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ETHICAL AND LEGAL ISSUES IN REPRODUCTIVE HEALTH

Enhancing the role of health professionals in the advancement of adolescent sexual health and rights in Africa

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ABSTRACT

To realize adolescents' right to sexual health, state parties' implementation of the obligations stipulated under Article 14 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa should reflect the key principles of the rights of the child, articulated under the Convention on the Rights of the Child and the African Charter on the Welfare and Rights of the Child. However, societal norms that stigmatize adolescent sexual conduct constitute barriers to adolescents' sexual health care, including their access to contraceptives to avoid unwanted pregnancies and protect themselves from STIs and HIV. States should sensitize and train health professionals to provide sexual health services and care in accordance with the principles of the rights of the child, and create enabling laws and policies to facilitate their work with adolescents.

1. Introduction

Sexuality development is an important aspect of human development and the realization of sexual health. Adolescence is a crucial period because adult health status is closely linked with experiences during adolescence [1]. Improvement of the sexual health status of a population over time depends on the extent to which states invest in adolescent sexual health. The present article discusses the relevance to adolescent sexual health of Article 14 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol) [2], which recognizes the right to sexual and reproductive health. For the purposes of the present article, adolescents will be considered as individuals aged 10–18 years.

The Maputo Protocol recognizes the right to choose any method of contraception under Article 14(1) (c), and the right to self-protection and to be protected against sexually transmitted infections (STIs), including HIV/AIDS, under Article 14(1) (d). Article 14(2) describes the measures states should undertake to realize these rights, which include provision of adequate, affordable, and accessible health services, including information and education. General Comment No. 2 adopted by the African Commission on Human and Peoples' Rights [3] offers guidance on implementation of Article 14 provisions. Others, such as Ngwena et al. [4], have elaborated on the significance of the General Comment in addressing gender and sex inequalities, and most especially the unmet sexual and reproductive health needs of girls in Africa. The present article responds to the need to give "sufficient attention to the specific concerns of adolescents as rights holders and to promoting their health and development" [5], and focuses especially on their access to contraceptives, and also self-protection against STIs and HIV. This is not to suggest that the other rights are less important. In fact, these rights are inextricably linked, interdependent, and indivisible. The circumscribed focus is merely to sacrifice breadth for depth given the limited space to discuss the subject of adolescent sexuality and sexual health.

The implementation of the obligations under Article 14 of the Maputo Protocol must be guided by the key principles of the rights of the child articulated under the Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child [6]. One of the obligations of the state is to ensure that health professionals competently provide adolescent sexual health care and services in a nonjudgmental manner, and in accordance with the principles of the rights of the child.

Criminalization of discriminatory conduct of health professionals could be one way of ensuring compliance with child rights principles. Malawi, for instance, imposes punitive measures on health officers who fail to comply with human rights standards, and these individuals can be liable to a fine or imprisonment for 3 years [7]. However, it is doubtful whether criminalization is the best way to achieve nondiscriminatory provision of sexual health services to adolescents. Discrimination against adolescent sexuality is systemic and entrenched in laws, and cultural and religious norms. Rather, states should eliminate the cultural, religious, and legal prejudices against adolescent sexuality, and at the same time sensitize and train health professionals in human rights approaches towards implementing adolescent sexual health care [4].

2. Societal prejudices against adolescent sexuality

Generally, adolescents are treated as asexual beings who do not have rights and responsibilities pertaining to sexual matters until a specific

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event occurs. In traditional Africa, the event is puberty, at which point initiation rites are performed and the child is recognized as an adult [6]. Usually, marriage is then arranged for girls. Premarital sex and pregnancy outside marriage are strongly discouraged and stigmatized, especially for girls. However, boys are expected to explore sexuality, and are sometimes encouraged to prove masculinity by having sex, even before marriage [6].

Social change has prolonged the period between puberty and marriage. Adolescents in modern times therefore have more time and opportunity to explore and engage in premarital sexual activity, which they do in spite of restrictive cultural norms. Two factors have reshaped traditional cultural norms on adolescent sexuality. First, African countries inherited criminal laws from colonizing European countries that introduced the concept of "age of consent" to sex through "anti-defilement" laws. Some countries have revised the received laws or created various schemes to regulate sexual conduct with adolescents. For instance, according to the Criminal Law Act 23 of 2004 of Zimbabwe, a child younger than 12 years is deemed not capable of consenting to sex, so any person who has sex with this child commits an offence of rape. However, the same law says that even if a child aged 12 years or older could be capable of consent, a person who has sexual intercourse with a child younger than 16 years still commits an offence [8] (Sections 61, 64, 70).

