Niamh Reilly
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Editor
Niamh Reilly
School of Political Science and Sociology
National University of Ireland
Galway, Ireland

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Advancing Sexual and Reproductive Health and Rights of Adolescents in Africa: The Role of the Courts

Ebenezer Durojaye

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Abstract

Across the world, adolescents encounter various challenges that may implicate the enjoyment of their sexual and reproductive health and rights. The situation of adolescents in Africa is aggravated by high poverty levels and a high disease burden in the region. Some of the challenges facing adolescents in Africa include high incidence of child marriage, unwanted pregnancy, unsafe abortion, and sexually transmitted infections, including HIV and maternal mortality. It is estimated that 1 in 3 girls is married before attaining 18 (UNFPA, Marrying too young: end child marriage. UN Population Fund, 2012), while an estimated 16 million adolescent girls aged 15–19 (most of them in poor regions, including Africa) give birth yearly. Also, about 31% of young women aged 20–24 in least-developed countries gave birth before age 18 between 2000 and 2009 (UNICEF et al., Violence against Children in Tanzania: Findings from a National Survey 2009. UN Children's Fund, US Centers for Disease Control and Prevention and Muhimbili University of Health and Allied Sciences, 2011). An in-depth study of

E. Durojaye (✉)
Dullah Omar Institute, University of the Western Cape,
Cape Town, South Africa
e-mail: ebenezerdurojaye19@gmail.com

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four sub-Saharan African countries found that 60% or more of adolescent men and women did not know how to prevent pregnancy and one-third or more did not know of a source for contraceptives (Guttmacher Institute and IPPF, Facts on the sexual and reproductive health of adolescent women in the developing world. Allan Guttmacher Institute and International Planned Parenthood Federation, 2010). The majority of about 300,000 women and girls that die annually (800 deaths per day) due to complications arising from childbirth are from Africa (UNFPA 2011).

Against this backdrop, this chapter examines how national courts can effectively realize the sexual and reproductive health and rights of adolescents in Africa. More particularly, the chapter discusses how courts can advance the autonomous decision-making powers of female adolescents by asking the "female adolescent question." The discussion in this chapter benefits largely from courts' decisions in Britain, South Africa, Colombia, and other jurisdictions. Before examining the roles of courts in the advancement of the sexual health of female adolescents, the chapter briefly discusses the social construction of adolescents. It concludes by noting that national courts will need to ask the female adolescent question in order to address some of the challenges militating against the sexual and reproductive health of adolescents in the region.

Keywords
Adolescents · Sexual health · Role of courts · Female adolescent question · Africa

Introduction

Across the world adolescents encounter various challenges that may implicate the enjoyment of their sexual and reproductive health and rights. The situation of adolescents in Africa is aggravated by high poverty levels and a high disease burden in the region. Some of the challenges facing adolescents in Africa include high incidence of child marriage, unwanted pregnancy, unsafe abortion, and sexually transmitted infections, including HIV and maternal mortality. It is estimated that 1 in 3 girls is married before attaining 18 (UNFPA 2012), while an estimated 16 million adolescent girls aged 15–19 (most of them in poor regions, including Africa) give birth yearly. Also, about 31% of young women aged 20–24 in least developed countries gave birth before age 18 between 2000 and 2009 (UNICEF et al. 2011). An in-depth study of four sub-Saharan African countries found that 60% or more of adolescent men and women did not know how to prevent pregnancy and one-third or more did not know of a source for contraceptives (Guttmacher Institute and IPPF 2010). The majority of about 300,000 women and girls that die annually (800 deaths per day) due to complications arising from childbirth are from Africa (UNFPA 2011).

In particular, young women are more vulnerable than young men: in Kenya, for example, women aged 15–24 are four times more likely to have HIV than males of

the same age (National AIDS Control Council 2010). Also, young people are said to account for the highest number of HIV-/AIDS-related deaths in the region (National AIDS Control Council 2010). Moreover, studies have revealed high incidences of sexual violence among adolescents in the region (UNICEF et al. 2012), especially in South Africa, where it is almost becoming an epidemic (HRW 2001; SAIRR 1999).

Despite these challenges facing adolescents worldwide, it has been observed that many governments have failed to take measures to adequately address the sexual health needs of young people, and access to comprehensive health-care services for adolescents has remained acutely lacking (Durojaye 2011; Stefiszyn 2014).

