files/reports/southSudan0313_forinsertWebVersion_0.pdf) (20 June 2013); E Loaiza & S Wong *Marrying too young: End child marriage* (2012) 39, available at

The imperative of investing in the SRH of adolescents generally and adolescent girls in particular is more urgent as the adolescent phase is the critical period when poverty and inequity are often passed on to the next generation through poor adolescent girls, who often bear the brunt of society's negligence, by giving birth to impoverished children.<sup>15</sup> Furthermore, the SRH of adolescents is a public health priority because preventing HIV transmission among this group can bring the epidemic to an end: 40% of new HIV infections worldwide occur in young people.<sup>16</sup>

Regardless of the process of sexual initiation, a constant fact remains that the engagement in sexual activities by female adolescents comes with responsibilities for which they are often not prepared. The reasons for their unpreparedness include their lack of skill to negotiate safe sexual relations and the absence of necessary contraceptive knowledge and information which result in onerous consequences.<sup>17</sup> The intent in this section is to examine briefly, the issue of adolescent girls (married and unmarried) and their access to contraceptive information and services. The reason for separating adolescent girls into distinct groups of 'married' and 'unmarried' can be attributed to the fact that the practise of child marriage exists to varying degrees in Nigeria and South Africa. Like their 'unmarried' counterparts, 'married' adolescent girls

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<http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/MarryingTooYoung.pdf> (20 June 2013); Chaaban & Cunningham (n 9 above) 4; S Cusack & R J Cook 'Combating Discrimination Based on Sex and Gender' in C Krause & M Scheinin (eds) *International Protection of human rights: A textbook* (2009) 222; J Bayisenge 'Early marriage as a barrier to girl's education: A developmental challenge in Africa' in C Ikekeonwu (ed) *Girl-Child Education in Africa* (2010) 7-8; P A Edewor 'Changing Perceptions of the Value of Daughters and Girls' Education among the Isoko of Nigeria' (2006) 21 *African Population Studies* 55-70.

<sup>15</sup> UNICEF *The state of the world's children 2011* (n 10 above) 3.

<sup>16</sup> A E Biddlecom *et al* *Protecting the next generation in sub-Saharan Africa: Learning from adolescents to prevent HIV and unintended pregnancy* (2007) 6, available at [http://www.guttmacher.org/pubs/2007/12/12/PNG\\_monograph.pdf](http://www.guttmacher.org/pubs/2007/12/12/PNG_monograph.pdf) (9 May 2013).

<sup>17</sup> In a majority of cases the female adolescents either become pregnant thereby losing their chances of improving their lives economically or become infected with sexually transmitted and HIV/AIDs. See WHO *The sexual and reproductive health of younger adolescents: Research issues in developing countries* (2011) 24-25, available at [http://whqlibdoc.who.int/publications/2011/9789241501552\\_eng.pdf](http://whqlibdoc.who.int/publications/2011/9789241501552_eng.pdf); Bankole & Malarcher (n 9 above) 118.

also experience difficulties in accessing contraceptive information and services although for different reasons.

## 2.1 Married adolescents and access to contraception

According to the UNFPA, whereas the attainment of puberty by girls should mark the beginning of a gradual transition to a healthy and productive adulthood, in some societies it marks the beginning of an accelerated journey by adolescent girls into inequality.<sup>18</sup> Child marriage, a damaging manifestation of the unequal power relations between females and males, occurs particularly in developing nations, including Africa.<sup>19</sup> The practice, begun as a means of protecting girls against unwelcome sexual advances as well as their gaining economic security, however, has undermined the very purposes it was meant to achieve in addition to being inconsistent with their best interests.<sup>20</sup>

The celebration of adolescent marriages, which is fuelled by poverty, illiteracy and low social status,<sup>21</sup> apart from being a violation of the right to equality and non-discrimination,<sup>22</sup> gives rise to the violation of the right to health care.<sup>23</sup>

<sup>18</sup> Loaiza & Wong (n 14 above) 6.

<sup>19</sup> Loaiza & Wong (n 14 above).

<sup>20</sup> R de Silva-de-Alwis *Child marriage and the law* (2008) 1, available at [http://www.unicef.org/policyanalysis/files/Child\\_Marriage\\_and\\_the\\_Law\(1\).pdf](http://www.unicef.org/policyanalysis/files/Child_Marriage_and_the_Law(1).pdf) (20 June 2013); Loaiza & Wong (n 14 above) 11.

<sup>21</sup> D Ityavar & I Bakari Jalingo *The state of married adolescents in Northern Nigeria* (2006) 8, available at <http://www.actionhealthinc.org/publications/docs/married.pdf> (20 June 2013); A S Erulkar & M Bello *The experience of married adolescent girls in northern Nigeria* (2007) 6 [http://www.popcouncil.org/pdfs/Nigeria\\_MarriedAdol.pdf](http://www.popcouncil.org/pdfs/Nigeria_MarriedAdol.pdf) (20 June 2013).

<sup>22</sup> The numerous human rights instruments guarantee the right of everyone (including adolescents) against discrimination – art 3 ICCPR, art 3 ICESCR, art 2 CRC, arts 2,3 & 18 African Charter, art 3 ACRWC and art 2 African Women Protocol (art 2). Other rights violated include the right to life, right to education, right to participation and the right to be free from abuse and exploitation among others.

<sup>23</sup> Art 12 ICESCR, art 24 CRC, art 16 African Charter, art 14 ACRWC and art 14 African Women's Protocol. See also L R Airede & B A Ekele 'Adolescent maternal mortality in Sokoto, Nigeria' (2003) 23 *Journal of Obstetrics and Gynaecology* 164; UNFPA *et al Child Marriages: 39,000 Every Day – More than 140 million girls will marry between 2011 and 2020* (2013) available at <http://www.unwomen.org/2013/03/child-marriages-39000-every-day-more-than-140-million-girls-will-marry-between-2011-and-2020/> (20 June 2013); Human Rights Watch (n 14 above); Erulkar & Bello (n 21 above) 10-11.

### 2.1.1 Married adolescents and access to contraception in Nigeria

The culture of child/adolescent marriage<sup>24</sup> persists in Nigeria<sup>25</sup> despite the existence of the CRA<sup>26</sup> which not only categorically specifies marriageable age but also provides for penalties that are accruable to a party who either marries a child or promotes the marriage of a child.<sup>27</sup> In addition to being contrary to the CRA, the practice of child/adolescent marriage also goes against the provisions of human rights instruments which call on state parties to ensure the elimination of child marriages in their respective countries, and to which Nigeria is a signatory.<sup>28</sup>

<sup>24</sup> It should be known that in some cultures girls who have not even attained the age of ten, the age recognized as the beginning of younger adolescence, are given in marriage as child brides. Developing countries in sub-Saharan Africa where the practice is predominant include Niger, Chad and Central African Republic, Bangladesh, Guinea, Mozambique, Mali, Burkina Faso, South Sudan and Malawi. See UNFPA *et al Child Marriages: 39,000 Every Day* (as above).

<sup>25</sup> Though considerable nationally, the practice of child marriage is predominant in Northern Nigeria where a majority of the citizens are of the Islamic faith. This is unlike the situation in the southern part of the country where in a majority of cases, sexual relations occur among unmarried adolescents due to the low level of child marriages in the area. See 'Nigeria: UN moves to improve adolescent sexual, reproductive health' *This Day* 25 July, 2013, available at <http://allafrica.com/stories/201307260659.html> (27 July 2013); Ityavar & Bakari Jalingo (n 21 above)15; P Makinwa-Adebusoye *Hidden: A profile of married adolescents in Northern Nigeria* (2006) 7 & 15-16, available at <http://www.actionhealthinc.org/publications/docs/hidden.pdf> (20 June 2013); Erulkar & Bello (n 21 above) 4-5 ; National Population Commission & ICF International *Nigeria demographic and health survey* (2013) 58 available at <http://dhsprogram.com/pubs/pdf/FR293/FR293.pdf> (24 September 2014). Also, statistics by the UNICEF reveal that the percentage of female adolescents married between 2002-2012 was 20.2%. see Unicef at a glance: Nigeria [http://www.unicef.org/infobycountry/nigeria\\_statistics.html](http://www.unicef.org/infobycountry/nigeria_statistics.html) (24 September 2014).

<sup>26</sup> Child's Right Act, Cap C50 LFN 2004. A major disadvantage suffered by the Act relates to its non-universal application due to the reason that state legislatures still need to pass similar Child Rights laws in their respective states before the Act can have legal effect in their states. While a majority of states in the southern, eastern and western part of the country have passed their Child Rights Laws which specifically state that age of marriage is 18 years, only a few states in the North have done so. A main criticism of opponents of the Act is based on the argument that some provisions in the Act are against the practice in their religion. See Ityavar & Bakari Jalingo (n 21 above) 11.

<sup>27</sup> Secs 21-23 Child Rights Act 2003.

<sup>28</sup> Art 16(2) CEDAW, art 21(2) ACRWC & art 6(b) prohibit the celebration of marriage and call upon state parties to take legislative measures to guarantee that the minimum age of marriage for women shall be 18 years. Also, para 5.5 of the ICPD Programme of Action 1994 provides that measures should be adopted and enforced to eliminate child marriages. While the prohibition of child marriages is not expressly referred to in the CRC, the Children's Convention contains provision calling for the elimination of traditional practices that are prejudicial to the health of children in art 24(3) of the Convention. See Loaiza & Wong (n 14 above) 10.

In addition to being a violation of the rights to health, equality and non-discrimination, the practice of child marriage also hinders the right of married adolescent girls in Nigeria to education. In a majority of cases married girls are prevented from achieving their educational potential due to the reason that they find combining the responsibilities of being a wife and mother with schooling burdensome, thereby limiting their chances of attaining socio-economic independence in the future.<sup>29</sup>

Comparable to the situation faced by their counterparts in other countries where child marriage is practised, the use of contraceptives by married adolescents in Nigeria is virtually non-existent.<sup>30</sup> As the UNFPA and IPPF notes in a study on contraceptive use by married female adolescents, apart from being pressurised to prove their fertility by giving birth very early in their marriages, a majority of the married adolescents are incapable of exercising autonomy and making reproductive health choices relating to their use of contraception.<sup>31</sup>

Furthermore, the non-access to contraception by married female adolescents puts them under the stress of frequent unplanned pregnancies<sup>32</sup> and makes them vulnerable to HIV and other STIs as a result of the fact that they operate from a position of

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<sup>29</sup> See L Arenyeka & E Eyoh 'Girl-child marriage threatens education – Experts' *Vanguard* 25 July, 2013 available at <http://www.vanguardngr.com/2013/07/girl-child-marriage-threatens-education-experts/> (27 July 2013); Ityavar & Bakari Jalingo (n 21 above) 16; Population Council *Nigeria: Child Marriage Briefing* (2005) available at [http://www.popcouncil.org/pdfs/briefingsheets/NIGERIA\\_2005.pdf](http://www.popcouncil.org/pdfs/briefingsheets/NIGERIA_2005.pdf) 921 June 2013).

<sup>30</sup> In addition to the fact that contraceptive use is virtually inexistent in Nigeria, the use of contraception is lower in the northern part of the country in comparison with the states in the south. See M Mandara 'Family planning in Nigeria and prospects for the future' (2012) 117 *International Journal of Gynecology and Obstetrics* 2-3; Erulkar & Bello (n 21 above) 12; National Population Commission & ICF International *Nigeria demographic and health survey* (n 25 above) 93.

<sup>31</sup> UNFPA & IPPF *Ending child marriage: A guide for global policy action* (2006) 11, available at <http://www.unfpa.org/webdav/site/global/shared/documents/publications/2006/endchildmarriage.pdf> (15 March 2014); Makinwa-Adebusoye (n 25 above) 21.

<sup>32</sup> For various reasons female adolescents greatly contribute to the current high national fertility levels in Nigeria as a result of their non-access to contraception. According to the 2008 Nigeria Demographic and Health Survey (NDHS), adolescent fertility rates in the country were over and above that of other African countries with 121 live births per 1,000 births. See 'More teenage girls in Nigeria are getting pregnant' *Channels Television* 15 July, 2013, available at <http://www.channelstv.com/home/2013/07/15/more-teenage-girls-in-nigeria-are-getting-pregnant/> (24 July 2013).

disadvantage and cannot negotiate sex or condom use with their often sexually experienced older husbands due to fear of violence.<sup>33</sup> Even in situations where the adolescent girls have information about contraception and personally desire to delay child bearing to later stages<sup>34</sup> or do not wish to bear children again for health reasons,<sup>35</sup> they are still unlikely to avail themselves of contraceptive services as a result of their economic dependency and limited decision making powers because they have to obtain spousal consent before attempting to access contraceptive services.<sup>36</sup> The above view corresponds with that of Cleland *et al*, who note that single young women have a greater tendency to use contraception than their married counterparts.<sup>37</sup>

### 2.1.2 Married adolescents and access to contraception in South Africa

Unlike Nigeria, South Africa draws minimal international attention when it comes to the high occurrence of child marriage. As evidenced by the Population Reference Bureau statistics on the *World Youth*, data on the percentage of married adolescents in the country is unavailable or inapplicable.<sup>38</sup> However, an earlier report by the UNICEF on the *State of the World's Children* revealed that the number of girls between the age of

<sup>33</sup> S Banerjee & U Sharma *Gender, sexuality, rights and HIV: An overview for community sector organizations* (2007) 10 & 28, available at [http://www.icaso.org/publications/genderreport\\_web\\_080331.pdf](http://www.icaso.org/publications/genderreport_web_080331.pdf) (20 June 2013); Ityavar & Bakari Jalingo (n 21 above) 20-21; UNFPA & IPPF *Ending child marriage* (n 31 above) 11; Human Rights Watch (n 14 above) 65; Loaiza & Wong (n 14 above) 4 & 11; Biddlecom *et al* (n 16 above) 15.

<sup>34</sup> N Prata & K Weidert *Meeting the need: Youth and family planning in Sub-Saharan Africa* (2011) 2, available at <http://uaps2011.princeton.edu/papers/110550> (20 June 2013).

<sup>35</sup> A Adhikari *The Silent Pain of Fallen Womb* 1-2, available at [http://pelvicorganprolapsesupport.org/yahoo\\_site\\_admin/assets/docs/Annas\\_Nepal\\_article\\_3.99120630.pdf](http://pelvicorganprolapsesupport.org/yahoo_site_admin/assets/docs/Annas_Nepal_article_3.99120630.pdf) (21 June 2013).

<sup>36</sup> UNFPA & IPPF *Ending child marriage* (n 31 above) 11; N Mwaura *Child Marriages on the Rise in Sub Saharan Africa, warn Advocates* (2013) available at [http://www.africasciencenews.org/en/index.php?option=com\\_content&view=article&id=773:child-marriages-on-the-rise-in-sub-saharan-africa-warn-advocates&catid=63:health&Itemid=114](http://www.africasciencenews.org/en/index.php?option=com_content&view=article&id=773:child-marriages-on-the-rise-in-sub-saharan-africa-warn-advocates&catid=63:health&Itemid=114) (20 June 2013).

<sup>37</sup> J Cleland *et al* Trends in protective behaviour among single vs. married young women in sub-Saharan Africa: the big picture (2006) 14 *Reproductive Health Matters* 17-22. See also K Ringheim & J Gribble *Improving the reproductive health of sub-Saharan Africa's youth: A route to achieve the millennium development goals* (2010) 19, available at <http://www.prb.org/pdf10/youthchartbook.pdf> (20 June 2013).

<sup>38</sup> Population Reference Bureau *The world's youth: 2013 data sheet* 12 & 16, available at <http://www.prb.org/pdf13/youth-data-sheet-2013.pdf> (21 June 2013).

15-19, who were married or in a union between 2000-2009 was 4%.<sup>39</sup> Thus the practice of child marriage exists<sup>40</sup> in some traditional societies<sup>41</sup> regardless of the existence of legal provisions protecting the rights of children, including female adolescents.<sup>42</sup> The current practice of *Ukuthwala*, where underage girls are abducted and forced into marriage infringes on the rights of adolescents girls not only guaranteed in South Africa's Constitution but also in the Children's Act.<sup>43</sup>

As already noted, in addition to children being entitled to all the rights guaranteed in the Constitution, they are specifically protected by the Constitution declaring that their best interests is paramount in all matters.<sup>44</sup> Also, the Children's Act not only guarantees the right of the child not be subjected to social, cultural and religious practices that are detrimental to their well-being<sup>45</sup> but expressly prohibits the arrangement of marriages

<sup>39</sup> UNICEF -*The state of the world's children* (n 10 above) 132.

<sup>40</sup> The difference between South Africa's situation and that of Nigeria is however based on the fact that the rates at which the practice occurs in the societies varies drastically. This position is evidenced in the UNICEF's *state of the world's children 2011*, where the percentage of Nigerian adolescents between the ages of 15-19 in marriages during the same period was 29%. See UNICEF -*The state of the world's children* (n 10 above) 132.

<sup>41</sup> A form of customary marriage in some KwaZulu-Natal, Free State and Eastern Cape traditional societies, the practice of 'ukuthwala' (forced marriage) was originally used to 'force' the hands of parents who did not approve of marriage between their daughters, who are of age(18 and above), to a particular man of her choice. The practice, initially, involved the abduction of the girl with her consent. Today however, the practice has been bastardised as young girls are kidnapped and practically 'sold' into marriages with connivance by their parents under the cover of practicing the custom. See L Mwambene & J Sloth-Nielsen 'Benign accommodation? *Ukuthwala*, 'forced marriage' and the South African Children's Act' (2011) 11 *African Human Rights Law Journal* 4; 'Parents promoting ukuthwala by 'selling their children for cows' *City Press* 16 November, 2012, available at <http://www.citypress.co.za/news/parents-promoting-ukuthwala-by-selling-their-children-for-cows-20121116/> (24 June 2013).

<sup>42</sup> 'Limpopo child bride: Sold into marriage, kept there by the system' *Daily Maverick* 1 February 2013 available at <http://www.dailymaverick.co.za/article/2013-02-01-limpopo-child-bride-sold-into-marriage-kept-there-by-the-system#.UcbeMP5BvIU> (23 June 2013).

<sup>43</sup> Apart from being contrary to the provisions of the Constitution and the Children's Act protecting the rights of adolescent girls, the practice of *Ukuthwala* as it relates to the forceful marrying of teenage girl automatically makes the perpetrator liable under secs 15, 16 & 17 Criminal Law (Sexual Offences and Related Matters) Amendment Act No. 32 of 2007.

<sup>44</sup> Sec 28 (1) & (2) Constitution of the Republic of South Africa 1996.

<sup>45</sup> Sec 12(1) Children's Act 2005.

or engagements for children below the ‘minimum age’ for a valid marriage.<sup>46</sup> In addition, the current position in relation to the celebration of civil law marriage of female adolescents is that, apart from the consent of the girl’s parents, the girl’s consent is compulsory. This stipulation is in addition to the fact that the minister’s consent may also be required.<sup>47</sup> For the celebration of customary law marriages with underage females the position is that the Minister’s consent is compulsorily required where the girl is between the ages of 12 and 18: the Recognition of Customary Marriages Act forbids the customary marriages of parties below the age of 18 years.<sup>48</sup>

Though South Africa’s Constitution recognises the application of customary law, it provides that customary law is to be applied subject to the Constitution and any legislation that specifically deals with customary law.<sup>49</sup> In agreement with Mwambene and Sloth-Nielsen, despite the recognition of cultural rights<sup>50</sup> the recognition does not provide a basis on which other rights may be restricted:<sup>51</sup> culture is protected so that it may enhance the development of human rights and not lead to the derogation of other

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<sup>46</sup> Sec 12(2) Children’s Act 2005. Before the passing of the Children’s Act, the minimum age for the celebration of valid marriages is set out in terms of common law which is twelve years for girls and fourteen years for boys. Probably as a check to prevent the indiscriminate forcing of underage girls into marriage, the Marriage Act No 25 of 1961 provides for the obtaining of the consent of the Minister of Home Affairs for the celebration of marriage with underage children – sec 26(1). See P Mahery & P Proudlock *Legal guide to age thresholds for children and young people* (2011) 22 -23, available at <http://www.ci.org.za/depts/ci/pubs/pdf/resources/guides/Ages%20Guide%20April%202011%20e-version.pdf> (20 June 2013).

<sup>47</sup> In this situation, the provisions of sec 12(2) & 18(3)(c)(i) of the Children’s Act is to be read in conjunction with the provision of sec 26(1) of the Marriage Act. It should be noted that the consent of the three parties (i.e., the girl, her parents and the Minister of Home Affairs) is only required where the girl is between the age of 12 & 14 years. Where the girl is between 15 & 17 years, only the girl’s consent and that of her parents is required. See Mahery & Proudlock (as above) 22.

<sup>48</sup> Sec 3 Recognition of Customary Marriages Act No. 120 of 1998. See also Mahery & Proudlock (as above) 23.

<sup>49</sup> Sec 211(1) & (3) Constitution of the Republic of South Africa 1996.

<sup>50</sup> Sec 31(1)(a) Constitution of the Republic of South Africa 1996.

<sup>51</sup> Sec 31(2) Constitution of the Republic of South Africa 1996.

rights. According to the writers, rather than protecting a culture at the expense of human rights, such culture, necessarily, must cede to universal standards.<sup>52</sup>

Like their counterparts internationally, including Nigeria, adolescent girls forced into marriage as a result of the *Ukuthwala* culture are not only deprived of opportunities to develop themselves educationally but are also subjected to a life of persistent poverty as a result of the violation.<sup>53</sup> Apart from the above, the girls suffer a number of negative health consequences, varying from the acquisition of HIV and other STIs to pregnancy induced complications as a result of their undeveloped reproductive organs.<sup>54</sup>

Despite statistics revealing the high use of contraceptives nationally,<sup>55</sup> and the existence of policy framework guaranteeing access to SRH care, including contraceptive services, South Africa continues to experience a high level of adolescent pregnancies<sup>56</sup> thereby indicating the existence of an unmet need for contraception among this group of people.<sup>57</sup>

However, it has been impossible to separately ascertain the use of contraceptives by married female adolescents in the country as available data tend to measure

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<sup>52</sup> Mwambene & Sloth-Nielsen (n 41 above) 12.

<sup>53</sup> M J Maluleke 'Culture, tradition, custom, law and gender equality' (2012) 15 *Potchefstroom Electronic Law Journal* 12.

<sup>54</sup> Maluleke (as above) 12; Department of Justice and Constitutional Development *Ukuthwala*, available at <http://www.justice.gov.za/brochure/ukuthwala/ukuthwala.html> (24 June 2013).

<sup>55</sup> Current contraceptive prevalence rate is 60%. The data is measured for married women between the ages of 15-49. See UNFPA country indicators – South Africa in *The state of the world's midwifery 2011* available at [http://www.unfpa.org/sowmy/resources/docs/country\\_info/profile/en\\_SouthAfrica\\_SoWMy\\_Profile.pdf](http://www.unfpa.org/sowmy/resources/docs/country_info/profile/en_SouthAfrica_SoWMy_Profile.pdf) (24 June 2013).

<sup>56</sup> According to the World Bank, the current adolescent fertility rate is 52 births per 1,000 women ages 15-19. See The World Bank *Data on Adolescent fertility rate* available at <http://data.worldbank.org/indicator/SP.ADO.TFRT/countries> (24 June 2013).

<sup>57</sup> UNFPA South Africa *Sexual and Reproductive Health* available at [http://countryoffice.unfpa.org/southafrica/2011/11/24/4255/reproductive\\_health\\_and\\_hiv/](http://countryoffice.unfpa.org/southafrica/2011/11/24/4255/reproductive_health_and_hiv/) (24 June 2013).

contraceptive use among married women between the ages 15-49 generally.<sup>58</sup> Another reason which may contribute to the non-availability of material on the specific use of contraceptives by this group of adolescents is due to the fact that a very high number of adolescent pregnancies and births occur outside marriage among unmarried adolescents. Furthermore, the practice of adolescent/child marriages, though in existence, is very low so that it escapes international attention<sup>59</sup> unlike the Nigerian situation where the practice of child/adolescent marriages is not only common in the North but childbirth frequently occurs within marriage hence the low use of contraceptive services.<sup>60</sup>

## 2.2 Unmarried adolescents and access to contraception

Unlike in the past when sexual relations were most often initiated within the confines of marriage,<sup>61</sup> today the opposite is the case as the period of adolescence is the stage when adolescents characteristically begin sexual activities early.<sup>62</sup> Numerous factors have been associated with the surge in adolescent pre-marital sexual relations. Some commentators have credited the increase in adolescent sexual activities to a breakdown of traditional values as occasioned by the removal of sexuality from the control of the community.<sup>63</sup> According to these people, the recognition of individual autonomy and

<sup>58</sup> See UNFPA country indicators – South Africa *The state of the world's midwifery* (n 55 above); World Bank *Data on contraceptive prevalence (% of women ages 15-49) rates in South Africa* available at <http://www.tradingeconomics.com/south-africa/contraceptive-prevalence-percent-of-women-ages-15-49-wb-data.html> (24 June 2013).

<sup>59</sup> Population Reference Bureau *The world's youth* (n 38 above) 11.

<sup>60</sup> Erulkar & Bello (n 21 above) 12.

<sup>61</sup> D Meekers 'Sexual initiation and pre-marital child bearing in sub-Saharan Africa' (1993) 5 *Demographic & Health Survey Working Paper 1*, available at <http://www.measuredhs.com/pubs/pdf/WP5/WP5.pdf> (24 June 2013).

<sup>62</sup> Biddlecom *et al* (n 16 above) 12; J Tripp & R Viner 'ABC of adolescence: Sexual health, contraception, and teenage pregnancy' (2005) 330 *British Medical Journal* 590.

<sup>63</sup> L A Adeokun 'Research on human sexuality in pattern II countries' in A Chouinard & J Albert (eds) *Human sexuality: Research perspectives in a world facing AIDS* (1989) 155 quoted by D Meekers 'Sexual initiation and pre-marital child bearing in sub-Saharan Africa' (1993) 5 *Demographic & Health Survey Working Paper 1*, available at <http://www.measuredhs.com/pubs/pdf/WP5/WP5.pdf> (24 June 2013).

decision-making powers means people are no longer accountable for their private choices to the community. On the hand, others are of the belief that unmarried adolescents use sexual relations and pregnancy to realise personal objectives, ranging from gaining economic benefits to achieving marital goals.<sup>64</sup>

According to Kroone, another reason which contributes to the increase in pre-marital sex is the tendency for young people to marry later than their parents due to changes in life style, the influence of western thinking and the increase in the amount of years spent studying.<sup>65</sup> In addition, Biddlecom *et al* explain that while a number of instances of sexual initiation among adolescents occur as a result of coercion, this does not discountenance the fact that a majority of sexual activities among this group takes place as a matter of choice.<sup>66</sup>

With the increase in pre-marital sex comes the attendant problem and risks associated with the beginning of adolescent sexual activities, including a high occurrence of unwanted teenage pregnancies and the transmission of HIV and other STIs. Galbraith *et al* acknowledge the existence of this problem. They remark that as a result of the fact that a majority of adolescent girls do not have access to SRH care services they are exposed to the risk of pregnancy and other negative outcomes.<sup>67</sup> Because initial sexual activities among adolescents are usually unplanned the tendency for it to be unprotected is higher.<sup>68</sup> The situation is particularly precarious for adolescent girls in sub-Saharan Africa, who are inclined to engage in sex at an earlier age than their male

<sup>64</sup> Meekers (n 61 above) 1 & 2.

<sup>65</sup> M H Kroone *Sexual practice of adolescents in Benin* (2010) 4, available at <http://www.aktiebenin.nl/userfiles/file/Papers/Sexual%20practice%20of%20adolescents%20in%20Benin%20Engels.pdf> (24 June 2013). See also S Singh & J E Darroch *Adding It Up: Costs and Benefits of Contraceptive Services Estimates for 2012* (2012) 4 & 5, available at <http://www.guttmacher.org/pubs/AIU-2012-estimates.pdf> (24 June 2013).

<sup>66</sup> Biddlecom *et al* (n 16 above) 13.

<sup>67</sup> A A Galbraith *et al* 'Health care access and utilization among pregnant adolescents' (1997) 21 *Journal of Adolescent Health* 253; L Ikamari & R Towett 'Sexual initiation and contraceptive use among female adolescents in Kenya' (2007) 14 *African Journal of Health Sciences* 1-2.

<sup>68</sup> Tripp & Viner (n 62 above) 590.

counterparts and thus, are exposed to a higher risk of HIV and other sexually transmitted diseases.<sup>69</sup>

According to the UNAIDS, of the 34 million people infected with HIV worldwide sub-Saharan Africa accounts for 69% with 23.5 million people living with HIV in the region.<sup>70</sup> The region also comprises 72% of new infections which occurred worldwide in 2011.<sup>71</sup> Due to gender inequality and the various ills suffered by women in African societies, women are disproportionately affected by the epidemic as they make up 58% of people living with HIV in the region.<sup>72</sup> Female adolescents and young women in the region account for double of the HIV infection rates found among young men as well as representing 31% of new infections which occur in sub-Saharan Africa.<sup>73</sup>

Despite the possibility of being infected with STIs or HIV and suffering numerous negative outcomes associated with the occurrence of teenage pregnancies,<sup>74</sup> a foremost problem experienced by unmarried female adolescents who have begun sexual relations relates to being guaranteed access to important contraceptive information and services. Singh and Darroch state that female adolescents, though unmarried but sexually active,

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<sup>69</sup> Biddlecom *et al* (n 16 above) 4; UNAIDS *Fact Sheet Adolescents, young people and HIV* (2012) available at [http://www.unaids.org/en/media/unaids/contentassets/documents/factsheet/2012/20120417\\_FS\\_adolescentsyoungpeoplehiv\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/factsheet/2012/20120417_FS_adolescentsyoungpeoplehiv_en.pdf) (25 June 2013).

<sup>70</sup> UNAIDS *Global Fact Sheet 2012* available at [http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/20121120\\_FactSheet\\_Global\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/20121120_FactSheet_Global_en.pdf) (25 June 2012); UNAIDS *World AIDS Day Report* (2012) 6, 7 & 10, available at [http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/JC2434\\_WorldAIDSday\\_results\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/JC2434_WorldAIDSday_results_en.pdf) (25 June 2013). Nigeria accounts for 3 million of the current rates while South Africa accounts for 5.6 million.

<sup>71</sup> 72% of the 2.5 million new infections which occurred worldwide were in sub-Saharan Africa. See UNAIDS *Global Fact Sheet 2012* (as above).

<sup>72</sup> UNAIDS *Regional Fact Sheet 2012* available at [http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/2012\\_FS\\_regional\\_ssa\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/2012_FS_regional_ssa_en.pdf) (25 June 2013).

<sup>73</sup> UNAIDS *Fact Sheet Adolescents, young people and HIV* (n 69 above).

<sup>74</sup> A Kumar *et al* 'Outcome of teenage pregnancy' (2007)74(10) *Indian Journal of Pediatrics* 927-931.

face greater difficulties in obtaining contraception than their married contemporaries.<sup>75</sup> The problem of inaccessibility, which occurs more in developing countries, especially in sub-Saharan Africa, according to the authors of the *2012 Adding It Up* report, to some extent is associated with the stigma attached to engaging in sexual activities before marriage.<sup>76</sup>

As reiterated, the use of contraceptives by adolescents generally and female adolescents in particular is of great importance as a result of numerous factors. Other than the general reason that contraceptive use prevents the spread of STIs, HIV, unwanted teenage pregnancies and results in lower abortion rates, there are specific reasons that can be adduced for unmarried adolescents having access to contraception. These include the fact that the use of contraceptives by adolescent girls allows them to realise their educational and economic aspirations as they do not become caught up in the problems of unwanted pregnancies.

Sonfield *et al*<sup>77</sup> in their study on the social and economic benefits of contraceptive access and consistent use by women highlight this issue when they discovered that female adolescents and young women who had access to contraceptives legally in the United States before the age of 21 graduated from college in significantly higher numbers than their counterparts who came of age before they had legal access to contraception.<sup>78</sup> In the same study it was also discovered that female adolescents and young women who had access to contraceptives were not only able to satisfy their educational yearnings but were also able to advance professionally as they could seek

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<sup>75</sup> Singh & Darroch (n 65 above) 6.

<sup>76</sup> As above.

<sup>77</sup> A Sonfield *et al* *The social and economic benefits of women's ability to determine whether and when to have children* (2013) available at <http://www.guttmacher.org/pubs/social-economic-benefits.pdf> (25 June 2013).

<sup>78</sup> Sonfield *et al* (as above) 7 & 9.

and attain professional significance in fields previously dominated by men and thereby enjoy economic stability.<sup>79</sup>

The above position corresponds with that maintained by the Centre for Reproductive Rights, which notes that when governments allow adolescent girls and women to access contraception, their level of autonomy is not only increased, but their social well-being is assured.<sup>80</sup> An addition to this positive consequence is the fact that guaranteeing unfettered access to contraception for female adolescents (both unmarried and married) promotes human development and economic growth for a nation.<sup>81</sup>

### 2.2.1 Unmarried adolescents and access to contraception in Nigeria

It is necessary to indicate from the outset, while both married adolescents (who are considerably more in Northern Nigeria) and unmarried adolescents (significant in Southern Nigeria) have common issues contributing to their non-access to contraceptive information and services, they have dissimilar reasons which contribute to their non-access.<sup>82</sup> Like their counterparts worldwide, female adolescents in Nigeria predominantly engage in premarital sexual activities<sup>83</sup> and every year a majority of them not only end up with unwanted pregnancies but also terminate them through back

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<sup>79</sup> Sonfield *et al* (as above) 11& 14.

<sup>80</sup> CRR *Access to Contraceptives: The Social and Economic Benefits and Role in Achieving Gender Equality* (2009) 2, available at [http://reproductiverights.org/sites/crr.civicactions.net/files/documents/pub\\_fac\\_slovak\\_socioeconomic%20Obenefits\\_9%2009\\_WEB.pdf](http://reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_fac_slovak_socioeconomic%20Obenefits_9%2009_WEB.pdf) (25 June 2013).

<sup>81</sup> Jimenez *et al* (n 9 above) 122-123.

<sup>82</sup> Apart from inaccessibility to contraceptives due to reasons including lack of autonomy, lack of information on where to access services, legal and socio-cultural impediments etc. which affects both groups of adolescents, married adolescents in a majority of cases don't have access to contraceptives due to spousal control while their unmarried counterparts cannot effectively negotiate safe sex as a result of economic reasons (unmarried adolescents cannot negotiate condom use with their sugar daddies).

<sup>83</sup> A major reason for engaging in premarital sex by adolescent girls is to alleviate economic hardship by dating older men who are financially capable of taking care of their needs. Other reasons include the decline in the age of early marriage especially in the Southern part of the country.

street abortions.<sup>84</sup> This social ill is in addition to their being vulnerable to numerous STIs and to reproductive ill-health.<sup>85</sup>

A main contributor to the problem of unwanted pregnancies and STIs transmission among unmarried adolescent girls in Nigeria is their inaccessibility to contraceptives due to their unmarried status. As will be discussed in detail in chapter six, apart from unmarried female adolescents being prevented from having access to contraception due to the negative attitude of health care providers, lack of confidentiality and institutionally imposed barriers,<sup>86</sup> unmarried adolescents (especially out-of-school adolescents) also experience a dearth of information about contraception generally as well as how to access the services.<sup>87</sup> Another reason for non-access for this group is the consequence of cultural and societal perceptions about contraceptive use, as this mainly prevents unmarried adolescent girls from accessing this important SRH care service.<sup>88</sup>

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<sup>84</sup> A Bankole *et al* *Unwanted pregnancy and induced abortion in Nigeria: Causes and consequences* (2006) 4 <http://www.guttmacher.org/pubs/2006/08/08/Nigeria-UP-IA.pdf> (25 June 2013). Abortion is only allowed in in Nigeria to save a woman's life. See secs 228-230 Criminal Code cap c38 LFN 2004 & secs 232-234 Penal Code cap p3 LFN 2004.

<sup>85</sup> WHO *Sexually transmitted infections: Issues in adolescent health and development* (2004) 4, available at [http://whqlibdoc.who.int/publications/2004/9241591420\\_eng.pdf](http://whqlibdoc.who.int/publications/2004/9241591420_eng.pdf) (26 June 2013).

<sup>86</sup> Institutionally imposed barriers in this instance relate to the imposition of the payment of user fees for services provided at government hospitals, including family planning services for adolescents.

<sup>87</sup> A Attahir *et al* 'Knowledge, perception and practice of emergency contraception among female adolescent hawkers in Rigasa sub-urban community of Kaduna State Nigeria' (2010) 4 *Journal of Family and Reproductive Health* 15-20.

<sup>88</sup> L O Omo-Aghoja *et al* 'Factors associated with the knowledge, practice and perceptions of contraception in rural Southern Nigeria' (2009) 43 *Ghana Medical Journal* 116. The belief exists that the use of modern contraceptive methods leads to subsequent infertility. This is in addition to the view that allowing unmarried adolescents to have access to contraception will encourage promiscuity. See also J W Kinaro *Perceptions as a barrier to contraceptive use among adolescents: A case study of Nairobi* (2011) 11-13, available at <http://uaps2011.princeton.edu/papers/110662> (25 June 2013).

### 2.2.2 Unmarried adolescents and access to contraception in South Africa

Probably as a result of the various legislative checks put in place to reduce female adolescent marriages<sup>89</sup> and the drive by the South African government<sup>90</sup> to achieve gender balance with respect to access to basic education, unmarried female adolescents in the country outnumber their married counterparts.<sup>91</sup> In spite of the achievement, however, a major impediment which poses a severe threat to the benefit achieved is the problem of teenage pregnancy. The occurrence of such pregnancies challenge efforts aimed at ensuring that adolescent girls attain higher education in order to improve their lot in life so that they are not only free from poverty but are empowered to a enjoy quality good life.<sup>92</sup>

The situation was highlighted by Oyedeji and Cassimjee who note that the issue of adolescent pregnancy is one of the most critical public health problems experienced in South Africa as a result of the reality that by the age of 19, 35% of female adolescents in the country have either given birth to a child or are currently pregnant.<sup>93</sup> Apart from the challenge of unplanned pregnancies, another problem which plagues adolescent girls

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<sup>89</sup> The provisions of secs 12, 17 & 18 of the Children's Act No. 38 of 2005; sec 26(1) of the Marriage Act No 25 of 1961, sec 3 of the Recognition of Customary Marriages Act No. 120 of 1998 and secs 15, 16 & 17 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act No. 32 of 2007, all combine to act as check to the indiscriminate perpetuation of child marriage.

<sup>90</sup> This effort has yielded fruits as girls now make up a majority of enrolments in secondary schools. See S Panday *et al* *Teenage pregnancy in South Africa: With a specific focus on school-going learners* (2009) 3, available at <http://www.education.gov.za/LinkClick.aspx?fileticket=ulqj%2BsyyccM%3D&> (26 June 2013).

<sup>91</sup> As explained earlier in relation to married adolescents, the issue of child marriage 'Ukuthwala' as it is practiced today exists only among some traditional societies in the country.

<sup>92</sup> Panday *et al* (n 90 above) 3; T Kanku & R Mash 'Attitudes, perceptions and understanding amongst teenagers regarding teenage pregnancy, sexuality and contraception in Taung' (2010) 52 *South African Family Practice* 564.

<sup>93</sup> O A Oyedeji & R Cassimjee 'A gendered study of young adult contraceptive use at one university in KwaZulu-Natal' (2006)29 *Curationis* 8.

relates to their vulnerability to HIV and other STIs as a majority of girls in this group disproportionately bear the burden of HIV infection, unlike their male counterparts.<sup>94</sup>

The large number of unintended pregnancies and the high prevalence of HIV and other STIs among unmarried female adolescents<sup>95</sup> is particularly worrisome since, ironically South Africa has put in place a legal framework that not only guarantees the right of women and adolescent girls' to reproductive health care services but also ensures that the services, including those related to contraception, are accessed freely. As noted in chapter three, apart from the constitutional guarantee on the right to access health care contained in sections 27(1) and 28(1)(c), the Children's Act recognises the right of children to access information on sexuality, reproduction, health promotion and the prevention of diseases.<sup>96</sup> In addition, the Act grants adolescents the autonomy to access contraception on request from the age of 12 and provides that their confidentiality is to be maintained in such instances.<sup>97</sup>

Although it can be stated that South Africa through its laws and policies on adolescent SRH; correctly understands the precarious nature of adolescence as the stage not only when female adolescents' attain sexual maturity but also begin to engage in sexual relations, unmarried female adolescents, like their Nigerian counterparts, for several

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<sup>94</sup> *Over quarter of South African school girls HIV positive: Minister* (2013) available at <http://www.abc.net.au/news/2013-03-14/over-25pc-of-s-african-schoolgirls-hiv-positive/4574134> (15 August 2013).

<sup>95</sup> A S Muula HIV 'Infection and AIDS Among Young Women in South Africa' (2008) 49 *Croatian Medical Journal* 423-435; A J Mason-Jones *et al School-based health clinics for adolescent sexual, reproductive and mental health* (2012) 1, available at <http://www.mrc.ac.za/policybriefs/Schoolbased.pdf> (26 June 2013); T M Mothiba & M S Maputle 'Factors contributing to teenage pregnancy in the Capricorn district of the Limpopo Province' (2012) 35 *Curationis* 1.

<sup>96</sup> Sec 13 Children's Act 2005. This is in addition to the provision in both the Constitution and the Children's Act which provides that the best interest of children is paramount in all instances. Sec 28(2) South Africa's Constitution & sec 9 Children's Act.

<sup>97</sup> Sec 134 Children's Act. The only situation where the confidentiality of children who access contraception is not assured is provided under sec 110 of the Act where there is reason to believe that a child has been the victim of sexual abuse or incest.

reasons, which will be examined in chapter six, don't access contraceptives, hence the high rate of unintended pregnancies.<sup>98</sup> This position was stressed in a recent study by Seutlwadi *et al* who remark that young people in the country are still engaging in unprotected sex as evidenced by the increase in premarital and unplanned pregnancies despite a 2003 Demographic Health Survey which indicated that about 97% of sexually active women in South Africa have knowledge of at least one contraceptive method.<sup>99</sup>

### 2.3 Conclusion

This section explored the issue of adolescent (married and unmarried) girls and contraception. With a large adolescent population world-wide, the majority of whom reside in developing countries, the need for investing in the protection of adolescent SRH care cannot be more self-evident. The literature reviewed in this section, however, reveals that despite the risks associated with the non-use of contraceptives<sup>100</sup> and the potentials that can be maximised with contraceptive usage,<sup>101</sup> for different reasons access by female adolescents (both married and unmarried) to contraceptive services remain low. This is especially the case in Nigeria.

Also, whilst the practice of child/adolescent marriage in both countries exists to different degrees, similar consequences still result from its occurrence, as not only the violation of the girls' rights follow but they become more liable to experience mortality

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<sup>98</sup> T M M Maja 'Factors impacting on contraceptive use among youth in Northern Tshwane: Part 2' (2007) 12 *Health SA Gesondheid* 43-45; K Child 'Teenage moms learn the hard way' Mail & Guardian, available at <http://mg.co.za/article/2011-11-04-teenage-moms-learn-the-hard-way> (14 August 2013).

<sup>99</sup> L Seutlwadi *et al* 'Contraceptive use and associated factors among South African youth (18 - 24 years): A population-based survey' (2012) 18 *South African Journal of Obstetrics and Gynaecology* 43. See also C MacPhail *et al* 'Contraception use and pregnancy among 15–24 year old South African women: A nationally representative cross-sectional survey' (2007) 5 *BMC Medicine* available at <http://www.biomedcentral.com/content/pdf/1741-7015-5-31.pdf> (26 June 2013).

<sup>100</sup> UNAIDS *Fact Sheet Adolescents, young people and HIV* (n 69 above).

<sup>101</sup> UNICEF *The state of the world's children* (n 10 above) 4-5.

and morbidity due to early pregnancy and childbirth.<sup>102</sup> In the next section of the study, the specific steps that have been adopted by the Nigerian government to ensure that female adolescents have access to contraceptive information and services are reviewed.

### 3 NIGERIA

#### 3.1 Realising access to contraceptive information and services by adolescent girls in Nigeria

The intention in this section is to examine specifically, the actual access by female adolescents in the Nigeria to contraceptive education/information and services. Such access is in accordance with the country's international and regional human rights obligation to respect, protect and promote the right to health (including reproductive health), as well as in fulfilment of its policies and laws which purportedly grant adolescents access to SRH care services generally and contraceptive services in particular.

Despite high growth rates, contraceptive usage in Nigeria remains low. Among the adolescent population, contraceptive use is still lower. According to statistics from the *Nigeria demographic and health survey 2013*; the contraceptive prevalence rate nationally is estimated to be 9.8% for any modern contraceptive method.<sup>103</sup> The adolescent fertility rate is estimated to be 123 live births per 1,000 births.<sup>104</sup>

<sup>102</sup> Airede & Ekele (n 23 above) 164; UNFPA *et al Child Marriages: 39,000 Every Day* (n 23 above); Human Rights Watch (n 14 above); Erulkar & Bello (n 21 above) 10-11.

<sup>103</sup> National Population Commission & ICF International *Nigeria demographic and health survey* (n 25 above) 97.

<sup>104</sup> UNFPA country indicators – Nigeria in *The state of the world's midwifery 2011* available at [http://www.unfpa.org/sowmy/resources/docs/country\\_info/profile/en\\_Nigeria\\_SoWMy\\_Profile.pdf](http://www.unfpa.org/sowmy/resources/docs/country_info/profile/en_Nigeria_SoWMy_Profile.pdf) (24 June 2013); 'More teenage girls in Nigeria are getting pregnant' (n 32 above). See also O E Onwujekwe *et al* 'Are modern contraceptives acceptable to people and where do they source them from across Nigeria?' (2013) 13 *BMC International Health and Human Rights* 2 <http://www.biomedcentral.com/1472-698X/13/7> (25 July 2013); CRR *Broken promises: Human Rights, Accountability, and Maternal Death in Nigeria* (2008) 27 available at [http://www.unfpa.org/sowmy/resources/docs/library/R422\\_CenterRepRights\\_2008\\_NIGERIABrokenPromisesNigeriaCentre\\_for\\_Hman\\_Rights.pdf](http://www.unfpa.org/sowmy/resources/docs/library/R422_CenterRepRights_2008_NIGERIABrokenPromisesNigeriaCentre_for_Hman_Rights.pdf) (16 August 2013).

### 3.2 Access to sexuality information and education

The sincere recognition by a nation of its human rights obligation to protect and promote the SRH of its adolescent population results in its overall economic development. The above view has been reiterated by various stake-holders, including the WHO and UNFPA, who constantly maintain that an investment in the SRH of young people through their access to contraceptive information and education is one of the most cost-effective development expenditures that a country can make, in addition to its generation of enormous socio-economic benefits.<sup>105</sup>

The need to allow female adolescents to gain access to the required information /education about contraception cannot be over-emphasised as it leads to the achievement of multiple advantages. Durojaye stresses that providing female adolescents access to contraceptive information and education not only creates important options for sexually active adolescents to avoid teenage pregnancies and STIs through the reduction of their exposure to numerous sexual harms but also positively enhances their social, educational and occupational chances.<sup>106</sup>

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<sup>105</sup> UNFPA *From childhood to womanhood: Meeting the sexual and reproductive health needs of adolescent girls* (2012) available at [http://www.unfpa.org/webdav/site/global/shared/documents/Reproductive%20Health/Fact%20Sheets/Adolescent%20Girls%20SRHealth\\_UNFPA%20Fact%20Sheet\\_July%205%202012.pdf](http://www.unfpa.org/webdav/site/global/shared/documents/Reproductive%20Health/Fact%20Sheets/Adolescent%20Girls%20SRHealth_UNFPA%20Fact%20Sheet_July%205%202012.pdf) (28 June 2013); Pathfinder International *A smart investment: Integrating sexual and reproductive health into multi-sectoral youth programs* (2011) available at [http://www2.pathfinder.org/site/DocServer/Pathfinder\\_\\_A\\_Smart\\_Investment\\_Integrating\\_Sexual\\_and\\_Reproductive\\_Health\\_into\\_Multi-Sectoral\\_Youth\\_Programs.pdf?docID=19381](http://www2.pathfinder.org/site/DocServer/Pathfinder__A_Smart_Investment_Integrating_Sexual_and_Reproductive_Health_into_Multi-Sectoral_Youth_Programs.pdf?docID=19381) (28 June 2013); WHO *Investing in our future: A framework for accelerating action for the sexual and reproductive health of the young people* (2006) 1, available at [http://www.wpro.who.int/publications/docs/investinginourfuture\\_framework.pdf](http://www.wpro.who.int/publications/docs/investinginourfuture_framework.pdf) (28 June 2013).

<sup>106</sup> E Durojaye 'Access to contraception for adolescents in Africa: A human rights challenge' (2011) 44 *Comparative International Law Journal of Southern Africa* 3-4; E Durojaye 'Realizing access to sexual health information and services for adolescents through the Protocol to the African Charter on the Rights of Women' (2009) 16 *Washington and Lee Journal of Civil Rights and Social Justice* 139-140. See also Population Reference Bureau *The time is now* (n 9 above); Guttmacher Institute *Facts on the sexual and reproductive health of adolescent women in the developing world* (2010) available at <http://www.guttmacher.org/pubs/FB-Adolescents-SRH.pdf> (28 June 2013).

Regardless of the numerous advantages to be gained from ensuring adolescent girls access to SRH information underscored above, in Nigeria guaranteeing adolescents' access to information and education on contraception and other SRH services has not been without its intrigues. Despite concerns about the particular negative effect which the HIV and AIDS<sup>107</sup> epidemic has upon the adolescent population, there is great resistance in African settings to attempts to properly educate adolescents generally and female adolescent in particular about their SRH needs.<sup>108</sup> The situation is made more precarious particularly as a result of beliefs which associate educating adolescent girls about contraception with an increase in sexual promiscuity and other immoral vices.<sup>109</sup>

As noted in chapter three, the Family Life and HIV Education (FLHE) Curriculum was introduced in 2001 in response to the need to curb the spread of the HIV epidemic among adolescents (especially adolescent girls).<sup>110</sup> Objectives for introducing the FLHE curriculum include that of creating opportunities for young people not only to acquire

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<sup>107</sup> Currently in Nigeria, 3 million people are infected and living with the HI virus. See UNAIDS Special report *How Africa turned AIDS around* (2013) 7, available at [http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2013/20130521\\_Update\\_Africa.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2013/20130521_Update_Africa.pdf) (14 August 2013).

<sup>108</sup> A Ogwezzy-Ndisika *Access to contraception information among adolescent girls: A study of the influence on their knowledge, attitude and practice in Nigeria* (2012) 19; G Sedgh *et al* Meeting young women's sexual and reproductive health needs in Nigeria (2009) 11, available at [http://www.guttmacher.org/pubs/2009/06/03/ASRH\\_Nigeria.pdf](http://www.guttmacher.org/pubs/2009/06/03/ASRH_Nigeria.pdf) (14 August 2013); C Nnorom & F Bammeke *Extent of adolescents' knowledge of sexual and reproductive health and rights in Nigeria: Implications for development* (2008) 4-5, available at <http://epc2008.princeton.edu/papers/80707> (10 July 2013). See also L M Williamson *et al* 'Limits to modern contraceptive use among young women in developing countries: A systematic review of qualitative research' (2009) 6 *Reproductive Health* available at <http://www.reproductive-health-journal.com/content/pdf/1742-4755-6-3.pdf> (10 July 2013); K Wood & R Jewkes 'Blood blockages and scolding nurses: Barriers to adolescent contraceptive use in South Africa' (2006) 14 *Reproductive Health Matters* 111-112.

<sup>109</sup> E Durojaye 'Realising access to contraception for adolescents in Nigeria: A human right analysis' University of Free State (2010) 93.

<sup>110</sup> A Ajuwon & W Brieger 'Evaluation of a school-based reproductive health education program in rural South Western, Nigeria' (2007) 11(2) *African Journal of Reproductive Health* 48.

the information and skills needed to prevent HIV and other STIs but also to enable the making of healthy decisions in relation to their sexual health.<sup>111</sup>

In spite of the good intentions associated with the adoption of the FLHE curriculum however, stiff opposition resulted in its being diluted before commencement. This was done in order to appease stakeholders who were opposed to its introduction contrary to opinions which have been constantly expressed that ensuring adolescents' access to quality and in-depth reproductive health information, especially at an early age, is a major strategy to promoting the practice of safer sexual behaviour.<sup>112</sup> Hence sexuality education not only should promote gender equality, decision-making and negotiation skills but also should provide information on pregnancy, anatomy, STIs and contraceptives including the various locations where the services can be accessed.<sup>113</sup>

Today, even though the National Family Life and HIV/AIDS Education (FLHE) curriculum has been widely adopted in various Nigerian states with the introduction of sexuality education in secondary schools,<sup>114</sup> as Esiet points out, its implementation remains poor

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<sup>111</sup> The curriculum covers topics that allow for the impartation of information on puberty, decision-making, communication skills, sexually transmitted infections and HIV/AIDS, abstinence, etc. See National *family life and HIV education curriculum for junior secondary schools* (2003) iii & 1-47, available at <http://www.actionhealthinc.org/publications/docs/jnrcurriculum.pdf> (15 August 2013).

<sup>112</sup> Due to the various cultural and religious impediments which contributed to the failure of previous national efforts to introduce sexuality education in schools and the disastrous impact of the HIV epidemic on the adolescent population, it is felt that the Nigerian government was pressed to make all efforts to ensure that the FLHE Curriculum was at least initially introduced in schools. This led to the dilution of the curriculum from the original contents proposed by civil society organisations. See Durojaye 'Realising access to contraception for adolescents in Nigeria' (n 109above) 206.

