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Age of consent: A case for harmonizing laws and policies to advance, promote and protect adolescents' sexual and reproductive health rights

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Abstract

The article assesses the legal and policy frameworks that have an impact on adolescents' sexual and reproductive health rights (ASRHR) in East and Southern Africa (ESA), confirming the interconnectedness of the ages of consent to sexual activity, marriage, and services and its influence on adolescents' human rights. It reviews international, continental and national legal instruments used to identify relevant provisions on ASRHR in the ESA region. The region demonstrates substantial disparities between realities of sexual debut among adolescents, national (statutory and customary) laws and policies on ages of consent to sex, marriage and medical services, and international standards around these SRHR issues. These disparities constitute negative consequences: criminalising adolescents, entrenching child marriage, and excluding adolescents from accessing medical services required to secure and promote ASRHR. While some ESA countries lack clear laws and policies on the three issues, cases of internal contradictions and disharmony with international standards abound. This impacts on the full realization of sexual and reproductive health rights of adolescents and young people in the region. *(Afr J Reprod Health 2021; 25[2]: 94-102).*

Keywords: Adolescents, age of consent, East and Southern Africa, public health, sexual and reproductive health rights

Résumé

L'article évalue les cadres juridiques et politiques qui ont un impact sur les droits des adolescents en matière de santé sexuelle et génésique (ASRHR) en Afrique de l'Est et australe (ESA), confirmant l'interconnexion de l'âge du consentement à l'activité sexuelle, au mariage et aux services et son influence sur les droits de l'homme des adolescents. Il passe en revue les instruments juridiques internationaux, continentaux et nationaux utilisés pour identifier les dispositions pertinentes sur l'ASRHR dans la région de l'ESA. La région présente d'importantes disparités entre les réalités des débuts sexuels chez les adolescents, les lois et politiques nationales (légales et coutumières) sur l'âge du consentement au sexe, au mariage et aux services médicaux, et les normes internationales relatives à ces questions liées à la RSR. Ces disparités ont des conséquences négatives : criminalisation des adolescents, enchâssement du mariage des enfants et exclusion des adolescents de l'accès aux services médicaux nécessaires à la sécurisation et à la promotion de l'ASRHR. Alors que certains pays de l'ESA ne disposent pas de lois et de politiques claires sur ces trois questions, les cas de contradictions internes et de discorde avec les normes internationales abondent. Cela a un impact sur la pleine réalisation des droits sexuels et génésique en matière de santé des adolescents et des jeunes de la région. *(Afr J Reprod Health 2021; 25[2]: 94-102).*

Mots-clés: Adolescents, âge du consentement, afrique de l'est et australe, santé publique, droits en matière de santé sexuelle et génésique

Introduction

Human rights embody and protect the essence of humanity. The quintessence of human rights is unquantifiable hence the myriad of international and continental human rights instruments that have been signed and ratified by States. Sexual and Reproductive Health and Rights (SRHR) are subsumed within, and are protected by, these instruments. They illustrate the interdependent nature of human rights and are integral aspects of the broader rights of people in its universality,

inalienability, indivisibility and interdependence. It follows that improving one of these rights facilitates the advancement of others. Conversely, an infringement on one right impairs the actualization of others[1].

Relative to young people, SRHR is crucial to enjoy a fruitful and productive life, and to actualise their potentials in their society. However, the ESA region houses some of the world's poorest countries and faces multiple SRHR challenges, many of which directly affect its adolescents. These include HIV prevalence, teenage pregnancies, school dropout, risky childbirths, child-mothers and associated maternal mortality and morbidity. These weigh heavily on the socio-economic development prospects of ESA countries. We therefore assess legal and policy frameworks that have an impact on Adolescent Sexual and Reproductive Health Rights (ASRHR) in ESA focusing on the ages of consent to sexual activity, marriage and access to SRHR services to buttress their interdependence.