Courts, regional human rights bodies, and other institutions such as national human rights institutions (NHRIs) and nongovernmental organizations (NGOs) have important roles to play in advancing the sexual health needs of adolescents, especially with regard to access to contraception. These institutions or bodies can play great roles in monitoring governments' obligations to realizing the sexual health needs of adolescents in their countries. They can also work together with governments to ensure speedy realization of adolescents' sexual health needs. However, the focus of this paper will be on the important roles of national courts in advancing the sexual health needs of adolescents, particularly with regard to access to contraception. Attention is given to national courts due to the fact that they occupy a pivotal position in the provision of remedies to the violations of rights at the national level and due to the remoteness of remedies provided by international or regional bodies.

Thus, this chapter examines how national courts can effectively realize the sexual and reproductive health and rights of adolescents in Africa. More particularly, the chapter discusses how courts can advance the autonomous decision-making powers of female adolescents by asking the "female adolescent question." The discussion in this chapter benefits largely from courts' decisions in Britain, South Africa, Colombia, and other jurisdictions. The focus on these countries is based on recent jurisprudence emerging on the sexual and reproductive health of adolescents. Before examining the roles of courts in the advancement of the sexual health of female adolescents, the chapter briefly discusses the social construction of adolescents. It concludes by noting that national courts will need to ask the female adolescent question in order to address some of the challenges militating against the sexual and reproductive health of adolescents in the region.

Autonomy and the Construction of Adolescents

Adolescence is often described as a stage between childhood and adulthood. It is typically a period where the major psychological task is to "determine identity; develop power to make decisions and be in control; and develop a mature sexuality" (WHO 2004). According to the World Health Organization, "adolescents" are people in the age group of 10 to 19 years, while "youth" are people within the ages of 15 to 24 years (WHO 2011). Development varies depending on the stages of an adolescent. The early stage of adolescence

(10–14 years) usually witnesses the beginning of sexual maturation and abstract thinking (Jenkins 1999). During this stage, the adolescent is unable to grapple with the vicissitude of life and is often susceptible to peer pressure more than family members would have thought or expected (Planned Parenthood 2001).

The stage of middle adolescence (15–17 years) is characterized by improved thinking skills and intelligence, great desire for emotional and psychosocial independence from parents, and increased sexual awareness and interaction with the opposite sex. Moreover, it is a stage at which most adolescents experience their first sexual acts. The last stage of adolescence (17–19) involves the manifestation of traits of maturity, independence, and more settled ideas and opinions. This is the stage at which the adolescent has fully manifested the qualities of an adult and is more interested in forming serious relationships.

Despite these developmental stages in adolescents, in most societies, adolescence has been equated with childhood. This position is unconsciously supported by the definition of a child under the CRC where a child is regarded as anyone under 18 years of age. The implication of this is that adolescents, like children, are viewed as vulnerable, dependent, weak, and innocent (Piper 2000). This perception of adolescents has often meant that they are always deserving of protection, and therefore steps need to be taken in order to afford them adequate protection in society. This protectionist approach tends to give way to a paternalistic view regarding adolescents. Based on this, adolescents are viewed erroneously as asexual, incapable of anything good, or unable to discern wrong from right; hence, parents and adults in society must save these "neophytes," lest they destroy themselves or be destroyed by others. Locke, for instance, argues that a child is an irrational being incapable of thinking for itself. He states further that children cannot do what is rational since they are yet unable to see what is rational (Archer 1993; Locke 1996, 33–36). It is believed that the adolescent's mind exists in a state of tabula rasa – emptiness. Locke is not alone in holding this view. Mill completely excluded children in his doctrine of liberty. He reasoned thus: "It is, perhaps, hardly necessary to say that this doctrine is meant to apply only to human beings in the maturity of their faculties. We are not speaking of children" (Mill 1863, 24).