<sup>113</sup> Durojaye 'Realising access to contraception for adolescents in Nigeria' (as above) 206; A Ajuwon *Benefits of Sexuality Education for Young People in Nigeria* (2005) available at <http://www.arsrc.org/downloads/uhsss/ajuwon.pdf> (15 July 2013); F Alli 'Comprehensive sexual and reproductive health care services for youth: A health sector priority' University of KwaZulu-Natal (2011) 31-32.

<sup>114</sup> Even though the FLHE curriculum has been widely adopted in almost all the states in the country, implementation of the programme in schools across the states still suffers from some hitches and remains inadequately resourced. Currently, states where the curriculum has been fully introduced include Lagos, Abia, Anambra, Enugu, Akwa-ibom and Sokoto among others. See A O Esiet *Adolescent Sexual and*

in spite of national policy backing.<sup>115</sup> Results collated from a national survey conducted by the Federal Ministry of Education on *HIV/AIDS Knowledge, Attitudes, Practices, Skills and School Health* reveal that many Nigerian children do not have access to FLHE education,<sup>116</sup> indicating an urgent need to equally guarantee the access of sexuality education as mandated under the various human rights instruments and consensus documents.<sup>117</sup>

Despite the above, however, it is still necessary to draw attention to the fact that in states where the FLHE curriculum is actively implemented, steps are continually being taken by the state governments to train teachers who teach family life skills and HIV education. The purpose is not only to make them comfortable with the overall content of the FLHE curriculum but also make sure that, as Master Trainers, they are well equipped to subsequently train others (including peer educators) who are involved in the delivery of the FLHE programme.<sup>118</sup>

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*Reproductive Health in Nigeria* (2009) available at <http://www.wilsoncenter.org/sites/default/files/Esiet%20Presentation.pdf> (27 July 2013).

<sup>115</sup> Esiet (as above).

<sup>116</sup> According to results received from the survey, while 37% of students have heard of Family Life education, 60% indicated that FLHE was taught in their schools. Even at this level the FLHE curriculum is mainly taught in secondary schools and not primary schools or tertiary institutions contrary to the stipulations of the Family Life and HIV Education (FLHE) Curriculum. See Lagos State AIDS Control Agency *Family life HIV Education implementation: An assessment of the status of implementation of the Family Life HIV Education Curriculum in Lagos State* (2012) 6, available at <http://www.google.com.ng/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=5&cad=rja&ved=0CFUQFjAE&url=http%3A%2F%2Fwww.lsaca.org%2Fwp-content%2Fuploads%2F2012%2F06%2FFLHE-Implementation-Report.doc&ei=IHcsUvrSCafLOAXopoCoAQ&usg=AFQjCNFhxTX0g3JIHxKjfvstLrljHjv-nQ&sig2=hwlHGp5PYXXVnNmVUWaSw&bvm=bv.51773540,d.d2k> (18 August 2013).

<sup>117</sup> Providing access to comprehensive SRH information will be in accordance with the dictates of the CRC Committee that access to these information will assist in the adoption of responsible sexual behaviour. See para 60 General comment 15 CRC Committee.

<sup>118</sup> For example in Lagos State, a non-governmental organisation, the Action Health Incorporated (AHI) has been involved in the creation of a framework for the implementation of the FLHE curriculum in collaboration with the state government in schools in the state. On a regular basis, teachers are trained so that they can acquire skills and knowledge that will enable them to teach adolescents about their sexual health and HIV/AIDS. See Lagos State AIDS Control Agency (n 116 above) 3; AHI *Foundation for a healthy*

Apart from the downside mentioned in chapter three that relevant information on topics relating to contraception, anatomy and unprotected sex, which can be used to pass on accurate sexuality information to adolescents in schools was omitted from the FLHE curriculum on the basis of their cultural offensiveness, in addition to other ‘perceived’ negative factors, the teaching of sexuality education in Nigerian schools is usually taught from an abstinence standpoint in which the religious belief of the instructor is a major determinant of how factual and in-depth the sexuality education will be.

The above view was confirmed in a study on the evaluation of teacher delivery and response to the implementation of the FLHE curriculum in Edo State, Nigeria<sup>119</sup> which revealed that even though teachers are in agreement that furnishing students with information on SRH contributes positively towards their adoption of healthy sexual behaviours they are still reluctant to teach on the use of contraception as a means of protection against teenage pregnancies, STIs and HIV. Their reluctance is due to their belief that imparting knowledge about contraceptives and condoms as a means of protection will encourage pre-marital sexual activity.<sup>120</sup>

While not discounting the gains which might have been achieved with the teaching of abstinence-only sexuality education,<sup>121</sup> it is believed that the pursuance of abstinence-

*adulthood: Lessons from school based Family Life and HIV Education Curriculum implementation in Lagos State* (2010) available at <http://www.actionhealthinc.org/publications/docs/Foundation%20for%20Healthy%20Adulthood.pdf> (17 July, 2013).

<sup>119</sup> N Dlamini *et al* ‘Empowering teachers to change youth practices: Evaluating teacher delivery and responses to the FLHE programme in Edo State, Nigeria’ (2012) 16 *African Journal of Reproductive Health* 87-102.

<sup>120</sup> Generally, abstinence from sexual activities is the message taught to students as protection against HIV and pregnancy. Currently, only a few instructors are comfortable mentioning condoms as a preventative method and this only happens where there is reason to believe that a student is already sexually active. See Dlamini *et al* (as above) 96-97.

<sup>121</sup> O Oladepo & M M Fayemi ‘Perceptions about sexual abstinence and knowledge of HIV/AIDS prevention among in-school adolescents in a western Nigerian city’ (2011) 11 *BMC Public Health* 1-10, available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3118238/pdf/1471-2458-11-304.pdf> (29 July, 2013).

only SRH education and programmes in Nigeria for adolescents, irrespective of their age or evolving capacities, is a shortcoming.<sup>122</sup> Instead, it is submitted that the view of the United Nations General Assembly in its *Key Actions for the Further Implementation of the Programme of Action* document, which urges states parties to ensure that adolescents receive factual information on SRH issues in order to enable them make responsible and informed choices,<sup>123</sup> is a better option.

The reason for the above submission is not far-fetched because as Jejeebhoy advises, with the large number of adolescents infected with HIV and undergoing unsafe abortions yearly, denying adolescents girls access to life-saving information on SRH matters, based on the misguided view that teaching abstinence-only sexuality education will ensure their protection from the ‘dangers of the modern world’, amounts to living in a fool’s paradise.<sup>124</sup>

As an alternative, it is proposed instead of the overall withholding of important SRH information, as adolescents grow older, that there is a need to review the content of FLHE curriculum from teaching abstinence-only sexuality education to include passing on factual information on contraception, pregnancy and other SRH care needs, including where the services can be obtained. The above view corresponds with findings in a study by Inyang and Inyang, which discovered that older adolescents, between the age

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<sup>122</sup> In addition, apart from STIs, HIV and teenage pregnancies, female adolescents also become susceptible to procuring backstreet and illegal abortions, which, in turn, result in fatal consequences of maternal mortality or morbidity.

<sup>123</sup> Para 73(e) ICPD +5 Key Actions Document, available at <http://www.un.org/documents/ga/res/21sp/a21spr02.htm> (5 October 2012).

<sup>124</sup> From these statistics; a majority of the affected adolescents and youths live in Asia and sub-Saharan Africa. See Economic and Social Council - *Fool’s Paradise’ to Think Denying Adolescents Health-Promoting, Life-Saving Services Shielded Them, Prevented Promiscuity, Population Commission Told* available at <http://www.un.org/News/Press/docs/2012/pop1003.doc.htm> (6 May 2013).

group of 14-19, were against the imparting of abstinence only sexual education in comparison with their younger counterparts in the age range of 11-13 years.<sup>125</sup>

It is necessary to point out that whilst it can be said that the FLHE curriculum provides an opportunity to cater to the needs of in-school adolescents (including female adolescent) to acquire information and skills for the protection of their SRH within the formal education system, however, it fails to respond to the demands of out-of-school adolescents who require access not only to general SRH care information but also specific information on contraception as a means of preventing STIs, HIV and adolescent pregnancies.

The importance of ensuring that out-of-school female adolescents also have access to important SRH care information cannot be over emphasised. Numerous reasons can be canvassed for ensuring that out-of-school girls have access to contraceptives and other SRH care information. A main reason, which is not far-fetched, relates to the fact that due to their desperate need for funds for survival, in a majority of cases out-of-school female adolescents are usually involved in cash for sex transactions with multiple older male partners without using any method of protection from pregnancy or STIs.<sup>126</sup> In fact, the immense need for sexuality education among this group of girls is evidenced by

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<sup>125</sup> M P Inyang & O P Inyang 'Nigerian secondary school adolescents' perspective on abstinence-only sexual education as an effective tool for promotion of sexual health' (2013) 2 *F1000Research* 17, available at <http://f1000research.com/articles/2-86/v1> (29 July 2013). See also C O Izugbara 'Representations of sexual abstinence among rural Nigerian adolescent males' (2007) 4 *Sexuality Research & Social Policy* 78 & 80; Makinwa- Adebusoye (n 25 above) 9.

<sup>126</sup> To cater to the SRH needs of out of school adolescents, programmes on sexuality education and information can be organised in conjunction with schools, centres for formal learning and NGOs involved in adolescent health issues. See AHI *A promise to keep: Supporting out-of-school adolescent girls to reach their potential* (2011) 17, available at <http://www.actionhealthinc.org/publications/docs/A%20Promise%20to%20Keep%20LR.pdf> (25 July 2013).

the fact that a large number of the girls have either begun childbearing or have had numerous episodes of back street abortions.<sup>127</sup>

Again, as noted in the International Conference on Population and Development (ICPD) Programme of Action and its Key Actions document, there is a need to devote special attention to vulnerable and disadvantaged adolescents and youths.<sup>128</sup> Even though it is accepted that out of-school adolescents are a difficult group to get hold of due to their high mobility,<sup>129</sup> it is still important that this group of adolescents is reached through various FLHE education and outreach enlightenment/empowerment programmes so that they can access not only essential contraceptive information but also acquire information in the areas of gender relations, equality, responsible family planning practices, decision-making and communication skills as well as STIs/HIV prevention among others.<sup>130</sup>

In addition to information received by adolescents from the formal education sector, major sources from which adolescents receive information on SRH issues include the mass media, peers and their parents. According to Nambambi and Mufune, the involvement of parents in the sexual education of their children is a major determinant for good adolescent sexual health.<sup>131</sup> However, in Nigeria and other parts of Africa a mere mention of the word 'sex' is culturally viewed as a taboo, with parents preferring to maintain traditional views on adolescent sexuality and therefore refusing to give straightforward advice on sexual matters. Even in instances where communication on

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<sup>127</sup> In some cases, out-of school-adolescents use dangerous homemade concoctions as either contraception or to procure abortions. See AHI *A promise to keep* (as above) 15-20; Attahir *et al* (n 87 above) 15-20.

<sup>128</sup> Para 7.47 ICPD Programme of Action; para 73(c) ICPD +5.

<sup>129</sup> G James 'Education and sexuality: Towards addressing adolescents' reproductive health needs in Nigeria' (2012) 4 *Current Research Journal of Social Sciences* 290.

<sup>130</sup> AHI *A promise to keep* (n 126 above) 27.

<sup>131</sup> N M Nambambi & P Mufune 'What is talked about when parents discuss sex with children: Family based sex education in Windhoek, Namibia' (2011) 15 *Journal of Reproductive Health* 120-129, available at <http://www.bioline.org.br/request?rh11059> (26 July 2013).

sexuality occurs it is usually conveyed in a negative sense and with deliberate misinformation, portraying sex as immoral.<sup>132</sup>

It is important to stress that the general depiction of sexuality (especially to adolescent girls) by parents and other gatekeepers in a negative manner, instead of scaring adolescents away from sex, achieves the opposite effect as it increases curiosity. This excites a need to experiment, leading to the engagement in unplanned and unprotected sex.<sup>133</sup> As Jejeebhoy opines, attitudes associated with the deliberate passing on of SRH misinformation due to cultural views are not effective, taking into consideration current levels of pre-marital sex and HIV particularly among female adolescents.<sup>134</sup> Instead of misinforming adolescent girls about sexuality it is submitted, that as canvassed by the various human rights documents,<sup>135</sup> that parents, taking into consideration the evolving capacities of their children, should ensure that their adolescents receive factual and adequate sexuality education as this fosters the adolescent's capacity to take responsible and informed decisions to delay sex, use contraception, reduce sexual partners, perhaps with the effect of bringing to a halt the spread of the STIs and HIV epidemic.<sup>136</sup>

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<sup>132</sup> O Ojo *et al* Pattern and socio-demographic correlates of parent–child communication on sexual and reproductive health issues in southwest Nigeria: A mixed method study (2011) 11 *The African Symposium* 35, available at [http://www.ncsu.edu/aern/TAS11.2/TAS11.2\\_4Ojo.pdf](http://www.ncsu.edu/aern/TAS11.2/TAS11.2_4Ojo.pdf) (27 July 2013); Nambambi & Mufune (as above) 120-129; Ankomah *et al* (n 9 above) 81.

<sup>133</sup> A S Jegede & O Odumosu 'Gender and Health Analysis of Sexual Behaviour in South-Western Nigeria' (2003) 7 *African Journal of Reproductive Health* 63–70; Nambambi & Mufune (n 131 above).

<sup>134</sup> Economic and Social Council - *Fool's Paradise* (n 124 above); C O Izugbara 'Tasting the forbidden fruit: The social context of debut sexual encounters among young persons in a rural Nigerian community' (2001) 5 *African Journal of Reproductive Health* 23.

<sup>135</sup> Para 7.45 *ICPD Programme of Action*; para 73(e) *ICPD +5*. See also art 14(2)(a) *Women Protocol*.

<sup>136</sup> Nambambi & Mufune (n 131 above) 120-129; Ajuwon (n 113 above) 3.

### 3.3 Access to contraception through health care services

Given the high level of premarital sexual activity among Nigerian adolescents,<sup>137</sup> the importance of safeguarding the health of female adolescents through their access to family planning methods and services is paramount. This is especially so with the existence of numerous reports which reveal abysmal findings on the huge number of adolescents who are infected not only with STIs and HIV but also undergo back street abortions at an alarming rate to get rid of unwanted pregnancies.<sup>138</sup>

Coupled with adolescent girls' receipt of comprehensive SRH education, is the need to back up received information with actual access to contraceptives and other SRH care services. The reason for this opinion is not far-fetched because, as discovered by Izugbara, the circumstances which lead to the initiation of sexual activities by adolescent girls reveal not only their level of vulnerability but also show that a lot of pressure is usually exercised on this group. Young girls are either coerced, threatened or raped (where they resist sexual advances), with a majority of the initial sexual encounters being unsafe as no form of contraception or protection is used to prevent infections or pregnancies.<sup>139</sup>

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<sup>137</sup> As noted numerous factors contribute to the high rate of premarital sexual relations among adolescents some of which include the need to satisfy curiosity, peer pressure and poverty.

<sup>138</sup> Yearly, the rate of induced abortion is 25 per 1000 women of reproductive age and adolescents constitute a sizeable portion of women who undergo the procedures. Also according to the *2010 National HIV Sero-prevalence Sentinel Survey*, 3% of female adolescents between the ages of 15-19 are HIV positive. See Ankomah *et al* (n 12 above) 75; A A Adewunmi *et al* 'Knowledge of emergency contraception among students in a tertiary institution in a developing country' (2012) 3 *Open Access Journal of Contraception* 24, available at <http://www.dovepress.com/knowledge-of-emergency-contraception-among-students-in-a-tertiary-inst-peer-reviewed-article-OAJC-recommendation1> (25 July 2013); Federal Ministry of Health *National HIV Sero-prevalence Sentinel Survey* (2010) 31, available at [http://www.nigeria-aids.org/documents/2010\\_National%20HIV%20Sero%20Prevalence%20Sentinel%20Survey.pdf](http://www.nigeria-aids.org/documents/2010_National%20HIV%20Sero%20Prevalence%20Sentinel%20Survey.pdf) (26 July 2013); C I Okereke 'Unmet reproductive health needs and health-seeking behaviour of adolescents in Owerri, Nigeria' (2010) 14 *African Journal of Reproductive Health* 50; M J Temin *et al* 'Perceptions of sexual behaviour and knowledge about sexually transmitted diseases among adolescents in Benin city, Nigeria' (1999) 25 *International Family Planning Perspectives* 186.

<sup>139</sup> Izugbara -Tasting the forbidden fruit (n 134 above) 27. See also B O Idonije *et al* 'A study on knowledge, attitude and practice of contraception among secondary school students in Ekpoma, Nigeria' (2011) 2

Additionally, in situations where an attempt to use contraception is made, wrong choices are often made. As adolescents either tend to adopt unsafe and unreliable methods with the belief that such methods will protect them from STIs and pregnancy<sup>140</sup> or even patronise roadside medicine operators or traditional healers instead of approaching qualified health care centres where they will be properly treated.<sup>141</sup>

Consequent upon the foregoing, in addition to curtailing the high rates of teenage pregnancies among female adolescents in the country through appropriate contraceptive use, there is a necessity to promote and ensure that adolescents access family planning services which offer dual protection<sup>142</sup> contraceptive options. This development is vital given the current global epidemic of STIs and HIV which is predominant among the adolescent population (female adolescents bear a greater burden of HIV than their male counterparts) in the sub-Saharan African region, Nigeria inclusive.<sup>143</sup>

According to the ICESCR Committee, core minimum essentials to be assured by every state party, including the Nigerian state,<sup>144</sup> in relation to adolescents' access to contraceptive services includes the establishment of sufficient adolescent friendly clinics

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*Journal of Pharmacy and Clinical Sciences* 26; I O Morhason-Bello *et al*'Sexual behaviour of in-school adolescents in Ibadan South-West Nigeria' (2008) 12 *African Journal of Reproductive Health* 94.

<sup>140</sup> Idonije *et al* (as above) 24; Attahir *et al* (n 87 above) 18; V O Otiode *et al* 'Why Nigerian adolescents seek abortion rather than contraception: Evidence from focus group discussion' (2001) 27 *International Family Planning Perspectives* 79; Izugbara 'Tasting the forbidden fruit' (as above) 27-28.

<sup>141</sup> Okereke (n 138 above) 50-52.

<sup>142</sup> Dual contraception is a method of contraceptive which adequately offers protection against not only pregnancies but also sexually transmitted diseases. Examples of dual protection contraceptive include the male and female condoms.

<sup>143</sup> UNAIDS Fact Sheet *Adolescents, young people and HIV* (n 69 above).

<sup>144</sup> According to the CESCR Committee, state parties are to ensure the availability, accessibility, acceptability and quality of health care services to its citizens. See para 12 general comment 14 ICESCR Committee, *Compilations of General Comments and Recommendations Adopted by Human rights Treaty Bodies, Vol I* available at [http://www.amnesty.nl/sites/default/files/public/generalcomments\\_0.pdf](http://www.amnesty.nl/sites/default/files/public/generalcomments_0.pdf) (24 October 2012).

where modern contraceptives<sup>145</sup> can be easily obtained by adolescent girls in both rural and urban areas. In addition, the minimum essentials also include the obligation to ensure that health care providers with positive attitudes only are employed to manage the clinics in order to forestall situations where female adolescents are discriminated against and discouraged from accessing family planning services due to the judgemental mind-set of the providers.<sup>146</sup>

It is necessary to point out that while in some states efforts have been made by the government to establish adolescent/youth friendly health centres in order to increase young people's access to SRH care information and services, a majority of the adolescent-friendly health centres (which are still very few when compared to the Nigerian adolescent population) available in the country are administered by NGOs and tertiary education institution's health units with financial and technical assistance from donor organisations.<sup>147</sup>

In spite of the above, major challenges of the adolescent-friendly centres, apart from inconvenient operating hours, include the fact that most of the facilities use a combined

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<sup>145</sup> Contraceptives constitute part of the essential drugs that must be available and accessible in reproductive health care centres and family planning clinics.

<sup>146</sup> The ICESCR Committee has consistently recommended that governments are to ensure that family planning services are available to everyone including adolescents residing in rural areas; in addition to the teaching of sex education so as to prevent early pregnancy and STIs. For example, see para 30 concluding observations ICESCR Committee on Russia 2011 E/C.12/RUS/CO/5.

<sup>147</sup> For example the Lagos state Ministry of Health in 2002 created an Adolescent/Youth sexual reproductive health unit named 'Hello Lagos' with the intention of bridging the gap and providing safe and confidential sexual and reproductive health care services for young people in the state. Also, other states with youth friendly health care centres include Ogun, Akwa-Ibom, Abuja, Bauchi, Rivers etc. See *Adolescent sexuality and reproductive health (Hello Lagos)* available at [http://www.lagosstateministryofhealth.com/programme\\_info.php?programme\\_id=22](http://www.lagosstateministryofhealth.com/programme_info.php?programme_id=22) (2 August 2013); Y Osanyin *Report on assessment of facilities providing youth friendly health services in Nigeria* (2011) 10, available at <http://ncceonline.net/download/files/Assessment%20of%20Youth%20Friendly%20Health%20Centers%20and%20Services.pdf> (3 August 2013); Federal Ministry of Health & AHI *Assessment Report of the National Response to Young People's Sexual and Reproductive Health (SRH) in Nigeria* (2009) 21-23.

approach in serving both adults and adolescents together, thereby creating a potential for female adolescents' reluctance to access the services due to the belief that their confidentiality and privacy will not be assured.<sup>148</sup> In addition, even in the few adolescent friendly facilities available, only some aspects of SRH care services are provided while essentials drugs (including contraceptives) needed to address the SRH concerns of adolescents are either not available or need to be purchased.<sup>149</sup> This lack may lead to a situation where adolescent girls in particular (adolescents' generally) are discouraged from further visiting the centres due to the impression that their SRH needs will not be met anyway.

As noted in chapter three, although Nigeria abounds with policies and frameworks which seek to promote adolescent SRH, the involvement of young people in SRH programmes in the country is not only minimal but their access to comprehensive SRH services including contraception, is still limited as the existence of the policies have not translated into a general provision or access to adolescent-friendly health care services.<sup>150</sup> The above reality was confirmed in a study by the Women's Health and Action Research Centre (WHARC) to assess the availability of adolescent/youth friendly services in primary health care (PHC) centres in the country's six geopolitical zones and the Federal Capital Territory, Abuja, where It was discovered that apart from the non-availability of well-established adolescent-friendly health care service units in the PHCs operating in the country, even the few available are not usually the first choice of

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<sup>148</sup> Osanyin (as above) 13, 22 & 33.

<sup>149</sup> While adolescents also request safe abortion services, the service is not provided at the centres due to the country's restrictive abortion laws which restrict instances when abortion can be procured. Osanyin ( as above) 14-19 & 24.

<sup>150</sup> Federal Ministry of Health & AHI *Assessment Report* (n 147 above) 8.

unmarried adolescents in need of SRH information or services due to their negative experience at the hands of health providers.<sup>151</sup>

### 3.4 Conclusion

In this section the approach adopted by Nigeria in fulfilling its obligation to secure female adolescents access to contraceptive services and information were reviewed. Even though the FLHE curriculum adopted as a policy to ensure the teaching of sexuality education is in operation, it is revealed that the contents of the curriculum are neither factual nor realistic. This flaw is the consequence of the government's tactic of trying to satisfying two parties: adolescents who require sexuality information and cultural and religious gate-keepers who intend to maintain the status quo of ignorance. It was also revealed that apart from the fact that the teaching of sexuality education has not been uniformly introduced throughout the country, teachers teaching sexuality education still experience difficulty in passing on factual information to the adolescents. The unrealistic nature of the sexuality information imparted to the adolescents contributes to the high incidence of adolescent pregnancy which, though declining in many countries, remains unabated in Nigeria.<sup>152</sup>

Additionally, as revealed in the section, apart from the fact that government financed youth friendly clinics are scarce and insufficient,<sup>153</sup> other adolescent-friendly centres run by NGOs are also few in number. Thus they do not meet the contraceptive/SRH needs of the teeming adolescent population. Moreover, charging user fees in some of the

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<sup>151</sup> Women's Health and Action Research Centre (WHARC) *Status of Youth Friendly Services in Nigerian Primary Health Centres* (2013) available at <http://www.wharc-online.org/2013/04/16/status-of-youth-friendly-services-in-nigerian-primary-health-centres/> (2 August 2013).

<sup>152</sup> A Udo *et al* 'Teenage pregnancy and adverse birth outcomes in Calabar, Nigeria' (2013) 17 *Internet Journal of Gynaecology and Obstetrics* available at <http://ispub.com/IJGO/17/2/2995> (10 November 2013); Durojaye 'Realising access to contraception for adolescents in Nigeria' (n 109 above) 206; Ojo *et al* (n 132 above) 35.

<sup>153</sup> Osanyin (n 147 above) 10; Federal Ministry of Health & AHI *Assessment Report* (n 147 above) 21-23.

existing youth friendly clinics automatically makes contraceptive services inaccessible to some adolescents. There is an urgent need for the Nigerian government to correct this anomaly.

In relation to adolescent girls' (married or unmarried) access to contraceptive services in Nigeria, it can be stated that the Nigerian government has not lived up to its obligations of guaranteeing adolescents (young girls inclusive) access to life-saving contraception and SRH care services. This failure is despite the existence of policies on adolescent reproductive health which proclaim the intention of the government to ensure that adolescents have access to youth-friendly health care services<sup>154</sup> where their SRH needs will be met. Therefore, the policies are nothing more than 'paper promises': as the policies are merely available on paper and have not been transformed into meaningful programmes that will positively impact on the lives of adolescents generally.<sup>155</sup> Likewise, mechanisms need to be put in place to correct the different problems that arise with the provision of adolescent-friendly health care services. Also, only providers who are comfortable providing adolescent SRH care services should be employed to operate the facilities.

As in this section, the intention in the next section is to review the approach that has been adopted by South Africa in assuring female adolescents' access to contraceptive information and services.

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<sup>154</sup> Paras 4.1.1 & 4.1.2 National Adolescent Policy.

<sup>155</sup> Sedgh *et al* (n 108 above) 16; Esiet (n 114 above).

## 4 SOUTH AFRICA

### 4.1 Realising access to contraceptive information and services by adolescent girls in South Africa

The intention in this section is to scrutinise the actual access of South African adolescents to contraceptive information, education and services in line with the country's human rights obligations and national laws/policies.

### 4.2 Access to sexuality information and education

Young people especially female adolescents are among those hardest hit by the HIV and AIDS epidemic.<sup>156</sup> Hence, the constant reiteration that the effective teaching of sexuality education from the period of adolescence is a necessity as it promotes the observance of responsible sexual behaviour and also instils in adolescents the knowledge and skills needed to maintain healthy human relationships.<sup>157</sup>

The need to guarantee access to sexual health education for female adolescents is more crucial given the fact that global estimates reveal that not only is the HIV infection rate among young women twice as high as that of young men, but that females account for 31% of new infections which occur in the sub-Saharan Africa region.<sup>158</sup> The necessity for sexuality education of South African adolescents is paramount due to the HIV epidemic in the country which, in the words of Mpangana<sup>159</sup> is of hyper-endemic status.

<sup>156</sup> UNAIDS Fact Sheet *Adolescents, young people and HIV* (n 69 above).

<sup>157</sup> T Nqoloba 'Attitudes of teachers towards sexuality and HIV and AIDs education' University of Zululand (2008) 10.

<sup>158</sup> As at 2011, 4.6 million young people aged 15-24 are living with HIV globally and in fact they account for 40% of all new HIV infections among adults. See UNAIDS Fact Sheet *Adolescents, young people and HIV* (n 69 above); UNAIDS *Youth organizations form a pact for social transformation in the AIDS response* (2013) available at <http://www.unaids.org/en/resources/presscentre/featurestories/2013/may/20130523youthpact/> (14 August 2013).

<sup>159</sup> R I Mpangana 'Implementation of the life skills HIV and AIDs program in Manyeleti circuit schools' University of Stellenbosch (2012) 7.

According to the *UNAIDS Global Report 2012*,<sup>160</sup> South Africa is a large contributor to the epidemic that is ravaging the region at an alarming rate<sup>161</sup> with a population of 5.6 million people living with HIV and a national HIV prevalence rate of 17.3%.<sup>162</sup>

A fallout of the HIV and AIDS problem is the realisation of the need to introduce several prevention/intervention efforts that will specifically target adolescents. They, coupled with the HIV and AIDS scourge,<sup>163</sup> have to contend with the problem of teenage pregnancy with its attendant effects<sup>164</sup> and also run the risk of contracting STIs due to their engagement in unsafe sexual relations. These ills have huge consequences, especially for female adolescents, as well as the society at large.<sup>165</sup> The above situation was noted by Ahmed *et al* who observe that the rise in school drop-out rates in South Africa could be attributed to early and unsafe sexual behaviour credited among the

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<sup>160</sup> UNAIDS Special report *How Africa turned AIDS around* (n 107 above) 7.

<sup>161</sup> HIV-prevalence rates for the adult population aged 15–49 in African countries vary between 1.1% in Burkina Faso to 26% in Swaziland. See UNAIDS Special report *How Africa turned AIDS around* (as above) 9.

<sup>162</sup> National Department of Health *National antenatal sentinel HIV & syphilis prevalence survey in South Africa* (2011) 61  
[http://www.doh.gov.za/docs/presentations/2013/Antenatal\\_Sentinel\\_survey\\_Report2012\\_final.pdf](http://www.doh.gov.za/docs/presentations/2013/Antenatal_Sentinel_survey_Report2012_final.pdf) (4 August 2013).

<sup>163</sup> According to recent reports and statistics, about 28% of South African school girls are HIV positive. See *Over quarter of South African school girls HIV positive: Minister* (n 94 above).

<sup>164</sup> WHO *Preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries: What the evidence says* (2012) 1, available at [http://whqlibdoc.who.int/hq/2012/WHO\\_FWC\\_MCA\\_12\\_02.pdf](http://whqlibdoc.who.int/hq/2012/WHO_FWC_MCA_12_02.pdf) (2 August 2013); Kanku & Mash (n 92 above) 564; L J Ralph & C D Brindis 'Access to reproductive healthcare for adolescents: Establishing healthy behaviours at a critical juncture in the life course' (2010) *Current Opinion in Obstetrics and Gynaecology* 369, available at <http://www.nmtpc.org/docs/contraceptive%20use%20among%20adolescents.pdf> (17 October 2013).

<sup>165</sup> G Mchunu 'Adolescent pregnancy and associated factors in South African youth' (2012) 12 *African Health Sciences* 426-427; D Kirby *The impact of sex education on the sexual behaviour of young people* (2011) 1, available at [http://www.un.org/esa/population/publications/expertpapers/2011-12\\_Kirby\\_Expert-Paper.pdf](http://www.un.org/esa/population/publications/expertpapers/2011-12_Kirby_Expert-Paper.pdf) (15 August 2013); H Schaalma & S F Kaaya 'Health education and the promotion of reproductive health: Theory and evidence-based development and diffusion of intervention programmes' in K I Klepp *et al* (eds) *Promoting adolescent sexual and reproductive health in East and Southern Africa* (2008) 61.

country's adolescents.<sup>166</sup> This behaviour raises the need for the introduction of prevention programmes that are aimed at learners in early school grades.

Like Nigeria, South Africa, in response to the HIV epidemic, acknowledges the role of the school as a site for sexual health promotion and developed its *National Policy on HIV and AIDS for Learners and Educators in Public Schools and Students and Educators in Further Education and Training Institutions*.<sup>167</sup> The policy is based on the underlying principle that it will provide an enabling framework that can be adopted by provinces and schools to develop approaches that will effectively enable students to adopt behaviours, knowledge, skills and attitudes that will protect them from HIV and STIs. To ensure in-depth education the policy advocates the compulsory teaching of Life Skills and HIV/AIDS in both primary and secondary schools through its integration into the Life Orientation (LO) curriculum. Topics that fall under the personal well-being focus area include substance abuse, sexuality, teenage pregnancy, STIs including HIV and AIDS, and the promotion of personal, community, and environmental health.<sup>168</sup>

However, unlike the Nigerian situation where for various reasons the FLHE curriculum has only been introduced in secondary schools and partially in primary schools,<sup>169</sup> the Life Orientation (LO) programme is compulsorily taught from Grade R in an age

<sup>166</sup> N Ahmed *et al* 'HIV education in South African schools: The dilemma and conflicts of educators' (2009) 37 *Scandinavian Journal of Public Health* 48.

<sup>167</sup> National Policy on HIV and AIDS for Learners and Educators in Public Schools and Students and Educators in Further Education and Training Institutions (1999) available at [http://wced.pgwc.gov.za/branchIDC/special\\_ed/hiv\\_aids/National\\_policy\\_on\\_HIV-AIDS.pdf](http://wced.pgwc.gov.za/branchIDC/special_ed/hiv_aids/National_policy_on_HIV-AIDS.pdf) (16 August 2013).

<sup>168</sup> The Life Orientation programme is based on four focus areas: personal well-being, citizenship education, recreation and physical activity and careers and career choices. See Department of Education *National Curriculum Statement Grades 10-12: Life Orientation* (2003) available at <http://www.education.gov.za/LinkClick.aspx?fileticket=xY8RaCOWqTY%3D&> (23 September 2013); National Policy on HIV and AIDS for Learners (as above); Mpangana (n 159 above) 1.

<sup>169</sup> As Abah explains challenges facing the implementation of the FLHE curriculum in Nigeria range from weak political commitment at subnational levels to non-availability of instructional materials and inadequate teachers' skills and ability to discuss sex related issues. See R C Abah 'The universal basic education programme and the family life HIV education in Nigeria' (2013) 2 *International Journal of Development and Sustainability* 9, available at <http://isdsnet.com/ijds-v2n2-23.pdf> (21 September, 2013).

appropriate manner in accordance with the reasoning and recommendation of the World Health Organisation (WHO). The WHO has maintained that sexuality education should not only be introduced to children at early stages of life but its contents should be progressively advanced as the children grow into the various stages of adolescence.<sup>170</sup>

Also appreciating the important role played by teachers in the dissemination of information relating to the teaching of the Life Skills and HIV/AIDS programme, the government acknowledges the need to effectively train educators so that they can adequately discharge their duties of teaching sexuality education with an open and unbiased mind. In order to achieve the above aim the HIV and AIDS Emergency Guidelines, which encourages educators to frankly discuss sexuality issues including abstinence and the use of condoms/contraceptive with the students was released in 2002. In addition, key educators were trained and chosen to act as facilitators for the development and teaching of life skills programmes in their schools.<sup>171</sup> In addition, peer educators are recruited among students to pass on important sexuality, reproductive health and contraceptive information to members of their age group through various media including youth clubs and other social meeting spaces.<sup>172</sup>

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<sup>170</sup> WHO *The sexual and reproductive health of younger adolescents* (n 17 above) 11.

<sup>171</sup> At inception of the programme, two teachers from every school in the country were selected for training. The trained teachers were in turn responsible for the implementation of the life skills programme in their various schools including the training of other teachers involved in teaching sexuality education. See L Thaver & A Leao *Sexual and HIV/AIDS Education in South African Secondary Schools* (2012) available at <http://www.osisa.org/buwa/south-africa/sexual-and-hiv-aids-education-south-african-secondary-schools> (18 August 2013). See also Department of Education *The HIV/AIDS Emergency Guidelines for Educators* (2002) 5-7, available at <http://www.education.gov.za/LinkClick.aspx?fileticket=fBnc9VU7mEw%3D&tabid=95&mid=507> (23 September 2013).

<sup>172</sup> Panday *et al* (n 90 above) 87.

The downside of the curricular approach adopted in South Africa, however, is that, unlike in Nigeria where a fixed curriculum<sup>173</sup> is used by teachers in teaching family life and sexuality education in schools, the Life Skills and HIV/AIDS programme, as Visser<sup>174</sup> explains, was not developed as a single pre-prepared manual. Instead, only guidelines on contents which formed the core of the programme were provided as an aid to instructors and schools in their development of a curriculum that will tackle the needs of the learners according to their cultural diversities.<sup>175</sup> A shortcoming of this procedure is that teachers focus only on providing information and awareness about HIV and AIDS to the detriment of imparting knowledge about the development of life skills that will help the students, and adolescents generally, adopt healthy life styles.<sup>176</sup>

It is necessary to emphasise that while admitting that in schools where full implementation of the Life Skills and HIV/AIDS programme has occurred there has been relative success in increasing student knowledge about HIV and AIDS, including reported condom use,<sup>177</sup> like the Nigerian situation, the ease and success of teaching sexuality education in schools depend on the instructors' beliefs and views, on one hand, and their personality and life experience on the other.<sup>178</sup> According to Smith and Harrison, teachers who solely believe in abstinence as the most appropriate prevention strategy for adolescents, experience discomfort in teaching comprehensive sexuality education, others, who are more comfortable with their sexuality, express great confidence in

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<sup>173</sup> National *family life and HIV education curriculum* (n 111 above).

<sup>174</sup> M J Visser 'Life skills training as HIV/AIDS preventive strategy in secondary schools: Evaluation of a large-scale implementation process' (2005)2(1) *Journal of Social Aspects of HIV/AIDS* 206.

<sup>175</sup> Visser (as above) 206.

<sup>176</sup> Visser (as above) 211 & 214.

<sup>177</sup> K A Smith & A Harrison 'Teachers' attitudes towards adolescent sexuality and life skills education in rural South Africa' (2013) 13 *Sex Education* 69; P Rose Life skills taught in school vital to reduce risk of HIV and AIDS (2012) available at <http://efareport.wordpress.com/2012/11/29/life-skills-taught-in-school-vital-to-reduce-risk-of-hiv-and-aids/> (19 August 2013).

<sup>178</sup> Smith & Harrison (as above) 69.

teaching sex education.<sup>179</sup> The above view also corresponds with Ahmed *et al* findings, that educators who, due to their personal beliefs, culture and values, are more inclined to communicate messages of abstinence, view the distribution of condoms in schools and promotion of safe sex messages to sexually active learners as endorsing their practice of sexual activities.<sup>180</sup>

As already noted and argued in relation to Nigeria, the teaching of abstinence and delay in initiating sexual intercourse works more for younger adolescents, unlike their older counterparts.<sup>181</sup> This fact necessitates ensuring the presentation of balanced information on the protection of adolescent sexual health. In addition, as Selesho and Modise point out, while accepting that sexual abstinence is the best and safest protection against STIs, HIV and unwanted pregnancies, sexually active learners require different HIV prevention strategies from the majority of high school learners who are not yet sexually active. Hence the need to encourage them to practise safe sex and use condoms.<sup>182</sup>

Some studies reveal that the teaching of life skills and HIV education has succeeded in empowering a majority of learners to possess an understanding of issues related to career advancement and HIV and AIDS prevention, including skills required to adopt responsible sexual behaviour.<sup>183</sup> However, the inevitability of ensuring uniformity in the sexuality information passed on to adolescents through the Life Orientation (LO) curriculum programme is particularly evidenced by the outcomes from other studies

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<sup>179</sup> Smith & Harrison (as above) 69-70.

<sup>180</sup> N Ahmed *et al* (n 166 above) 50-51.

<sup>181</sup> Population Council Incorporated “*Dare to be Different: Enhancing Life Skills Education for HIV Prevention in South African Schools* (2008)<sup>2</sup> available at [http://www.popcouncil.org/pdfs/horizons/SouthAfrica\\_ABLifeskills.pdf](http://www.popcouncil.org/pdfs/horizons/SouthAfrica_ABLifeskills.pdf) (19 August 2013).

<sup>182</sup> J M Selesho & A M Modise ‘Strategy (is) in dealing with HIV/AIDS in our schools: Changing the Lenses’ (2012) 38 *Journal of Human Ecology* 183.

<sup>183</sup> Selesho & Modise (as above) 184-187.

which reveal that while the learners had received some sex education (including information on contraceptives) in the Life Skills and HIV/AIDS class, the information provided to the students was neither adequate nor comprehensive, thus, revealing the importance of providing more facts and information at the learning sessions.<sup>184</sup>

The *Integrated School Health Policy*<sup>185</sup> introduced by the South African government which mandates the incorporation of health education<sup>186</sup> into schools' curriculum and provided thorough Life Orientation learning areas, also recommends that the teaching of life skills be additionally supplemented with co-curricular school-based activities.<sup>187</sup> This direction is meant to address issues related to adolescent's SRH, amongst others.<sup>188</sup>

Ideally, in addition to the teaching of SRH education in schools, the importance of involving parents and the larger community as joint collaborators with government and teachers in the bid to ensure that adolescents (especially adolescent girls) receive adequate information about their sexuality is paramount. However, in a majority of cases, this is not the case: First, as a result of the dysfunctional homes of learners who not only have parents as poor role models but also have them expressing conflicting views on sexual relationships. Second, because of opposition from religious groups and the larger community who operate upon the common belief that sexuality education

<sup>184</sup> S Willan *A review of teenage pregnancy in South Africa: Experiences of schooling, and knowledge and access to sexual & reproductive health services* (2013) 27 available at <http://www.hst.org.za/sites/default/files/Teenage%20Pregnancy%20in%20South%20Africa%20Final%2010%20May%202013.pdf> (18 September 2013). See also UNFPA *Sexuality education: A ten-country review of school curricula in East and Southern Africa* (2012) 62 available at [http://esaro.unfpa.org/webdav/site/africa/users/Lbarnes/public/ESA%20Sexuality%20Education%20Curriculum%20Scan%20Report\\_FINAL.pdf](http://esaro.unfpa.org/webdav/site/africa/users/Lbarnes/public/ESA%20Sexuality%20Education%20Curriculum%20Scan%20Report_FINAL.pdf) (11 March 2014).

<sup>185</sup> *Integrated School Health Policy* (2012) available at [http://www.doh.gov.za/docs/policy/2012/Integrated\\_School\\_Health\\_Policy.pdf](http://www.doh.gov.za/docs/policy/2012/Integrated_School_Health_Policy.pdf) (18 September, 2013).

<sup>186</sup> The health education component for learners from grade 7 to 12 must include education on Sexual & reproductive health, menstruation, contraception, STIs including HIV education, teenage pregnancy, choice on termination of pregnancy and prevention of mother to child transmission. See *Integrated School Health Policy* (as above) 14.

<sup>187</sup> Para 2.6 *Integrated School Health Policy* (n 185 above).

<sup>188</sup> Para 2.6 *Integrated School Health Policy* (n 185 above).

should be taught privately, thereby preventing the dissemination of accurate and quality information to students.<sup>189</sup> In a study carried out by Wood *et al*, it was discovered that adolescents were provided with virtually no useful information on SRH matters and, even in situations where an attempt is made to initiate conversation on sexuality issues, it was not done in a straight forward manner.<sup>190</sup>

In addition, the enormous hold which communal and parental dictates have over the effective dissemination of sexuality education was observed by Harley *et al*, who note that often educators feel trapped between observing policy values and communal/parental values and there is usually the application of pressure to teach values deemed acceptable by the local community.<sup>191</sup>

It is important to stress that in view of current happenings adolescents concurrently require both formal and informal sexuality information and education delivered both in the school and within the family for their maintenance of good SRH and there is no need for them to be opposed to each other. Therefore, the adoption of a defeatist attitude by schools/teachers who choose to teach Life Skills and HIV education based on societal dictates is wrong. According to Ngwena, the aim of sexuality education should always be for the imparting of essential information required for the protection of the SRH of students and not otherwise.<sup>192</sup> Moreover, as Walker<sup>193</sup> emphasises, even though the avoidance of sex education by parents may be conscious or subconscious due to numerous factors, including embarrassment, lack of confidence or poor communication

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<sup>189</sup> Thaver & Leao (n 171 above) 88; N Ahmed *et al* (n 166 above) 50.

<sup>190</sup> K Wood *et al* Adolescent sex and contraceptive experiences: Perspectives of teenagers and clinic nurses in the Northern Province (1997) 7, available at <http://www.mrc.ac.za/gender/contra.pdf> (18 September 2013).

<sup>191</sup> D A Francis 'Sexuality Education in South Africa: Wedged within a Triad of Contradictory Values' (2011) 21 *Journal of Psychology in Africa* 321.

<sup>192</sup> Francis (as above) 321.

<sup>193</sup> J Walker 'Parents and sex education: Looking beyond the birds and the bees' (2004) 4 *Sex Education* 239-254.

skills, surveys of sexual attitudes have revealed that the use of contraception is generally lower amongst adolescents who do not discuss sexual matters with their parents.<sup>194</sup> Therefore, there is an obligation which parents owe adolescents to discuss sexual matters instead of leaving them to be educated through risky sexual experiments.

### 4.3 Access to contraception through health care services

As Heunis *et al* point out, guaranteeing the provision of good reproductive health care services should include the freedom from risk of sexual diseases and the ability to regulate one's own fertility with a full knowledge of contraceptive choices without discrimination on the grounds of age, marital status, income or similar considerations.<sup>195</sup> Since 1994, the South African government has consistently adopted a reproductive health policy package which has been lauded as one of the most progressive in the world.<sup>196</sup> Furthering its commitment towards the protection of the reproductive health of its people through guaranteed access to contraception, the government has adopted various contraceptive policies which not only prioritise the availability of family planning services but endeavour to make comprehensive contraceptive and fertility management services generally available as part of its broader SRH package to both adults and youths (including adolescents) alike.<sup>197</sup>

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<sup>194</sup> Walker (as above) 242-243.

<sup>195</sup> C Heunis *et al* 'A "Youth Multi-function Centre" in the Free State: An alternative to clinic-based HIV/AIDS prevention and care' (2000) *Curationis* 56.

<sup>196</sup> P Maharaj & M Rogan *Reproductive Health and Emergency Contraception in South Africa: Policy Context and Emerging Challenges* (2007) 3, available at <http://sds.ukzn.ac.za/files/WP%2048%20WEB.pdf> (23 August 2013).

<sup>197</sup> National Contraception Policy Guidelines within a reproductive health framework 2001, National Contraception Service Delivery Guidelines 2003 and National Contraception and Fertility Planning Policy and Service Delivery Guidelines 2012.

To achieve this end, there is a necessity to create an environment where the sexuality and contraceptive information received by adolescents' (particularly adolescent girls) in South African schools through the teaching of the Life Skills and HIV/AIDS education curriculum is backed up with corresponding access to contraceptive and other reproductive health care services. Although, as Willan explains, the initiation of sexual activities by adolescents is 'a common and normal bridge to adulthood' which should be neither stigmatised nor condemned,<sup>198</sup> a major rationale for the clamour to corroborate sexuality education with access to contraceptive services is due to the fact that, like their Nigerian counterparts, South African adolescents, as a result of several factors,<sup>199</sup> engage in high levels of premarital sexual engagements which necessitate the need to protect their reproductive health in order to forestall incidences of STIs, HIV and teenage pregnancy.<sup>200</sup>

Besides the benefit gained by female adolescents through the provisions contained in the National Contraception and Fertility Planning Policy and Service Delivery Guidelines which adopt a rights based approach to contraception and fertility planning and promote expanded choice through contraceptive availability and accessibility as part of a broader SRH package,<sup>201</sup> South African adolescents have simultaneously benefited from other laws and health policies directed at addressing the SRH care needs of the population at large and, specifically, their reproductive health care needs.<sup>202</sup>

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<sup>198</sup> Willan (n 184 above) 15.

<sup>199</sup> Although the initiation of sexual activities at an early age occurs among both female and male adolescents alike, in most cases as a result of factors including poverty, child marriage, peer pressure etc, sexual relations occur earlier among females than their male counterparts.

<sup>200</sup> J Rangiah 'The experiences of pregnant teenagers about their pregnancy' Stellenbosch University (2012) 10; Mason-Jones *et al* (n 95 above) 1; Mothiba & Maputle (n 95 above) 423-435.

<sup>201</sup> Paras 3.1 & 3.2 National Contraception and Fertility Planning Policy and Service Delivery Guidelines (2012) available at [http://www.doh.gov.za/docs/policy/2013/contraception\\_fertility\\_planning.pdf](http://www.doh.gov.za/docs/policy/2013/contraception_fertility_planning.pdf) (3 May 2013).

<sup>202</sup> The laws and policies include the Constitution of South Africa, the National Health Act, the Children's Act as amended in 2007, Choice on Termination of Pregnancy Act, etc.

Furthermore, the government has taken an extra step by ensuring that the contraceptive (including emergency contraceptives) services provided at its public health facilities *via* its primary health care centres (PHCs) and district hospitals are accessed freely, thereby assuring female adolescents' access to contraceptive services.<sup>203</sup> It is stressed that the availability of free contraceptive services at the public health facilities is responsible for South Africa having one of the highest contraceptive prevalence rates at 60% in comparison with other countries in the region.<sup>204</sup>

Regardless of the above efforts, in relation to adolescents girls a major issue that needs constant reiteration is the reality that despite the effort of the government in guaranteeing the provision of free contraceptive health care services at its numerous health care centres, adolescents generally, and female adolescents in particular, will only access confidential and quality SRH care services in 'welcoming settings'.<sup>205</sup> Therefore, there is a need to create adolescent-friendly avenues which will assist in ensuring that important contraceptive services and information get to young people who require it most.

As Senderowitz *et al* note in their publication on a *Rapid Assessment of Youth Friendly Reproductive Health Services*, unlike health programmes which serve the SRH needs of adults, programmes which aim to cater to the sexuality health requests of adolescents are required to be culturally and politically sensitive. The reason for this is that a

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<sup>203</sup> National Contraception and Fertility Planning Policy (n 201 above) 36-37; Maharaj & Rogan (n 196 above) 13.

<sup>204</sup> Despite the high contraceptive usage, the country experiences a huge number of teenage pregnancies. See UNFPA country indicators: South Africa *The state of the world's midwifery* (n 55 above); The World Bank *Data on Adolescent fertility rate* (n 56 above); UNFPA South Africa *Sexual and Reproductive Health* (n 57 above).

<sup>205</sup> R J Cook *et al* 'Respecting adolescents' confidentiality and reproductive and sexual choices' (2007) 98 *International Journal of Gynaecology and Obstetrics* 186; R J Cook and B M Dickens 'Recognizing adolescents' 'evolving capacities' to exercise choice in reproductive healthcare' (2000) 70 *International Journal of Gynaecology & Obstetrics* 17.

majority of societies are opposed to the idea of adolescents being engaged in sexual relationships. Therefore, to be effective, there is an increased obligation not only to ensure privacy and confidentiality but also to use neutral language such as youth ‘friendly services’ and employ specially trained providers who are comfortable communicating on sensitive topics in order to reduce stigmatisation.<sup>206</sup>

Appreciating the above and in view of the realisation that a successful SRH campaign must be supported by health services which accommodate the needs of young people at the PHC level has led to the creation of the *National Adolescent Friendly Clinic Initiative* (NAFCI) programme.<sup>207</sup> The NAFCI, which has among its aims and objectives the goal of establishing national standards and criteria that will be observed by clinics in the provision of adolescent health care services throughout the country, recognises that for a clinic to be acknowledged as an adolescent-friendly clinic, it must not only guarantee that services appropriate to the needs of adolescents will be available and accessible but also that its physical environment will be conducive to the provision of adolescent-friendly health care services.<sup>208</sup> In addition, the clinics are to provide SRH information, drugs and services that are consistent with the essential service package as identified by the country’s National Department of Health.<sup>209</sup>

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<sup>206</sup> J Senderowitz *et al* A Rapid Assessment of Youth Friendly Reproductive Health Services (2003) 4 available at [http://www2.pathfinder.org/site/DocServer/%20%20YFS\\_TG\\_Final\\_web\\_version.pdf?docID=762](http://www2.pathfinder.org/site/DocServer/%20%20YFS_TG_Final_web_version.pdf?docID=762) (18 September 2013).

<sup>207</sup> The *National Adolescent Friendly Clinic Initiative* (NAFCI) programme was developed and coordinated by the Reproductive Health Research Unit (RHRU), University of Witwatersrand & Chris Hani Baragwaneth Hospital, in partnership with LoveLife, a joint initiative of leading South African non-government organisations which promotes AIDS free living among South African adolescents. See MIET Africa *Literature Review: Youth-friendly Health Services* (2011) 14, available at <http://www.google.co.za/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=6&cad=rja&ved=0CEMQFjAF&url=http%3A%2F%2Fwww.miet.co.za%2Fsite%2Fsearch%2Fdownloadencode%2FnLaaqWMqp2zp4Sx&ei=MQw7Uov4lNKRhQfq5YGQBg&usg=AFQjCNEpY0ySITw7Y0u3wh8hNr7EFfy-g&bvm=bv.52288139,d.Yms> (14 September 2013).

<sup>208</sup> MIET Africa (as above) 15.

<sup>209</sup> The drugs in the Essential Service Package include various contraceptive methods such as oral contraceptive pills, emergency contraception, injectables and condoms. Information to be provided includes sexually

Unlike the situation in Nigeria where the adolescent-friendly centres in existence are few in number, the opposite is the situation in South Africa where there are various dedicated adolescent-friendly health clinics involved in the provision of essential contraceptive and reproductive health services to adolescents.<sup>210</sup> The NAFCI clinics engage peer educators, known as ground breakers,<sup>211</sup> who are recruited to assist clinic staff in improving adolescent-friendly services at the centres through their action as communication bridges between the clinic and community. This is in addition to their involvement in outreach sensitisation activities and provision of peer education to their colleagues who visit the clinics.<sup>212</sup> Other adolescent/youth friendly centres, such as the *LoveLife Youth Centres*, are involved in the spreading of sexuality and HIV prevention information to young people through the mass media and other outlets so as to increase awareness/ knowledge on SRH issues while reducing the possibility of engaging in high risk sexual behaviours.<sup>213</sup>

In confirmation of Tylee *et al's* observation that the use of contraceptives is significantly higher among unmarried young people in communities where adolescent-friendly

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transmitted infections information, including information on the effective prevention of STIs and HIV. Services to be provided also include the diagnosis and management of STIs, pregnancy testing and counselling, antenatal and postnatal care, pre- and post-termination of pregnancy counselling and referral, among others. See J Ashton *et al Evolution of the national Adolescent-Friendly Clinic Initiative in South Africa* (2009) 15, available at [http://whqlibdoc.who.int/publications/2009/9789241598361\\_eng.pdf](http://whqlibdoc.who.int/publications/2009/9789241598361_eng.pdf) (17 September 2013).