Second, Abrahamic religions reinforced the cultural stigma against premarital sex by introducing the notion that one does not acquire full rights and responsibilities on sexual matters at puberty or at a specific age, but at marriage celebrated under religious rites. Religion enforces its norms by stigmatizing proscribed sexual behavior. The influence of religion on sexual experience and behavior is insidious and influences sexual-health-seeking behavior of adolescents, and also sexual-health service provision by the health professional.

Tamale [9] articulately described the combined impact and effect of patriarchal cultural norms, religion, and criminal laws on sex and gender equality in Africa. For instance, patriarchal norms disempower married girls from protecting themselves from STIs and HIV; unmarried adolescents are denied access to contraceptives, information, and education on sexuality because of prejudiced attitudes of health providers. Criminal laws indiscriminately proscribe sexual conduct between adolescents, exposing them to criminal liability when they engage in consensual sex [10].

Public policy, and cultural and religious norms that stigmatize adolescent sexual experiences and conduct are harmful societal norms that create barriers to adolescent sexual health care. They discourage adolescents from seeking guidance on sexual matters from parents, care-givers, and even health professionals, especially when they are perceived to hold judgmental attitudes [10]. Although states should sensitize and train health professionals in child rights, it is important that states also ensure that public policies are consistent with the rights of the child.

3. Applying human rights principles to adolescent sexual health care

The first General Comment of the African Committee of Experts on the Rights and Welfare of the Child, which monitors the implementation of the African Charter on the Rights and Welfare of the Child, reiterated the key principles on the rights of the child [11]. These principles should also be applied to implementation of Article 14 obligations of the Maputo Protocol. The General Comment provides an African orientation to the work of the Committee on Rights of the Child, which monitors the implementation of the Convention on the Rights of the Child. The Committee on the Rights of the Child has issued several General Comments that expound on the key principles of the rights of the child.

The principle of nondiscrimination ensures that the status of being a child does not prejudice adolescents in access to sexual health services [12]. The principle of serving the best interests of the child means that the interests of the adolescent should always be prioritized [13]. Pursuant to the principle of protecting the life, survival, and development, sexuality development should be treated as an important and integral aspect of adolescent well-being [14]. The principle of seeking and respecting the views of the child means that adolescents should participate in the shaping of their experience of sexual health care such as removing barriers to access of care [12]. The principle of respecting adolescents' evolving capacities means that health professionals should take cognizance of an autonomy, capacity and maturity their own in matters of sexuality and sexual health care [12,15].

The present article centers the discussion of applying child rights principles to access to contraceptives, and enabling adolescents to protect themselves from STIs and HIV. However, this is not meant to bridle imagination on application of child rights principles to encompass adolescent sexual health care in its fullest sense.

4. Access to contraceptives

It would be against the principle of nondiscrimination, for instance, to provide morality counselling to dissuade an adolescent from accessing condoms on the basis of the health professional's religious or cultural beliefs [12] (paragraph 69). Rather, applying the principle of recognizing evolving capacities, the health professional should determine whether the adolescent is of sufficient maturity and capacity to understand the consequences and risks of using and not using the contraceptive [14] (paragraph 20). In the best interest of the child, the health professional should also ensure that the child is not in an exploitative or abusive sexual relationship. It should not be taken for granted that a married adolescent is not at risk or is less so because of their married status [5] (paragraph 20).

When the child is of insufficient maturity or might be involved in risky behavior, the health professional should be cautious when involving third parties such as parents to avoid discouraging the adolescent from seeking care. The health professional should work with the adolescent and other caregivers or parents to "facilitate the development of a relationship of trust and confidence in which issues regarding, for example, sexuality and sexual behavior and risky lifestyles can be openly discussed and acceptable solutions found that respect the adolescent's rights" [5] (paragraph 16). This should involve taking into account the views of the adolescent [12] (paragraph 19).

Because health professionals need to take into account laws and policies that affect their relationship with the adolescent seeking care, states should also ensure that public policy is not complicit with prejudicial views on adolescent sexuality and sexual conduct. Public policy on adolescent sexuality and access to sexual health services varies widely across jurisdictions. In Lesotho, an adolescent aged 12 years can give legal consent to medical treatment including access to contraceptives if he or she is "of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the treatment or operation" [16]. In Ghana, the age of legal consent to medical treatment is 18 years but a health professional can provide care without parental consent to a 16-year-old if it is in the best interests of the child [17]. In countries where the age of legal consent is not explicitly stated in legislation, usually the age of majority is interpreted to be the default age of consent to health services. Across the countries, the age of majority generally falls between 18 and 21.

Laws that indiscriminately proscribe consensual sexual conduct between adolescents perpetuate stigma and hinder adolescents' access to sexual health care. The South African Constitutional Court found such laws to be in violation of the rights of the child [10]. The High Court of Kenya, however, held the contrary view that laws that criminalized consensual sex between two 16-year-olds were constitutional [18]. Such laws create apprehension for a health professional who might be liable as party to the offence if they provided condoms to adolescents having illegal sex. One measure to enable health professionals to provide services that would be consistent with the rights of the child

could be to promulgate unequivocal policies that exempt liability of health professionals when they provide services to adolescents, just as Ghana's HIV Policy does for health professionals working with vulnerable groups [17].

