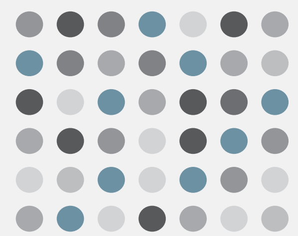
POLICY BRIEF

STRENGTHENING ADOLESCENT SEXUAL AND REPRODUCTIVE RIGHTS IN SOUTHERN AND EAST AFRICA

ARASA
AIDS & Rights Alliance for Southern Africa



INTRODUCTION

This Policy Brief aims to support ARASA partner countries in Southern and East Africa (SEA) to strengthen adolescents' sexual and reproductive health and rights, in order to provide safe, accessible and effective health care for all adolescents, including those 'most left behind'.

It is aimed specifically at providing information and recommendations for action to National Human Rights Institutions (NHRIs) involved with, inter alia, investigations into human rights violations, research, advocacy and human rights education. *The Third Committee of the United Nations (UN) General Assembly's November 2019 Resolution* recognises the critical role of NHRIs in promoting and protecting human rights and fundamental freedoms, preventing human rights violations, holding governments accountable to their human rights commitments and ensuring progress towards the implementation of Agenda 2030 for Sustainable Development.

WHO ARE ADOLESCENTS?

The United Nations (UN) considers **young people** as those aged 10 to 24 years.

The World Health Organization (WHO) regards **adolescents** as young people aged 10 to 19 years.

Children are defined in terms of the Convention on the Rights of the Child (CRC) as people below 18 years of age.

The Policy Brief, however, can also be used by other key stakeholders, including governments, civil society organisations (CSOs) and key population networks working to protect and promote human rights, gender equality and health.

The Policy Brief is based on recent research on legal, human rights and social barriers to adolescent sexual and reproductive health in SEA, with particular reference to ARASA's 2019 report *Sexual and Reproductive Health, HIV, TB and Human Rights in Southern and East Africa* and the Center for Reproductive Rights' 2017 report on *Capacity and Consent: Empowering Adolescents to Exercise their Reproductive Rights*.

ARASA'S 18 PARTNER COUNTRIES IN *SEA* INCLUDE:

- Angola
- Botswana
- Comoros
- Democratic Republic of Congo (DRC)
- Kenya
- Lesotho
- Madagascar
- Malawi
- Mauritius
- Mozambique
- Namibia
- Seychelles
- South Africa
- Swaziland
- Tanzania
- Uganda
- Zambia
- Zimbabwe

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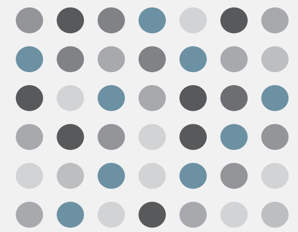
WHY FOCUS ON ADOLESCENTS' SEXUAL AND REPRODUCTIVE HEALTH?



ADOLESCENTS ARE CENTRAL TO HEALTH EFFORTS

Adolescents make up the greatest proportion of the population in sub-Saharan Africa, with 23% of the region's population aged between 10 – 19 years.[1] In some SEA countries, around half of the population is below the age of 18 years. Young people are therefore central to any efforts to improve the health and welfare of people in SEA countries, in order to achieve the Sustainable Development Goals (SDGs) of 'ensuring healthy lives for all,' including by ending AIDS and TB and improving sexual and reproductive health. In addition, adolescents present an opportunity to reach individuals early with information and services to encourage behavioral and social changes that could reduce sexual and reproductive health risks such as HIV and other sexually transmitted infections (STIs).

