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Realizing Access to Sexual Health Information and Services for Adolescents Through the Protocol to the African Charter on the Rights of Women

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I. Introduction

One of the goals agreed to at the International Conference on Population and Development (ICPD) in Cairo 1994, was to ensure that universal access to sexual and reproductive health services is guaranteed to all, especially women and adolescents, by the year 2015.[1] Several years after this commitment was made, the hope of realizing this goal seems to be diminishing by the day, particularly for young people in developing countries including Africa. Over the years sexual and reproductive health needs of adolescents have continued to receive little attention from governments in developing countries, particularly Africa.[2] This in turn has led to unmet needs of adolescents' sexual health.[3] It is estimated that about 14 million adolescents within the ages of fifteen to nineteen years give birth annually.[4] Many of these births, and a great number of abortions, occur in developing countries, where adolescents lack access to comprehensive sexual health care services.[5]

The worldwide average rate for births per 1000 among young women in sub-Saharan Africa is put at about 143 compared to twenty-five and fifty-nine in Europe and Central Asia respectively.[6] Equally, "[s]exually transmitted infections (STIs), including HIV/AIDS, are the second most

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1. *See* International Conference on Population and Development (ICPD), September 5–13, 1994, *Report of the International Conference on Population and Development*, ¶ 1.12, U.N. Doc A/CONF.171/13 (Oct. 18, 1994) (presenting the goals adopted with regards to health services); *see also* Fourth World Conference on Women, Sept. 4–15, 1995, *Report of the Fourth World Conference on Women*, U.N. Doc A/CONF.177/20 (Oct. 17, 1995) (reaffirming women's need for access to health services).

2. *See* ANN E. BIDDLECOM ET AL., PROTECTING THE NEXT GENERATION IN SUB-SAHARAN AFRICA: LEARNING FROM ADOLESCENTS TO PREVENT HIV AND UNINTENDED PREGNANCY 6 (2007) ("The attention paid to HIV and AIDS in Sub-Saharan Africa has exposed a range of unmet sexual and reproductive health care needs among adolescents, exemplified by the high rates of unintended pregnancy and unsafe abortion in the region.").

3. *See id.* (suggesting that supplying better health care needs would result in healthier adolescents).

4. *See* MARIA DE BRUYN & SARAH PACKER, ADOLESCENTS, UNWANTED PREGNANCY AND ABORTION: POLICIES, COUNSELING AND CLINICAL CARE 7 (2004) (introducing background information on adolescent pregnancy).

5. *See id.* at 1 ("[A]t least 2–4.4 million abortions occur among adolescent women in developing countries each year. Because adolescents are less likely to have information about abortion or resources to access safe services, they more often use unsafe methods when they try to self-induce an abortion.").

6. *Id.* (listing the worldwide average rate of births in countries all over the world which makes up the 14 million women between fifteen and nineteen that give birth every year).

important cause of loss of health in women, especially young women."[7] Adolescents remain particularly susceptible to "sexual and reproductive ill health as they often have unexpected sex and find access to services difficult or denied."[8] Moreover, access to comprehensive sexual health information and services is often lacking.[9] Access to sexual health information and services can help in preventing unintended pregnancy, risks of pregnancy, STIs (including HIV/AIDS) and unsafe abortion among adolescents.[10]

Whilst it is true that adolescents all over the world suffer from great neglect in regard to their sexual health,[11] the case of adolescents in sub-Saharan Africa is particularly worrisome. Available data with regard to the sexual and reproductive health conditions of adolescents in the region paint a very grim picture.[12] For instance, adolescents between the ages of fifteen to twenty-four constitute a growing percentage of infections in some provinces in the central and southern zones of Lesotho and Mozambique.[13] Also, in 2007, more than 90% of an estimated 270,000 HIV/AIDS-related deaths of children under fifteen years of age occurred in sub-Saharan Africa.[14] It is estimated that over 4 million unsafe abortions occur each year in Africa as a whole, especially among women fifteen to forty-nine.[15]

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7. Anna Glasier et al., *Sexual and Reproductive Health: A Matter of Life and Death*, 368 LANCET 1595, 1595 (2006).

8. *Id.*

9. *See* DE BRUYN, *supra* note 4, at 3 (discussing the policy reform needed in different countries in order to provide access to sexuality and reproductive health information which has been stymied); *see also* BIDDLECOM, *supra* note 2, at 22 (suggesting that public sensitivity to providing sexual and reproductive health information to adolescents adds to the void of knowledge).

10. *See* World Health Organization Technical Consultation on Sexual Health, January 28–31, 2002, *Defining Sexual Health,* 21 (2006) (compiling a comprehensive list of proposals on how to address negative issues of sexual health, almost all including some form of education).

11. *See* UNAIDS, REPORT ON THE GLOBAL AIDS EPIDEMIC 33 (2008) ("Young people aged 15–24 account for an estimated 45% of new HIV infections worldwide.").

12. *See id.* ("Globally, the number of children younger than 15 years living with HIV increased from 1.6 million [. . .] in 2001 to 2.0 million [. . .] in 2007. Almost 90% live in sub-Saharan Africa.").

13. *See id.* at 39–40 (providing statistics on the AIDS prevalence for adults and young people throughout Africa).

14. *See id.* at 37 (presenting data on child deaths due to AIDS in sub-Saharan Africa).

15. *See* Elizabeth Ahman & Iqbal Shah, *Unsafe Abortion: Worldwide Estimates for 2000*, 10 REPROD. HEALTH MATTERS 13, 15 (2002) (estimating that 4.2 million abortions take place per year, with an unsafe abortion rate of twenty-two per 1000 women or one unsafe abortion per seven live births); *see also* DE BRUYN, *supra* note 4, at 1 (explaining the

Moreover, approximately 52% of sexually active unmarried adolescents in West Africa, 47% in Eastern and Southern Africa and 31% in Central Africa have been reported to have an unmet need for contraception.[16]

Early marriage and its attendant consequences is a big challenge, particularly in areas such as Western and Central parts of Africa.[17] A survey has shown that on the average over 40% of girls before they reach 18 are already married in the region.[18] In some countries such as Niger and Democratic Republic of Congo the percentage of married fifteen to nineteen year old girls is as high as 70% and 74% respectively.[19] A major consequence of early marriage is the risk of vesico-vaginal fistulas (VVF), a condition related to the tearing of the vaginal walls of young girls due to their underdevelopment.[20] Given all these challenges, "increased and sustained investment in the sexual and reproductive health of adolescents is a sensible long-term public health priority."[21] This is because "[s]ustained and increased investment in sexual and reproductive health services in developing countries promises tremendous benefits to women, families and societies."[22] It will also help nations across the globe in realizing some of the goals of the United Nations' Millennium Development Goals.[23] Moreover, aside from contributing to good health, sexual and reproductive health services enhance "economic growth, . . . gender equity, and

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likelihood of unsafe abortions as a result of a lack of information or safe methods).

16. *See* BIDDLECOM, *supra* note 2, at 17 (proving that levels of unmet need for contraception are higher among sexually active never-married adolescent females than among those who are married, suggesting a reason for the high abortion rates).

17. *See* UNICEF, *Early Marriage: Child Spouses*, 7 INNOCENTI DIG. 4 (2001), *available at* http: //www.unicef-irc.org/presscentre/presskit/innocentidigest/pressrelease id7.pdf ("[A]ffecting 40 per cent and 49 per cent respectively of girls under 19–compared to 27 [percent] in East Africa and 20 per cent in North and Southern Africa.").

18. *Id.*; *see also* ALAN GUTTMACHER INSTITUTE, INTO A NEW WORLD: YOUNG WOMEN'S SEXUAL AND REPRODUCTIVE LIVES 4–8 (1998) (presenting the substantial percentage of young women married or in a union before age 18 for all different countries in Africa and elsewhere).

19. *See* UNICEF, *supra* note 17, at 4 (comparing the percentage of girls married between the ages of 15 and 19 to the number of boys, which is much lower).

20. *See* BIDDLECOM, *supra* note 2, at 8 ("Young women who are malnourished and have small pelvic widths are especially susceptible . . . fistula is most common in very poor countries of Africa where child marriage is common.").

21. *Id.* at 6.

22. *See* SUSHEELA SINGH ET AL., ALAN GUTTMACHER INSTITUTE, ADDING IT UP: THE BENEFITS OF INVESTING IN SEXUAL AND REPRODUCTIVE HEALTH CARE, at ii (2004) (quoting the Executive Summary).

23. *See id.* ("Improved sexual and reproductive health underpins all of the Millennium Development Goals.").

democratic governance."[24] More importantly, it is a step forward in realizing the right to health of adolescents. Despite these benefits, however, access to sexual health information and services for young people in developing countries, particularly Africa, remains very challenging.

Against this backdrop, this Article examines the factors hindering access to comprehensive sexual health information and services to adolescents in Africa. It similarly examines the relevance of human rights provisions contained in the African Charter on the Rights and Welfare of the Child (African Children's Charter),[25] the African Charter on Human and Peoples' Rights (African Charter),[26] and the latest human rights instrument in the region, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol)[27] in advancing the sexual health of adolescents in the region. This Article argues that these regional human rights instruments have provisions that can be invoked to advance access to sexual health information and services for adolescents. It particularly notes that given the fact that female adolescents are more disposed to sexual ill health in the region, the African Women's Protocol provides a very unique opportunity to address the sexual health needs of female adolescents. This Article then concludes that the success or otherwise of the application of the African Women's Protocol to meet the challenges of female adolescents in the region depends largely on the commitment of African governments.

II. Importance of Sexual Health Information and Services for Adolescents

Access to sexual health information and services provides important options for sexually active adolescents to avoid unwanted pregnancy and sexually transmitted infections (STIs) including HIV.[28] Ensuring access to

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24. *Id.*

25. Organisation of African Unity (OAU), 1990, *African Charter on the Rights and Welfare of the Child*, OAU Doc CAB/LEG/24.0/49 (Nov. 29, 1999).

26. OAU, June 27, 1981, *African Charter on Human and Peoples' Rights*, OAU Doc CAB/LEG/67/3/Rev 5 (Oct. 21, 1986).

27. Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, *adopted* July 11, 2003, *reprinted in* Martin Semalulu Nsibirwa, *A Brief Analysis of the Draft Protocol to the African Charter on Human and People's Rights in Africa*, 1 AFR. HUM. RTS. L.J. 40, 53 (2001) [hereinafter Protocol].

28. *See* CENTER FOR REPRODUCTIVE RIGHTS, STATE OF DENIAL: ADOLESCENT REPRODUCTIVE RIGHTS IN ZIMBABWE 17–18 (2002), *available at* http://reproductiverights.org/en/document/state-of-denial-adolescent-reproductive-rights-in-zimbabwe (exploring the broader implications of providing access to services and information on dual protection

information and services on sexual health to adolescents, would not only reduce their risk of exposure to serious sexual harms, "but could also positively affect their educational, occupational and social opportunities."[29] Over the years attempts have been made to ensure access to sexual health services, particularly contraceptive services, to adolescents in many parts of the world.[30] However, great disparity still exists in terms of region and groups having access to sexual health services.[31] In many African countries access to comprehensive sexual health information and services for young people, especially young women, remains very difficult.[32]

Lack of access to comprehensive sexual health information and services will deprive adolescents, especially adolescent girls, the ability to develop their full human potential and their health will likely suffer.[33] As mentioned earlier, unmet need for contraception remains high, and unintended pregnancies are a major contributor to the overall burden of disease in the developing world.[34] A report has shown that the proportion of currently pregnant women under twenty years in Ghana, Kenya and Namibia who reported that their pregnancies were mistimed or unwanted was 46%, 50% and 55% respectively.[35] Similarly, a study among

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contraception methods).