The majority of the countries in East and Southern Africa set the legal age of majority as 18 years old while the average age of criminal responsibility is 12.1 years[2]. The average age for sexual debut ranges across East and Southern Africa from 15 years in Angola and 16 in Mozambique to 19 years in Namibia and 20 in Burundi[3]. Yet the laws on age of consent to sexual activity in the region do not necessarily reflect the reality. The majority of countries do not have a minimum age of consent to sexual activity clearly set out in their legislation[3]. Consequently, the age of consent needs to be gleaned from a reading of sections that relate to criminal sexual activities. This makes it difficult for young people and communities to determine, with certainty, what the minimum legal age is. In some countries where the age of consent is stated, the age of consent is lower for girls than for boys, which creates further barriers to accessing services and perpetuates discrimination and early girl child marriage. Clearly defining the age of consent in the law does not encourage sexual activity but provides further options for an adolescent or young person to make safe decisions about their health. Setting an appropriate age of consent to sexual activity requires a balance of the right to protection and the recognition of the evolving capacity and autonomy of adolescents and young people as they mature. For example, a 12-year-old child will not require the same level of health services as an 18-year-old. If laws support access to adolescent SRHR, this can delay sexual debut by encouraging and enabling informed decision-making[3].

Studies show that young people, adolescent girls in particular, are most adversely affected by the HIV, AIDS and Tuberculosis epidemics, as well as being exposed to a high prevalence of violence, trauma and injuries[4]. For instance, in sub-Saharan Africa, young women aged 15 to 24 years are twice as likely as young men of the same age to be living with HIV[4]. This underscores the immense need to eliminate barriers for this age group to access quality health services and medical treatment. While some countries have policies that aim to enable access to SRHR services for adolescents and young people regardless of age, these policies are not enough. Clear legislative provisions need to be in place that consider young people's autonomy and evolving capacities. The majority of countries in the region do not have clear laws and policies that determine the age of consent to access SRHR services, including access to contraceptives, HIV testing and counselling services, and abortions (where legal). This can lead to confusion as to when young people may access SRHR services without third party consent (parent or guardian's consent). This uncertainty also creates a barrier to accessing services. Health-care providers end up using personal discretion on 'an appropriate age' instead of practising within the legal framework. Only three countries (Malawi, South Africa and Uganda) have made legislative provision for the age of consent to HIV testing and counselling by setting the minimum age at 12 years[3].

In October 2016, the "General Comment on the implementation of the rights of the child during adolescence"[5] was published by the Committee on the Rights of the Child advocating for countries to set up minimum ages in their legislation. In General Comment No. 10 the Committee recommends that the absolute minimum age of criminal responsibility should be 12 years, with encouragement for States to continue to raise it[6].

In General Comment No. 4 the Committee recommends that States increase the minimum age for marriage with and without parental consent to 18 years, while allowing for exceptional

circumstances, in which a mature and capable child over the age of 16 may marry. It also entails the recommendation to set a minimum age for sexual consent, which should be equal for boys and girls, yet, without specifying at what age this should be set[7].

The United Nations Convention on the Rights of the Child (UNCRC)[8] calls upon States to "take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse" (Art. 19)[8]. More generally, signatory States "shall undertake all appropriate legislative, administrative, and other measures for the implementation of the rights recognized in the present Convention" (Art. 2 and 4)[8]. Therefore, they have to be guided by the principles of non-discrimination (Art. 2); best interests of the child (Art. 3); respect for the views of the child (Art. 12)[8], and take into account the evolving capacities of the child (Art.5)[8]. Setting non-discriminatory equal minimum ages has an important function in realising all adolescents' rights. In this regard, the joint United Nations Statement on ending discrimination in health care settings clearly states the need for Countries to review and strengthen laws to prohibit discrimination in the provision and distribution of health care services[9].