<sup>210</sup> According to *MIET Africa*, as at 2005, there were 350 active NAFCI sites in operation in the country. *MIET Africa* (n 207 above) 15.

<sup>211</sup> 'Ground breakers' are young people between the ages of 18 and 25 who have been specifically trained through their involvement in various loveLife programmes for a year.

<sup>212</sup> Ashton *et al* (n 209 above) 31 & 41.

<sup>213</sup> Unlike the NAFCI which majorly offer clinical services, the Lovelife Youth Centres are multipurpose centres open six days a week between 12 noon and 6 pm. In addition to providing programmes which encourage life skills development, the Y centres are involved in the spread of sexual health information, the organisation of recreational activities and provision of a limited range of sexual and reproductive health services in non-clinical settings. See A E Pettifor *et al 'Challenge of evaluating a national HIV prevention programme: The case of loveLife, South Africa'* (2007) 83 *Sexually Transmitted Infections* 70; LoveLife Youth '*What we do*' available at <http://www.lovelife.org.za/corporate/lovelife-programmes/> (18 September 2013).

information and services which aim to increase contraceptive use are provided,<sup>214</sup> a study conducted by the WHO in 2009<sup>215</sup> revealed that more young people were using NAFCI clinics for reasons associated with the fact that clinic staff possessed skills to solve adolescent SRH problems. Further reasons include that staff attitudes had changed drastically towards youth sexuality and outreach activities were being conducted in schools so as to increase adolescent information on the availability of the services being offered.

Maharaj and Rogan are of the opinion that ‘on paper, South Africans have access to an extensive range of reproductive health services and products’,<sup>216</sup> yet, it is necessary to draw attention to the fact that although South Africa has one of the best legal frameworks for the protection of the adolescent girl’s right to reproductive health care, including access to free contraception. This has however not really translated into female adolescents’ full access to contraceptive services and therefore total protection from STIs/HIV infections or unintended pregnancies.<sup>217</sup>

Obviously taking note of the deficiency of the previous contraception policy and guidelines and the endemic situation of unplanned teenage pregnancy, South Africa’s government in 2012 introduced the *Integrated School Health Policy*<sup>218</sup> and the *National*

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<sup>214</sup> A Tylee et al ‘Youth-friendly primary-care services: How are we doing and what more needs to be done?’ (2007) 369 *The Lancet* 1565-1573.

<sup>215</sup> Ashton *et al* (n 209 above) 44.

<sup>216</sup> Maharaj & Rogan (n 196 above) 9.

<sup>217</sup> For example, according to findings in the South African National HIV Communications Survey (2012), HIV prevalence has remained high among adolescent girls who have a prevalence ratio that is 2.7 times higher than among males of the same age. In the same vein, while the country in the last few decades has recorded a decline in teenage fertility, according to Samantha Willan, the rates are still high. Around 30% of 15-19 year olds reporting having ever been pregnant. Perceived causes of this shortcoming will be examined in the next chapter. See Willan (n 184 above) 7; *Key findings of the Third South African National HIV Communication Survey* (2012) available at <http://www.hivsharespace.net/system/files/ZANationalHIVCommunicationSurvey2012.pdf> (18 September, 2013); National Contraception and Fertility Planning Policy (n 201 above) 18.

<sup>218</sup> *Integrated School Health Policy* (n 185 above).

*Contraception and Fertility Planning Policy and Service Delivery Guidelines*<sup>219</sup> at the tail end of the year in order not only to improve access, choice, quality care, service delivery and continuous/ efficient contraceptives supply in the government health facilities, private hospitals and other designated outlets<sup>220</sup> but also to ensure that learners in grades 4 to 12 have access to onsite individual counselling regarding adolescent SRH needs, including the provision of contraceptives and referral services where required in their schools.<sup>221</sup>

#### 4.4 Conclusion

South Africa's approach towards ensuring the actual access of adolescent girls to contraceptive information and services in its battle to combat the increase in teenage pregnancy rates and the spread of the HIV and AIDS epidemic has been more pragmatic than that of Nigeria. This section has revealed the existence of education policies<sup>222</sup> which not only aim at enabling adolescents' to undergo attitudinal and social changes that will ensure their protection from HIV and STIs but also assure their access to comprehensive sexuality education and information at various levels of schooling.

It is expected that the Integrated School Health Policy which was recently adopted to enable adolescents (female adolescents included) to have access to onsite SRH services and counselling in schools, in addition to their receiving of a health education that is supplemented with co-curricular school-based activities, should result in the achievement of the twin goals of advancing adolescents' access to contraceptive information and services. Also, for the overall achievement of success, it is suggested that there is a need for the adoption of a fixed curriculum that would be followed in

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<sup>219</sup> National Contraception and Fertility Planning Policy (n 201 above).

<sup>220</sup> National Contraception and Fertility Planning Policy (as above) 3 & 34-37.

<sup>221</sup> Integrated School Health Policy (n 185 above).

<sup>222</sup> National Policy on HIV and AIDS for Learners and Educators (n 167 above); Integrated School Health Policy (n 185 above).

teaching Life Skills and HIV/AIDS education, as the use of a similar curriculum will definitely result in the uniformity of sexuality education information passed on to students.

In relation to contraceptive services, while the government's efforts at guaranteeing access to contraceptive services for adolescent girls' through its provision of free family planning services at government health care facilities and adolescent-friendly centres are observed, these efforts have not been fully successful as current statistics reveal.<sup>223</sup> Like the situation in Nigeria, the hostile attitude of health care providers, socio-cultural beliefs and other impediments discussed in chapter six contribute to inaccessibility. The aim in the next section is to evaluate the international best practices on adolescent girls' access to contraceptive information and services in selected jurisdictions.

## 5 International best practices relating to female adolescents' access to contraception

### 5.1 Introduction

Despite socio-cultural, political, and economic differences, adolescents in other countries initiate sexual relationships at an early age (like their Nigerian and South African counterparts)<sup>224</sup> thereby exposing them to problems associated with teenage pregnancy and the risk of contracting STIs and HIV.<sup>225</sup> Notwithstanding the similarity in

<sup>223</sup> Willan (n 184 above) 7; *Key findings of the Third South African National HIV Communication Survey* (n 217 above); National Contraception and Fertility Planning Policy (n 201 above) 18.

<sup>224</sup> Statistics reveal a drastic reduction in the current average age at first intercourse from the median age recorded in the early 1950s. For example in France, the average age at first intercourse is now 17 years unlike in the past when it was in the early 20s. See A S Madkour *et al* 'Early adolescent sexual initiation and physical/psychological symptoms: A comparative analysis of five nations' (2010) 39 *Journal of Youth and Adolescence* 1213; E Ketting & C Winkelmann *Sexual Health (SH) of young people in the WHO European Region* in *Sexual Health: A public health challenge in Europe* (2011) 72 *Entre Nous- The European Magazine for Sexual and Reproductive Health* 12, available at [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0019/142570/en72.pdf](http://www.euro.who.int/__data/assets/pdf_file/0019/142570/en72.pdf) (19 September 2013).

<sup>225</sup> WHO Adolescent pregnancy: Unmet needs and undone deeds (2007) 8-9, available at [http://whqlibdoc.who.int/publications/2007/9789241595650\\_eng.pdf](http://whqlibdoc.who.int/publications/2007/9789241595650_eng.pdf) (21 September 2013); L Smylie *et al*

adolescent sexual behaviour, however, some countries have been successful, as a result of their reaction and response, in reducing to the minimum the occurrence of negative outcomes normally associated with the expression of adolescent sexuality.<sup>226</sup> According to Madkour *et al*,<sup>227</sup> notwithstanding similar overall levels of sexual activity among adolescents across countries, the potential consequences of adolescent sexual activity still vary among nations as a result of numerous factors, including the accessibility of adolescents to reproductive health care information and services and parental reaction towards adolescent sexuality among others.<sup>228</sup>

In this section, while the immediate impulse will be to merely review the position in developed countries with low teenage pregnancy and STIs statistics in order to discover approaches they have adopted in assuring access to contraceptive and other SRH related information and services, it is also imperative to consider best practices<sup>229</sup> that may have been successful in African countries as well.

In relation to the above, since a review of the approaches that have been adopted by Nigeria and South Africa to assure access to contraceptive information and services for female adolescents has already been done, the purpose in this section is to briefly appraise the methods embraced by the government and NGOs in Denmark and

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'Evaluation of a school-based sex education programme delivered to Grade Nine students in Canada' (2008) 8 *Sex Education* 25.

<sup>226</sup> Example of such countries includes Denmark, France, Netherlands and Germany. See J Friedman 'The battle for effective sexuality education' (2004) 2 *Journal of Student Social Work* 11.

<sup>227</sup> Madkour *et al* (n 224 above) 1211- 1225.

<sup>228</sup> For example, according to the authors, the fact that parents in European countries are more open in their discussion and acceptance of adolescent sexual relationships compared to parents in the USA reflects in the disparity in adolescent birth and STI rates in European nations and the USA despite similar overall levels of sexual activity among the young. See Madkour *et al* (n 224 above) 1211- 1225. See also R Parker *et al* 'Sexuality education in Europe: an overview of current policies' (2009) 9(3) *Sex Education* 227.

<sup>229</sup> Best Practice in this instance refers to approaches that have been adopted in guaranteeing female adolescents' access to SRH care which have produced the most beneficial outcome and result.

Mozambique<sup>230</sup> that have resulted in the achievement of positive results towards the realisation of female adolescents' access to contraceptive services and information. This is done so as to uncover the existence of strategies that may be useful in Nigeria and South Africa.

## 5.2 Denmark

The Danish policy on family planning has over the years evolved on the basis of adapting legislation to meet the specific needs of its population.<sup>231</sup> Although Denmark also initially had the problem of high adolescent pregnancy rates, in 1970, despite opposition, it adopted the pragmatic approach of compulsorily introducing the teaching of sexuality education in its schools.<sup>232</sup>

The teaching of sexuality education, which normally begins at an early age,<sup>233</sup> is taught through a varying combination of methods including formal classroom lessons and peer

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<sup>230</sup> In relation to the countries selected: Denmark was selected as a result of the fact that it is one of many developed nations that already have established mechanisms of ensuring its adolescents' access to contraceptives and other SRH care information and services, which have resulted in the achievement of positive results. On the other hand, Mozambique despite having poorer statistics on HIV and teenage pregnancy than even South Africa was selected as a result of the documented successes of its *Geracao Biz* programme; a multi-sectoral adolescent SRH programme that involves collaboration with the UNFPA, Mozambican government, Pathfinder International and other local NGOs.

<sup>231</sup> H P David *et al* 'United States and Denmark: Different Approaches to Health Care and Family Planning' (1990) 21 *Studies in Family Planning* 1.

<sup>232</sup> Sex education was introduced into Denmark state schools by virtue of Act No. 235 of 27 May 1970. See also University of Michigan *Sex Education* available at [http://sitemaker.umich.edu/final3isaacson.356/sex\\_education](http://sitemaker.umich.edu/final3isaacson.356/sex_education) (19 September 2013). In *Kjeldsen, Busk Madsen and Pedersen v Denmark* (1976) ECHR 6, (1976) 1 EHRR 711, a case brought before the European Court of Human Rights by the applicants, parents with children in Denmark public schools. The applicants were opposed to the policy which introduced the compulsory teaching of sex education in Danish state schools on the ground that it violated their right to choose the religious and moral education of their children.

<sup>233</sup> Though sexuality education begins at early ages, it is usually imparted in an age appropriate manner basis. However, by the time the children become adolescents from the age of 12-13, it becomes strictly compulsory to receive the education in the schools.

group education.<sup>234</sup> While the responsibility for providing sex education rests principally with teachers, other stake-holders, including health providers and NGOs, assist in imparting sexuality information to the students with topics taught ranging from contraception, STIs, physiological and biological formation, including emotional issues such as shyness and puberty among others.<sup>235</sup> A major benefit that has been achieved with the compulsory teaching of factual sexuality education without exemption relates to the fact that rather than promoting promiscuity among adolescents, initial sexual relationships occur in late adolescence (at almost 17 years of age) with 80% use of contraception during the experience.<sup>236</sup>

Apart from the fact that Danish adolescents have guaranteed access to contraceptive and other reproductive health care information and counselling, the country was the first to legalise the right of adolescents (including those under the age of sexual consent)<sup>237</sup> to free contraceptive and other SRH care services in confidential settings without stigma or fear of oppression.<sup>238</sup> In addition to the fact that female adolescents can readily access contraceptives at clinics, modern contraception is also readily available and accessible for purchase at pharmacies based on a prescription from the general practitioner or clinics.<sup>239</sup>

According to Wielandt and Knudsen, the fact that Danish adolescents can easily access contraceptives contributes greatly to the low teenage pregnancies, abortion and STI

<sup>234</sup> Parker *et al* 'Sexuality education in Europe' (n 224 above) 233; IPPF *Sexuality Education in Europe* (2006) 36, available at <http://www.ippfen.org/NR/rdonlyres/7DDD1FA1-6BE4-415D-B3C2-87694F37CD50/0/sexed.pdf> (18 September 2013).

<sup>235</sup> Parker *et al* 'Sexuality education in Europe' (n 228 above) 233; IPPF *Sexuality Education in Europe* (as above) 36.

<sup>236</sup> H Wielandt & L B Knudsen 'Birth Control: Some Experiences from Denmark' (1997) 55 *Contraception* 304; University of Michigan (n 232 above).

<sup>237</sup> In Denmark, it is an offence to have sexual relations with adolescents under the age of fifteen. See section 222(1) of the Danish Penal Code 1930.

<sup>238</sup> IPPF *Sexuality Education in Europe* (n 234 above) 35; David *et al* (n 231 above) 5.

<sup>239</sup> David *et al* (n 231 above) 5-6.

rates recorded in the country.<sup>240</sup> Also, according to the writers, because the low birth rates recorded among female adolescents has not been concurrently counter-balanced by an increase in abortion rates, the reduced birth rates accomplished among adolescent girls is achieved through their effective use of contraceptives and not as a result of their procurement of induced abortion at the health facilities.<sup>241</sup>

### 5.3 Mozambique

In addition to facing a public health crises occasioned as a result of the HIV and AIDS epidemics, like other countries in sub-Sahara Africa, Mozambique faces problems associated with the SRH of its adolescents.<sup>242</sup> Responding to the crises the country's Ministry of Education, as part of its educational reforms, introduced the teaching of SRH and HIV education in its primary and secondary schools in age appropriate segments.<sup>243</sup> Integrated into other subjects, curricular contents include not only the passing on of information on anatomy, reproductive organs and system, STIs, HIV and AIDS, puberty, pregnancy, childbirth, consequences of teenage pregnancy, contraception, but also teaching about values, beliefs, attitudes and behaviours relating to sexuality.<sup>244</sup>

<sup>240</sup> The pregnancy rate among 15-19 year olds dropped from 19.2 per 1,000 in 1986 to 7.7 per 1,000 in 1998. See F F Lauszus 'No change in adolescents' neglect on contraceptive use over two decades' (2011) 283 *Archives of Gynecology and Obstetrics* 551; Wielandt & Knudsen (n 236 above) 304; University of Michigan (n 232 above) 304.

<sup>241</sup> Wielandt & Knudsen (as above) 304.

<sup>242</sup> UNFPA State of the World's Midwifery - Country Profile Mozambique (2011) available at [http://www.unfpa.org/sowmy/resources/docs/country\\_info/profile/en\\_Mozambique\\_SoWMy\\_Profile.pdf](http://www.unfpa.org/sowmy/resources/docs/country_info/profile/en_Mozambique_SoWMy_Profile.pdf) (14 March 2014); T Vilaça *et al* The curricula of sexuality education in Mozambican and Portuguese schools: What are the challenges for teachers and international partnerships? (2012) 3, available at [http://repositorium.sdum.uminho.pt/bitstream/1822/24795/1/Vilac%CC%A7a%20T.,%20Nota%20J.,%20Mabote%20C.%20\(2013\)\\_atee\\_2012\\_proceedings.pdf](http://repositorium.sdum.uminho.pt/bitstream/1822/24795/1/Vilac%CC%A7a%20T.,%20Nota%20J.,%20Mabote%20C.%20(2013)_atee_2012_proceedings.pdf) (12 March 2014).

<sup>243</sup> UNAIDS *UNGA Special Session on HIV and AIDS: Progress report 2008 to 2009 – Mozambique* (2010) 62, available at [http://www.unaids.org/en/dataanalysis/knownyourresponse/countryprogressreports/2010countries/mozambique\\_2010\\_country\\_progress\\_report\\_en.pdf](http://www.unaids.org/en/dataanalysis/knownyourresponse/countryprogressreports/2010countries/mozambique_2010_country_progress_report_en.pdf) (12 March 2014).

<sup>244</sup> In addition peer educators are used in extra-curricular life-skills education activities and the media is used to disseminate HIV prevention information throughout the provinces. See UNAIDS *UNGA Special Session on HIV and AIDS* (as above) 63; Vilaça *et al* (n 242 above) 3-11.

However, probably one of the greatest achievement in ensuring adolescents access to contraceptives and other SRH care information and services in Mozambique is the ‘*Geração Biz*’ (busy generation) programme,<sup>245</sup> a multi-sectoral adolescent and youth friendly initiative implemented all over the country by the Ministries of Education, Youth and Sports and Health with support from the UNFPA, Pathfinder International and local NGOs.<sup>246</sup> Adopting a flexible management design that allows for monitoring, evaluation and the opportunity to make changes as further experience is acquired, the *Geração Biz* which started in two provinces, has been successfully extended to all provinces within the country.<sup>247</sup>

With a goal of improving adolescent SRH, reducing early and unwanted pregnancies, STI and HIV through activities aimed at equipping adolescents with the knowledge and skills required for positive behavioural changes,<sup>248</sup> the programme uses its multi-sectoral design to realise the achievement of its objectives. While the Ministry of Health is responsible for establishing youth friendly clinics where young people receive health care for different SRH services, including contraception, STI prevention and treatment, antenatal, postnatal or post-abortion care, voluntary counselling and testing for HIV and antiretroviral therapy, the Ministry of Education is in charge of in-school interventions ranging from peer education, creation of adolescent counselling corners in both primary

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<sup>245</sup> R Eghtessadi *Documenting sexual and reproductive health best practices in the SADC* (2012) 14, available at [http://www.slideshare.net/Rouzeh/documenting-sexual-and-reproductive-health-best-practices-in-sadc?qid=d386e1e3-37ac-4724-ad08-5c2f8df31342&v=qf1&b=&from\\_search=1](http://www.slideshare.net/Rouzeh/documenting-sexual-and-reproductive-health-best-practices-in-sadc?qid=d386e1e3-37ac-4724-ad08-5c2f8df31342&v=qf1&b=&from_search=1) (14 March 2014); J M Matsinhe *Programa Geracao Biz- Investing in youth: The story of a national SRH programme for adolescents and youths in Mozambique* (2011) available at [http://mozambique.unfpa.org/drive/INVESTING\\_IN\\_YOUTH\\_\\_17\\_10\\_2011web.pdf](http://mozambique.unfpa.org/drive/INVESTING_IN_YOUTH__17_10_2011web.pdf) (14 March 2014).

<sup>246</sup> WHO *From inception to large scale: The Geração Biz Programme in Mozambique* (2009) 11, available at <http://www.pathfinder.org/publications-tools/pdfs/From-Inception-to-Large-Scale-The-Geracao-Biz-Programme-in-Mozambique.pdf> (11 March 2014).

<sup>247</sup> WHO *From inception to large scale* (n 246 above) 11; Matsinhe (n 245 above) 16.

<sup>248</sup> WHO *From inception to large scale* (as above) 13.

and secondary schools and the organisation of intra- and extra-curricular SRH education.<sup>249</sup>

Additionally, the Ministry of Youth and Sports manages community outreach activities with out-of-school peer educators and community-based youth centres used in passing on important information to young people.<sup>250</sup> Despite the occurrence of different activities simultaneously, the *Geração Biz Programme* has a referral linkage system between teachers, peer educators, adolescent corners, community youth centres and the youth friendly health facilities in order to increase service utilisation and also to maximise impact.<sup>251</sup>

It is necessary to point out that the success recorded by the *Geração Biz Programme* can be majorly attributed to its multi-sectoral coordination design which not only allows teachers to sensitise students and their parents on the need to avail themselves of the services offered at the adolescent-friendly clinics but also allows for the community outreach section to target out-of-school adolescents.<sup>252</sup> The opening of adolescent-friendly centres in the various communities is usually signalled with the organisation of ceremonies in which community stakeholders, media and parents participate. Additionally, periodic meetings are held with parents to discuss issues ranging from teenage pregnancy and use of services available at the facilities to prevent unwanted pregnancies, to ways of assisting pregnant adolescents to remain in school.<sup>253</sup>

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<sup>249</sup> WHO *From inception to large scale* (as above) 14.

<sup>250</sup> WHO *From inception to large scale* (as above) 14.

<sup>251</sup> It is necessary to state that as the *Geração Biz* is not viewed as an external project but rather part and parcel of the government's overall mandate of ensuring the protection of adolescents sexual and reproductive health care, the respective provincial and district directorates of the ministries assist at their levels in order to ensure that the programme is directly felt by adolescents at the grass-roots. WHO *From inception to large scale* (as above) 14-15.

<sup>252</sup> WHO *From inception to large scale* (n 246 above) 26.

<sup>253</sup> WHO *From inception to large scale* (as above) 26.

Finally, although a lot still requires to be done as peculiar problems associated with financing, high adolescent pregnancy rates and HIV rates still exist,<sup>254</sup> the *Geração Biz Programme* has been successful in many respects. Apart from ensuring an increase in knowledge about HIV and other SRH issues generally, the programme as at 2011 was fully visible in 124 out of the 149 districts in the country.<sup>255</sup> In addition, the programme has succeeded in effecting attitudinal changes because community stake-holders actively participate in its activities.<sup>256</sup> Also, the *Geracao Biz* has resulted in increasing female adolescents' confidence in using contraceptive and other reproductive health care services available at the facilities thereby resulting in a significant decline in pregnancies recorded among in-school adolescents.<sup>257</sup>

#### 5.4 Conclusion

Even though allowing adolescents (generally and female adolescents in particular) access to comprehensive contraceptive information, education and services has always been a contentious issue,<sup>258</sup> the necessity to guarantee their access to information and services is vital since access to sexuality education is one of the most important tools required to ensure that young people not only receive the essential SRH care

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<sup>254</sup> Mozambique is one of the world's least developed countries and the country's health status has been considerably weakened as a result of the HIV epidemic which heavily affects young women. WHO *From inception to large scale* (as above) 38 & 41.

<sup>255</sup> Matsinhe (n 245 above) 16-21.

<sup>256</sup> Matsinhe (as above) 21.

<sup>257</sup> Matsinhe (as above) 16-21; WHO *From inception to large scale* (n 246 above) 32-36.

<sup>258</sup> In *Kjeldsen, Busk Madsen, and Pedersen v. Denmark* (1976) 1 European Human Rights Report 711, the objection of parents to the teaching of sexuality education to their children in public schools was overruled by the European Court on Human Rights who held that the rights (including their children's right to education under art 2 of Prot 1 of the European Convention on Human Rights) alleged to have been infringed had not been violated since the teaching of sex education in the schools was for the protection of public interest. Also, in the English cases of *Gillick v. West Norfolk and Wisbech Area Health Authority and Another* (1986) 1 AC 112, (1985) 3 All ER 402 & *R (Axon) v Secretary of State for Health* (2006) EWHC 37 (Admin), the English courts allowed female adolescents access to contraception and abortion services without parental interference once it is ascertained that the adolescent is able to understand the nature of the treatment she has requested.

information required to make informed choices but also know where to access the services.<sup>259</sup>

This section examined successful approaches that have been adopted by Denmark and Mozambique in guaranteeing the right of their female adolescents to contraceptive information and services. Denmark has been able to achieve success as a result of the liberal and forward-thinking attitude of the Danish government with collaboration from other stake-holders Mozambique's Busy Generation programme has not only succeeded in changing parochial attitudes of societal gate-keepers but also in increasing access to contraceptive information and services for adolescent girls.<sup>260</sup>

South Africa has put in place structures similar to that of Denmark to encourage its adolescent population to access contraceptives services and information but a lot still needs to be done in order to, specifically, change attitudes to ensure the achievement of results comparable to those achieved by Denmark. On the other hand, Nigeria needs to learn and adopt good practices from the other three countries- Denmark, Mozambique and South Africa – in relation to the creation of a legal and policy mechanism that works and also by guaranteeing access to factual and available contraceptive services and information. Nigeria needs to adopt the multi-sectoral approach used in Mozambique. While the current efforts of NGOs in Nigeria is appreciated, it is felt that the use of joint collaborative effort with the relevant ministries at national, state and local government levels will result in greater success.

Even though a major reason associated with the non-access of adolescent girls to contraceptives in Africa (Nigeria and South Africa inclusive) relates to belief that

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<sup>259</sup> M Marques & N Ressab 'The sexuality education initiative: A programme involving teenagers, schools, parents and sexual health services in Los Angeles, CA, USA' (2013) 21 *Reproductive Health Matters* 126.

<sup>260</sup> Matsinhe (n 245 above) 16-21; WHO *From inception to large scale* (n 246 above) 32-36.

contraceptive use encourages the taking of sexual risks, the fear is unsubstantiated as studies Denmark and other countries have revealed.<sup>261</sup>

## 6 Chapter conclusion

As the UNFPA notes, investment in the SRH of young people, particularly adolescent girls, is one of the most cost-effective development expenditures a country can make.<sup>262</sup> Such an investment is an opportunity to fulfil state obligations relating to the protection of the fundamental human right to health care of young women recognised under international, regional and national instruments and laws which guarantee female adolescents access to contraceptive education, information and services. As well, investing in adolescent SRH presents a major opportunity to improve the well-being of adolescent girls themselves and accelerate progress towards the achievement of maternal and child health goals that currently head the international agenda.<sup>263</sup> In addition, it is an investment which will assist in achieving a quicker end to the HIV and AIDS pandemic, especially in the African region.<sup>264</sup>

<sup>261</sup> Wielandt & Knudsen ( n 236 above) 304; C Moreau *et al* 'The impact of pharmacy access to emergency contraceptive pills in France' (2006) 73 *Contraception* 606 &607; J Zeitlin *et al* *European perinatal health report: Health and care of pregnant women and babies in Europe in 2010* (2010) 58, available at <http://www.europeristat.com/images/doc/Peristat%202013%20V2.pdf> (23 September 2013); J S Santelli & A T Schalet *A New Vision for Adolescent Sexual and Reproductive Health* (2009) 3, available at [http://www.google.co.za/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&cad=rja&ved=0CCKQFjAA&url=http%3A%2F%2Fecommons.cornell.edu%2Fbitstream%2F1813%2F19323%2F2%2FNewVision\\_Nov09.pdf&ei=BhVEUuXmHlerhQevwoCoDw&usg=AFQjCNFB\\_NxSVxAKLQxhvCZmvsjp-IOaXw&bvm=bv.53217764,d.ZG4](http://www.google.co.za/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&cad=rja&ved=0CCKQFjAA&url=http%3A%2F%2Fecommons.cornell.edu%2Fbitstream%2F1813%2F19323%2F2%2FNewVision_Nov09.pdf&ei=BhVEUuXmHlerhQevwoCoDw&usg=AFQjCNFB_NxSVxAKLQxhvCZmvsjp-IOaXw&bvm=bv.53217764,d.ZG4) (23 September 2013); Advocates for Youth *Adolescent sexual health in Europe and the United States: The case for a rights, respect and responsibility approach* (2011) available at <http://www.advocatesforyouth.org/component/content/article/419-adolescent-sexual-health-in-europe-and-the-us> (20 September 2013).

<sup>262</sup> UNFPA - From *childhood to womanhood* (n 105 above).

<sup>263</sup> M Temin & R Levine *Start with a girl: A new agenda for global health* (2009) 2, available at [http://www.cgdev.org/files/1422899\\_file\\_Start\\_with\\_a\\_Girl\\_FINAL.pdf](http://www.cgdev.org/files/1422899_file_Start_with_a_Girl_FINAL.pdf) (23 September 2013).

<sup>264</sup> Temin & Levine (as above) 2.

Although adolescents in Nigeria and South Africa are currently exposed to sex education through the Family Life and HIV Education (FLHE) and Life Skills and HIV/AIDS programme currently taught in Nigerian and South African schools (as noted in sections 3.2 and 4.2 above) their content and curricula vary. It is submitted that there is an urgent need for Nigeria to review its sexuality education policy and curriculum contents to take cognisance of current realities in relation to adolescent SRH.<sup>265</sup> As well it should back the policy review with the necessary implementation and monitoring mechanisms to guarantee effectiveness. In relation to South Africa, in order to ensure uniformity of sexuality education received by students, there is need for South Africa to put in place a fixed curriculum for teaching Life Skills and HIV/AIDS education and to also give mandate that the curriculum must be compulsorily adhered to by schools.<sup>266</sup>

An obvious similarity observed in the teaching of the sexuality education curriculum in the two countries relates to the fact that the ease and success of teaching sexuality education in schools depend on the educators' religious/cultural beliefs, personal views and life experience. Given the rates of HIV and unintended pregnancy among female adolescents in both Nigeria and South Africa, it is submitted that there is an urgent need for the teaching of sexuality education to be factual and in-depth and not based upon religious or cultural limitations. Towards achieving this, FLHE and Life Orientation instructors in Nigeria and South Africa are to be encouraged to go beyond the obligatory sexual health topics to address, where necessary, other questions which adolescents might have in relation to sexuality and the protection of their SRH.

Achieving the above aim in both countries may require the specific training of special instructors who are passionate about adolescent sexuality issues, who would then be specifically attached to the schools to teach the subject taking into consideration the

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<sup>265</sup> Ajuwon (n 113 above); Durojaye 'Realising access to contraception for adolescents in Nigeria' (n 109 above) 206.

<sup>266</sup> Visser (n 174 above) 206, 211 & 214.

evolving capacities, development and age of the intended pupils. While instructing on the need to delay initiating sexual intercourse may work more for younger adolescents, their older counterparts should be exposed to more comprehensive sexuality education, especially relating to procreation, contraception, pregnancy, STIs and communication skills, among other issues, in order to raise adolescents who are not only aware of their sexuality but also possess the ability to make informed and healthy decisions as the need arises.

The *ICPD Programme of Action* and its *Key Actions* document recommend the provision of age-appropriate, gender-sensitive and user-friendly services that will address adolescent health needs.<sup>267</sup> Likewise, the ICESCR Committee General Comment 14, which specifies that core minimum essentials in relation to the right to health<sup>268</sup> must not only be made available but also accessible by state parties, makes it mandatory for the governments of South Africa and Nigeria to ensure that female adolescents' in both rural and urban areas have access to adolescent-friendly clinics where modern contraceptives can be easily obtained from health care providers who are neither judgemental nor discriminatory.<sup>269</sup>

Even though South Africa has performed better in providing access to contraceptive information and services, there is still need for both countries (especially Nigeria) to learn from the positive efforts adopted by Denmark through the assumption of a more liberal and tolerant approach which encourages parents and other gate keepers to change their cultural and parochial attitudes while accepting the reality of adolescent sexuality. Also, while South Africa already has in place the NAFCI programme, it is felt

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<sup>267</sup> UNFPA *Investing in People: National Progress in Implementing the ICPD Programme of Action 1994-2004* (2004) 54, available at [https://www.unfpa.org/webdav/site/global/shared/parliamentarians/docs/284\\_filename\\_globalsurvey.pdf](https://www.unfpa.org/webdav/site/global/shared/parliamentarians/docs/284_filename_globalsurvey.pdf) (25 September 2013).

<sup>268</sup> Para 12 general comment 14 ICESCR Committee.

<sup>269</sup> Concluding Observations of the ICESCR Committee on Russia (n 144 above).

that Nigeria has a lot to learn from the Mozambican *Geração Biz* programme. Instead of the current disjointed efforts to provide adolescent-friendly services, it is submitted that the Nigerian government can adopt a multi-sectoral methodology in ensuring that its youth and adolescent-friendly reproductive health care services get to the targeted audience. Also, South Africa can adopt the modality used in the *Geração Biz* programme where parents are invited to schools to specifically sensitise them about the importance of allowing their children avail themselves of the services offered at adolescent-friendly clinics.

Finally, instead of viewing the engagement of adolescents in sexual relations as a sin, there is the need to realise that adolescents will benefit more when they receive realistic information which teaches them about sexual responsibility from adults (especially parents). Also, health care providers (both in government and private health facilities) are to be specially and continuously trained in order to not only gradually effect attitudinal and social change towards adolescent SRH issues, but also to make them realise that the protection of the SRH of adolescents is an ethical and major responsibility. Such a programme requires placing ‘all hands on deck’ in order to achieve a drastic reduction of teenage fertility and STI and HIV infection rates, especially among female adolescents, as has been achieved in Denmark.

In the next chapter the discussion turns to the various barriers hindering female adolescents in Nigeria and South Africa when they access contraceptive information and services including the consequences that result from the existence of the barriers.

## CHAPTER 6

# BARRIERS TO FEMALE ADOLESCENTS' ACCESS TO CONTRACEPTIVE INFORMATION AND SERVICES AND THEIR RESULTING CONSEQUENCES

### Outline

- 1 Introduction**
- 2 Barriers to female adolescents' access to contraceptive information and services in Nigeria**
  - 2.1 Introduction
  - 2.2 Legal barriers
  - 2.3 Socio-cultural barriers
  - 2.4 Economic and logistical barriers
  - 2.5 Religious barriers
  - 2.6 Demographic barriers
  - 2.7 Conclusion
- 3 Barriers to female adolescents' access to contraceptive information and services in South Africa**
  - 3.1 Introduction
  - 3.2 Legal barriers
  - 3.3 Socio-cultural barriers
  - 3.4 Economic barriers
  - 3.5 Religious barriers
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- 5 NIGERIA**
  - 5.1 Consequences of barriers to access contraceptives in Nigeria
  - 5.2 Teenage pregnancies
  - 5.3 Abortion
  - 5.4 HIV and STIs
  - 5.5 Socio-economic consequences
  - 5.6 Conclusion
- 6 SOUTH AFRICA**
  - 6.1 Consequences of barriers to access contraceptives in South Africa
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  - 6.3 Abortion
  - 6.4 HIV and STIs
  - 6.5 Socio-economic consequences
  - 6.6 Conclusion
- 7 Chapter conclusion**

## 1 Introduction

The provision of detailed and accurate SRH care services and information is a significant factor in ensuring that the sexual and reproductive rights of people are fulfilled.<sup>1</sup> Ensuring that female adolescents in Nigeria and South Africa have access to complete contraceptive and SRH education from an early age facilitates the development of their autonomy which, in turn, allows them to make informed choices about their SRH later in life.<sup>2</sup> In addition, guaranteeing them access to and realising access to quality SRH care services which include family planning ensures that they not only enjoy the right to health assured in numerous human rights instruments<sup>3</sup> and laws,<sup>4</sup> but that they have the opportunity to realise their educational and developmental potential; thereby achieving economic security and independence.<sup>5</sup>

Despite the existence of dangers occasioned by adolescents' poor sexual health practices,<sup>6</sup> and regardless of the potential that abounds in situations where there is guaranteed access to modern contraceptive services and information, access to comprehensive SRH care services and information continues to elude the majority of

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<sup>1</sup> CRR *Submission to the Committee on the Rights of Persons with Disabilities* (2013) 2, available at <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/DGD17April2013.aspx> (2 October 2013).

<sup>2</sup> UNFPA *Comprehensive sexuality education: Advancing human rights, gender equality and improved sexual and reproductive health* (2010) 12, available at <http://www.unfpa.org/webdav/site/global/groups/youth/public/Comprehensive%20Sexuality%20Education%20Advancing%20Human%20Rights%20Gender%20Equality%20and%20Improved%20SRH-1.pdf> (8 October 2013).

<sup>3</sup> Art 12 ICESCR; art 24 CRC; art 16 African Charter; art 14 ACRWC.

<sup>4</sup> Secs 27(1)(a) & 28(1)(c) Constitution of the Republic of South Africa 1996; sec 13 Child Rights Act 2003; Sec 134(1) Children's Act 2005; etc.

<sup>5</sup> International Center for Research on Women (ICRW) *Girls' education, empowerment, and transitions to adulthood: The case for a shared agenda* (2012) 8-9, available at [http://www.basiced.org/wp-content/uploads/Publication\\_Library/ICRW-Girls\\_Education\\_Empowerment\\_and\\_Transitions\\_to\\_Adulthood-2013.pdf](http://www.basiced.org/wp-content/uploads/Publication_Library/ICRW-Girls_Education_Empowerment_and_Transitions_to_Adulthood-2013.pdf) (8 October 2013).

<sup>6</sup> WHO *Adolescent development: A critical transition* available at [http://www.who.int/maternal\\_child\\_adolescent/topics/adolescence/dev/en/](http://www.who.int/maternal_child_adolescent/topics/adolescence/dev/en/) (8 October 2013); E Durojaye 'Realising access to sexual health information and services for adolescents through the Protocol to the African Charter on the Rights of Women' (2009) 16 *Washington and Lee Journal of Civil Rights and Social Justice* 136-137.

adolescent girls in sub-Saharan Africa (including Nigeria and South Africa). These girls, unfortunately, are drastically affected by their unmet contraception needs.<sup>7</sup>

As noted in the previous chapter, even though adolescents in Nigeria and South Africa are provided with sex education, the degree of their exposure to such education differs. The Nigerian FLHE curriculum is neither factual nor in-depth, while South Africa, though possessing guidelines which specify the teaching of sexuality issues, does not have a fixed curriculum. This results in non-uniformity as the content of sexuality education taught in different schools varies.<sup>8</sup>

In the case of the provision of contraceptive services to female adolescents the situation is similarly disappointing. Nigeria has not fulfilled its duty to guarantee adolescents access to contraceptive services, despite the presence of numerous policies on adolescent reproductive health. There are not sufficient and well-regulated adolescent-friendly centres in the country: the few youth centres in existence are predominantly administered by NGOs. In contrast, South Africa has put in place facilities which allow women (young girls also) to access free family planning and contraceptive services at its health care centres. Furthermore, the existence of the National Adolescent Friendly Clinic Initiative (NAFCI) programme in South Africa which sets standards that are

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<sup>7</sup> C Ngwena 'Introduction to the symposium issue: Reproductive and sexual health and the African Women's Protocol Women' (2009) 16 *Washington and Lee Journal of Civil Rights and Social Justice* 4; CRR Submission to the CRPD Committee (n 1 above) 4; K Casey *Adolescent Reproductive Health in Nigeria* (2001) available at <http://www.advocatesforyouth.org/storage/advfy/documents/fsnigeria.pdf> (8 October 2013).

<sup>8</sup> E Durojaye 'Realising access to contraception for adolescents in Nigeria: A human right analysis' University of Free State (2010) 206; A O Esiet *Adolescent Sexual and Reproductive Health in Nigeria* (2009) available at <http://www.wilsoncenter.org/sites/default/files/Esiet%20Presentation.pdf> (27 July 2013); Department of Education *The HIV/AIDs Emergency Guidelines for Educators* (2002) 5-7, available at <http://www.education.gov.za/LinkClick.aspx?fileticket=fBnc9VU7mEw%3D&tabid=95&mid=507> (23 September 2013); A Ajuwon *Benefits of Sexuality Education for Young People in Nigeria* (2005) available at <http://www.arsrc.org/downloads/uhsss/ajuwon.pdf> (15 July 2013); M J Visser 'Life skills training as HIV/AIDS preventive strategy in secondary schools: Evaluation of a large-scale implementation process' (2005) 2 *Journal of Social Aspects of HIV/AIDS* 206, 211 & 214; R I Mpangana 'Implementation of the life skills HIV and AIDs program in Manyeleti circuit schools' University of Stellenbosch (2012) 30.

adopted by NGOs for the provision of adolescent health care services in the country goes a long way in ensuring contraceptive availability and accessibility to adolescents.<sup>9</sup>

Notwithstanding the above, however, in Nigeria's case, apart from the government's inefficiency, other factors exist which prevent female adolescents from accessing the few contraceptive and SRH care facilities available. Also in the case of South Africa, regardless of efforts made to ensure the availability and accessibility of contraceptive services, other issues persist which prevent adolescent girls from using the available facilities. Alli<sup>10</sup> notes that while contraceptive trends in Africa can be attributed to past policies, research also reveals that the low rate of contraceptive use among adolescents can be attributed to social norms and various other obstacles which they encounter when seeking these services, therefore resulting in devastating consequences.<sup>11</sup>

This chapter, therefore, aims to identify and examine those additional barriers which render inaccessible contraceptive information and services to female adolescents (married and unmarried) in both countries. As well, in addition to examining the obstacles that prevent adolescent girls' access to contraceptive information and services, general consequences that result from their non-access to this important information and services will be examined. The situation in Nigeria is discussed first, followed by that in South Africa.

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<sup>9</sup> G Sedgh *et al Meeting young women's sexual and reproductive health needs in Nigeria* (2009) 16, available at [http://www.guttmacher.org/pubs/2009/06/03/ASRH\\_Nigeria.pdf](http://www.guttmacher.org/pubs/2009/06/03/ASRH_Nigeria.pdf) (14 August 2013); National Contraception and Fertility Planning Policy and Service Delivery Guidelines (2012) 36-37, available at [http://www.doh.gov.za/docs/policy/2013/contraception\\_fertility\\_planning.pdf](http://www.doh.gov.za/docs/policy/2013/contraception_fertility_planning.pdf) (3 May 2013); P Maharaj & M Rogan *Reproductive Health and Emergency Contraception in South Africa: Policy Context and Emerging Challenges* (2007) 13, available at <http://sds.ukzn.ac.za/files/WP%2048%20WEB.pdf> (23 August 2013).

<sup>10</sup> F Alli 'Comprehensive sexual and reproductive health care services for youth: A health sector priority' University of KwaZulu-Natal (2011).

<sup>11</sup> Alli (as above) 28.

## 2 Barriers to female adolescents' access to contraceptive information and services in Nigeria

### 2.1 Introduction

Adolescents constitute a large proportion of Nigerian society<sup>12</sup> and, like adolescents in other countries, they continue to be a source of public health concern in view of their poor SRH outcomes. Studies continually reveal that young people not only lack access to realistic contraceptive information and services, but that they also often have erroneous ideas about reproduction.<sup>13</sup> These factors result in female adolescents accounting for a large proportion of hospital admissions arising from abortion complications,<sup>14</sup> an adolescent fertility rate that is estimated as 123 live births per 1,000 births,<sup>15</sup> and their vulnerability to diverse STIs, including HIV.<sup>16</sup>

Realising that state parties have not given sufficient attention to the specific concerns of promoting the health and development of adolescents as rights holders, the Committee on the Rights of the Child explains that the obligation to respect, protect and fulfil the rights of children by state parties includes a duty to ensure that adolescents not only have access to available SRH information which is essential for their health and

<sup>12</sup> Unicef 'At a glance: Nigeria statistics' available at [http://www.unicef.org/infobycountry/nigeria\\_statistics.html#91](http://www.unicef.org/infobycountry/nigeria_statistics.html#91) (6 March 2013); Federal Ministry of Health *Assessment report of the national response to young people's sexual and reproductive health in Nigeria* (2009) 5, available at [http://hivaidsclearinghouse.unesco.org/search/resources/5713\\_AssessmentReportNigeria.pdf](http://hivaidsclearinghouse.unesco.org/search/resources/5713_AssessmentReportNigeria.pdf) (9 October 2-13).

<sup>13</sup> A O Arowojolu *et al* 'Sexuality, contraceptive choice and aids awareness among Nigerian undergraduates' (2002) 6 *African Journal of Reproductive Health* 60-70.

<sup>14</sup> A Tayo *et al* 'Contraceptive knowledge and usage amongst female secondary school students in Lagos, Southwest Nigeria' (2011) 3 *Journal of Public Health and Epidemiology* 34.

<sup>15</sup> UNFPA country indicators – Nigeria in *The state of the world's midwifery 2011* available at [http://www.unfpa.org/sowmy/resources/docs/country\\_info/profile/en\\_Nigeria\\_SoWMy\\_Profile.pdf](http://www.unfpa.org/sowmy/resources/docs/country_info/profile/en_Nigeria_SoWMy_Profile.pdf) (24 June 2013); 'More teenage girls in Nigeria are getting pregnant' *Channels Television* 15 July, 2013, available at <http://www.channelstv.com/home/2013/07/15/more-teenage-girls-in-nigeria-are-getting-pregnant/> (24 July 2013).

<sup>16</sup> K N Mmari 'STI treatment seeking behaviors among youth in Nigeria: Are there gender differences?' (2010) 36 *International Perspectives on Sexual and Reproductive Health* 72.

development but also access available contraception and other SRH care services of appropriate quality according to their evolving capacities.<sup>17</sup> Additionally, noting that adolescents are constantly at risk of infection, STIs and HIV/AIDS inclusive, the committee mandates state parties to take several measures, including the development of effective prevention programmes aimed at changing cultural views about adolescents' sexuality and need for contraception, and the adoption of legislation to combat practices which increase adolescents' risk of infection. Likewise, the committee urged states to take measures aimed at removing barriers hindering adolescents' access to preventive measures, such as contraceptives.<sup>18</sup>

According to Durojaye (quoting Cook *et al*), there are four vital elements which influence human health outcomes: providence, people, politicians and health care providers.<sup>19</sup> As the authors note, while providence determines the genetic constitution of people, including the kind of diseases to which they are vulnerable. The kind of lifestyle people adopt automatically has implications not only on their health but also for the health of others who relate intimately with them. Politicians are catalysts affecting the society through the progressive nature, or otherwise, of the laws and policies on health which they enact. Health care providers are essential in restoring and maintaining the health of all 'people', especially the vulnerable, who definitely include adolescents, women and children.<sup>20</sup> In agreement with Durojaye, it is argued that the

<sup>17</sup> Paras 35(b) & (c) & 37 CRC Committee general comment 4 *Compilations of General Comments and Recommendations Adopted by Human rights Treaty Bodies, Vol II*, available at [http://www.bayefsky.com/general/hri\\_gen\\_1\\_rev9\\_vol\\_ii.pdf](http://www.bayefsky.com/general/hri_gen_1_rev9_vol_ii.pdf) (27 October 2012); C Ngwenya *Sexual health and human rights in the African Region* (2011) 206 – 207 [http://www.ichrp.org/files/papers/185/140\\_Ngwenya\\_Africa\\_2011.pdf](http://www.ichrp.org/files/papers/185/140_Ngwenya_Africa_2011.pdf) (9 October 2013).

<sup>18</sup> Para 26 CRC Committee general comment 4.

<sup>19</sup> Durojaye 'Realising access to contraception for adolescents in Nigeria' (n 8 above) 91.

<sup>20</sup> Durojaye 'Realising access to contraception for adolescents in Nigeria' (as above) 92.

above elements necessarily contribute to the health outcomes of female adolescents in relation to their access to contraceptives.<sup>21</sup>

Additionally, barriers exist which prevent adolescents (female adolescents in particular) from accessing contraceptive information and services. The hindrances, not peculiar to Nigeria, continue to prevent young people from obtaining genuine and factual contraceptive information and services and therefore need to be overcome in order to ensure accessibility. In view of the above situation, the objective specifically in this section is to scrutinise the various obstacles and hindrances which prevent the guarantee of available, affordable, accessible and quality contraceptive and SRH care services to female adolescents in Nigeria.

## 2.2 Legal barriers

For many years, a major area that continued to generate controversy and concern relates to the matter of sexual relations between adolescents and adults. Occasioned by the phenomenon of child sexual abuse and the perpetuation of sexual crimes against children,<sup>22</sup> the law prohibiting sexual activity with children has operated on the basis of the recognition of age limits below which children cannot consent to sexual activity with adults and other children.<sup>23</sup>

The age of consent to sexual intercourse varies among countries, and sexual relations with adolescents below the age recognised by law are usually categorised as the offence of statutory rape. This is based upon the principle that a child is incapable of giving

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<sup>21</sup> As above.

<sup>22</sup> C A Phipps 'Children, adults, sex and the criminal law: in search of reason' (1997) *Seton Hall Legislative Journal* 4.

<sup>23</sup> K Sutherland 'From jailbird to jailbait: Age of consent laws and the construction of teenage sexualities' (2002) 9, available at *William and Mary Journal of Women and the Law* 313; C Ferguson *Do teenagers have a human right to consensual sexual activity?* (2010) available at <http://www.theguardian.com/commentisfree/libertycentral/2010/apr/15/teenagers-law-human-right-consensual-sex> (9 October 2013).

sexual consent.<sup>24</sup> In Nigeria, before the passage of the CRA,<sup>25</sup> the offence of statutory rape was already recognised under the country's Criminal Code<sup>26</sup> and Penal Code<sup>27</sup> Acts. Under the Penal Code operating in Northern Nigeria, children under the age of 14 and 16 are incapable of consenting to sexual acts or acts of 'gross indecency'.<sup>28</sup> In Southern Nigeria, the Criminal Code not only forbids engaging in sexual intercourse, or attempting to engage in sexual intercourse, with a girl of less than 13 years but provides that such offences attract a punishment of life imprisonment or 14 years imprisonment.<sup>29</sup> Also, offences of sexual assault against girls below the age of 13 and between the ages of 13 and 16 are punishable by terms of imprisonment ranging from two to three years.<sup>30</sup>

Regarding the offence of statutory rape, the CRA 2003 succinctly provides that no one shall have sexual intercourse with a child and the penalty for a contravention of the law attracts a punishment of life imprisonment.<sup>31</sup> According to the Act, where a person has been charged with the offence of statutory rape, it is immaterial that the offender believed the person to be of or above the age of eighteen years or the sexual intercourse was with the consent of the child.<sup>32</sup>

The provisions of the more recent CRA and the older Criminal and Penal Code Acts can be lauded for their attempts at protecting children (including adolescents) from sexual abuse. However, an apparent conflict that is immediately obvious relates to the fact that while the Penal and Criminal Codes set the age limit at 16 years as the age before which

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<sup>24</sup> F B Alokun 'Child sexual abuse: A potential damage to children' (2012) *2Journal of Educational and Social Research* 361; CRR *Women of the World: Laws and policies affecting their reproductive lives* (2003) 172, available at <http://reproductiverights.org/sites/crr.civicactions.net/files/documents/WOWAA09.pdf> (9 October 2013); Sutherland (n 23 above) 314-315.

<sup>25</sup> Child Rights Act cap c50 LFN 2004.

<sup>26</sup> Criminal Code cap c38 LFN 2004.

<sup>27</sup> Penal Code cap p3 LFN 2004.

<sup>28</sup> Secs 39 & 285 Penal Code.

<sup>29</sup> Sec 218 Criminal Code.

<sup>30</sup> Secs 221 & 222 Criminal Code.

<sup>31</sup> Sec 31(1) & (2) Child Rights Act.

<sup>32</sup> Sec 31(3) (a) &(b) Child Rights Act.

consent to sexual acts cannot be given, the CRA goes further to increase the age of sexual consent to 18 years for both sexes.<sup>33</sup> It is necessary to point out that the provision contained in the CRA does not yet apply universally in Nigeria as a majority of northern states are yet to domesticate the Act.<sup>34</sup>

A major point to which attention needs to be called relates to the apparent barrier that the provisions of the three laws discussed above would have on the willingness of adolescent girls in the country to access contraceptive and other SRH care services as girls would forgo obtaining contraception, which will protect them from unplanned pregnancies and STIs, rather than attempting to access the services and ‘risk’ exposing their older sexual partners.

Also, the fact that the offence of statutory rape as recognised under the laws does not take cognisance of consensual sexual relations between adolescents is a shortcoming as, in a majority of cases, female adolescents also have sexual relationships with their peers.<sup>35</sup> The situation was succinctly summed by Amazigo *et al* who note that adolescents are usually involved in sexual relationships with two types of partners: their peers and older ‘business’ persons. According to the writers, findings revealed during focus group discussions show that the adolescents described peer relationships as being ‘for love’ and relationships with older men as being ‘for money’.<sup>36</sup> The above was further confirmed by Oladokun *et al* in their study on the sexual behaviour and contraceptive usage of secondary school adolescents in Ibadan, a Nigerian city. They note, contrary to observations that most adolescents are involved in sexual activities

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<sup>33</sup> Secs 39 & 285 Penal Code; secs 218, 221 & 222 Criminal Code & sec 31 Child Rights Act.

<sup>34</sup> The reason for this anomaly is because matters relating to the protection of the rights of children are specifically provided for in the residual list of the Nigerian Constitution, thereby giving states exclusivity over which laws to adopt for child protection issues. See UNICEF Nigeria –Fact sheet on Child rights legislation in Nigeria, available at [http://www.unicef.org/nigeria/Child\\_rights\\_legislation\\_in\\_Nigeria.pdf](http://www.unicef.org/nigeria/Child_rights_legislation_in_Nigeria.pdf) (6 April 2013).

<sup>35</sup> U Amazigo *et al* ‘Sexual activity and contraceptive knowledge and use among in-school adolescents in Nigeria’ (1997) 23 *International Family Planning Perspectives* 30.