ADOLESCENTS ARE AT HIGHER RISK

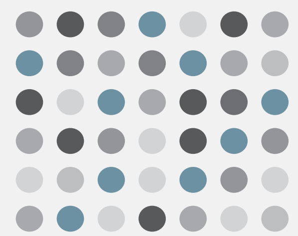
Adolescents are particularly vulnerable to sexual and reproductive health risks. For example, adolescent girls and young women (AGYW) are at high risk of unintended pregnancies, unsafe abortions and child marriage. About 1 million girls under 15 give birth every year, around 3 million girls aged 15 to 19 undergo unsafe abortions and 39 000 child marriages take place every day, impacting on their sexual and reproductive health.[2]

Adolescents also account for a significant number of new HIV and other STIs in countries in SEA. Approximately 610 000 adolescents and young people were newly infected with HIV in 2016, of which 260 000 were adolescents between the age of 15 – 19 years. Young women aged 15– 24 years accounted for 26% of new HIV infections in 2016 despite making up just 10% of the population.[3] Young people may also intersect with key populations for HIV – in the case of young men who have sex with men, young transgender people, young people who inject drugs and young people above 18 years of age who sell sex. Young key populations are made especially vulnerable to HIV due to the widespread stigma, discrimination and violence facing key populations, combined with the specific vulnerabilities of youth, power imbalances in relationships and sometimes alienation from family and friends. These factors may increase their risk of engaging, willingly or not, in behaviours that place them at higher risk of HIV exposure.[4]

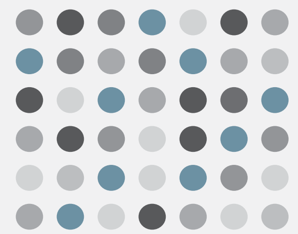
ADOLESCENTS HAVE RIGHTS

> ***"State parties are under an obligation to ensure access to comprehensive sexual and reproductive health services"***
>
> Joint General Comment of the African Commission on Human and Peoples' Rights (ACHPR) and the African Committee of Experts on the Rights and Welfare of the Child (ACERWC) on Ending Child Marriage.

Countries have a legal obligation to support the rights of those under 18 years of age to life, health and development.[5] They have also committed to achieve their sexual and reproductive health, in terms of various international and regional human rights documents.[6] This requires, amongst other things, creating a legal, regulatory and policy framework that not only provides adolescents with SRH services but also prohibits discrimination and inequality, including gender inequality, removes legal and policy barriers to SRH services and protects, respects, promotes and fulfils adolescents' sexual and reproductive health and rights,[7] including the rights of all persons to:



- have their bodily integrity, privacy and personal autonomy respected;
- the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health;
- decide whether, when and whom to marry;
- decide whether, when and by what means to have a child or children, and how many children to have;
- have safe and pleasurable sexual experiences;
- freely define their own sexuality, including sexual orientation and gender identity and expression; decide whether and when to be sexually active;
- choose their sexual partners; and
- have access over their lifetimes to the information, resources, services and support necessary to achieve all the above, free from discrimination, coercion, exploitation and violence.[8]



ESSENTIAL INTERNATIONAL GOALS RELATED TO ADOLESCENT'S SRHR

African Union: Agenda 2063 - The Africa we want

Agenda 2063 is the African Union (AU)'s master plan for transforming Africa in 50 years, from 2013 to 2063. Protecting the human rights of the youth is central to the agenda, which states that by the year 2063, "all forms of systemic inequalities, exploitation, marginalisation and discrimination of young people will be eliminated and youth issues mainstreamed in all development agendas." Agenda 2063 also commits to securing the health and welfare of young people: "Africa's youth shall be guaranteed full access to for example education and health services."

UN: The Sustainable Development Goals

17 Sustainable Development Goals (SDGs) were adopted by all United Nations Member States in 2015 as a universal call to action to end poverty, protect the planet and ensure that all people enjoy peace and prosperity by 2030:

Goal 3 includes ending the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases by 2030. Furthermore, universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes should be ensured as well as universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

Goal 5 focuses on gender equality, it includes targets on sexual and reproductive health and rights and also requires all countries to take measures to end discrimination and eliminate violence against women and girls as well as to end harmful practices, such as child, early and forced marriage and female genital mutilation.

Goal 10 requires states to ensure equal opportunity and reduce inequalities of outcome, including by eliminating discriminatory laws, policies and practices and promoting appropriate legislation, policies and action in this regard by 2030. Furthermore, states should empower and promote the social, economic and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status.

