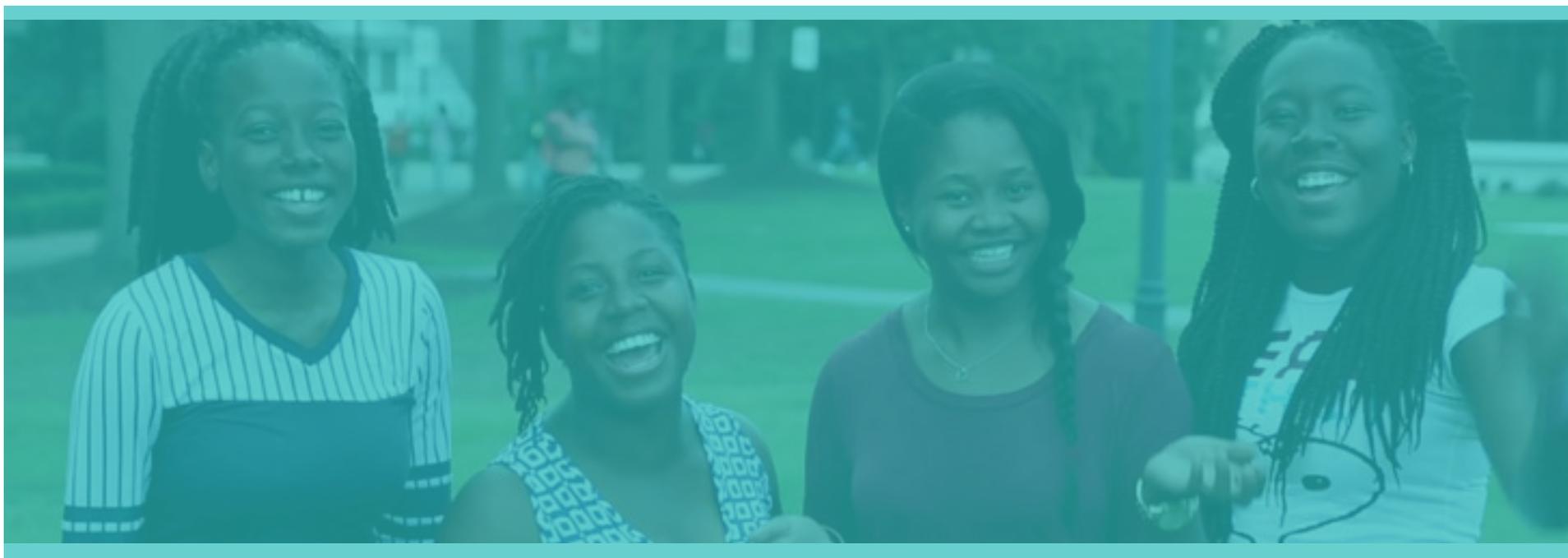


WHY LOWERING
THE AGE OF CONSENT TO SEXUAL AND
REPRODUCTIVE HEALTH SERVICES IS BENEFICIAL
FOR ADOLESCENTS' HEALTH AND WELLBEING



Why is lowering the age of consent to sexual and reproductive health services beneficial to adolescent health and wellbeing?



