Access to contraception for adolescents in Africa: a human rights challenge

Ebenezer Durojaye[*]

Abstract

This article examines threats to adolescents' lives and health arising as a result of the lack of access to contraceptive information and services. It then considers the health benefits of ensuring access to contraceptive information and services for adolescents in Africa. More importantly, the article discusses certain barriers to access to contraceptive information and services and the implications for the human rights of adolescents. The article concludes that in line with their obligations under international law, African governments will need to do more with regard to meeting the sexual and reproductive health needs of adolescents in the region.

INTRODUCTION

Reproductive health eludes many people globally because of such factors as inadequate knowledge about human sexuality and inappropriate or poor-quality reproductive health information and services; the prevalence of high-risk sexual behaviour; discriminatory social practices; negative attitudes towards women and girls; and the limited power many women and girls have over their sexual and reproductive lives. Adolescents are particularly vulnerable because of their lack of information and access to relevant services in most countries.[1]

Adolescence is a critical period of transition to adulthood. According to the World Health Organisation (WHO) *et al,* adolescents are often described as persons between the ages of ten and nineteen while young people are those between fifteen to twenty-four years.[2] Today, it is estimated that nearly 1.1

[*] Department of Constitutional Law: University of the Free State, South Africa. The author is grateful to Professor Charles Ngwena of the University of the Free State, Professor Akin Oyebode of the University of Lagos and Nontombeko Ncinitwa for their support always.

[1] Report of the International Conference on Population and Development (ICPD) 7, UN Doc A/CONF.171/13 (1994) par 7.3

[2] UNDP, UNFPA, WHO and World Bank Special Programme of Research *Development and research training in human reproduction: progress in reproductive health research* (2002) 3. For the purpose of this article the terms 'female adolescents', 'adolescent girls'

billion people (eighty-five per cent of them living in developing countries) in the world are adolescents, half of which will have sexual intercourse by age sixteen and most of them by twenty.[3] In addition to grappling with problems such as conflicts and poverty, Africa continues to bear the greatest burden of sexual and reproductive ill health in the world. While this region constitutes only ten per cent of the world's population, it is home to about sixty-eight per cent of people living with HIV.[4] Recent figures show that of about thirty-three million people said to be living with HIV worldwide, Africa constitutes twenty-three million of these figures.[5] The majority of new infections and mortality resulting from HIV/AIDS complications are found in Africa. Worst affected by these sexual and reproductive health challenges are female adolescents in the region.[6]

In many parts of the world, including Africa, adolescents are struggling with the physical and emotional transformations that usually accompany their change of status. Many of them are becoming sexually active at an earlier age more than ever before. Yet the majority of adolescents lack proper access to information and services relating to their sexuality, especially with regard to contraception**.** Over the years, the sexual and reproductive health needs of adolescents have continued to be ignored or treated with levity. This in turn has led to unmet needs of adolescents' sexual health needs. It is estimated that about fifteen million adolescents worldwide between the ages of fifteen to nineteen years give birth annually.[7] Many of these births occur in developing countries, where adolescents lack access to comprehensive sexual health care services. 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.[8] Equally, sexually transmitted infections (STIs), excluding HIV/AIDS, are the second most important cause of loss of health in women, especially young women.[9] Adolescents remain particularly susceptible to sexual and reproductive health problems due to the fact that they often experience unexpected sex and have

---

and 'young women' are used interchangeably to mean the same.

3 A Grunseit *Impact of HIV and sexual health education on the sexual behaviour of young people: a review update* (1997) 7.

4 UNADIS *Global AIDS Epidemic Report* (2010).

5 *Ibid*.

6 *Id* at 130.

7 M de Bruyn & S Parker *Adolescents, pregnancy and abortion: polices, counselling and clinical care* (2004) 7.

8 World Health Organisation (WHO) *Contraception issues in adolescents' health and development* (2004) 6.

9 A Glasier *et al* 'Sexual and reproductive health: a matter of life and death' (2006) 368 *Lancet* 1595.

difficulty accessing health services.[10] It is estimated that each year over four million unsafe abortions occur, especially among young women in the region.[11] Moreover, approximately fifty-five per cent of unmarried adolescents in West Africa, forty-seven per cent in Eastern and Southern Africa and thirty-two per cent in Central Africa have an unmet need for contraception.[12]

It should be noted that in the last fifty or more years, efforts have been made to ensure that access to modern contraception for all women has moved from being merely a key element in primary health care services to being a basic human right of women. This is due to the sudden prominence given to women's reproductive health and rights across the globe. Thus, at several meetings and fora such as the International Conference on Population and Development (ICPD)[13] and the Beijing Platform of Action,[14] including their follow-up meetings,[15] it has been reiterated that couples and individuals have the right to freely and responsibly decide on matters related to their sexuality. Despite these developments, however, a significant number of adolescents in Africa still lack adequate access to contraceptive information and services.[16]

Against this backdrop, this article examines the importance of ensuring access to contraceptive information and services for adolescents, particularly female adolescents, in Africa. The article examines threats to the realisation of the rights to health, life and non-discrimination of adolescents, which may arise due to lack of access to contraceptive information and services. Due to their gravity and negative impacts on adolescents' lives and health, emphasis is on two major health challenges: unwanted pregnancy and the HIV/AIDS pandemic. Although other health challenges such as cervical cancer and

---

10 *Ibid*.

11 See E Ahman & I Shah 'Unsafe abortion worldwide estimates for 2000' (2002) *Reproductive Health Matters*, 10 who refer to an unsafe abortion as an abortion carried out by unqualified medical personnel. It usually occurs in countries where there are restrictive abortion laws; see also Glasier *et al* n 9 above.

12 AE Biddlecom *et al Protecting the next generation in Sub-Saharan Africa: learning from adolescents to prevent HIV and unintended pregnancies* (2007) 17.

13 Report of the International Conference on Population and Development n 1 above.

14 Fourth World Conference on Women Beijing held on 15 September 1995 A/CONF.177/20.

15 Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development,(ICPD +5) UN GAOR, 21st Special Sess, New York 30 June–2 July 1999, UN Doc A/S–21/5/Add 1 (1999).

16 The phrase 'contraceptive information and services' refers to information and services in relation to contraception that will enable an adolescent to prevent an unwanted pregnancy and sexually transmitted infections.

sexual violence remain threats to the lives of adolescents, these issues are not discussed in detail in this article. The article then considers the health benefits of ensuring access to contraceptive information and services for adolescents in the region. More importantly, the article discusses certain barriers to access to contraception and their implications for adolescents' human rights. It concludes by assessing whether African governments, in line with their obligations under international human rights law, are doing enough with regard to meeting the sexual and reproductive health needs of adolescents.

THE IMPORTANCE OF ACCESS TO CONTRACEPTION FOR ADOLESCENTS

Contraception provides important options for sexually active adolescents to avoid unwanted pregnancy and sexually transmitted infections (STIs), including HIV. Ensuring access to information and services in relation to contraception to adolescents not only reduces their risk of exposure to serious sexual harms, it could also promote their educational, occupational and social opportunities.[17] While it has been noted that the use of contraception worldwide has increased, disparity still exists regionally and according to groups having access to contraception. Many parts of developing countries, particularly Africa, still lack adequate access to contraception and young women among all others are often denied access to contraceptive information and services.[18]

Without access to modern contraception, adolescents' (especially female adolescents') ability to develop their full human potential is retarded, and the public health suffers.[19] As mentioned earlier, the unmet need for contraception remains high and unintended pregnancies are a major contributor to the overall burden of disease in the developing world.[20] The proportion of pregnant women below the age of twenty in Ghana, Kenya and Namibia who in 2005 reported that their pregnancies were unplanned or unwanted, was forty-six per cent, fifty per cent and fifty-five per cent

---

17 Centre for Reproductive Law and Policy (CRLP) and Child and Law Foundation (CLF) *State of denial: adolescents reproductive health in Zimbabwe* (2002) 17.