Goal 16 requires states to promote the rule of law at the national and international levels and ensure equal access to justice for all. This includes promotion and enforcement of non-discriminatory laws and policies for sustainable development.

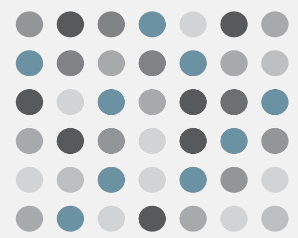
UN: The 90-90-90 goals

The Joint United Nations Programme on HIV/AIDS (UNAIDS)' Fast Track Strategy sets out the 90-90-90 targets for prevention and treatment:

- **By 2020, 90% of all people living with HIV will know their HIV status.**
- **By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy.**
- **By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression.**

To achieve the 90-90-90 targets, UNAIDS emphasises 5 prevention pillars, one of which prioritises AGYW and another key populations.

Despite significant progress in SEA, many countries are far from reaching the 90-90-90. In 2018, an estimated 85% of people living with HIV in the SEA region knew their HIV status; 67% of those diagnosed were receiving sustained antiretroviral therapy and 58% were virally supressed.



ADOLESCENTS ARE VULNERABLE TO RIGHTS VIOLATIONS

Adolescents have the right to available, accessible, acceptable and quality sexual and reproductive health care services that respect and protect their sexual and reproductive health and rights. However, research shows that they experience barriers to accessing services, as well as other violations of their sexual and reproductive health and rights.[9]

KEY ISSUES BLOCKING ADOLESCENT ACCESS TO SRHR

STIGMA AND DISCRIMINATION, INCLUDING WITHIN HEALTH CARE:

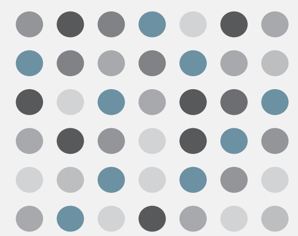
Adolescents' perceptions and experiences of the treatment, care and levels of confidentiality that they receive can heavily influence their decisions about accessing sexual and reproductive health services.[10] The stigma surrounding adolescent sexuality can prevent adolescents from seeking information about their sexual and reproductive health, discussing their sexual and reproductive health needs, and accessing sexual and reproductive health services. This stigma can stem from the belief that adolescents and/or unmarried persons should not be sexually active or the prejudicial stereotype that adolescents lack the requisite maturity, capacity, or responsibility to consent to and engage in sexual activity. Where adolescents are also discriminated against and mistreated by health care providers – for example, when they are chastised or shamed for being sexually active, denied access to quality treatment or have their confidentiality breached, it may also deter them from seeking health services in the future.

RESTRICTIVE LEGAL AND POLICY FRAMEWORKS:

In many countries, laws and policies – or the lack of them - act as barriers to adolescents accessing services. For example, some laws and policies explicitly deny adolescents the right to access sexual and reproductive health services. Other laws require parental notification or the consent of a parent, guardian or even a judicial authority in order for adolescents to access services. Studies demonstrate that these laws and policies discourage adolescents from accessing services. For example, where adolescents are required to receive parental authorisation for sexual and reproductive health services, they may opt to forgo such services, although they still engage in sexual activity.[11] Judicial authorisation requirements create a range of barriers for adolescents in accessing formal judicial mechanisms, given the stigma surrounding young people's sexual and reproductive health services, and the discretion afforded to judges means they may simply deny the request. Where laws and policies are silent on whether adolescents can access specific services, stigma surrounding adolescent sexuality may result in health care providers interpreting this to mean that minors are not permitted to receive such services.