<sup>36</sup> Amazigo *et al* (as above) 30.

with older partners, findings from their study reveal that in-school adolescents have sexual partners who are either younger, of their age or older as the case may be.<sup>37</sup>

While not overlooking the reality that activities of sexual predators are on the increase in the country,<sup>38</sup> it is felt that an important issue which needs to be considered when amending or replacing the criminal laws operating in the Nigeria relates to the amendment of the provisions on statutory rape contained in the laws.<sup>39</sup> The reason for adopting this position is not far-fetched. One of the intended effects of criminal sanctions is for the sanction to act as a form of deterrence<sup>40</sup> towards the prevention of further commission of a crime. It is felt, in this instance, that the existence of blanket penalty provisions on statutory rape which do not take into cognisance consensual sexual relationships between adolescents of similar age-groups or, for example, those with a two year gap between them, will fail in their endeavour to act as a deterrent against the engagement in sexual relationships by adolescents. Adolescents will continue having sex with each other, whether the country's criminal laws sanctions such behaviour or not.

<sup>37</sup> A Oladokun *et al* 'Sexual Behaviour and Contraceptive Usage of Secondary School Adolescents in Ibadan, Nigeria' (2007) 18 *Journal of Reproduction & Contraception* 287.

<sup>38</sup> N Odeh 'Why sexual abuse of kids is increasing' PM News 30 April 2013, available at <http://pmnewsnigeria.com/2013/04/30/why-sexual-abuse-of-kids-is-increasing/> (9 October 2013); A Alhassan Ahman 'Child rape: Who speaks for the victims?' Hope for Nigeria 5 May 2013, available at <http://www.hopefornigeriaonline.com/child-rape-who-speaks-for-the-victims/> (9 October 2013); E Akinkuotu 'Child abuse, rape rise in Lagos –OPD' Punch 11 April 2012, available at <http://www.punchng.com/metro/child-abuse-rape-rise-in-lagos-opd/> (9 October 2013); 'Rape: When old vice becomes new monster' Vanguard April 18 2012, available at <http://www.vanguardngr.com/2012/04/rape-when-old-vice-becomes-new-monster/> (9 October 2013); IRIN 'Nigeria: Child rape in Kano on the increase' (2008) available at <http://www.irinnews.org/report/76087/nigeria-child-rape-in-kano-on-the-increase> (9 October 2013).

<sup>39</sup> The two laws which regulate criminal matters are both a colonial heritage, so there is an urgent need to either amend or replace them totally. While the Criminal Code which operates in the southern part of the country was enacted in 1916; the Penal Code that is applicable in the north was passed as law in 1959.

<sup>40</sup> The traditional aims of criminal law are deterrence, rehabilitation and incapacitation. See B Fisse 'Reconstructing corporate criminal law: Deterrence, retribution, fault, and sanctions (1983) 56 *Southern California Law Review* 1146.

Instead, the general sanctions contained in the criminal laws on statutory rape have the potential effect of being counter-productive in the sense that the sanctions will render adolescent reproductive health policies which aim to protect the SRH of adolescent girls ineffective as female adolescents will rather not get their peers into trouble with the law by attempting to access preventive or protective contraceptive information and services. The above reasoning aligns with that of the Constitutional Court in *The Teddy Bear Clinic for Abused Children and Another v Minister of Justice and Constitutional Development and Another*<sup>41</sup> where the court, taking note of the expert report which detailed the ‘high rates of negative experiences and consequences of sexual behaviour’, stated that if children are not made to feel that there are safe environments within which they can discuss their sexual experiences, they will not only be stripped of the benefit of guidance at a sensitive and developmental stage of their lives but will also silence and isolate adolescents thereby making the adoption of unhealthy behaviour and poor developmental outcomes more likely.<sup>42</sup>

### 2.3 Socio-cultural barriers

Cultural and social mores have a great impact on adolescents’ reproductive lives and behaviour.<sup>43</sup> They are a major factor that has continued to impede calls for global action to ensure that female adolescents gain access to beneficial and lifesaving contraceptive and SRH information and services.

In the majority of African societies, social norms, which perpetuate gender roles and stereotype women as primarily mothers and care-givers, have been used to restrict women’s access to affordable contraception and other SRH care services and information. Also, cultural norms have been used to influence female adolescents away

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<sup>41</sup> *The Teddy Bear Clinic for Abused Children and Another v Minister of Justice and Constitutional Development and Another* (CCT 12/13) [2013] ZACC 35.

<sup>42</sup> Paras 45, 47 & 73 *Teddy Bear Clinic for Abused Children* case.

<sup>43</sup> E Presler-Marshall & N Jones Charting *the future: Empowering girls to prevent early pregnancy* (2012) 26.

from negotiating sexual activity or accessing contraceptive information and services.<sup>44</sup> These trends were observed by Adjetey, who stated that, at a very early age, female children in Africa are not only taught that the man is the head of the household, but are also advised to remain in complete subjugation to their husbands in all matters, including sexual matters.<sup>45</sup> The above was affirmed by Durojaye quoting Gordon, who asserts:

The society defined requirement of femininity came to include the motherly characteristics - softness, self –effacement, passivity, sensitivity, and so forth and to preclude fatherly ones – power, assertiveness, freedom and so forth.<sup>46</sup>

According to Oloruntoba-Oju, women are generally more sexually vulnerable than men, but the sexual vulnerability of female adolescents is not only higher but is further aggravated by cultural values and perceptions of gender and sexual roles which are generally skewed against adolescent girls as a result of the unequal gender and power relations among male and female members of society.<sup>47</sup> Whereas male adolescents are encouraged to engage in sexual relations in order to prove their sexual prowess, the situation is different for female adolescents. Female adolescents are advised to either shun pre-marital sex or are discouraged from using contraceptives due to the cultural importance attached to female fertility and myths which associate contraceptive use

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<sup>44</sup> S Cusack & R J Cook 'Stereotyping women in the health sector: Lessons from CEDAW' (2009) 16 *Washington and Lee Journal of Civil Rights and Social Justice* 50, 59-60; N Newton *Applying best practices to youth reproductive health* (2000) 3.

<sup>45</sup> F N Adjetey 'Reclaiming the African Woman's Individuality: The struggle between women's reproductive autonomy and African society and culture' (1995) 44 *American University Law Review* 1356.

<sup>46</sup> Durojaye 'Realising access to contraception for adolescents in Nigeria' (n 8 above) 96.

<sup>47</sup> A M Mwinga 'Factors contributing to unsafe sex among teenagers in the secondary schools of Botswana' *University of South Africa* (2012) 17; T Oloruntoba-Oju 'Young, female and African: Issues in sexual vulnerability' (2011) 7(1) *Sexuality in Africa: Magazine & Monographs* 3, available at <http://www.arsrc.org/downloads/sia/jun11/jun11.pdf> (15 October 2013).

with promiscuity and infertility, thereby resulting in their engaging in unprotected sex and high pregnancy rates.<sup>48</sup>

A mistaken belief in Nigeria, which is fuelled by culture and held by parents, law makers and other gate keepers alike, relates to the view that allowing female adolescents to access contraceptive information will encourage their initiation and practice of sexual relations. This perception is, however, wrong. Abundant studies highlight, although female adolescents (especially the unmarried ones) are ill informed about contraception and other SRH matters, that it has not deterred them from engaging in sexual relations.<sup>49</sup> The above assessment is particularly true in relation to Nigeria, a patriarchal society, where in a majority of cases, adolescent girls not only indulge in premarital sex before the age of 18 years but also have multiple sexual partners,<sup>50</sup> even though they are expected to be ignorant about sexual matters and discussions relating to sex are a taboo in the home.<sup>51</sup>

Apart from the fact that in Nigerian society, parents, because of cultural inclinations, refuse to discuss matters pertaining to sexuality with their unmarried daughters, the

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<sup>48</sup> C O Izugbara 'The socio-cultural context of adolescents' notions of sex and sexuality in rural South-Eastern Nigeria' (2005) 8 *Sexualities* 607-609; C A Varga 'How gender roles influence sexual and reproductive health among South African adolescents' (2003) 34 *Studies in Family Planning* 160-172; Arowojolu *et al* (n 13 above) 60-70; Y Enuameh *et al* 'Perceived facilitators and barriers to interventions aimed at reducing unintended pregnancies among adolescents in low and middle income (developing) countries: A Systematic Review of Qualitative Evidence' (2012) 10 *Joanna Briggs Institute (JBI) Library of Systematic Reviews* 3351 & 3354.

<sup>49</sup> Newton (n 44 above) 3; Brenda 'The problems that sexually active teenagers experience in accessing contraceptive information and services in Lusaka (urban) and Sesheke (rural) Zambia' University of Zimbabwe (2004) available at <http://uzweb.uz.ac.zw/law/women/dissertations/Sexually%20active%20teenagers.pdf> (28 September 2013).

<sup>50</sup> B O Nwankwo & E A Nwoke 'Risky sexual behaviours among adolescents in Owerri municipal: Predictors of unmet family health needs' (2009) 13 *African Journal of Reproductive Health* 138-140; P I Okonta 'Adolescent sexual and reproductive health in the Niger Delta region of Nigeria: Issues and challenges' (2007) 11 *African Journal of Reproductive Health* 115-116; Izugbara 'The socio-cultural context of adolescents' (n 48 above) 602; E O Orji & O A Esimai 'Sexual behaviour and contraceptive use among secondary school students in Ilesha South West Nigeria' (2005) 25 *Journal of Obstetrics and Gynaecology* 271.

<sup>51</sup> Durojaye 'Realising access to contraception for adolescents in Nigeria' (n 8 above) 92.

situation of married adolescents (especially in Northern Nigeria) is more precarious. In addition to the situation that the girls enter into marriage in a state of total ignorance about sexual matters, they face greater reproductive health risks even than their unmarried counterparts. They are exposed not only to the constant risk of HIV infection from their polygamously inclined older husbands but are also under frequent health risks due to early pregnancies for which they can neither negotiate contraception nor access contraceptive services because they need to obtain the consent of their spouse.<sup>52</sup> Sedgh *et al* assert, the conservative social values of developing countries in which female adolescents in marriages are expected to justify and fulfil their new status by becoming pregnant as soon as possible may be responsible for their non-use of contraception despite the fact that that they may be exposing themselves to great health hazards.<sup>53</sup>

It is necessary to underscore that the effect of culture and gender in hindering female adolescents' access to contraception is not peculiar to Nigeria. Mwinga remarks that in Swaziland, which also is a patriarchal society, men are not only the head of the family but are also the only decision maker in relation to contraceptive use. In addition, due to ingrained cultural beliefs, not only do female adolescents themselves not support the use of contraception as a result of the fear of future side effects but the engagement in unprotected sex is deliberately encouraged as the social status of boys who successfully impregnate girls is higher than that of their counterparts who endeavour to practice safe sexual relations.<sup>54</sup>

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<sup>52</sup> P Makinwa – Adebusoye *Hidden: A Profile of Married Adolescents in Northern Nigeria* (2006) 8, 9, 19-22, available at <http://www.actionhealthinc.org/publications/docs/hidden.pdf> (20 June 2013).

<sup>53</sup> Sedgh *et al* 'Meeting young women's sexual and reproductive health needs' (n 9 above) 10.

<sup>54</sup> Mwinga (n 47 above) 19.

Addressing this issue in its concluding observation to Nigeria's sixth periodic report,<sup>55</sup> the CEDAW Committee took notice of the persistent existence of 'patriarchal attitudes' and 'deep-rooted' stereotypes which are used to perpetuate the subordination of women and, therefore, adolescent girls within Nigerian society. It urged the government to not only endeavour to continue to eliminate the stereotypes but to engage in awareness-raising campaigns in order to increase women's knowledge about health issues, especially those relating to the prevention and control of STIs and HIV/AIDS.<sup>56</sup>

An example which specifically illustrates the negative hold which the strict observance of culture and tradition has in preventing female adolescents from accessing factual contraceptive information can be particularly gleaned from the struggle which took place between the Nigerian government and various religious/ conservative interest groups, before the FLHE curriculum for schools could be approved.<sup>57</sup> The opposition was such that it eventually led to a dilution of the curriculum with sensitive topics relating to issues such as contraception being removed from the curriculum. At the same time individual states were given the leeway to adapt the curriculum in such a way that it will suit their socio-cultural characteristics.<sup>58</sup> Even in relation to the 'few' topics being imparted to students in the FLHE classes instructors readily teach sexuality education only from the abstinence point of view. Teachers are reluctant to teach on contraception due to the belief that making such information available to adolescents,

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<sup>55</sup> Concluding observations of the CEDAW Committee on Nigeria (2008) CEDAW/C/NGA/CO/6 <http://www2.ohchr.org/english/bodies/cedaw/docs/co/CEDAW-C-NGA-CO-6.pdf> (23 September 2014).

<sup>56</sup> Paras 322, 323 & 335 concluding observations of the CEDAW Committee on Nigeria (2008) CEDAW/C/NGA/CO/6 <http://www2.ohchr.org/english/bodies/cedaw/docs/co/CEDAW-C-NGA-CO-6.pdf> (24 September 2014). See also Para 62(d) CRC Committee concluding observations on Nigeria (2010) CRC/C/NGA/CO/3-4, available at <http://www2.ohchr.org/english/bodies/crc/crcs54.htm> (22 September 2014).

<sup>57</sup> UNESCO *Levers of success: case studies of national sexuality education programmes* (2010) 32-33, available at <http://unesdoc.unesco.org/images/0018/001884/188495e.pdf> (15 October 2013).

<sup>58</sup> UNESCO- *Levers of success* (as above) 33; Durojaye 'Realising access to contraception for adolescents in Nigeria' (n 8 above) 206.

generally, and female adolescents in particular, will not only fuel promiscuity but also have implications for future fertility.<sup>59</sup>

Furthermore, it should be known that even where teachers are reluctant to teach sexuality education from any point of view but the abstinence stand-point, female adolescents receive information relating to contraceptives from media and other sources, including their peers.<sup>60</sup> However, it is necessary to point out that the knowledge received on contraception by adolescent girls from the media and other public awareness-raising sources, has not translated into an increased uptake in contraceptive usage because of factors associated with provider bias and the fear of side effects. In a study carried out by Orji and Esimai on the sexual behaviour and contraceptive usage of secondary school students in Ilesha, South West Nigeria, it was revealed that apart from the fact that, in a majority of instances, contraceptive is not used because sexual intercourse by adolescents is usually unplanned, another major hindrance to contraceptive use by this group is the fear of side effects.<sup>61</sup>

## 2.4 Systemic and health provider bias

The problem of provider-bias is also a major impediment to female adolescents' access to contraceptive services in Nigeria. Health care providers, who are meant to be 'understanding' and more interested in protecting the health of all, especially young

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<sup>59</sup> N Dlamini *et al* 'Empowering teachers to change youth practices: Evaluating teacher delivery and responses to the FLHE programme in Edo State, Nigeria' (2012) 16 *African Journal of Reproductive Health* 96-97; C A Iyaniwura 'Attitude of teachers to school based adolescent reproductive health interventions' (2004) 16 *Journal of Community Medicine & Primary Health Care* 7.

<sup>60</sup> It should be noted that the veracity of the contraceptive information received from adolescent peers is another matter entirely. See Durojaye 'Realising access to sexual health information and services' (n 6 above) 148; Okonta (n 50 above) 117-118; V O Otiode *et al* 'Why Nigerian adolescents seek abortion rather than contraception: Evidence from focus group discussion'(2001) 27 *International Family Planning Perspectives* 79.

<sup>61</sup> T C Orisaremi & O Alubo 'Gender and the Reproductive Rights of Tarok Women in Central Nigeria' (2012) 6(1) *African Journal of Reproductive Health* 92; Orji & Esima (n 50 above) 270; A Bankole *et al* *Unwanted pregnancy and induced abortion in Nigeria: Causes and consequences* (2006) 12, available at <http://www.guttmacher.org/pubs/2006/08/08/Nigeria-UP-IA.pdf> (19 October 2013).

members of the population, not only stigmatise clients but also exhibit unfriendly and judgemental attitudes to female adolescents. This attitude is the consequence of their socio-cultural belief that adolescent girls are still too young to be involved in using contraception. The above situation contributes to the disillusionment of adolescent girls regarding contraceptive use and therefore results in them not bothering to make further attempts to access contraceptive services, since it is their belief that their privacy will not be assured anyway.<sup>62</sup>

In Monjok *et al's* view, the poor contribution and unfriendly attitude exhibited by health workers towards the dissemination and provision of contraceptive information and services to female adolescents is rooted in the cultural fabric of the Nigerian society. The common belief is that family planning services are the preserve of married people only and discussions about sex and contraception with young people is inappropriate.<sup>63</sup> The same position relating to the use of oral contraception by adolescent girls also applies to their use of emergency contraceptives. According to Williams, although Nigeria integrated the use of emergency contraception into its family planning guidelines since 2006, it has not translated into an availability of the drug in health facilities to female adolescents. Health providers' attitudes towards emergency contraception use by adolescent girls are even more conservative. They believe that the use of emergency contraception promotes promiscuity and should be discouraged among adolescents.<sup>64</sup> The existence of this situation goes against the CEDAW's

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<sup>62</sup> The reason is that the confidentiality of female adolescents who access contraceptive services in health care setting is not guaranteed as there exists a high probability that the health care providers will report the adolescents to their parents and other community members. See Durojaye 'Realising access to sexual health information and services' (n 6 above) 150; Enameh *et al* (n 48 above) 3354-3355.

<sup>63</sup> E Monjok *et al* 'Contraceptive practices in Nigeria: Literature review and recommendation for future policy decisions' (2010)1 *Open Access Journal of Contraception* 14.

<sup>64</sup> K Williams *Provider-related barriers to accessing emergency contraception in developing countries: A literature review* (2011) 6 & 16, available at [http://www.popcouncil.org/pdfs/2011RH\\_ECBarrriersLitReview.pdf](http://www.popcouncil.org/pdfs/2011RH_ECBarrriersLitReview.pdf) (19 October 2013). See also UNFPA & USAID *Contraceptive Security in Nigeria: Assessing Strengths and Weaknesses* (2009) 11, available at

recommendation to Nigeria's periodic report in 2008 where it advocated the implementation of awareness-raising campaigns targeted towards increasing knowledge about reproductive health issues among women and adolescents' alike.<sup>65</sup>

In line with the directive contained in the ICPD programme of action and its Key Action document,<sup>66</sup> the Nigerian government, as a matter of priority, has the undisputed obligation, in conformity with relevant existing international instruments and agreements, of ensuring that female adolescents have access to user friendly SRH care services, which should safeguard not only their right to privacy, confidentiality and informed consent but also respect their cultural values and religious beliefs.<sup>67</sup>

The importance of ensuring that female adolescents have access to contraceptive services in friendly settings with 'welcoming' health care providers can never be overstated. A common occurrence in Nigeria relates to the fact that adolescents (when they decide to use contraceptives) generally prefer to approach patent medicine dealers for contraceptive information and services<sup>68</sup> because they are usually made to feel unwelcome at the publicly funded family planning clinics and they cannot afford to access services provided at the private clinics.

## 2.5 Economic and logistic barriers

The unavailability and non-accessibility of life saving contraceptive services to adolescent girls in Nigeria is an indication of unmet contraceptive need that not only

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[http://deliver.jsi.com/dlvr\\_content/resources/allpubs/countryreports/NG\\_ContSecuStreWeak.pdf](http://deliver.jsi.com/dlvr_content/resources/allpubs/countryreports/NG_ContSecuStreWeak.pdf) (21 October 2013).

<sup>65</sup> Para 337 Concluding observation of the CEDAW Committee on Nigeria (2008) CEDAW/C/NGA/CO/6.

<sup>66</sup> ICPD - Programme of Action - A/CONF.171/13/Rev.1, available at <http://www.unfpa.org/public/publications/pid/1973> (20 September, 2012); ICPD +5 Key Actions Document, available at <http://www.un.org/documents/ga/res/21sp/a21spr02.htm> (5 October 2012).

<sup>67</sup> Para 73 (a) ICPD +5 Key Actions Document.

<sup>68</sup> In a majority of cases, since the patent medicine sellers are just traders doing business and who may have little or no knowledge about contraception, the probability that the information and drugs given to the children will be incorrect and dangerous is high. See also Monjok *et al* (n 63 above) 14.

traps them into a cycle of poverty but also results in their being burdened by poor SRH outcomes. Apart from the existence of socio-cultural barriers which impede female adolescents' use of contraceptives, another obstacle which prevents adolescent girls from accessing contraceptive services is connected with the affordability of family planning services, on the hand, and the economic and financial circumstances of female adolescent on the other.

In the previous chapter it was noted that the contraceptive-use prevalence rate among the Nigerian population is generally low.<sup>69</sup> A reason that has been offered for contraceptive non-use relates to the issue of non-affordability as family planning services were deemed to be too expensive,<sup>70</sup> especially by women and female adolescents with low economic empowerment. It is necessary to point out that as a result of poverty and the unaffordable cost of contraception, even in situations where adolescents attempt to make use of contraception, the most common type of contraceptive utilised is the male condom, which requires male approval and cooperation for successful use.<sup>71</sup> As Onwujekwe *et al* explain, the payment for contraception through out of pocket expenses automatically deters the vulnerable (especially poor women and adolescent girls) from accessing family planning services,

<sup>69</sup> DFID Nigeria *Scaling up access to contraceptive commodities in Nigeria* (2011) 7, available at <http://profiles.unfpa.org/uploads/documents/1373287034-dfid-contraceptivesproposal-june-2011.pdf> (19 October 2013); CRR *Broken promises: Human Rights, Accountability, and Maternal Death in Nigeria* (2008) 27, available at [http://www.unfpa.org/sowmy/resources/docs/library/R422\\_CenterRepRights\\_2008\\_NIGERIABrokenPromisesNigeriaCentre\\_for\\_Hman\\_Rights.pdf](http://www.unfpa.org/sowmy/resources/docs/library/R422_CenterRepRights_2008_NIGERIABrokenPromisesNigeriaCentre_for_Hman_Rights.pdf) (16 August 2013); Bankole *et al* 'Unwanted pregnancy and induced abortion in Nigeria' (n 61 above) 4.

<sup>70</sup> G Sedgh *et al* 'Unwanted pregnancy and associated factors among Nigerian women' (2006) 32(4) *International Family Planning Perspectives* 180. See also O Onwujekwe 'Are people really using modern contraceptives and how much do they pay for them?' (2013) 1 *African Journal of Health Economics* 11 & 12.

<sup>71</sup> The fact that as a result of poverty, the male condom is the major form of contraception used by women and adolescent girls is still a major impediment for access to contraception as a main socio-cultural factor fuelling contraceptive non-use is the problem of gender imbalance, male dominance and partner objection. See Onwujekwe 'Are people really using modern contraceptives' (as above) 7; Monjok *et al* (n 63 above) 13; L M Williamson 'Limits to modern contraceptive use among young women in developing countries: A systematic review of qualitative research' (2009) 6 *Reproductive Health* 8, available at <http://www.reproductive-health-journal.com/content/pdf/1742-4755-6-3.pdf> (17 September 2013).

thereby limiting their access to modern contraceptives and contributing to a low level of usage.<sup>72</sup>

The barrier experienced in accessing contraceptive services due to the non-affordability of contraception was noted by the Center for Reproductive Rights (CRR)<sup>73</sup> in their 2008 report on the causes of maternal mortality in Nigeria. The inconsistent use of contraception was credited to the irregular availability of contraceptives at health facilities as a result of logistic delays at the nation's ports.<sup>74</sup> In addition, the problem of affordability was also cited as a contributory factor to contraceptive non-use as a result of studies which reveal that not only do large discrepancies exist among rural and urban dwellers on contraceptive usage as a result of the high cost of contraception but also that contraceptive usage is significantly higher among rich people than poor people.<sup>75</sup> The results from the 2008 *National Demographic and Health Survey* reveal that teenage pregnancy and child bearing is common among girls from the poorest households in comparison with their counterparts from rich homes.<sup>76</sup>

Because of irregular availability of contraceptives at public hospitals the main source of contraception in Nigeria is the private sector clinics, pharmacies and patent medicine dealers,<sup>77</sup> where contraception though easily available and easier to access by

<sup>72</sup> Onwujekwe 'Are people really using modern contraceptives' (n 70 above) 3 & 4. See also A Ankomah *et al* 'Barriers to Contraceptive use among married young adults in Nigeria: A qualitative study' (2013) 3 *International Journal of Tropical Disease* 278.

<sup>73</sup> CRR - *Broken promises* (n 69above).

<sup>74</sup> CRR - *Broken promises* (as above) 30. Even as at 2011, a major problem which has continued to contribute to contraceptive non accessibility is that of stock outs at service delivery points (both private and public) See UNFPA *Nigeria: Contraceptive logistics management system assessment report* (2011) 16-17, available at [http://deliver.jsi.com/dlvr\\_content/resources/allpubs/countryreports/NG\\_ContLogiMana.pdf](http://deliver.jsi.com/dlvr_content/resources/allpubs/countryreports/NG_ContLogiMana.pdf) (21 October 2013).

<sup>75</sup> CRR - *Broken promises* (n 69 above) 31-32.

<sup>76</sup> National Population Commission (NPC) & ICF Macro *Nigeria Demographic and Health Survey 2008* (2009) 3, available at <http://www.measuredhs.com/pubs/pdf/SR173/SR173.pdf> (21 October 2013).

<sup>77</sup> Family Health International *The effectiveness of community-based access to injectable contraceptives in Nigeria: A Technical Report* (2010) 11, available at <http://www.k4health.org/toolkits/cba2i/effectiveness-community-based-access-injectable-contraceptives-nigeria-technical> (21 October 2013); UNFPA & USAID

adolescent girls, is definitely more expensive. As a result a majority of adolescent girls, who cannot afford accessing contraceptives from these dealers, engage in unprotected sex and risk unintended pregnancies. In a report by Osanyin based on an assessment of the few facilities providing youth-friendly health services in Nigeria, in addition to the fact that consumables and drugs were inadequate or lacking in most of the facilities visited, it was clearly noted that, although a majority of the centres were providing family planning services to young people, that contraceptives were made available to the adolescents upon payment of fees. Thus, adolescent girls who need to access contraception can only do so if they can afford the cost.<sup>78</sup>

The prospect of adolescents (especially female adolescents), who might be barred from accessing contraception as a result of the payment of user fees, led the CRC Committee in its concluding observations/recommendation on Nigeria's combined 3<sup>rd</sup> and 4<sup>th</sup> reports to urge the Nigerian government to take appropriate action. Apart from urging the government to take cognisance of the Committee's General comment 4 on adolescent health and development, the Committee also recommended that the country should make efforts to abolish the payment of user fees in order to increase female adolescents' access to affordable health care services, including free contraceptives, so that they can prevent unwanted pregnancies.<sup>79</sup>

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*Contraceptive Security* (n 64 above) 13; National Population Commission (NPC) & ICF Macro - *Nigeria Demographic and Health Survey* (2009) (as above) 5; Arowojolu *et al* (n 13 above) 60-70.

<sup>78</sup> Y Osanyin Report on *assessment of facilities providing youth friendly health services in Nigeria* (2011) 7 & 14, available at <http://ncceonline.net/download/files/Assessment%20of%20Youth%20Friendly%20Health%20Centers%20and%20Services.pdf> (3 August 2013).

<sup>79</sup> Para 62(a) CRC Committee concluding observations on Nigeria (2010) CRC/C/NGA/CO/3-4, available at <http://www2.ohchr.org/english/bodies/crc/crcs54.htm> (accessed 22 October 2013). It is important to highlight that before the CRC committee's concluding observation in 2010, in 1998 & 2004 respectively, the CEDAW Committee had made similar observations and recommendation that the Nigerian government should increase women and adolescent girls' access to affordable health care services, including reproductive health care and that access to affordable family planning services should be for all and a priority for government. See CRR - *Broken promises* (n 69 above) 32.

Probably in response to calls by international bodies that the government should guarantee access to affordable health care services for all Nigerians and free contraceptive services for adolescents, in April 2011, the Nigerian government announced a policy which removed the payment of user fees for family planning services in public hospitals in order to break down the barrier of non-affordability as a reason for contraceptive non-use.<sup>80</sup> It is, however unclear whether this directive has yielded positive results, especially in relation to female adolescents' access to contraception, because, at the time the contraceptive logistics management system assessment was being implemented, a larger percentage of service delivery points were still charging user fees for contraceptives contrary to policy directives.<sup>81</sup>

In agreement with the opinion of the CRR, the discrepancy in contraceptive usage<sup>82</sup> suggests an unacceptable position. The cost of contraceptives prevents many women and female adolescents from accessing contraception. Since the use of contraception should not be dependent on economic ability,<sup>83</sup> it is felt that the Nigerian government has an enormous obligation to ensure that adolescent girls have unfettered access to contraceptives. This obligation is in line with the recommendation of the ICESCR committee in its general comment 14 on the issue of economic accessibility: 'State parties are to ensure that vulnerable groups are not disproportionately burdened with health expenses and that health services are to be provided in a manner that will be affordable for all'.<sup>84</sup> Presently, the 2011 directive by the Nigerian government that the

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<sup>80</sup> Nigeria *Country Implementation Plan for Prioritized Life-Saving Commodities for Women and Children* available at [http://www.rhsupplies.org/fileadmin/user\\_upload/CoLSC/Meeting\\_Documents/Dakar\\_2-5\\_July\\_2013/NIGERIA-Implementation\\_Plan.pdf](http://www.rhsupplies.org/fileadmin/user_upload/CoLSC/Meeting_Documents/Dakar_2-5_July_2013/NIGERIA-Implementation_Plan.pdf) (21 October 2013).

<sup>81</sup> UNFPA *Nigeria: Contraceptive logistics management system assessment report* (n 74 above) 31-32.

<sup>82</sup> In this instance, the major issue in contention is that whether women and adolescent girls live in rural/urban areas or are rich/poor, the high cost of contraception should not be a reason for contraceptive non-use among adolescent girls.

<sup>83</sup> CRR - *Broken promises* (n 69 above) 32-33.

<sup>84</sup> Para 12(b) general comment 14 ICESCR Committee *Compilations of General Comments and Recommendations adopted by human rights treaty bodies Vol I*, available at [http://www.minoritycentre.org/sites/default/files/HRI-GEN-1-Rev.9%20\(Vol.%20I\).pdf](http://www.minoritycentre.org/sites/default/files/HRI-GEN-1-Rev.9%20(Vol.%20I).pdf) (21 October 2013).

payment of user fees for family planning services in public hospitals be cancelled seems like a paper direction and promise.

As noted earlier, in addition to the problem of non-affordability as an economic barrier to contraceptive usage, a further barrier which affects contraceptive use by adolescent girls relates to role played by the economic/financial circumstances of the female adolescent, viz the problem of poverty. Previously, attention has been concentrated on the increase in pre-marital sexual relationships among adolescents in sub-Saharan Africa and the fact that female adolescents do not use contraception despite engaging in risky relationships thereby contributing to their poor SRH including infection with STIs and HIV.<sup>85</sup> However, an important factor which fuels contraceptive non usage is the problem of inter-generational sex.

According to Luke and Kurz, a motivator for the occurrence of inter-generational sexual activity is the problem of extreme household poverty. Adolescent girls, for reasons ranging from economic survival to increasing their life prospects, engage in relationships with older men who, more often than not, have higher rates of HIV infection than adolescent boys.<sup>86</sup> According to the writers, the girls are capable of negotiating to some extent modalities for relationship initiation and continuance, but because power imbalances are the norm in heterosexual relationships in Africa, they are not able to

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<sup>85</sup> Currently among adolescent population in sub-Saharan Africa, female adolescents are more infected with HIV than their male counterparts. See UNAIDS Report on the global AIDS epidemic (2012) 15, available at [http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/20121120\\_UNAIDS\\_Global\\_Report\\_2012\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/20121120_UNAIDS_Global_Report_2012_en.pdf) (23 October 2013).

<sup>86</sup> N Luke & K M Kurz *Cross-generational and transactional sexual relations in sub-Saharan Africa: Prevalence of behavior and implications for negotiating safer sexual practices* (2002) 3-5, available at <http://www.icrw.org/files/publications/Cross-generational-and-Transactional-Sexual-Relations-in-Sub-Saharan-Africa-Prevalence-of-Behavior-and-Implications-for-Negotiating-Safer-Sexual-Practices.pdf> (22 October 2013).

control the format of sexual activities in the relationship. The men not only control the conditions of sexual intercourse but also determine contraceptive and condom usage.<sup>87</sup>

Even though the problem of inter-generational sexual relationships is not peculiar to sub-Saharan African settings, factors associated with poverty and gender imbalances which exist in African settings have contributed to the high prevalence of HIV and STIs among female adolescents who are involved not only in sexual liaisons with older partners for pecuniary gains but also cannot negotiate condom use for the safety of their SRH as they feel that they need to show appreciation of the man's generosity.<sup>88</sup>

The position was corroborated by Mwinga, who remarks, in a study carried out in Ghana, that quantitative data generated reveal that not only did 33% of the adolescent girls, who were the subject matter of the study, engage in sex for financial rewards but also that a majority of the adolescents engaged in unsafe/unprotected sex.<sup>89</sup>

The above situation applies in Nigeria as well, as female adolescents are involved in the practice of inter-generational sex.<sup>90</sup> According to statistics from the 2008 *Demographic and Health Survey*, adolescent girls not only engage in sexual relationships with older men for pecuniary gain but also do not use any form contraceptives or condoms to prevent sexual and reproductive ill-health and infections.<sup>91</sup> Confirming the proposition that poverty is a major factor contributing to adolescent girls engagement in risky sexual associations and therefore non contraceptive usage, Oyediran *et al* observe that the wealth index of female adolescents was negatively associated with the involvement of young females in inter-generational sexual relationships as adolescent girls from poorer

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<sup>87</sup> Luke & Kurz (as above) 3-4.

<sup>88</sup> D Clifton *Combating Cross-Generational Sex in Uganda* (2009) available at <http://www.prb.org/Publications/Articles/2009/crossgenerationalsex.aspx> (21 October 2013). See also Luke & Kurz (n 86 above) 1.

<sup>89</sup> Mwinga (n 47 above) 18.

<sup>90</sup> Ankomah *et al* (n 72 above) 81.

<sup>91</sup> National Population Commission (NPC) & ICF Macro - *Nigeria Demographic and Health Survey* (2009) (n 76 above) 232.

households are more likely to engage in high risk affairs with older men than their wealthier counterparts.<sup>92</sup>

## 2.6 Religious barriers

Due to the culture of silence regarding matters related to sexuality by both religious and cultural gate-keepers in Nigeria, another factor that has continued to influence and affect the use of contraceptives by female adolescents is the issue of religious beliefs. Yusuf and Booth note, given that religion plays a role in human society, that it automatically follows that the religious beliefs of people will influence decisions (including sexuality decisions) adopted in their everyday lives.<sup>93</sup>

In Nigeria, the two major religions practiced by the people - Christianity and Islam - place a great value on the sexual purity of adolescents before marriage. Adolescent girls are not only prevented from obtaining in-depth information on sexuality but are also expected to remain virgins until they enter into marital union.<sup>94</sup> It is rightly acknowledged, as Odimegwu observes, that religion plays the role of a moral custodian in the Nigerian society as evidenced by various religious groups' discouragement of premarital sex. While the success achieved by religion in positively influencing adolescent girls with strong religious beliefs into adopting greater commitment towards sexual abstinence before marriage is noted,<sup>95</sup> the effect of religion on the access to contraception and other SRH care services by non-religious adolescent girls ought to be

<sup>92</sup> K A Oyediran *et al* 'Intergenerational sexual relationship in Nigeria: Implications for negotiating safe sexual practices' in G Letamo (ed) *Social and Psychological Aspects of HIV/AIDS and their Ramifications* (2011) 61, available at [http://cdn.intechopen.com/pdfs/22543/InTech-Intergenerational\\_sexual\\_relationship\\_in\\_nigeria\\_implications\\_for\\_negotiating\\_safe\\_sexual\\_practices.pdf](http://cdn.intechopen.com/pdfs/22543/InTech-Intergenerational_sexual_relationship_in_nigeria_implications_for_negotiating_safe_sexual_practices.pdf) (23 October 2013).

<sup>93</sup> Yusuf & R Booth 'Religious, Ethnic, and Gender Factors Affecting Sexuality' in R T Francoeur & R J Noonan (eds) *The continuum complete international encyclopaedia of sexuality* (2004) 755-756.

<sup>94</sup> It is necessary to point out that in a majority of cases, religious organizations address the issue of adolescent sexuality within the context of faith and abstinence from sexual acts which are deemed as being immoral.

<sup>95</sup> C Odimegwu 'Influence of religion on adolescent sexual attitudes and behaviour among Nigerian university students: Affiliation or commitment?' (2005) 9 *African Journal of Reproductive Health* 126-127; Ankomah *et al* (n 72 above) 82.

taken into consideration as well. According to the writer, while religious adolescents held strict conservative views on the issue of premarital sexual relations, the results generated from the same study reveal that non-religious adolescents were not totally in support of adolescent sexual intercourse only in marriage.<sup>96</sup> Also, as Wusu notes, the role of religion in preventing adolescents from abstaining in sexual intercourse is only effective before the initiation of sex. Once the adolescent has initiated sexual intercourse, religion ceases to be effective in preventing further sexual acts<sup>97</sup> thereby giving rise to a situation where adolescents' access to contraception becomes imperative in order to avoid disastrous consequences.

According to Durojaye, due to the value placed by religion on the issue of sexual purity, female adolescents who either seek to access contraceptive information and services are not only tagged as irresponsible and immoral but are also deemed as being unsuitable for marriage.<sup>98</sup> The above view was corroborated by Oyediran *et al* who note that even in the face of modernisation and its consequences on other cultural practices, the culture of religion still holds sway by maintaining a firm grip on moral values in Nigerian society especially those values relating to sexual practices and behaviour.<sup>99</sup>

The detrimental role played by religion in opposing access to contraception information and services for adolescent girls, especially in the wake of current global HIV and STI epidemic, cannot be over stated. Young girls currently bear the brunt of sexual ill-health occasioned as a result of their ignorance and inaccessibility of contraceptive information and services. HIV prevalence among young Nigerian women aged 15 – 24 years is

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<sup>96</sup> Odimegwu (as above) 133.

<sup>97</sup> O Wusu 'Religion, religiosity and adolescent risky sexual health behaviour in Lagos Metropolis, Nigeria' (2011) 3 *Inkanyiso Journal of Humanities and Social Science* 49-53.

<sup>98</sup> Durojaye 'Realising access to contraception for adolescents in Nigeria' (n 8 above) 93.

<sup>99</sup> Oyediran *et al* (n 92 above) 55.

estimated to be three times higher than that of their male counterparts.<sup>100</sup> The fear of stigma, exposure and punishment is more dominant in the North where sharia is practiced.<sup>101</sup> Unmarried girls caught engaging in sexual activities are subject to severe ridicule and chastisement.<sup>102</sup> According to Ojo, Christian religious beliefs as well have been applied in suppressing and justifying opposition to adolescent pre-marital sexual relations.<sup>103</sup> In fact, the role of religion in influencing contraceptive usage and how contraceptives are sourced was noted by Monjok *et al* who elucidate that Christians of the Catholic faith and Muslims prefer patronising patent medicine shops rather than hospitals as a result of religious objection to the use of modern contraceptive methods.<sup>104</sup>

As noted in the section on socio-cultural barriers, initial stiff opposition by religious and cultural gate keepers to the introduction of sexuality education in Nigerian schools led to the delay in the commencement of the teaching of the FLHE curriculum in schools and resulted in the reduction of the realistic nature of its contents.<sup>105</sup> A major disadvantage of the hold of religion on the sexual practices of adolescent girls is evident in the fact that female adolescents' can refuse to access contraceptive services or use contraception as a result of the stigma and disgrace they will experience if caught attempting to purchase contraception.<sup>106</sup>

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<sup>100</sup> NACA *Women, girls and HIV in Nigeria* available at [http://naca.gov.ng/index2.php?option=com\\_docman&task=doc\\_view&gid=110&Itemid=268](http://naca.gov.ng/index2.php?option=com_docman&task=doc_view&gid=110&Itemid=268) (21 October 2013).

<sup>101</sup> C Pereira *Zina and transgressive heterosexuality in Northern Nigeria* (2005) 5 *Feminist Africa* 60, available at [http://agi.ac.za/sites/agi.ac.za/files/fa\\_5\\_feature\\_article\\_3.pdf](http://agi.ac.za/sites/agi.ac.za/files/fa_5_feature_article_3.pdf) (23 October 2013).

<sup>102</sup> Pereira (as above) 5.

<sup>103</sup> See M Ojo 'Religion and sexuality: Individuality, choice and sexual rights in Nigerian Christianity' quoted by Durojaye 'Realising access to contraception for adolescents in Nigeria' (n 8 above) 93.

<sup>104</sup> Monjok *et al* (n 63 above) 14. See also Ankomah *et al* (n 72 above) 275; UNFPA & USAID – *Contraceptive Security in Nigeria* (n 64 above) 18.

<sup>105</sup> UNESCO - *Levers of success* (n 57 above) 33; Durojaye 'Realising access to contraception for adolescents in Nigeria' (n 8 above) 206.

<sup>106</sup> Enuameh *et al* 'Perceived facilitators and barriers to interventions' (n 48 above) 3351.

## 2.7 Demographic barriers

Another factor which affects access to contraception in Nigeria is the problem of demographic and physical accessibility. Results generated from the 2008 National Demographic and Health Survey on Nigeria<sup>107</sup> and its 2013 counterpart reveal several facts: First, female adolescents from poorer households constitute a greater portion of adolescents with unintended adolescent pregnancies. Second, the percentage of unmarried women (including adolescent girls) using contraception was higher than their married counterparts. Third, the survey also revealed that the use of modern contraception varied according to residence as the percentage of women residing in urban areas using contraception was higher than their rural counterparts<sup>108</sup> and fourth, female adolescents in rural areas have a much higher total fertility rate than girls in urban areas.<sup>109</sup>

The NDHS findings, which associate the relative ease of accessibility to the physical location of health facilities providing family planning services as a factor for higher contraceptive use among urban residents, was also noted by Onwujekwe *et al.*<sup>110</sup> According to the writers, while urban dwellers had more options from which they could access contraception; women (including female adolescents) residing in rural areas mostly rely on patent medicine dealers.<sup>111</sup> These dealers may not provide the best confidential environment for adolescent girls to get contraceptive drugs since every member of the community accesses their contraception from the same source. Automatically, access to modern contraceptive and family planning services are therefore, limited.

<sup>107</sup> National Population Commission (NPC) & ICF Macro - *Nigeria Demographic and Health Survey* (2009) (n 76 above).

<sup>108</sup> National Population Commission (NPC) & ICF Macro - *Nigeria Demographic and Health Survey* (2009) (n 76 above) 69 & 75.

<sup>109</sup> National Population Commission & ICF International *Nigeria demographic and health survey* (2013) 66 – 68 available at <http://dhsprogram.com/pubs/pdf/FR293/FR293.pdf> (24 September 2014).

<sup>110</sup> O Onwujekwe *et al* 'Are modern contraceptives acceptable to people and where do they source them from across Nigeria?' (2013) 13 *International Health and Human Rights* available at <http://www.biomedcentral.com/1472-698X/13/7> (23 October 2013).

<sup>111</sup> Onwujekwe *et al* 'Are modern contraceptives acceptable to people' (as above) 13.

In addition, as noted by Durojaye<sup>112</sup> and Osanyin,<sup>113</sup> besides the problem of physical inaccessibility, the issue of inconvenient operating hours is a barrier to female adolescents' access to contraception. In some instances, not only are health care facilities where contraceptives can be obtained far-away but also that the facilities have operating hours that are inconvenient for adolescents thereby discouraging them from accessing SRH care services, including contraception.<sup>114</sup>

It should be noted that the shortage of qualified health care providers, especially in the country's rural areas, also contributes to the problem of inaccessibility to contraception. Adolescent girls who live in rural areas are disadvantaged by the lack of qualified health practitioners who can ensure that female adolescents not only have access to contraceptives but also ensure that they are given contraceptives that is suitable for their body type after carrying out the necessary health checks and examinations.<sup>115</sup>

## 2.8 Conclusion

This section has analysed how various factors contribute towards adolescent girls' non-access to contraceptive information and services in Nigeria. While responsibility for fixing problems associated with legal, economic accessibility and demographic barriers rest solely on the shoulders of Nigeria's government, it is the view that resolving the problem of female adolescents' contraceptive non-usage due to socio-cultural and religious impediments rests on both the society and the government.

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<sup>112</sup> Durojaye 'Realising access to contraception for adolescents in Nigeria' (n 8 above) 100.

<sup>113</sup> Osanyin (n 78 above) 12.

<sup>114</sup> Ankomah *et al* (n 72 above) 278.

<sup>115</sup> It should be noted that the availability of modern contraceptive methods in rural areas is usually limited and affected by existing weak distribution chain which causes situations where even the few primary health centres and SRH care centres in rural areas experience weeks of being out of contraceptive stock. See Family Health International -The effectiveness of community-based access to injectable contraceptives in Nigeria (n 77 above) 11.

In this instance, it is submitted that the government needs to organise serious media- and awareness-raising campaigns, in collaboration mainly with religious and community leaders who wield great influence over their people. In order to bring about the achievement of better results with religious and community leaders, it is felt that there is a need first to make them realise the disastrous effects that have been fuelled and occasioned as a result of the adoption of unrealistic decisions in the past. To achieve this objective, the government will need to present current facts and figures on teenage pregnancy and HIV and AIDS relating to adolescent girls in comparison not only with those of their male counterparts but also their contemporaries in other nations with better statistics. It is expected that organising continuous consultations with societal and religious gate-keepers and relentless awareness-raising crusades will gradually pave way for attitudinal and social change in relation to adolescent sexuality issues, including their use of contraceptives.

In relation to the issue of economic barriers which prevent adolescent girls from accessing and using contraception, as noted in the case of Nigeria, the difficulty is two-fold: young girls have to grapple with the problem of the un-affordability of family planning services, on one hand, and, the fact that due to poverty, they engage in transactional/inter-generational sexual relationships where they can neither negotiate safer sexual practices nor condom use on the other. As noted by Onwujekwe *et al*<sup>116</sup> and Osanyin,<sup>117</sup> paying for contraceptives out-of-pocket is a major deterrence for modern contraceptive use for adolescent girls. There is a need for the Nigerian government to be more proactive in ensuring the availability of free contraceptives for adolescent girls in all circumstances. The process of ensuring the availability, affordability and accessibility to contraceptives should go beyond the Nigerian

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<sup>116</sup> Onwujekwe 'Are people really using modern contraceptives' (n 70 above) 3 & 4. See also Ankomah *et al* (n 72 above) 278.

<sup>117</sup> Osanyin (n 78 above) 7 & 14.

government's 2011 policy announcement removing the payment of user fees for family planning services in public hospitals, to include active monitoring of public health care facilities (PHCs inclusive) to ensure that the contraceptives are actually provided free of charge.

In the next section, the barriers that prevent South African female adolescents from accessing contraceptive information and services are discussed.

### 3 Barriers to female adolescents' access to contraceptive information and services in South Africa

#### 3.1 Introduction

Regardless of the progressive efforts in guaranteeing their access to contraceptives and other SRH care services in fulfilment of the country's constitutional and human rights obligations,<sup>118</sup> female adolescents in South Africa, like Nigerian adolescents, encounter barriers which affect their access to contraception and result in alarmingly high teenage pregnancy rates.<sup>119</sup>

As in the section on Nigeria, the intention in this section is to examine the barriers which affect adolescent girls' access to available and accessible contraceptive information and services in South Africa.

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<sup>118</sup> Sec 27(a) Constitution of the Republic of South Africa; Art 12 ICESCR; arts 24(1) & 24(2)(f) CRC; art 16 African Charter ; art 14 ACRWC; art 14 African Women Protocol.

<sup>119</sup> Although when compared with other countries in the sub-Saharan African region, South Africa has lower adolescent pregnancy rates and more favourable health indicators, the problem of adolescent pregnancy still exists and remains unacceptably high. See World Bank Data on Adolescent fertility rate (births per 1,000 women ages 15-19) available at <http://data.worldbank.org/indicator/SP.ADO.TFRT> (26 October 2013); UNFPA country indicators – South Africa in *The state of the world's midwifery 2011* available at [http://www.unfpa.org/sowmy/resources/docs/country\\_info/profile/en\\_SouthAfrica\\_SoWMy\\_Profile.pdf](http://www.unfpa.org/sowmy/resources/docs/country_info/profile/en_SouthAfrica_SoWMy_Profile.pdf) (24 June 2013); S Panday *et al Teenage pregnancy in South Africa with a specific focus on school-going learners* (2009) 12, available at <http://www.education.gov.za/LinkClick.aspx?fileticket=ulqj%2BsyccM%3D&> (27 October 2013).

### 3.2 Legal barriers

The setting of a specific age of consent for the initiation of sexual activities, including sexual intercourse, is common in African countries and South Africa is no exception.<sup>120</sup> Under South African law people under the age of 18 years are legally recognised as children,<sup>121</sup> who are entitled not only to the special protections guaranteed under the Constitution<sup>122</sup> and the Children's Act,<sup>123</sup> but are deemed as possessing limited legal capacity to act independently without the assistance of adults.<sup>124</sup> On the other hand, recognising the provisions of international human rights treaties on the protection of the rights of the child, especially in relation to the evolving capacities and best interests of children, the same Constitution and the Children's Act allow for instances where children can consent and make independent decisions without parental or adult involvement.<sup>125</sup>

A major point of departure under the law, however, relates to the issue of adolescent consent to sexual activities as the provisions of the Criminal Law (Sexual Offences and Related Matters) Amendment Act<sup>126</sup> create age limits where consent to sexual relations cannot be given, irrespective of circumstances.<sup>127</sup> According to the provisions of the

<sup>120</sup> Ngwena 'Sexual health and human rights in the African Region' (n 17 above) 119.

<sup>121</sup> Sec 28(3) Constitution of the Republic of South Africa & sec 17 Children's Act.

<sup>122</sup> Sec 28 Constitution of the Republic of South Africa. Apart from the protection under section 28, children are also generally entitled to protection afforded adults under the constitution.

<sup>123</sup> Secs 7 -14 Children's Act.

<sup>124</sup> A Strode *et al* 'Child consent in South African law: Implications for researchers, service providers and policy-makers' (2010) 100 *South African Medical Journal* 247.

<sup>125</sup> Readily examples of circumstances where children can make independent decisions and therefore give consent include situations pertaining to medical treatments including HIV testing, access to contraception and termination of pregnancy services among others. See, generally, secs 129, 130, 134 Children's Act; sec 5 COTPA Act.

<sup>126</sup> The Criminal Law (Sexual Offences and Related Matters) Amendment Act No. 32 of 2007 which came into effect in December 2007 replaced the Sexual Offences Act 23 of 1957 and makes provisions for the prosecution and punishment of sexual offenders for sexual crimes committed after the promulgation date. See Criminal Law (Sexual Offences and Related Matters) Amendment Act No. 32 of 2007.

<sup>127</sup> Secs 1, 15(1), 16(1) & 15(1) Criminal Law (Sexual Offences and Related Matters) Amendment Act. According to the Act, notwithstanding anything to the contrary, a child who is below 12 years is totally incapable of consenting to sexual activities. It is necessary to point out from the onset that by virtue of the recent

Act, sexual intercourse with children below the age of 16 attracts criminal punishment as the law presumes that these children are incapable of consenting to sex.<sup>128</sup>

Whilst the reason for enacting the Criminal Law (Sexual Offences and Related Matters) Amendment Act, which is based upon the recognition of the susceptibility of women and young children (including adolescents) in South Africa to sexual abuse and exploitation, is understood,<sup>129</sup> the fact that the Act not only criminalises consensual sexual acts between adolescents within the age group of 12-16 years but also mandates compulsory reporting of the occurrence of the sexual act to an enforcement officer, has the potential for serious consequences.<sup>130</sup>

As noted by Perumal, prosecuting adolescents between the ages of 12 and 16 for sexual activities which normally occur due to curiosity and the need to experiment is an anomaly and not in the best interests of adolescents within the affected age-group as

decision of the Constitutional Court in *Teddy Bear Clinic for Abused Children and Another v Minister of Justice and Constitutional Development and Another* (CCT 12/13) [2013] ZACC 35, the sections have been declared unconstitutional in relation to consensual sex between adolescents between the ages of 12 and 16 years.

<sup>128</sup> In spite of provisions of the law, it is necessary to point that evidence has constantly revealed that adolescents below the age of 16 engage in sexual intercourse. See D Perumal 'Misguided reform: Regulating consensual sexual activity between adolescents in South African law from a gender perspective' (2013) 27 *Agenda* 2, available at <http://www.tandfonline.com/doi/pdf/10.1080/10130950.2013.849789> (28 October 2013); T M Mothiba & M S Maputle 'Factors contributing to teenage pregnancy in the Capricorn district of the Limpopo Province' (2012) 35 *Curatonia* 4, available at <http://www.curationis.org.za/index.php/curationis/article/viewFile/19/61> (27 October 2013); D U Ramathuba *et al* 'Knowledge, attitudes and practice of secondary school girls towards contraception in Limpopo Province' (2012) 35(1) 1, available at <http://www.curationis.org.za/index.php/curationis/article/viewFile/45/64> (27 October 2013); N Manzini 'Sexual Initiation and Childbearing among Adolescent Girls in KwaZulu Natal, South Africa' (2001) 9 *Reproductive Health Matters* 44.

<sup>129</sup> See generally, the preamble to the Criminal Law (Sexual Offences and Related Matters) Amendment Act 2007.