18 See WHO n 8 above; see also Glasier *et al* n 9 above.

19 See MJ Welsh *et al* 'Access to modern contraception' (2006) 3 *Best Practice and Research Clinical Obstetrics and Gynecology* 325.

20 J Ross & W Winfrey 'Unmet need for contraception in the developing world and former Soviet Union: an updated estimate' (2002) 28 *International Family Planning Perspectives* 1318–1343.

respectively.[21] A 1988 report indicated that almost one million girls in Nigeria became pregnant each year and most of those pregnancies were either unwanted or unintended.[22] More recent studies have shown that the situation has not changed. For instance, a study conducted among women (the majority of whom were younger than thirty years of age) in eight states in Nigeria has revealed that about twenty-eight per cent of them had experienced an unwanted pregnancy at some point in their lives. Of this figure, the majority of these pregnancies occurred among the unmarried.[23] Similarly, a study among adolescents in South Africa has shown that about 40 per cent of adolescents aged fifteen to nineteen years had been pregnant at some point.[24] This percentage varies from one province to another and from rural areas to urban areas.

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 and nineteen can be very risky as they are more likely to die due to pregnancy-related complications compared to adolescents in their twenties.[25] 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.[26] The burden of maternal mortality is greatest where resources are most scarce, with 99 per cent of the estimated half million maternal deaths each year occurring in developing countries. It has been reported that approximately 45 million unintended pregnancies end in abortion each year. More than 40 per cent of these occur among young women aged fifteen to twenty-four years and under unsafe conditions, which can lead to loss of fertility and even death.[27] Early or 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 weights and higher mortality rates.[28]

---

21 See C Parker *Adolescents and emergency contraceptive pills in developing countries* (2005) 1.

22 UNFPA *State of the World Population Report* (1998).

23 G Sedge *et al* 'Unwanted pregnancy and associated factors among Nigerian women' (2006) 32 *International Family Planning Perspectives* 175–184.

24 Department of Health *South African Demographic and Health Survey 1998* (1998) 143.

25 De Bruyn & Parker n 7 above at 7.

26 M Collubiem *et al Non use and use of effective methods of contraception: comparative quantification of health risks global and regional burden of disease attributable to selected risk factors* (2004).

27 World Health Organisation (WHO) *Reproductive health strategy to accelerate progress towards the attainment of international development goals and targets* (2004) 7.

28 Parker n 21 above at 2.

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 who fall pregnant may likely experience violence or may even be disowned by their parents.[29] Pregnancy among female adolescents may severely limit their opportunity to pursue their education and render them economically dependent on partners or family members. Access to comprehensive information and services on contraception can avoid these deleterious consequences to female adolescents.

In addition to the problem of unwanted pregnancy among adolescents in Africa, there is also the challenge of sexually transmitted infections (STIs), including HIV/AIDS. The negative impacts of unprotected sex among adolescents are more serious for female than their male counterparts. 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.[30] This usually accounts for the higher prevalence of STIs other than HIV among women than men. A report on the analysis of HIV prevalence in Ghana has found that having sex at a young age is strongly associated with an HIV positive status among young women.[31] A study in Malawi has found that about 20 per cent of Malawian young people aged fifteen to twenty-four (with young women five times more likely than men) are HIV positive.[32]

Also, a report has shown a high HIV prevalence among young women compared to their male counterparts in South Africa.[33] 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.[34] With this great challenge posed by the HIV/AIDS pandemic, the role of effective

---

29 AC Munthali *et al* 'Adolescent sexual and reproductive health in Malawi: a synthesis of research evidence' *Occasional Report* 15 (2004) 14.

30 AE 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) 65–68.

31 L Hessburg *et al Protecting the next generation in Ghana: new evidence on adolescents' sexual and reproductive health needs* (2004).

32 H Chendi HIV/AIDS *Life skills progammes in Southern Africa: the case of Malawi* (unpublished working paper cited in AC Munthali *et al* n 29 above).

33 See Department of Health *South Africa National HIV and syphilis prevalence survey 2006* (2007) 7.

34 Human Rights Watch *Scared at school: sexual violence against girls in South African schools* (2001) 13.

contraception in the primary prevention of mother-to-child transmission outlined by the World Health Organisation (WHO) provides yet another compelling rationale to expand access to contraception for all women, especially young women.[35] The reason for this is that young women are more vulnerable to HIV infection than other groups in the region. 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, especially young women worldwide, and has robbed societies of their potential intellectual contributions.[36] More importantly, lack of access to sexual health information and services for adolescents violates their rights to health, life, information and non-discrimination guaranteed in international and regional human rights instruments. These instruments outline states' obligations with regard to ensuring access to health care facilities and goods, including contraceptive services, for women and girls.

BARRIERS TO ACCESS TO CONTRACEPTION AND IMPLICATIONS FOR ADOLESCENTS' HUMAN RIGHTS

In Africa there are various barriers to access to contraceptive information and services**.** Some of the factors responsible for high teenage pregnancies and HIV prevalence in Africa, include lack of access to accurate sexual and reproductive health information and services; incidence of unprotected sex and poor contraceptive use among sexually active adolescents; gender inequality and unfriendly nature of the health care setting.[37] This section of the article now considers three of these factors, namely limited access to sexual and reproductive health information, gender inequality and challenges in the health care-setting and their implications for the human rights of adolescents. The choice of these factors is based on the fact that they intersect with other factors that limit access to contraceptive information and services for adolescents. While it is recognised that culture and religion play an important role in the lives of Africans and are often potential barriers to access to sexual health services for adolescents, this section of the article does not engage in the cultural relativism debate. Rather, the section merely identifies that a strict adherence to culture and religion, in the context of sexual health services, may lead to the violation of the rights of adolescents.

---

35 HW Reynolds *et al* 'Contraception's proved potential to fight HIV' (2005) 81 *Sexually transmitted infection* 184.

36 World Health Organisation (WHO) 'Strategic approaches to the prevention of HIV infection in infants' *Report of a WHO Conference 20–22 March 2002 Switzerland* (2003).

37 See for instance, Munthali *et al* n 29 above; Sedge *et al* n 23 above; Biddlecom *et al* n 30 above.

Limited access to sexual and reproductive health information

One of the major barriers to access to the use of contraception in Africa is ignorance on the part of adolescents. Many adolescents lack adequate knowledge and information with regard to their sexuality. Thus, when they are growing up and becoming sexually active they tend to know little or nothing about contraception. They are, therefore, unable to prevent unwanted pregnancies or STIs. In many parts of Africa, discussion about sex or sexuality is regarded as taboo. Therefore, most parents shy away from discussing such an issue with their children**.** Hence, rather than relying on information from parents or guardians, studies have shown that most adolescents look elsewhere for information regarding their sexuality.[38] For instance, a study has shown that the source of information of most adolescents regarding sexuality is either their peers or the media.[39] Most parents do not realise the fact that they are the primary sexuality educators of their children. Often in the name of tradition or religion, parents deliberately eschew talking to their children about their sexuality. Sometimes parents even deliberately pass wrong messages across to adolescents that may confuse or even mislead them.[40] But the truth remains that adolescents want to be talked to by their parents or guardians.