29. *See id.* at 17.

30. *See id.* at 8 ("In an attempt to navigate the conflict between cultural values and the reality of adolescents' lives, the Zimbabwean government has issued inconsistent and confusing laws and policies in recent years.").

31. *See id.* at 24 ("Rural areas suffer most from lack of access to health care, as evidence by surveys that indicate that, in some remote rural areas, people have to walk about five kilometers to get to the nearest health care center because of problems associated with lack of accessible roads and transport."); *see also* DEPARTMENT OF HEALTH, SOUTH AFRICA, SOUTH AFRICA DEMOGRAPHIC AND HEALTH SURVEY 1998 48 (1998) ("Provincial differences in contraceptive prevalence are large.").

32. *See* DE BRUYN, *supra* note 4, at 7 (presenting the fact that less than 5% of the poorest young people worldwide use modern contraceptive methods and the fact that 60 million young people in extreme poverty live in sub-Saharan Africa).

33. *See* M.J. Welsh et al., *Access to Modern Contraception*, 20 BEST PRAC. & RES. CLIN. OBSTET. AND GYNAECOL. 323, 325 (2006) ("At the level of an individual woman, lack of access to contraception or the empowering knowledge that leads to its use has frustrated the aspirations of generations of women worldwide, and has robbed societies of their potential intellectual contributions.").

34. *See* John A. Ross & William L. Winfrey, *Unmet Need for Contraception in the Developing World and the Former Soviet Union: An Updated Estimate*, 28 INT'L FAM. PLAN. PERSP. 138, 138–143 (2002) (compiling recent information on the need for contraception in the developing world).

35. *See* CHRIS PARKER, ADOLESCENTS AND EMERGENCY CONTRACEPTIVE PILLS IN DEVELOPING COUNTRIES 1 (William Finger ed., 2005) (exploring the need for contraceptive pills for youth).

adolescents in South Africa has shown that about 35% of adolescents aged 19 years had ever been pregnant.[36] Many of these pregnancies have been mistimed.[37] This percentage varies from one province to another and from rural areas to urban areas, an indication that teenage pregnancy is a problem in the country.[38]

There are several health consequences that often arise as a result of early or unwanted pregnancies among young people. It has been shown that pregnancies among adolescents within the ages of fifteen to nineteen can be very risky as they are more likely to die due to pregnancy-related complications compared to adolescents in their twenties.[39] Also, it has been noted that if maternal illnesses are included, unintended births result in the loss of 4.5 million disability-adjusted life years each year.[40] The burden of maternal mortality is greatest where resources are most scarce, with 99% of the estimated half-a-million maternal deaths each year occurring in developing countries, particularly Africa.[41] It has been reported that approximately forty-five million unintended pregnancies end in abortion each year and "an estimated nineteen million . . . are unsafe."[42] More than 40% of unsafe abortions occur among young women aged fifteen to twenty-four years, which can lead to loss of fertility and even death.[43] Early or

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36. *See* SOUTH AFRICA DEMOGRAPHIC AND HEALTH SURVEY, *supra* note 31, at 142 (showing "considerable variation in adolescent fertility by region, education and population group" in South Africa).

37. *See id.* at 74 ("The dissatisfaction amongst South African women regarding early commencement of childbearing is also reflected in the fact that two thirds of all births to women in their teenaged years (under 19 years of age) were reported as mistimed.").

38. *See* CENTER FOR REPRODUCTIVE RIGHTS, STATE OF DENIAL: ADOLESCENT REPRODUCTIVE RIGHTS IN ZIMBABWE, *supra* note 28, at 20 ("The mean age at which women have their first child is 18.9 years. However, it is not uncommon for girls to bear children as early as age 13.").

39. *See* R. Rivera et al., *Contraception for Adolescents: Social, Clinical and Service Delivery Considerations*, 75 INT'L J. GYNEC. & OBSTET. 149, 150 (2001) ("Women aged 15–19 are three times more likely to die from complications of pregnancy than women aged 20–24 years, especially if they are unmarried and, thus, less likely to receive prenatal care.").

40. *See* Martine Collumbien et al., *Non-Use and Use of Effective Methods of Contraception*, *in* 2 COMPARATIVE QUANTIFICATION OF HEALTH RISKS: GLOBAL AND REGIONAL BURDEN OF DISEASE ATTRIBUTION TO SELECTED MAJOR RISK FACTORS 1255, 1256 (2004) (estimating the burden of disease attributable to non-use of contraception and use of ineffective methods).

41. *See id.* at 1257 (estimating the number of maternal deaths in 1995).

42. *See* WORLD HEALTH ORGANIZATION, REPRODUCTIVE HEALTH STRATEGY TO ACCELERATE PROGRESS TOWARDS THE ATTAINMENT OF INTERNATIONAL DEVELOPMENT GOALS AND TARGETS 14 (May 2004) (laying out the exposure to risk of adolescents without effective family planning or contraceptive methods).

43. *See id.* (presenting data for policymakers on the rates and effects of unsafe

unwanted pregnancy among adolescents is not only dangerous for the young mother but can also endanger the life of the unborn child since the "infants of teenagers have higher rates of premature birth, lower birth weights, and higher mortality rates."[44]

Apart from the risk to the health of adolescents, unwanted pregnancy also brings along with it adverse social and economic consequences for an adolescent. Because premarital pregnancy is usually frowned upon in many African communities, unmarried adolescent girls that get pregnant may likely experience violence or even be disowned by their parents.[45] Pregnancy among female adolescents may severely limit their opportunity to pursue their education and render them economically dependent on partners or family members.[46]

In addition to the problem of unwanted pregnancy among adolescents in Africa, lack of access to sexual health information and services for adolescents may also bring about the challenge of sexually transmitted infections (STIs), including HIV/AIDS.[47] The negative impacts of unprotected sex among adolescents are more serious for females than their male counterparts.[48] This is because women are more prone than men to HIV infection due to the fact that the greater area of a woman's mucous membrane is often exposed during sex.[49] This usually accounts for the higher prevalence of STIs other than HIV among women than men.[50]

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abortion).

44. PARKER, *supra* note 35, at 2.

45. *See* ALISTER C. MUNTHALI ET AL., ALAN GUTTMACHER INSTITUTE, ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH IN MALAWI: A SYNTHESIS OF RESEARCH EVIDENCE 14 (15th ed. 2004) (discussing the lack of control girls have in sexual activities which place them in powerless subordinate situations in the culture).

46. *See, e.g., id.* at 17 (providing the consequences of unplanned pregnancies in Malawian society).

47. *See* REPRODUCTIVE HEALTH STRATEGY, *supra* note 42, at 14 (explaining that both treatable and non-treatable sexually transmitted infections are not diagnosed or treated because "competent, affordable services are lacking").

48. *See* MUNTHALI, *supra* note 45, at 13 ("While parents and the society at large exercise strict controls and closely monitor girls' sexual behavior, boys are often left alone to explore relationships.").

49. *See* Ann E. Biddlecom et al., *Women, Gender and HIV/AIDS: Women Bear the Heaviest HIV/AIDS Burden*, COUNTDOWN 2015: SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS FOR ALL, 2004, at 66 (explaining that women are more physically vulnerable than men to HIV).

50. *See id.* ("Women also have higher rates of certain sexually transmitted infections, such as genital herpes, that increase both the infectiousness of HIV-positive people and the susceptibility of HIV-negative people.").

Analysis of HIV prevalence in sub-Saharan Africa shows that estimates are high among fifteen to twenty-four year olds.[51] Also, a study in Malawi has found that about 20% of Malawian young people between the ages of fifteen and twenty-three were HIV positive, with five times as many young women than men.[52]

Similarly, a report based on surveillance of antenatal clinics has shown a high HIV prevalence rate of 37.0% among women between thirty and thirty-four years of age in 2006.[53] This high prevalence among young women cannot be isolated from the high rate of sexual violence in South Africa. Indeed, it has been reported that South Africa has one of the worst incidences of sexual violence in the world.[54] With this great challenge posed by the HIV/AIDS pandemic, the role of effective contraception in the primary prevention of mother-to-child transmission outlined by the World Health Organization (WHO) provides yet another compelling rationale to expand access to sexual health services for all women, especially young women.[55]

III. Understanding Sexual Health and Rights

While it is noted that the concept of reproductive health over the years has gained the attention of the world, sexual health is more or less a recent development. Although the concept of reproductive health was broadly expounded at the ICPD, sexual health was merely defined as part of reproductive health.[56] Thus, for a long time the contents and nature of

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51. *See* BIDDLECOM, *supra* note 2, at 8–9 (arguing that there is good cause to be concerned about the sexual and reproductive health of adolescents).

52. *See* MUNTHALI, *supra* note 45, at 17–18 (citing H. Chendi, HIV/AIDS LIFE SKILL PROGRAMS IN SOUTHERN AFRICA: THE CASE OF MALAWI (1998) unpublished manuscript)).

53. *See* DEPARTMENT OF HEALTH, SOUTH AFRICA, NATIONAL HIV AND SYPHILIS PREVALENCE SURVEY 2006 9 (2007) (noting the increase could be a result of younger women already infected moving into an older age group).

54. *See* HUMAN RIGHTS WATCH, SCARED AT SCHOOL: SEXUAL VIOLENCE AGAINST GIRLS IN SOUTH AFRICAN SCHOOLS 21 (2001) ("According to the most recently available South African Police Service statistics, there were 51,249 cases of rape reported to police nationally in 1999.").

55. *See* Heidi W. Reynolds et al., *Contraception's Proved Potential to Fight HIV,* 81 SEXUALLY TRANSMITTED INFECTION 184, 184 (2005) (urging action be taken through family planning to prevent HIV infections).

56. *See Report of the International Conference on Population and Development, supra* note 1, at ¶ 7.4 ("Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.").

sexual health could not be clarified. Of late, however, the World Health Organization (WHO) has been focusing on developing the concept of sexual health.[57] As part of this development, WHO has come up with a definition of sexual health.[58] This definition comprehensively describes sexual health in the following words:

> Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.[59]

An important point to note with this definition is that it is broad and emphasizes the inter-related nature of the physical, mental and social dimension of sexuality, particularly the notion of sexual well-being.[60]

Similarly, an attempt has been made by WHO at defining sexual rights broadly as embracing "human rights that are already recognized in national laws, international human rights documents and other consensus statements."[61] Sexual rights therefore:

[I]nclude the rights of all persons, free of coercion, discrimination and violence, to:

- the highest attainable standard of sexual health, including access to sexual and reproductive health care services;
- seek, receive and impart information related to sexuality;
- sexuality education;
- respect for bodily integrity;
- choose their partner;
- decide to be sexually active or not;
- consensual sexual relations;

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57. *See Defining Sexual Health, supra* note 10, at 1 (determining that freedom of sexuality and respect for bodily integrity needed to be included within the scope of the Committee's goals).