<sup>130</sup> The requirement to report consensual sexual acts between adolescents to enforcement officers for possible prosecution is catastrophic as the affected adolescents will not only be subjected to the operation of the criminal justice system as they can be arrested, prosecuted and even sentenced but they will also be subject to public ridicule and embarrassment for private consensual actions which can be effectively resolved by parents through counselling, advice and communication. See secs 15, 16, 50, 54 and 55 Criminal Law (Sexual Offences and Related Matters) Amendment Act; Perumal (n 128 above) 3; D McQuoid-Mason 'Mandatory reporting of sexual abuse under the Sexual Offences Act and the 'best interests of the child' (2011) 4 *South African Journal of Bioethics and Law* 74-78.

the adolescent's journey towards adulthood involves the passing through of important biological high points, including sexual initiation which is necessary for the development of sexual maturity and identity.<sup>131</sup>

Due to the reason that the portion of the Criminal Law (Sexual Offences and Related Matters) Amendment Act which criminalised consensual sexual activities between adolescents with a two year difference between them not only violated the right of adolescents to dignity, privacy, bodily and psychological integrity and reproductive health decision-making but also breached the constitutional mandate of protecting and regarding the best interests of children as paramount in all circumstances<sup>132</sup> as previously confirmed in numerous decisions of the South African Constitutional Court,<sup>133</sup> the case of *Teddy Bear Clinic for Abused Children and RAPCAN v Minister of Justice and Constitutional Development and Another*<sup>134</sup> was initiated in the Gauteng High Court in order to declare unconstitutional the provisions of sections 15, 16 and 56(2)(b) as applied to adolescents between the ages of 12 and 16 who engage in consensual sexual intercourse. According to the applicants, the affected provisions could neither be justified in terms of the provision of section 36 of the 1996 Constitution on the limitation of rights,<sup>135</sup> nor did it did take cognisance of the fact that the period of adolescence, being a developmental stage when adolescents explore, including sexual matters, requires careful balancing in order to ensure that while adolescents are

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<sup>131</sup> Perumal (n 128 above) 2. See also *S v M (Centre for Child Law as Amicus Curiae)* 2008 (3) SA 232 (CC) para 19.

<sup>132</sup> Sec 28(2) Constitution of the Republic of South Africa 1996.

<sup>133</sup> *Minister of Welfare and Population Development v Fitzpatrick* 2000 (3) SA 422 (CC) para 17; *Van Deijl v Van Deijl* 1966(4) SA 261 H; *Christian Education South Africa v Minister of Education* 2000 (4) SA 757 (CC) para 38.

<sup>134</sup> *Teddy Bear Clinic* case (n 41 above).

<sup>135</sup> *Teddy Bear Clinic* case para 25.

protected from undue sexual harm, they are also given the space for healthy sexuality development and autonomous growth.<sup>136</sup>

The negative effect<sup>137</sup> that will result from the continued implementation of the provisions of sections 15 and 16 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act led Rabie J to declare the offending sections incompatible with the intent of the Constitution of the Republic of South Africa and, therefore, unconstitutional.<sup>138</sup> After the High Court's judgement, the matter was further referred to the country's Constitutional Court for confirmation, in accordance with the provisions of section 172(2) (a) which requires:

the Supreme Court of Appeal, a High Court or a court of similar status may make an order concerning the constitutional validity of an Act of Parliament, a provincial Act or any conduct of the President, but an order of constitutional invalidity has no force unless it is confirmed by the Constitutional Court.<sup>139</sup>

At the Constitutional Court, the applicants acknowledged that although the provisions in question were enacted to protect children, they were of the opinion that the way it was couched violated children's rights to dignity and privacy among others, and had the potential of harming the very children the Act intended to protect.<sup>140</sup> Further, the applicants argued that there are less restrictive means of achieving the same results.<sup>141</sup> On the other hand, the respondents argued that rather than infringing rights, the statutory prohibitions functioned to advance and protect children's rights by delaying

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<sup>136</sup> Perumal (n 128 above) 2.

<sup>137</sup> As a result of the offending sections in the Act, children not only will be exposed to all kinds of SRH risks as they will refuse to access contraceptive services but health care providers will also be put in a placed in quagmire as they will be forced to go against their professional duty of keeping the confidence of their young patents due to the reporting provisions in the Act. See McQuoid-Mason (n 130 above) 74-78.

<sup>138</sup> *Teddy Bear Clinic* case (n 41 above) para 27.

<sup>139</sup> Sec 172(2) (a) Constitution of the Republic of South Africa.

<sup>140</sup> *Teddy Bear Clinic* case (n 41 above) paras 28.

<sup>141</sup> *Teddy Bear Clinic* case paras 28-30.

the choice to engage in consensual sexual activities and were therefore, reasonable and justifiable within the meaning of section 36.<sup>142</sup>

After listening to both sides, the Court, through Khampepe J, remarked that children as individual rights-bearers enjoy each of the fundamental rights granted to ‘everyone’ in the Constitution.<sup>143</sup> Also, in agreement with the expert evidence submitted, the Court took note that:

during adolescence children ordinarily engage in some form of sexual activity, ranging from kissing to masturbation to intercourse. Exploration of at least some of these activities is “potentially healthy if conducted in ways for which the individual is emotionally and physically ready and willing.” What is of utmost importance is ensuring that children are appropriately supported by the adults in their lives, to enable them to make healthy choices. This is particularly so given the awkwardness and embarrassment children often feel when discussing sexual relations with adults. If children are not made to feel that there are safe environments within which they can discuss their sexual experiences, they will be stripped of the benefit of guidance at a sensitive and developmental stage of their lives. Such guidance is particularly important given the “high rates of negative experiences and consequences of sexual behaviour” unearthed by the expert report.<sup>144</sup>

In addition, the Court further observed that children charged with statutory rape under the provisions of sections 15 or 16 will feel a ‘mixture of shame, embarrassment, anger, and regret’ which will not only negatively impact their development by inhibiting and preventing them from seeking help on sexual issues, but will instead contribute to social taboos and silences surrounding adolescent sexuality and also disable adults from providing appropriate and helpful guidance and support that will assist in promoting adolescents’ growth and development thereby giving rise to increase in adolescent risky behaviours and outcomes.<sup>145</sup>

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<sup>142</sup> *Teddy Bear Clinic* case para 31.

<sup>143</sup> *Teddy Bear Clinic* case paras 38 & 40.

<sup>144</sup> *Teddy Bear Clinic* case para 45.

<sup>145</sup> *Teddy Bear Clinic* case paras 47 & 89.

Finally, confirming the High Court's decision on the unconstitutionality of sections 15 and 16 and their unjustifiability in terms of section 36 to the extent of the imposition of criminal liability on children under the age of 16 years, the Constitutional Court stated that there are in existence other methods that encourage adolescents to discuss sex/sexual health with their parents and enable them access comprehensive sex education and services. According to the court these non-criminal methods have greater positive influence on adolescent sexual behaviour.<sup>146</sup>

### 3.3 Socio- cultural barriers

A major problem which affects female adolescents' use of contraceptive services in South Africa is rooted in social-cultural beliefs which entrench patriarchy and encourage gender inequality. In spite of the existence of progressive laws and policies which assure adolescent girls unfettered access to confidential SRH care information and services, including the right to make autonomous reproductive health care decisions,<sup>147</sup> South Africa still records a high rate of teenage pregnancies. Research reveals that about 30% of 19 year-olds are not only teenage mothers, either as a result of their ineffective use of contraception or non-utilisation of available contraceptive services,<sup>148</sup> but, that like their counterparts in Nigeria and the rest of sub-Saharan Africa, South African female adolescents also constitute a larger percentage of adolescents infected with HIV<sup>149</sup>

As a result of gender attitudes, while the sexual activities of adolescent boys are acknowledged based upon the opinion that boys will always experiment with sex,

<sup>146</sup> *Teddy Bear Clinic* case paras 98-102, & 117(1).

<sup>147</sup> Secs 12(2) & 27(1)(a) Constitution of the Republic of South Africa; sec 134 Children's Act; sec 5(1)(2) & (3) COTP.

<sup>148</sup> P Mudhovozi *et al* 'Adolescent sexuality and culture: South African mothers' perspective' (2012) 16 *African Sociological Review* 119; Mothiba & Maputle (n 128 above) 1; Ramathuba *et al* (n 128 above) 1-2 .

<sup>149</sup> UNFPA *HIV prevention: Fact sheet* (2012) available at [http://countryoffice.unfpa.org/filemanager/files/southafrica/HIV\\_Prevention\\_Fact\\_Sheet%20.pdf](http://countryoffice.unfpa.org/filemanager/files/southafrica/HIV_Prevention_Fact_Sheet%20.pdf) (28 October 2013).

teenage girls are kept under close surveillance in order to restrain them from exploring their sexuality. However, as Jewkes *et al* observe, evidence on the age of adolescent girls at first encounter with sex and the preponderance of teenage pregnancy reveal that neither the surveillance nor moral authority of mothers is usually enough to prevent it.<sup>150</sup>

A number of factors contribute to female adolescents' non-use of contraceptives in the country. One of these factors relates to cultural beliefs (especially within black communities) which prevent young women from gaining information about sexuality as it is regarded as culturally inappropriate for parents to share or discuss sexual information with their children.<sup>151</sup> The above situation was noted by Ngwena *et al* who explain that while the home is traditionally meant to be the primary environment for socialisation, with parents assuming a principal role in the guidance of their children's transition from childhood to adulthood in all areas including in relation to sexuality, in African communities the reverse is the case.<sup>152</sup> According to them, parents are inclined to play lesser roles in the passing on of sexual education to their adolescents as it is regarded as a taboo to discuss sexuality issues in public and parents are embarrassed to discuss such matters with their children.<sup>153</sup>

Recently, a study conducted among mothers drawn from the VhaVenda ethnic group, who were of different educational backgrounds and had adolescent daughters aged between 12 and 19 years, revealed that the participants not only refused to view adolescent sexuality as an inevitable phase of development but also regarded sexuality

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<sup>150</sup> R Jewkes *et al* 'Empowering teenagers to prevent pregnancy: lessons from South Africa (2009) 11(7) *Culture, Health & Sexuality* 678 & 679.

<sup>151</sup> Ramathuba *et al* (n 128 above).

<sup>152</sup> C Ngwena *et al* *Assessing termination of pregnancy by minors in the Free State: Identifying barriers and possible interventions* (2005) 20, available at [http://humanities.ufs.ac.za/dl/userfiles/Documents/00000/198\\_eng.pdf](http://humanities.ufs.ac.za/dl/userfiles/Documents/00000/198_eng.pdf) (29 October 2013).

<sup>153</sup> Ngwena *et al* 'Assessing termination of pregnancy by minors' (as above) 20.

communication as inciting adolescents with sexual ideas and encouraging disrespect.<sup>154</sup> In the same study, although it was acknowledged that female adolescents were involved in sexual activities, majority of the participants still expressed conservative attitudes towards the use of contraceptive by female adolescents'.<sup>155</sup> The views expressed ranged from:

'I will never encourage her to use contraceptives because they are not good especially for young people.' 'I would discourage her to even think about using contraceptives and I will tell her that they are bad'

to:

'If she wants to use contraceptives, she can use them but it would be without my approval and my knowledge because if she asked me I will not allow it'.<sup>156</sup>

The lack of communication (as a result of socio-cultural beliefs) on family planning and contraceptive use between female adolescents' and their parents is a major stumbling block which usually results in unplanned pregnancies. Female adolescents are either afraid of the negative reactions which their questions might evoke or believe that they may become the object of ridicule and embarrassment in the family. In the words of a female adolescent who participated in a study on the factors that impact on the use of contraceptives among youths in the northern Tshwane area: *'it's not always easy to discuss sexuality issues and contraception with your parents ... my mother is more approachable than my father ... but I don't just have the guts to start these topics with my parents as they always think that we are children who do not have sexual needs ... and must be obedient as long as you are dependent on them'*.<sup>157</sup> Here, the negative effect which parental non-communication as a result of cultural beliefs has on

<sup>154</sup> Mudhovozi *et al* (n 148 above) 127-128.

<sup>155</sup> Mudhovozi *et al* (as above) 128 & 130.

<sup>156</sup> Mudhovozi *et al* (as above) 130 & 131.

<sup>157</sup> T M M Maja 'Factors impacting on contraceptive use among youth in Northern Tshwane: Part 2' (2007) 12 *Health SA Gesondheid* 43 & 44. See also R T Lebeso *et al* 'Teenagers' experiences of sexual health dialogue in the rural villages of the Vhembe District, Limpopo Province' (2011) 16 *Health SA Gesondheid* 7.

adolescents is revealed, as the girls will prefer to have unprotected sex rather than visit health centres to access contraceptives and risk the information getting back to their parents.

Apart from the issue of non-parental support of contraceptive utilisation, it is important to point out that even though adolescents require knowledge before they can consider using contraceptives, knowledge alone might still not be enough as cultural perceptions and stigma may still colour adolescents acceptability of and use of contraception. Some studies reveal that even though South African adolescents acknowledged that they have access to contraceptive information and services, they still prefer not using contraception, either as a result of the fear of complications and parental detection or because it was felt that using contraceptives resulted in irregular bleeding or caused weight gain.<sup>158</sup> According to MacPhail, due to misconceptions, in a majority of instances the use of contraception is usually associated with a previous adolescent pregnancy.<sup>159</sup>

This was noted in a study where an adolescent explained:

‘If you're not on the injection, the blood stays somewhere next to the womb, and if you don't conceive that month, the blood can get out; but if you use Nur-isterate, this blood doesn't pass easily to the place next to the womb, and it means your body will never be as it was before, and this blood prevents you from ever falling pregnant.’<sup>160</sup>

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<sup>158</sup> Mothiba & Maputle (n 128 above) 4; Partners in Sexual Health *A review of teenage pregnancy in South Africa: Experiences of schooling, and knowledge and access to sexual & reproductive health services* (2013) 26 & 27.

<sup>159</sup> C MacPhail ‘Contraception use and pregnancy among 15–24 year old South African women: a nationally representative cross-sectional survey’ (2007) 5 *BMC Medicine* available at <http://www.biomedcentral.com/1741-7015/5/31> (29 October 2013).

<sup>160</sup> Nur-Isterate is a hormonal contraceptive which protects against conception through its suppression of ovulation and alteration of the cervical mucus in females so as to impair sperm movement into the uterine cavity. See K Wood & R Jewkes ‘Blood Blockages and Scolding Nurses: Barriers to Adolescent Contraceptive Use in South Africa’ (2006) 14 *Reproductive Health Matters* 113.

Additionally, although adolescent pregnancies are often the result of sexual risk-taking,<sup>161</sup> a common factor which influences the high rate of teenage pregnancies and contraceptive non-use is the problem of gender imbalance as, a partner's dislike or disapproval of contraceptives or desire to have a child to prove his fertility is enough reason not to use contraception.<sup>162</sup>

Finally, other factors which influence contraceptive use include the issue of trust as adolescent girls in stable or long term relationship tend to disregard the use of contraception, unlike their counterparts who engage in casual sex.<sup>163</sup> Despite the fact that adolescent girls bear the brunt of teenage pregnancies, taking steps to protect themselves through the use of contraception is culturally volatile as she is neither able to suggest the use of condoms to her partner for fear of being branded as being of loose morals, nor can she attempt to visit neighbourhood family planning clinics for fear of been seen and reported to her parents.<sup>164</sup> As a result, adolescent girls who wish to avoid pregnancy, as Varga suggests, are placed in a no-win situation.<sup>165</sup>

South Africa submitted a combined report in 2010. In its concluding observation on the report, the committee expressed concern about the extent of HIV epidemic, including the fact that women and girls were disproportionately affected. The necessity for the South African government to increase awareness-raising campaigns and education that

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<sup>161</sup> Enuameh *et al* (n 48 above) 3338; Mothiba & Maputle (n 128 above) 4; V J Ehlers 'Adolescent mothers' knowledge and perceptions of contraceptives in Tshwane, South Africa' (2003) 8 *Health SA Gesondheid* 20.

<sup>162</sup> Maja (n 157 above) 33; E M Yako & J M Yako 'A descriptive study of the reasons and consequences of pregnancy among single adolescent mothers in Lesotho' (2007) 30 *Curatiosis* 77.

<sup>163</sup> PEPFAR *et al* Key findings of the third South African National HIV Communication Survey (2012) 3, available at <http://www.hivsharespace.net/system/files/ZANationalHIVCommunicationSurvey2012.pdf> (3 November 2013).

<sup>164</sup> Varga (n 48 above) 164; Maja (n 157 above) 44-45.

<sup>165</sup> Varga (n 48 above) 164. In most cases, adolescent mothers only begin using contraceptives after they have fallen into the trap of unintended pregnancy. See MacPhail *et al* (n 159 above) 5; C X Williams & T R Mavundla 'Teenage mothers knowledge of sex education in a general hospital of the Umtata District (1999) 22 *Curatiosis* 59.

will be of benefit to women (including adolescent girls) and improve access to health care services was also noted.<sup>166</sup>

In its concluding observation to South Africa's report in 2011, the CEDAW Committee expressed concern about the HIV epidemic, noting that adolescent girls and women were disproportionately affected unlike their male counterparts. It urged the South African government to increase enlightenment campaigns and education that will be of benefit to women (including adolescent girls). The importance of improving access to health care services to vulnerable and disadvantaged groups such as adolescent girls was also noted.<sup>167</sup>

### 3.4 Systemic and health provider bias

Additionally, another impediment to female adolescents' use of contraceptives is that health care providers are either high-handed as they forcefully impose a particular type of contraceptive which they perceive as the most reliable form of contraception for the adolescents, or embarrass and stigmatise the girls by asking questions which reflect their bias against providing contraceptive to young girls, thus making the girls ashamed and reluctant to go back for further services. In some instances the providers even give incorrect information which frightens adolescent girls away from using contraceptives.<sup>168</sup>

As a result of the hostile attitude of health care providers and their exhibition of impatience in giving information on contraception to adolescents, female adolescents use contraceptives incorrectly. A study revealed that while adolescent girls sometimes

<sup>166</sup> Paras 36 & 38 concluding observation of the CEDAW Committee on South Africa 2011 CEDAW/C/ZAF/CO/4, available at [http://www.iwraw-ap.org/committee/pdf/48\\_concluding\\_observations/southafrica.pdf](http://www.iwraw-ap.org/committee/pdf/48_concluding_observations/southafrica.pdf) (28 February 2013).

<sup>167</sup> Paras 36 & 38 Concluding observations of the CEDAW Committee on South Africa 2011 CEDAW/C/ZAF/CO/4, available at [http://www.iwraw-ap.org/committee/pdf/48\\_concluding\\_observations/southafrica.pdf](http://www.iwraw-ap.org/committee/pdf/48_concluding_observations/southafrica.pdf) (23 September 2014).

<sup>168</sup> Wood & Jewkes (n 160 above) 111 & 113.

limit contraceptive use to when partners visit, others resort to taking a half dosage of contraception in order to reduce weight gain, thereby decreasing the effectiveness of the contraceptive method and increasing the chances of experiencing an unintended pregnancy.<sup>169</sup>

The position on the impatience of health care workers in giving adolescents information on contraceptive use mentioned above was also confirmed in a stimulated study on adolescents' access to youth friendly services in South Africa. The study revealed that health care providers tended to feel that they were wasting valuable time in providing contraceptive information to adolescents who could access such information from pamphlets outside when they had to attend to many people waiting to receive contraceptive injections. Also that, sometimes, the health care workers adopted medically unnecessary protocols, such as mandating female adolescents' who wish to use contraception to come back only when they have started their periods with 'evidence to show'. This action is contrary to provisions contained in the *National Contraception and Fertility Planning Policy and Service Delivery Guidelines* which provide that the timing of initiation of hormonal contraceptives should not be restricted to menstruation since the use of contraceptives does not terminate existing pregnancies thereby creating unnecessary impediments which affect adolescents' initiation of contraception.<sup>170</sup>

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<sup>169</sup> Panday *et al* (n 119 above).

<sup>170</sup> R S Geary *et al* *Youth friendly services? Using stimulated clients to evaluate sexual health services in South Africa* (2013) 10 -11, available at [http://www.iussp.org/sites/default/files/event\\_call\\_for\\_papers/Youth%20Friendly%20Services%3F%20Using%20simulated%20clients%20to%20evaluate%20sexual%20health%20services%20in%20urban%20South%20Africa.pdf](http://www.iussp.org/sites/default/files/event_call_for_papers/Youth%20Friendly%20Services%3F%20Using%20simulated%20clients%20to%20evaluate%20sexual%20health%20services%20in%20urban%20South%20Africa.pdf) (31 October 2013).

### 3.5 Economic barriers

Since 1994, the South African government, has not only adopted reproductive health care policies that are admired and praised as among the world's most progressive,<sup>171</sup> but has also consistently earned recognition as a global leader in the incorporation of human rights standards into domestic law.<sup>172</sup>

Towards the fulfilment of the right to reproductive health care of its people, South Africa guarantees access to free contraception (and other health care services) in public health facilities. Also, it has extended its commitment with the creation of mobile clinics to provide primary health care services to under-served and remote rural areas so as to ensure that comprehensive contraceptive and fertility management services are generally accessible to adults and adolescents alike.<sup>173</sup> It is necessary to point out that the South African position is unlike the situation in Nigeria where contraceptive non-affordability is a barrier to contraceptive use by adolescents.<sup>174</sup>

Despite the fact that contraceptives are freely and widely available in South African public hospitals and primary health centres, a major factor which continues to fuel the non-use of contraceptives among female adolescents in South Africa is the issue of economic barriers caused by poverty.

African society reveals the existence of vast socio-economic disparities<sup>175</sup> which ultimately influence female adolescents' adoption of dangerous sexual behaviours. As

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<sup>171</sup> Maharaj & Rogan (n 9 above) 3.

<sup>172</sup> Ngwena 'Sexual health and human rights in the African Region' (n 17 above) 20.

<sup>173</sup> See, generally, National Contraception and Fertility Planning Policy and Service Delivery Guidelines 2012 (n 9 above).

<sup>174</sup> Despite the Nigerian government's directive in 2011 that the payment of user-fees for contraceptives be removed, it is unclear whether the directive has been totally obeyed in the country. See Nigeria *Country Implementation Plan for Prioritized Life-Saving Commodities for Women and Children* (n 80 above); UNFPA *Nigeria - Contraceptive logistics management system assessment report* (n 74 above) 31-32.

<sup>175</sup> As a result of the injustice and unfairness of the apartheid era, massive inequities in income and health status exist in South Africa with the population divided into haves and have-nots. The existence of a large

Brooks<sup>176</sup> explains, adolescent girls who live in poverty tend to be more vulnerable to adopting risky sexual behaviours than their wealthier counterparts as a result of their lack of economic empowerment which makes it impossible for them to negotiate safer sexual behaviours, including condom use.<sup>177</sup> Also, socio-cultural norms which link gender, love and exchange together do not help as; instead, they stimulate adolescent girls' willingness to have sex with older men in exchange for money to support not only their immediate economic needs but also their desire to acquire 'luxury' goods for 'improved' social status. In research on transactional relationships between taxi sugar daddies and taxi queens,<sup>178</sup> it was revealed that the relationship between both parties is one that creates 'status'. Taxi drivers who have young girlfriends are, usually, the subject of admiration from other men, while adolescent girls in such relationships are regarded as being 'cool' and admired by their friends.<sup>179</sup>

The increase in the practice of transactional or inter-generational sex among South African female adolescents was aptly noted by Potgieter *et al* who explain that the 2009 *National HIV Prevalence, Incidence, Behaviour and Communication Survey* specifically identified the increase in the practice of intergenerational sex as a significant factor which contributes to female adolescents' risk and vulnerability to HIV infection.<sup>180</sup>

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number of poor people, which invariably includes adolescent girls from poor households, fuels the practice of intergenerational sex or sex in exchange of cash.

<sup>176</sup> D W Brook 'South African adolescents: Pathways to risky sexual behaviour' (2006) 18 *AIDS Education and Prevention* 259-272.

<sup>177</sup> Brook (as above) 261-262. See also Luke & Kurz (n 86 above) 3-5.

<sup>178</sup> The term 'taxi sugar daddies' and 'taxi queens' is used to denote taxi drivers who are involved in transactional sexual relations with adolescent girls and vice versa. See C Potgieter *et al* 'Taxi 'sugar daddies' and taxi queens: Male taxi driver attitudes regarding transactional relationships in the Western Cape, South Africa' (2012) 9 *Journal of Social Aspects of HIV/AIDS* 192-199.

<sup>179</sup> Potgieter *et al* (as above) 195.

<sup>180</sup> In the survey, it was noted that the percentage of young women with older sexual partners (more than five years) had increased from 18.5% in 2005 to 27.6% in 2008. Potgieter *et al* (as above) 193 & 195. Also, in the *Millennium Development Goals Country Report 2010*, the South African government took note of the fact that young women and adolescents were more vulnerable to HIV as HIV prevalence among women peaks at 25 to 29 years unlike males where HIV prevalence peaks more slowly at 30 to 39 years. See STATSSA & UNDP *Millennium Development Goals Country Report* (2010) available at

### 3.6 Religious barriers

In Africa, like other regions in the world, apart from cultural beliefs and traditions which affect women's fertility and contraceptive use, the religious beliefs of women (adolescent girls inclusive), also generally influences their uptake of contraception. Primarily, this behaviour is based upon the belief that children, being gifts from God, cannot be rejected. Gender-based inequalities incorporate the belief that men should control the sexuality of women. Women (adolescent girls inclusive) who attempt to push for contraceptive use are at risk of being branded promiscuous and adulterous. As noted in the case of Nigeria, in South Africa, religious beliefs also affect adolescents' use of contraception.

Religion, when applied positively through the organisation of educative seminars which seek to encourage adolescent girls to adopt healthier SRH life styles, may be advantageous, as explained by Mbokane, in response to the observations by Murray *et al* and Makhetha, who state that religious adolescents tend to delay engaging in pre-marital sexual activities.<sup>181</sup> However, the negative effect of religion as a barrier to contraceptive use can be gleaned from Mash *et al* who made clear that a majority of religious communities not only associate the use of condoms and contraceptives with immoral and sinful behaviour,<sup>182</sup> but some communities also preach that the use of contraception 'punctures and spoils the eggs'.<sup>183</sup> Thereby, they contribute to the unfounded belief that the use of family planning methods could result in future infertility and scare girls from using it.

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[http://www.statssa.gov.za/news\\_archive/Docs/MDGR\\_2010.pdf](http://www.statssa.gov.za/news_archive/Docs/MDGR_2010.pdf) (3 November 2013). See also Department of Health & Medical Research Council *South Africa Demographic and Health Survey* (2003) 158, available at <http://www.measuredhs.com/pubs/pdf/FR206/FR206.pdf> (3 November 2013).

<sup>181</sup> A N Mbokane 'The utilisation of contraceptives by women who requested termination of pregnancy services in the Gert Sibande District (Mpumalanga)' University of South Africa (2004) 39.

<sup>182</sup> R Mash *et al* 'Why don't you just use a condom?': Understanding the motivational tensions in the minds of South African women' (2010) 2 *African Journal of Primary Health Care and Family Medicine* 79-82.

<sup>183</sup> Wood & Jewkes (n 160 above) 111.

### 3.7 Demographic barriers

Despite a general decline in South Africa's fertility trend and increase in contraceptive prevalence rates which is comparable to rates globally;<sup>184</sup> the problem of teenage pregnancy still remains. According to results from the 2003 South African Demographic Health Survey, while the proportion of teenagers (15-19 year old) who had begun childbearing had reduced to 27% from that the 1998 survey which stood at 35%,<sup>185</sup> data generated from the same survey revealed that being a teenage mother was more prevalent in non-urban areas and that there was greater possibility of condoms use at first sex in the urban areas.<sup>186</sup>

As the a survey shows and in spite of the fact that there are currently in existence mobile clinics which assist in ensuring health care (including contraceptives and other SRH care services) delivery to people residing in remote communities in the country,<sup>187</sup> it is uncontroversial that there is still room for improvement because remote rural are still greatly underserved.<sup>188</sup>

<sup>184</sup> Statistics South Africa Midyear population estimates (2013) 5, available at <http://www.statssa.gov.za/publications/P0302/P03022013.pdf> (2 November 2013); N Peer & N Morojele 'Factors associated with contraceptive use in a rural area in Western Cape Province' (2013) 103 *South African Medical Journal* 406-412; L Swartz *Fertility transition in South Africa and its implications on the four major population groups* (2002) 539, available at <http://www.un.org/esa/population/publications/completingfertility/RevisedSwartzpaper.PDF> (3 November 2013).

<sup>185</sup> Department of Health & Medical Research Council (MRC) *South Africa Demographic and Health Survey* (n 180 above) 161. See also MRC South Africa & Measure DHS+ *South Africa Demographic and Health Survey* (1998) 142, available at <http://www.measuredhs.com/pubs/pdf/FR206/FR206.pdf> (3 November 2013).

<sup>186</sup> Department of Health & Medical Research Council (MRC) *South Africa Demographic and Health Survey* (as above) 160 & 161. See also Jewkes *et al* (n 150 above) 678.

<sup>187</sup> Mobile Clinics Bring Health Care to South Africa Countryside (2013) <http://reliefweb.int/report/south-africa/mobile-clinics-bring-health-care-south-africa-countryside> (14 March 2014).

<sup>188</sup> Peer & Morojele (n 184 above); McQuoid-Mason (n 130 above) 406-412.

The Committee to the ICESCR stresses that health facilities are to be located within the physical reach of all sections of the population,<sup>189</sup> especially the vulnerable who include female adolescents with SRH care needs. Thus, it is vital that the distance from adolescent-friendly clinics where female adolescents are able to access contraceptives in a confidential setting and the operating hours of the clinics must be such that it does not interfere with adolescents' use of contraceptives. Distance has been noted in studies as a barrier to female adolescents' contraceptive usage.<sup>190</sup>

### 3.8 Conclusion

The recent decision by the Constitutional Court in the *Teddy Bear Clinic* case which confirmed the High Court's decision on the unconstitutionality of the provisions of sections 15 and 16 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act and its unjustifiability in terms of section 36 of the country's Constitution to the extent of its imposition of criminal liability on children under sixteen years for consensual sexual acts, hopefully has settled the problem posed by the threat of legal sanction to female adolescents' access to contraceptive services.

In relation to barriers associated with religion, culture and economic impediment caused by poverty, as submitted in the case of Nigeria, there is need for the organisation of continual awareness and sensitisation programmes among adolescents, their parents, communal and religious leaders in the various provinces so as to effect gradual attitudinal and behavioural changes.

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<sup>189</sup> ICESCR Committee *general comment 14* para 12(b), *Compilations of General Comments and Recommendations Adopted by Human rights Treaty Bodies, Vol I*, available at [http://www.amnesty.nl/sites/default/files/public/generalcomments\\_0.pdf](http://www.amnesty.nl/sites/default/files/public/generalcomments_0.pdf) (24 October 2012).

<sup>190</sup> Maja (n 157 above) 44.

The intention in the next section is to examine the consequences that result from the existence of barriers which prevent adolescent girls' from accessing contraceptive information and services.

## 4 Consequences of barriers to access contraceptive information and services in Nigeria and South Africa

### 4.1 Introduction

Despite that the various human rights committees, including the Committee on the ICESCR and its CRC counterpart, have continually explained that the right to health includes not only the freedom to control one's SRH without interference,<sup>191</sup> but also that parents and guardians have a duty to provide appropriate guidance to adolescents (including on SRH matters) in a manner that is consistent with their evolving capacities,<sup>192</sup> the existence of the different barriers discussed above continue to impede and prevent female adolescents' free access to contraceptive information and services.

The existence of the barriers, which affect female adolescents' access to contraception, and which result in numerous consequences that adversely impact on their socio-economic growth and development are discussed in this section.

## 5 NIGERIA

### 5.1 Consequences of barriers to access contraceptives in Nigeria

Similar to Davis' observation regarding the indecisiveness of American society in relation to adolescents' right to access SRH care, which result in teenagers being denied access

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<sup>191</sup> Paras 8 & 33 General comment 14 ICESCR Committee *Compilations of General Comments and Recommendations adopted by human rights treaty bodies* Vol I, available at [http://www.minoritycentre.org/sites/default/files/HRI-GEN-1-Rev.9%20\(Vol.%20I\).pdf](http://www.minoritycentre.org/sites/default/files/HRI-GEN-1-Rev.9%20(Vol.%20I).pdf) (21 October 2013).

<sup>192</sup> Paras 3, 22, 24 & 26 general comment 4 CRC Committee *Compilations of General Comments and Recommendations adopted by human rights treaty bodies* Vol II, available at [http://www.bayefsky.com/general/hri\\_gen\\_1\\_rev9\\_vol\\_ii.pdf](http://www.bayefsky.com/general/hri_gen_1_rev9_vol_ii.pdf) (23 October 2013).

to information and services that will safeguard them from unintended pregnancies and STIs,<sup>193</sup> the Nigerian society is also extremely indecisive about the issue of adolescent sexuality. Even though adolescents are required to be sexually responsible, the existence of socio-cultural, religious, legal and other barriers hinders and prevents female adolescents in the country from accessing contraceptive information and services in confidential settings. This failure contributes to their SRH vulnerability and results in disastrous consequences such as teenage pregnancies, abortion, STIs HIV-infection, as well as the loss of economic developmental potential.

## 5.2 Teenage pregnancies

As noted in Chapter five, in spite of socio-cultural and economic differences among countries in both the developed and undeveloped regions in the world, it remains a fact that adolescents initiate sexual relationships at a young age and long before marriage. In the past the age of sexual initiation was higher.<sup>194</sup> The similarity between developed countries and their developing counterparts, however, ends here as the consequences occasioned by female adolescents' early introduction to sexual activities in the jurisdictions differ due to the reaction of governments and other relevant stakeholders (including parents) to adolescent SRH issues, including in relation to their access to contraceptives.<sup>195</sup>

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<sup>193</sup> As noted by the writer, while American society want teens to be sexually responsible, it also develops and funds programmes that deny them access to information and services needed to protect them from unintended pregnancy, HIV and STIs. See L Davis *Adolescent sexual health and the dynamics of oppression: A call for cultural competency* (2010) 2, available at [http://www.advocatesforyouth.org/storage/advfy/documents/adolescent\\_sexual\\_health\\_and\\_the\\_dynamics.pdf](http://www.advocatesforyouth.org/storage/advfy/documents/adolescent_sexual_health_and_the_dynamics.pdf) (5 November 2013).

<sup>194</sup> A S Madkour *et al* 'Early adolescent sexual initiation and physical/psychological symptoms: A comparative analysis of five nations' (2010) 39 *Journal of Youth and Adolescence* 1213; E Ketting & C Winkelmann *Sexual Health (SH) of young people in the WHO European Region* in *Sexual Health: A public health challenge in Europe* (2011) 72 *Entre Nous- The European Magazine for Sexual and Reproductive Health* 12, available at [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0019/142570/en72.pdf](http://www.euro.who.int/__data/assets/pdf_file/0019/142570/en72.pdf) (19 September 2013).

<sup>195</sup> For example, while parents in countries like the Netherlands and France exhibit openness and allow communication on sexuality issues to occur between themselves and their children, the opposite is the case

A very obvious outcome of the different reactions of stakeholders to adolescent girls' commencement of sexual activities relates to the problem of teenage pregnancy. According to the World Health Organisation (WHO), about 16 million adolescent girls give birth every year.<sup>196</sup> For some adolescents the pregnancies may actually be planned and wanted, however, in a lot of cases, pregnancies by adolescent girls are neither planned nor wanted.<sup>197</sup> Evidence of the disparity between developed and developing countries on adolescent sexuality issues is further fuelled by the fact that, as the WHO notes, 95% of adolescent births not only occur in low and middle income countries, but more than 50% of births which take place during adolescence occur in sub-Saharan Africa, Nigeria inclusive.<sup>198</sup>

In Nigeria, teenage pregnancy constitutes a huge problem as the adolescent birth rate in the country is currently estimated at 123 per 1 000 women aged 15-19 years<sup>199</sup> which, as Udo *et al* observes, is exceedingly high when compared to adolescent fertility rates quoted for most countries of the world outside sub-Saharan Africa.<sup>200</sup> Fuelled by the cultural practice of child marriage, which occurs predominately in Northern Nigeria, and the lack of access by adolescent girls (especially unmarried ones) to contraceptive services as a result of factors associated with socio-cultural beliefs, religious perceptions and lack of financial wherewithal, and coupled with the low utilisation of contraceptives

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in relation to parents in Nigeria and South Africa. See, generally, J Friedman 'The battle for effective sexuality education' (2004) 2 *Journal of Student Social Work* 11; Madkour *et al* (as above) 1212 -1213.

<sup>196</sup> WHO *Guidelines on preventing early pregnancy and poor reproductive outcomes: Among adolescents in developing countries* (2011) IX, available at [http://whqlibdoc.who.int/publications/2011/9789241502214\\_eng.pdf](http://whqlibdoc.who.int/publications/2011/9789241502214_eng.pdf) (5 November 2013).

<sup>197</sup> WHO *Guidelines on preventing early pregnancy and poor reproductive outcomes* (as above) IX.

<sup>198</sup> Apart from sub-Saharan Africa, other regions which contribute to the high level of pregnant adolescents include Asia and Latin America. See WHO *Adolescent pregnancy* available at [http://www.who.int/maternal\\_child\\_adolescent/topics/maternal/adolescent\\_pregnancy/en/](http://www.who.int/maternal_child_adolescent/topics/maternal/adolescent_pregnancy/en/) (5 November 2013).

<sup>199</sup> Adolescent fertility rates have been estimated to be between 121-123 live births per 1,000 births. See 'UNFPA country indicators – Nigeria' in *The state of the world's midwifery* (n 15 above).

<sup>200</sup> A Udo *et al* 'Teenage pregnancy and adverse birth outcomes in Calabar, Nigeria' (2013) 17 *Internet Journal of Gynaecology and Obstetrics* available at <http://ispub.com/IJGO/17/2/2995> (10 November 2013).

by married teenage girls who require spousal permission in order to avail themselves of family planning services, the incidence of adolescent pregnancy, which is declining in many countries, remains unabated in Nigeria.<sup>201</sup> According to Erulkar, in Nigeria the median age at first birth varies across regions. While a considerable number of girls in the northern region give birth by the age of 15 years, such births are within marriage unlike the situation in the southern region where a predominant number of teenage births are premarital.<sup>202</sup> Overall, by the age of 18 years, a large number of female adolescents are already teen mothers.<sup>203</sup>

Although adolescent girls get pregnant as a result of their non-use or incorrect use of contraceptives due to the barriers already highlighted in the previous chapter, as Durojaye remarks, this is because they are improperly educated about sexuality issues including important information on contraceptive use.<sup>204</sup> According to the writer, by reason of non-access to factual and in-depth sexuality education, both in schools and at home, young girls operate under the mistaken belief that a single act of sexual intercourse cannot result in pregnancy.<sup>205</sup>

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<sup>201</sup> Teenage pregnancy as noted in chapter three, as a matter of compromise to cultural and religious gatekeepers, perceived offensive words like masturbation, vagina, contraception, condom, unprotected sex etc. were deliberately omitted and removed from the FLHE curriculum. Also, due to the reason that the Nigerian environment is steeped in a culture where the mere mention of the word 'sex' is traditionally viewed as a taboo, parents likewise maintain traditional views on adolescent sexuality and therefore refuse to give straightforward advice to adolescent girls on sexual matters. See, generally, Udo *et al* (as above); Durojaye 'Realising access to contraception for adolescents in Nigeria' (n 8 above) 206; O Ojo *et al* Pattern and socio-demographic correlates of parent-child communication on sexual and reproductive health issues in southwest Nigeria: A mixed method study (2011) 11 *The African Symposium* 35, available at [http://www.ncsu.edu/aern/TAS11.2/TAS11.2\\_4Ojo.pdf](http://www.ncsu.edu/aern/TAS11.2/TAS11.2_4Ojo.pdf) (27 July 2013).

<sup>202</sup> A S Erulkar & M Bello *The experience of married adolescent girls in northern Nigeria* (2007) 9, available at [http://www.popcouncil.org/pdfs/Nigeria\\_MarriedAdol.pdf](http://www.popcouncil.org/pdfs/Nigeria_MarriedAdol.pdf) (20 June 2013).

<sup>203</sup> Erulkar & Bello (as above) 9; G James 'Socio-cultural context of adolescents' motivation for marriage and childbearing in North-Western Nigeria: A qualitative approach (2010) 2 *Current Research Journal of Social Sciences* 269-270.

<sup>204</sup> Durojaye 'Realising access to contraception for adolescents in Nigeria' (n 8 above) 105.

<sup>205</sup> As above.

Aside from the reality that the main reason for high adolescent birth rates needs to be laid at the doorstep of the Nigerian government as a result of its obvious lack of political determination to fulfil its human rights obligations by drastically curbing the existence of barriers which continue to deny adolescent girls their right to contraceptive information and services guaranteed under human rights instruments, it is necessary to point out that the government's failure results in adolescent girls' being exposed to a higher risk of maternal deaths<sup>206</sup> and morbidity.<sup>207</sup>

Recently, whilst urging the Nigerian government to implement the national and international conventions that seek to curtail teenage pregnancy, the National Population Commission took note of the continuous threat posed by the high number of pregnancies among adolescent girls, and explained that pregnancy is not only the biggest killer of teenage girls (especially in Northern Nigeria), but that pregnant adolescents had a greater probability of experiencing pregnancy complications, poor

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<sup>206</sup> Female adolescents are, in most cases, not yet physically ready to undergo the rigours of childbirth; they usually suffer negative medical outcomes. Various reports make reference to the fact that complications of pregnancy and childbirth are the leading cause of death among young women aged 15–19 years. Also children of adolescent mothers experience higher levels of morbidity and mortality. See A I Isa *et al* 'Socio-demographic determinants of teenage pregnancy in the Niger Delta of Nigeria' (2012) 2 *Open Journal of Obstetrics and Gynaecology* 240; S A Aderibigbe *et al* 'Teenage pregnancy and prevalence of abortion among in-school adolescents in North Central, Nigeria (2011) 7 *International Journal of Asian Social Science* 123; WHO *Guidelines on preventing early pregnancy and poor reproductive outcomes* (n 196 above) IX; C Cortes *To reduce teen pregnancies, start with educating girls* (2012) available at <http://www.ipsnews.net/2012/07/to-reduce-teen-pregnancies-start-with-educating-girls/> (7 November 2013); WHO *Adolescent pregnancy* (n 198 above).

<sup>207</sup> As many as 65% of women with obstetric fistula develop the condition as adolescents due to the reason that pregnant adolescent girls face a greater risk of experiencing obstructed labour. See generally C U Iklaki *et al* 'Perinatal outcome in unbooked teenage pregnancies in the University of Calabar Teaching Hospital, Calabar, Nigeria' (2012) *International Scholarly Research Network (ISRN) Obstetrics and Gynecology* 2; UNFPA *Sexual and reproductive health for all: reducing poverty, advancing development and protecting human rights* (2010) 21, available at [http://www.unfpa.org/webdav/site/global/shared/documents/publications/2010/uah\\_report\\_2010.pdf](http://www.unfpa.org/webdav/site/global/shared/documents/publications/2010/uah_report_2010.pdf) (9 November 2013); S Adebayo 'Teenage pregnancy' *The Punch* 2 August 2013, available at <http://www.punchng.com/healthwise/teenage-pregnancy/> (8 November 2013); WHO *Adolescent pregnancy* (as above); J Ebeniro 'The geography of maternal mortality in Nigeria' *University of North Texas* (2012) 15-16.

antenatal care and also weak reproductive health outcomes with higher numbers of caesarean sections carried out to save teenage mothers' lives.<sup>208</sup>

### 5.3 Abortion

Generally, the problem of unsafe abortions is a recurring reproductive health care problem, especially among women and female adolescents in developing countries.<sup>209</sup>

Involving the termination of unwanted and unintended pregnancies either by unskilled persons or in environments where minimal medical skills are observed,<sup>210</sup> the effect of unsafe abortion to a greater extent is usually felt by unmarried adolescent girls who, as a result of numerous socio-cultural, religious and gender biases, experience prejudice that disallows them from having access to important contraceptive information and services that are required to protect them from teenage pregnancies and other negative SRH consequences.

Abortion is a sensitive and contentious issue with religious, moral, cultural, and political undertones.<sup>211</sup> A majority of women and girls of reproductive age live in countries where abortion procedures are prohibited and permitted only to save the woman's life.<sup>212</sup> However regardless of the above fact, abortions still occur daily; with a majority of the procedures carried out by inexperienced and unqualified persons under

<sup>208</sup> A Aminu 'NPC Commissioner: North-West has Highest Number of Teenage Pregnancies' *Daily Times* 11 April 2013, available at <http://www.dailytimes.com.ng/article/npc-commissioner-north-west-has-highest-number-teenage-pregnancies> (5 November 2013). See also J T Mutihir & W E Maduka 'Comparison of pregnancy outcome between teenage and older primigravidae in Jos University Teaching Hospital, Jos, North-Central Nigeria' (2006) 5 *Annals of African Medicine* 101-106.

<sup>209</sup> Abortion is the deliberate termination of a human pregnancy or intentional expulsion of a foetus from a woman's womb before it reaches a stage of viability.

<sup>210</sup> I K Warriner & I H Shah (eds) *Preventing unsafe abortion and its consequences: Priorities for research and action* (2006) vii; Population Reference Bureau Abortion: Facts & figures (2011) 13, available at <http://www.prb.org/pdf11/abortion-facts-and-figures-2011.pdf> ( 8 November 2013).

<sup>211</sup> F Adeleke *Comparative abortion jurisprudence: Reproductive rights paradigm* (2013) 5.

<sup>212</sup> Population Reference Bureau Abortion: Facts & figures (n 210 above) 1.

insanitary and dangerous conditions.<sup>213</sup> Warriner comments that the issue of unsafe abortion is a preventable contributor to the challenge of maternal mortality which is ravaging countries in sub-Saharan Africa.<sup>214</sup> This includes Nigeria, where abortion is illegal<sup>215</sup> and unsafe abortion is recognised as a leading cause of maternal mortality.<sup>216</sup>

It is important to highlight that as a result of the sensitive nature of the issue, it is impossible to get accurate data on the number of abortions that occur in Nigeria. However, the *Guttmacher Institute* reveals that as at 2006 the number of abortions carried out in the country was estimated to have risen to 760,000 with more than 3,000 women conservatively estimated as haven died as a result of unsafe abortion.<sup>217</sup>

As explained previously, especially in Nigeria where societal stigma, patriarchy, conservative religious practices and economic disability prevent adolescent girls' from accessing contraceptive services making them vulnerable to unintended pregnancies,

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<sup>213</sup> According to the Population Reference Bureau (PRB), estimates reveal that about 42 million abortions are performed yearly and almost half of them are procured outside the legal system. In sub-Sahara Africa, almost 60% of the women who undergo abortion are under the age of 25 years; 25% of whom are also adolescents. See Population Reference Bureau Abortion: Facts & figures (as above) 1, 5 & 7. See also J Benson *et al* 'Public hospital costs of treatment of abortion complications in Nigeria' (2012) 118 *International Journal of Gynaecology and Obstetrics* S134.

<sup>214</sup> I K Warriner 'Unsafe abortion: An overview of priorities and needs' in Warriner & Shah (eds) (n 210 above) 1.

<sup>215</sup> Secs 228 & 229 Criminal Code cap c38 LFN 2004 & secs 232 & 233 Penal Code cap p3 LFN 2004. See also Adeleke (n 211 above) 37-39.

<sup>216</sup> Aderibigbe *et al* (n 206 above) 124; Adeleke (as above) 46-47. This is especially so in Nigeria where current maternal mortality ratio stands at 630 for every 100,000 live births. Nigeria's maternal mortality rate, which is the second highest in the world after India, makes it impossible for the country to meet the Millenium Development Goal 5 target of reducing maternal mortality ratio by three quarters by 2015. See generally K Singh *et al* 'Gender equality and childbirth in a health facility: Nigeria and MDG 5' (2012) 16 *African Journal of Reproductive Health* 122-128; World Bank *Maternal mortality ratio* available at <http://data.worldbank.org/indicator/SH.STA.MMRT> ( 15 February 2014).

<sup>217</sup> M Sudhinaraset *In brief: Reducing unsafe abortion in Nigeria* (2008) available at [http://www.guttmacher.org/pubs/2008/11/18/IB\\_UnsafeAbortionNigeria.pdf](http://www.guttmacher.org/pubs/2008/11/18/IB_UnsafeAbortionNigeria.pdf) ( 9 November 2013). See also A A Akinyemi *et al* 'Abortion and challenges of teenage pregnancy in Lagos, Nigeria' (2012) 3 *International Journal of Scientific & Engineering Research* 2; R Ogbu 'Illegal abortion in Nigeria: The cringing reality' *Daily Times* 11 April 2013, available at <http://www.dailytimes.com.ng/article/npc-commissioner-north-west-has-highest-number-teenage-pregnancies> (5 November 2013).

the prohibition of abortion services except to save a woman's life<sup>218</sup> automatically 'forces' pregnant adolescent girls, more often than not, to procure backstreet and unsafe abortions. A practice which further exposes them to complications which eventually contributes to the country's high rate of maternal mortality<sup>219</sup> or morbidity as the case may be.<sup>220</sup> According to Adeleke, about half of the women who die from abortion complications are adolescents.<sup>221</sup>

The high prevalence of abortion and the unwanted nature of pregnancy by female adolescents in Nigeria was noted by Aderibigbe who reports that in a study on teenage pregnancy and the prevalence of abortion among in-school adolescents in North Central, Nigeria, the procurement of induced abortion among pregnant teenagers was common as almost 100% of the adolescent girls in the study reported a case of having induced an abortion.<sup>222</sup> The above situation was also confirmed by Okereke in a study in which he notes that the occurrence of unintended pregnancy among adolescents in Owerri, a state in South Eastern Nigeria, is not strange.<sup>223</sup> According to the writer, not only is pre-marital sex on the increase but so also is the case of the induced abortion of unintended pregnancies. A majority of participants, while reporting having been

<sup>218</sup> Sec 228 & 229 Criminal Code cap c38 LFN 2004 & sec 232 & 233 Penal Code cap p3 LFN 2004.

<sup>219</sup> Maternal mortality rates in the country is currently estimated at 630 deaths per 100 000 live births. Out of the 287 000 maternal deaths that occurred globally in 2010, Nigeria accounted for 40,000 deaths. See WHO *Trends in maternal mortality: 1990 to 2010* (2012) 1 & 22, available at [http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Trends\\_in\\_maternal\\_mortality\\_A4-1.pdf](http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Trends_in_maternal_mortality_A4-1.pdf) (7 November 2013); CIA *The world fact book* (2013) available at <https://www.cia.gov/library/publications/the-world-factbook/geos/ni.html> (7 November 2013).

<sup>220</sup> Apart from dying, female adolescents who procure unsafe abortion are at risk of suffering various complications, including uterine scarring, severe anaemia, pelvic inflammatory disease and infertility. See N A Akani *et al* 'Hysterectomy in Adolescents, in Port Harcourt, Nigeria' (2008) 8 *Nigerian Health Journal* 20-23.

<sup>221</sup> Adeleke (n 211 above) 47.

<sup>222</sup> Aderibigbe *et al* (n 206 above) 124.

<sup>223</sup> C I Okereke 'Unmet Reproductive Health Needs and Health-Seeking Behaviour of Adolescents in Owerri, Nigeria' (2010) 14 43-54.

previously pregnant, also revealed that the pregnancies had either led to their bearing a child or procuring unsafe abortions since they have no choice as they are not married.<sup>224</sup>

Noting the adverse outcomes occasioned by the failure by the Nigerian government to respect, protect, fulfil and promote the right to health care (including SRH) of adolescent girls; the vulnerable victims of the government's insincerity, it is necessary to emphasise, as the ICPD maintains, that there is an urgent need for the government and its agencies to deal with the health impact occasioned as a result of non-access to contraceptive services. Not only should adolescent girls be assured of improved access to family planning services, information and counselling but preventing the need for abortion should be a priority and every attempt should be made to ensure the elimination of unsafe abortions.<sup>225</sup>

#### 5.4 HIV and STIs

In addition to the fact that adolescent girls in Nigeria become exposed to the risk of unintended pregnancies and have to procure unsafe abortion as a result of the country's highly restrictive abortion laws to terminate unwanted pregnancies as a result of their non-access to contraceptives, another side-effect of female adolescents inaccessibility to contraceptive information and services relates to their susceptibility to HIV and other STIs.

Today, worldwide, the menace of STIs among adolescents is of specific concern to many people, including those who work on improving the health status of populations.<sup>226</sup>

Though not evenly distributed, infection with STIs and HIV is particularly common

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<sup>224</sup> Okereke (as above) 43-54.

<sup>225</sup> See para 63 (i) & (ii) ICPD +5 Key Actions Document, available at <http://www.un.org/documents/ga/res/21sp/a21spr02.htm> (5 October 2012).

<sup>226</sup> K L Dehne & G Riedner *Sexually transmitted infections among adolescents: The need for adequate health services* (2005) IX, available at <http://whqlibdoc.who.int/publications/2005/9241562889.pdf> (9 November 2013).

among some groups of adolescents', especially female adolescents.<sup>227</sup> Adolescent girls' are not only vulnerable to infection due to reasons associated with gender inequality which results in their initiation into sexual activities at an early age, but they are also prevented by cultural, religious and other man imposed barriers from assessing contraceptives and condoms that will naturally protect them from pregnancies and STIs, including HIV and AIDS.