LACK OF INFORMATION:

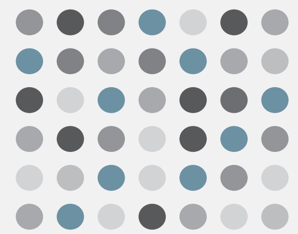
Where adolescents do not receive adequate comprehensive sexuality education to understand their sexual and reproductive health needs, they are unable to take measures to prevent unintended pregnancy, sexually transmitted infections (STIs) and other diseases such as HIV. Comprehensive sexuality education is critical for informing adolescents about sexual and reproductive health services, their right to access such services and the right to make decisions about their sexuality and reproduction free from violence, pressure or coercion.



INACCESSIBLE AND UNAFFORDABLE SERVICES:

Where sexual and reproductive health services are too far away, adolescents may be unable to access or afford the required transportation, or they may be unable to explain their whereabouts during the time it takes to access these services without disclosing their personal sexual and reproductive health needs. Also, many adolescents lack an independent source of income and due to the sensitive nature of sexual and reproductive health services may be unable to ask their parents for financial support. Many adolescents who do work are expected to turn their earnings over to their parents. Where adolescents are covered by their guardian's health insurance or a public health insurance scheme, they may be prevented from using these to cover the cost out of fear that the administrative components, such as the paperwork associated with billing and processing, could unintentionally disclose their use of sexual and reproductive health services to their guardian. Privacy and confidentiality concerns are thus significant barriers to access to SRHR services for adolescents.

The impact of limiting adolescents' access to sexual and reproductive health and rights can be severe, with not only health but broader social and economic consequences. For instance, half of pregnancies among girls aged 15 to 19 years in developing regions are unintended, due to factors such as unmet needs for modern contraception, coercive sex and inequitable gender norms. Adolescent pregnancy is a major contributor to maternal and child mortality, unsafe abortion, maternal mortality and lasting health problems. It also leads to stigma, rejection by parents and peers, girls being forced out or dropping out of schools, unemployment and perpetuates cycles of poverty. This has a further national economic cost – the failure to provide access to quality health care and education results in countries losing the opportunity to reap a demographic dividend [12] from young women's income earning potential. [13]



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AGE OF CONSENT LAWS AND ADOLESCENT ACCESS TO SRHR

In SEA, punitive, restrictive and discriminatory laws remain major obstacles to realising universal adolescent sexual and reproductive health and rights. This policy brief explores two key issues in law and policy that create barriers to sexual and reproductive health access for adolescents, namely laws and policies governing age of consent to treatment and age of consent to sex or criminalisation of consentual sex between adolescents and other young people.

AGE AS A BARRIER TO ACCESS HEALTH SERVICES

One of the key legal and policy barriers specifically limiting access to sexual and reproductive health information and services, such as modern contraception for AGYW and young people, relates to age of consent to treatment laws in countries in SEA.

These laws (or policies) stipulate the minimum age at which adolescents are recognised as persons capable of independent consent to medical treatment. Some countries in SEA set relatively high ages of consent (16 to 18 years) which fail to account for the evolving capacity of children. The laws or policies require that all adolescents below that age require the consent of a parent or guardian to access health care services. The majority of countries do not have clear laws or policies.[14]

It has been argued that laws that fail to set a clear age of consent or fail to stipulate a minimum age of consent for independent access to healthcare services - such as HIV testing and contraception - deny minors the right to access services.[15] According to UNFPA (2017) ***Harmonizing the Legal Environment for Adolescent Sexual and Reproductive Health and Rights*** the minimum age or lack of legal and policy provisions for clear age of consent to services such as contraception, HIV testing and other SRH services can lead to confusion as to when adolescents can consent to receive health services, including medical treatment. This uncertainty creates a barrier to accessing sexual and reproductive health services and allows health-care providers to enforce their own belief systems regarding an appropriate age of consent.

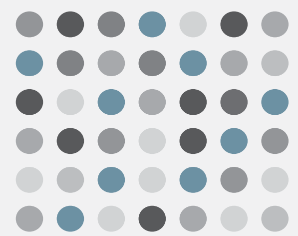
AGE OF CONSENT TO ACCESS SRH SERVICES IN SEA[16]

Democratic Republic of Congo (DRC), Mauritius, Seychelles, eSwatini and Tanzania require minors below the age of 18 years to have parental consent for access to sexual and reproductive health services. In Zambia and Zimbabwe, minors below 16 years of age require parental consent to access sexual and reproductive healthcare services. However, some countries – such as South Africa and Lesotho - provide for young people to independently consent to access contraception, HIV testing, treatment and care from 12 years of age.