National Courts and Adolescents' Sexual and Reproductive Health

Courts can hold governments accountable for their failure to live up to their obligation of realizing the sexual health and rights of adolescents as guaranteed under national constitutions or international human rights instruments. Also, courts can set standards which will guide governments in ensuring the realization of the right to health, including sexual health and the rights of adolescents. Courts have the primary responsibility to interpret the law and give life to the provisions of laws. In this regard, courts are expected to demonstrate a level of activism and creativeness in advancing the human rights of citizens. In some cases, courts have been found to champion legal reforms through their decisions. For instance, the first recognition for

the right to abortion in the United States was not through legislation, but rather, through judicial decision in the case of *Roe v Wade* (1973). Also, courts can become catalysts for change and transformation in society through their decisions. However, the extent of the roles courts can play in advancing health-related rights, including sexual and reproductive rights, will depend largely on the ability of courts to purposively interpret the provisions of constitutions and other laws.

Judicial Decisions Relating to the Sexual Health Needs of Adolescents

As regards sensitive issues such as advancing the sexual and reproductive health needs of adolescents, courts can interpret the law purposively so as to remove any barrier created under the law to adolescents' access to sexual health information and services. This will be so if the provisions of laws are unclear or conflicting with one another. In doing this, it will be necessary for courts to bear in mind the female adolescent question. In other words, the implications of a court's decision on the life of a female adolescent should always be prioritized, because of their disadvantaged position in society and their susceptibility to sexual ill health. Cook (2004) has observed that courts can play a great role in holding governments accountable for the failure to protect individuals' right to health by allowing their agencies or private agencies to trample on the rights of citizens. Judicial decisions often lay down precedents which are followed in subsequent court decisions.

In dealing with issues relating to the sexual health needs of adolescents, it may be useful for courts to adopt the "practical measure" (Twinomugisha 2007) approach. This allows the courts to critically evaluate steps taken by African governments in realizing the right to health of the people in general, and access to sexual health services for adolescents in particular. Whenever courts are faced with a case dealing with human rights violations in the context of access to sexual health services for adolescents, courts may draw inspiration from international norms or standards and from the experiences of courts in other jurisdictions to ask the following questions:

- To what extent do policy and budgetary measures respect, protect, and fulfill the right to health-care services, particularly for vulnerable groups such as adolescents?
- Do these measures prioritize access to contraception for adolescents?
- Are these measures faithful to accessibility, availability, acceptability, and good quality in the context of access to sexual and reproductive health for adolescents in general and female adolescents in particular?
- Do these measures recognize the evolving capacities (autonomy) of adolescents on matters relating to their sexuality?
- How justified or reasonable are the measures in question?
- What are the gender implications of the measures in question?

These questions are by no means exhaustive, but rather, they are only intended to serve as guides for the courts when dealing with issues relating to adolescents' sexual health in the context of access to contraception. Therefore, national courts are at liberty to further develop other relevant questions depending on the circumstances of a case. However, recourse to questions as these will help the courts in coming to a logical conclusion on issues bordering on access to sexual health services (including contraceptive services) for adolescents. For instance, a court may wish to know the nature of laws and policies that have been enacted in relation to access to sexual health services for adolescents, and whether these laws or policies facilitate or hinder access to sexual health services to adolescents, particularly female adolescents.

The significance of adopting the abovementioned set of questions and indicators lies in the fact that they serve as a marking scheme for courts in determining governments' commitment to respecting, protecting, and fulfilling the sexual and reproductive health and rights of adolescents. In other words, they can serve as good criteria in assessing governments' commitment to advancing the sexual health and rights of adolescents. Moreover, these questions will help national courts in Africa to achieve consistency in their decisions when dealing with issues such as access to sexual health services for adolescents.

These decisions will be evaluated based on two broad subheadings: Recognizing adolescents' decision-making capability (autonomy) and recognizing the gender dimension of adolescents' decision-making powers (asking the female adolescent question).

Recognizing Adolescents' Decision-Making Capability (Autonomy)

As noted earlier, the capability of adolescents to exercise full decision-making powers with respect to sexual health matters is often doubted, hence the need to involve parents, guardians, the court or even health-care providers. Although, usually, the need to involve a third party in decision-making by an adolescent is often stronger in cases relating to invasive medical treatment such as abortion, nonetheless, this requirement has almost always been applied to all cases involving adolescents. With regard to abortion, it is believed that making a decision on this issue involves emotional and psychological challenges, which an adolescent may not be competent to handle. Thus, in jurisdictions such as the United Kingdom and America, the involvement of third parties (parents, courts, or health-care providers) is often mandated in order to ensure that the adolescent comes to a reasonable decision-making conclusion.