Key points

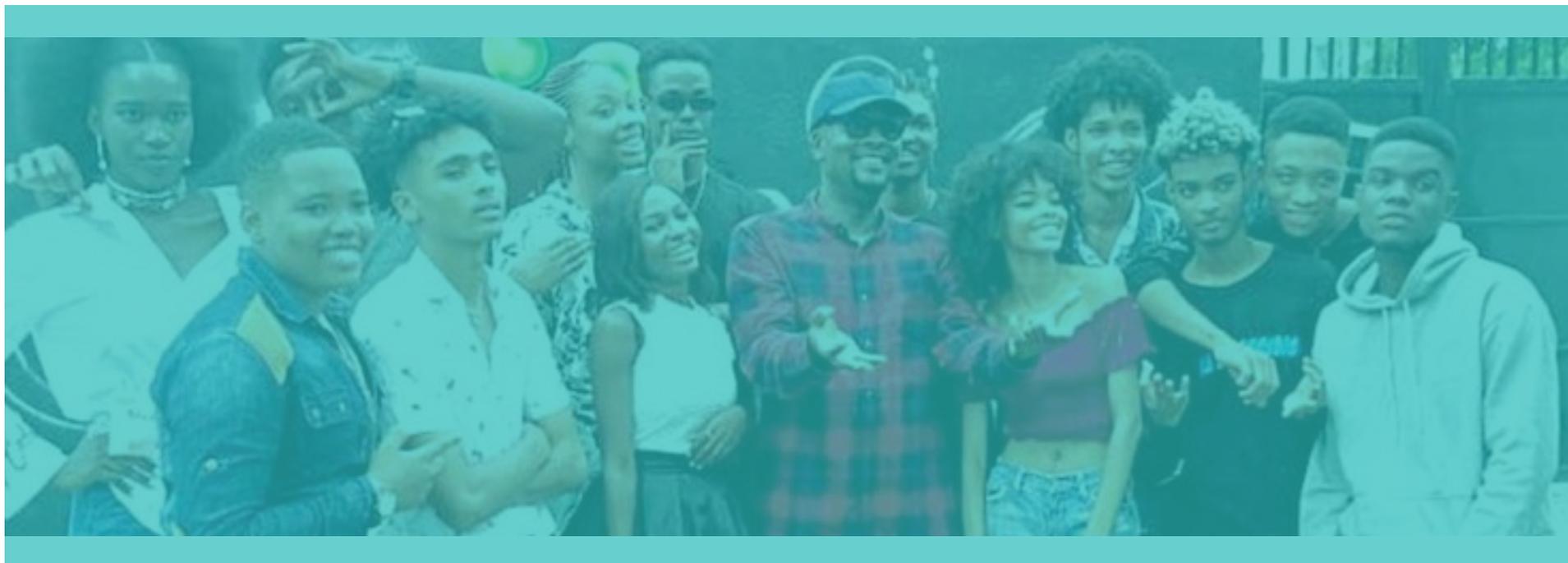
- Even though the age of consent law is meant to protect adolescents, requiring parental consent could mean young people are sometimes denied lifesaving services.
- Our review shows that adolescents enjoy better access to reproductive health services in countries without parental consent barrier compared to those with laws mandating consent.
- Some sub-Saharan African countries have amended their laws to allow health workers to provide care for adolescents without the parental consent requirement if they deem the service to be in the best interest of the adolescent.
- However, Zimbabwe's laws are unclear on whether adolescents can access reproductive health services without parental consent. The Parliament should act by adopting a rights-based approach in to law-making, clarifying that every adolescent has a right to access sexual and reproductive health services and information irrespective of their age, gender, sexual orientation, or socioeconomic background.

Background

Age of consent laws enacted to protect children from different forms of abuse¹⁻⁴. The minimum age of consent to sex law, for example, is meant to protect minors from sexual exploitation, abuse, and the adverse effects of early sexual activities on their health and wellbeing¹⁻⁴. This law is premised on the assumption that age and experience create a power imbalance that disadvantages minors⁵, making it impossible for them to give informed consent⁶.

Until recently, people view the age of consent laws as protective and beneficial. However, with increasing recognition of adolescents' sexual and reproductive health challenges, many have begun questioning if the age of consent laws hinder or improve access to sexual and reproductive health services.

In Zimbabwe, adolescents and especially girls, face several sexual and reproductive health problems. A 2016 study estimated 45,387 unintended pregnancies and 4,155 induced abortions among adolescent girls (15-19 years) in Zimbabwe⁷. According to the 2015 Demographic and Health Survey report⁸, about 22 percent of girls had begun childbearing by 19 years. Adolescents (15-19 years) are also disproportionately more at risk of acquiring HIV, accounting for one-third of all infections among adults⁹. Consequently, HIV and early unintended pregnancy are among the leading causes of death among adolescents.





Despite the constitutional provision guaranteeing all Zimbabweans the right to the highest attainable health (including SRHR), young people are still the least likely to test for HIV, with over 48 percent of young people not knowing their HIV status. Over half of sexually active female adolescents are not using any contraceptives¹¹. The majority of young people also lack access to comprehensive sexuality education. For instance, only 46.4 percent of young people aged 15-24 years have comprehensive knowledge of HIV prevention.