In 2018, WHO released a guidance note sharing recommendations on adolescent sexual and reproductive health and rights[10]. This document provides an overview of sexual and reproductive health and rights issues that may be important for the human rights, health and well-being of adolescents (aged 10–19 years). The guidance affirms that adolescents need different health, education and social services. Further, the right of adolescents below the age of 18 years to these services is enshrined in the Convention on the Rights of the Child. The reality is that in many places, neither the providers of these services nor the systems in which they operate are geared towards meeting the needs and fulfilling the rights of adolescents[10]. The report clearly states that in many places, major barriers to the fulfilment of adolescent sexual and reproductive health rights include: Absence of enabling laws; the presence of contradictory laws, such as when a law or policy requiring the ministry of health to provide contraceptive information and services to all individuals of reproductive age is undermined by another law that requires mandatory parental consent for the provision of health services to legal minors; the presence of exceptions to laws, such as where age-of-marriage laws can be waived on different grounds; and the presence of restrictive laws[10]. Moreover, it affirms that Laws that require parental consent for legal minors to obtain health services hinder access to contraceptive information and services and, for example, to HIV testing and counselling[10].

Methods

This article is an outcome of a United Nations Populations Fund East and Southern African Regional Office (UNFPA ESARO) and the University of Pretoria collaborative effort to develop a study on existent legal and policy frameworks to advance, secure and promote ASRHR in the 23 ESA countries. The study was developed under the auspices of the Safeguard Young People Programme supported by the Swiss Agency for Development and Cooperation (SDC). It focused on the following countries: Angola, Botswana, Burundi, Comoros, Democratic Republic of the Congo, Eritrea, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Seychelles, South Africa, South Sudan, Swaziland, United Republic of Tanzania, Uganda, Zambia and Zimbabwe.

Data for this study was collected through an in-depth desktop review of international and continental human rights instruments – conventions, covenants, declarations, and General Comments – as well as national laws and policies used to identify and analyse relevant provisions regarding SRHR in general and specifically the ages of consent to sexual activity, marriage and access to SRHR services, including HIV testing and counselling. In addition, empirical data from six ESA countries was analysed in-depth– Malawi, South Africa, Eswatini, United Republic of Tanzania, Uganda and Zambia. These emerged from literature and reports drawn from the perspectives of adolescents and young people (10- to 24-years-old), health providers, representatives of the education sector, NGOs and legal experts in these countries. The relevant qualitative data was collected through a mixed approach of key

informant interviews and focus group discussions. Ethical approvals were obtained for each one of the countries targeted for the qualitative data collection and in-depth review.

The ensuing analysis linked laws and policies with the concrete experiences of youths to illustrate both the necessity to secure their rights, and to harmonised policies and legal frameworks, at national level, that would enable more effective access to integrated sexual and reproductive health services in order to fulfil the target of universal access to SRHR services as defined by the Sustainable Development Goal 3[4]. The findings of the regional study were validated by a technical advisory committee composed by representatives of the Africa Union Commission – Youth Division, the Southern Africa Development Community, the East Africa Community, UN agencies, Academia, Civil Society organizations, Development partners and youth leaders. Finally, the recommendations from the study informed the development of a Regional Legal Framework pertaining to adolescent sexual and reproductive health and rights.

The next section presents the study's findings as it pertains to ages of consent to sexual activity, marriage and access to SRHR services in the ESA region, including HIV testing and counselling services. The goal here is to demonstrate that some (existent) legislations and policies in ESA countries are not fully aligned to international legal provisions that most of them have signed and/or ratified.

Results

Age of consent to sexual activity

A major finding of this study entails the lack of legislation that expressly and clearly defines or establishes the age of consent to sexual activity[3]. While the age of consent to sexual activity exists in most ESA countries, they must be gleaned from sections of criminal and penal codes. As such, ascertaining the legal age(s) of consent is negative because it is linked mostly to the criminalization of unlawful sexual activities between adults and minors as defined by the criminal code[3]. This accounts for criminalizing consensual activities between minors, which is problematic for protecting and promoting ASRHR. A comprehensive approach would entail enacting a legislation that specifically stipulates the age of consent to sexual activity to ensure that young people (adolescents) and the broader community have a clear grasp of the minimum legal age to enable them "… to make safe decisions about their health"[3].