Some countries have taken steps to strengthen young people’s access to SRH services in laws, policies and guidelines. In Namibia the Child Care and Protection Act 3 of 2015, which entered into force in Jan 2019 provides that a child may consent to a medical intervention (including HIV testing) from 14 years.

Zimbabwe’s National Guidelines on Clinical Adolescent and Youth Friendly Sexual and Reproductive Health Service Provision 2016, are intended to facilitate access to youth friendly sexual and reproductive health services. The guidelines do not specify a minimum age at which adolescents can receive SRH services without parental consent but do expressly state that age should not be a barrier to receiving services. They specifically state that adolescents should be able to access contraception regardless of age or marital status.

In September 2017, the National AIDS Council of the DRC held consultations to discuss fast-tracking the DRC’s prevention efforts. The consultation recommended passing a revised HIV law that would allow adolescents to access HIV prevention services.



The Zambian government developed a position paper on HIV prevention in 2017. The recommendations to scale up prevention include developing a policy for in and out of school youth that defines age specific services and clarifies the age of consent to SRH services, reviewing the legal framework to identify and address barriers to HIV prevention for key populations and increasing government's commitment to address legal barriers to providing condoms and lubricants to men who have sex with men and prisoners.

AGE OF CONSENT TO SEX AND CRIMINALISATION OF CONSENSUAL SEX BETWEEN ADOLESCENTS

Laws on age of consent to sex describe the minimum age below which certain sexual acts are prohibited. While these laws are important in addressing sexual violence against minors, age of consent to sex laws that criminalise and stigmatise consensual /non-exploitative adolescent sexual behaviour, particulary between two adolescents or young people, create further barriers to access to contraception and other sexual and reproductive health information and services. [17]

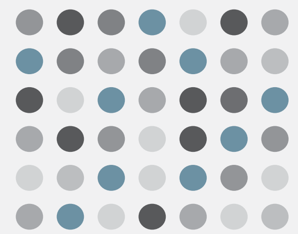
Criminalisation of noncoercive and non-exploitative sexual conduct between adolescent minors creates numerous challenges. It punishes adolescents for what is a natural part of development. Adolescent sexual exploration is a normal part of development and sexual activity amoung peers without coercion or force should not be regulated by criminal law.

Age of consent to sex laws which have the effect of criminalising non-exploitative sexual conduct between adolescents often results in adolescent males being imprisoned and, in some cases, ending up with a permanent criminal record for engaging in consensual sexual conduct with other adolescents. In some jurisdictions both males and females can be criminalised. [18]

They furthermore create confusion for adolescents, guardians, healthcare workers and law enforcement officials about when they may lawfully engage in consensual sexual activity and how officials and service providers should respond to adolescent sexuality.

In SEA, many countries criminalise underage sex between consenting adolescents and/ or consensual same-sex sexual activity between adolescents. Age of consent to sex laws that have the impact of criminalising non-exploitative sexual conduct between adolescents create barriers to access to comprehensive SRH services by fueling the stigmas and myths surrounding adolescent sexuality.

The WHO recognises that, "An adolescent's decision to go to a health service for sexual health care or advice is likely to be influenced by whether they will get into trouble with parents or guardians, or even with the law, in places where sexual activity under a certain age… is against the law. [19]



AGE OF CONSENT LAWS IN SEA COUNTRIES

In African countries, the ages of consent vary widely from 12 years in Tanzania to 18 years in countries such as Lesotho, Mozambique and the Seychelles. Some countries are in between, for instance 13 years in Comoros, 14 years in Namibia and for girls in DRC and Zambia and 16 years in eSwatini, Malawi, Mauritius and South Africa. Most countries are concentrated in the 16 – 18 range which sometimes does not reflect the reality of average age of sexual debut.