There is evidence that requiring parental consent to access services infringes on young people's rights to sexual and reproductive health services¹². Even though the age of consent law is meant to protect adolescents, requiring parental consent means young people are sometimes denied lifesaving services. In this brief, we elucidate the unintended consequences of having laws requiring parental consent to sexual and reproductive health services or unclear provisions for adolescent access to services. We also compare the conditions adolescents are allowed to access specific—but critical—sexual and reproductive health services in Zimbabwe to selected sub-Saharan African countries. We propose relevant policy reforms in light of scientific evidence.

How does Zimbabwe age of consent law compare with other sub-Saharan African countries?

Our review shows that laws and policies are largely unclear whether adolescents can access critical sexual and reproductive health services without parental consent in Zimbabwe. For example, section 35 of the Public Health Act [Chapter 15:17] does not specify the age a person can give "informed consent" to lifesaving health services. In cases where the laws are clear, like in HIV testing, young people who need the services are restricted by law from accessing services without parental consent unless they are married/a parent/pregnant or demonstrate maturity. Where the laws are unclear, it is assumed that the age of majority (18 years) applies. When there is a lack of clarity on the age adolescents can be served without parental consent, two things may happen. First, young people themselves may not access services. Second, if they do, providers may not provide the services needed without parental consent.

The age of consent to sex in Zimbabwe is 16 years, but there is no "close-in-age" clause (otherwise known as Romeo and Juliet clause) exemption. Without this clause, romantic relationships between young people of similar age may be criminalized. South Africa is an example of countries that have included this clause, thereby decriminalizing sex between two minors. There are legal and policy provisions stipulating that ten and 13-year-old adolescents can access barrier methods of contraceptives in Botswana and South Africa, respectively. However, there are no laws in Zimbabwe either permitting or restricting adolescents' access to barrier methods of contraception (See fig 1).

Parental consent is required for access to hormonal contraception in Zimbabwe, but adolescents as young as 10 years in Botswana and 13 years in South Africa can access hormonal contraception (fig 2).

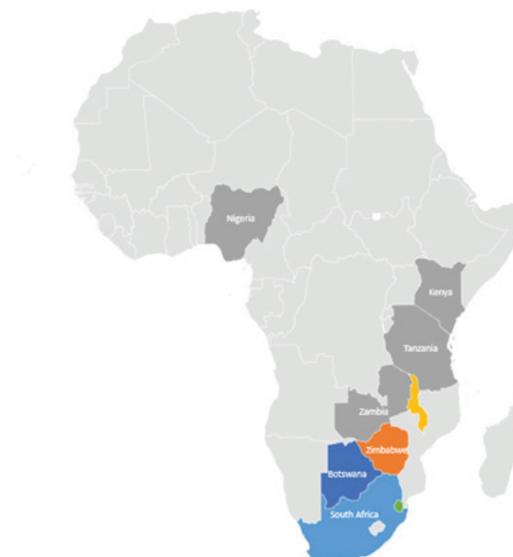


Age of consent laws

Age of consent laws - Barrier methods of contraception
 ■ Ten(10) ■ Twenty-one(21) ■ No Age Restriction ■ No Parental Consent ■ Twelve(12)



Age of consent laws- Hormonal contraceptions
 ■ 10(only in the event of rape) ■ Parental Consent ■ No Age Restriction ■ Unclear ■ thirteen(13) ■ Eighteen(18)



The law is also unclear on whether adolescents can access antenatal care, antiretroviral treatment, and pre-and post-exposure prophylaxes without parental consent in Zimbabwe, but young persons aged 12-17 years can consent to medical treatment on their own behalf if they have sufficient maturity and mental capacity in South Africa (Table 1).

Parental consent is required for accessing HIV testing for adolescents younger than 16 years in Zimbabwe, but a 12-year-old can access HIV testing in South Africa and Eswatini. The legal age of consent to HIV testing is 13 years in Malawi.