States should therefore review laws and policies on legal consent to sexual health services, but also that regulate sexual conduct between adolescents to align them with principles of the rights of the child. This would foster a favorable environment for building relationships of trust and confidence between an adolescent seeking sexual health care, and the health professional.

5. Self-protection, and protection from STIs and HIV

Implementation of the right to self-protection and to be protected from STIs and HIV should embrace the principle of protecting life, survival, and development, which the Committee on the Rights of the Child affirmed includes the child's physical, mental, spiritual, moral, psychological, and social development [14] (paragraphs 11, 16). The right to self-protection entails building the capacity of the adolescent to consistently and confidently exercise autonomy and self-determination on matters relating to sexuality. Sexuality development is a "multidimensional process, intertwined with the basic human needs of being liked and accepted, displaying and receiving affection, feeling valued and attractive, and sharing thoughts and feelings" [19]. Adolescents need guidance and support to draw on their inner resources and faculties—the psychological, emotional, mental, spiritual, and moral—to make life choices consistent with sexual health.

A study reported by Loos et al. [20] revealed that sometimes adolescents living with HIV engage in sexual activity to cope with the emotional challenges of growing up with HIV, including the pain of rejection and social exclusion. This was also the experience of clinicians working with adolescents living with HIV at Baylor International Paediatric AIDS Initiative in Malawi, who have stated: "Many [adolescents living with HIV] attempt to engage in sexual relationships to gain acceptance, especially teens who are orphaned and/or facing discrimination/stigma at home" (written communication, A. McKenney, April 2013). The clinicians discovered that some adolescents living with HIV engaged in high-risk sexual behaviors, such as sex with multiple partners without protection, because they believed this would make them be accepted as HIV-free. Therefore, to promote the right of adolescents living with HIV to sexual health, health professionals should go beyond biomedical interventions, and address adolescents' developmental needs holistically, including empowering the adolescent to deal with social rejection or exclusion issues.

Promoting the right to self-protection also means supporting the adolescent to deal constructively with social and structural determinants of sexual health, such as gender inequality [12] (paragraph 9–10). For instance, patriarchal norms socialize boys to dominate in sexual relationships with girls, creating expectations that boys will make decisions—e.g. about condom use—and girls will just acquiesce. Therefore, availability and accessibility of condoms would not necessarily lead to self-protection unless the girl child is able to confidently discuss sex with her partner and negotiate condom use [6]. To realize the right to self-protection, boys need support to address masculinity notions that lead to increased risky behavior, and girls need support to enhance their sexual autonomy.

It is not the intention here to comprehensively describe the breadth of the right of adolescents to self-protection, and the right to be protected from STIs and HIV, but suffice it to say that health professionals need to competently engage sexuality and gender norms that impact on adolescent sexual health. This could demand more than technical competence. It is crucial that health professionals themselves attain some level of psychological integration to prevent their personal psychosexual history negatively influencing their responsiveness to the needs of adolescents under their care.

6. Information and education

The rights to access contraceptives, and to self-protection from STIs and HIV are meaningless if not accompanied by provision of adequate information and education [12] (paragraphs 60, 69). Evidence shows that, despite making contraceptives readily available to adolescents, failure to provide requisite information and education leads to minimal uptake [6].

African states have looked on sexuality education warily, despite international consensus that sexuality education is critical to advance sexual health. When the former UN Rapporteur on education purported to promote the right to sexuality education, the African United Nations Regional Group of Member States discredited the report arguing that there is no such right [21]. Underlying this argument is the anxiety that sexuality education would promote wanton premarital sexual conduct among adolescents. However, this fear is not supported by evidence, which has actually shown that family planning counselling of adolescents does not promote onset of sexual activity among non-sexually active teens, but does increase contraceptive use among adolescents who are already sexually active [22].

Health professionals often have several crucial roles as educators and counsellors within and beyond the clinic, and adolescents often rely on them for guidance and counsel. They also provide important linkages between the clinical setting and school-based and community-based sexual health education. For health professionals to empower adolescents, they must integrate the promotion of human rights and gender equality in the education and counselling of adolescents [23].

7. Conclusion

To ensure that the rights to sexual and reproductive health under Article 14 of the Maputo Protocol are realized for the adolescent, it is imperative that the protocol's implementation be guided by key principles of the rights of the child. Entrenched societal prejudices militate against adolescents' sexual health and discourage them from seeking care; when they do seek care, they sometimes face prejudicial attitudes regarding their sexuality from health professionals. Health professionals are uniquely placed at the interface between the health system and adolescents, and have crucial roles as services providers, educators, and counsellors in promoting the right to sexual health of adolescents. States have the obligation to ensure that health professionals are sensitized and trained to provide sexual health services in a manner that respects the rights of the child, and that public policy on adolescent sexuality and health is consistent with the rights of the child.