58. *See id.* at 4–5 (proposing working definitions for sexual health in response to changing times).

59. *Id.*

60. *See id.* at 6 (exemplifying that sexuality is a fundamental right to being a human).

61. *Id.* at 5.

- consensual marriage;
- decide whether or not, and when, to have children; and
- pursue a satisfying, safe and pleasurable sexual life.[62]

Part of this definition which affirms individual's right to "decide to be sexually active or not' and 'pursue a satisfying, safe and pleasurable sexual life"[63] underlies the importance of ensuring comprehensive access to sexual health information and services to adolescents. It particularly recognizes an individual's positive right not only to engage in sexual activity but also to be assured that such activity is safe and enjoyable.[64]

It should be noted that sexual health and rights are emerging concepts that have often been misconstrued by people generally.[65] Moreover, these concepts have provoked controversy and debate among different social and religious groups in Africa.[66] Due to this situation, little or no attention has been given to issues relating to sexual health of the population, especially vulnerable groups such as women and adolescents.[67]

No doubt from the explanation above, it is clear that there exists a link between sexual and reproductive health. The two, though distinct, are interrelated. Exploring the linkages between the two concepts Ruth Dixon-Mueller, prior to Cairo, has attempted to divide the elements of reproductive health care into two categories—sexual health and reproductive health—each with specific components.[68] For sexual health its components include the following factors: "[p]rotection from STDs; . . . [p]rotection from harmful practices and violence . . . [c]ontrol over sexual access . . . [s]exual enjoyment . . . [and] "[i]nformation on sexuality."[69] On the other hand, the components of reproductive health

62. *Id.*

63. *Id.*

64. *See id.* (suggesting a positive and respectful approach to sexuality is needed in order to reduce the stress of sexuality).

65. *See id.* at 7 ("Sexual development is often typified as something problematic to be contained and controlled, especially for girls. This characterization often has more to do with the anxieties, fears, and beliefs of adults than the reality experienced by adolescents.").

66. *See id.* at 11 (identifying the risk that religion can play in one's sexual health).

67. *See id.* at 9 (highlighting the need for collective action and discussion on sexual health, even though uncomfortable, in order to prevent sexual violence against women and children).

68. *See* Ruth Dixon-Mueller, *The Sexuality Connection in Reproductive Health*, 24 STUD. FAM. PLAN. 269, 277 (1993) (constructing linkages between the sexuality/gender framework and reproductive health in order to aid planning providers, policymakers, and researchers).

69. *Id.* (listing the components of sexual health).

include these factors: "[s]afe, effective protection from (and termination of) unwanted pregnancies . . . [c]ontraceptive choice and satisfaction with method . . . [p]rotection from harmful reproductive practices . . . [s]afe pregnancy and delivery . . . [c]ontraceptive and reproductive information . . . [and] [t]reatment of infertility."[70] She further submits that these components are shaped by characteristics of the society at large rooted in "social and economic institutions that determine power hierarchies and life choices based on gender, age, class, ethnicity, and other distinctions; and by ideologies of gender (and other differences) that each system elaborates."[71]

Alice M. Miller has rightly contended that a discussion on sexual health and rights goes beyond traditionally conceived notions of reproduction and heterosexuality.[72] Rather such a discussion embraces diverse groups of people and issues including homosexual and heterosexual and reproductive and non-reproductive sexual activities.[73] She particularly argues that limiting sexual relations to procreation alone will lead to "disappearance" of certain categories of people such as gay and lesbian and those who merely engage in sex for pleasure.[74] Miller's observation, which has received the support of Charles Ngwena, is quite pertinent for our discussion on realizing access to sexual health information and services for adolescents.[75] As studies have shown, adolescents in many countries become sexually active at an early age and may wish to engage in a safe and pleasurable non-procreative, non-coercive sexual act, hence the need to

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70. *Id.* (listing the components of reproductive health).

71. *Id.* at 276.

72. *See* Alice M. Miller, *Sexual but Not Reproductive: Exploring the Junction and Disjunction of Sexual and Reproductive Rights*, 4 HEALTH & HUM. RTS. 68, 86–87 (2000) (explaining that sexual health and rights include homosexuality and non-procreative practices).

73. *See id.* (arguing for a more inclusive framework defining sexual health and rights, in opposition to the traditional framework of heterosexuality and procreation which is far too restrictive of a large portion of the population's sexual expression).

74. *See id.* at 87 ("The dominant conservative political position that deems sex within (heterosexual) marriage for the purposes of procreation to be the only practice worthy of rights protection . . . lead[s] to arguments that define sexual rights in the shadow of reproductive rights.").

75. *See* Charles Ngwena, *Sexuality Rights as Human Rights in Southern Africa with Particular Reference to South Africa*, 17 S. AFR. PUB. L. 2–3 (2002) (promoting sexuality rights as an expansive form of rights including "rights to equality, non-discrimination, sexual orientation, human dignity, reproductive decision-making, bodily integrity . . . health care services and other socio-economic good").

assure them means of protection from negative consequences which this act may bring.[76]

IV. Factors Limiting Access to Sexual Health Information and Services for Adolescents

Several factors have been identified as militating against access to sexual health information and services for adolescents in many developing countries including Africa. These factors can be classified under two broad headings: socio-cultural factors and barriers associated with the health care setting. These factors are considered below.

A. Socio-Cultural Factors

In a male oriented society such as Africa, adolescent girls are expected to be in the dark with regard to their sexuality, and discussion about sex between parents and wards is almost a taboo.[77] Little can be known by adolescent girls regarding the means of avoiding pregnancy or preventing transmission of STIs.[78] Time and again, parents and guardians are failing in their responsibilities to equip their children with the essential information they require for their healthy growth.[79] Most parents fail to realize that they are the primary sexuality educators of their children.[80] Oftentimes in the name of tradition or religion, parents deliberately eschew talking to their young ones or even pass wrong messages across to adolescents that may

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76. *See id.* at 95 (developing the broadest possible framework of sexual rights as a way to coalesce the largest and most diverse array of people together for the purpose of making changes in the society and protecting those outside the cultural norm).

77. *See* AKIM J. MTURI, POPULATION AND POVERTY STUDIES PROGRAMME, SCHOOL OF DEVELOPMENT STUDIES, UNIVERSITY OF NATAL, PARENTS' ATTITUDES TO ADOLESCENT SEXUAL BEHAVIOUR IN LESOTHO 1–2 (2001) (talking to parents about their knowledge regarding the sexual activities of their children).

78. *See* INTERNATIONAL WOMEN'S HEALTH COALITION, ON HEALTH AND RIGHTS, YOUNG ADOLESCENTS' SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS: SUB-SAHARAN AFRICA 3 (2007) (noting a great lack of sex education for all adolescents, but especially for girls).

79. *See* Jane Hughes & Ann P McCauley, *Improving the Fit: Adolescents' Needs and Future Programs for Sexual and Reproductive Health in Developing Countries*, 29 STUD. IN FAM. PLAN. 233, 234 (1998) (noting that both parents and children see parents as the preferred source of information on sexual health, but that parents are unprepared to give it).

80. *See* MTURI, *supra* note 77, at 1–2 (indicating that parents are preferred and influential sources of sexual health information).

confuse or even mislead them.[81] But the truth remains that adolescents want to be talked to by their parents or guardians.[82] This desire for communication between parents and adolescents is captured in a plaintive plea by a fourteen-year old girl from Botswana: "In my country Botswana, there is a serious problem of communication between parents and their children. This is a cry from our hearts. Parents talk to us! Without your communication, guidance, and dialogue we are a lost generation."[83]

Moreover, adolescent girls are censured from seeking information about their sexuality and any girl that defies this censure is tagged "irresponsible," "immoral," and unsuitable for marriage.[84] There is often the fear that exposing unmarried adolescent girls to information with regard to their sexual health is more or less a license for promiscuity in society.[85] Such negative societal norms and values about adolescent girls are often used as a veritable weapon of social control of women and their sexuality.[86] Additionally, these negative societal norms are causing unnecessary suffering and harm to the health of adolescents generally, and female adolescents in particular.[87] It is little wonder then that rather than relying on information from parents or guardians, studies have shown that most adolescents look elsewhere for information in regards to their sexuality.[88]

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81. *See id.* at 7–8 (stating several reasons parents gave for why they do not talk to their children about sex).

82. *See* Hughes & McCauley, *supra* note 79, at 234 (describing how many children would like their parents to be their primary source of information on sexual health).

83. UNAIDS, FORCE FOR CHANGE: WORLD AIDS CAMPAIGN WITH YOUNG PEOPLE 7, *available at* data.unaids.org/publications/IRC-pub03/ffc_en.pdf (1998).

84. *See* Charles Nzioka, *Dealing with the Risks of Unwanted Pregnancy and Sexually Transmitted Infections Among Adolescents: Some Experiences from Kenya*, 5 AFR. J. REPROD. HEALTH 133,145 (2001) (discussing how Kenyan youth are generally aware of how to avoid risky sexual behavior but have difficulty doing so in practice).

85. *See* Verónica Shiappacasse & Soledad Diaz, *Access to Emergency Contraception*, 94 INT'L J. GYNEC. & OBSTET. 301, 302 (2006) (noting the common presumption that educating adolescents about sexual health encourages promiscuity).

86. *See* Akosua Adomako Ampofo, *"When Men Speak Women Listen"; Gender Socialisation and Young Adolescents' Attitudes to Sexual and Reproductive Issues* 5 AFR. J. REPROD. HEALTH 196, 198 (2001) (analyzing the effects of gender roles and stereotypes on the interactions of sexually active adolescents).

87. *See* CENTER FOR REPRODUCTIVE RIGHTS (CRR), BRIEFING PAPER: THE PROTOCOL ON THE RIGHTS OF WOMEN IN AFRICA; AN INSTRUMENT FOR ADVANCING REPRODUCTIVE AND SEXUAL RIGHTS 1 (2006) (discussing the many health risks faced by adolescent girls in Africa).

88. *See* Ogoh Alubo, *Adolescent Reproductive Health Practices in Nigeria*, 5 AFR. J. REPROD. HEALTH 109, 117 (2001) (addressing the common practice among Nigerian adolescents of exchanging folk remedies for sexual health problems among peers, rather than visiting health clinics).

For instance, a study has shown that most adolescents' source of information about sexuality is from either their peers or the media.[89]

Furthermore, a study conducted in Lagos, Nigeria has shown that adolescents' education levels are crucial to their knowledge of preventative factors that can predispose them to sexual and reproductive ill health.[90] The more educated an adolescent, the better his/her chances of taking precaution to prevent unwanted pregnancies and STIs and vice versa.[91] Similarly, another study has shown that poverty and lack of resources can play a major role in determining access to health care services such as sexual health services for adolescents.[92] The issue of cost in regard to sexual health services for adolescents can be particularly challenging in a world where it was estimated in 2000 that approximately 22.5% of young people worldwide were living below one United States Dollar (USD) per day.[93] Nearly 90% of these young people live in developing countries including Africa.[94] Of the number of young people living in sub-Saharan Africa, it is estimated that about sixty million of them live in extreme poverty,[95] and less than five percent of these poorest young people worldwide are currently using a method of contraception.[96] The implication of this is that most adolescents will have to depend on their parents for health care services.