In the context of other sexual health services, experience has also shown that adolescents are often required to involve third parties before they are allowed access. This approach is rooted in paternalism or what Cook and Bernard referred to as "parentalism." It is generally believed that parents or guardians have the moral and social responsibility to look after their children and wards. This responsibility includes providing for the health needs of adolescents. Thus, adolescents

seeking medical advice, including sexual health advice, are expected to obtain their parents' consent before such advice is provided. The decision of the English House of Lords in *Gillick v West Norfolk* case (1986) centers on this controversial issue. In that case, a claimant had challenged as unlawful a guidance issued by the Secretary of State permitting a person under 16 to seek contraceptive advice and treatment. The question for determination before the Court was whether a doctor could lawfully give contraceptive advice or treatment to a girl under 16 without the consent of the girl's parents. The majority decision of the court was of the view that a doctor could lawfully give such an advice and treatment to such a girl 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.

The approach adopted by the majority of the Court in that case seems to have taken into consideration the peculiar life experiences of young women seeking sexual health services. Rather than the conservative and restrictive approach of the minority in that case, the majority had taken a more realistic approach by examining the incidence of teenage pregnancy among young women in Britain and the need to address such a challenge. According to the majority, rather than imposing a blanket restriction on a girl under 16 from consenting to sexual health treatment, the important consideration should be whether such a girl has the maturity to understand the nature of treatment being provided and the implications of such treatment. Although the majority did admit that the ideal thing to do would be for the doctor to advise the girl to inform her parents of such treatment, however, if she declines to so act, treatment should not be denied if she has exhibited the maturity to understand the nature of the treatment and its implications. In the view of the majority, "parental rights to control a child do not exist for the benefit of the parent. They exist for the benefit of the child and they are justified only in so far as they enable the parent to perform his [sic] duties towards the child and towards other children in the family" (per Lord Fraser, *Gillick v West Norfolk* (1986), para 170). This would seem not only to be a realistic approach, but also a gender-sensitive approach. It is trite that most of the adolescents who require sexual health treatment are females; therefore, the issue of parental consent (even though it affects all adolescents) tends to have more serious implications for female adolescents than their male counterparts.

The anti-*Gillick* judges (minority decision made up of Lords Brandon and Templeman) failed to see the gender implications of insisting that a girl under 16, who is seeking sexual health treatment, must obtain parental consent before being attended to by a health-care provider. They had reasoned that a girl under 16 lacked the capability to consent to contraceptive treatment without parental consent. The basis of the anti-*Gillick* judges' reasoning was rooted in conservatism and moral sentiments. For instance, Lord Brandon had reasoned that to provide contraceptive advice to a girl under 16, to examine her with a view to her using contraception and to prescribe contraceptive treatment for her, would encourage or facilitate the commission of an offence under the Sexual Offences Act of 1956.

In Lord Templeman's view, a girl under 16 could not be said to be "sufficiently mature" enough as to engage in sexual intercourse and thus be able to give valid consent to medical treatment, particularly with regard to contraceptive treatment. He too had relied on the provision of the Sexual Offences Act to come to the conclusion that it was never the intention of the parliament to confer autonomy on a girl under 16 to make crucial decisions regarding her life. Lord Templeman had reasoned further that parents have the right under the law to make decisions on behalf of "the infants" on all matters in which "the infant" is unable to decide (Pilcher 1997). As for him, it may be possible for an infant to consent to a medical treatment in certain circumstances depending on his or her age of understanding; however, he concluded by saying that a girl under 16 is incompetent to make decisions in relation to contraceptive treatment.

There are two important conclusions that can be drawn from the reasoning of the anti-*Gillick* judges. One is that, children are not "persons" and, therefore, are not entitled to the rights of "personhood" usually enjoyed by persons, that is, adults, particularly with regard to contraceptive services. The second is that children are incompetent and immature and, therefore, they do not possess the right to self-determination, albeit in relation to contraceptive treatment. According to Erdman (2009), these conclusions are not only misleading but also reinforce the paternalistic view of children. She argues further that empirical evidence has shown that the involvement of a third party in adolescents' sexual health decision-making does not necessarily improve the quality of such decisions.