References

[1] World Health Organisation. Defining sexual health: Report of a technical consultation on sexual health, 28–31 January 2002, Geneva. http://www.who.int/reproductivehealth/publications/sexual_health/defining_sexual_health.pdf. Published 2006. Accessed September 5, 2015.
[2] African Commission on Human and Peoples' Rights. Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa. http://www.achpr.org/files/instruments/women-protocol/achpr_instr_proto_women_eng.pdf. Published 2003. Accessed September 1, 2015.
[3] African Commission on Human and Peoples' Rights. General Comment No 2 on Article 14.1 (a), (b), (c) and (f) and Article 14.2 (a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, Adopted by the African Commission on November 28, 2014. http://www.achpr.org/files/instruments/general-comments-rights-women/achpr_instr_general_comment2_rights_of_women_in_africa_eng.pdf. Accessed October 17, 2015.
[4] Ngwena CG, Brookman-Amissah E, Skuster P. Human rights advances in women's reproductive health in Africa. Int J Gynecol Obstet 2015;129(2):184–7.
[5] UN Committee on the Rights of the Child. CRC General Comment No. 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child. http://www.refworld.org/docid/4538834f0.html. Published July 2003. Accessed October 17, 2015.
[6] Kangaude G, Banda T. Sexual health and rights of adolescents: A dialogue with sub Saharan Africa. In: Ngwena C, Durojaye E, editors. Strengthening the protection of sexual and reproductive health through human rights in the African Region through human rights. Pretoria: University of Pretoria Law Press; 2014. p. 251–78.
[7] Gender Equality Act No. 3 of 2013 (Malawi).

[8] Criminal Law (Codification and Reform) Act [CAP 9:23] (Zimbabwe).
[9] Tamale S. Exploring the contours of African sexualities: Religion, law and power. Afr Hum Rights Law J 2014;14(1):150–77.
[10] *The Teddy Bear Clinic for Abused Children and Another v Minister of Justice and Constitutional Development and Another* (CCT 12/13) [2013] ZACC 35.
[11] African Committee of Experts on the Rights and Welfare of the Child. General Comment No. 1 (Article 30 of the African Charter on the Rights and Welfare of the Child) on "children of incarcerated and imprisoned parents and primary caregivers". Adopted by the African Committee of Experts on the Rights and Welfare of the Child on November 8, 2013. http://acerwc.org/?wpdmdl=8597. Published 2013. Accessed September 5, 2015.
[12] UN Committee on the Rights of the Child. General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24). http://www.refworld.org/docid/51ef9e134.html. Published April 2013. Accessed October 17, 2015.
[13] UN Committee on the Rights of the Child. General comment No. 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration (art. 3, para. 1). http://www.refworld.org/docid/51a84b5e4.html. Published May 2013. Accessed October 17, 2015.
[14] UN Committee on the Rights of the Child. General comment No. 3 (2003): HIV/AIDS and the rights of the child. http://www.refworld.org/docid/4538834e15.html. Published March 2003. Accessed October 17, 2015.
[15] Cook R, Dickens BM. Recognizing adolescents' "evolving capacities" to exercise choice in reproductive healthcare. Int J Gynecol Obstet 2000;70(1):13–21.
[16] Children's Protection and Welfare Act No. 7 of 2011 sec 232 (2) (Lesotho).
[17] National HIV and AIDS, STI Policy, 2013 (Ghana).
[18] *C K W v Attorney General & another,* Petition No. 6 of 2013 (High Court, Kenya).
[19] Murphy N. Sexuality in children and adolescents with disabilities. Dev Med Child Neurol 2005;47(9):640–4.
[20] Loos J, Nöstlinger C, Murungi I, Adipo D, Amimo B, Bakeera-Kitaka S, et al. Having sex, becoming somebody: A qualitative study assessing (sexual) identity development of adolescents living with HIV/AIDS. Vulnerable Child Youth Stud 2013;8(2):149–60.
[21] United Nations. General Assembly, Human Rights Council texts declaring water, sanitation human right 'breakthrough'; challenge now to turn right 'into a reality', Third Committee told. http://www.un.org/press/en/2010/gashc3987.doc.htm. Published October 25, 2010. Accessed September 3, 2015.
[22] Berger DK, Perez G, Kyman W, Perez L, Garson J, Menéndez M, et al. Influence of family planning counseling in an adolescent clinic on sexual activity and contraceptive use. J Adolesc Health Care 1987;8(5):436–40.
[23] Haberland N, Rogow D. Sexuality education: emerging trends in evidence and practice. J Adolesc Health 2015;56(1 Suppl):S15–21.