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89. *See* Adegbenga M. Sunmola et al., *Reproductive, Sexual and Contraceptive Behaviour of Adolescents in Niger State, Nigeria*, 6 AFR. J. REPROD. HEALTH 82, 87 (2002) (discussing the large percentage of adolescents who rely on peers for information on contraceptive measures); *see also* Hughes & McCauley, *supra* note 79, at 234 (noting that young people rely primarily on friends and the media for information on sexual health and practices).

90. *See* Munirat Ayoka Ogunlayi, *An Assessment of the Awareness of Sexual and Reproductive Rights among Adolescents in South Western Nigeria*, 9 AFR. J. REPROD. HEALTH 99, 108 (2005) (noting the strong correlation between lack of education and a lack of knowledge on reproductive issues).

91. *See id.* (analyzing statistics which showed education and knowledge about sexual health were directly correlated).

92. *See* Alubo, *supra* note 88, at 117 (indicating that adolescents would use health services facilities rather than folk remedies if health services was less expensive and more available).

93. *See* DE BRUYN & PARKER, *supra* note 4, at 7 (discussing the risk of pregnancy and STDs among adolescent girls in Africa, and how it is complicated by extreme poverty).

94. *See id.* (breaking down the number of youths living in developing countries and in extreme poverty).

95. *See id.* (contributing to the severe risk of STD and unintended pregnancies facing poor adolescents in Africa).

96. *See id.* (indicating that lack of access to healthcare forces many African adolescents to rely on folk remedies which are often ineffective or dangerous).

B. Barriers in the Health Care Setting

It is ironic to note that the health care institution that ought to serve as a beacon of hope to adolescents has turned out to be a place of disillusionment for them, partly because of the judgmental attitudes of health providers and unfriendly nature of the health setting itself.[97] While studies have identified the health care institution as a possible place where adolescents can seek information and services on sexual health including contraception, many adolescents are avoiding use of the health care institution for this purpose.[98]

Most adolescents often shy away from seeking advice on sexual health from health care providers because they fear they might be misunderstood or misjudged.[99] Adolescents are quite sensitive to their surroundings especially when they have become sexually active, hence, they tend to show some discomfort when they are not certain this fact will be kept away from their parents or guardians.[100] While commenting on challenges in the health care sector hindering access to emergency contraception (EC) in developing countries, Verónica Shiappacasse and Soledad Diaz have observed that lack of privacy, unfriendly attitudes towards adolescents, and high cost of the EC are stumbling blocks to adolescents' access to the product.[101]

Gemma Hobcraft and Tanya Baker have identified four major barriers to adolescents' access to sexual and reproductive treatment in the health care setting:[102] (1) poor remuneration of health care providers; (2) a

97. *See* Hughes & McCauley, *supra* note 79, at 234–35 (noting that clinic personnel may not approve of adolescents seeking health care information, and may refuse to give it to them or chastise them for trying to get it).

98. *See* MARY AMUYUNZU-NYAMONGO ET AL., THE GUTTMACHER INSTITUTE, QUALITATIVE EVIDENCE ON ADOLESCENTS' VIEW ON SEXUAL AND REPRODUCTIVE HEALTH IN SUB-SAHARAN AFRICA, ORIGINAL REPORT NO. 16, 36–37 (2005) (discussing problems like inconvenience, cost, and health care worker attitudes which keep adolescents from seeking their advice or help).

99. *See* Annabel S. Erulkar et al., *What is Youth-Friendly? Adolescents' Preferences for Reproductive Health Services in Kenya and Zimbabwe,* 9 AFR. J. REPROD. HEALTH 51, 52 (2005) (noting that young people are often made to feel unwelcome at clinics when they seek sexual health care).

100. *See id.* (discussing factors that adolescents seeking sexual health advice value the most when deciding whether to seek or not seek health care).

101. *See* Shiappacasse & Diaz, *supra* note 85, at 302–03 (citing an often hostile attitude towards adolescents who seek sexual health care and a feared inability to treat them privately as roadblocks to adequate health care).

102. *See* G. Hobcraft & T. Baker, *Special Needs of Adolescents and Young Women in Accessing Reproductive Health: Promoting Partnership Between Young People and Health*

working environment poorly equipped to deal with young people; (3) personal biases of health care providers; and (4) uncoordinated parallel programs in the health care system.[103] These concerns are neither limited to EC nor to developing countries, they also apply to other forms of sexual health services and to developed countries as well.[104] For instance, a study with middle high school students in Los Angeles, California, has found that although there is a significant increase in knowledge, this has not translated into better sexual behavior or increase in contraceptive use.[105]

Experience has shown that sometimes health care providers exhibit little knowledge or skill with regard to responding to adolescents' sexual health needs including access to contraceptive services.[106] In some cases the environment may appear too cold for adolescents' comfort.[107] This situation often puts adolescents in a dilemma and sometimes betrays their confidence in the health care system so that they are reluctant to seek sexual health advice even when in dire need.[108] Furthermore, health care institutions are sometimes located far away and operate at times when adolescents cannot visit them, which can be frustrating for adolescents.[109]

Care Providers, 94 INT'L J. GYNEC. & OBSTET. 350, 351–53 (2006) (discussing reasons why adolescents may choose to not go to health clinics when they need to).

103. *See id.* (excerpting the progress notes of a health care professional's consultation with an adolescent to illustrate problem areas in the health care setting for young people); *see also* D. Braeken et al., *Access to Sexual and Reproductive Health care: Adolescents and Young People*, 98 INT'L J. GYNEC. & OBSTET. 172, 173 (2007) (discussing good practices for health care providers).

104. *See* Douglas Kirby et al., *An Impact of Evaluation Project* SNAPP*: An AIDS and Pregnancy Prevention in Middle School Program*, 9 AIDS EDUC. & PREVENTION, SUPPLEMENT A 44, (1997) (discussing the failures of a sexual health program in California to make a significant impact on the sexual behavior of enrolled adolescents).

105. *See id.* at 45 (analyzing the fact that even though students in a special sexual health program were more informed about sexual health matters, they did not put their knowledge into practice at a greater rate than their peers).

106. *See* Hughes & McCauley, *supra* note 79, at 234 (illustrating difficulties in the way health care providers and adolescents interact).

107. *See* AMUYUNZU-NYAMONGO, *supra* note 98, at 39–40 (detailing experiences of humiliation, shame, or lack of caring at health care centers as major reasons why adolescents do not use them).

108. *See* Press Release, Info. & Knowledge for Optimal Health (INFO) Project of the Johns Hopkins Bloomberg Sch. of Pub. Health's Center for Comm. Programs (CCP), Hopkins Report: Youth Crucial to Stopping HIV/AIDS (Dec. 12, 2001) (on file with author) (explaining that adolescents will not seek sexual health care even when at high risk of STIs).

109. *See* Erulkar et al., *supra* note 99, at 56 (noting that adolescents can be discouraged from seeking sexual health care if the clinic is too far away).

It is important not only that health care facilities be friendly to adolescents, but they must also guarantee the confidentiality of adolescents' health care matters as well. This will include an assurance that others will not find out about adolescents' visits to a health care facility and that personal information about them and their sexuality is private. This assurance is more pertinent in regard to advice on contraception for sexually active adolescent girls. Studies have confirmed that the inability of most health care facilities to assure adolescents confidential health care services has been responsible for poor use of the health care system by most adolescents.[110] These situations are common in African countries, thus confirming the serious challenge adolescents face with regard to their sexual health needs.[111] This situation calls for a drastic change and requires the commitment of African governments to advancing the sexual health needs of adolescents in the region. One way of doing this is to invoke principles and standards contained in regional human rights instruments.

V. African Regional Human Rights Instruments and Access to Sexual Health Services for Adolescents

Adopting a rights-based approach to an issue such as realizing access to sexual health information and services for adolescents is important in the sense that it provides an avenue for holding states accountable to their commitments under international law. Moreover, applying a human rights approach to an issue such as access to sexual health services for adolescents and young people ensures that these categories of people are not treated merely as objects of welfare but rights holders whose rights need to be protected and safeguarded. The most appropriate human rights instrument in the region dealing with the rights of children and adolescents is the African Children's Charter.[112] This instrument, which came into force in 1999, is greatly influenced by the provisions of the Convention on the

110. *See* Regional Office for South-East Asia, World Health Organization, Consent and Confidentiality: Increasing Adolescents' Access To Health Services for HIV and Sexual and Reproductive Health, Report Of Regional Consultation 15 (2007) (discussing legal hurdles to discussing sexual health matters with children under eighteen).

111. *See* Erulkar et al., *supra* note 99, at 52 (summarizing major complaints adolescents have with seeking information from health care centers).

112. *See African Charter on the Rights and Welfare of the Child, supra* note 25 (laying out the rights of children to be enforced in the Organization of African Unity's member states).

Rights of the Child (CRC).[113] The African Children's Charter contains a number of important provisions that can be invoked to advance access to sexual health services for adolescents in the region.[114] For instance, the instrument recognizes the twin principles of "best interests of the child"[115] and the "evolving capacities of the child"[116] which are crucial to ensuring access to sexual health information and services for adolescents.[117]

In addition to these two principles, the African Children's Charter also guarantees certain human rights of children, which are relevant in ensuring access to sexual health services for children and adolescents in the region.[118] Some of these rights include the right to health,[119] privacy,[120] information,[121] non-discrimination,[122] and life.[123] The provision on the right to health can be interpreted to obligate African governments to ensure access to sexual health services for children and adolescents in the region.[124] The provision on the right to information can be invoked to

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113. *See* Convention on the Rights of the Child, G.A. Res. 44/25, U.N. Doc. A/44/49 (Nov. 20, 1989); *see also African Charter on the Rights and Welfare of the Child, supra* note 25, at Preamble (reaffirming adherence to the UN Convention on the Rights of the Child).

114. *See* CLAUDIA AHUMADA & SHANNON KOWALSKI-MORTON, A YOUTH ACTIVIST'S GUIDE TO SEXUAL AND REPRODUCTIVE RIGHTS 12–13 (The Youth Coalition) (2006) (advancing the idea that the right to health specifically includes sexual and reproductive health).

115. *See African Charter on the Rights and Welfare of the Child, supra* note 25, Art. 4 (affirming the need for authorities determining the best interests of a child to consider the child's wishes when possible).

116. *See id.* Art. 9.2 (affirming a child's freedom of thought, conscience, and religion).

117. *See* AHUMADA & KOWALSKI-MORTON, *supra* note 114, at 23 (noting that "best interests" and "evolving capacities," within the context of the Children's Rights Convention, means that children are entitled to privacy with regards to their sexual and reproductive health).

118. *See* AHUMADA & KOWALSKI-MORTON, *supra* note 114, at 12 (noting Article 14 of the African Children's Charter, among other relevant charters, as protecting health rights of children).

119. *See African Charter on the Rights and Welfare of the Child, supra* note 25, Art. 14 (providing that children have a right to best physical health, and commanding signatory states to ensure access to health care).

120. *See id.* Art. 10 (providing for legal protection against unlawful intrusions into a child's privacy).

121. *See id.* Art. 9 (providing for protections for freedom of thought, conscience, and religion).

122. *See id.* Art. 3 (providing for the protection of children regardless of background).

123. *See id.* Art. 5 (providing for state protection of the lives of children and exempting them from the death penalty).