As the WHO notes, globally, HIV is the leading cause of death and disease in women (including adolescent girls) who are of reproductive age.<sup>228</sup> The reason for this can be associated to a combination of factors. First, due to their biological makeup, women are more likely to acquire HIV from partners that are already infected with the virus during unprotected heterosexual intercourse. When combined with the second factor which relates to cultures that support gender inequality by limiting women's knowledge about HIV, including their ability to negotiate safer sex, and unjustifiably stigmatises girls who attempt to access contraceptive information and services, the risk of women and girls to STIs and HIV drastically increases.<sup>229</sup>

Given the levels of the HIV and AIDS pandemic in the sub-Saharan African region where 23.5 million people out of the total of 35 million people living with HIV in the world reside,<sup>230</sup> the situation of female adolescents become more precarious, especially in Nigeria, where an estimated 3.7 million people are already infected with the virus.<sup>231</sup>

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<sup>227</sup> Apart from adolescent girls, STIS and HIV is also common among other adolescent groups including adolescent sex workers, out of school adolescents and adolescent boys who have sex with men or other boys. See Dehne & Riedner (as above) XI.

<sup>228</sup> WHO *Health and women: Today's evidence tomorrow's agenda* (2009) 43, available at [http://whqlibdoc.who.int/publications/2009/9789241563857\\_eng.pdf](http://whqlibdoc.who.int/publications/2009/9789241563857_eng.pdf) (9 November 2013).

<sup>229</sup> WHO *Health and women* (as above) 44 & 45; N I Aniekwu 'Gender and Human Rights Dimensions of HIV/AIDS in Nigeria' (2002) 6 *African Journal of Reproductive Health* 31.

<sup>230</sup> UNAIDs *Special report: How Africa turned AIDS around* (2013) 6 & 7, available at [http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2013/20130521\\_Update\\_Africa.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2013/20130521_Update_Africa.pdf) (10 November 2013).

<sup>231</sup> UNICEF *At a glance Nigeria Statistics* (n 12 above).

The reason for this is not far-fetched. Whilst adolescent sexual behaviour in Nigeria is similar to that of their international counterparts and they begin to engage in sexual relations at an earlier age than in the past, it has been noted, unlike the case in Denmark where a liberal approach is adopted to deal with the issue of adolescent sexuality through the impartation of sexuality education and free access to contraceptive services upon request,<sup>232</sup> that Nigerian society thrives on traditional values that encourage female submissiveness, on one hand, and advises them to shun pre-marital sex on the other thereby placing adolescent in a conflicting position which makes it easier for them to be coerced into sexual relationships.<sup>233</sup>

Additionally, as highlighted in the preceding section, even though the consistent use of condoms, especially during engagement in casual sex as well as in a faithful relationship with a single sexual partner, has been revealed as an effective means of avoiding HIV and AIDS, adolescent girls, in particular, and young persons', generally, who are most vulnerable, are often neglected in discussions relating to sex.<sup>234</sup> Negative and judgmental attitudes among health care providers, who do not guarantee confidentiality, and poverty, which increases the practice of cross-generational sex with older men who have had previous sexual partners and with whom the girls cannot negotiate condom use, continues to increase their powerlessness to prevent infection.

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<sup>232</sup> C Moreau *et al* 'The impact of pharmacy access to emergency contraceptive pills in France' (2006) 73 *Contraception* 602; R Parker *et al* 'Sexuality education in Europe: an overview of current policies' (2009) 9 *Sex Education* 227-242.

<sup>233</sup> It is important to state that while sometimes, an overt encouragement of male adolescents engagement in sexual relations may not occur, the society silently encourages boys to prove their sexual prowess as a 'blind eye' is usually turned on boys who access condoms unlike the girls who are harshly termed promiscuous.

<sup>234</sup> S T Omoyeni 'Adolescents and HIV-related Behaviour in Nigeria: Does knowledge of HIV/AIDS promote protective sexual behaviour among sexually active adolescents?' (2012) 4, available at <http://paa2012.princeton.edu/papers/120500> (9 November 2013).

The effect of the above situation was exposed when the UNICEF<sup>235</sup> revealed, as a result of the entrenchment of socio-cultural values that promote girl submissiveness and the practise of gender roles fuelling myths about contraception, that cases of HIV and AIDS infection are also reported among pre-teenagers in the country as well. According to the National Agency for the Control of AIDS (NACA), not only do females constitute 58% of persons living with HIV in the country but also the prevalence rate among young women aged 15-24 years is estimated to be three times higher than that among their male counterparts.<sup>236</sup>

*Advocates for Youths*,<sup>237</sup> corroborates the fact that Nigeria's development is regrettably affected by the SRH issues afflicting its young population as the deprivation of adolescents' access to sexual health information and services make them vulnerable to STIs and HIV.<sup>238</sup> According to the organisation, not only do female adolescents possess incorrect knowledge about STIs but young girls are almost three times more likely to be infected with HIV than adolescent boys as a result of traditional gender roles that limit young girls' autonomy.<sup>239</sup>

In line with the objective of the Committee on the Convention on the Rights of the Child in its general comment 3 that there is the necessity to identify measures and good practices that will allow state parties to fulfil their obligation of guaranteeing the right to

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<sup>235</sup> UNICEF Nigeria HIV/AIDS available at [http://www.unicef.org/nigeria/children\\_1940.html](http://www.unicef.org/nigeria/children_1940.html) (9 November 2013).

<sup>236</sup> NACA *Key statistics on HIV in Nigeria* available at [http://naca.gov.ng/index2.php?option=com\\_docman&task=doc\\_view&gid=110&Itemid=268](http://naca.gov.ng/index2.php?option=com_docman&task=doc_view&gid=110&Itemid=268) (9 November 2013).

<sup>237</sup> *Advocates for Youth* is a non-governmental and non-profit organisation and advocacy group that champions efforts that will assist adolescents and youths in making informed and responsible decisions about their reproductive and sexual health.

<sup>238</sup> *Advocates for Youth Youth reproductive & sexual health in Nigeria* available at <http://www.advocatesforyouth.org/publications/1450> (9 November 2013).

<sup>239</sup> *Advocates for Youth* (as above).

health of children and protecting them from HIV and AIDS,<sup>240</sup> the Nigerian government needs to be more pro-active in censuring third parties who, as a result of their rigid views and opinions, contribute to denying girls access to contraceptives information and services, thereby increasing their exposure to HIV and STIs. The government also should take note of good approaches adopted by other countries in ensuring their adolescents access to contraceptives.

### 5.5 Socio-economic consequences

Adolescents girls who have sex without a corresponding access to contraceptive services are at risk of getting pregnant, making them candidates for unsafe abortion or experiencing the numerous risks to which teenage mothers are susceptible or even increasing their risk of being infected with HIV. Furthermore, denying sexually active female adolescents access to contraception fosters their being further entrenched in poverty.<sup>241</sup>

The reason for the above is because adolescent girls from poor families are not only ‘forced’ or lured into engaging in transactional and unsafe sexual activities for monetary reward with older men who have higher rates of HIV infection than adolescent boys, but they are also prevented from accessing contraceptives as a result of poverty and stigmatisation, thereby exposing them to pregnancy.<sup>242</sup> Once pregnant, however, the girls where school-going, are either expelled from school as a result of the pregnancy or drop out of school due to the shame and stigma attached to adolescent pregnancy.<sup>243</sup>

<sup>240</sup> Para 2(3) general comment 3 CRC Committee 3 *Compilations of General Comments and Recommendations adopted by human rights treaty bodies Vol II*, available at [http://www.bayefsky.com/general/hri\\_gen\\_1\\_rev9\\_vol\\_ii.pdf](http://www.bayefsky.com/general/hri_gen_1_rev9_vol_ii.pdf) (8 November 2013).

<sup>241</sup> Onwujekwe ‘Are people really using modern contraceptives’ (n 70 above) 3 & 4; Durojaye ‘Realising access to sexual health information and services’ (n 6 above) 150; Y Enuameh *et al* (n 48 above) 3354 & 3355.

<sup>242</sup> Luke & Kurz (n 86 above) 3-5.

<sup>243</sup> CRR *Forced out: Mandatory pregnancy testing and the expulsion of pregnant students in Tanzanian schools* (2013) 74, available at

It is important to emphasise that in most cases once the adolescent girls drops out of school as a result of pregnancy, in addition to the condemnation faced from community and family members, such girls are either forced into marriage, and their chances of returning to school after childbirth becomes slimmer, or have limited employment opportunities, making it challenging for them to take care of their children. The above description of the situation is supported by the UNFPA in one of its publications in which it explains that because 40% of girls in developing countries give birth to their first child before the age of 20 years they usually face the prospect of dropping out of school and losing their chances of improving their economic status in life.<sup>244</sup>

In Nigeria, Onyeka *et al* note that, indoctrination with cultural and religious beliefs prevents adults from discussing sexuality issues with adolescent girls. Instead, they are often exposed to myths about sex which make them liable to dangers associated with early and unprotected sexual activities, including unintended pregnancy, which, in addition to attracting stigmatisation from individuals and community members, also subjects the girl to expulsion in order to prevent her from ‘contaminating’ other students.<sup>245</sup> Izugbara reveals in a study on debut sexual encounters of adolescents in a rural community in Nigeria that sometimes adolescent girls who are ‘unfortunate’ to be impregnated experience further trauma as their sexual partners deny being responsible for their pregnancies<sup>246</sup> leaving them to suffer socio-economic consequences, including dismissal from schools, poor education and lower income later in life.<sup>247</sup>

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[http://reproductiverights.org/sites/crr.civicaactions.net/files/documents/crr\\_Tanzania\\_Report\\_Part1.pdf](http://reproductiverights.org/sites/crr.civicaactions.net/files/documents/crr_Tanzania_Report_Part1.pdf) (9 November 2013).

<sup>244</sup> UNFPA *Sexual and reproductive health for all* (n 207 above) 21.

<sup>245</sup> I N Onyeka *et al* ‘Unintended pregnancy and termination of studies among students in Anambra state, Nigeria: Are secondary schools playing their part?’ (2011) 15 *African Journal of Reproductive Health* 109-116.

<sup>246</sup> C O Izugbara ‘Tasting the forbidden fruit: The social context of debut sexual encounters among young persons in a rural Nigerian community’ (2001) 5 *African Journal of Reproductive Health* 28.

<sup>247</sup> I I Ayuba & G Owoeye ‘Outcome of teenage pregnancy in the Niger-delta of Nigeria’ (2012) 22 *Ethiopian Journal of Health Sciences* 46.

It is hereby emphasised that all the barriers expatiated on above which prevent adolescent girls from accessing contraceptive information and services not only foster adolescent's adoption of unsafe and dangerous sexual lifestyles<sup>248</sup> which brings with them the risk of pregnancy with its attendant ills of illiteracy and poverty, but is also an infringement of their right to reproductive health care and information which are guaranteed under the international and regional human rights instruments signed by Nigeria's government.

## 5.6 Conclusion

The consequences of the barriers which prevent adolescent girls in Nigeria from accessing contraceptive information and services have been analysed in this section. As already noted, adolescent girls (both married and unmarried) for varying reasons associated with socio-cultural and religious barriers are prevented from accessing contraceptive services resulting in a very high adolescent fertility rate. The drastic consequences of the barriers are felt especially in Northern Nigeria where a large number of adolescent girls battle with a major consequence of attributed to pregnancies by underage girls not yet reproductively or biologically mature to carry pregnancies.<sup>249</sup>

In addition, the fact that accessing safe abortion is illegal in Nigeria does not help as girls who are victims of cultural and religious barriers that prevent them from having access to contraceptives are again barred from accessing safe abortion services. The consequence is they take their destinies in their hands by procuring unsafe back-street abortions with increased risks of maternal mortality or suffer injuries to reproductive organs that may render future fertility impossible. The HIV and STIs rate among

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<sup>248</sup> Adolescents being a curious group will still engage in sex either because they are forced into sexual relations or in order to satisfy their curiosity or for economic and monetary needs.

<sup>249</sup> Ebeniro (n 207 above) 15-16; Iklaki *et al* (n 207 above) 2; Adebayo (n 207 above); WHO *Adolescent pregnancy* (n 198 above).

adolescent girls, which is higher than that of their male counterparts,<sup>250</sup> is further evidence of contraceptive non-access.

In view of the evidence noted, it is submitted that the result of Nigeria's in-action in ensuring actual access to contraceptives for female adolescents greatly out-weighs socio-cultural and other reasons that may be advocated for their non-access to contraceptive information and services. Consequent to the above, it is submitted that there is not only a need for the government to face reality by guaranteeing actual access to contraceptive information and services for adolescent girls, but there is also need for the transformation of views in Nigerian society in order to prevent the situation from further worsening.

In the next section, the consequences of female adolescents' non-access to contraceptive information and services in South Africa are discussed.

## 6 SOUTH AFRICA

### 6.1 Consequences of barriers to access contraceptives in South Africa

South Africa makes provision for adolescents to access free contraceptive and other reproductive health care services. However, as a result of the barriers discussed above, on the whole, female adolescents in the country do not make use of available contraceptive services and, therefore, are still disposed to experiencing the negative consequences associated with contraceptive non-use.

This section considers the consequences that result from female adolescents' non-use of contraceptives: including teenage pregnancies, abortion, infection with sexually transmitted diseases, as well as the loss of career prospects and other developmental potentials which entrench them in a life of poverty.

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<sup>250</sup> NACA *Key statistics on HIV in Nigeria* (n 236 above).

## 6.2 Teenage pregnancies

In comparison with other African countries, South Africa has better health indicators. According to available data, the country has one of the lowest total birth rates in the region, and it also has a significantly higher contraceptive prevalence rate.<sup>251</sup> Despite these figures, however, the country still has a high teenage fertility rate with around 30% of 15-19 year old adolescent girls reported as having ever been pregnant.<sup>252</sup> Affecting both in-school and out-of-school adolescent girls, Ramulumo & Pitsoe observe that there is a high rate of teenage childbearing in South Africa despite public awareness campaigns on sex education and the teaching of life orientation at schools.<sup>253</sup>

Regardless of the fact that the South African government has adopted a reproductive health policy that furthers its commitment towards the protection of the reproductive health of women, including female adolescents, by providing access to contraceptive services and information,<sup>254</sup> the continued occurrence of unplanned teenage pregnancies among adolescent girls is powered by a number of factors. These factors range from socio-cultural beliefs which encourage the adoption of unequal gender attitudes and views on teenage sexuality to the outright stigmatisation of girls who

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<sup>251</sup> WHO *The state of the world's midwifery: Delivering health, saving lives* (2011) 132-133, available at [http://www.who.int/pmnch/media/membernews/2011/2011\\_sowmr\\_en.pdf](http://www.who.int/pmnch/media/membernews/2011/2011_sowmr_en.pdf) (9 November 2013).

<sup>252</sup> According to the WHO *state of the world's midwifery*, adolescent birth rate in the country stands at 54 for every 1,000 live births among girls aged 15-19 years. Also, research reveals that Mpumalanga, Northern Cape, Limpopo and the Eastern Cape Provinces are worst hit by the high levels of adolescent pregnancies. See S Willan *A review of teenage pregnancy in South Africa: Experiences of schooling, and knowledge and access to sexual & reproductive health services* (2013) 7, available at <http://www.hst.org.za/sites/default/files/Teenage%20Pregnancy%20in%20South%20Africa%20Final%2010%20May%202013.pdf> (18 September 2013); M R Ramulumo & V J Pitsoe 'Teenage Pregnancy in South African Schools: Challenges, Trends and Policy Issues' (2013) 4 *Mediterranean Journal of Social Sciences* 756; Statistics South Africa General household survey (2012) 18, available at <http://www.statssa.gov.za/publications/P0318/P0318April2012.pdf> (9 November 2013); WHO *The state of the world's midwifery* (as above) 133.

<sup>253</sup> Ramulumo & Pitsoe (as above) 756.

<sup>254</sup> The recent National Contraception and Fertility Planning Policy and Service Delivery Guidelines adopts a rights based approach to contraception and fertility planning by promoting expanded choice through contraceptive availability and accessibility to all people, women and female adolescents' especially. See National Contraception and Fertility Planning Policy and Service Delivery Guidelines 2012 (n 9 above) paras 3.1.& 3.2.

attempt to use contraception,<sup>255</sup> to the effect of poverty which makes girls engage in transactional sex, multiple sexual partnerships and relationship with older men for monetary gain.<sup>256</sup> This is coupled with the hostile attitudes of health officers who are impatient with female adolescents who seek SRH information and services.<sup>257</sup> Also, given the central role that fertility plays, especially, in a black South African woman's identity, the occurrence of an adolescent pregnancy is usually more readily accepted than the prospects of infertility from contraceptive use leading to a situation where female adolescents are actually encouraged to 'prove' their fertility by parents and sexual partners.<sup>258</sup>

It is necessary to point out that the subject of teenage pregnancy is one which evokes a lot of emotions in South Africa. While some of the research on teenage pregnancy in South Africa specifically addresses the consequences of early pregnancy; a majority of the researchers adopt the views of earlier American and British writers who regard teenage pregnancy as a 'catastrophe', having negative consequences, but without attempting to examine the root causes of the 'catastrophe'.<sup>259</sup> Others argue that teenage pregnancy in South Africa is not as detrimental as it holds little stigma and the decision to begin child bearing early is a conscious choice made by disadvantaged adolescents, who are already out of school and therefore see no reason or purpose in delaying pregnancy.<sup>260</sup> Macleod expresses the opinion that urgently casting the 'toga' of disaster on the issue of teenage pregnancy without understanding the gender, historical or power relation dynamic within which adolescent pregnancy occurs is inadequate since

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<sup>255</sup> Willan (n 252 above) 7.

<sup>256</sup> Panday *et al* (n 119 above).

<sup>257</sup> Wood & Jewkes (n 160 above) 111-113.

<sup>258</sup> S M Lee-Rife *The educational trajectories of pregnant adolescents in South Africa* (2005) 1, available at <http://paa2005.princeton.edu/papers/51102> (12 November 2013).

<sup>259</sup> C Macleod 'Teenage pregnancy and its 'negative' consequences: Review of South African research-Part 1' (1999) *South African Journal of Psychology* 1-7.

<sup>260</sup> C Macleod 'Economic security and the social science literature on teenage pregnancy in South Africa' (2002) 16 *Gender and Society* 648.

various factors contribute to a female adolescents' decision or reason for getting pregnant.<sup>261</sup>

Several writers agree with Macleod's view that the issue of adolescent pregnancy goes beyond female adolescents' accessing reproductive health care on the grounds that socio-cultural and economic factors, which automatically act as barriers by truncating efforts made by government to guarantee female adolescents access to contraceptive services, continue to exist. Panday *et al*, observing that older adolescents accounted for the bulk of teenage fertility and pregnancies in South Africa, took notice of the fact that fertility rates were higher among black adolescent girls in comparison with their counterparts from other racial groups.<sup>262</sup> According to the writers even though blame for the difference may be laid at the doorstep of the social conditions under which young people grow up including their inequitable access to education, health care services and poverty, other factors relating to cultural beliefs and practices go a long way in determining the large differential in teenage pregnancy rates among the different population groups.<sup>263</sup>

Willan, quoting Jewkes *et al*, notes that the problem of teenage pregnancy is not just an issue of reproductive health and young women's bodies but rather one that is rooted in women's gendered social environment.<sup>264</sup> In the writer's opinion the menace of teenage pregnancy in South Africa is enveloped by gendered norms, sexual taboos, especially surrounding adolescent sexuality, and the existence of gender inequalities

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<sup>261</sup> Even though it has been touted that one of the reasons why female adolescents may be 'deliberately' getting pregnant because of the child support grant paid to adolescent mothers, this assertion is however unfounded as evidence revealed that only a few percentage of adolescent girls actually benefit from the grant unlike the number of teenage pregnancies that actually occur in the country yearly. See Macleod 'Teenage pregnancy and its 'negative' consequences (n 259 above) 1-7; M Richter 'Bread, baby shoes or blusher? Myths about social grants and 'lazy' young mothers' (2009) 99 *South African Medical Journal* 94.

<sup>262</sup> Panday *et al* (n 119 above).

<sup>263</sup> Panday *et al* (as above) 11, 12 & 21.

<sup>264</sup> Willan (n 252 above) 14.

within the society which continue greatly to influence how, when and why teenagers have sex.<sup>265</sup>

Especially in South Africa, the continued existence of myths about contraceptives and the discouraging attitude of parents and partners<sup>266</sup> prevent adolescent girls from utilising available and accessible contraceptive information and services and continue to place adolescent girls at risk of pregnancies. Like their Nigerian contemporaries, they are also exposed to major medical consequences that result from teenage pregnancies, including having higher probabilities of experiencing elevated risks of maternal deaths and obstetrics complications, including vesico-vaginal fistula (VVF).<sup>267</sup>

### 6.3 Abortion

Similar to the Nigerian situation, the non-use of contraceptives by adolescent girls in South Africa (for whatever reason) increases their chances of becoming pregnant. While a majority of teenage girls go ahead to give birth to their babies, as is evidenced by the large number of adolescent mothers in South African Society,<sup>268</sup> some have an abortion of the unwanted pregnancy for reasons associated with fear of parents and shame, as

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<sup>265</sup> Willan (as above) 14.

<sup>266</sup> Mudhovozi *et al* (n 148 above) 130 & 131; Mothiba & Maputle (n 128 above) 4; Partners in Sexual Health (n 158 above) 26 & 27. See also Dr I S Ziyane & V J Ehlers 'Swazi youths' attitudes and perceptions concerning adolescent pregnancies and contraception' (2006) 11 *Health SA Gesondheid* 36.

<sup>267</sup> Vesico-vaginal fistula is a condition which causes continuous involuntary discharge of urine into the vaginal vault and is often caused by prolonged labour and childbirth which presses the unborn child tightly against the immaturely-developed pelvis. See Panday *et al* (n 119 above).

<sup>268</sup> According to facts from the 2003 demographic health survey, the number of teenagers who have begun childbearing rose from two per cent at 15 years to 27% at the age of 19. See Department of Health & Medical Research Council (MRC) *South Africa Demographic and Health Survey* (n 180 above) 161. In the South African health review 2011, it was revealed that as at 2008, 21.9 adolescents were already mothers. See C Day *et al* 'Health and related indicators' in *South African Health Review* (2011) 180, available at <http://www.hst.org.za/sites/default/files/Chap%2011%20Indicators.pdf> (11 November 2013).

well as the inability to care for child due to financial constraints and their wish to continue schooling.<sup>269</sup>

As noted in chapter three, South Africa is one of the few countries within Africa where the procurement of abortion upon a woman or adolescent girl's request is legal as the Choice On Termination of Pregnancy Act<sup>270</sup> allows a woman of any age to solely reach a decision to terminate her pregnancy within the first 12 weeks without the consent or interference of anybody, free of charge.<sup>271</sup> Yet, a lot of girls still undergo unsafe and illegal abortion procedures, instead of approaching public hospitals for the services as a result of the social stigma attached to the termination of pregnancy.<sup>272</sup>

Noting the extent of stigmatisation of abortion in South Africa, Trueman states that the conscientious objection exception is used extensively to prevent adolescent girls who get pregnant from accessing legal abortion. According to her, it is not only health providers who stigmatise but also security men, receptionists and even maintenance workers in health care facilities.<sup>273</sup> Coupled with the societal stigmatisation experienced by providers of abortions who are often placed out of view in hospital setting, the number of termination of pregnancies performed in the public sector decreases yearly.<sup>274</sup> Adolescent girls who get pregnant patronise quacks outside the sector for abortion services which poses greater risks, since it increases the chances of maternal

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<sup>269</sup> M E Ratlabala *et al* 'Perceptions of adolescents in low resourced areas towards pregnancy and the choice on termination of pregnancy (CTOP)' (2007) 30 *Curationis* 29.

<sup>270</sup> COTP Act.

<sup>271</sup> After twelve weeks, other factors and steps need to be considered and put into consideration before termination of pregnancy can occur. Secs 2 & 5(2)(3) COTP Act .

<sup>272</sup> Unsafe Abortion in South Africa: A Preventable Pandemic (2012) available at <http://www.ngopulse.org/blogs/unsafe-abortion-south-africa-preventable-pandemic> (9 November 2013); MacPhail *et al* (n 159 above) 5.

<sup>273</sup> IPAS *Is the door to safe abortion services slowly closing in South Africa?* (2013) available at <http://www.ipas.org/en/News/2013/April/Is-the-door-to-safe-abortion-services-slowly-closing-in-South-Africa.aspx> (12 November 2013).

<sup>274</sup> Day *et al* 'Health and related indicators' (n 268 above) 178-179.

deaths, excessive bleeding, incomplete abortion, injury of the reproductive organs which may result in infertility and exposes them to contracting STIs and HIV.<sup>275</sup>

According to the WHO *Trends in maternal mortality: 1990 to 2010*<sup>276</sup> report, maternal mortality rates in South Africa have an increased maternal mortality ratio of 300 deaths per 100 000 live births.<sup>277</sup> The country's fifth Saving Mothers report 2008-2010, a confidential enquiry into the causes of maternal deaths in South Africa,<sup>278</sup> showed that of the 4,867 maternal deaths that were recorded between 2008 and 2010, 186 of them related to miscarriage in public health care facilities.<sup>279</sup> It has been emphasised that 44 of the 186 maternal deaths involved complications from unsafe abortion.<sup>280</sup>

#### 6.4 HIV and STIs

As noted in the paragraph dealing with HIV and STIs in Nigeria, another major problem that adolescent girls in South Africa face, in addition to the problem of unwanted/unintended teenage pregnancies, relates to the challenge posed to the maintenance of good SRH as a result of their engagement in unsafe sexual practices without the use of condoms thereby increasing their risk of STIs and HIV infection.<sup>281</sup> According to Panday *et al*, the magnitude of the HIV and AIDS hazard is such

<sup>275</sup> Ratlabala *et al* (n 269 above) 29.

<sup>276</sup> WHO *Trends in maternal mortality: 1990 to 2010* (n 219 above). See also CIA *The world fact book* (n 219 above).

<sup>277</sup> When compared to the 1990 MMR of 250. See WHO *Trends in maternal mortality: 1990 to 2010* (as above) 44.

<sup>278</sup> Department of Health *Saving Mothers 2008-2010: Fifth report on the confidential enquiries into maternal deaths in South Africa* (2012) available at <http://www.doh.gov.za/docs/reports/2012/savingmothersshort.pdf> (11 November 2013).

<sup>279</sup> Department of Health *Saving Mothers 2008-2010* (as above) 4.

<sup>280</sup> Department of Health *Saving Mothers 2008-2010* (as above) 4; South Africa NGO *Pulse Unsafe Abortion in South Africa: A Preventable Pandemic* (2012) available at <http://www.ngopulse.org/blogs/unsafe-abortion-south-africa-> November preventable-pandemic (11 November 2013).

<sup>281</sup> E Durojaye 'Access to contraception for adolescents in Africa: A human rights challenge' (2011) 44 *Comparative International Law Journal of Southern Africa* 6.

that it is now recognised as the primary reproductive health concern for adolescents, overtaking the long-standing emphasis on adolescent fertility.<sup>282</sup>

Observing that over half of the estimated four million episodes of STIs which occur yearly in South Africa are among adolescents and young adults, Dickson-Tetteh and Ladha surmise that adolescents are particularly vulnerable to sexually transmitted diseases because they are susceptible to peer pressure and have a tendency to engage in sexual risk-taking.<sup>283</sup> Confirming the effect of socio-cultural barriers which prevent female adolescents from accessing or using contraceptives, Day and Gray in the recent *South African Health Review of 2012/13* explain that issues of gender inequality and access to formal education, rather than the lack of knowledge about HIV/AIDS or lack of knowledge on how to practice safe sexual relations, was responsible for the non-use of contraceptives or dual protection methods, as the self-perceived ability to choose to use a condom was significantly lower with steady partners as compared to casual partners.<sup>284</sup>

Further proving that the barriers which prevent female adolescents from using contraceptives has a negative effect and impact, not only on their SRH but also on their total wellbeing, statistics released by the UNICEF based on 2011 data revealed that South African female adolescents and young women constitute a larger percentage of adolescents infected with HIV. The HIV prevalence rate among this group of women amounts to 11.9% as compared to that of their male counterparts which stands at

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<sup>282</sup> Panday *et al* (n 119 above).

<sup>283</sup> Out of the total HIV prevalence rate of 17.3%, adolescents and youths constitute 8.6%. See K Dickson-Tetteh & S Ladha 'Youth health' in *South Africa Health Review* (2000) 396, available at [http://www.healthlink.org.za/uploads/files/chapter20\\_00.pdf](http://www.healthlink.org.za/uploads/files/chapter20_00.pdf) (11 November 2013); UNICEF *South Africa Statistics* available at [http://www.unicef.org/infobycountry/southafrica\\_statistics.html#102](http://www.unicef.org/infobycountry/southafrica_statistics.html#102) (28 October 2013).

<sup>284</sup> C Day & A Gray 'Health and related indicators' in A Padarath & R English (eds) *South African Health Review* (2013) 236.

5.3%.<sup>285</sup> Correlating with the above fact, the 2011 National Antenatal Prevalence Survey revealed that the HIV prevalence among 15 - 24 year old pregnant women was 20.5%.<sup>286</sup>

## 6.5 Socio-economic consequences

Unlike most developing countries, including Nigeria, where adolescent girls who become pregnant are expelled from schools in order not to contaminate the 'morals' of other girls, female adolescents in South Africa are neither expelled nor forbidden to return to school after giving birth due to legislative and constitutional provisions put in place to guarantee teenage girls access to education at all cost. This provision arises through an understanding of the effect of education in reducing gender imbalance and improving the socio-economic circumstances of adolescent girls. Whilst constitutional provisions on the right to education<sup>287</sup> and equality<sup>288</sup> guarantee adolescent girls' a right to education without discrimination, even on grounds of pregnancy, the provisions of the South African Schools Act,<sup>289</sup> which mandates compulsory attendance in school of all children, irrespective of sex, until the age of 15 years or until reaching the 9<sup>th</sup> grade seeks to protect and permit school attendance for pregnant adolescents and returning adolescent mothers in order to ensure that they get an education and increase their economic standing.<sup>290</sup>

In spite of the proactive step, however, evidence continually reveals that, in a majority of instances, adolescent mothers are usually unable to return to school as a result of

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<sup>285</sup> UNCEF *South Africa Statistics* (n 283 above). See also UNFPA *HIV prevention: Fact sheet* (n 149 above).

<sup>286</sup> Department of Health *The National Antenatal Sentinel HIV and Syphilis Prevalence Survey South Africa 2011* (2012) V, available at [http://www.doh.gov.za/docs/presentations/2013/Antenatal\\_Sentinel\\_survey\\_Report2012\\_final.pdf](http://www.doh.gov.za/docs/presentations/2013/Antenatal_Sentinel_survey_Report2012_final.pdf) (12 November 2013).

<sup>287</sup> Sec 29(1) Constitution of the Republic of South Africa.

<sup>288</sup> Sec 9(3) Constitution of the Republic of South Africa.

<sup>289</sup> South African Schools Act No. 84 of 1996.

<sup>290</sup> Willan (n 252 above) 34; D Bhana *et al* 'South African teachers' responses to teenage pregnancy and teenage mothers in schools' (2010) 12 *Culture, Health & Sexuality: An International Journal for Research, Intervention and Care* 872.

several factors. Quoting Chigona and Chetty's assertion that female adolescents most affected by teen pregnancy are those who are already living in impoverished conditions before becoming pregnant, Willan explains that approximately, only one third of teenage mothers return to school following childbirth.<sup>291</sup> The factors which determine whether an adolescent mother returns to complete schooling vary. Bhana *et al* note that 'the ability to navigate the world of parenting and schooling is strongly associated with race/class and gender'. According to the writers, a majority of teenage mothers are disadvantaged, not by pregnancy alone, but by existing social structures which prevent economically disadvantaged girls from juggling between both schooling and parenting.<sup>292</sup>

Whilst some adolescent girls are unable to cope with schooling because of the stress involved in caring for a child and studying at the same time, others drop out of school because they do not possess the financial wherewithal to feed or provide for the child's needs without working as a baby brings about additional expenses for already poor households.<sup>293</sup> Other reasons for not returning to school include the problem of stigmatisation as the pregnant teenagers are shunned by their peers and receive harsh treatment and insufficient support from their schools and teachers.<sup>294</sup>

Whatever the reasons adduced for dropping out of school, it is argued that the effect of socio-cultural, financial, religious barriers, which continue to prevent adolescent girls from having access to contraception and enjoying good SRH, is enormous. The reality is, in a majority of cases, that adolescent girls who get pregnant have a higher possibility of being unable to complete schooling or achieving their educational goals. Instead of

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<sup>291</sup> Willan (as above) 34 & 44.

<sup>292</sup> Bhana *et al* (n 290 above) 877.

<sup>293</sup> See generally Willan (n 252 above) 44-45; Bhana *et al* (as above) 877; L Luffman *South Africa's school-age mothers struggle to stay in education* (2013) available at <http://www.soschildrevillages.org.uk/about-our-charity/archive/2013/09/south-africas-school-age-mothers-struggle-to-stay-in-education> (15 November 2013).

<sup>294</sup> Willan (as above).

being able to develop themselves educationally, in order to break-out of the trap of poverty, in most instances, they become further encased in it by losing their chances of improving their economic status later in life.

## 6.6 Conclusion

The consequences of the barriers that make access to contraceptive information and services impossible for South African adolescent girls have been analysed. It is clear that South Africa has taken giant steps to mitigate the disastrous effects occasioned by societal barriers to contraceptives usage through its enactment of legislation that allows access to safe abortion services for adolescent girls who may wish to terminate their pregnancies. As well, provisions on the right to education and non-discrimination guaranteed under the South African Bill of Rights and the Schools Act 1996 seek to prevent the discrimination of pregnant teenagers and provide them with the opportunity of returning to school after pregnancy.

The guarantee of access to safe abortion services has not fully achieved its intended objective as a result of its frustration by the same socio-cultural barrier that prevents contraceptive use. This results in girls resorting to unsafe abortion procedures. Similarly, giving adolescent girls the opportunity of returning to school after pregnancy has not been totally successful in ensuring greater school completion rates since other factors, such as poverty and child care issues, continue to affect the ability to complete schooling by adolescent mothers, with the result that they lose the opportunity to improve their economic circumstances. In addition, even though the HIV and AIDS epidemics are severe in South Africa, the effects of the barriers affecting female adolescent access to contraception are also felt in the sense that HIV infection rates are

three times higher among adolescent girls and young women than their male contemporaries.<sup>295</sup>

As submitted earlier, the socio-cultural and religious reasons which are used in preventing female adolescents' access to contraceptives are not worth the consequences as a result of these barriers. As a result, there is need for the South African government to engage in substantial sensitisation campaigns to encourage a change of attitude. Especially among black South African communities, there is need for a transformation of views by jettisoning myths and superstitions associated with contraceptive usage. The eventual outcome of adolescent girls making use of available family planning services is not only enormous but will contribute greatly towards the economic empowerment of the girl child.

## 7 Chapter conclusion

The focus in this chapter has been on the various factors which impede female adolescents' access to contraceptive information and services in Nigeria and South Africa, and the consequences that result from the existence of these barriers. Specifically, the effect of the legal, socio-cultural, economic, religious and demographic dynamics on adolescents' uptake and use of contraception was examined in order to determine whether these factors contribute positively or negatively to adolescent girls' use of contraceptives.

Even though the regulation of adolescent sexuality through fixing the age of consent to sexual intercourse as a means of protecting adolescent girls from the activities of sexual predators is supported and approved of, it is submitted that the insertion of blanket provisions, which generally criminalise sex with 'minors' in the Criminal Code, Penal

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<sup>295</sup> UNCEF *South Africa Statistics* (n 283 above); UNFPA *HIV prevention: Fact sheet* (n 149 above); Department of Health *The National Antenatal Sentinel HIV and Syphilis Prevalence Survey South Africa 2011* (n 286 above) V.

Code and CRA without taking cognisance of consensual sexual activities between adolescents, is a shortcoming. Studies have revealed that, apart from having sex with older men for pecuniary gain, adolescent girls also have sexual relationships with their peers<sup>296</sup> and will prefer forgoing contraception rather than expose their sexual partners.

In order to achieve the twin intentions of ensuring that adolescent girls are protected from sexual predators and also guarantee access to contraceptive services, it is felt that there is a need for the Nigerian legislature to review the country's criminal laws on statutory rape. Such a review ought to distinguish between situations of consensual sex between adolescents with more than a two to three year age-gap, and take cognisance of the reasons which influenced the Constitutional Court's decision in the *Teddy Bear Clinic* case, so as to ensure that the best interests of adolescent girls in Nigeria are served in relation to the protection of their SRH. In addition, the fact that the three laws (the Criminal Code, Penal Code and CRA) provide for different ages of sexual consent reveals the need for revision in order to achieve uniformity.

In the case of South Africa, there is a need for the South African legislature to speedily resolve and address the conflicts generated as a result of the controversial sections in the Criminal Law (Sexual Offences and Related Matters) Amendment Act<sup>297</sup> through the adoption of measures that not only promote good adolescent SRH practices, but also assist in constructively deterring the initiation of early sexual activities among adolescents. This must be done without the application of criminal sanctions.

It is important to point out that while the problem of societal stigmatisation, including provider hostility, is one of numerous factors which prevent adolescent girls in Nigeria from going to public health care facilities to access contraception, thereby leaving them

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<sup>296</sup> See secs 39 & 285 Penal Code; secs 218,221 & 222 Criminal Code; sec 31(1) & (2) Child Rights Act & *Amazigo et al* (n 35 above) 30.

<sup>297</sup> Secs 15, 16 & 56 Criminal Law (Sexual Offences and Related Matters) Amendment Act.

to the mercy of charlatans and patent drug sellers, in South Africa the major barrier which prevents adolescent girls from using contraception relates to socio-cultural factors that stigmatise adolescent contraceptive use and promote the spread of superstitious beliefs of infertility, as well as provider-bias in serving adolescent SRH care needs. The fact that communication on sexuality between parents and adolescents is regarded as a cultural taboo in both countries does not help matters. Adolescents, generally, still seek other means of getting SRH information, although such information may be wrong, false or destructive. In view of the above, as submitted in the concluding sections of this chapter for both countries, there is a need for the governments to adopt serious sensitisation campaigns that will achieve social and attitudinal changes in order to disabuse people (including health providers) of the negative opinions and superstitions associated with contraceptive use and future infertility so that more female adolescents can start using contraceptives in order to protect themselves, not only from unintended pregnancies, but also STIs.

Pertaining to the problem of inter-generational and transactional sex which affects both Nigerian and South African female adolescents, it is submitted that the issue of poverty has to be tackled extensively. Only the total upliftment of the socio-economic status of the female members of the society can assist in the elimination of factors which fuel unequal gender interactions. As Samuels *et al* observe, the HIV and AIDS epidemics are mainly prevalent in socio-economic settings characterised by unequal gender relations and poor economic backgrounds/living conditions, which currently apply to both Nigerian and South African societies and which heighten the vulnerability of women and adolescent girls.<sup>298</sup>

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<sup>298</sup> Samuels *et al* *HIV vulnerabilities and the potential for strengthening social protection responses in the context of HIV in Nigeria* (2012) 10, available at <http://www.odi.org.uk/sites/odi.org.uk/files/odi-assets/publications-opinion-files/7581.pdf> (5 November 2013). See also V A Onwuliri & O M Jolayemi 'Reaching vulnerable and high-risk groups in Nigeria' in *AIDS in Nigeria: A Nation on the Threshold* (2006)

Additionally, in relation to the barrier posed by demographic factors which especially reduce the access of female adolescents in rural areas to contraceptive information and services (especially in the case of Nigeria), there is the need to further strengthen public health care systems in rural areas. The facilities should have adequate equipment, drugs and man-power, and also, they should be situated at distances that will be easily accessible to adolescent girls who require SRH care services. As well, while South Africa still needs to increase the number of existing mobile clinics providing health care services in order to reach more women (adolescent girls especially) in need of contraceptives, Nigeria needs to adopt the idea of mobile clinics in order to ensure that health care services, including contraceptives and other SRH care services, get to adolescents and women residing in rural communities.

Also, in view of the fact that a major reason that prevents adolescents girls from using government health care facilities in rural areas relates to the view that their privacy and confidentiality will not be assured as a result of the fact that most rural communities are close-knit, there is a need to ensure that adolescent-friendly centres where female adolescents can access contraception are not only situated in discreet areas but also provide other social interaction services, and operate adolescent-friendly hours which will encourage more female adolescents to visit the facilities.

In addition to examining the barriers that prevent female adolescents' access to contraceptive information and services, the consequences of the numerous barriers in both countries were analysed. Grouped under four major headings - teenage pregnancy, abortion, HIV and STIs and socio-economic consequences - an attempt was made to look into how the various outcomes affect adolescent girls and prevent them from enjoying their reproductive health rights as guaranteed under international and regional human

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313, available at <http://www.apin.harvard.edu/Chapter14.pdf> (5 November 2013); Brook (n 176 above) 261-262; Esiet (n 8 above); Luke & Kurz (n 86 above)3.

rights instruments, as well as agreed to in consensus documents signed by the Nigerian and South African governments.

In addition to the suggestions already advanced in the concluding parts of the sections of this chapter on the consequences of barriers on Nigeria and South Africa, and taking note of the overall effect of the consequences occasioned as a result of the lack of access of adolescent girls to contraceptive and other life-saving reproductive health care services, it is crucial to state, as Durojaye suggests, that there is a paramount need for the governments of Nigeria and South Africa (especially the Nigerian government) to ask the 'female adolescent question'.<sup>299</sup> This action is necessary in order to appraise the steps that have been adopted so as to discover whether such measures are not only gender sensitive, but have been effective in guaranteeing adolescent girls access to contraceptive information and services and protecting them from negative SRH consequences.

The intention in the next chapter is, specifically, to undertake a comparative analysis of those salient similarities and differences, noticed throughout the thesis, in legislation, policies and the approaches of Nigeria and South Africa in guaranteeing adolescent girls' access to contraceptive information and services.

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<sup>299</sup> According to Durojaye, asking the 'female adolescent question', just like the 'woman question' is a necessary tool in evaluating the effectiveness or otherwise of laws and policies relating to the SRH needs of adolescent girls. See Durojaye 'Realising access to contraception for adolescents in Nigeria' (n 8 above) 63.

## CHAPTER 7

# CONCLUSIONS REGARDING THE COMPARATIVE STUDY ON FEMALE ADOLESCENTS' ACCESS TO CONTRACEPTIVE INFORMATION AND SERVICES IN NIGERIA AND SOUTH AFRICA

### Outline

- 1 Introduction**
- 2 Conclusions drawn from the comparative study of female adolescents' rights to contraceptive information and services in Nigeria and South Africa**
  - 2.1 Applicability of ratified human rights instruments in Nigeria and South Africa
  - 2.2 Comparison of fundamental rights in Nigeria and South Africa
    - 2.2.1 Comparing the right to health care in Nigeria and South Africa
    - 2.2.2 Comparing the right to life in Nigeria and South Africa
    - 2.2.3 Comparing the right to dignity in Nigeria and South Africa
    - 2.2.4 Comparing the right to privacy in Nigeria and South Africa
    - 2.2.5 Comparing the right to information in Nigeria and South Africa
    - 2.2.6 Comparing the right to be free from discrimination in Nigeria and South Africa
  - 2.3 Comparing the extent of children's rights in Nigeria and South Africa
    - 2.3.1 Autonomy
    - 2.3.2 Best interests
  - 2.4 Comparing child marriage in Nigeria and South Africa
  - 2.5 Comparing laws and policies other than the Constitution in Nigeria and South Africa
  - 2.6 Comparing sexuality education in Nigeria and South Africa
  - 2.7 Comparing access to sexual and reproductive health care services in Nigeria and South Africa
  - 2.8 Comparing consequences resulting from non-access to contraceptive information and services in Nigeria and South Africa
  - 2.9 Comparing judicial intervention in relation to the right to health care in Nigeria and South Africa
- 3 Chapter conclusion**

## 1 Introduction

Chapters 2 and 3 analysed human rights instruments and national legislation guaranteeing female adolescents' right to access contraceptive information and services in Nigeria and South Africa; Chapters 4 and 5 examined the concept of autonomy: its importance to adolescent girls SRH decision-making processes and the approaches adopted by Nigeria and South Africa in fulfilling their obligation to respect, protect and fulfil<sup>1</sup> adolescent girls' right to contraceptives and reproductive health care. In the previous chapter, impediments preventing access to contraceptive information and services for female adolescents' in the two countries and their resulting consequences were scrutinised.

In view of the fact that the thesis is a comparative study of female adolescents' right to access contraceptive information and services in Nigeria and South Africa, in this chapter my aim is to offer conclusions regarding the situation in Nigeria and South Africa, based on an assessment and comparison of adolescent girls' access to contraceptive information and services in both countries. To achieve the goal, I intend to compare the position adopted by the two countries in relation to the application of ratified human rights instruments, the fundamental rights relevant to female adolescents' access to contraceptive information and services, the approach adopted in teaching sexuality education, and national legislation which guarantees access to SRH information and services. As well, the obstacles which hinder access and their consequences in both countries will be compared.

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<sup>1</sup> Para 33 General comment 14 ICESCR Committee *Compilations of General Comments and recommendations adopted by human rights treaty bodies Vol I*, available at [http://www.minoritycentre.org/sites/default/files/HRI-GEN-1-Rev.9%20\(Vol.%20I\).pdf](http://www.minoritycentre.org/sites/default/files/HRI-GEN-1-Rev.9%20(Vol.%20I).pdf) (21 October 2013).

Finally, I will compare the role played by the judiciary in ensuring government compliance with the duty to respect, protect and fulfil the right to health care of adolescent girls so as to draw conclusions therefrom.

## **2 Conclusions drawn from the comparative study of female adolescents' right to contraceptive information and services in Nigeria and South Africa**

From the studies undertaken in previous chapters of this thesis, it is evident that similarities as well as differences exist in the legal frameworks adopted by Nigeria and South Africa in protecting the human rights of its citizens, in general, as well as with regards to the right of adolescent girls to contraceptive information and services.

Although both Nigeria and South Africa are signatories and parties<sup>2</sup> to human rights treaties and declarations affirming the protection of the right to health and SRH, they differ in their methods of interpretation, protection, enforcement and limitation of the enjoyment of these rights. The central focus in this section, therefore, is on highlighting the similarities and differences which require attention in relation to the postulates of the thesis.

### **2.1 Applicability of ratified human rights instruments in Nigeria and South Africa**

As noted in Chapter 2, although state parties are bound by human rights instruments<sup>3</sup> they ratify, such ratification is nevertheless dependent upon the status of those treaties and their mode of application in the legal systems of the ratifying states.

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<sup>2</sup> It is necessary to highlight the fact that South Africa is only a signatory to the ICESCR which it signed in October 1994.

<sup>3</sup> A O Enabulele & C O Imoedemhe 'Unification of the application of international law in the municipal realm: A challenge for contemporary international law' (2008) 12 *Electronic Journal of Comparative Law (EJCL)* 6.

Both Nigeria and South Africa are signatories and parties to the international and regional instruments which assure female adolescents protection of their rights to contraceptive information and services, but the method adopted in giving effect to the ratified treaties differ and, ultimately, this difference goes a long way to influence how effective these human right instruments are in the two jurisdictions.

Nigeria's foreign policy objective contained in the 1999 Constitution declares the intention to encourage international co-operation in order to consolidate the achievement of universal peace and mutual respect among all nations, eliminate discrimination in all its manifestations and ensure respect for international law and treaty obligations.<sup>4</sup> The same Constitution, in making provision for the implementation of treaties, provides that 'no treaty between the Federation and any other country shall have the force of law except it has been enacted into law (domesticated) by the National Assembly'.<sup>5</sup>

As is the case with dualist states that aim to preserve their sovereignty from foreign influences in the guise of international law,<sup>6</sup> section 12 renders unenforceable in Nigeria any treaty that has not been domesticated as Nigerian law by the National Assembly and, in some cases, the State Houses of Assembly.<sup>7</sup> To date, despite the large number of human rights instruments that have been ratified by Nigeria, the only human right instruments that can be considered domesticated, and therefore given state enforceability in Nigerian courts, is the ACHPR<sup>8</sup> and the CRC, with its regional

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<sup>4</sup> Sec 19 (c) & (d) Nigerian Constitution 1999.

<sup>5</sup> Sec 12(1) Nigerian Constitution 1999.

<sup>6</sup> A O Enabulele 'Implementation of treaties in Nigeria and the status question: Whither Nigerian courts?' (2009) 17 *African Journal of International and Comparative Law* 328.

<sup>7</sup> Sec 12(2) & (3) Nigerian Constitution 1999.

<sup>8</sup> Nigeria domesticated the ACHPR through the African Charter on Human and Peoples Rights (Ratification and Enforcement) Act Cap A9, LFN 2004, available at [http://www.aidh.org/Biblio/Txt\\_Afr/Images/Charte%20A%20Ratifications.pdf](http://www.aidh.org/Biblio/Txt_Afr/Images/Charte%20A%20Ratifications.pdf) accessed (8<sup>th</sup> October, 2012).

counterpart the ACRWC.<sup>9</sup> It is important to reiterate, as mentioned in Chapter 3, the domestication of the CRC as a national legislation does not guarantee universal enforceability throughout the country as State Houses of Assembly still need to pass similar legislation in order to make the Convention enforceable as issues relating to child rights protection are on the residual list of the Nigerian Constitution.<sup>10</sup>

It is argued that the position adopted by Nigeria in its Constitution by making a ‘blanketed’ provision of domestication before the applicability of ratified treaties nationally does not take cognisance of the human rights contents of treaties that do not require further or special measures for their application. This impulse has natural consequence: the current state of affairs where, even though the country has ratified a number of human rights treaties, their provisions are unenforceable as a result of the section 12(1) constitutional provision.

South Africa, too, is a dualist state in terms of the country’s 1996 Constitution. While allowing the executive to negotiate and sign all international agreements on behalf of the state, the Constitution provides that such international agreements (especially those that require ratification and accession), only bind the Republic after their approval by means of resolution, in both the National Assembly and the National Council of Provinces.<sup>11</sup>

Unlike the position in Nigeria however, the Constitution of the Republic of South Africa allows for direct application of self-executory provisions in treaties that have been approved and ratified by Parliament in so far as the provisions are not inconsistent with

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<sup>9</sup> Child Rights Act cap C50 Laws of the Federation of Nigeria 2004.

<sup>10</sup> This gives state governments the exclusive responsibility and jurisdiction to make laws for children in their respective states according to their relevant and specific situations. See specifically the section relating to the CRA already discussed in Chapter 3 of this thesis.

<sup>11</sup> Sec 231(1) (2) Constitution of the Republic of South Africa. It should be noted that only treaties that are non-self-executory require domestication by the country’s legislative arm.

the Constitution or other existing legislation.<sup>12</sup> In addition to the direct inclusion of a provision allowing for such recognition and the direct application of self-executory provisions as law, the Constitution mandates the courts to take cognisance of international law when interpreting provisions contained in its Bill of Rights.<sup>13</sup>

Whilst the reason for dualism is understood, basically, as a means of protecting the sovereignty of state parties by allowing them to determine the extent to which international law is incorporated into their legal systems, I feel that the position adopted by South Africa, in making certain human right provisions of treaties approved by Parliament self-executory, as well as compulsorily mandating its courts to take notice of international law when interpreting human rights issues, is a better approach, unlike the current Nigerian position where human rights treaties, whether self-executory or not, first have to be domesticated and incorporated into the legal system by the legislative arm of government. This requirement creates a situation where, even though a plethora of human rights instruments have been adopted by the country, such treaties continue to be unenforceable as a result of their non-domestication.

Nigeria should note the South Africa position in order to re-evaluate its stance on the issue in the near future in order to assure its citizens (in this case female adolescents) of its determination to fulfil their right to health through access to contraceptive information and services.

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<sup>12</sup> Sec 231(4) Constitution of the Republic of South Africa. See J D Mujuzi 'The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa: South Africa's reservations and interpretative declarations' (2008) 12(2) *Law, Democracy and Development* 43; E M Ngolele 'The content of the doctrine of self-execution and its limited effect in South African law' (2006) 31 *South African Yearbook of International Law* 161. It is necessary to point out here that South Africa is yet to ratify the ICESCR despite signing the Covenant in 1994. Going by the interpretation of section 231(4), its self-executory provisions in the ICESCR cannot apply to South Africa as a result of non-ratification. However, the fact that most provisions contained in the ICESCR (including the right to health care) are already contained in the country's Bill of Rights, allows for the enjoyment of socio-economic rights in the country.

<sup>13</sup> Sec 39(1)(b) Constitution of the Republic of South Africa.

## 2.2 Comparison of fundamental rights in Nigeria and South Africa

As noted in Chapter 3, both Nigeria and South Africa recognise the necessity of protecting the fundamental rights of their citizens. Nigeria provides for Fundamental Rights in chapter four of its Constitution; South Africa has a Bill of Rights which is contained in chapter two of its Constitution.

Thus, both Nigeria and South Africa have constitutional provisions on human rights in their constitutions. A study of the relevant sections in their constitutions reveals various similarities and differences. In the next sub-section the focus will be on those rights which have a specific bearing on the research issue.

### 2.2.1 Comparing the right to health care in Nigeria and South Africa

As noted by Ngwena, through the recognition of the right to health care (including reproductive health care) in section 27 of its Constitution, South Africa recognises the ‘indivisibility and interdependence of human rights that has been espoused in human rights jurisprudence’.<sup>14</sup> As explained in Chapter 3, South Africa’s constitutional recognition of the right to health care allows for the conferment of a justiciable right to all citizens (including adolescent girls) and permits the institution of a positive right that entitles access to health care on an equal basis in order to eliminate, or reduce to the minimum, disadvantages which prevent its inaccessibility.<sup>15</sup>

The above, differs greatly from the Nigerian position where as elucidated in Chapter 3, there is no constitutional guarantee of the right to health care or other socio-economic rights. Instead, health care is only mentioned under the country’s fundamental

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<sup>14</sup> C Ngwena ‘The recognition of access to health care as a human right in South Africa: Is it enough?’ (2000) 5 *Health and human rights* 28.