In October 2013, the South African Constitutional Court handed down a judgment in The Teddy Bear Clinic for Abused Children v Minister of Justice and Constitutional Development, declaring as unconstitutional, the criminalisation of consensual sexual conduct between children[11]. The case dealt with consensual sexual activities between adolescents aged between 12 and 16 years but not older than 16. Before the Constitutional Court's ruling, the Sexual Offences and Related Matters Act 32 of 2007 (Sexual Offences Act) criminalised consensual sexual activities between adolescents. The Act obliged the reporting of sexual conduct between adolescents, by any person who had knowledge of such conduct, and if the adolescents were found guilty, their names would be place of the National Register of Sex Offenders[12].

The court noted: "children are precious members of society and any law that affects them must have due regard to their vulnerability and need for guidance…We must be careful, however, to ensure, that in attempting to guide and protect children, our interventions do not expose them too harsh circumstances which can only have adverse effects on their development"[11]. This judgement recognised the evolving capacities of children and that children should not be treated as criminals when they begin to explore their sexuality. Rather, the State has a responsibility to facilitate appropriate guidance for children on the exercise of these rights.

The liberal approach in The Teddy Bear Clinic case has not found favour in Kenya where a 16-year-old adolescent cited as C.K.W. challenged the constitutionality of section 8(1) and 11(1) of the Kenyan Sexual Offences Act in so far as it criminalised consensual sexual relationships between adolescents[13]. C.K.W's submission was that he had consensual sex with his girlfriend but the section infringed on his rights, including his right to privacy, equal protection of the law[13]. Furthermore, CKW argued that the Sexual Offences Act discriminated against minors on the

ground of age since adults who engage in consensual sex are not subject to criminal prosecution and that this approach results in stigma and degradation for these[13].

The court ruled against C.K.W stating that considering the Sexual Offences Act's definition of "defilement", the absence otherwise of consent was not a factor – the crime has been committed[13]. Also, "the law protects adolescents from harmful sexual conduct where such conduct was directed at them by adults or by adolescents. To the extent that the law is geared towards the protection of the child, it does not discriminate against the perpetrator (C.K.W)"[13]. The provisions of the Sexual Offences Act, the court argued, aimed to achieve an important societal goal of protecting children from engaging in premature sexual conduct[13]. While the court dismissed this application, the judge noted: "although he was unsuccessful, I find that … they need to [re]consider whether or not there are other measures which were more appropriate and desirable, for dealing with children, without having to resort to criminal proceedings"[13].

South Africa is one of the few countries with vivid Case Law and legislation on the age of consent to sexual activity. However, many ESA countries lack unambiguous legislations thus resulting in an inability to balance children's evolving capacity and autonomy with their right to protection[3]. Similarly, the ages of consent to sexual activity differ across these ESA countries ranging from 13 years in Comoros to 18 years in Angola, Burundi, Democratic Republic of Congo (DRC), Ethiopia, Kenya, Mozambique, Rwanda, South Sudan, Tanzania, and Uganda[3]. The age disparity is also 'gendered' in some countries, as there are different ages of consent for boys and girls. These disparities and contradictions pose serious challenges to ascertaining the legal age of consent to sexual activity within many ESA countries. It totally ignores the evolving nature of humans and the need to recognise the increasing autonomy of adolescents as they edge closer to adulthood.

Age of consent to access HIV testing and counselling services in terms of policy

The study found that while there are policy guidelines within some ESA countries on the provision of access to medical treatment to young people and adolescents without discrimination, the same cannot be said about legal provisions. Indeed, there are national HIV Testing and Counselling Services (HCT/HTC) policy guidelines and frameworks that provide guidance on the age of consent in order for young people to access health care services, especially in relation to HIV and AIDS[1,14].

Many young people (adolescents) are left in the dark as to when they can access services autonomously and when they require the consent of their parents or guardians. This situation can negatively affect access to information about SHR and access to contraceptives especially among adolescents who are sexually active. Furthermore, this uncertainty creates a barrier to gaining access to SRHR as health services providers may also lack clarity about what the ages of consent are. Considering that apart from South Africa, no ESA country appears to be regulating the age of access to contraceptives, the concern is high especially considering the drive to stem the rise of new HIV infections among young people[3].