In addition, most countries do not clearly set out an age of consent to sex, this has to be gleaned from sexual offence and criminal laws. In some jurisdictions, sexual offences laws specifically extend the application of sexual offence laws for engaging in sexual conduct with a minor to everyone, including a minor who has had sexual intercourse with his or her peers. [20]

In addition, several countries in Africa have discriminatory age limits in age of consent to sex laws, usually setting a different age for girls and boys.

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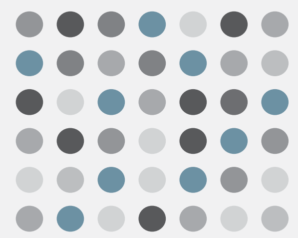


WHAT SHOULD COUNTRIES DO?

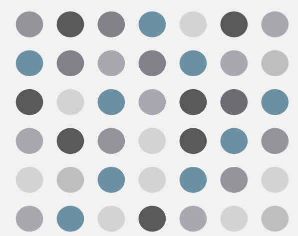
SEXUAL AND REPRODUCTIVE HEALTH SERVICES SHOULD INCLUDE:

- Comprehensive sexuality education
- Access to sexual health services
- Prevention of and responses to gender-based violence
- Access to contraception
- Access to safe and effective antenatal, childbirth and postnatal care
- Access to abortion and post-abortion care
- Infertility treatment
- Access to STIs, including HIV prevention and treatment
- Access to TB prevention and treatment services
- Access to services for reproductive cancers

In order to ensure adolescents access to available, accessible, acceptable and quality sexual and reproductive health care services, countries should review and reform any discriminatory, restrictive or punitive laws, regulations and policies that perpetuate inequality, place adolescents - including AGYW and young key populations - at higher risk of HIV and other sexual and reproductive health risks, and create barriers to adolescent access to SRHR.[21]

The Global Commission on HIV and the Law (GCHL), an independent Commission set up to examine the impact of law on HIV responses, noted in its 2018 ***Risks, Rights & Health Supplement***, that adolescent girls and young women are further behind in access to HIV-related and sexual and reproductive health care services and recommends that governments "adopt and enforce laws that protect and promote sexual and reproductive health and rights" and "remove legal barriers to accessing the full range of sexual and reproductive health services.

In addition, there are specific recommendations at both international and regional level in relation to age of consent laws, recommending that countries review age of consent laws (including age of consent to sex, age of consent to medical treatment and age of consent to marriage) in order to balance protecting the autonomy rights of young people, promoting access to sexual and reproductive health and rights and also preventing harm. Recently, the Convention on the Rights of the Child (CRC)'s 2016 ***General Comment on Adolescence*** recognises that States should remove parental authorisation requirements for sexual and reproductive health information and services. It also calls on states to balance the need for protection and the recognition of the evolving capacity of the child, when defining the legal age for sexual consent. It recommends avoiding criminalising adolescents of similar ages for consensual and non-exploitative sexual activity.[21] It also calls for mandatory school-based, age-appropriate, comprehensive and inclusive sexual and reproductive health education.[23]



GENERAL COMMENT BY THE AFRICAN COMMISSION

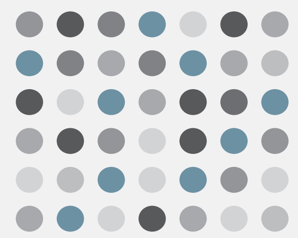
The Joint General Comment of the ACHPR and the African Committee of Experts on the Rights and Welfare of the Child (ACERWC) on Ending Child Marriage recommends that ***"[third party permission for accessing these services should not be required and services should be integrated, rights-based, women-centered and/or youth-friendly and free of coercion, discrimination and violence."***

It further calls on countries to develop and implement comprehensive sexuality education (CSE) programmes that deal with a range of sexual and reproductive health information, including information about legal rights and age of consent laws, human rights, gender equality and the impact of harmful gender norms:

"States Parties should develop and implement comprehensive sexuality education and information programmes. Age appropriate information about sex, sexuality, sexual and reproductive health rights and sexually transmitted infections, including HIV and AIDS, should form part of the formal school curriculum and should also be disseminated widely among the general public, including in non-school settings and in media which reaches rural and remote settings. Comprehensive sexuality education should also include age appropriate information about what constitutes consent to sex, as distinct from consent to marriage, and information about gender, sexuality and social norms and stereotypes that perpetuate gender inequality and its manifestations, including child marriage."