However, the pro-*Gillick* judges (majority decision made up of Lords Fraser, Scarman and Bridge) were more eager to advance the autonomy of a girl under the age of 16 by holding that a doctor could, in certain circumstances, provide contraceptive treatment to her without parental consent or knowledge. Lord Scarman rejected the argument of the anti-*Gillick* judges that the parliament never intended to confer autonomous decision-making power on a girl under 16, claiming that there was nothing in the law to suggest this restrictive interpretation. According to him, the law has never treated the powers of parents over their children as "sovereign" and "unquestionable"; rather such rights existed for the benefits and welfare of the child and must be exercised only if they are in the best interests of the child. In other words, the exercise of parental rights and responsibilities over the child is only justifiable if it satisfies the "best interests" principle. Lord Scarman then summed up his argument in these words:

> [A]s a matter of law, the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates, if and when the child attains a sufficient understanding and intelligence to enable him [sic] to understand fully what is proposed. (*Gillick v West Norfolk*, para 423)

After a careful review of important laws such as the Sexual Offences Act and other pieces of legislation, the majority came to the conclusion that none of these laws suggests that a child under the age of 16 cannot consent to contraceptive advice or treatment. In coming to such a decision, a doctor must consider the following conditions often referred to as "Lord Fraser's Guidelines":

(i) That the girl (although under 16 years of age) will understand the doctor's advice
(ii) That the doctor cannot persuade the girl to inform her parents that she is seeking contraceptive advice
(iii) That the girl is very likely to begin or continue having sexual intercourse with or without contraceptive treatment
(iv) That unless she receives contraceptive advice or treatment, her physical and/or mental health are likely to suffer
(v) That her best interests require the doctor to give her contraceptive advice and/or treatment without parental consent (*Gillick v West Norfolk*, para 413)

These requirements, which must be satisfied by a girl under the age of 16 before being provided with contraceptive services, are intended to advance the sexual autonomy of adolescent girls to seek sexual health services, especially with regard to contraception. In other words, a girl under the age of 16, who is "*Gillick*-competent" (Douglas 1992), will be regarded as mature and capable of making lawful decisions to seek contraceptive services without the need for parental consent. This is consistent with the principle of the evolving capacities of the child recognized in both the Convention on the Rights of the Child (CRC) and the African Charter on the Rights and Welfare of the Child (African Children's Charter).

In the *Axon* case (*R on the Application of Axon v Secretary of State for Health*, 2006), the Court seems to have followed the same approach by the majority in the *Gillick* decision. In that case, a mother of five daughters challenged a health guidance purporting to allow a girl under 16 to seek contraceptive advice and treatment without parental consent. According to Mrs. Axon, such a health guidance is unlawful and illegal. Justice Silber adopted wholly the reasoning of the pro-*Gillick* judges to refuse the application of Mrs. Axon challenging the health guidance in question. He rejected the argument that a health guidance, which allows a girl under 16 to seek sexual health treatment without parental consent or knowledge, was illegal or unlawful. According to him, "the very basis and nature of the information which a doctor or a medical professional receives relating to the sexual and reproductive health of any patient of whatever age deserves the highest degree of confidentiality." The court was not convinced by the argument that allowing a girl under 16 to consent to sexual health treatment would interfere with the right to family life.

While admitting that this issue may potentially pit the rights of parents against that of the child, the court resolved that in such situations a balance must be struck between the conflicting interests. Relying on the decision of the European Court of Human Rights in the case of *Yousef v the Netherlands* (2003), the Court asserted that in the event of a conflict between parental right and the right of an adolescent to autonomous sexual health decisions, the latter should take priority over the former. This, according to the court, will be consistent with the principles of the best interests of the child and the evolving capacities of the child both recognized under the CRC. The Court further emphasized the importance of ensuring confidential sexual health

treatment to adolescents, noting that without such assurance, young people will shun treatment thereby causing "undesirable and troubled consequences" for them. The reliance on the principle of evolving capacities of the child by the court to arrive at its decision is an affirmation of the sexual autonomy of adolescent to consent to sexual health services without parental consent. It is a welcome development and it is commendable.

The Court in *Axon* did recognize the importance of third-party involvement in adolescents' decision-making, particularly with regard to invasive treatment such as abortion; however the court was not convinced that such an involvement should override the autonomy of the adolescent. This is a clear affirmation of the ability of adolescents to make crucial decisions with regard to their sexuality. It is a positive decision which can potentially be relied on to advance the sexual autonomy of adolescents and young people in general and adolescent girls in particular. In a world where the sexuality of adolescents (particularly female adolescents) has often been subjected to moralization, the decision in *Axon* provides a glimmer of hope for the realization of the sexual health needs of adolescents, particularly in the context of access to contraception. The decision exemplifies pragmatism and sensitivity to the sexual health needs of female adolescents.