A compilation of data from Demographic and Health Surveys since 1990 has shown that quite a substantial number of adolescent women in approximately 37 countries in the world are able to identify at least one form of contraception.[41] The compilation similarly reveals that in about 21 countries, eight out of ten or more adolescent women are aware of one method of contraception. However, this study shows great disparity in the level of knowledge found among adolescents in sub-Saharan Africa. For instance, knowledge is found to be lowest in a country such as Madagascar, where fewer than half of all adolescent women know of one method, whereas knowledge is highest in countries such as Kenya, Rwanda and Zimbabwe,

---

38 O Alubo 'Adolescent reproductive health practices in Nigeria' (2001) 5 *African Journal of Reproductive Health* 117.

39 AM Sunmola *et al* 'Reproductive knowledge, sexual behaviour and contraceptive use among adolescents in Niger State of Nigeria' (2002) 6 *African Journal of Reproductive Health* 82–92.

40 J Hughes & AP McCauley 'Improving the fit: adolescents' needs and future programmes for sexual and reproductive health in developing countries' (1998) 29 *Studies in Family Planning* 233.

41 AK Blanc & AA Way 'Sexual behaviour and contraceptive knowledge and use among adolescents in developing countries' (1998) 29 *Studies in Family Planning* 154–166.

where close to 90 per cent of adolescent women show familiarity with some contraceptive methods.[42]

Even when adolescents are aware of or have knowledge of contraception, many of them do not use contraception regularly. For instance, a 2004 study among adolescents aged sixteen to nineteen years who had had sex in the last three months in Ghana, has shown that only sixty-four per cent of males and fifty-four per cent of females not in a union and thirty-eight per cent of females in a union reported that they were using a modern contraceptive method. This may suggest that general knowledge of contraception on the part of adolescents is not the same as having a deep understanding of the use of contraception.[43]

It should be noted that the right to freedom of information is a fundamental right guaranteed in most human rights instruments. For example, Article 19 of the International Covenant on Civil and Political Rights (ICCPR) guarantees the right to information of all.[44] More specifically, in relation to sexual health information, Articles 10(h) and 16.1(e) of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)[45] recognise the rights of women, particularly those in rural areas, to have access to information related to family planning. These provisions are broad enough so as to include access to contraceptive information for adolescents, especially female adolescents. Adolescents require accurate information with regard to their sexual health, including information related to contraception, otherwise they may take decisions which could be injurious to their health and lives.[46] Indeed, the Committee of CEDAW has urged states to provide without prejudice, access to information and education on sexual health information (including those related to contraception) to girls within their jurisdictions.[47]

---

42 *Ibid*.

43 Hessburg *et al* n 31 above.

44 International Covenant on Civil and Political Rights, GA Res 2200, UN GAOR, Supp 16 at 52, UN DOC A/6316 (1966), 999 UNTS 171, 174 (entered into force on March 23, 1976) (hereinafter ICCPR).

45 Convention on the Elimination of All Forms of Discrimination against Women GA Res 54/180 UN GAOR 34th Session Supp No 46 UN Doc A/34/46 1980, ratified by nearly all African countries with the exception of Somalia and Sudan.

46 See Centre for Reproductive Rights (CRR) *Briefing paper: implementing adolescent reproductive rights through the Convention on the Rights of the Child* (1999) 4.

47 See General Recommendation 24 of CEDAW on Women and Health UN GAOR 1999, Doc A/54/38 Rev 1 par 18.

The Committee further explains that access to sexual health information and education forms an integral part of the enjoyment of the right to health. According to the Committee, states are obligated to 'ensure the rights of female and male adolescents to sexual and reproductive health education by properly trained personnel in specially designed programs that respect their rights to privacy and confidentiality'.[48] Similarly, the Committee in its General Recommendation 21 has noted as follows:

> In order to make an informed decision about safe and reliable contraceptive measures, women must have information about contraceptive measures and their use, and guaranteed access to sex education and family planning services as provided in article 10(h) of the Convention.[49]

In relation to children and adolescents, Article 13(1) of the Convention on the Rights of the Child (CRC) specifically guarantees to young people, the right to 'seek, receive and impart information and ideas of all kinds'.[50] This provision is broad enough to accommodate information related to contraception for adolescents. Under Article 13(2)(b), it is further provided that the right of a child to seek, receive and impart information may be limited for the sake of public health or morals. This provision could be interpreted to provide a fertile ground for opposition to adolescents' access to sexual health information, including access to contraceptive information. This may be relevant in respect of some African countries, as shown above, where deep religious and cultural norms on sexuality prohibit premarital sex for young people. Adherents of these norms may rely on the provision of Article 13(2)(b) to justify their opposition to access to sex education or information on contraception for adolescents, particularly female adolescents, in their countries.

Such an interpretation should not be permitted as it would be inconsistent with the spirit of the CRC, which is aimed at ensuring children's and adolescents' physical and mental well-being. Freeman argues that if states were to take children's rights seriously, then all actions taken with regard to

---

48 *Ibid*.

49 Committee on CEDAW General Recommendation 21 on Equality in Marriage and Family Relations' Thirteenth Session, General Assembly Report Supplement 38 (A/49/38) pars 1–10).

50 Convention on the Rights of the Child, adopted in 1989, UN Doc A/44/49, entering into force 2 September 1990. This convention has been ratified by virtually all African countries, with the exception of Somalia.

them must be for the sake of their interests and not to their detriment.[51] Thus, this provision deserves a purposive interpretation which must be to the benefits of children and adolescents. Indeed, the Committee on CRC in its General Comments 3[52] and 4[53] has urged states to guarantee access to sexual health information and education (including those related to contraception) to adolescents. According to the Committee, states parties to the Convention should refrain 'from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information'.[54] The Committee further notes that this will be consistent with realising the right to the highest attainable standard of physical and mental health and the right to life, survival and development for adolescents.[55]

Similarly, the Committee has noted, in its General Comment 4, as follows:

> Adolescents have the right to access adequate information essential for their health and development and for their ability to participate meaningfully in society. It is the obligation of States parties to ensure that all adolescent girls and boys, both in and out of school, are provided with, and not denied, accurate and appropriate information on how to protect their health and development and practise healthy behaviours.[56]

Furthermore, in its General Comment 1 on the Aims of Education, the Committee 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 pursuits of life options.[57] Also, Article 24 of the CRC dealing with the right to health of children can be invoked to apply to ensuring access to contraceptive education and information to adolescents.

---

51 M Freeman 'The limits of children's rights' in M Freeman & P Veerman (eds) *The ideologies of children's rights* (1992) 29, 38.

52 UN Committee on the Rights of the Child (CRC) *CRC General Comment No 3: Adolescent Health and Development in the Context of the Convention on the Rights of the Child*, 1 July 2003, CRC/GC/2003/4 par 15.

53 UN Committee on the Rights of the Child (CRC) *CRC General Comment No 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child*, 1 July 2003, CRC/GC/2003/4 par 28.

54 Note 52 above at par 16.

55 *Ibid*.

56 Note 53 above at par 26.

57 UN Committee on the Rights of the Child (CRC), *CRC General Comment No 1: The Aims of Education*, 17 April 2001, CRC/GC/2001/1).