Age of consent laws

Table 1: Legal and policy landscape of age of consent in selected sub-Saharan African countries

Country	Sexual intercourse (Years)	Legal Abortion and post-abortion care	Antenatal care (Year)	Access to HPV and Cervical Cancer screening (Year)	ARV without parent consent (Years)	HIV testing without parental consent (Year)	HIV status reporting (Year)	Access to PEP (Year)	Access to PrEP (Year)
Botswana	16	18	APC	PC	NP (18 applies, but providers will give)	16	16	NS (18 applies, but providers will provide)	NS (18 applies, but providers will give)
Côte d'Ivoire	21	NS (21 applies)	NS- but girls can access service	NS (girls 15 can get it in school or with PC)	NS (21 applies)	16	Law allows reporting to parents for <21	NS (21 applies or given to girls with a child)	NS (21 applies or given to girls with a child)
Kenya	18	PC	NS	NPC	PC	18	TCP	PC	PC
Malawi	16	NS (16)	NS (16)	NPC	NS (16)	13	13	Unclear (16)	NS (16)
Zambia	16	NS (16)	NS (16)	16	NS (16)	16	NS (16)	NS (16)	NS
Zimbabwe	16	NS (16)	NS (16)	10 & 16	NS (16)	16	16	NS (16)	NS (15)
South Africa	16	NPC	12 - 17	9 - 10	12 - 17	12	TCP	12 - 17	12 - 17
Nigeria	18	18	NS	NS	NS	NS	TCP	NS	NS
Eswatini	16	18	NS (16)	NS (16)	12	12	TCP	12	12
Tanzania	18	NS (18)	NS	NS	NS	16	18	NS	NS

NOTE: NPC – No parental consent required according to the policy or law, PC – Parental Consent needed in the absence of clear policy guideline, NS -Not specified but likely to be the age indicated, TCP – To Consenting Party

Impact of legal age of consent laws on HIV testing uptake among adolescents

A review of how the legal age of consent affects the coverage of HIV testing among adolescents shows that setting the age of consent below 16 years was associated with 11 percentage point increase in coverage of HIV testing among adolescent boys and girls ¹². As shown in Table 2, lowering the age of consent is beneficial in terms of HIV testing.



Table 2: Legal and policy landscape of age of consent in selected sub-Saharan African countries

Country	Legal age of consent for HIV testing, years	% of adolescents tested for HIV in the past 12 months	
		Male	Females
Democratic Republic of the Congo	18	1.3	3.6
Cameroon	18	5.6	4.8
Côte d'Ivoire	18	5.2	8.3
Zimbabwe	16	21.1	24.8
Zambia	16	22.1	25.0
Kenya	15	27.3	31.1
Rwanda	15	26.0	30.0
Malawi	13	24.3	23.7
Lesotho	12	30.4	32.8
South Africa	12	46.5	50.5
Uganda	12	16.6	26.4

Unintended consequences of the age of consent laws

Several studies have shown that young people value privacy and confidentiality when it comes to sexual and reproductive health services^{13 14}. Requiring parental consent infringes on their privacy and may deter them from using sexual and reproductive health services. For example, studies have shown that requiring parental consent deters adolescents from testing for HIV^{12 15}. The danger of not testing is considerable for sexually active adolescents who rate their risk of contracting HIV as high. Such adolescents may later present with a late-stage disease or AIDS-defining symptoms, requiring prolonged hospitalization and substantial financial outlay and potentially resulting in death¹⁶.

Age of consent laws may well harm adolescents' health and wellbeing if they—as a result of these laws—are denied services or refuse to access services. Laws requiring parental consent before adolescents are provided sexual and reproductive health services may also prevent health care providers from fulfilling their oath of caring for everyone. Health care providers are restricted in their capacity to make critical decisions beneficial for their patients in fear of legal action.

Conclusion

Setting the age of consent to sexual and reproductive health to 16 or 18 may well have its advantages, but the risks it presents to young people's health outweigh these benefits. The rationale for lowering the age of consent to sexual and reproductive health services from 18 to 12 or 14 is unambiguous. The benefits in terms of increased access to life-saving services and prevention of sexually transmitted infections and unintended pregnancies are enormous, surpassing any potential cons. When laws are ambiguous, people suffer. Requiring parental consent for sexual and reproductive health services infringes on adolescents' right to the highest attainable health guaranteed under the Zimbabwean constitution. The constitution is clear and explicit that everyone in the country has the right to access health care services. This right is absolute and should therefore not be restricted under the guise of protecting adolescents. It is, therefore, imperative for the Parliament to act. The Parliament should adopt a rights-based approach to law-making. This approach will clarify that every adolescent has a right to access sexual and reproductive health services and information irrespective of their gender, status, sexual orientation, or socioeconomic background. Also, parliament should ensure that all laws regarding access to reproductive health services are aligned with the constitution provision that already guarantee all Zimbabweans the right to the highest attainable health.



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