<sup>15</sup> Ngwena ‘The recognition of access to health care as a human right’ (as above) 29.

objectives and directive principles of state policy<sup>16</sup> without allowing for mechanisms that will make government inaction justiciable before the domestic courts.<sup>17</sup> Litigation to enforce the performance of state duties and obligations on the right to health has to be instituted in a ‘round about’ manner: either through the provision on the right to health contained in the African Charter which has been domesticated in the country,<sup>18</sup> or by instituting action for the infringement of the constitutionally-recognised right to life.

The right to health care and other socio-economic rights in the Constitution of the Republic of South Africa relating to adults as well as children are subject to the availability of resources.<sup>19</sup> However, children’s rights, including the right of children to basic health care, are constitutionally entrenched in section 28(1) but are unqualified by the proviso of ‘availability of resources’ contained in section 27(2). As Robinson explains, the use of the word ‘basic’ implies the minimum level of health care services that children require to live dignified lives.<sup>20</sup>

Apart from the recognition of the right to health care, which is an area of difference between the Nigerian Constitution and its South African counterpart, it is also acknowledged that the specific inclusion of children’s rights in South Africa’s Constitution is a particular area of distinction as well. It is hoped, that in the future

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<sup>16</sup> Sec 17(3) (d) Nigerian Constitution.

<sup>17</sup> 6(6)(c) Nigerian Constitution. The provisions of section 6(6)(c) ousts the jurisdiction of Nigerian courts to adjudicate matters listed under chapter two of the Constitution, thereby making it difficult to ensure protection or enforce performance. As explained in ch 3 and decided in *AG Ondo v A G Federation* (2002) 9 NWLR (Pt 772) 222 at 272, the provisions contained in chapter two of the Nigerian constitution can be made justiciable by means of legislation.

<sup>18</sup> Art 16 of the African Charter has been domesticated in Nigeria through the African Charter on Human and Peoples Rights (Ratification and Enforcement) Act Cap A9, LFN 2004.

<sup>19</sup> Secs 26(2) & 27(2) Constitution of the Republic of South Africa.

<sup>20</sup> See sub-section on the Constitution of the Republic of South Africa discussed in Chapter 3 and J A Robinson ‘Children’s rights in the South African Constitution’ (2003) 6 *Potchefstroom Electronic Law Journal* 41 & 42.

Nigeria will adopt a similar position by reviewing its constitution and inserting provisions that will, at least constitutionally, assure the provision of children's rights.

### 2.2.2 Comparing the right to life in Nigeria and South Africa

Both Nigeria and South Africa recognise the necessity of protecting the right to life in their constitutions, albeit with some differences. Whilst South Africa has abolished the death penalty as the right to life contained in the constitution is unqualified, in Nigeria, the opposite is the case, as the right to life of persons is qualified, in the sense that it can be limited on the execution of a court's sentence in respect of a criminal offence upon which the guilt of the offender has been established.<sup>21</sup>

In relation to the right to reproductive health care and access to contraceptive information and services, however, the need for female adolescents in Nigeria to rely on the protection afforded by the protection of the right to life cannot be overstated. The Nigerian Constitution makes no provision for the explicit recognition of a right to health (care) as is the case in South Africa. As pointed out in Chapter 3, going the court's explanation in *C.P.C v Nyako* that a broad and liberal interpretation should be adopted when interpreting a matter involving constitutional interpretation of fundamental rights<sup>22</sup> and as done in India,<sup>23</sup> the right to life can be used to canvass for the protection of the right to access contraceptives by adolescent girls in the country based upon the reasoning that their inaccessibility to contraceptive services exposes them to serious

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<sup>21</sup> Sec 33(1) Nigerian Constitution 1999 & sec 11 Constitution of the Republic of South Africa. See also Nigerian case of *Kalu v The State* (1988) 13 NWLR 531, 590.

<sup>22</sup> (2011) 17NWLR ( Pt 1277) 458.

<sup>23</sup> Art 21 Indian Constitution 1949. See *Parmanand Katara v Union Of India & Others* (1989) AIR 2039, (1989) SCR (3) 997; *Paschim Banga Khet Mazdoor Samity v State Of West Bengal & Another* (1996) SCC (4) 37.

health hazards (including STIs, HIV and unsafe abortion),<sup>24</sup> which may occasion death and, is therefore an infringement of their right to life.

Indeed, it is argued that the constitutional guarantee afforded by the protection of the right to life in Nigeria can be used to hold the Nigerian government accountable for the unnecessary loss of female adolescents' lives. This argument is in the sense that they are 'forced' to procure unsafe abortion services to terminate unwanted pregnancies as a result of the Nigerian government's inability to live up to their responsibility and duty of providing adequate access to affordable contraception and other SRH care services.

### 2.2.3 Comparing the right to dignity in Nigeria and South Africa

The importance of ensuring that people live dignified lives is recognised in both Nigeria and South Africa. The Constitutions of both countries acknowledge the necessity of guaranteeing the right to dignity.<sup>25</sup> Nigeria expressly forbids the subjection of people (including adolescent girls) to inhuman or degrading treatment; South Africa regards the right to dignity, one of the founding values of the country's constitution, as absolutely non-derogable and an acknowledgement of the intrinsic worth of human beings as persons worthy of respect and protection.<sup>26</sup>

As revealed in Chapter 5, a major impediment affecting female adolescents' access to contraceptive information and services in Nigeria and South Africa relates to the undignified treatment they receive from prejudiced health practitioners, who subject adolescent girls that attempt to access contraceptive services to embarrassment as a result of their cultural or religious bias. Given that adolescent girls will only endeavour

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<sup>24</sup> As pointed out in Chapter 7, the procurement of safe abortion procedures in Nigeria is also illegal except in situations where the life of the woman is in danger. See Secs 228 & 229 Criminal Code cap c38 LFN 2004 & secs 232 & 233 Penal Code cap p3 LFN 2004.

<sup>25</sup> Sec 34 Nigerian Constitution 1999 & sec 10 Constitution of the Republic of South Africa.

<sup>26</sup> Sec 37(5) Constitution of the Republic of South Africa; *S v Makwanyane and Anor* (1995) (3) SA 391 (CC), 1995 (6) BCLR 665 (CC) para 328.

to access contraception in circumstances where they are assured of receiving dignified and confidential treatment in adolescent-friendly environments, it is imperative that both governments become more pro-active by ensuring that adequate adolescent-friendly facilities are established all over the country. Correspondingly, the governments of Nigeria and South Africa need to make sure that only qualified health professionals that are comfortable dealing with adolescent sexuality and contraceptive issues are employed to be in charge of/work in such facilities.

#### 2.2.4 Comparing the right to privacy in Nigeria and South Africa

Looking at the manner in which the privacy right of individuals is drafted under the constitutions of both Nigeria and South Africa, it is patent that the right to privacy is cherished in both countries. Nigeria straight-forwardly provides that ‘the privacy of citizens, their homes, correspondence, telephone conversations and telegraphic communications is hereby guaranteed and protected’;<sup>27</sup> South Africa, apart from broadly stating that ‘everyone has the right to privacy’, includes areas protection of the right to privacy to include protection from unlawful searches and seizures.<sup>28</sup>

In relation to the right to health care, including SRH, apart from the general right to privacy provided in section 14 of the Constitution of the Republic of South Africa, provision is made specifically for the right of people (including women and girls) to bodily and psychological integrity, including the right to make (*private*) decisions concerning reproduction and have control of their body.<sup>29</sup> The specific inclusion of the sub-section on the right to make decisions on reproduction, therefore, makes it easier for South African female adolescents not to only have a right to privacy but also to possess a concurrent right to make decisions on reproduction which include making

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<sup>27</sup> Sec 37 Nigerian Constitution.

<sup>28</sup> Sec 14 Constitution of the Republic of South Africa 1996.

<sup>29</sup> Secs 12(2)(a) & (b) Constitution of the Republic of South Africa.

personal choices on whether to access contraceptive services and information or not, privately.

As explained in Chapter 4, the South African court's refusal, in its decision in *Christian Lawyers Association v Minister of Health & Others (Reproductive Health Alliance as Amicus Curaie)*,<sup>30</sup> to declare the COTP Act unconstitutional, despite arguments that the Act allowed adolescent girls' access abortion services without parental knowledge or consent, is a succinct indicator of the court's approval and recognition of the right of South African adolescent girls to access reproductive health care services in a private and confidential setting. According to the court, the legislature did not leave the area of the termination of pregnancy unregulated, as modalities had been laid down to ensure that only people (including adolescent girls') capable of giving informed consent can access the services in the first place.<sup>31</sup>

Although the right to make SRH decisions or the right to health care is not specifically provided in the Nigeria's Constitution, the provision of the right to privacy naturally provides ample grounds from which the right of female adolescents to privately access confidential contraceptive services can be inferred. It is however expected, as the case in South Africa, that future amendments of the Nigerian Constitution will take note of the difference highlighted above to make provision for more instances where privacy rights will be protected, such as the right to bodily and psychological integrity, including the right to make (*private*) decisions concerning reproduction.

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<sup>30</sup> *Christian Lawyers Association v Minister of Health & Others (Reproductive Health Alliance as Amicus Curaie)* 2005 (1) SA 509 (T).

<sup>31</sup> See generally the sections on adolescents and the need for autonomy and confidentiality in Chapter 4 of this thesis.

### 2.2.5 Comparing the right to information in Nigeria and South Africa

The right to information,<sup>32</sup> though provided for in both constitutions, is broader in the Constitution of the Republic of South Africa than in its Nigerian counterpart. Apart from the provision on the freedom to receive and impart information provided in section 16(1)(b) of South Africa's Bill of Rights, there is a further provision on the right to information, specifically, made in section 32 of the right of everyone to access any information that is required for the exercise or protection of any rights.<sup>33</sup> It is argued that the provision of this sub-section provides further constitutional backing for female adolescents' right to access contraceptive information and services in South Africa.

In Nigeria, as indicated in Chapter 3, unlike in the past, when the right to information only pertained to the freedom to seek and receive information on ideas without governmental interference, the frontiers of the right to information, as Coliver explains, has evolved to impose concrete and immediate obligations on state parties not only to provide access to information that is needed for the promotion and protection of the reproductive health choices of adolescent girls but also to refrain its agents from preventing access to such information.<sup>34</sup> It is submitted that the frontier of the right to information in Nigeria can be broadened to include the right, specifically to access information that is crucial for the protection and promotion of healthy SRH choices by adolescent girls in Nigeria.

It will be a positive step, if a provision specifically providing for the right to access information that is required for the exercise or protection of any rights can be drafted into subsequent amendments of the Nigerian Constitution, as is the case in South Africa.

<sup>32</sup> Sec 39(1) Nigerian Constitution 1999 and sec 16(1)(b) Constitution of the Republic of South Africa 1996.

<sup>33</sup> Sec 32(1)(b) Constitution of the Republic of South Africa 1996.

<sup>34</sup> S Coliver 'The right to information necessary for reproductive health and choice under international law' in S Coliver (ed) *The Right to Know: Human rights and access to reproductive health information* (1995) 39.

### 2.2.6 Comparing the right to be free from discrimination in Nigeria and South Africa

Although both Nigeria and South Africa provide for the right to be free from discrimination,<sup>35</sup> as highlighted in Chapter 3, the right to equality, as drafted in the Constitution of the Republic of South Africa, is wider in scope and clearer than that of Nigeria. Nigeria provides for the right not to be subjected to discrimination on the grounds of sex, religion, ethnic group, place of origin and political opinion; it does not provide for the grounds upon which female adolescents in the country are constantly subjected to discrimination, discrimination as a result of age and marital status. This is unlike South Africa, where other grounds, such as pregnancy and marital status, are included, thereby attempting, as much as possible, to cover more instances where female adolescents, generally, experience discrimination when attempting to access contraceptive information and services.

Apart from the fact that the Nigerian Constitution does not differentiate between ‘fair’ and ‘unfair’ or ‘direct’ and ‘indirect’ discrimination, the fact that there are limited grounds upon which discrimination can be alleged under the Nigerian Constitution is a wrong. As already noted in Chapter 6, major reasons which contribute to female adolescents’ non-access to contraceptive information and services in Nigeria, apart from the ground of sex, are those of age and marital status. Adolescent girls are deliberately prevented from accessing contraceptive services and information based on the belief that giving young unmarried girls in-depth information on SRH issues will result in promiscuity.

As previously noted in Chapter 6, despite South Africa’s effort to prevent discrimination in all spheres, one of the main reasons for contraceptive non-use by adolescent girls in the country relates to discrimination. Health care providers providing contraceptive to

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<sup>35</sup> Sec 42 Nigerian Constitution 1999 and sec 9(3) Constitution of the Republic of South Africa 1996.

young girls are not only high-handed, but deliberately stigmatise the girls by asking questions which reflect their bias.<sup>36</sup>

As a result, it is imperative for the governments of Nigeria and South Africa to try to put in place various sensitisation mechanisms that will increase the awareness of the people about the importance of cooperation in ensuring that adolescents obtain timely access to contraception and other important SRH care services through social and attitudinal change.

### 2.3 Comparing the extent of children's rights in Nigeria and South Africa

Nigeria and South Africa both have legislations which specially protect children's rights and serve as a means of domesticating international and regional human rights instruments on the protection of children. A major difference, is that while South Africa's children's' legislation applies automatically throughout the country, as explained in Chapter 3, the Nigerian CRA still requires several adoptions by the various State Houses of Assembly to enjoy universal application in the country.

Other obvious differences exist, which make the South Africa's Children's Act, in several respects a better piece of legislation than its Nigerian equivalent. First, in the CRA there is nothing relating to the right of children to access contraception. South Africa's Children's Act, noting, rightly, the preponderance of evidence which reveals that adolescent girls continually face numerous problems as a result of teenage pregnancy and exposure to HIV,<sup>37</sup> expressly provides for the right of children to access contraceptives from the age of twelve.<sup>38</sup> I submit that the CRA provision in section 13(3)(b) that children are to be given necessary medical assistance, especially that

<sup>36</sup> K Wood & R Jewkes 'Blood blockages and scolding nurses: Barriers to adolescent contraceptive use in South Africa' (2006) 14 *Reproductive Health Matters* 111 & 113.

<sup>37</sup> S Panday *et al* *Teenage pregnancy in South Africa: With a specific focus on school-going learners* (2009) 20, available at <http://www.education.gov.za/LinkClick.aspx?fileticket=ulqj%2BsyyccM%3D&>. (3 August 2012).

<sup>38</sup> Sec 143(1) Children's Act.

related to the development of primary health care, can be interpreted to include adolescent girls being given medical assistance in relation to accessing contraceptives.

Second, although the CRA guarantees children privacy rights that can be used in advancing female adolescents' access to confidential contraceptive health care services and information in section 8(1),<sup>39</sup> the right is limited by a subsequent provision which limits privacy by providing for reasonable parental supervision and control over their ward's conduct.<sup>40</sup> Not discounting the need for parental supervision of their children, in line with Durojaye's<sup>41</sup> submission, the inclusion of sub-section 8(3), without providing flexibility for situations in which adolescent girls need to access contraceptive services in private settings, is a discouragement, as this will automatically dissuade girls from accessing contraception.<sup>42</sup> South Africa's Children's Act guarantees the right of children to privacy on different fronts. In addition to explicitly explaining that the rights contained in the Children's Act are supplements to constitutionally entrenched rights,<sup>43</sup> the Children Act endorses the confidentiality of medical records pertaining to children and the maintenance of privacy for adolescent girls when accessing contraceptive services.<sup>44</sup>

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<sup>39</sup> Sec 8(1) Child's Rights Act.

<sup>40</sup> Sec 8(3) Child's Rights Act.

<sup>41</sup> E Durojaye 'Realising access to contraception for adolescents in Nigeria: A human right analysis' University of Free State (2010) 183-184

<sup>42</sup> Despite this shortcoming however, the provisions of section 3 of the CRA, which provides that the rights guaranteed in Chap IV of the Nigerian Constitution 1999 automatically apply to children as if expressly stated in the Act, means that adolescent girls, like adults are also entitled to privacy when accessing sexual and reproductive health care services. See also Centre for Reproductive Rights & UNFPA *The Right to Contraceptive Information and Services for Women and Adolescents* (2010) available at <http://www.unfpa.org/webdav/site/global/shared/documents/publications/2011/Contraception.pdf>. (26 October 2012).

<sup>43</sup> Sec 8(1) Children's Act.

<sup>44</sup> Sec 13(1)(d) & sec 134(3) above. As noted in chapter three, the confidentiality of female adolescents who access sexual and reproductive health care services can only be breached where maintaining such confidentiality is not in the best interests of the child, such as where the child has been a victim of rape or other incestuous acts.

Third, another provision of the South African Children's Act which deserves particular mention is the provision on access to information on health care. According to the Act, children are entitled to access information on the promotion of health, including information relating to the 'prevention and treatment of ill health and diseases, sexuality and reproduction in a format that will be easily accessible and understandable by them'.<sup>45</sup> The insertion of the above provision in the South African Children's Act is another area of difference from its Nigerian counterpart. The CRA does not contain any provision to this effect. In fact, the CRA does not contain anything on the right of children to information. In this instance, an alternative means for adolescent girls to exercise a right to access information on contraception can only be gotten from either the right to education guaranteed in section 15 of the Act or the right to information guaranteed in the 1999 Nigerian Constitution.

### 2.3.1 Autonomy

Another area exhibiting a vast difference between Nigerian and South African efforts to guarantee adolescent girls access to contraceptive information and services relates to the area of autonomy. Following the footsteps laid down in the English *Gillick case* on the mature minor (*Gillick* competent) doctrine, which expanded adolescents' decision-making capabilities in confidential settings especially in relation to their making reproductive and sexual health care choices so far they fully understand the nature of their request and its implications,<sup>46</sup> South Africa currently recognises the age of twelve as the threshold for adolescents giving consent for medical treatment, in so far as it has

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<sup>45</sup> Sec 13(1)(a) & 13(2) Children's Act.

<sup>46</sup> *Gillick v. West Norfolk and Wisbech Area Health Authority and Another* (1986) 1 AC 112, (1985) 3 All ER 402 at 409-410.

been established that the child possesses sufficient maturity and mental capacity to understand the benefits and risks associated with the treatment.<sup>47</sup>

The Children's Act makes allowance for children to participate in decision-making processes on issues affecting them,<sup>48</sup> thereby giving adolescents ample opportunities to consent and make decisions on medical procedures involving them including those relating to the protection of their sexual and reproductive wellbeing. In Nigeria the CRA is completely silent on the right of children to consent to medical treatment or participate in decisions affecting them. Moreover, the Code of Ethics of Medical and Dental Professionals require parental or guardian consent for medical treatment on adolescents.<sup>49</sup>

As explained in Chapter 4, in *Christian Lawyers Association v Minister of Health and Others (Reproductive Health Alliance as Amicus Curiae)*,<sup>50</sup> the court rejected the claims of the applicant that certain sections of the CTOP Act should be declared unconstitutional because they allowed adolescents under the age of eighteen, who are 'incapable of giving consent' to terminate their pregnancies without parental consent. The basis of the decision was that the legislature already required that the informed consent of a woman or girl is obtained before termination of pregnancy and that valid

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<sup>47</sup> Sec 129 Children's Act. For termination of pregnancy however, the threshold of twelve years does not apply as the CTOP Act allows a woman of 'any age' to give consent to the termination of her pregnancy. See secs 1(xi) & 5(1)(2) & (3) Choice on Termination of Pregnancy Act.

<sup>48</sup> Sec 10 Children's Act.

<sup>49</sup> Sec 19 Code of Ethics of Medical and Dental Professionals in Nigeria, available at <http://www.mdcnigeria.org/Downloads/CODE%20OF%20CONDUCTS.pdf> (20 February 2014). In special circumstances, consent of the court is to be obtained. See also *Esabunor v Fayewa* [2008] 12 NWLR (pt 1102) 794, available at [http://www.lawpavilionpersonal.com/lawreportssummary\\_ca.jsp?suite=olabisi@9thfloor&pk=CA/L/226/2003&apk=42587](http://www.lawpavilionpersonal.com/lawreportssummary_ca.jsp?suite=olabisi@9thfloor&pk=CA/L/226/2003&apk=42587) (7 June 2013).

<sup>50</sup> *Christian Lawyers No 2* (n 30 above).

consent could only be given by persons who possess the intellectual and emotional capacity to appreciate the nature of the medical treatment requested.<sup>51</sup>

As noted in Chapter 4, the path adopted by the CRA on consent issues is disappointing, especially as it entrenches paternalistic views that adolescent girls and children generally cannot make any medical decisions, including those relating to the protection of their SRH. This position goes against current international dictates which recommend that the competence of adolescents to consent and participate in health care treatment should be based on their maturity and capacity to understand/ comprehend the nature of treatment, rather than on their age.<sup>52</sup> There is definitely a need for the review of this specific issue in the Nigerian CRA.

Another area of dissimilarity relates to privacy and confidentiality issues. Even though the CRA guarantees children privacy rights<sup>53</sup> that can be used in advancing female adolescents' access to confidential contraceptive health care services and information, as explained in Chapter 3 and above, the blanket limitation of the right, without taking cognisance of adolescent girls' need to access contraceptive services privately, is capable of discouraging them from accessing contraceptive services and information.

Adopting a different approach, South Africa's Children's Act guarantees the right of children to privacy severally. In addition to explicitly explaining that the rights contained in the Children's Act are supplements to constitutionally entrenched rights,<sup>54</sup> the Act endorses the confidentiality of medical records pertaining to children and also the maintenance of privacy for adolescent girls when accessing contraception services.<sup>55</sup> As

<sup>51</sup> *Christian Lawyers No 2* 515-516.

<sup>52</sup> C Ngwena 'Health care decision-making and the competent minor: The limits of self-determination' (1996) *Acta Juridica* 137; *Gillick's case* (n 46 above); *R (Axon) v Secretary of State for Health* (2006) EWHC 37 (Admin), available at <http://www.bailii.org/ew/cases/EWHC/Admin/2006/37.html> (25 October 2012).

<sup>53</sup> Sec 8(1) Child's Rights Act 2003.

<sup>54</sup> Sec 8(1) Children's Act.

<sup>55</sup> Sec 13(1)(d) & sec 134(3) above.

often reiterated, it is hoped that the Nigerian state will reconsider its position on these issues in the near future.

### 2.3.2 Best Interests

As demanded under international human rights law on the rights of children that the best interests of the child should be considered in actions relating to children, South Africa and Nigeria, in their respective children's legislation make provision for the protection of the best interests of children. Nigeria's CRA provides that in every action concerning a child, the best interests of the child shall be 'the *primary consideration*'.<sup>56</sup> South Africa's Children's Act provides that in all matters pertaining to the child, the best interests of the child is 'of *paramount importance*'.<sup>57</sup>

The provision on best interests contained in the children's legislations of Nigeria and South Africa is a vast improvement on that contained in the major human rights instrument protecting the right of the child internationally: the CRC.<sup>58</sup> By declaring the best interests of children as paramount, both in the Children's Act and the Constitution,<sup>59</sup> South Africa has already raised the bar on the best interests principle by placing it in a position of paramountcy that must always be considered in all decisions

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<sup>56</sup> Sec 1 Child Rights Act. In addition, it should be noted that by virtue of the provisions of sec 3, Nigerian children are entitled to the right already guaranteed under chapter IV of the Nigerian Constitution 1999.

<sup>57</sup> Sec 9 Children's Act.

<sup>58</sup> Article 3(1) of the Convention on the Rights of the Child 1990 provides:

In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be 'a *primary consideration*'.

The use of the sentence 'a primary consideration' has been criticised because it means that the best interests of the child may not always be the single, overriding factor to be used in determining matters concerning a child.

<sup>59</sup> Sec 28(2) Constitution of the Republic of South Africa 1996. Also see generally the sections on the Constitution of the Republic of South Africa and Children's Act previously discussed in Chapter 3 of this thesis.

involving children.<sup>60</sup> In *Minister of Welfare and Population Development v Fitzpatrick*,<sup>61</sup> the Constitutional Court declared the provision of section 28(2) as a right on its own apart from it being used to support other rights protected in section 28(1).<sup>62</sup>

In relation to the above, I am of the opinion that Nigeria needs to embrace the approach that has been adopted by South Africa in using the ‘best interests’ of children principle to solve problems which arise from female adolescents’ need to access contraceptive services and information.

South Africa has put in place better structures to ensure that their adolescents have access to contraceptive services, but a lot more still needs to be done so that adolescent girls can benefit from the arrangements already available, along the lines, presented in Chapter 5, where Denmark acceptance of a more liberal and tolerant approach has resulted in the achievement of greater benefits.<sup>63</sup>

## 2.4 Comparing child marriage in Nigeria and South Africa

Regardless of the fact that Nigeria is a signatory to human rights conventions which deplore the practice of child marriages and despite the existence of the CRA which

<sup>60</sup> Sec 7 Children’s Act 2005. See also C J Davel & A M Skelton *Commentary on the Children’s Act (2007)* 2-6 & 2-7.

<sup>61</sup> *Minister of Welfare and Population Development v Fitzpatrick* 2000 (3) SA 422 (CC) para 17.

<sup>62</sup> Other cases where the best interest principle has been used in reaching appropriate decisions on children include *Mfolo v Minister of Education, Bophuthatswana* 1992 (3) SA 181 (BG); *Minister of Welfare and Population Development v Fitzpatrick* (as above) paras 17-18; *Director of Public Prosecutions, KwaZulu-Natal v P* 2006 (1) SACR 243(SCA) para 18; *S v M (Centre for Child Law as Amicus Curiae)* 2008 (3) SA 232 (CC) para 22; *Teddy Bear Clinic for Abused Children and RAPCAN v Minister of Justice and Constitutional Development and Another* Case No: 73300/10 para 72.

<sup>63</sup> H Wielandt & L B Knudsen ‘Birth Control: Some Experiences from Denmark’ (1997) 55 *Contraception* 304; C Moreau *et al* ‘The impact of pharmacy access to emergency contraceptive pills in France’ (2006) 73 *Contraception* 602, 606 & 607; L Berne & B Huberman *European Approaches to Adolescent Sexual Behavior & Responsibility* (1999) 31-32, available at <http://www.advocatesforyouth.org/storage/advfy/documents/european.pdf> (23 September 2013); C Solomon-Fears *Teenage pregnancy prevention: Statistics and programs* (2013) 6, available at <http://www.fas.org/sgp/crs/misc/RS20301.pdf> (23 September 2013).

purposely prohibits the celebration of child marriages,<sup>64</sup> the celebration and practice of child marriages continue to occur in Nigeria, especially among Muslims, who are predominant in Northern Nigeria.<sup>65</sup>

South Africa draws little international attention in relation to the practice of child marriage unlike Nigeria, yet, the practice of *Ukuthwala* exists in some traditional societies.<sup>66</sup> This practice is regardless of the existence of legal provisions in the country protecting the rights of children, including female adolescents.<sup>67</sup> As pointed out in the previous chapter, like their counterparts in Nigeria, South African female adolescents subjected to child marriages are susceptible to experiencing complications during pregnancy as a result of their undeveloped reproductive organs.

As explained in Chapter 5, the menace of child marriage which continues to occur alarmingly in Nigeria, despite the existence of the CRA and the country's membership of human rights bodies that deplore the practice of child marriage, aptly demonstrates the impotency of law when it is unaccompanied with the will for societal change. Nigeria needs to be more proactive by adopting measures that will result in the CRA enjoying universal application throughout the country so that its provisions can become

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<sup>64</sup> Secs 21-23 Child Right Act (n 14 above), Art 16(2) CEDAW, art 21(2) ACRWC & art 6(b) Women Protocol prohibit the celebration of marriage.

<sup>65</sup> D Ityavar & I Bakari Jalingo *The state of married adolescents in Northern Nigeria* (2006) 15, available at <http://www.actionhealthinc.org/publications/docs/married.pdf> (20 June 2013); P Makinwa-Adebusoye *Hidden: A Profile of Married Adolescents in Northern Nigeria* (2006) 7 & 15-16, available at <http://www.actionhealthinc.org/publications/docs/hidden.pdf> (20 June 2013).

<sup>66</sup> L Mwambene & J Sloth-Nielsen 'Benign accommodation? *Ukuthwala*, 'forced marriage' and the South African Children's Act' (2011) 11 *African Human Rights Law Journal* 4.

<sup>67</sup> Secs 12(1), 12 (2), 18(3)(c)(i) Children's Act; sec 26(1) Marriage Act; sec 3 Recognition of Customary Marriages Act; secs 15, 16 & 17 Criminal Law (Sexual Offences and Related Matters) Amendment Act.

universally operatable. There is also an urgent need for constitutional amendment<sup>68</sup> to reflect the illegality of contracting child marriages. Both Nigeria and South Africa need to engage in extensive campaigns and sensitisation to change the mind-set of their citizens in relation to engagement in the practice.

## 2.5 Comparing laws and policies other than the Constitution in Nigeria and South Africa

Both countries have legislation and policies that precisely protect children's rights and domesticate international and regional human rights instruments on children. In addition to the CRA and Children's Act which domesticate provisions of the CRC and ACRWC, as examined in Chapter 3, Nigeria and South Africa have other legislation and policies that guarantee and protect female adolescents' SRH rights, including their right to access contraceptive services and information.<sup>69</sup>

Despite the above similarity however, it is important to point out that the level of commitment invested in ensuring female adolescents' protection and access to contraceptive information and services is different. An example to back up this assertion

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<sup>68</sup> Recently, the continued practice of child marriage became a subject of national debate in Nigeria with argument from members of the Islamic faith that by virtue of the provision contained in Item 61 of the Second Schedule of the 1999 Constitution, legislators were not permitted to interfere or legislate on marriages contracted under Islamic and customary law, thereby tactically giving support to the continued practice of child marriage recognised under religion. This is despite the existence of evidence which documents the negative effects of early marriages on the girl child. Agreeing with Mwambene and Sloth-Nielsen's argument that recognition of the practice of customary law should not provide a basis for the violation of other rights, it is submitted that appropriate proviso should be inserted in the Constitution to take cognisance of situations where the right to practise custom or religion will be over-ruled or curtailed, as the case maybe. See, generally, Mwambene & Sloth-Nielsen (n 66 above) 12; B Ademola-Olateju 'Senator Yerima, child marriage, and woman right' *Premium Times* 23 July 2013, available at <http://www.premiumtimesng.com/opinion/141467-bamidele-upfront-senator-yerima-child-marriage-and-woman-right-by-bamidele-ademola-olateju.html> (14 March 2014).

<sup>69</sup> While Nigeria has in place the National Health Policy 2004, the National Reproductive Health Policy 2001, National Policy on Health & Development of Adolescents & Young People 2007, National Youth Policy 2009 among others; South Africa has the National Health Act, the Choice on Termination of Pregnancy Act, the integrated School Health Policy and the National Contraception & Fertility Planning & Service Delivery Guideline 2012, among others.

relates to the fact that while South Africa's recently adopted National Contraception and Fertility Planning Policy and Service Delivery Guidelines reveal a system that is constantly monitoring the implementation of its policies in order to correct shortcomings,<sup>70</sup> in the case of Nigeria the opposite is the case as the current National Reproductive Health Policy which replaced the Maternal and Child Health Policy was adopted in 2001 with no further amendment to date.<sup>71</sup>

The present National Policy on Health & Development of Adolescents & Young People was adopted in 2007, thereby revealing that there is no recent policy on SRH especially for adolescents in the country. The current Nigerian position reveals the non-existence of genuine efforts to coordinate implementation of existing policies or effectively monitor their performance. The above assertion is based on the reasoning that the existence of frequent monitoring mechanisms would have revealed defects in need of review in the existing policies with subsequent moves made for their correction.<sup>72</sup>

As well, the recently adopted Integrated School Health Policy, reviewed in Chapter 3, which seeks to enable adolescents, have access to on the site SRH care services in schools, in addition to sexuality information, is a positive step. This is a major area of difference between the approaches adopted by Nigeria and South Africa in fulfilling the right of their female adolescents to access contraceptive information and services.

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<sup>70</sup> Part of the reason for the new Contraception and Fertility Planning Policy and Service Delivery Guidelines was to reprioritise contraception and fertility planning services and address problems encountered by adolescents in accessing contraception in order to protect their reproductive health. See Para 6.1.2 National Contraception and Fertility Planning Policy and Service Delivery Guidelines, available at [http://www.doh.gov.za/docs/policy/2013/contraception\\_fertility\\_planning.pdf](http://www.doh.gov.za/docs/policy/2013/contraception_fertility_planning.pdf) (3 May 2013).

<sup>71</sup> The Maternal and Child Health Policy was replaced with the National Reproductive Health Policy due to a paradigm shift which sought to protect reproductive health generally rather than only maternal, child health and family planning.

<sup>72</sup> N I Aniekwu *The development of reproductive health laws: Considerations for the Nigerian legal system 1*, available at <http://www.nigerianlawguru.com/articles/general/THE%20DEVELOPMENT%20OF%20REPRODUCTIVE%20HEALTH%20LAWS,%20CONSIDERATIONS%20FOR%20THE%20NIGERIAN%20LEGAL%20SYSTEM.pdf> (24 September 2012); N I Aniekwu *Engendering sexuality: Human rights issues in reproductive and sexual health* (2006) 38 <http://www.arsrc.org/downloads/features/aniekwu.pdf> (4 March 2013).

Nigeria does not presently have this kind of programme. In addition, as noted in Chapter 3, South Africa has succeeded in passing a National Health Act which has been in operation since 2005, whereas Nigeria's proposed National Health Bill has been a source of serious contention between various health groups since 2008 when moves towards its adoption were initiated.<sup>73</sup>

Finally, unlike the African Youth Charter<sup>74</sup> and South Africa's National Youth Policy<sup>75</sup> which extended the scope of protection offered in terms of age from between the ages of 14 to 35 years, and which contain various youth oriented provisions including those relating to the management of SRH issues, the Nigerian Youth Policy actually narrowed the scope of adolescents and youths protected to those between the ages of 18- 35 years.<sup>76</sup> This move not only contravenes age stipulations contained in the African Youth Charter but also adopts an unrealistic attitude towards adolescent sexuality matters. It is submitted that Nigeria needs to correct its attitude in relation to the issues raised.

## 2.6 Comparing sexuality education in Nigeria and South Africa

Nigeria and South Africa currently have sexuality education programmes on ground through which SRH information is passed on to adolescents. Nigeria has the Family Life

<sup>73</sup> S Ayo-Aderere 'Rid proposed Health Bill of contentious items —CSOs' (2013) available at <http://www.punchng.com/health/rid-proposed-health-bill-of-contentious-items-csos/> (21 March 2013); NIMASA 'NIGERIA: National Health Bill 2013' available at <http://nimsanigeria.wordpress.com/2013/02/13/nigeria-national-health-bill-2013/> (21 March 2013); Fast-track National Health Act to improve health care – NMA (2014) available at <http://www.mydailynewswatchng.com/2014/02/27/fast-track-national-health-act-improve-health-care-nma/> (27 February 2014).

<sup>74</sup> The Youth Charter came into operation in 2009.

<sup>75</sup> National Youth Policy 2009 – 2014 available at <http://www.thepresidency.gov.za/MediaLib/Downloads/Home/Publications/YouthPublications/NationalYouthPolicyPDF/NYP.pdf> (6 April 2013).

<sup>76</sup> Para 1.3 Nigerian Youth Policy (2009) available at [http://planipolis.iiep.unesco.org/upload/Youth/Nigeria/Nigeria\\_YouthPolicy.pdf](http://planipolis.iiep.unesco.org/upload/Youth/Nigeria/Nigeria_YouthPolicy.pdf) (23 October 2012). See Chapter 3 of this thesis.

and HIV Education (FLHE) curriculum; South Africa implemented its Life Skills and HIV/AIDS Programme.

Despite the similarity of having adopted policies and programmes in which sex education is taught, the curriculum and content of the information passed on differ. Nigeria has a fixed curriculum which allows for uniform teaching of topics, ranging from puberty, decision-making, self-esteem, communication skills, STIs, HIV and AIDs and abstinence, but topics relating to contraception and pregnancy are avoided.<sup>77</sup> South Africa allows the teaching of more in-depth topics, including sexuality, teenage pregnancy, substance abuse, HIV and STIs, contraceptive and condom use, but does not possess a fixed curriculum. The non-existence of a fixed curriculum for teaching sexuality education in South Africa paves the way for non-uniformity since topics taught vary from schools to schools resulting in different outcomes.<sup>78</sup>

In the case of Nigeria, the possession of a fixed curriculum, however, has not achieved much, due to the reason pointed out in Chapter 5 that despite national policy backing, the implementation of the FLHE education programme remains poor.<sup>79</sup>

South Africa also mandates the teaching of Life Skills, HIV and AIDs education from Grade R, in accordance with directions from international bodies which support the introduction of sex education to children from an early age with a gradual advance in

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<sup>77</sup> *National family life and HIV education curriculum* (n 112 above) iii & 1-47, available at <http://www.actionhealthinc.org/publications/docs/jnrcurriculum.pdf> (15 August 2013); Durojaye 'Realising access to contraception for adolescents in Nigeria' (n 41 above) 206.

<sup>78</sup> Department of Education - *HIV/AIDs Emergency Guidelines* available at <http://www.education.gov.za/LinkClick.aspx?fileticket=fBnc9VU7mEw%3D&tabid=95&mid=507> (23 September 2013); M J Visser 'Life skills training as HIV/AIDs preventive strategy in secondary schools: Evaluation of a large-scale implementation process' (2005)2 *Journal of Social Aspects of HIV/AIDs* 206, 211 & 214; R I Mpangana 'Implementation of the life skills HIV and AIDs program in Manyeleti circuit schools' University of Stellenbosch (2012) 30.

<sup>79</sup> A O Esiet *Adolescent Sexual and Reproductive Health in Nigeria* (2009) available at <http://www.wilsoncenter.org/sites/default/files/Esiet%20Presentation.pdf> (27 July 2013).

curriculum contents.<sup>80</sup> In Nigeria's part, although the teaching of the FLHE curriculum has been introduced in secondary schools, its teaching in upper primary and private schools was only recently introduced with encouragement and financial assistance from donors.<sup>81</sup> Despite this development, teaching sexuality education has not been successfully introduced all over the country.

While South Africa's early introduction and 'actual' teaching of sexuality education in schools from young ages tallies with what obtains internationally in countries such as Denmark, Nigeria needs to be realistic and accept the inevitability that allowing early in-depth teaching of sexuality and family life education in its schools is a positive way of disseminating and ensuring that important information on the protection of SRH generally becomes ingrained in the consciousness of adolescents.

In terms to similarities: a major resemblance in relation to the teaching of sexuality education in the two countries relates to the fact that the accomplishment achieved in teaching sexuality education in schools depends on the broadmindedness of the instructors teaching the subject. In both countries most teachers have reservations about teaching adolescents about sexuality as a result of their religious and cultural beliefs.<sup>82</sup> Also, in both Nigeria and South Africa parents, religious leaders and other societal gate keepers usually express great reluctance to discuss sexuality issues with adolescent girls, unlike the case in relation to their male counterparts.

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<sup>80</sup> WHO *The sexual and reproductive health of younger adolescents: Research issues in developing countries* available at (2011) 11 [http://libdoc.who.int/publications/2011/9789241501552\\_eng.pdf](http://libdoc.who.int/publications/2011/9789241501552_eng.pdf) (22 August 2013).

<sup>81</sup> R C Abah 'The universal basic education programme and the family life HIV education in Nigeria' (2013) 2, available at *International Journal of Development and Sustainability* 9 <http://isdsnet.com/ijds-v2n2-23.pdf> (21 September, 2013).

<sup>82</sup> N Dlamini *et al* 'Empowering teachers to change youth practices: Evaluating teacher delivery and responses to the FLHE programme in Edo State, Nigeria' (2012) 16 *African Journal of Reproductive Health* 96-97; K A Smith & A Harrison 'Teachers' attitudes towards adolescent sexuality and life skills education in rural South Africa' (2013) 13 *Sex Education* 69.

As I have previously argued, there is certainly a need for societal and attitude change in this regard in both South Africa and Nigeria. Societal and cultural gatekeepers need to face up to reality, and accept changes which have occurred in relation to adolescent sexuality. Instead of preventing access to contraceptive and other SRH care information and services, they need to take urgent steps to ensure that adolescents' are adequately informed about how to maintain good SRH.

## 2.7 Comparing access to sexual and reproductive health care services in Nigeria and South Africa

As noted in Chapters 3, Nigeria and South Africa have adopted and implemented policies aimed at ensuring that adolescents generally, and female adolescents in particular, have access to contraceptive and other reproductive health care services. This is however where the similarity ends as the Nigerian government has not lived up to expectations in fulfilling its obligation of ensuring that female adolescents have 'actual' access to life saving contraception and other SRH care services.<sup>83</sup>

As revealed in Chapter 5, in addition to the reality that adolescent-friendly clinics operated by the government are insufficient in Nigeria, the adolescent-friendly centres administered by NGOs are few in number compared to the nation's adolescent population. Also, as Osanyin notes, in some of the few existing clinics adolescents have to pay for contraceptives, resulting in situations where their right to access contraception is curtailed by their economic and financial circumstances.<sup>84</sup>

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<sup>83</sup> G Sedgh *et al* Meeting young women's sexual and reproductive health needs in Nigeria (2009) 11, available at [http://www.guttmacher.org/pubs/2009/06/03/ASRH\\_Nigeria.pdf](http://www.guttmacher.org/pubs/2009/06/03/ASRH_Nigeria.pdf) (14 August 2013) 16; Esiet (n 78 above).

<sup>84</sup> Y Osanyin Report *on assessment of facilities providing youth friendly health services in Nigeria* (2011) 10, available at <http://ncconline.net/download/files/Assessment%20of%20Youth%20Friendly%20Health%20Centers%20and%20Services.pdf> (3 August 2013)14.

This picture is in contrast with the situation in South Africa where adolescent girls have access to contraception due to the existence of policies that give precedence to the availability and accessibility of free family planning services at public health centres.<sup>85</sup> Also, as explained in Chapter 5, collaborative efforts with NGOs have resulted in the initiation of the National Adolescent Friendly Clinic Initiative (NAFCI) Programme which sets standards that are used in regulating the provision of adolescent-friendly services within the country. These efforts have resulted in various adolescent clinics (though not yet enough the quantity is still greater than presently in Nigeria) being operated in different locations within the country. Furthermore, the use of peer instructors encourages greater adolescent patronage.<sup>86</sup>

As earlier stated, the approach embraced by South Africa through the adoption of the Integrated School Health Policy which allows adolescents access to onsite SRH services and counselling in schools is a practice that is not available in Nigeria. Finally, it is submitted that there is need for the Nigeria to invest greater political and financial commitment towards assuring female adolescents access to contraceptive information and services, as is the case in South Africa.

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<sup>85</sup> National Contraception and Fertility Planning Policy (n 70 above) 36-37; P Maharaj & M Rogan *Reproductive Health and Emergency Contraception in South Africa: Policy Context and Emerging Challenges* (2007) 13, available at <http://sds.ukzn.ac.za/files/WP%2048%20WEB.pdf> (23 August 2013).

<sup>86</sup> MIET Africa *Literature Review: Youth-friendly Health Services* (2011) 14-15, available at <http://www.google.co.za/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=6&cad=rja&ved=0CEMQFjAF&url=http%3A%2F%2Fwww.miet.co.za%2Fsite%2Fsearch%2Fdownloadencode%2FnLaaaqWMqp2zp45x&ei=MQw7Uov4INKRhQfq5YGQBg&usg=AFQjCNEpY0ySITw7Y0u3wh8hNr7EFfy-g&bvm=bv.52288139,d.Yms> (14 September 2013); A E Pettifor *et al* 'Challenge of evaluating a national HIV prevention programme: The case of LoveLife, South Africa' (2007) 83 *Sexually Transmitted Infections* 70; LoveLife Youth 'What we do' available at <http://www.lovelife.org.za/corporate/lovelife-programmes/> (18 September 2013).

## 2.8 Comparing consequences resulting from non-access to contraceptive information and services in Nigeria and South Africa

As examined in Chapters 6, female adolescents in Nigeria and South Africa encounter similar impediments<sup>87</sup> which not only prevent them from gaining access to essential contraceptive information and services but, ultimately, encourage their being denied opportunities of enjoying their right to access quality reproductive health care services as recommended in human rights instruments and their monitoring committees.<sup>88</sup> While the levels of some of the barriers experienced in the two countries may differ, a major fact remains that similar consequences result from the existence of the barriers.

As noted in the previous chapter, in both Nigeria and South Africa, teenage pregnancy continues to constitute a problem. In Nigeria, the adolescent birth rate is currently estimated at 123 per 1,000, one of the highest in the world.<sup>89</sup> South Africa, despite having one of the lowest total fertility rates in the region, has a high teenage fertility rate with around 30% of 15-19 year old adolescent girls reported as having ever been pregnant.<sup>90</sup>

<sup>87</sup> The barriers which prevent female adolescents in Nigeria and South Africa from accessing contraceptive information and services range from socio-cultural, legal and religious barriers, to barriers associated with demography.

<sup>88</sup> Art 12 ICESCR (n 5 above); Art 25 UDHR, art 12 CEDAW, arts 24(1) & 24(2)(f) CRC, art 16 African Charter, arts 14(1), 14(2)(b) & 14(2)(f) ACRWC, art 14(1) (a) (c) (d) & (g) African Women Protocol, para 12 General comment 14 of the ICESCR Committee *Compilations of General Comments and Recommendations Adopted by Human rights Treaty Bodies, Vol I*, available at [http://www.amnesty.nl/sites/default/files/public/generalcomments\\_0.pdf](http://www.amnesty.nl/sites/default/files/public/generalcomments_0.pdf) (24 October 2012).

<sup>89</sup> WHO *The state of the world's midwifery: Delivering health, saving lives* (2011) available at [http://www.unfpa.org/sowmy/resources/docs/country\\_info/profile/en\\_Nigeria\\_SoWMy\\_Profile.pdf](http://www.unfpa.org/sowmy/resources/docs/country_info/profile/en_Nigeria_SoWMy_Profile.pdf) (pls confirm website address) (24 June 2013); A Udo *et al* 'Teenage pregnancy and adverse birth outcomes in Calabar, Nigeria' (2013) 17 *Internet Journal of Gynaecology and Obstetrics* available at <http://ispub.com/IJGO/17/2/2995> (10 November 2013).

<sup>90</sup> WHO *The state of the world's midwifery: Delivering health, saving lives* (as above) 133; S Willan *A review of teenage pregnancy in South Africa: Experiences of schooling, and knowledge and access to sexual & reproductive health services* (2013) 7, available at <http://www.hst.org.za/sites/default/files/Teenage%20Pregnancy%20in%20South%20Africa%20Final%2010%20May%202013.pdf> (18 September 2013); M R Ramulumo & V J Pitsoe 'Teenage Pregnancy in South African Schools: Challenges, Trends and Policy Issues' (2013) 4 *Mediterranean Journal of Social Sciences* 756;

In Nigeria and South Africa, the high rate of adolescent pregnancies is fuelled by several factors. In Nigeria, it is stimulated by a lack of financial wherewithal to purchase contraceptives as free family planning commodities are not readily available or accessible despite the government's claims.<sup>91</sup> Factors common to both countries, highlighted in Chapter 6 include socio-cultural and religious beliefs (*viz* hostile and unfriendly attitudes of health officers in charge of SRH services), general societal stigmatisation of adolescent girls who attempt to access contraception and poverty which encourages their engaging in transactional sex with little or no bargaining powers.

Another similarity occasioned as a result of inaccessibility to contraception in Nigeria and South Africa noted in Chapter 6, is that of female adolescents' procurement of unsafe abortion services. While Nigeria's female adolescents engage in unsafe abortion because obtaining safe abortion services is illegal,<sup>92</sup> South Africa's female adolescents' procure back-street abortions because of the social stigma attached to the termination of pregnancy in the country despite the country's legalisation of abortion and the provision of free termination of pregnancy services.<sup>93</sup>

Additionally, a major similarity between the countries relates to the feminisation of HIV and other STIs among adolescent girls. The above is a major result of the continued existence of socio-cultural beliefs and values that encourage gender imbalance, especially in relation to SRH issues. In Nigeria, the National Agency for the Control of AIDS (NACA) states that not only do females constitute 58% of persons living with HIV

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Statistics South Africa General household survey (2012) 18, available at <http://www.statssa.gov.za/publications/P0318/P0318April2012.pdf> (9 November 2013).

<sup>91</sup> See the section on economic and logistical barriers relating to Nigeria discussed in Chapter 6 of this thesis.

<sup>92</sup> Sec 228 & 229 Criminal Code cap c38 LFN 2004 & sec 232 & 233 Penal Code cap p3 LFN 2004.

<sup>93</sup> Unsafe Abortion in South Africa: A Preventable Pandemic (2012) available at <http://www.ngopulse.org/blogs/unsafe-abortion-south-africa-preventable-pandemic> (9 November 2013); C Day *et al* 'Health and related indicators' in *South African Health Review* (2011) 178- 180, available at <http://www.hst.org.za/sites/default/files/Chap%2011%20Indicators.pdf> (11 November 2013); C MacPhail *et al* 'Contraception use and pregnancy among 15–24 year old South African women: A nationally representative cross-sectional survey' (2007) 5 *BMC Medicine* available at <http://www.biomedcentral.com/content/pdf/1741-7015-5-31.pdf> (26 June 2013).

but the prevalence rate among young women aged 15-24 years is estimated to be three times higher than their male counterparts.<sup>94</sup> The same situation applies in South Africa as South African female adolescents constitute a larger percentage of adolescents infected with HIV. The HIV prevalence rate among this group of women amounts to 11.9% as compared to that of their male counterparts, which stands at 5.3%.<sup>95</sup>

Finally, as observed in Chapter 6, in a majority of instances, female adolescents, Nigerian and South African, lose their chances of improving their economic and social status in life, a consequence that result from the denial of their right to SRH care due to the factors which bar their access to contraceptive information and services. It is necessary to state here that the loss of economic empowerment still occurs among South African adolescent girls despite the existence of legislation which provides that pregnant adolescents are neither to be expelled nor forbidden from returning to school after giving birth unlike the situation that, normally, occur in Nigerian schools.<sup>96</sup>

## 2.9 Comparing judicial intervention in relation to the right to health care in Nigeria and South Africa

The approaches adopted by the national courts of Nigeria and South Africa in intervening in matters involving the protection of the rights of children generally, and

<sup>94</sup> NACA *Key statistics on HIV in Nigeria* available at [http://naca.gov.ng/index2.php?option=com\\_docman&task=doc\\_view&gid=110&Itemid=268](http://naca.gov.ng/index2.php?option=com_docman&task=doc_view&gid=110&Itemid=268) (9 November 2013). See also UNICEF *Nigeria HIV/AIDS*, available at [http://www.unicef.org/nigeria/children\\_1940.html](http://www.unicef.org/nigeria/children_1940.html) (9 November 2013).

<sup>95</sup> See generally Department of Health *National Antenatal Sentinel HIV and Syphilis Prevalence Survey* (n 4 above) V; UNICEF *South Africa Statistics* available at [http://www.unicef.org/infobycountry/southafrica\\_statistics.html#102](http://www.unicef.org/infobycountry/southafrica_statistics.html#102) (28 October 2013); UNFPA *HIV prevention: Fact sheet* (2012) available at [http://countryoffice.unfpa.org/filemanager/files/southafrica/HIV\\_Prevention\\_Fact\\_Sheet%20.pdf](http://countryoffice.unfpa.org/filemanager/files/southafrica/HIV_Prevention_Fact_Sheet%20.pdf) (28 October 2013); C Day & A Gray 'Health and related indicators' in A Padarath & R English (eds) *South African Health Review* (2013) 236.

<sup>96</sup> I I Ayuba & G Owoeye 'Outcome of teenage pregnancy in the Niger-delta of Nigeria' (2012) 22 *Ethiopian Journal of Health Sciences* 46; I N Onyeka *et al* 'Unintended pregnancy and termination of studies among students in Anambra state, Nigeria: Are secondary schools playing their part?' (2011) 15 *African Journal of Reproductive Health* 109-116; Willan (n 90 above) 34 & 44; D Bhana *et al* 'South African teachers' responses to teenage pregnancy and teenage mothers in schools' (2010) 12 *Culture, Health & Sexuality: An International Journal for Research, Intervention and Care* 877.

their right to health care in particular, differ. South African courts have been particularly helpful in advancing the protection of the socio-economic rights of children generally (including adolescent girls). The achievement is bolstered by the fact that the right to health care and children's rights to basic social amenities, including health care, are constitutionally guaranteed. In Nigeria issues relating to the protection of socio-economic rights are merely mentioned under chapter two of the country's Constitution as directive principles that are not justiciable in court.<sup>97</sup>

As explained in Chapter 3, South African courts have been actively involved in ensuring that the rights and best interests of children are protected in several cases: the *TAC's case*<sup>98</sup> in which the court declared a violation of sections 27(1) & (2) and ordered the implementation of a comprehensive programme to ensure universal access to Nevirapine, a PMCT drug in public hospitals;<sup>99</sup> the *Minister of Welfare and Population Development v Fitzpatrick*<sup>100</sup> case in which the Constitutional Court clearly elucidated that the 'best interests' of children principle, recognised as paramount in sec 28(2) of the country's Constitution, encompasses the rights specified in section 28(1) to create a right on its own.<sup>101</sup>

Particularly in relation to matters concerning the protection of the SRH rights of children and in line with the English courts' decisions in *Gillick v West Norfolk and Wisbech Area Health Authority and Another*<sup>102</sup> and *R (Axon) v Secretary of State for Health*<sup>103</sup> that competent adolescents who understood the nature of services requested and their implications could access confidential SRH services, South African courts in *Christian*

<sup>97</sup> Sec 6(6)(c) Nigerian Constitution 1999.