124. *See* WORLD HEALTH ORGANIZATION (WHO), REGIONAL OFFICE FOR THE EASTERN MEDITERRANEAN, HEALTH AND HUMAN RIGHTS: AFRICAN CHARTER ON THE RIGHTS AND

obligate governments to ensure access to sexual health education for young people to prevent the consequences of sexual ill health.[125] The African Committee of Experts on the Rights and Welfare is saddled with the responsibility of monitoring the implementation of the African Children's Charter. However, this body has just recently been constituted and is yet to provide clarifications on the nature and contents of rights contained in the African Children's Charter.[126]

Furthermore, it should be noted that the principal human rights treaty in the region, the African Charter, contains important provisions that can be invoked to ensure access to sexual health information and services for young people.[127] These include the right to health,[128] equality and non-discrimination,[129] dignity,[130] information,[131] life,[132] and so on. However, one of the criticisms against these two instruments is the fact that they are too generally worded and gender-neutral in nature.[133] Despite the fact that women, especially young women, continue to bear the greatest percentage

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WELFARE OF THE CHILD 3 (discussing indirect linkages to health in the African Children's Charter).

125. *See* AHUMADA & KOWALSKI-MORTON, *supra* note 114, at 12–13 (noting that the right to health implies a right to health services, which must give adolescents consultations on reproductive and sexual health issues).

126. *See* Benyam D. Mezmur & Julia Sloth-Nielsen, *An Ice-Breaker: State Party Reports and the 11th Session of the African Committee of Experts on the Rights and Welfare of the Child*, 8 AFR. HUM. RTS. L.J. 596, 605–612, (2008) (discussing the possibility that the brief meeting served as an ice-breaker and heralded future progress); *see also* Amanda Lloyd, *Evolution of the African Charter on the Rights and Welfare of the Child and the African Committee of Experts: Raising the Gauntlets*, 10 INT'L. J. CHILD. RTS. 179, 186 (2002) (giving a general overview of the Charter and its history, as well as ways it could benefit African children).

127. *See* Amnesty Int'l, *A Guide to the African Charter on Human and Peoples' Rights*, AI Index IOR 63/005/2006, Oct. 19, 2006 (noting that laws pertaining to health must respect women's sexual and reproductive rights).

128. *See African Charter on Human and Peoples' Rights*, *supra* note 26, Art. 16 (recognizing the right to the best attainable health, and the state's role in providing for it).

129. See *id.* Arts. 2–3 (recognizing that the provisions of the Charter are available to all, and that all are equal before it).

130. *See id.* Art. 5 (recognizing the general dignity of human life and prohibiting infringements like slavery or torture).

131. *See id.* Art. 9 (recognizing the right to receive information and give opinions).

132. *See id.* Art. 4 (recognizing the integrity of each person and forbidding the arbitrary deprivation of life).

133. *See* ROSEMARY S. MUKASA, THE AFRICAN WOMEN'S PROTOCOL: HARNESSING A POTENTIAL FORCE FOR POSITIVE CHANGE 7 (Oxfam 2008) (discussing how embracing African traditions wholesale leads to the sanctioning of traditionally discriminatory practices).

of people suffering from sexual ill health in the region, neither of these instruments have given enough attention to the protection of women's rights.[134] In particular, the African Charter is said to contain provisions which give preference to customary practices over women's rights and only makes reference to women once.[135] Indeed, it has been argued that the African Charter protects African culture at the expense of women by, for example, not specifically addressing issues related to harmful traditional practices against women.[136]

On the other hand, the African Children's Charter is criticized for failing to adequately protect the rights of girls in the region.[137] For instance, its provision on non-discrimination, which is couched in a similar version as that of the CRC, has been criticized for being gender-insensitive and blind to adolescent girls' sufferings.[138] Moreover, the African Children's Charter omitted a provision on HIV/AIDS or even on contraceptive use for adolescents in the region, despite the fact that the HIV pandemic had become a serious problem for Africa when the Children's Charter was drafted in the 1990s.[139] These shortcomings necessitated the drafting of a new instrument on women's rights for the region.[140] For many women's rights activists in the region, the need for a human rights

134. *See* Rachael Murray, *A Feminist Perspective on Reform of the African Human Rights System*, 2 AFR. HUM. RTS. L.J. 205, 206 (2001) (mentioning the provisions of the African Charter are very broad and make only casual reference to women specifically).

135. *See id.* (discussing the limited sections of the Charter which refer directly to women).

136. *See id.* at 208–09 (discussing the Charter's disappointingly small effect on traditional practices like female genital mutilation); *see also* Manisuli Ssenyonjo, *Culture and the Human Rights of Women in Africa: Between Light and Shadow*, 1 J. AFR. L. 39, 44 (2007) (noting the tension between traditional practices and women's rights).

137. *See* DAVID MUGAWE ET AL., BORN TO HIGH RISK: VIOLENCE AGAINST GIRLS IN AFRICA 7 (Lucy Southwood & Katie Taft, eds., 2006) (documenting the extreme risks of violence African girls face despite the protection of the African Children's Charter and other international treaties).

138. *See* Deirdre Fottrell, *One Step Forward or Two Steps Sideways? Assessing the First Decade of the United Nations Convention on the Rights of the Child*, *in* REVISITING CHILDREN'S RIGHTS: 10 YEARS OF THE UN CONVENTION ON THE RIGHTS OF THE CHILD 1, 10 (Dierdre Fottrell ed., 2000) (pointing out the inadequate protections afforded girls by the CRC, which served as an inspiration for the African Children's Charter).

139. *See* Polly R. Walker et al., *Sexual Transmission of HIV in Africa*, 422 NATURE 679 (2003) (noting that during the 1990s the rate of HIV infections in South Africa increased roughly twenty-five percent).

140. *See* Danwood M. Chirwa, *Reclaiming (Wo)manity: The Merits and Demerits of the African Protocol on Women's Rights*, NETH. INT'L L. REV. 63, 68 (2006) (discussing how insufficient protections of women's rights lead to the adoption of the African Women's Protocol).

instrument specifically addressing women's and girls' rights was long overdue.[141] Thus, the coming into force of the women's rights activist in Africa was viewed as a beacon of hope to women and girls in the region.[142]

VI. Relevant Provisions of the Protocol Applicable to Adolescents' Access to Sexual Health Information and Services

The African Women's Protocol is a product of rigorous and consistent activism on the part of several women's organizations and civil society groups in Africa.[143] The agitation for a women specific human rights instrument in Africa was mainly due to the failure of the principal human rights instrument in the region, the African Charter, to explicitly address the needs of women.[144] Although as stated earlier, certain provisions of the African Charter such as the provision on equality and non-discrimination can be invoked indirectly to apply to women's rights, the African Charter generally addresses individual and peoples' rights and contains very scanty provisions to address gender inequality experienced by women in the region.[145] Article 18(3) of the Charter, which is the only provision specifically proscribing discrimination against women in the Charter, has been found inadequate to meeting the challenges faced by African women.[146] Thus, women's rights were continuing to be violated without redress.[147]

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141. *See* Murray, *supra* note 134, at 205–06 (discussing failures of previous human rights documents to address women's issues and the need for on specifically tailored to their needs).

142. *See* Chirwa, *supra* note 140, at 64 (describing how gender activists proclaimed the adoption of the African Women's Protocol as a landmark moment for the rights of women).

143. *See* ROSEMARY M. MUKASA, THE AFRICAN WOMEN'S PROTOCOL: HARNESSING A POTENTIAL FORCE FOR POSITIVE CHANGE 4–5 (Fanele, 2008) (noting the advocacy of Oxfam, among others, in making the African Women's Protocol a reality).

144. *See* Murray, *supra* note 134, at 206 (noting the failure of the Charter to specifically address women's issues and its subsequent failure to adequately address them).

145. *See id.* (concluding that the African Charter has not done any more to affect women's rights than any other broadly-worded human rights document).

146. *See id.* (discussing how the section deals primarily with discrimination, and only briefly mentions women at the end).

147. *See* Fareda Banda, *Blazing a Trail: The African Protocol on Women's Rights Comes Into Force*, 50 J. AFR. L. 72 (2006) (pointing out the failure of previous human rights charters to adequately protect women's rights).

These gaps in the African Charter led to the drafting and adoption of the Women's Protocol in 2003.[148] It eventually came into force on the 25th of November 2005 after fifteen African States ratified the Protocol.[149] The Protocol was greatly influenced by the provisions of the CEDAW and other consensus documents such as the Vienna Programme of Action, the UN Declaration on Violence against Women, International Conference on Population and Development and the Beijing Declaration and Programme of Action.[150] More importantly, the Protocol contains radical and ground-breaking provisions more than the CEDAW.[151] It aims at rooting out the disadvantaged status suffered by women and girls in Africa, by boldly addressing specific burning issues affecting women.[152] It strongly recognises and safeguards the crucial role of women in the preservation of African values based on the principles of equality, peace, freedom, dignity, justice, solidarity, and democracy.[153] Indeed, Mukasa has asserted that by the provisions of the Protocol, it can no longer be said that "women's rights are transplants from the western world with no roots in African values and norms."[154] In a nutshell, the Protocol is a homegrown human rights instrument "developed by Africans for African women."[155]

The African Women's Protocol aims at holistically addressing discriminatory practices against African women.[156] The Protocol, highlighting the implications of such practices to women's health, provides that any practice that hinders or endangers the normal growth; and affects

148. *See* MUKASA, *supra* note 143, at 4 (addressing gaps in the African Charter and the Role that the Women's Protocol should play in fixing them).

149. *See id.* (describing the large role NGOs played in getting countries to ratify the protocol).

150. *See id.* at 7–8 (noting how the Women's Protocol was drafted with the influence of these documents but also in response to some of their perceived failings).

151. *See id.* (identifying new areas addressed by the Women's Protocol, like HIV/AIDS and reproductive rights, that were not addressed by CEDAW).

152. *See* Chirwa, *supra* note 140, at 96 (listing some of the critical issues addressed by the Women's Protocol, like conflicts between gender and family rights and female genital mutilation).

153. *See* Banda, *supra* note 147, at 75 (noting that while the African Charter only mentioned African principals in vague terms, they are specifically named in the Women's Protocol).

154. *See* MUKASA, *supra* note 143, at 5 (noting that the Women's Protocol addressed issues unique to Africa, like female genital mutilation).

155. *Id.*

156. *See* Chirwa, *supra* note 140, at 88 (noting the Women's Protocol's approach to rights as one of joining them together as opposed to viewing them as separate, distinct rights).

the physical and psychological development of; women and girls should be condemned and eliminated.[157] It defines broadly in its preamble the word "women" to include girls.[158] This is a welcome development as the numerous rights guaranteed under the instrument will equally apply to adolescent girls. Some of the important provisions relevant to advancing access to sexual information and services to adolescents are discussed below. The focus here is on the Protocol itself, but when necessary, reference is made to the interpretation provided by treaty monitoring bodies on some of these rights. Also reference to consensus statements on these rights will be made as they tend to shed light on the nature of commitment expected from states.