International and regional guidance also note the importance of taking steps beyond the review of laws and policies, to ensure that rights are implemented and enforced in practice. They further recommend the development of strategies and programmes to:

- Empower key and vulnerable populations to know their rights
- Strengthen legal support services to support populations to challenge rights violations and to enforce their rights
- Sensitise law and policy makers and law enforcers on sexual and reproductive health and rights, including for young people, and
- Train health care workers on the sexual and reproductive health and rights of young people.



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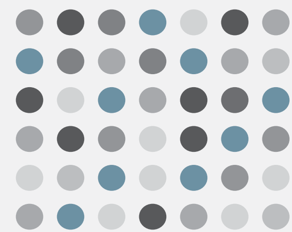
RECOMMENDATIONS

National human rights institutions have a critical role in ensuring that human rights are respected, protected, promoted and fulfilled. In the case of adolescent sexual and reproductive health and rights, NHRIs can:

- Investigate allegations of violations of adolescents' access to sexual and reproductive health and rights, including denial of access to services and discrimination in access to services, in contravention of national laws, policies and human rights commitments.
- Conduct research into adolescent access to sexual and reproductive health and rights to determine whether adolescents are able to access their rights, common rights violations and the impact of age of consent laws (and other legal and policy barriers) on access to sexual and reproductive health and rights.
- Monitor adolescent access to sexual and reproductive health and rights in their country in terms of national age of consent (and other) laws and policies, and in terms of broader human rights commitments.
- Propose law and policy review and reform to age of consent (and other relevant) laws and policies to promote independent and unfettered access to adolescent sexual and reproductive health and rights.
- Educate law and policy makers on the importance of reviewing and removing legal and policy barriers, including age of consent laws that block access to adolescent sexual and reproductive health and rights.
- Educating and sensitising health care providers on adolescent sexual and reproductive health and rights, including the importance of providing non-discriminatory access to health care services in line with health, age of consent and related laws, policies and guidelines.
- Educating and sensitising young people on their rights to sexual and reproductive health care, within the ambit of broader CSE.
- Educating and sensitising the general public on adolescent's sexual and reproductive health and rights to promote non-discrimination and acceptance towards young people's sexuality.



[1] UNICEF (October 2019) Adolescent Demographics. Available at https://data.unicef.org/topic/adolescents/demographics/ [accessed 13 December 2019].

[2] World Health Organization (2019) Sexual and Reproductive Health. Available online at https://www.who.int/reproductivehealth/topics/adolescence/en/ [accessed 13 December 2019].

[3] ARASA (2019) Sexual and Reproductive Health, HIV, TB and Human Rights in Southern and East Africa.

[4] WHO (2016) Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations: Annex 6.

[5] UN General Assembly, Convention on the Rights of the Child, 20 November 1989. Available at: https://www.refworld.org/docid/3ae6b38f0.html [accessed 13 December 2019].

[6] See, for instance, Committee on Economic, Social and Cultural Rights General Comment No. 22 (2016) on the Right to Sexual and Reproductive Health. Available at http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4slQ6QSmlBEDzFEovLCuW1a0Szab0oXTdImnsJZZVQfQejF-41Tob4CvIjeTiAP6sGFQktiae1vlbbOAekmaOwDOWsUe7N8TLm%2BP3HJPzxjHySkUoHMavD%2Fpyfcp3Ylzg [accessed 13 December 2019].