As noted earlier, the right to freedom of information is explicitly guaranteed under Article 19 of the ICCPR. Although this provision is couched in a broad language, it has been interpreted by the Human Rights Committee to request governments to provide sexual health education, including contraceptive education, to their citizens.[58] Coliver has explained that women need basic information about their reproductive physiology, including the manner in which diseases can be transmitted sexually, the risk of transmission be minimised, as well as information relating to the benefits and risks of the various methods of contraception, and safe options to adopt when those methods fail.[59] She notes further that without information, an individual is unable to make crucial decisions with regard to matters concerning his/her reproductive health, thus resulting in violation of individual's rights to liberty and dignity.[60]

Under the African Charter on the Rights and Welfare of the Child (African Children's Charter),[61] Article 14(f) enjoins states to take measures to realise the right to health of children by developing preventive health care and family life education and provision of services. No doubt this provision is an improvement on the ambiguous provision of Article 24 of the CRC. It clearly obligates states to ensure that information and education in relation to sexual health is made available to children and adolescents. Also, under Article 11 of the Charter the childrens' right education is guaranteed. This can similarly be relied on to facilitate access to information on sexual health to adolescents. Thus, it may be argued that the Charter's holistic view and approach to rights to health and education of children easily provides a platform for ensuring access to sexual health information for young people.

The Protocol to the African Charter on the Rights of Women (Women's Protocol)[62] in Article 12(2) enjoins states to promote literacy among women.

---

58 For example, in one of its Concluding Observations to Poland, the committee asked the state party to 'introduce policies and programmes promoting full and non-discriminatory access to all methods of family planning and reintroduce sexual education at public schools'; see Concluding Observations of the Human Rights Committee: Poland, 66th session 1764–1765th mtgs par. 11, UN Doc CCPR/C/79/Add 110 (1999), hereafter Concluding Observations HRC: Poland.

59 See S Coliver 'The right to information necessary for reproductive health and choice under international law' (1995) 44 *The American University Law Review* 1279–1280.

60 *Id* 1288.

61 African Charter on the Rights and Welfare of the Child, OAU Doc CAB/LEG/24.0/49 (1990) (entered into force 29 November 1999).

62 Protocol to the African Charter on the Rights of Women, adopted by the 2nd Ordinary Session of the African Union General Assembly in 2003 in Maputo CAB/LEG/66.6 (2003), entered into force 25 November, 2005. The instrument has been ratified by

Since a strong correlation exists between girls' access to education and literacy and capacity to protect themselves from sexual ill health,[63] this provision will ultimately be useful in advancing the sexual and reproductive health of adolescents in the region. This no doubt will include sexual health education, including education related to contraception. Specifically, Article 14(f) of the Protocol requires states to provide family planning education for all women, including adolescent girls (based on the definition of 'women' in article 1 of the Protocol). This explicit provision for family planning education readily provides a strong justification to compel states to make available to all women, including young women, sexual health information and education, including information related to contraception.

The right to information and freedom of expression has, over the years, evolved so as to impose a concrete and immediate obligation on states to provide access to information and to refrain from interfering with the communication of information that is essential for the promotion and protection of sexual health and choices.[64] Clarifying the nature of this right, the European Court of Human Rights in the *Open Door* case[65] has held that any attempt by a state to hinder access to sexual health information will amount to a violation of the right to information under international law. While recognising the fact that this right is not absolute, the court further held that any restriction on this right must be justifiable at law. In the same manner, the African Commission on Human and Peoples' Rights has held that the freedom of expression is a basic right that is essential to an individual's personal development.[66] Coliver argues that the obligation created by this right is both positive and negative. That is, governments are duty-bound to provide information related to sexual and reproductive health for their citizens and at the same time governments must not hinder access to this form of information.[67]

---

twenty-seven African countries.

63 RJ Cook *et al Reproductive health and human rights: integrating medicine, ethics and law* (2003) 211; Centre for Reproductive Rights n 46 above at 6.

64 See E Durojaye & A Muchiri 'Addressing the link between gender inequality and access to microbicides in HIV/AIDS response in Africa' 2008 *African Journal of International and Comparative Law* 197–218.

65 *Open Door Counseling & Dublin Well Woman Centre v Ireland* Eur Ct HR (ser A) (1992) 246.

66 See *Constitutional Rights Project and Others v Nigeria* (2000) AHRLR 227 (ACHPR 1999).

67 Coliver n 59 above at 1293.

In addition to the provisions of these binding human rights instruments, there are also consensus statements and resolutions supporting the need for sexual health information for adolescents. For instance, at the ICPD it was agreed that sexual health information should be made available to adolescents so as to help them understand their sexuality and protect them from incidence of sexually transmitted infections and unwanted pregnancies.[68] Similarly, at Beijing, governments of the world recognised the peculiar vulnerability of adolescents to sexual and reproductive ill-health, therefore, states were urged to provide them with access to comprehensive information and education with regard to their sexuality and health needs.[69] Although specific reference to contraception was not made, nonetheless, it is argued that the reference to sexual health education necessarily includes contraceptive education.

At the regional level, the Maputo Plan of Action agreed to by African health ministers in Maputo in 2006, emphasised the importance of creating an enabling environment for women and adolescents and empowering them so as to safeguard their sexual and reproductive health.[70] This will obviously include guaranteeing access to health-related information, particularly contraceptive information, which will help adolescents protect themselves from STIs, including HIV/AIDS. A state may be in violation of the right to health if it distorts health-related information or prevents access to such information among its people.

Gender inequality

Gender is a critical issue in ensuring access to preventive health goods and services such as contraception. Gender-based inequalities limit access to preventive health care information, goods and services, such as contraception. It equally makes it difficult for adolescent girls to negotiate contraceptive use with their partners. In most parts of the world, and especially Africa, boys and girls are treated differently. Girls generally, unlike boys who can flaunt their sexuality, are expected to be sexually passive and are not expected to exhibit any knowledge about their sexuality. Cultural norms are widely held in many African societies that women should be inexperienced and naïve about sexual matters and that pleasing men is the

---

68 ICPD n 1 above at par 7.41.

69 FWCW n 14 above at par 106(2)(m).

70 The African Union Conference of Ministers of Health, Universal Access to Comprehensive Sexual and Reproductive Health Services in Africa. Special session: Maputo Plan of Action for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights 2007–2010 Sp/MIN/CAMH/5(1) September 2006.

primary goal of sex.[71] Therefore, most parents do not discuss sex with their children, particularly adolescent girls, nor do they allow them to seek information related to their sexuality. Unwillingness to discuss sexual matters with adolescent girls is based on the erroneous belief that such discussion may lead adolescent girls to experiment with sex or become promiscuous.