A. The Right to Health

This implies the right of an individual to the highest attainable standard of physical and mental health.[159] It broadly encompasses sexual and reproductive health of an individual.[160] Under Article 14 of the Women's Protocol, states are required to "ensure that the right to health of women, including the sexual and reproductive health of women, is respected and promoted."[161] In addition, states should respect and promote:

> (a) the right to control their fertility;
>
> (b) the right to decide whether to have children, the number of children and the spacing of children;
>
> (c) the right to choose any method of contraception;
>
> (d) the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS;(e) the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognized standards and best practices;

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157. Protocol, *supra* note 27, Art. 14.

158. *See id.* Art. 1 (including a definition of women as all female persons, including girls).

159. *See id.* Art. 14 (protecting a right to health, which is defined as encompassing sexual and reproductive health as well).

160. *See id.* (assuring a right to health that is defined in Article 14 primarily by its protections of sexual and reproductive rights).

161. *Id.*

> (e) the right to have family planning education.[162]

Similarly, state parties are expected to take appropriate measures to:

> (a) provide adequate, affordable and accessible health services, including information, education and communication programs to women, especially those in rural areas;
>
> (b) establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding.[163]

By these elaborate and radical provisions, the African Women's Protocol has become a pace-setter under international human rights law as the first human rights instrument that clearly recognizes women's sexual and reproductive health as human rights and contains specific provisions on women's protection in the context of HIV/AIDS and access to contraception.[164] In a region where about 60% of HIV infection prevalence is among women, and deaths and morbidities associated with early pregnancy are rife, Article 14 will no doubt serve the interest of women and girls in the region.[165] Banda submits that by these provisions, the African Women's Protocol has blazed the trail in terms of explicit recognition of sexual and reproductive rights of women.[166] Since the African Women's Protocol applies to all women, including girls; it becomes one of the strongest human rights instruments that can be invoked to support female adolescents' right to access sexual health information and services.[167] It clearly accords female adolescents the autonomy with regard to their sexual health needs.

Though provisions of Article 14 of the Protocol are similar to that of Articles 16 and 14 respectively of the African Charter and the African

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162. *Id.*

163. *Id.*

164. *See* CRR BRIEFING PAPER, *supra* note 87, at 7 (noting that HIV/AIDS is not mentioned in other international human rights documents); *see also* Ebenezer Durojaye, *Advancing Gender Equity in Access to HIV Treatment Through the Protocol on the Rights of Women in Africa*, 6 AFR. HUM. RTS. L.J. 188, 195 (2006) (noting that HIV/AIDS is discussed as a problem specifically harmful to women).

165. *See id.* at 189 (identifying women as comprising 57% of people infected with HIV).

166. *See* Banda, *supra* note 147, at 72 (going so far as to use the term "blazing" in his article's title).

167. *See* Protocol, *supra* note 27, Arts. 1, 14 (defining women to include adolescents, and commanding that women be given access to sexual health information and services, meaning those same requirements apply to young girls).

Children's Charter, they are nonetheless more detailed than either of these instruments.[168] Explaining the significance of Article 16 of the African Charter, the African Commission in the *Purohit* case has held that "[e]njoyment of the human right to health as it is widely known is vital to all aspects of a person's life and well-being, and is crucial to the realisation of all the other fundamental human rights and freedoms."[169] It states further that this right includes the right to health facilities, access to goods and services to be guaranteed to all without discrimination of any kind.[170]

The African Women's Protocol in its Article 14(2) has adopted a standard similar to that of the Committee on ESCR with regard to states' obligations regarding the right to health.[171] The Protocol obligates African governments to ensure adequate, affordable, and accessible health care services, including sexual health services to all women.[172] The Committee on ESCR in its General Comment 14, while clarifying the content of the right to health, has urged states to provide access to comprehensive sexual and reproductive health care services (including access to contraception) for adolescents.[173] The Committee has noted that health care services, including sexual and reproductive health care services, must be adequate, accessible, affordable and of good quality to all, especially vulnerable groups such as women and adolescents.[174] The notion of accessibility implies physical,

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168. *Compare* Protocol, *supra* note 27, Art. 14 (detailing the kinds of sexual health services required for all women), *with* African Charter on Human and Peoples' Rights, *supra* note 26, Art. 16 (describing a very broad right to mental and physical health), *and African Charter on the Rights and Welfare of the Child, supra* note 25, Art. 14 (concerning primarily infant health and primary care).

169. Purohit and Moore v. The Gambia, African Comm. Hum. & Peoples' Rights, Comm. No. 241/2001 80 (May 29, 2003) (concerning a case against Gambia. The suit alleged that the Gambian Lunatic Detention Act made no definition of who qualified as a lunatic, and that furthermore conditions were substandard and in violation of the African Charter. The judgment was for the plaintiffs).

170. *See id.* (noting that Article 18(4) of the African Charter requires special care be given to the infirm and the aged according to their specific need).

171. *See* Banda, *supra* note 147, at 82 (requiring States to give women access to sexual health services and information, especially in rural areas).

172. *See id.* (noting that some parts of the requirement are controversial, such as requiring abortions be provided in certain cases).

173. *See* U.N. ECON. AND SOC. COUNCIL [ECOSOC], COMMITTEE ON ECON., SOC., AND CULTURAL RTS, *Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights, General Comment No. 14 (2000)*, ¶ 23 U.N. DOC. E/C/12/2000/4 (Aug. 11, 2000) (describing these services as part of the overall requirement to provide for the highest standards of health for adolescents).

174. *See id.* at ¶ 12(b) (defining the term "accessibility" within the context of the committee report and its goals and purposes).

economic, and information accessibility.[175] In other words, barriers relating to costs, distance, or unfriendly nature of health care services for adolescents must be removed. Equally, adequate information on services, including sexual health goods and facilities, must be made accessible to adolescents.

In its General Comment 4 the Committee of the CRC has urged states to develop and implement programs that ensure provision of sexual and reproductive health services, including access to contraception for adolescents.[176] The Committee further imposes obligations on states to ensure that health facilities, goods and services (including contraception) are of good quality and are sensitive to the specific needs of adolescents.[177] Also, in one of its Concluding Observations to Belize, the Committee has noted with great concern the high teenage pregnancy rate existing in the country and therefore urged the government of Belize to "ensure access to reproductive healthcare services to all adolescents" in the country.[178] A health care service that is sensitive to the needs of adolescents must no doubt respect their autonomous decision-making powers to seek information and services related to their sexual health. It would therefore seem that the elaborate and radical provisions of Article 14 of the Women Protocol must be interpreted in the light of the clarifications provided by the treaty-monitoring bodies above.

Despite the fact that the provisions of Article 14 have been hailed as groundbreaking, it has been criticized for its stereotypical approach to women's and girls' sexuality.[179] For instance, a commentator has expressed

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175. *See id.* (noting the overlapping dimensions of accessibility, how they interact, and how they should be implemented).

176. *See* UN Committee on the Rights of a Child (CRC), *General Comment No. 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child*, 33d Sess., ¶ 26, CRC/GC/2003/4 (May 19, 2003) (arguing that if sexual healthcare services are made available to adolescents, adolescents must in turn be properly educated about those services to best prevent the spread of sexually transmitted diseases).

177. *See id.* at ¶ 39(c) (obligating the states with measures to, "ensure that health facilities, goods, and services, including counselling (sic) and health services for mental and sexual and reproductive health, of appropriate quality and sensitive to adolescents' concerns are available to all adolescents.").

178. *See* UN Committee on CRC, *Concluding Observations: Belize*, ¶ 55 UN Doc CRC/C/146 (July 19, 2005) (recommending a stronger implementation of sexual and reproductive healthcare policy).

179. *See* Mashood A. Baderin, *Recent Developments in the African Regional Rights System*, 5 HUM. RTS. L. REV. 117, 122–23 (2005) (critiquing the Protocol's less than affirmative stance on enforcing equal marital rights, most markedly its failure to prohibit polygamy).

dissatisfaction with the manner the Protocol treats issues such as sexuality and marriage, especially polygamy and maternity.[180] It is argued further that the African Women's Protocol equates being a woman with reproduction and thus emphasizes reproductive health concern at the expense of reproductive rights.[181] Thus, Article 14 of the Protocol merely conceives a woman's and girl's sexuality from the typical child-bearing position. Moreover, the issue of sexuality is only addressed as a public health challenge laying emphasis on protection of women from sexually transmitted infection including HIV/AIDS.[182] Article 14 fails to affirm the positive rights of women and girls to express their sexual autonomy.

B. The Right to Information and Education on Sexual Health

The right to the freedom of information is a recognized right under international law which can be invoked to ensure access to sexual health information to adolescents in Africa.[183] Provisions of human rights instruments on the right to education are often invoked to support the need to provide adolescents information in relation to their sexuality.[184] The African Women's Protocol does not contain a specific provision with regard to the right to information, however, under Article 12 the right of all women to education on equal basis with men is adequately guaranteed.[185] This provision also enjoins African governments to "promote literacy

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180. *Id.*

181. *See* MUKASA, *supra* note 133, at 5 (highlighting the general failures of the Protocol in comparison to its overall progressiveness and likelihood of success).

182. *See* Protocol, *supra* note 27, Art. 14 (stating, for example, that women have the right to "be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices").

183. *See* Universal Declaration of Human Rights, G.A. Res. 217A, at 71, U.N. GAOR, 3d Sess., 1st plen. Mtg., U.N. Doc. A/810 (Dec. 12, 1948) (proclaiming that "[e]veryone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers").

184. *See* Rebecca J. Cook, *Human Rights and Reproductive Self-Determination*, 44 AM. U. L. REV. 975, 979 (1994–1995) (noting that most countries have committed themselves to respect human dignity, which often includes a respect for reproductive rights by way of the followed human rights instrument's declaration for education rights).

185. *See* Protocol, *supra* note 27, Art. 12 (ordering all states to "eliminate all forms of discrimination against women and guarantee equal opportunity and access in the sphere of education and training").

among women."[186] The promotion of literacy would no doubt necessarily include information related to the sexual health needs of female adolescents. In a region where great disparity exists between boy and girl enrolment in schools and where sex education remains a contentious issue, this provision provides a good opportunity to bridge the enrolment gap and to equip girls with sexual health education.

Studies have shown that although more girls than ever before are in school in Africa, the number of girls in schools are fewer compared with boys.[187] While it is agreed that factors other than knowledge influence young people's sexual behaviours, schools nevertheless provide a good avenue for young people to acquire knowledge with regard to their sexual health.[188] Moreover, there is evidence to support the fact that formal education does appear to improve adolescents' capability to make healthy decisions, as this has a positive link with behaviour such as use of contraception.[189]

Realizing the importance of education to the growth and development of girls, the African Women's Protocol in Article 12(2)(c) provides that states shall "promote the enrolment and retention of girls in schools and other training institutions and the organization of programs for women who leave school prematurely".[190] This provision will no doubt benefit adolescent girls in the region as school provides opportunity for a great number of young people to be reached and equipped with vital knowledge and information regarding their sexuality.[191] More specifically, Article 14(1) provides that states shall guarantee women the right to have family-planning education.[192] Also, Article 14(2)(a) obligates African

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186. *Id.*

187. *See* Sharon Lafranire, *Another School Barrier for African Girls: No Toilet*, N.Y TIMES, Dec. 23, 2005, at A1 (reporting on the general inequalities of sub-Saharan African girls' educations, and the specific trend of depriving them of adequate bathroom facilities).

188. *See* BIDDLECOM, *supra* note 2, at 24, (providing numerous reasons as to why schools are perhaps the best forum for educating young Africans about their sexual health).