Age of consent to marriage

Pertaining to the legislation on the minimum age of consent to marriage within the ESA region, we found that all 23 countries in the region have a minimum age of consent to marriage ranging from 12 and 14 years respectively for girls and boys in South Africa (with ministerial consent) to 21 years[15]. There is a marked similarity between the ages of consent to sexual activity and the ages of consent to marriage in that the set ages of consent to marriage differ across the ESA countries and are in some instances 'gendered' such as in Namibia, which has a minimum age of 18 years for boys and 15 years for girls. This illustrates that ESA states have failed to adhere to international and continental standards despite being signatories thereto[3]. More so, there are contradictory provisions and disharmony between statutory and customary law provisions in countries like South Africa where there are approximately three age provisions: 12, 14 and 18 years. Thus, among all 23 ESA countries, only eight countries have the age of consent to marriage set at 18 years without exception. These include Eritrea, Kenya, Malawi, Mozambique, Rwanda, South Sudan, Uganda and Zimbabwe[3].

In 2016, the Constitutional Court in Zimbabwe handed down a judgment that is in line with international and continental standards in the case of Mudzuru v Minister of Justice[16]. The case was brought before the court by two women aged 19 and 18 respectively, in the public interest. The applicants argued that the Marriage Act was unconstitutional for two reasons. Firstly, the Constitution – enacted after the Marriage Act – defines a child as anyone below the ages of 18 implying that the Act promoted child marriage. Secondly, it allowed girls from the age of 16 to marry with the consent of a parent or guardian whilst boys under the age of 18 could not marry except with the consent of the Minister of Justice. The Court held that, "the Constitution sets the minimum age of marriage in Zimbabwe at 18 and that any other law, custom or practice which allows marriage of parties below that age is unconstitutional and invalid as of the date of the judgment"[16].

Although the Mudzuru judgment is overall a great judgment, one cannot help but notice a paragraph therein: "…The age of sexual consent, which currently stands at sixteen years is now seriously misaligned with the new minimum age of marriage of eighteen years. This means that, absent legislative intervention and other measures, the scourge of early sexual activity, child pregnancies and related devastating health complications are likely to continue and even increase. The upside is that the new age of marriage might have the positive effect of delaying sexual activity or childbearing until spouses are nearer the age of eighteen. The downside is that children between sixteen and eighteen years may be preyed upon by the sexually irresponsible (adults) without such people being called upon to take responsibility and immediately marry them. Thus, there is an urgent need, while respecting children's sexual rights especially as between age mates as opposed to inter-generational sexual relationships, to extend to the under-eighteens the kind of protection currently existing for under-sixteens with the necessary adjustments and exceptions"[16].

The aforementioned quote clearly highlights the interrelatedness and contested nature of the recognition of sexual autonomy of adolescents on the one hand, and the need to protect them from adults who may prey on them. While setting the minimum age of consent to marriage at 18 years is in line with international and regional obligations, including the recent Joint General Comment on Ending Child Marriage of the African Commission on Human and People's Rights and the Committee of Experts on the Rights and Welfare of the Child[17], this age should not be used to advocate for higher age of consent to sexual activity as this may hamper adolescents' access to SRHR. The danger of this approach is also evident from the remarks of the judge in C.K.W v Attorney General where he says that the fact that the age of consent to sex is 18 years means that those under 18 years have no business engaging in sex[13]. Age of consent to marriage and age of consent to sexual activity have a different role in legislation. Therefore, harmonization of the two ages of consent is far from setting the same legal age. The age of consent to marriage needs to be set at 18 with no exceptions because this provision aims to guard against children been given out in marriage without their consent and ensuring that children at least finish school before marriage. While the age of consent to sexual activity is a provision set to protect adolescents against adult who may prey on them, it also recognizes that with their evolving capacity, adolescents should be able to consent to sex the closer they are to 18 years of age. This also influences the criminalization of adolescents and access to services.