Thus, gender-based inequalities may likely put adolescent girls at increased risk of acquiring STIs, including HIV and may damage their physical and mental health.[72] Mensch *et al* have succinctly captured the disadvantaged position of girls in many societies as follows:

> During adolescence, the world expands for boys and contracts for girls. Boys enjoy new privileges reserved for men; girls endure new restrictions reserved for women. Boys gain autonomy, mobility, opportunity, and power (including power over girls' sexual and reproductive lives); girls are systematically deprived of these assets.[73]

In addressing these inequalities, it is important to consider the different needs and constraints of young women and to design interventions accordingly.[74]

Social, educational, religious and economic inequalities underlie the reasons why girls and young women often do not seek or use contraceptive services. Moreover, in many African countries, socio-cultural factors often limit girls' access to sexual health, including information on contraception. Thus, they do not know about contraception, are not allowed by their families to use contraceptives, or do not have money to pay for them.[75] Understanding the social position of girls and young women within societies and population sub-groups is crucial in identifying strategies for the effective provision of contraceptive services to all adolescents, especially female adolescents. In many African societies where a belief in male supremacy co-exists with restrictive social structures that limit womens' economic, social and legal independence, men often maintain strong control over female sexuality.[76]

---

71 Hessburg *et al* n 31 above at 13.

72 G Sen *et al Unequal, unfair, ineffective and inefficient gender inequality in health: why it exists and how we can change it* (2007) 1.

73 BS Mensch *et al, The uncharted passage: girls' adolescence in the developing world* (1998) 2.

74 KL Dehne & G. Riedner *Sexually transmitted infections among adolescents: the need for adequate health services* (2005) ix.

75 A Germain 'Reproductive health and human rights' (2004) 363 *Lancet* 65–66.

76 MN Kisekka *The culture of silence reproductive tract infections among women in the Third World* available at: http://www.iwhc.org/docUploads/CULTUREOFSILENCE.PDF (accessed on 11 August

The result is that even when contraception is available, a female adolescent may be unable to use it because of power imbalance. This is particularly true in the case of condoms, which often require the cooperation of men. Thus, there has been a call in recent times for a woman-centered contraception, such as the microbicides in the fight against HIV/AIDS in Africa.[77]

Differential treatment between adolescent boys and girls may lead to the violation of the right to equality or non-discrimination of adolescent girls. The right to equality or non-discrimination has been recognised in almost all international and regional human rights instruments. The concept of non-discrimination implies that an individual should not be treated differently from others in an adverse manner. With regard to adolescents, discrimination may arise where laws and policies bar access to information and services in relation to their sexuality, simply based on their age. More specifically, it can amount to discrimination if access to information and services relating to contraception is deliberately denied to female adolescents or adolescents in rural areas due to religious or cultural practices. Articles 2 of both the ICCPR and the ICESCR provide that everyone is equal before the law and that no one should be subjected to discrimination based on sex, race, religion, political belief or other status. Explaining the importance of Article 2 of the ICCPR, the Human Rights Committee[78] has noted that '[n]on-discrimination together with equality before the law and equal protection of the law without discrimination constitutes a basic and general principle relating to the protection of human rights'. Similarly, the Committee, in some of its Concluding Observations, has noted that women's lack of access to contraception to women amounts to discrimination.[79]

The CEDAW in Article 2 urges states to take measures to eliminate all forms of discrimination against women. Article 12 specifically provides for access to health care services for women on equal basis with men. This provision no doubt can be invoked to ensure equal access to contraceptive information and services for female adolescents. Indeed, as mentioned earlier, the Committee

---

2010).

77 See for instance, Durojaye & Muchiri n 64 above.

78 General Comments of the Human Rights Committee on the Non-Discrimination clauses of the ICCPR (adopted on 9 November 1989): see also J Möller 'Article 7' in A Eide *et al* (eds) *The Universal Declaration of Human Rights: a commentary* (1992) 115.

79 See for instance, Concluding Observations of the Human Rights Committee: Georgia, 1564–1566th mtgs, par 12, UN Doc CCPR/C/79/Add75 (1997); Concluding Observation HRC: Poland n 58 above at par 11; Concluding Observations of the Human Rights Committee: Argentina, 17th session 1883rd1884st mtgs., par. 14, UN Doc CCPR/CO/70/ARG (2000).

on CEDAW has interpreted this provision to apply to the needs of girls.[80] The Committee has urged states to eliminate discrimination in health care services to women and girls in their jurisdiction. In the same manner, the Committee on CESCR has noted that access to health care services, including sexual and reproductive health services, should be guaranteed to all without discrimination as to sex or age.[81] These clarifications would seem to cover elimination of discrimination to female adolescents seeking contraceptive information and services.

Virtually all the above mentioned instruments proscribe discrimination on prohibited grounds that may prevent an individual from enjoying the rights guaranteed under these instruments. The term 'other status' contained in almost all of these instruments has been explained to include age, economic or marital status.[82] One of the core principles underlining the CRC is non-discrimination. This principle is guaranteed under Article 2 of the CRC, which prohibits discrimination against children. A purposive interpretation of the CRC would suggest a proscription of discriminatory practices against adolescent girls with regard to access to health care services, including contraceptive services. The provisions of the CRC, however, have been criticised for failing to contextualise the challenges encountered by female children and adolescents in their daily lives. Fottrel, for instance, has argued that the provisions of the CRC are essentially drafted to soothe the needs of white, boy children and are insensitive to the disadvantages and challenges faced by girl children in developing regions such as Africa.[83] This is because the CRC does not explicitly address issues such as harmful traditional practices such as female genital cutting/mutilation (FGC/FGM), nor does it deal with early marriage prevalent in most parts of Africa. Moreover, the CRC fails to specify measures that should be taken by states to address the needs of girls in many developing countries. She argues further:[84]

> The main protection offered to girls is found in article 2, which guarantees equality and non-discrimination, but the reality of many girls' lives is beyond the scope of such declaratory provisions and this must be viewed as an oversight by the drafters. Paper equality cannot be considered a cure-all for the effects of centuries of discrimination.

---

80 General Recommendation 24 of CEDAW n 47 above at par 18.

81 'The right to the highest attainable standard of health' UN Committee on Economic, Social and Cultural Rights General Comment 14, UN Doc E/C/12/2000/4.

82 CRLP and CLF n 17 above at 46.

83 D Fottrel *Revisiting children's rights: 10 years of the Convention on the Rights of the Child* (2000) 10.

84 *Ibid*.

While this argument would seem valid and genuine, it should, however, be noted that the Committee on CRC has tried as much as possible to give attention to gender issues in its interpretations of the provisions of the Convention. For instance, the Committee has explained that discrimination against girl children often leads to denial of access to sexuality information and services to them. It further expresses concern about gender-based discrimination combined with taboos or judgmental attitudes to sexual activities of girls, which potentially limit access to information and preventive health care services, such as contraception, to them. States are therefore urged to take adequate measures with a view to eliminating gender-based discrimination, which makes the girl child more vulnerable to STIs and HIV infection.[85]

Under the African human rights system, Article 3 of the African Children's Charter prohibits discrimination against every child, irrespective of the child's or his/her parents' race, religion, sex, ethnic group, language, birth and other status. Equally, Article 2 of the Women's Protocol specifically calls on states to eliminate all forms of discrimination against women in the region. 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 marital status, of human rights and fundamental freedoms in all spheres of life.[86]

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.

Article 3 of the African Children's Charter is essentially similar to Article 2 of the CRC. Therefore, the criticism referred to above with regard to the gender insensitivity of the CRC equally applies to the African Children's Charter. Given the fact that the African Children's Charter was drafted after the CRC, and considering the peculiar challenges (cultural and religious, including life-threatening epidemic such as HIV/AIDS) faced by adolescent girls in Africa, one would have thought that the drafters of the African Children's Charter would avoid the mistakes of the CRC by giving more attention to the needs of adolescent girls in the region. Unfortunately, this is

---

85 Committee on *CRC General Comment No 3* n 52 above at pars 7 and 8.

86 Article 1 of the Women's Protocol.

not the case. The African Children's Charter is silent on important issues, such as the prevalence of child marriage in Africa, which is potentially harmful to the health and lives of girls. However, the 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. For instance, as stated above, the Protocol explicitly guarantees women's sexual and reproductive rights, provides that women should be protected from STIs including HIV/AIDS, recognises the right ofwomen and girls to seek contraceptive services[87] and prohibits marriage of a girl under the age of 18.[88] One may conclude that the provisions of the Women's Protocol are by far the most gender-sensitive human rights instrument in the region, which is potent in protecting the sexual health needs, including contraceptive needs, of adolescent girls.