189. *See id.* (arguing that school is an appropriate location for the distribution of contraceptives).

190. Protocol, *supra* note 27, Art. 12(2)(c).

191. *See* Robert Araujo, *Sovereignty, Human Rights, and Self-Determination: The Meaning of International Law*, 24 FORDHAM INT'L L. J. 1477, 1511 (2000–2001) (noting that internationally imposed sexual education in Africa will greatly expose adolescents to information and knowledge concerning sexual healthcare, but in doing so, will likely obstruct parental rights to control what their children learn).

192. *See* Protocol, *supra* note 27, Art. 14(1) (giving women "the right to have family planning education").

governments to provide information, education and communication programs to all women, particularly those in the rural areas.[193] These provisions clearly impose obligations on African governments to ensure access to sexual health information for female adolescents in the region. Therefore, the current situation in which adolescents, especially female adolescents in the region, are denied sex education in the name of religion and morality is a violation of the rights of adolescents.

In explaining the importance of the right to education under Article 10 of the ICESCR, the Committee on ESCR in its General Comments 13 has reasoned that education must be provided for all and must adapt to the changing societies.[194] This can be interpreted as ensuring access to health education needed for the development of adolescents.[195] Indeed, the Committee in some of its Concluding Observations has interpreted the provision on the right to education to also include sexual health education.[196] Similarly, the Committee has linked lack of sexual health education to high incidence of unwanted pregnancies and abortion.[197] Also, the Committee on CRC in its General Comment 1 on the Aims of Education has adopted a holistic approach to education so as to encompass certain life skills needed by children to develop a healthy lifestyle, good social relationships, and responsibility, which are crucial to their life options.[198]

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193. *See id.* Art. 14(2)(a) ("States Parties shall take all appropriate measures to . . . provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas.").

194. *See* International Covenant on Economic, Social and Cultural Rights, *General Comment 13: The Right to Education*, 21st Sess. E/C.12/1999/10 (Aug. 12, 1999) (addressing the basic right to universal education and suggesting methods for its institution).

195. *See* Corinne A Parker, *Preventing Adolescent Pregnancy: The Protection Offered by International Human Rights Law*, 5 INT'L J. CHILD. RTS. 47, 56 (1997) (noting the rights to obtain information about family planning and sexual healthcare).

196. *See* UN Committee on Economic, Social and Cultural Rights, *Concluding Observations: Cameroon*, 41st–43rd mtgs., ¶ 45, U.N. Doc.E/C.12/1/Add.40 (Dec. 2, 1999) (urging state review of health policies "in order to address . . . maternal mortality, adolescent pregnancies and the HIV/AIDS epidemic. In this respect, the Committee also urges the Government to review its family planning policies with a view to increasing access to information concerning contraceptives through *educational programmes*.") (emphasis added).

197. *See* Center for Reproductive Law and Policy (CRLP) and Child and Law Foundation (CLF): *State of Denial: Adolescents' Reproductive Health in Zimbabwe* at 41 (2002) (stating how the Committee has interpreted different provisions of international human rights instruments).

198. *See* Committee on CRC, *General Comment 1: The Aims of Education*, ¶ 9, CRC/GC/2001/1 (Apr. 17, 2001) (addressing the obligations of state organizations in

C. The Right to Non-Discrimination

The concept of non-discrimination insists that an individual should not be treated differently from others in an adverse manner.[199] The right to non-discrimination is protected in virtually all human rights instruments.[200] With regard to adolescents, discrimination may arise where laws and polices debar access to information and services in relation to their sexuality, simply based on their age.[201] More specifically, it can amount to discrimination if access to information and services on sexual health is deliberately denied to female adolescents or adolescents in rural areas.[202]

Article 2 of the African Women's Protocol specifically calls for states to eliminate all forms of discrimination against women in the region.[203] The Protocol broadly defines discrimination in the following way: "Any distinction, exclusion or restriction or any differential treatment based on sex and whose objectives or effects compromise or destroy the recognition, enjoyment, or the exercise by women, regardless of their mental status, of human rights and fundamental freedoms in all spheres of life."[204]

This definition, inspired by a provision of CEDAW, seems to cover all aspects of human endeavors and seeks to prevent states from hiding under any disguise to perpetuate discriminatory acts against women, including girls.[205] Additionally, Article 5 of the Protocol urges states to take adequate steps and measures to eliminate harmful traditional practices, which entrench discrimination against women and girls in the region.[206] These

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planning education effective relating to their respective social contexts).

199. *See* Protocol, *supra* note 27, Art. 1(f) (defining "discrimination against women").

200. *See* Universal Declaration of Human Rights, *supra* note 183, Art. 7 ("All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination.").

201. *See* Cook, *supra* note 184, at 1009 (finding that age-specific laws requiring parental consent to access sexual healthcare services "are liable to be upheld by courts whose judges are as unaware of the phenomenon [of mature minors] as are members of the legislatures who propose and support such laws").

202. *Id.* at 989 (including rural areas as a location where discrimination severely stunts access to adequate sexual healthcare services).

203. Protocol, *supra* note 27, Art. 2(1).

204. *Id.* Art. 1(f).

205. *See* U.N. Committee on the Elimination of Discrimination Against Women (CEDAW), *General Recommendation 24: Article 12 of the Convention (Women and Health)*, 20th Sess., ¶ 29 A/54/38/Rev.1 (Jan. 19, 1999) (providing that a comprehensive state strategy will ensure universal access for women to proper healthcare services).

206. Protocol, *supra* note 27, Art. 5 (listing traditional harmful practices and suggesting

provisions are very important to address various cultural and religious practices that hinder access to sexual health information and services to women and girls in the region.[207]

The African Women's Protocol, unlike the African Children's Charter, contains broad and radical provisions relating to the sexual and reproductive health needs of women and girls in Africa.[208] For instance, as earlier mentioned, the Protocol explicitly guarantees women's sexual and reproductive rights;[209] it provides that women should be protected from STIs including HIV/AIDS;[210] it recognizes women's and girls' rights to seek contraception services;[211] and, it forbids marriage of a girl below eighteen years.[212] It may be argued, indubitably, that the provisions of the African Women's Protocol are by far the most gender-sensitive human rights instrument in the region that is potent in protecting the sexual health needs of adolescent girls.

It should be noted that under Article 2 of the African Charter it is provided that everyone is equal before the law and that no one should be discriminated against on the basis of gender, religion, political beliefs or other status.[213] Also, Article 3 guarantees every individual the right to equality and equal protection of the law.[214] The African Commission on Human and Peoples' Rights in the case of *Legal Resource Foundation v Zambia* has explained the relevance of Articles 2 and 3 of the African Charter dealing with non-discrimination and equal protection of the law. According to the Commission:

> The right to equality is very important. It means that citizens should expect to be treated fairly and justly within the legal system and be assured of equal treatment before the law and equal enjoyment of all the rights available to all other citizens. The right to equality is important

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for their condemnation and removal from society).

207. *Id.* (emphasizing the necessity of quickly eliminating such practices).

208. *See* Karen Stefiszyn, *African Union: Challenges and Opportunities for Women*, 5 AFR. HUM. RTS. L.J. 358, 378 (2005) (noting that although the violations against women articulated in the African Women's Protocol can be alleged under the African Charter, the Charter's cumbersome procedural process makes the Protocol much more effective in its comprehensiveness).

209. Protocol, *supra* note 27, Art. 14.

210. *Id.* Art. 14(1)(d).

211. *Id.* Art. 14(1)(c).

212. *Id.* Art. 6(b).

213. Organization of African Unity, *African Charter on Human and Peoples' Rights*, at 2, O.A.U. Doc. CAB/LEG/67/3.Rev 5 (June 27, 1981).

214. *Id.* at 3.

> for a second reason. Equality or lack of it affects the capacity of one to enjoy many other rights.[215]

This decision provides a strong basis for arguing that adolescents, particularly adolescent girls, should not be denied access to sexual health information and services on grounds of gender, age, or marital status. The situation whereby adolescent girls due to cultural and religious practices are denied access to sexual health information and expected to remain virgin until marriage, would need to be addressed by African governments.[216] Governments will need to strive to remove all forms of barriers to access to sexual health services to adolescents in their countries.[217]

It must be borne in mind that one of the goals of the MDGs is to address the pervading gender inequality worldwide, specifically emphasizing the importance of promoting gender equality and women's empowerment as an effective pathway to combat poverty, hunger and disease, and to stimulate truly sustainable development.[218] This can only be achieved by addressing gender inequality that exists in the area of access to sexual health services for women and girls in the region.

The Solemn Declaration on Gender Equality in Africa enjoins African countries to accelerate the implementation of gender specific economic and social programs so as to prevent the spread of STIs, including HIV/AIDS among women.[219] In addition, states are to "ensure the active promotion and protection of all human rights for women and girls, including the right to development".[220] This can be interpreted to apply to discrimination relating to access to sexual health information and services for adolescents in the region.[221] Furthermore, at the Grand Bay Declaration and Plan of Action, African governments were urged to work "assiduously towards elimination of discrimination against women and the abolition of cultural

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215. Legal Resource Foundation v Zambia, ¶ 63, Comm. No. 211/98 (2001) AHRLP 84.

216. *See* Protocol, *supra* note 27, Art. 2(2) (calling for the elimination of harmful cultural practices "which are based on the idea of the inferiority or the superiority of either of the sexes, or on stereotyped roles for women and men").

217. *See* Protocol, *supra* note 27, Art. 5 (listing many current barriers preventing adequate access to healthcare services, and calling for their eradication).

218. *See* G.A. Res. 55/2, ¶ 20, U.N. Doc A/RES/55/2 (Sept. 18, 2000) (listing its resolutions for the social, technological, and economic advancement of Africa).

219. Heads of State and Government of Member States of the African Union, *Solemn Declaration on Gender Equality in Africa*, 3d Sess., ¶ 1 (July 6, 2004).

220. *Id.* at ¶ 6.

221. *See id.* (stating states should do all things necessary to ensure that the promotion of women's rights will be protected, including the enactment of legislation).

practices which demean and dehumanize women and children."[222] This will go a long way in ensuring equal access to healthcare services, particularly sexual health services, for women and girls in the region.

D. The Right to Autonomy

The right to autonomy encompasses the right of an individual to determine his or her sexual and reproductive autonomy.[223] Although this right is not specifically guaranteed in any human rights instruments, the right nonetheless is intrinsically linked with other rights such as the right to privacy, security, liberty, and dignity.[224] These combinations of rights form the basis of an individual's right to make choices with regard to his or her sexuality.[225] They also support the fact that adolescents are entitled to seek confidential information and services with regard to their sexual health without the need for parental consent.[226] As it has been noted earlier, unless the privacy and confidentiality of adolescents is guaranteed, they may avoid seeking necessary help with regard to their sexual health.[227] It must be noted that the right to independent decision-making on the part of adolescents in the context of sexual health services inextricably intersects with their ability to exercise their right to health and dignity.[228]

Under the African Women's Protocol the right of all women to human dignity is guaranteed: Article 3 provides, "[e]very woman shall have the

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222. First OAU Ministerial Conference on Human Rights, *Grand Bay (Mauritius) Declaration and Plan of Action*, ¶ 6, CONF/HRA/DECL (Apr. 12–16, 1999).