[7] Office of the High Commissioner for Human Rights Information Series on Sexual and Reproductive Health and Rights: Adolescents. Available at https://www.ohchr.org/Documents/Issues/Women/WRGS/SexualHealth/INFO_Adolescents_WEB.pdf [accessed 13 December 2019].

[8] This definition, proposed by Starrs, A.M. et al., (2018) Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission, is built on agreements, such as the UN Population Fund (1994) Programme of action adopted at the International Conference on Population and Development; WHO publications and international human rights treaties and principles.

[9] Center for Reproductive Rights (2017) Capacity and Consent: Empowering Adolescents to Exercise their Reproductive Rights.

[10] UNFPA (2013) Motherhood in Childhood Available at https://www.unfpa.org/sites/default/files/pub-pdf/EN-SWOP2013.pdf [accessed 13 December 2019].

[11] Jones, R.K and H Boonstra (2004) Confidential Reproductive Health Services for Minors: The Potential Impact of Mandated Parental Involvement for Contraception. Available at https://www.guttmacher.org/journals/psrh/2004/confidential-reproductive-health-services-minors-potential-impact-mandated [accessed 13 December 2019].

[12] Demographic dividend, as defined by the United Nations Population Fund, means "the economic growth potential that can result from shifts in a population's age structure, mainly when the share of the working-age population (15 to 64) is larger than the non-working-age share of the population (14 and younger, and 65 and older). In other words, it is a "boost in economic productivity that occurs when there are growing numbers of people in the workforce relative the number of dependents". However, the working age population needs good health, quality education, decent employment and a lower proportion of young dependents to achieve a demographic dividend.

[13] World Health Organization (2018) Fact Sheet: Adolescent Pregnancy. Available at https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy [accessed 13 December 2019].

[14] UNFPA (2017) Harmonizing the Legal Environment for Adolescent Sexual and Reproductive Health and Rights.

[15] See, for instance, McKinnon, B. and A. Vandermorris (2019) National Age of Consent Laws and Adolescent HIV Testing in sub-Saharan Africa. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6307515/ [accessed 13 December 2019].

[16] ARASA (2019) Sexual and Reproductive Health, HIV, TB and Human Rights in Southern and East Africa.

[17] Accountability International (2019) Policy Brief: Challenging Criminalisation of Adolescent Sexuality in Africa.

[18] Center for Reproductive Rights and Federation of Women Lawyers in Kenya "Briefing Paper - Criminalizing Adolescents: A call to Reform the Sexual Offences Act. Available https://reproductiverights.org/sites/default/files/documents/Designed%20Long%20Version%20of%20Briefing%20Paper%20on%20Adolescent%20SRHR-Covers1.pdf (Accessed 13 December 2019).

[19] WORLD HEALTH ORGANIZATION ET AL., SEXUAL HEALTH, HUMAN RIGHTS, AND THE LAW, 19 (2015), available at http://apps.who.int/iris/bitstream/handle/10665/175556/9789241564984_eng.pdf;jsessionid=2854B737ED602436A644F72BEFCD9C00?sequence=1 (Accessed 13 December 2019).

[20] See, for example the case of Kenya in Center for Reproductive Rights and Federation of Women Lawyers in Kenya "Briefing Paper - Criminalizing Adolescents: A call to Reform the Sexual Offences Act". Available at https://reproductiverights.org/sites/default/files/documents/Designed%20Long%20Version%20of%20Briefing%20Paper%20on%20Adolescent%20SRHR-Covers1.pdf (Accessed 13 December 2019).

[21] OHCHR Information Series on Sexual and Reproductive Health and Rights: Adolescents. Available at https://www.ohchr.org/Documents/Issues/Women/WRGS/SexualHealth/INFO_Adolescents_WEB.pdf [accessed 13 December 2019].

[22] UN Committee on the Rights of the Child (CRC), General comment No. 20 (2016) on the implementation of the rights of the child during adolescence, Available at: https://www.refworld.org/docid/589dad3d4.html [accessed 13 January 2019] at para 60.

[23] Ibid., at para 40.