The African Charter in Article 2 provides that everyone is equal before the law and that no one should be discriminated against on grounds such as gender, religion, political beliefs or other status. Article 3 similarly guarantees every individual the right to equality and equal protection of the law. The African Commission on Human and Peoples' Rights in the case of *Legal Resource Foundation v Zambia*[89] 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 be expected 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 for a second reason. Equality or lack of it affects the capacity of one to enjoy many other rights.

This decision provides a strong basis for arguing that adolescents, particularly adolescent girls, should not be denied access to contraceptive information and services on grounds of gender, age or marital status. Therefore, African governments are required to take necessary steps with a view to removing all forms of barriers to access to sexual health services for adolescents in their countries.

---

87 *Id* at art 14.
88 *Id* at art 6
89 *Legal Resource Foundation v Zambia* (2001) AHRLP 84 (ACHPR 2001) par 63.

At both the ICPD and the Beijing conferences it was agreed that if improvements were to be brought to women's health, there will be a need to address gender inequality across the globe. The Beijing conference particularly recognised that some customary practices are harmful to the health of women and perpetuate discrimination against them.[90] Both conferences also resolved that women should enjoy their sexual and reproductive rights without coercion, violence or discrimination.[91] One of the targets of the Millennium Development Goals (MDGs) is to address the pervading gender inequality worldwide. In this regard, goal No 3 of the MDGs emphasises 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.[92] At the World Summit on Children it was affirmed as follows:

> We are determined to eliminate all forms of discrimination against the girl child throughout her life cycle and to provide special attention to her needs in order to promote and protect all her human rights, including her right to be free from coercion and from harmful practices and sexual exploitation. We will promote equal access to basic social services such as … health care including sexual and reproductive health care….[93]

.

The Solemn Declaration on Gender Equality in Africa[94] enjoins African countries to accelerate the implementation of gender specific economic and social programmes so as to prevent the spread of STIs, including HIV/AIDS, among women. In addition, states are to ensure 'the active promotion and protection of all human rights for women and girls to development…'.[95] This can be interpreted to mean addressing discrimination relating to access to contraceptive information and services for adolescents in the region. 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 practices which demean and dehumanize women and children'.[96]

---

90 FWCW n 14 above.

91 *Id* par 91 and ICPD n 1 above at par 7.8.

92 UN Millennium Declaration and Millennium Development Goals launched in 2000 A/RES/55/2.

93 UN General Assembly Resolution 'A World Fit for Children' adopted at the Twenty-Seventh Special Session held on 11 October 2002 AR/RES/S-27/2 par 23.

94 Solemn Declaration on Gender Equality in African adopted at the AU Assembly of Heads of State and Government meeting in Addis Ababa in July 2004.

95 *Id* at par 6.

96 The first OAU Ministerial Conference on Human Rights held from 12–16 April, 1999 at Grand Bay, Mauritius.

Challenges in the health care setting

Many adolescents in developing countries, including Africa, avoid using the health setting for fear of stigma or unwelcoming attitudes on the part of health care providers. Moreover, adolescents, particularly female adolescents, are often uncertain whether their visits to health care settings to seek sexual health services, such as contraceptive services, will be made known to their parents. 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 not be disclosed to their parents or guardians.[97] While commenting on challenges in the health care sector limiting access to emergency contraception (EC) in developing countries, Shiappacasse and Diaz have observed that lack of privacy, unfriendly attitudes towards adolescents and the high cost of the EC often act as stumbling blocks to adolescents' access to the product.[98]

Hobcraft and Baker have identified four major barriers to adolescents' access to sexual and reproductive treatment in the health care setting. These are:–

- poor remuneration of health care providers;
- a working environment poorly equipped to deal with young people;
- personal biases of health care providers;
- and uncoordinated parallel programmes in the health care system.[99]

Thus, even when many adolescents have indicated that their preferred source of contraceptive services is either a public clinic or hospital, most of them do not use either of these mediums.[100] A study among sexually experienced adolescents in Ghana, who knew a source for contraceptive or STI treatment, has shown that 53 per cent reported that feelings of shyness or embarrassment were a barrier to obtaining contraceptives.[101] These concerns are neither limited to EC nor to developing countries alone, they apply to

---

97 See for instance, AS Erukhar *et al* 'What is youth-friendly? Adolescents' preference for reproductive health services in Kenya and Zimbabwe' (2005) 9 *African Journal of Reproductive Health* 52.

98 V Shiappacasse & S Diaz, 'Access to emergency contraception' (2006) 94 *International Journal of Gynaecology and Obstetrics* 302.

99 G Hobcraft & T Baker 'Special needs of adolescent and young women in accessing reproductive health: promoting partnership between young people and health care providers' (2006) 94 *International Journal of Gynecology and Obstetrics* 352; see also, D Breaken *et al* 'Access to sexual and reproductive health care: adolescents and young people' (2007) 98 *International Journal of Gynecology and Obstetrics* 172–174.

100 Alubo n 38 above.

101 Hessburg *et al* n 31 above at 25.

other forms of sexual health services and to developed countries as well.[102] For instance, a study in middle high school students in Los Angeles in the United States has found that although there is a significant increase in knowledge relating to sexual health services, this has not translated into better sexual behaviour or an increase in contraceptive use.[103]

Furthermore, in some situations it has been found that health care providers often lack adequate knowledge and skills with regard to contraceptive services. For instance, a study among health care providers in Nigeria has shown that a considerable number of those surveyed exhibited lack of adequate knowledge with regard to EC.[104] The implication of this is that health care providers are unlikely to give advice or prescribe such contraception to adolescents. Sometimes health care providers are faced with the ethical issue of whether to seek parental consent before providing sexual health services, such as services related to contraception for adolescents. This has remained a very controversial issue in many African countries as some parents believe that their responsibility to cater for their children extends to knowing the kind of treatment they seek. Experience has shown that many health providers are more readily inclined to seek parental consent before providing treatment for adolescents. However, a judicial pronouncement by the English House of Lords would seem to have clarified this contentious ethical issue. The Court held in the *Gillick* case that a doctor could lawfully give contraceptive advice and treatment to a girl under the age of sixteen without parental consent if it was established that she had 'sufficient maturity and intelligence' to understand the nature and implications of the proposed treatment sought and provided that certain conditions were fulfilled.[105] This decision would seem to affirm the fact that in some situations, children and adolescents may make decisions regarding their sexuality in an adult-like manner.

Although it is noted that the background and context of the *Gillick* case may be different from situations dealing with the same issue in Africa, courts in Africa may nonetheless decide to adopt the principles enunciated in this case

---

102 *Ibid.*

103 D Kirby *et al* 'An impact of evaluation Project SNAPP: an AIDS and pregnancy prevention in middle school programmes' (1997) *Aids Education and Prevention Supplement* 44–61.