<sup>98</sup> *Minister of Health v Treatment Action Campaign (TAC)* 2002 (5) SA 721 (CC).

<sup>99</sup> *Treatment Action Campaign's case* (as above) para 135.

<sup>100</sup> *Minister of Welfare and Population Development v Fitzpatrick* (n 61above).

<sup>101</sup> *Minister of Welfare and Population Development v Fitzpatrick* (as above) para 17.

<sup>102</sup> *Gillick's case* (n 46 above).

<sup>103</sup> *R (Axon) v Secretary of State for Health* (n 52 above).

*Lawyers Association v Minister of Health & Others (Reproductive Health Alliance as Amicus Curaie)*,<sup>104</sup> refused to declare the CTOP Act unconstitutional on the argument that the Act allowed adolescent girls' incapable of giving consent to access abortion services without parental involvement.

As severally noted, the court explained that the Act had already put in place modalities to ensure that only 'women' who could give informed consent could access abortion services in the hospitals, thereby preserving the rights of female adolescents in the country to confidentiality when accessing SRH care services, especially where such an adolescent staunchly refuses to inform her parents. Also, in the recent decision of the Constitutional Court in the *Teddy Bear Clinic's case*,<sup>105</sup> the court, in declaring some portions of the Criminal Law (Sexual Offences and Related Matters) Amendment Act<sup>106</sup> unconstitutional, noted that children enjoyed fundamental rights granted everyone as individual bearers of human rights.<sup>107</sup> According to the court, the dignity rights of children are not only of special importance but also independent of the rights of their parents, neither are the rights held in abeyance until they reach a certain age.<sup>108</sup>

As explained in Chapter 3, even though the right to health is not recognised like its chapter IV counterparts in Nigeria, other rights, such as the rights to life, dignity, privacy and information that are relevant to the right to health, are protected in the constitution and can be used by the domestic courts to interpret the Nigerian government's obligation to fulfil, not only the right to health care of children but also adolescents' right to access contraceptive health care services and information, as was

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<sup>104</sup> *Christian Lawyers No 2* (n 30 above).

<sup>105</sup> *Teddy Bear Clinic for Abused Children and Another v Minister of Justice and Constitutional Development and Another* CCT 12/13 [2013] ZACC 35; 2013 (12) BCLR 1429 (CC); 2014 (2) SA 168 (CC).

<sup>106</sup> Secs 15 & 16 Criminal Law (Sexual Offences and Related Matters) Amendment Act (n 67 above).

<sup>107</sup> *Teddy Bear Clinic* case (n 105 above) paras 38 .

<sup>108</sup> *Teddy Bear Clinic* case (as above) paras 52.

done by Indian courts in *Paschim Banga Khet Mazdoor Samity & Ors v State of West Bengal & Another*.<sup>109</sup>

Additionally, taking note of the provision of the Fundamental Rights Enforcement Procedure Rules<sup>110</sup> that mandates courts to take judicial notice of human rights instruments when determining the infringement of human rights cases, domestic courts can act proactively, not only by taking judicial notice of international and regional human rights instruments acceded to by the country, but by extensively using the provisions of the African Charter which have been domesticated in the country to hold the government responsible for breaches of its obligations on the right to health, especially if the violation is not in the best interests of children.

In this regard, the action of a Nigerian court in *Gbemre v Shell Petroleum Development Company and Others*,<sup>111</sup> in holding the Nigerian government liable for endangering the health of citizens in a Niger-Delta community and violating their right to life as protected under section 33 of the Nigerian Constitution and their right to health under article 16 of the African Charter is a welcome development. Also, the recent decision of another court in *Georgina Ahamefule v Imperial Medical Center & Alex Molokwu*<sup>112</sup> in holding the defendants liable for the violation of the provisions of article 16 of the African Charter is encouraging.

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<sup>109</sup> *Paschim Banga Khet Mazdoor Samity & Ors v State of West Bengal & Anor* (n 23 above).

<sup>110</sup> Para 3(b) Preamble to Fundamental Rights (Enforcement Procedure) Rules 2009.

<sup>111</sup> (2005) Suit No FHC/B/CS/53/05 (unreported) available at <http://www.chr.up.ac.za/index.php/browse-by-subject/418-nigeria-gbemre-v-shell-petroleum-development-company-nigeria-limited-and-others-2005-ahrlr-151-nghc-2005.html> (7 March, 2013).

<sup>112</sup> *Georgina Ahamefule v Imperial Medical Center & Alex Molokwu* (unreported), available at [www.scribd.com/doc/126185950/Georgiana-Ahamefule-vs-Imperial-Medical-Centre-Dr-Alex-Molokwu-ID-1627-2000-Judgement](http://www.scribd.com/doc/126185950/Georgiana-Ahamefule-vs-Imperial-Medical-Centre-Dr-Alex-Molokwu-ID-1627-2000-Judgement) (8 March 2013).

### 3 Chapter conclusion

By virtue of the thesis being a comparative study of female adolescents' access to contraceptive information and services in Nigeria and South Africa, this chapter scrutinised the areas of similarity and difference in the legislation, policies and approaches adopted by the two countries. Various issues relating to female adolescents' access to contraceptive services and information in Chapters 2 to 6 were highlighted and compared with conclusions drawn. Also, areas of deficiencies in need of reform were emphasised in order to single them out for correction.

As a result of earlier discussions and conclusions already made in earlier sections of this chapter, it is felt, in order to avoid repetition that conclusions already drawn in the sections suffice. The intention in the next chapter - the final chapter - is to arrive at overall conclusions for the study. These conclusions will be supported with recommendations on the way forward for the two countries under investigation in the thesis.

## CHAPTER 8

### CONCLUSIONS AND RECOMMENDATIONS

Outline	
<b>1</b>	<b>Introduction</b>
<b>2</b>	<b>Overview of chapter findings</b>
<b>3</b>	<b>Conclusions</b>
<b>4</b>	<b>Recommendations</b>
4.1	Nigeria
4.2	South Africa
<b>5</b>	<b>Final remarks</b>

#### 1 Introduction

As pointed out at various stages in the argument so far, the period of adolescence is fraught with many challenges. Apart from being a stage of transition from childhood to adulthood, characterised by critical physical and psychological changes, it is also a phase where the adolescent acquires sexual and social interaction skills that she carries with her to adulthood.<sup>1</sup> As the WHO observes, although adolescence presents an opportunity to establish a foundation for a healthy and productive adulthood, it is also a period of risk, as SRH problems that might have immediate or future consequences.<sup>2</sup>

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<sup>1</sup> WHO *Strategic directions for improving adolescent health in South-East Asia Region* (2011) 1, available at [http://apps.searo.who.int/PDS\\_DOCS/B4771.pdf](http://apps.searo.who.int/PDS_DOCS/B4771.pdf) (23 January 2014); WHO *Strengthening the health sector response to adolescent health and development* (2010) 2, available at [http://www.who.int/maternal\\_child\\_adolescent/documents/cah\\_adh\\_flyer\\_2010\\_12\\_en.pdf?ua=1](http://www.who.int/maternal_child_adolescent/documents/cah_adh_flyer_2010_12_en.pdf?ua=1) (12 December 2013); WHO *The health of young people: A challenge and a promise* (1993) 1-2.

<sup>2</sup> WHO *Strengthening the health sector response to adolescent health and development* (as above) 2.

Whilst STIs and HIV are increasingly recorded among the adolescent population generally, and although it is believed that male adolescents are more likely to engage in risky sexual behaviour than their female counterparts,<sup>3</sup> data continue to reveal that adolescent girls for various reasons in both developed and developing countries are more susceptible to STIs (including HIV).<sup>4</sup>

As noted in Chapters 2, 3 and 5, acknowledging the outcomes associated with the increase in adolescent sexual activity and the obligation imposed on state parties to take steps towards achieving the full realisation of the right of children to the highest attainable standard of health, including those related to family planning education and services,<sup>5</sup> the Committee on the CRC urged states to ensure that appropriate services and information for the prevention and treatment of STIs, HIV and AIDS are not only available and accessible, but that barriers which hinder access of adolescents to such information are removed.<sup>6</sup>

In addition, realising the significance of effective contraceptive use in guaranteeing good SRH, especially, in view of the negative SRH outcomes associated with Nigerian and

<sup>3</sup> UNICEF *The state of the world's children 2011: Adolescence an Age of Opportunity* (2011) 22, available at [http://www.unicef.org/sowc2011/pdfs/SOWC-2011-Main-Report\\_EN\\_02092011.pdf](http://www.unicef.org/sowc2011/pdfs/SOWC-2011-Main-Report_EN_02092011.pdf) ( 23 January 2014).

<sup>4</sup> K L Dehne & G Riedner *Sexually transmitted infections among adolescents: The need for adequate health services* (2005) IX, available at <http://whqlibdoc.who.int/publications/2005/9241562889.pdf> (9 November 2013); M De Bruyn *Gender, adolescents and the HIV/AIDS epidemic: The need for comprehensive sexual and reproductive health responses* (2000) available at <http://www.un.org/womenwatch/daw/csw/hiv aids/De%20bruy n.htm> (23 January 2014); NACA *Key statistics on HIV in Nigeria* available at [http://naca.gov.ng/index2.php?option=com\\_docman&task=doc\\_view&gid=110&Itemid=268](http://naca.gov.ng/index2.php?option=com_docman&task=doc_view&gid=110&Itemid=268) (9 November 2013); Department of Health *The National Antenatal Sentinel HIV and Syphilis Prevalence Survey South Africa 2011* (2012) V, available at [http://www.doh.gov.za/docs/presentations/2013/Antenatal\\_Sentinel\\_survey\\_Report2012\\_final.pdf](http://www.doh.gov.za/docs/presentations/2013/Antenatal_Sentinel_survey_Report2012_final.pdf) (12 November 2013).

<sup>5</sup> Article 2(1) ICESCR; arts 24(1) & 24(2)(f) CRC.

<sup>6</sup> Paras 17 & 26 CRC Committee General Comment 4 *Compilations of General Comments and Recommendations Adopted by Human rights Treaty Bodies, Vol II*, available at [http://www.bayefsky.com/general/hri\\_gen\\_1\\_rev9\\_vol\\_ii.pdf](http://www.bayefsky.com/general/hri_gen_1_rev9_vol_ii.pdf) (27 October 2012).

South African female adolescents' engagement in sexual relationships<sup>7</sup> despite their countries being parties to human rights treaties guaranteeing the protection of the right to health care, this thesis sought to examine the rights of adolescent girls in Nigeria and South Africa to reproductive health care through their access to contraceptive information and services. In addition, the thesis examined the barriers that prevent female adolescents from accessing contraceptive information and services in the two countries.

In order to investigate the above, the following research questions were proposed:

- 1 Are the legal frameworks of Nigeria and South Africa on reproductive health consistent with international human rights provisions?
- 2 What are the barriers or challenges faced by adolescent girls when they seek to access contraceptive information and services in South Africa and Nigeria?
- 3 What are the effects of these barriers on their realisation of access in Nigeria and South Africa?
- 4 What are the international best practices relating to female adolescents' access to contraception? What may Nigeria and South Africa learn from these best practices?

As the final chapter of the thesis, and, conclusively, to answer the research questions, I first present an overview of the findings of the previous chapters. Thereafter, I draw final conclusions based upon these findings and, further, use these findings in order to offer recommendations.

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<sup>7</sup> A Udo *et al* 'Teenage pregnancy and adverse birth outcomes in Calabar, Nigeria' (2013) 17(2) *Internet Journal of Gynaecology and Obstetrics* available at <http://ispub.com/IJGO/17/2/2995> (10 November 2013); S Willan *A review of teenage pregnancy in South Africa: Experiences of schooling, and knowledge and access to sexual & reproductive health services* (2013) 7, available at <http://www.hst.org.za/sites/default/files/Teenage%20Pregnancy%20in%20South%20Africa%20Final%2010%20May%202013.pdf> (18 September 2013); UNICEF Nigeria HIV/AIDS, available at [http://www.unicef.org/nigeria/children\\_1940.html](http://www.unicef.org/nigeria/children_1940.html) (9 November 2013); UNICEF *South Africa Statistics* available at [http://www.unicef.org/infobycountry/southafrica\\_statistics.html#102](http://www.unicef.org/infobycountry/southafrica_statistics.html#102) (28 October 2013).

## 2 Overview of chapter findings

Chapter 2 of the thesis contextualised the study by inquiring into the international human rights framework governing the right to health, generally, and the right to reproductive health care in particular. The review of human rights treaties (both international and regional) and declarations revealed that Nigeria and South Africa are both parties and signatories to the treaties from which the right of female adolescents to access contraceptive information and services can be inferred. As well, the two countries are signatories who agreed to be bound by the contents of the ICPD Programme of Action and its sister instrument, the Beijing Platform for Action. The rights recognised in these human rights instruments provide the backbone and legal framework upon which the right to access contraceptive information and services hinges.

Specifically highlighting provisions of treaties that support the right of adolescent girls to access contraceptive information and services, Chapter 2 of the thesis explained that the effect of ratified international instruments in the jurisdiction of state parties depend on the method of domestication adopted in each state. Nigeria strictly adopts the dualist approach that allows for the application of human rights instruments in the domestic jurisdiction only upon domestication by its legislative arm of government. South Africa adopts a mixed approach, with section 231(4) allowing for self-executory provisions of treaties approved by Parliament having immediate effect without the necessity for domestication. Notwithstanding the fact that South Africa is yet to ratify the ICESCR, it was indicated that most of the provisions contained in the instrument are already guaranteed by the Constitution of the Republic of South Africa.

It was also pointed out in the chapter that, whereas Nigeria does not recognise the right to health care as a justiciable right in its Constitution, the domestication of the ACHPR in the country is advantageous as the recognition of the right to health in the Charter can

be applied to ‘force’ the Nigerian government to live up to its international human rights obligations.

Proceeding to the domestic realm, in Chapter 3, in addition to the Nigerian and South African Constitutions, other national legislation and policies giving flesh to the contents of international human rights instruments protecting adolescent girls’ rights to access contraceptive information and services domestically were reviewed.

The conclusions of the study undertaken in the chapter reveal, even though Nigeria and South Africa have taken steps to guarantee access to the contraceptive information and services for adolescents generally, that their levels of commitment to ensure this protection differ in several respects. Besides protecting children’s rights in its Children’s Act, the chapter points out that South Africa also recognises children’s rights in section 28 of its Constitution and elevates the protection of their best interests to a position of paramountcy. Court decisions in cases such as *Minister of Welfare and Population Development v Fitzpatrick*<sup>8</sup> affirmed the above. In Nigeria children’s rights are contained only in the CRA 2003.

As well, it was noticed in the case of Nigeria that the fact that the CRA does not enjoy universal application is a major constraint which limits adolescent girls’ access to contraception. This situation is in contrast to South Africa’s position where children’s legislation has universal application, encouraging uniformity in the overall protection of the right of adolescent girls to access contraceptives in confidential settings.

Other conclusions arrived at in Chapter 3 include the fact that, unlike the African Youth Charter and its South African counterpart which increase the scope of people which the charter protects, Nigeria’s position is different as it actually narrows the scope of protection to people between the ages of 18-35, revealing its unrealistic stance

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<sup>8</sup> *Minister of Welfare and Population Development v Fitzpatrick* 2000 (3) SA 422 (CC).

regarding adolescent sexuality issues. Finally, it was established in the chapter that though many policies exist in Nigeria, as in South Africa, these policies are neither seriously monitored nor implemented, and that the lack of cooperation among health departments results in the duplication of efforts.

Chapter 4 is conceptual in nature, examining the concept of autonomy in relation to female adolescents' access to contraceptive information and services. Acknowledging the unease that accompanies discussions on adolescents' need for autonomy, especially in relation to their making SRH decisions, the opinions of writers on opposite sides were canvassed and analysed. Some writers, like Campbell, are of the belief that allowing children autonomy rights would amount to redrawing boundary lines between childhood and adulthood and put children under constant stress;<sup>9</sup> others, like Hill, are of the view that respecting the autonomy of individuals should be because they are humans deserving of utmost respect.<sup>10</sup> In the chapter it was submitted that Fortin's opinion that adolescents' capacity to take responsibility for their lives by making autonomous decisions on whether to access contraceptives or not should be encouraged as they mature and develop into adolescence.<sup>11</sup>

Taking into consideration African beliefs on the autonomy of children, which correspond with the view of communitarians and which apply in both Nigeria and South Africa, the differences between the two governments' responses to consent to medical interventions and confidentiality issues relating to adolescents accessing medical treatment, including contraceptive services, were outlined. The focus was especially in relation to provisions contained in sections 129 and 134 of South Africa's Children's Act.

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<sup>9</sup> T D Campbell 'The rights of the minor: As person, as child, as juvenile, as future adult' (1992) 6 *International Journal of Law, Policy and the Family* 1-23. See also V Morrow 'We are people too': Children's and young people's perspectives on children's rights and decision-making in England' (1999) 7 *The International Journal of Children's Rights* 150.

<sup>10</sup> T E Hill *Autonomy and self-respect* (1991) 15.

<sup>11</sup> J Fortin *Children's Rights and the developing law* (2009) 7.

These sections allow adolescents access to contraceptive services in confidential settings and also allow for adolescents to give independent informed consent to medical treatment from the age of 12 years. This position is highlighted in the Court's decision in *Christian Lawyers Association v Minister of Health and Others (Reproductive Health Alliance as Amicus Curiae)*.<sup>12</sup> In contrast, the Nigerian position is that adolescents, generally, cannot independently consent to or access health care services confidentially, even where they are mature and can comprehend the nature of treatment requested.<sup>13</sup> In fact, it is submitted that the blatant silence on the age of consent to medical treatment by children, the obvious lack of confidentiality of adolescents when accessing contraceptive services, and the non-inclusion of age and marital status as grounds for non-discrimination are strong evidence of deficiencies in Nigeria's plethora of laws.

In addition to the above, and in keeping with Lansdown's and Wernham's opinion that the need to allow adolescents to exercise their autonomy is particularly contentious in relation to SRH matters,<sup>14</sup> the chapter evaluated the contradictions generated as a result of parents' need to protect their children in line with their cultural beliefs and traditions, in contrast to female adolescents' need to exercise their autonomy by accessing contraceptives according to their evolving capacities as recommended under article 5 of the CRC. Despite the impulse of parents towards the creation of limits to adolescents' exposure to harm, the importance of allowing opportunities where adolescent girls may become empowered by acquiring skills and confidence to negotiate consensual and safe sex was highlighted as of greater value and in their best interests.

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<sup>12</sup> 2005 (1) SA 509 (T).

<sup>13</sup> Sec 8(3) Child Rights Act 2003 & sec 19 Code of Ethics for Medical and Dental Practitioners.

<sup>14</sup> G Lansdown & M Wernham 'Are protection and autonomy opposing concepts?' in IPPF (ed) *Understanding young people's right to decide* (2012) 3, available at [http://www.ippf.org/sites/default/files/ippf\\_right\\_to\\_decide\\_03.pdf](http://www.ippf.org/sites/default/files/ippf_right_to_decide_03.pdf) (12 June 2013).

Specifically, in answer to the first research question on whether the legal frameworks of Nigeria and South Africa on reproductive health are consistent with international human rights provisions, these are the findings.

It is clear from the discussion in the thesis, and particularly from the analysis in Chapter 2, that although Nigeria and South Africa are signatories to various human rights conventions and declarations guaranteeing the right to health care, including reproductive health care, based on the study in Chapters 3 and 4, in addition to the comparison carried out in Chapter 8, it is evident that South Africa's legal framework on female adolescents' access to health care including contraceptives and other SRH services is more consistent with international provisions on the right to reproductive health than that of Nigeria.

In Chapter 5, the approaches and modalities adopted by Nigeria and South Africa to guarantee access to contraceptive information and services for their female adolescents were scrutinised. Although the two countries have both adopted modalities for teaching sexuality education to adolescents, it was concluded that the realistic nature of curricular contents is predicated upon the different views and approaches adopted in the two countries. Likewise, in providing access to contraceptives and other SRH services, it was also noticed that accessing contraceptive services by adolescent girls in Nigeria remains elusive as adolescent-friendly centres where the services can be obtained are virtually non-existent when compared to the needs of the country's adolescent population.

In answer to the fourth research question posed in Chapter 1, which seeks to examine international best practices relating to female adolescents' access to contraception and what Nigeria and South Africa may learn from these best practices, Chapter 5 notes, regardless of the social, cultural, political, and economic differences among countries, that a constant factor is that adolescents initiate sexual relationships at an early age. As

pointed out in Chapter 5, the government of Denmark has been successful over the years in guaranteeing the rights of its female adolescents to contraceptive information and services, notwithstanding opposition from different quarters.<sup>15</sup> Apart from pragmatically introducing the compulsory teaching of factual sexuality education in public schools through a varying combination of methods,<sup>16</sup> adolescents have guaranteed access to contraceptives and other reproductive health-care information and counselling in confidential settings located at easily-accessible areas without fear of stigmatisation or oppression.<sup>17</sup> The analysis of the position in Denmark regarding its approaches and tactics towards adolescent sexuality issues shows that these approaches have been successful in ensuring that low teenage pregnancies rates and low abortion and STI rates are recorded in that country.<sup>18</sup> Also, the adoption of a more liberal and tolerant approach by Danish stake-holders, who have accepted the reality of adolescent sexuality, is an added bonus. Instead of viewing adolescents engaging in sexual relations as immoral, adolescents benefit by receiving realistic and factual information which teaches them sexual responsibility. It is submitted that Nigeria and South Africa have a lot to learn from this approach.

As explained in Chapter 5, the selection of Mozambique for review of best practices in adolescent SRH was based on the fact, despite having poorer statistics on HIV and

<sup>15</sup> *Kjeldsen, Busk Madsen, and Pedersen v. Denmark* (1976) 1 European Human Rights Report 711; *Dojan and others v Germany* - Application no 319/08,2455/08, 7908/10, 8152/10 and 8155/10, available at [http://www.menschenrechte.ac.at/orig/11\\_5/Dojan.pdf](http://www.menschenrechte.ac.at/orig/11_5/Dojan.pdf) (23 September 2013).

<sup>16</sup> R Parker *et al* 'Sexuality education in Europe: an overview of current policies' (2009) 9 *Sex Education* 233; IPPF *Sexuality Education in Europe* (2006) 45, available at <http://www.ippfen.org/NR/rdonlyres/7DDD1FA1-6BE4-415D-B3C2-87694F37CD50/0/sexed.pdf> (18 September 2013); IPPF European Network *Sexuality education in schools* (2007) 64, available at <http://www.ippfen.org/NR/rdonlyres/61C8D3F0-D94D-4285-B576-0A61EB979EC3/0/Sexeducationinschools.pdf> (18 September 2013).

<sup>17</sup> L Berne & B Huberman *European Approaches to Adolescent Sexual Behavior & Responsibility* (1999) 29-31, available at <http://www.advocatesforyouth.org/storage/advfy/documents/european.pdf> (23 September 2013); C Moreau *et al* 'The impact of pharmacy access to emergency contraceptive pills in France' (2006) 73 *Contraception* 602; C C Harper *et al* 'The effect of increased access to emergency contraception among young adolescents' (2005) 106 *Obstetrics & Gynecology* 484.

<sup>18</sup> F F Lauszus 'No change in adolescents' neglect on contraceptive use over two decades' (2011) 283 *Archives of Gynaecology and Obstetrics* 551; H Wielandt & L B Knudsen 'Birth Control: Some Experiences from Denmark' (1997) 55 *Contraception* 304.

teenage pregnancies than even South Africa, that its *Geracao Biz* Programme has achieved unprecedented success through its use of a multi-sectoral approach in ensuring that adolescents have access to contraceptive information and services, as well as changing the parochial attitudes of societal gate-keepers.<sup>19</sup> Nigeria and South Africa can learn from this example.

In answer to the second and third research questions on the challenges faced by female adolescents in Nigeria and South Africa in accessing contraceptive information and services and the consequences of these challenges, Chapter 6 examined the numerous barriers that prevent female adolescents from accessing contraceptive information and services, in spite of governmental efforts to guarantee access to contraceptives and other SRH care services for adolescents as well as the various consequences that ensue as a result of these impediments.

Chapter 6 took a critical look at the impediments affecting adolescent girls' access to contraception grouped under five sub-headings, namely, legal, economic, socio-cultural, religious and demographic barriers. It was stressed that Nigerian female adolescents' problems in relation to accessing contraceptives can be attributed to problems from all of these barriers, as they face legal, economic, socio-cultural, religious and demographic barriers, all of which have substantially contributed to the consequences discussed in the chapter.

In the case of adolescent girls in South Africa, the same obstacles prevent their access to contraceptive information and services as were discussed in relation to adolescents in Nigeria. Nevertheless, it is important to note that despite the existence of South Africa's

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<sup>19</sup> WHO *From inception to large scale: The Geração Biz Programme in Mozambique* (2009) 26 & 32-36, available at <http://www.pathfinder.org/publications-tools/pdfs/From-Inception-to-Large-Scale-The-Geracao-Biz-Programme-in-Mozambique.pdf> (11 March 2014); J M Matsinhe *Programa Geracao Biz-Investing in youth: The story of a national SRH programme for adolescents and youths in Mozambique* (2011) 16-21, available at [http://mozambique.unfpa.org/drive/INVESTING\\_IN\\_YOUTH\\_\\_17\\_10\\_2011web.pdf](http://mozambique.unfpa.org/drive/INVESTING_IN_YOUTH__17_10_2011web.pdf) (14 March 2014).

numerous positive legislation and policies which assure adolescent's access to contraceptives and other reproductive health-care services, the chief factor responsible for the failure of ensuring total success, is the continuous existence of cultural and religious beliefs that prevent female adolescents from accessing available services. This failure is occasioned by the fact that discussions relating to adolescent sexuality are normally viewed negatively. The above state of affairs is compounded by adolescent girls' engagement in inter-generational and transactional sex as a result of poverty.

Despite the fact that the level and extent of the barriers faced by adolescent girls in Nigeria and South Africa when accessing contraceptive services and information vary, it was concluded that the consequences of the existence of these barriers are similar. This led to the conclusion that there is an urgent need to adopt Durojaye's suggestion relating to the need for the Nigerian and South African governments to ask the 'female adolescent question' in order to appraise previously-adopted approaches so as to discover whether the modalities have been effective in guaranteeing adolescent girls access to contraceptive information and services and protecting them from negative SRH consequences. According to Durojaye, 'the female adolescent question' is a necessary tool that can be used in the evaluation of the effectiveness, or otherwise, of laws and policies adopted by government in relation to the SRH needs of adolescent girls. When the evaluation is carried out it will reveal the defects or shortcomings of the legislations and policies in place so that a review of the affected legislation can take place.<sup>20</sup>

Finally, in Chapter 7, a comparative analysis of areas of similarities and differences between the two countries in the study was undertaken. The two countries' constitutional and legal frameworks, policy approaches and judicial stances were

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<sup>20</sup> E Durojaye 'Realising access to contraception for adolescents in Nigeria: A human right analysis' University of Free State (2010) 63.

distinguished. The shortcomings and deficiencies that were highlighted in Chapter 7 will form the basis for recommendations below.

### 3 Conclusions

The expression of sexuality is multi-dimensional and involves the physical, emotional, social, moral and spiritual aspects of human life. As an integral function of humanity, the expression of sexuality by adolescents is natural and to be expected. However, if adolescents do not possess adequate information or access to sufficient protection, this lack may lead to disastrous consequences.<sup>21</sup>

According to Haider, because adolescence is a stage of life where children begin to mature into adulthood, it is often times a battleground for control as discussions relating to the sexuality of young persons' are regarded as provocative, notwithstanding the gravity of the health issues at stake.<sup>22</sup> Even though it is acknowledged that children have a whole variety of rights which include the right to care and protection which parents are best positioned to offer, the need to encourage adolescent capacities to make reasoned and healthy choices according to their evolving abilities through access to relevant SRH information and services is paramount, especially as they mature physically and mentally.<sup>23</sup>

Before proceeding, at this stage it is necessary to emphasise that while the intention in the thesis is to advocate the unfettered access of female adolescents in Nigeria and South Africa to contraceptive services and information in order to protect their SRH, it is also important to stress that granting such access should be supported by the

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<sup>21</sup> G James 'Education and sexuality: Towards addressing adolescents' reproductive health needs in Nigeria' (2012) 4 *Current Research Journal of Social Sciences* 291.

<sup>22</sup> A Haider 'Adolescents under international law: Autonomy as the key to reproductive health' (2008) 14 *William & Mary Journal of Women and the Law* 607.

<sup>23</sup> Fortin (n 11 above) 7.

adolescent girl's ability to give free and informed consent.<sup>24</sup> Female adolescents who wish to access contraceptive services should be individually subjected to questioning in order to discover whether they not only understand the nature of the services requested, but also appreciate the risks associated with engaging in early sexual relations (including effects associated with the use of particular types of contraception). The importance of ensuring that these pre-conditions be fulfilled will make the services inaccessible to emotionally and mentally immature adolescent girls.

As several writers note,<sup>25</sup> not only is the concept of African adolescents' possessing autonomy rights usually limited by beliefs which regard children as too unwise or imprudent to take serious decisions on issues affecting their lives, but female adolescents in Africa are especially vulnerable due to the existence of socio-cultural and religious beliefs which encourage their subordination to their male counterparts. These socio-cultural and religious beliefs prevent them from exercising their ability to make autonomous decisions in all respects, including their reproductive lives. It is concluded that the existence of this state of affairs is responsible for the numerous negative SRH outcomes and ill-health attributed to adolescent girls who are denied access to contraceptive information and services as a result of parochial and out-dated beliefs.

Chapter 5 emphasised that socio-cultural and religious factors fostered by the culture of silence practised by parents who refuse to discuss sexuality issues with their wards (especially adolescent girls) in the belief that having such conversations amount to a tacit approval of the adolescent engaging in promiscuous behaviour is a major bane

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<sup>24</sup> *Christian Lawyers No 2* (n 12 above) 515; *Gillick v West Norfolk and Wisbech Area Health Authority and Another* (1986) 1 AC 112, (1985) 3 All ER 402; T L Beauchamp & J F Childress *Principles of biomedical ethics* (2009) 120-121; K Moodley *Medical Ethics, Law and Human Rights: A South African Perspective* (2011) 44.

<sup>25</sup> Durojaye 'Realising access to contraception for adolescents in Nigeria' (n 20 above) 37-38; F Adjetej 'Reclaiming the African woman's individuality: the struggle between women's reproductive autonomy and African society and culture' (1995) 44 *American University Law Review* 1353; C O Izugbara 'The Socio-Cultural Context of Adolescents' Notions of Sex and Sexuality in Rural South-Eastern Nigeria' (2005) 8(5): 600-617.

preventing female adolescents' contraceptive usage in Nigeria and South Africa. In fact, especially in relation to accessing contraceptive information and services, adolescent girls in Nigeria and South Africa require emancipation from paternalistic traditional and religious beliefs which prevent their access to confidential SRH care services and information; there is a need for serious attitudinal and societal changes as well. Such change can be achieved only through extensive sensitisation campaigns. The need to acknowledge adolescent girls' autonomy in relation to contraceptive use is a prerequisite for assuring their successful protection from STIs, HIV and teenage pregnancies. It is also a means of guaranteeing their elevation from a position of socio-economic disadvantage.

In relation to the problem of married adolescents not having access to contraceptive services and information, it is submitted irrespective of the various reasons for which adolescent girls might have become entangled in the problem of child marriage that a constant factor remains: it is the responsibility of Nigeria and South Africa's governments to ensure the protection and promotion of the right of its female adolescent population to contraceptive and other SRH care information and services in accordance with the provisions of human rights instruments acceded to by them. Hence, there is a need for both governments to be more proactive in ensuring that female adolescents (whether married, unmarried, in school or out of school) not only have guaranteed access to contraceptive information and education but also to ensure that the services are accessible, both physically and financially.

Nigeria and South Africa have indicated their acceptance to be bound by human rights treaties recognising the right to health care, as emphasised in answer to the first research question. Yet Nigeria's performance in relation to bringing its laws into accord with international human rights provisions relating to the protection of female adolescents right to reproductive health care and, therefore, contraceptive information

and services, falls below expectations. Apart from laws which are visibly inconsistent with human rights dictates on adolescent consent and confidentiality issues, especially when accessing contraceptive services, the existence of other shortcomings in relation to the fulfilment of its obligation to provide adolescent girls access to contraceptives and other SRH care needs, reveals a lack of political will on the part of Nigeria's government

In addition, South Africa's constant review of its policies on access to contraceptive services and information and SRH generally, as evidenced by the recent National Contraception and Fertility Planning Policy and Service Delivery Guidelines and Integrated School Health Policy, reveals a situation where the effort is continually made to fulfil international obligations imposed on the South African state as a result of its membership of human rights conventions protecting the right to health. Pertaining to Nigeria, and in agreement with Aniekwu and Durojaye,<sup>26</sup> the existence of laws and policies on SRH care, including access to contraceptives services for female adolescents, has not translated into the desired result as a consequence of lack of evaluation mechanisms that are necessary for monitoring and coordinating the implementation of existing policies in order to effectively monitor their performance. Again, this state of affairs points to the fact that the Nigerian government needs to intensify its efforts to ensure that adolescents' generally have access contraceptive information and services.

A major reason that has been adduced for non-access to contraceptives in Nigeria is that of economic accessibility, despite the CEDAW Committee's recommendation that the Nigerian government should make effort to improve availability, affordability and

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<sup>26</sup> Durojaye 'Realising access to contraception for adolescents in Nigeria' (n 20 above) 63; N I Aniekwu *The development of reproductive health laws: Considerations for the Nigerian legal system* 1, available at <http://www.nigerianlawguru.com/articles/general/THE%20DEVELOPMENT%20OF%20REPRODUCTIVE%20HEALTH%20LAWS,%20CONSIDERATIONS%20FOR%20THE%20NIGERIAN%20LEGAL%20SYSTEM.pdf> (24 September 2012); N I Aniekwu *Engendering sexuality: Human rights issues in reproductive and sexual health* (2006) 38, available at <http://www.arsrc.org/downloads/features/aniekwu.pdf> (4 March 2013).

accessibility to contraceptives services particularly at the primary level and in rural areas.<sup>27</sup> The CRC Committee also recommended the abolishment of user fees and the implementation of child friendly awareness programmes on contraception use.<sup>28</sup> In spite of the above, it is particularly worrisome that the opposite situation still persist thereby casting doubts on the government's sincerity in its promises to ensure access to contraceptive information and services for adolescents.

Taking cognisance of the recent general comment 14 of the CRC Committee that the judgment of adults on what is perceived to be in a child's best interests should not be a reason for overriding the obligation to respect the rights of children contained in the Convention,<sup>29</sup> there is an immediate need for Nigeria to review its laws. Such a review is necessary in order to speedily ensure that shortcomings highlighted in relation to the constitutional guarantee of a right to health (care), best interests, age of consent, confidentiality (especially in relation to access to contraceptives) and access to information on the promotion of health (care) by children, be eliminated through the insertion of these provisions into relevant laws, as has been done in South Africa. In addition, apart from legislative and policy reforms, other financial and administrative improvements should be geared towards ensuring adequate funding of the health sector in order to bring to reality 'paper promises' alluding to free contraception.<sup>30</sup> As well, there is need to bring under control, the demonstration of unfriendly attitudes exhibited by health providers dealing with adolescents SRH issues.

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<sup>27</sup> Paras 335-337 concluding observation of the CEDAW Committee on Nigeria 2008 CEDAW/C/NGA/CO/6, available at <http://www2.ohchr.org/english/bodies/cedaw/docs/co/CEDAW-C-NGA-CO-6.pdf> (28 February 2013).

<sup>28</sup> Para 62 concluding observations of the CRC Committee on Nigeria 2010 UN Doc CRC/C/NGA/CO/3-4, available at <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G10/431/92/PDF/G1043192.pdf?OpenElement> (25 October 2012).

<sup>29</sup> Para 4 general comment 14 CRC Committee on (2013) available at <http://www.refworld.org/docid/51a84b5e4.html> (3 March 2014).

<sup>30</sup> Paras 4.1.1 & 4.1.2. National Policy on Health and Development of Adolescents and Young People 2007 (National Adolescent Policy).

In relation to the ratification of the ICESCR by South Africa, it is specially noted, although, by constitutionally recognising the protection of socio-economic rights in its Bill of Rights, South Africa has indirectly given recognition to the provisions of the ICESCR which it signed October 1994, it is on record that the country is yet to ratify the Covenant or sign its optional protocol which entered into force in 2013. It is submitted that there is an urgent need for ratification in order to pave the way for its accession to the ICESCR optional protocol which allows individuals in member states to bring complaints of violations to the ICESCR Committee.

On the other hand, Nigeria has ratified all human rights instruments protecting the right to health care including the ICESCR, though it is yet to domesticate a majority of them. In fact, as explained in Chapter 2, Nigeria has only succeeded in domesticating two human rights instruments acceded to: the African Charter and the Convention on the Rights of the Child. It is felt that the domestication of all human rights instruments acceded to by Nigeria will stimulate better performance in the protection of human rights in the country. Like South Africa, Nigeria has not ratified the ICESCR optional protocol. It is submitted that ratifying and domesticating the ICESCR optional protocol may motivate the governments (Nigeria especially) to become more enthusiastic towards fulfilling their obligations which arise from the ratification of the ICESCR in order to prevent continual embarrassment as a result of constant reporting by their citizens.

As noted in Chapter 2 with regard to the submission of state reports, there is need for Nigeria and South Africa to take their reporting obligations more seriously as constant and regular submission of state reports by the countries will assist in illuminating areas in relation to the fulfilment of their obligations in respect of female adolescents' access to contraceptive information and services where their actions are lagging. NGOs can be of great assistance in this respect, as their submission of shadow reports to the

monitoring bodies of the human rights instruments will assist the various committees to obtain ‘balanced’ views that will enable them make recommendations as appropriate.

In relation to international best practices, it is the view, as in Denmark, that the acceptance of the reality of adolescent sexuality ensures greater benefits than harm, in the sense that instead of viewing the engagement by adolescents in sexual relations as immoral, female adolescents get to benefit through the imparting of realistic and factual information that teaches them about sexual responsibility. The adoption of these forward-thinking attitudes has resulted not only in low teenage pregnancies, abortion and STI rates in Denmark,<sup>31</sup> but has also disproved a major reason for preventing adolescent girls’ access to contraceptives - that access to contraceptives encourages risky sexual behaviour.<sup>32</sup> It is submitted that Nigeria and South have a lot to learn from this approach.

Though Mozambique is plagued by the usual problems of STIs, HIV and teenage pregnancy peculiar to countries in sub-Sahara Africa, as explained in Chapter 5, the country’s Busy Generation programme (*Geração Biz*), has resulted in the achievement of positive results towards the realisation of female adolescents’ access to contraceptive services and information. The programme has not only changed the parochial attitudes of societal gate-keepers but has increased access to contraceptive information and services for adolescent girls as well.<sup>33</sup>

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<sup>31</sup> Lauszus (n 18 above) 283; J Zeitlin et al *European perinatal health report: Health and care of pregnant women and babies in Europe in 2010* (2010) 58, available at <http://www.europeristat.com/images/doc/Peristat%202013%20V2.pdf> (23 September 2013); J S Santelli & AT Schalet A New Vision for Adolescent Sexual and Reproductive Health (2009) 3, available at [http://www.google.co.za/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&cad=rja&ved=0CckQFjAA&url=http%3A%2F%2Fecommons.cornell.edu%2Fbitstream%2F1813%2F19323%2F2%2FNewVision\\_Nov09.pdf&ei=BhVEUuXmHlerhQevwoCoDw&usg=AFQjCNFB\\_NxSVxAKLQxhvCZmvsjp-IOaXw&bvm=bv.53217764,d.ZG4](http://www.google.co.za/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&cad=rja&ved=0CckQFjAA&url=http%3A%2F%2Fecommons.cornell.edu%2Fbitstream%2F1813%2F19323%2F2%2FNewVision_Nov09.pdf&ei=BhVEUuXmHlerhQevwoCoDw&usg=AFQjCNFB_NxSVxAKLQxhvCZmvsjp-IOaXw&bvm=bv.53217764,d.ZG4) (23 September 2013).

<sup>32</sup> Moreau et al (n 17 above) 606-607.

<sup>33</sup> Matsinhe (n 19 above) 16-21; WHO *From inception to large scale* (n 19 above) 32-36.

As suggested in Chapter 5, though the efforts of NGOs in Nigeria is appreciated, it is felt that adopting the Mozambican government approach of collaborative effort with various stake-holders will lead to the achievement of better results. Even though South Africa already has the NAFCI programme, which is successful, it is felt that it too can adopt the modality used in the *Geração Biz* programme in which parents are invited to schools, specifically, to sensitise them to the importance of allowing their children to use services offered in adolescent-friendly clinics.

Finally, while allowing female adolescents in Nigeria and South Africa unfettered access to contraceptive and other sexual and reproductive health care information and services, continues to be a source of great concern, like the situation in other developing countries, the thesis maintains that the promotion of cultures of patriarchy and silence in relation to female adolescents' access to contraceptive information and services has been a major bane responsible for adolescents' adoption of risky sexual behaviours with consequent high pregnancy, unsafe abortion, HIV and STI rates. It is submitted that no matter how appealing is traditional society's urge (in Nigeria and South Africa) to 'protect' adolescents from sexual immorality and vices, the resulting benefits from their adoption of a more liberal attitude and approach towards adolescent sexuality issues and contraception will greatly overshadow the supposed undesirable and harmful results.

#### **4 Recommendations**

Based on the above, and flowing from the comparative study undertaken in the thesis, the following recommendations are offered.

## 4.1 Nigeria

### 4.1.1 International human rights obligations

It is not enough that Nigeria keeps acceding to every human right treaty or instrument that becomes available for ratification, both internationally and regionally. Instead, the government needs to show greater commitment towards fulfilling the responsibilities created by instruments already ratified. As noted in the study, even though Nigeria has ratified several human rights instruments guaranteeing protection of female adolescents' right to access health care, including contraceptives and other SRH services, the level of responsibility exhibited by the government towards the fulfilment of its obligations is inadequate as problems of availability, accessibility, acceptability and quality continue to plague the smooth implementation of the instruments.

In addition to ensuring domestication of ratified instruments so that the country's laws can become aligned with treaty provisions, the necessary implementation and enforcement mechanisms need to be put in place all over the country to not only monitor compliance and levels of success achieved, but also to take note of difficulties experienced for immediate correction so that factual and true accessibility to contraception by adolescents can be achieved.

The Nigerian state needs to exhibit its commitment towards achieving the obligations imposed by the human rights instruments by ensuring its timeous submission of state reports immediately they become due, since submission of state reports to treaty monitoring bodies allows for an immediate exposure of areas of deficiencies.

### 4.1.2 Review of domestic legislations and policies

As noted in Chapters 3 and 6 of this study, several of the country's laws, including the Constitution, Child Rights Act and Criminal/Penal Codes, among several others, need to be reviewed in order to correct disparities which currently exist in the laws. The

necessity for review is especially important in relation to aligning the age of sexual consent in the laws and also to take cognisance of consensual sexual relationships between adolescents with not more than a two year age difference in order to encourage them to access contraceptive services so as to prevent disastrous consequences.

While the review of the Constitution to accommodate the recognition of the right to health care for all citizens will be appreciated, at the minimum, there should be a recognition of children's right to basic health care services, including the provision of contraceptives in order to protect adolescents SRH.

Also, there is need for a review of the current provisions on children's consent and privacy in medical situations especially in relation to their ability to access confidential contraceptive services in the case of adolescents who are '*Gillick*' competent. In this regard, there is a need to review existing legislation on the age of consent to medical treatment in order to create avenues for the waiver of parental consent for 'mature' adolescents, especially when accessing contraceptive and other SRH care services.

As well, it is important for the government to review the current Family Life and HIV Education Curriculum taught in Nigerian schools so as to cater in-depth for topics relating to sexuality, contraception, abortion and other important reproductive health issues.

#### **4.1.3 Universal acceptance of the Child Right Act**

As noted in Chapter 3, the CRA 2003 does not enjoy universal application, as is the case in relation to its South African counterpart. The situation as currently exists undoubtedly, has resulted in various versions being adopted in different states but also led to some states absolutely refusing to implement corresponding state Child Rights Laws. Female adolescents bear the brunt of the ill consequences of the non-uniformity.

In order to correct the present situation and ensure uniformity there is a need for the Federal Government to move the protection of children's rights into the exclusive or concurrent legislative list of Nigeria's Constitution so that the CRA itself can become automatically enforceable in states where there is staunch refusal to implement corresponding laws.

On the other hand, the Federal Government can organise serious advocacy and enlightenment campaigns in the affected states in order to prompt people residing in the states to 'encourage' their legislatures to act on the passage of corresponding Child Right Laws.

#### **4.1.4 Sensitisation and awareness programmes**

In order to change cultural and religious perceptions/attitudes towards female adolescents' access to contraceptives and other SRH care services, there is need for the Nigerian government to embark on numerous awareness and sensitisation campaigns in the various information media in order to effect gradual societal and attitudinal change.

Community and religious leaders need to be convinced of the need to encourage adolescents to access SRH care services through the presentation of factual evidence on the negative effects occasioned as a result of preventing female adolescents access to contraceptive information and services. In addition, community and religious leaders should be specifically drafted as points-men to assist in the implementation and monitoring activities of adolescent SRH health programmes in their various communities.

#### **4.1.5 Training**

Taking note of the important position occupied by health care providers in guaranteeing female adolescents access to contraceptive services and information, there is need for the Nigerian government to train and re-train health providers involved in adolescent

SRH care services so as to improve their communication and inter-personal skills with the view of making them sensitive to female adolescents' needs. In addition to the above, sexuality education instructors have a great role to play in the impartation of factual and in-depth sex education to adolescents, so there is a need for government continually to organise training programmes for this group of people too.

Also, modalities to adequately remunerate these groups of people should be put in place, especially health care providers working in rural areas. While the necessity for constant training is to make them knowledgeable about current events in relation to adolescent sexuality issues, the need to compensate fairly is to make them more dedicated towards the provision of adolescent-friendly services and information.

#### **4.1.6 Governmental commitment**

Nigeria needs to show more commitment towards assuring female adolescents access to contraceptive information and services by urgently setting up more adolescent-friendly clinics all over the country. As in the case in South Africa, it should ask for assistance of NGOs in putting together a national programme like the *National Adolescent Friendly Clinic Initiative* (NAFCI) or Mozambique's *Geração Biz* which will set standards that have to be maintained by adolescent-friendly clinics, but will adopt a multi-sectoral approach by ensuring that various sectors come together to assist in improving adolescent SRH as well.

While the contribution of NGOs in ensuring that adolescents access contraceptive information and services in the country is noted, it is recommended that the Nigerian government needs to establish a more cordial relationship with these organisations in order to benefit from their expertise and knowledge of adolescent SRH issues.

The NGOs should assist the government in fulfilling its obligation to guarantee the right of adolescent girls to contraceptive information and services by setting up independent

monitoring mechanisms so that when hitches in implementation are uncovered they can be shared with the appropriate governmental agencies or mentioned in their shadow reports to the relevant human rights monitoring committees.

#### **4.1.7 Encourage adolescent participation in programmes**

As advocated, it is in adolescents' best interests to be actively involved in decision-making processes on issues relating to the protection of their SRH. To this end, there is a need for the government and other departments involved in adolescent issues to ensure that adolescents are compulsorily drafted and encouraged to participate in programmes intended for their benefit in order to achieve better results.

#### **4.1.8 Judicial involvement**

The recent brave stance of domestic courts in holding the Nigerian government and third parties<sup>34</sup> liable for a breach of the right to life provisions in the constitution and right to health provisions under the domesticated African Charter is commendable. It is recommended that the courts should go further, by assisting in assuring the guarantee of female adolescents' right to access contraceptive information and services through a purposive interpretation of a duty to provide access to confidential and safe SRH care services for female adolescents from the right to life, dignity and non-discrimination as guaranteed in Chapter four of the Nigerian Constitution.

#### **4.1.9 Adoption of best practices**

Finally, the Nigerian government can take note of structures already put in place by South Africa to improve female adolescents' access to contraceptive information and

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<sup>34</sup> *Gbemre v Shell Petroleum Development Company and Others* (2005) Suit No. FHC/B/CS/53/05 (unreported) available at <http://www.chr.up.ac.za/index.php/browse-by-subject/418-nigeria-gbemre-v-shell-petroleum-development-company-nigeria-limited-and-others-2005-ahrlr-151-nghc-2005.html> (7 March, 2013); *Georgina Ahamefule v Imperial Medical Center & Alex Molokwu* (unreported) available at Suit NO. ID/1627/2000 [www.scribd.com/doc/126185950/Georgiana-Ahamefule-vs-Imperial-Medical-Centre-Dr-Alex-Molokwu-ID-1627-2000-Judgement](http://www.scribd.com/doc/126185950/Georgiana-Ahamefule-vs-Imperial-Medical-Centre-Dr-Alex-Molokwu-ID-1627-2000-Judgement) (8 March 2013).

services. Also, other international best practices relating to adolescent SRH, generally, and access to contraceptive information and services, in particular, can be noted and adopted in order to improve the current situation in the country.

## **4.2 South Africa**

### **4.2.1 Constant monitoring**

In addition to the existence of constitutional guarantees on the right to health care, South Africa has performed creditably in enacting laws and policies protecting female adolescents' access to contraceptive information and services in confidential settings. Despite this achievement, it is still pertinent to state that without putting in place effective implementation or monitoring mechanisms, the enacted laws or policies will be mere writing on a piece of paper. To prevent this from occurring it is important that the South African government ensures that the apparatus already in place to monitor implementation of the legislation continues to be effective. Where it is found wanting, immediate steps should be undertaken to change or introduce other measures that will allow for effective monitoring.

### **4.2.2 International human rights obligations**

As noted in the study, South Africa, like Nigeria, has signed or ratified human rights instruments protecting the right to health care. However, since signing the ICESCR in 1994, the country is yet, officially, to ratify the instrument. It is important that the South African Government does this immediately. As has been recommended for Nigeria, ratification of the instruments is not enough, South Africa needs to show greater commitment towards fulfilling responsibilities created as a result of ratification, particularly with reference to the submission of state reports when due since this is a specific area where the country is currently lacking.

### **4.2.3 Sensitisation and awareness programmes**

It was revealed in the study that the major bane, which prevents the achievement of total success of South Africa's forward-thinking legislation and policies' protecting female adolescents' right to access qualitative health care including contraceptive information and services, is associated with the continued existence of socio-cultural and religious views which support the entrenchment of gender inequality. In order to change this situation, there is need for the continuous organisation of massive sensitisation and awareness/ enlightenment campaigns in order to achieve attitudinal and societal transformation.

Similar to the recommendation in the case of Nigeria, community and religious leaders should be drafted to assist in communal implementation and monitoring activities.

### **4.2.4 Training**

As recommended for Nigeria, South Africa should organise programmes to train sexuality education instructors and health care practitioners providing contraceptive services to adolescents. It should also put in place mechanisms for compensation and encouragement (especially for health workers in rural areas) in order to boost performance and assure the dedication of those involved in the provision of adolescent-friendly services.

### **4.2.5 Review and unification of sexuality education programme**

There is an urgent need to create uniformity in the Life Skills and HIV/AIDs Curriculum taught in South African schools. Where efforts are being unnecessarily duplicated, such programmes can be merged to ensure greater effectiveness in teaching. Instructors should continue to be encouraged to adopt factual and realistic teaching of the subject, since access to correct sexuality information is the main gateway towards the adoption of safer adolescent sexuality behaviour.

#### 4.2.6 Encourage adolescent participation in programmes

Adolescents should be encouraged to participate more in enlightenment programmes organised to increase their knowledge on SRH matters. Their constant involvement in decision-making processes on issues affecting their SHR should be encouraged by governmental departments involved in carrying out enlightenment and awareness programmes.

#### 4.2.7 Adoption of best practices

Even though the introduction of the *National Adolescent Friendly Clinic Initiative* (NAFCI) programme has resulted in the adoption of higher standards towards the provision of adolescent-friendly facilities, it is felt that more adolescent-friendly centres need be created as existing facilities are insufficient in catering to the needs of adolescents.

As was recommended in the case of Nigeria, NGOs can assist the government in fulfilling their human rights obligations by setting up independent monitoring mechanisms in order to discover areas of lack and deficiencies. The submission of shadow reports by NGOs to the relevant human rights monitoring committees will assist the committee in making appropriate recommendations to the South African state.

In addition, South Africa can adopt the modality used in the *Geração Biz* Programme by getting parents to become more involved in the bid to ensure adolescent adoption of healthy SRH practices. In relation to this, parents can be periodically invited to schools to sensitise them about the importance of allowing their children to use services offered in adolescent-friendly clinics.

Finally, South Africa should take notice of international best practices relating to adolescent SRH as found in Denmark and other developed countries in order to improve access to its already-guaranteed contraceptive services for adolescent girls.

## 5 Final remarks

The journey towards assuring the protection of the right of female adolescents in Nigeria and South Africa to contraceptive information and services is difficult and fraught with challenges. There remains a long way to go as a place of ‘rest’ has not yet been reached. Undoubtedly, the Nigerian and South African governments have taken measures to ensure female adolescents’ access to contraceptive information and services in their respective countries, but gaps still exist that require the collaboration of all interested parties if they are to be filled.

Acceptance of the reality of adolescent sexual behaviour is a definite step towards the achievement of greater SRH results and benefits. Though the achievements realised by taking ‘little’ steps towards guaranteeing female adolescents’ access to contraception may seem insignificant, continued advances will eventually lead to the achievement of the desired result.

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ICPD	+5	Key	Actions	Document
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