Discussion

The emphasis on this interdependence between the three ages of consent stems from understanding the impact of legislative provisions on adolescent SRHR where ages of consent are linked to the age of majority. This includes possibilities of excluding sexually active adolescents from accessing medical services if the age of consent to medical services is set higher than the age to consent to sexual activity.

Also, the non-existence of legislative provisions impacts on ASRHR mainly because it creates a gap in policy and hands over the protection of ASRHR to the whims of service providers who may impose their beliefs on young people. The downside here is that young people will lose trust for these institutions and embark on risky self-help options.

Alternatively, a reduced legal age of consent to sexual activity would prompt lowering the age of consent to access SRHR services,

including HIV testing and counselling services and consequently reduce possibilities of criminalising adolescents while also improving access to health services. This is because sexually active adolescents require access to services, including HIV testing and counselling, treatment and even contraceptives, in some cases, to prevent unintended pregnancies, HIV infection, as well as counselling and treatment to secure them. Since children, from age 12, are capable of exploring their sexuality in various ways[18,19], a legislative provision that reduces the age of consent to SRHR services would prove useful in securing their sexual and reproductive health and rights.

The age of sexual debut in the ESA region is situated, on average, between from 15 years to 20 years[3]. This implies that many young people commence sexual activity before their 16th birthday[20]. However, existent legislations around the age of consent to sexual activity in ESA tend to place consent from 16 to 18 years. This means that criminalizing unlawful sexual activities – even consensual – by situating the age of consent to sexual activity with the criminal code would culminate in criminalizing many young people engaging in consensual sexual activities before the legal age.

On marriage, we see that legislative provisions in many countries that have set ages of consent to marriage below 18 years detract from international standards for the minimum age of marriage, and this poses serious challenges to the SRHR of adolescents. Similarly, disharmony between statutory and customary law provisions on the age of consent to marriage led to the disparity in the ages of consent within countries. It is thus critical to harmonize domestic legislations and constitutional provisions on the age of consent to marriage to be consistent.

We recommend establishing and harmonizing legislation around these three ages of consent. This will help to keep the legislation within the ESA region in harmony with international standards and prioritise the rights of adolescents to dignity as well as their sexual and reproductive health.

Regarding the possible criminalisation of consensual sexual activity between minors, this study recommends the adoption of the 'Romeo and Juliet'[3] or close in age defence as a compromise between ensuring protection from statutory rape and consensual sex among adolescents. This would be vital to reducing cases of defilement and criminalization of consensual sexual activity.

In addition, drawing from the principle of non-discrimination and gender equality enunciated in international and continental human rights instruments, we recommend removing the 'gendered' differentiation in the ages of consent assigned to adolescents.

Furthermore, legislative provisions should build on the SADC model law on child marriages, prohibiting and criminalizing giving out a child in marriage or facilitating of a child. Consequently, these provisions should also "ensure that the minimum age of consent to marriage takes precedence over any cultural, traditional or religious customs and practices and include a provision that child and forced marriages are harmful practices"[3]. A rigorous birth registration and marriage registration would ensure effective compliance with the minimum age of consent to marriage. Policies should also provide guidance on the recognition of the evolving capacities of adolescents and normative sexual development.

Conclusion

The linkages between ages of consent to sexual activity, marriage and access to sexual and reproductive health services made clear that the age of consent to sexual activity invariably affects the access to services for adolescent and young people. This is because many young people are engaging in sexual activity and – while there should be efforts to encourage delayed sexual debut – there is need to protect their sexual and reproductive health through ensuring availability, accessibility, suitability and adequacy of youth friendly health services. The law should not create obstacles for them to access the health services that they require to live a healthy life.

In conclusion, we recommend that laws and policies recognize the evolving capacities of adolescents and the concept of normative sexual development. This will promote the adoption of national policies and programmes aimed at addressing the root causes of child and forced marriages; foster the provision and institutionalization of youth friendly ASRH services while ensuring implementation and compliance of the legal and policy provisions.

Contribution of authors

All authors made significant contributions to the work towards the conceptualisation, development, draft and review of the manuscript. They also read through and approved the final version of the manuscript.

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