104 OM Ebuche *et al* 'Health care providers' knowledge of, attitudes toward and provision of emergency contraceptives in Lagos, Nigeria' (2006) 32 *International Family Perspectives* 83.

105 *Gillick* v *West Norfolk and Wisbech Health Authority and Department of Health and Social Security* [1986] 1 AC 112.

to deal with similar cases. This is because adolescents in Britain and Africa often experience similar challenges relating to their sexual health.[106] While one might argue that Africa is more culturally and religiously polarised compared to Britain, this should not in anyway deter African courts from affirming the sexual autonomy of female adolescents to seeking contraceptive services. This is because culture and tradition are neither sacrosanct nor static, but change with time.[107] It should be noted that the provision of the South African Children's Act,[108] which permits a child of twelve and above to seek contraceptive services without the need for parental consent, can be said to have been greatly influenced by the decision in *Gillick*.

The situations described above capture the nature of sexual and reproductive health challenges faced by adolescents in Africa, thus confirming that gaps exist in realising the health needs of adolescents in the region. This calls for a drastic change and require the commitment of African governments to advance the sexual health needs of adolescents. One way of doing this is to invoke principles and standards contained in international and regional human rights instruments.

Under international law, states have the obligation to promote and protect the right to health of their citizens, including realising access to contraception for adolescents. According to the World Health Organisation (WHO), health is broadly defined as a state of complete physical, social and mental well being and not merely absence of disease or infirmity.[109] It is further stated that the enjoyment of the right to health is a fundamental right of all. Though criticised for being too aspirational and utopian in nature,[110] this definition has provided a solid foundation for the recognition of the right to health in

---

106 LD Jacobson *et al* 'Teenage pregnancy in the United Kingdom in the 1990s: the implications for primary care' (1995) 12 *Family Practice* 232; see also, N Manzini 'Sexual initiation and childbearing among adolescent girls in KwaZulu-Natal, South Africa' (2001) 9 *Reproductive Health Matters* 44.

107 G Terry *Women's rights* (2007) 45.

108 See s 134 of the South African Children's Act 38 of 2005. In what appears to be the codification of the decision in *Gillick*, s 130 of the Act provides that in the case of HIV testing, a child aged twelve with 'sufficient maturity' to understand the implications of such a test, may lawfully give consent.

109 The Constitution of the WHO was adopted by the International Health Conference, New York, 19–22 June 1945; opened for signature on 22 July 1946 by the representatives of sixty-one states; 14 UNTS 185.

110 See for instance, T Evans 'A human right to health?' (2002) 23 *Third World Quarterly* 197–215, 198, where he argues that if the definition of health as provided by WHO in its Constitution is taken at face value, then we may end up in an absurd claim to eliminate disease, infirmities brought on by aging and even mortality.

subsequent human rights documents that emerged after the WHO's Constitution. For instance, Article 25(1) of the Universal Declaration of Human Rights (UDHR) provides that 'everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services'.[111] Perhaps the most comprehensive recognition of this right is contained in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR)[112] where it is provided that 'States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'. Article 12(2) further contains among others, important determinants of the right to health, such as prevention and treatment of diseases, essential for the enjoyment of the right.

It should be noted that the right to health as contained in these instruments does not by any means guarantee perfect health for everybody.[113] It is not in contention, however, that this right encompasses an obligation on a state to ensure access to preventive health services for all.[114] In other words, states are legally obligated to ensure access to preventive health services. It is submitted that this includes access by adolescents to information and services regarding contraception. The Committee on CESCR 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.[115] Also, the Committee has noted that states are obligated to ensure available, accessible, acceptable and quality health care services to all on a non-discriminatory basis. This is no doubt an implicit recognition of the fact that adolescents should be assured unimpeded access to contraceptive information and services.

With specific regard to the health of adolescents, Article 24 of the Convention on the Rights of the Child (CRC)[116] recognises the right of

---

111 Universal Declaration of Human Rights, GA Res 217 A (III), UN Doc A/810 (10 December 1948).

112 International Covenant on Economic, Social and Cultural Rights, adopted 16 December 1966; GA Res 2200 (XXI), UN Doc A/6316 (1966) 993 UNTS 3 (entered into force 3 January 1976). This instrument has been ratified by all African countries with the exception of South Africa, which has merely signed, but yet has to ratify.

113 BC Toebes *The right to health under international human rights law* (1999) 19.

114 Centre for Reproductive Law and Policy (CRLP) and Child and Law Foundation (CLF) n 17 above at 40.

115 Committee on Economic, Social and Cultural Rights, General Comment 14 n 81 above at par 23.

116 Convention on the Rights of the Child n 50 above.

children to the enjoyment of the highest attainable standard of health. Article 24(f) further enjoins states to develop preventive health care guidance for parents and family planning services. A careful look at this provision does not seem to explicitly refer to adolescents. Packer observes that this provision is worded in such a way as to give room for ambiguity.[117] According to her, the provision is capable of two possible interpretations. It could mean ensuring access to family planning services for the parents of an adolescent. Alternatively, it could imply ensuring access to family planning services to an adolescent in order to prevent unwanted pregnancies. The latter interpretation is more plausible. Clearly, the intention of the drafters of this article could have been made more explicit to avoid this unnecessary ambiguity.[118] It may be argued that the poor use of language here is a reflection of the opposition to sexual health education and services for adolescents. Based on this, Packer submits that this provision neither includes nor excludes adolescents from preventive health care services.[119]

However, in its General Comment 4, the Committee of the CRC has urged states to develop and implement programmes that ensure the provision of sexual and reproductive health services, including access to contraception, for adolescents.[120] 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.[121] Also, in one of its Concluding Observations to Belize, the Committee has noted with great concern the high number of teenage pregnancies existing in the country and therefore urged the government of Belize to ensure comprehensive and appropriate access to sexual and reproductive health care services to all adolescents in the country.[122] A health care service that is sensitive to the needs of adolescents must no doubt respect their autonomous decision-making powers to seek preventive treatment such as contraception.

---

117 CA Packer *The right to reproductive choices* (1996) 85; see also, D Fottrel n 83 above at 4, where the author castigates the drafting style of the Convention as being broadly framed to the extent that their meanings are ambiguous and/or they fail to improve on existing standards.

118 See S Toope 'The Convention on the Rights of the Child: Implications for Canada' in M Freeman (ed) *Children's rights: a comparative perspective* (1996) 33, 43, where the provisions of the Convention have been criticised for being 'loosely, if not sloppily' drafted; see also D Gomien 'Whose rights (and whose duty) is it? An analysis of the substance and implementation of the Convention on the Rights of the Child' (1989) 7 *New York Law School Journal of Human Rights* 161–175, 162.

119 Packer n 117 above at 85.

120 See Committee on the Right of the Child, General Comment 4 n 53 above at par 31.

121 *Id* at par 39(c).