223. *See* Sarah Y. Lai & Regan E. Ralph, *Female Sexual Autonomy and Human Rights*, 8 HARV. HUM. RTS. J. 201, 201–02 (1995) (noting that a woman's right to control her body, both sexually and reproductively, is fundamental to her dignity).

224. *See* CEDAW, *supra* note 205, at ¶ 31(e) (designating the right to autonomy as one many human rights of women).

225. *See, e.g.*, Cook, *supra* note 184, at 983 (arguing for the "[p]rotection of women's collective reproductive rights" so as to further their sexual autonomy).

226. *See* Catherine J. Ross, *Emerging Right for Mature Minors to Receive Information*, 2 U. PA. J. CONST. L. 223, 250 (1999–2000) (commenting on minors' rights to partake in sex education against their parents' wishes and noting that "the right to receive information is reinforced when it is combined with other autonomy claims protected by [a human rights instrument]").

227. *See* Shiappacasse & Diaz, *supra* note 85, at 301 (arguing for the implementation of confidentiality standards).

228. *See* Rebecca J. Cook & Bennard Dickens, *Recognising Adolescents' "Evolving Capacities" to Exercise Choice in Reproductive Healthcare*, 70 INT'L J. OF GYNEC. & OBSTET. 13, 20 (2000) (arguing that many minors are able to make mature decisions thus it is imperative that they are allowed to do so regarding their sexual health).

right to dignity inherent in a human being and to the recognition and protection of her human and legal rights."[229] As noted above, one of the barriers to access to comprehensive sexual health information and services for female adolescents in Africa is the need for parental consent.[230] When adolescents are prevented from seeking information and services with regard to their sexual health, particularly access to contraception, their dignity as human beings is impugned.[231] Dignity, unlike social honor, is not a positional good. It is supposed to be accorded to everybody, even to the one who is nobody, by virtue of the most universal common denominator of being human."[232] Carmel Shalev has similarly argued, "[t]he right to autonomy in making health decisions in general, and sexual and reproductive decisions in particular, derives from the fundamental human right to liberty."[233] All individuals, including adolescents, have the liberty to make choices with respect to their sexual health.[234] In other words, one is entitled to the recognition of one's capacity as a human being to exercise choices in the shaping of one's life.[235]

The Committee on CEDAW in its General Recommendation 24 has emphasized the need for women and girls to be assured their right to sexual and reproductive self-determination.[236] The Committee has similarly, in some of its Concluding Observations to states, called on states to recognize women and girls as autonomous decision-makers by refraining from taking any action that will obstruct their health goals.[237] Also, the Committee has

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229. Protocol, *supra* note 27, Art. 3.

230. *See* Cook, *supra* note 184, at 1009 (finding that parental consent is a significant impediment to adolescents' rights to healthcare services).

231. *See id.* ("Whatever the source of interference, adolescents who are not free to seek treatment, counseling, and protection on the same terms of confidentiality as adults suffer unjust discrimination.").

232. AVISHAR MARGALIT, THE ETHICS OF MEMORY 114 (2002).

233. Carmel Shalev, *Rights to Sexual and Reproductive Health: The International Conference on Population and Development and the Convention on the Elimination of All Forms of Discrimination against Women*, 4 HEALTH & HUMAN RIGHTS 38, 46 (2000).

234. *See African Charter on the Rights and Welfare of the Child*, *supra* note 25, Art. 14(1) ("Every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health.").

235. Isaiah Berlin, *Two Concepts of Liberty*, *in* FOUR ESSAYS ON LIBERTY 120–23 (1969) (commenting on humans' most fundamental necessity, freedom).

236. *See* CEDAW, *supra* note 205, at ¶ 14 (urging states not to obstruct women in their pursuit of healthcare, but instead monitor healthcare providers so as to prevent restraints on women's healthcare based solely on societal values).

237. *See, e.g.*, U.N. Committee on CEDAW, *Concluding Observations: Belize*, 21st Sess., 432nd–433rd, 438th mtgs., ¶ 56–57, U.N. Doc.CEDAW/A/54/38 (June 14, 1999)

pointed out the need to respect the free and informed decision making of adolescents by constantly recommending state parties to increase their access to sexual health information and services.[238]

During the ICPD it was affirmed that all individuals shall have the freedom to make personal decisions regarding their sexual and reproductive health needs.[239] More particularly, this consensus statement made reference to the fact that adolescents need to be assured of respect for informed consent, confidentiality, and privacy so as to address issues of sexual abuse and other sexual and reproductive health matters.[240] This position was reiterated at the ICPD+5 when governments were called upon to guarantee access to appropriate youth-friendly health care services, including sexual and reproductive health care to adolescents.[241] It was further agreed that such services should respect the confidentiality and privacy of adolescents.[242] A similar position was taken at Beijing where it was agreed that respect for adolescents' confidentiality and privacy in health care services is essential in guaranteeing their equality and securing their

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(finding that restrictive abortion laws have created numerous health problems for women, resulting the fifth cause of hospitalization in the state); *see also* U.N. Committee on CEDAW, *Concluding Observations: Greece*, 20th Sess., 415–416th mtgs., ¶ 207, U.N. Doc. A/54/38 (January 28, 1999) (noting that the high rate of abortions in Greece indicates a lack of information and education on contraceptives and a lack of family-planning education, putting into question the extent of funding for contraception); *see also* U.N. Committee on CEDAW, *Concluding Observations: Mauritius*, 268th & 271st mtgs., ¶ 211, U.N. Doc. A/50/38 (January 20, 1995) (noting the lack of explanation for the high teenage pregnancy rates despite improved family-planning education, but positing whether marital status may have affected family-planning availability).

238. *See* U.N. Committee on CEDAW, *Concluding Observations: Indonesia*, 377th mtg., ¶ 284(c), U.N. Doc. A/53/38 (February 2, 1998) (noting concern about a state law that requires women to prove spousal consent before having an abortion or being sterilized); *see also* U.N. Committee on CEDAW, *Concluding Observation: Turkey*, 16th Sess., 318–319th mtgs., ¶¶ 184, 196, U.N. Doc. A/52/38/Rev.1 (Jan. 17, 1997) (noting and requesting review of the state law requiring spousal consent for abortion).

239. *See Report of the ICPD*, *supra* note 1, at ¶ 7.5(a) (resolving to "ensure that comprehensive and factual information and a full range of reproductive healthcare services, including family planning, are accessible, affordable, acceptable and convenient to all users").

240. *See id.* at ¶ 7.3 ("[F]ull attention should be given to . . . meeting the educational needs of adolescents to enable them to deal in a positive and responsible way with their sexuality.").

241. U.N. General Assembly: *Overall Review and Appraisal of the Implementation of the Programme of Action of the International Conference on Population and Development*, 21st Special Sess., ¶ 73(a), U.N. Doc.A/S-21/5/Add.1 (June 30, 1999) (adopting the previous resolutions for the promotion and implementation of adolescent healthcare services).

242. *Id.* at ¶ 73(c).

future.[243] At the World Summit for Children, world leaders resolved to take action to protect the rights of children and adolescents by respecting their dignity and securing their well being.[244]

In addition to all these provisions, African governments have undertaken under Article 26(2) of the *African Women's Protocol* to adopt all necessary measures, particularly budgetary and other resources to ensure the full and effective implementation of all rights guaranteed under the Protocol.[245] This provision can be invoked to hold African governments accountable for poor or lack of sexual health services for adolescents in the region.[246] The provision is more or less a reinstatement of the commitment made by African governments in Abuja 2001.[247] At the Abuja Declaration, African governments agreed to commit at least 15% of their annual budgetary allocations to the health sector.[248] Unfortunately years after this commitment, the majority of African governments are not living up to their promise.[249]

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243. *See* Fourth World Conference on Women Beijing held on 15 September 1995 A/CONF.177/20.para 93 (finding that confidentiality is virtually non-existent and contributes to the discrimination of sexual health facing female adolescents); *see also* U.N. General Assembly, *Implementation of the Outcome of the Fourth World Conference on Women and of the Special Session of the General Assembly entitled "Women 2000: Gender Equality, Development and Peace in the Twenty-first Century"*, 55th Sess., ¶ 79(f), A/55/341 (August 30, 2000) (finding that privacy and confidentiality are indispensable factors in providing sexual and reproductive healthcare services).

244. *See* G.A. Res. S-27/2, U.N. Doc.A/RES/S-27/2 (October 11, 2002) (declaring the commitment to promote and protect the rights of children, and stating the means for doing so).

245. Protocol, *supra* note 27, Art. 26(2).

246. *See id.*, Arts. 26–29 (stating the Protocol's enforcement and implementation guidelines).

247. *See* African Summit on HIV/AIDS, Tuberculosis, and Other Related Infectious Diseases, *Abuja Declaration on HIV/AIDS, Tuberculosis, and Other Infectious Diseases*, ¶ 26, O.A.U. Doc. SPS/ABUJA/3 (April 24–27, 2001) (committing to "take all necessary measures to ensure that the needed resources are made available from all sources and that they are efficiently and effectively utilized").

248. *Id.*

249. *See* Sabelo Gumedze, *HIV/AIDS and Human Rights: The Role of the African Commission on Human and Peoples' Rights*, 4 AFR. HUM. RTS. L.J. 181, 194–95 (2004) (illustrating that many African governments have not fulfilled human rights instruments such as the Abuja Declaration by failing to transform their intentions into concrete action).

VI. Conclusion

No doubt, the African Women's Protocol remains the most gender-sensitive human rights instrument in the region today. Its provisions are very radical and are capable of advancing the sexual health needs of women and girls in the region. But how well these progressive provisions are realized depends largely on the commitments of African governments. For a continent that continues to grapple with the devastating effects of the HIV/AIDS pandemic, loss of lives and morbidities arising from early pregnancy, much more is required from African governments than what presently occurs in the region.[250] At present, out of about fifty-three countries, only twenty-seven African countries have ratified the African Women's Protocol and those that have ratified it seem to be paying lip service to its provisions.[251] This scenario is not good considering the fact that access to sexual healthcare services for adolescents is a matter of life and death.[252] If the goal set for universal access to sexual and reproductive healthcare services is to be realized, then African governments will need to redouble their efforts in ensuring access to sexual health information and services for adolescents in the region. This goal cannot be realized by mere rhetoric; rather, it requires political will and sincerity on the part of African governments. The time is now for African governments to wake-up and live-up to their obligations under the African Women's Protocol.

250. *See id.* at 200 (concluding that "[a]s long as the African Commission does not tackle the issue of HIV/AIDS in a more robust manner, joining hands with other organisations in caring partnership, . . . the full enjoyment of human rights in Africa will remain a pipe dream").

251. *See* Norah Matovu Winyi, *A Call to Action: Implement the African Women's Rights Protocol*, PAMBAZUKA NEWS (Jun. 25, 2009), *available at* http//pambazuka.org/en/category/features/57219 ("6 countries have ratified the Africa Women's Rights Protocol . . . they are now expected to domesticate the protocol . . . to make the protocol applicable in the national context . . . as well as taking appropriate policy, administrative and practical measures and actions to facilitate its full implementation.").

252. *See* Glasier, *supra* note 7, at 1595 (providing death rates and other appropriate statistics reflecting the fatal consequences of inadequate sexual healthcare services in Africa).