122 Committee on CRC Concluding Observations: Belize UN Doc CRC/C/146 2005 par 347.

Furthermore, the right to health has been guaranteed under Article 12 of Convention on the Elimination of All Forms of Discrimination against Women (CEDAW),[123] which provides that states shall take all necessary measures to eliminate discrimination against women in the field of health care in order to ensure access to treatment for women on equal basis with men. This provision is very important in ensuring access to contraception for female adolescents and improving their health. As shown above, lack of access to contraception can compromise the health of adolescents. In addition to this provision, Article 16 guarantees the right to family planning services for all women. Also, Article 14 specifically guarantees access to family planning services for women in rural areas. These provisions of CEDAW are one of the most explicit and perhaps broadest recognitions of the general right to family planning treatment (including access to contraception) for women, especially female adolescents.[124] In its clarification of the content of CEDAW, the CEDAW Committee has observed that its provisions guarantee access to health care services, including services on contraception and STIs prevention to adolescents.[125] In what appears to be an affirmation of the sexual autonomy of adolescents, the Committee in General Recommendation 24 has urged states parties to ensure access to sexual and reproductive health care services, without prejudice to all women and girls.[126]

At the regional level, the right to health is guaranteed in the major human rights instruments under the African human rights system. For instance, Article 16 of the African Charter on Human and People's Rights (African Charter)[127] provides that every individual shall have the right to the best attainable state of physical and mental health. This provision is broad enough and would seem to encompass access to sexual health services, including contraception. Indeed, in the *Purohit* case, the African Commission on Human and Peoples' Rights (African Commission) has noted that the enjoyment of the right to health is crucial to all aspects of an individual's life and well-being and significant to the realisation of all the other fundamental

---

123 CEDAW Convention on Elimination of all Forms of Discrimination against Women n 45 above.

124 CRLP and CLF n 17 above at 40.

125 General Recommendation 24 of CEDAW n 47 above.

126 *Id* par 21.

127 African Charter on Human and Peoples' Rights OAU Doc CAB/LEG/67/3/Rev 5, adopted by the Organisation of African Unity, 27 June 1981, entered into force 21 October 1986. This instrument has been ratified by all the fifty-three countries that make up the African Union.

human rights and freedoms.[128] It explains further that this right broadly includes the right to health facilities, access to goods and services to be guaranteed to all without discrimination of any kind. In a similar vein, Article 14 of the African Charter on the Rights and Welfare of the Child (African Children's Charter)[129] provides that every child shall be entitled to the best attainable standard of physical and spiritual health. It further guarantees the right to preventive health care services for children.

The Protocol to the African Charter on the Rights of Women (Women's Protocol), contains in Article 14[130] elaborate and explicit provisions recognising the right to health, including sexual and reproductive health of women. This important article further provides that states should respect and promote a woman's right to control her fertility; decide the number and spacing of her children; choose any method of contraception, self-protection from sexually transmitted infections, including HIV/AIDS; legal abortion in certain situations and family planning. Also, the provision enjoins states parties to take appropriate measures to 'provide adequate, affordable and accessible health services, including information, education and communication programmes to women, especially those in rural areas'. By these unique and radical provisions, the Women's Protocol has become a pace-setter under international human rights law, as the first human rights instrument that clearly recognises 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.[131] Banda submits that by these provisions, the Women's Protocol has blazed the trail in terms of explicit recognition of sexual and reproductive rights of women.[132] It should be noted that the Women's Protocol applies to all women, including girls.[133] Therefore, it becomes one of the strongest human rights instruments that can

---

128 *Purohit and Moore v The Gambia Purohit and Moore v The Gambia* (2003) AHRLR96 (ACHPR 2003).

129 African Charter on the Rights and Welfare of the Child, OAU Doc CAB/LEG/24.0/49 (1990) (entered into force 29 November 1999).

130 Protocol to the African Charter on the Rights of Women n 62 above.

131 See Centre for Reproductive Rights (CRR) *Briefing Paper: The Protocol on the Rights of Women in Africa: An Instrument for Advancing Reproductive and Sexual Rights* (2005) 4–7; see also, E Durojaye 'Advancing gender equity in access to HIV treatment through the Protocol on the Rights of Women in Africa' (2006) 6 *African Human Rights Law Journal* 187–207.

132 See F Banda 'Blazing a trail: the African Protocol on Women's Rights comes into force' (2006) 50 *Journal of African Law* 81; see also CM Danwood 'Reclaiming (wo)manity: the merits and demerits of the African Protocol on Women's Rights' (2006) 53 *Netherlands International Law Review* 63–96.

133 See art 1 of the Women's Protocol.

be invoked to support female adolescents' right to access contraceptive information and services. It clearly accords female adolescents the autonomy with regard to their sexual health needs.

In addition to the above mentioned human rights instruments, various non-binding consensus statements and resolutions such as the ICPD,[134] ICPD plus five[135] and Beijing Declaration[136] have all emphasised the need to ensure access to health care services to adolescents in order to prevent unwanted pregnancies and STIs and promote the health of girls. Also, at the follow-up meeting to the Millennium Development Goals (MDGs) in 2005, it was reiterated that to achieve the health-related goals of the MDGs, it would be necessary to assure universal access to sexual and reproductive health care services for all by the year 2015.[137] This will surely include access to information and services related to contraception.

The Maputo Plan of Action, which was the brain child of African ministers of health, has recognised that facilitating access to sexual health services, including contraceptive services for adolescents, is imperative for attaining universal access to sexual and reproductive health services in the region.[138] It particularly urges African governments to implement policies and measures that support provision of sexual and reproductive health care services (including those related to contraception) that address the needs of adolescents in the region. Undoubtedly, such policies and measures must recognise the autonomous decision-making capability of adolescents to seek sexual health services.

CONCLUSION

This article has shown that adolescents, especially female adolescents in Africa, continue to face threats to their health and lives due to lack of access

---

134 ICPD n 1 above at par 7.41.

135 Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development, (ICPD +5) UN GAOR, 21st special session, New York, United States, June 30–July 2, 1999, par. 10, UN Doc A/S-21/5/Add.1 (1999).

136 FWCW n 14 above at par 106 (B).

137 See The Draft Resolution of the High-Level Plenary Meeting of the General Assembly on the World Summit, 15 September 2005, par 57(g).

138 Maputo Plan of Action for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights 2007–2010 (special session at the African Union Conference of Ministers of Health on the universal access to comprehensive sexual and reproductive health services in Africa, September 2006) Sp/MIN/CAMH.

to contraceptive information and services. Death and injuries arising from sexual and reproductive ill-health among adolescents in the region are preventable if adolescents have access to comprehensive sexual and reproductive heath services. It would appear that African countries are not paying enough attention to the health needs of their adolescents. Much more would need to be done in order to advance the sexual and reproductive health of adolescents in the region.

More importantly, African governments must show commitment to the health of the young people by increasing their health budgets generally and relating to young people specifically. It would be recalled that at the Abuja Declaration of 2001,[139] African leaders agreed to commit no less than 15 per cent of their annual budgets to the health sector to address challenges posed by HIV/AIDS and other diseases in the region. However, several years after this promise was made, only few African countries are meeting this target. Africa must realise that if it must meet the health-related targets of the MDGs, it needs to take more seriously the sexual and reproductive health needs of its adolescents. A step in this direction will be to integrate comprehensive sexual and reproductive health services, including access to contraception, into primary health care services. This will be in line with the Maputo Plan of Action as agreed by African health ministers.

Also, it will be necessary to intensify efforts to monitor health care providers so that they are more sensitive to the sexual and reproductive health of adolescents. Moreover, education awareness programmes to address myths and stereotypes relating to girls and young women will be necessary, particularly among community members. The young people of today are tomorrow's leaders. Therefore, African governments need not be reminded that failure to ensure them good health will have serious implications, not only for young people, but the region as a whole.

---

[139] African Summit on HIV/AIDS, Tuberculosis and other Related Infectious Diseases, Abuja-Nigeria April 24–27 2001 OAU/SPS/ABUJA/3.