Another important case where the court has affirmed the autonomy of adolescents to consent to sexual health treatment without the need for parental consent is the South African case of *Christian Lawyers Association v Minister of Health* (2004). In that case, a High Court was called upon to determine the legality of Section 5 of the Choice on Termination of Pregnancy Act (CTPA), which allows a girl under 18 to seek an abortion without parental consent. The applicant in that case had challenged this provision as being contrary to Sections 28(1) (b) (family care), 28(1) (d) (best interests of the child) and 9(1) (equality) of the South African Constitution of 1996, and as such unlawful. In its judgment, the court rejected this contention saying that the provision of CTPA allows every woman regardless of whether she is 18 or not to seek abortion during the first trimester and that there is no compulsion on such a woman to seek parental consent but that she is merely obliged to consult with her parents if she so desires. In arriving at its decision, the court noted that under the CTPA "all women" can consent to abortion services within the first 12 weeks and therefore the issue of age should not be a barrier; otherwise the essence of the law will be defeated.

Moreover, the Court invoked the provision of Section 12 of the South African Constitution, which guarantees the right to bodily and psychological integrity, to hold that a woman under 18 has the autonomy to make decisions regarding her sexuality. According to the court, "It cannot be in the interest of the pregnant minor girl to adopt a rigid age-based approach that takes no account, little or inadequate account of her individual peculiarities" (para 56). This is a purposive approach to interpreting the law, which pays attention to the plights of young women in South Africa. By this statement, the Court seems to be asking the female adolescent question. The provision of Section 5 of CTPA at issue is broadly drafted in such a way as to limit the powers or influence of parents in decision-making of children or adolescents. Indeed, from the wording of this section, there is now a reduction in

"parental roles in decision-making from the authoritative role embodied in the notion of parental power under common law to voluntary consultation by the child, medical professionals acting as 'gate keepers' to this potential parent/child consultation" (Himonga and Cooke 2007). To this extent, this provision adopts a more radical approach to children's and adolescents' autonomy more than the CRC.

While this decision seems to affirm the right of a young woman to seek abortion services, it fails, however, to critically evaluate the logic behind this conclusion. The Court seems to have been preoccupied with explaining the meaning of "informed consent," generally without paying attention to an equally important issue raised in that case – capacity to consent to treatment for adolescents. In particular, the court fails to elucidate its decision with reference to international human rights standards such as the principle of the evolving capacities of the child as contained in the CRC and the African Children's Charter. To this extent, one may argue that though the conclusion of the court was correct, the means of reaching this conclusion are less than satisfactory. Bearing in mind that South Africa has ratified both the CRC and the African Children's Charter, one would have expected the court to invoke these instruments as aids in coming to its conclusion. It should be noted that Section 39 of the South African Constitution enjoins the court to consider international law while interpreting the provisions relating to the Bill of Rights.

Notwithstanding these shortcomings in the *Christian Lawyers Association* case, an important lesson to be drawn from the case is that young women under the age of 18 are by no means less capable of exercising sexual health choices, particularly with regard to issues relating to abortion and contraception. What is important to bear in mind is that the adolescent girl making these choices must have made them having a good understanding of the issues and their implications. By affirming the autonomy of a girl under 18 to seek abortion services without the need for parental consent, the court is more or less recognizing the capability of female adolescents to make important sexual choices that concern them.

In a more recent case, the South African Constitutional Court has affirmed the right of adolescents to engage in consensual sexual act as this is consistent with respect for their dignity. In that case, a challenge against Sections 15 and 16 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act was brought, arguing that these sections are constitutionally invalid to the extent that they criminalize consensual sexual conduct between children. The applicants had argued before the court that Sections 15 and 16 of the act unjustifiably infringe children's constitutional rights to dignity, privacy, and bodily and psychological integrity, as well as the principle in Section 28(2) of the Constitution that a child's best interests must be of paramount importance in all matters concerning the child. In a unanimous decision, the Constitutional Court held that Sections 15 and 16 of the act are unconstitutional in that they infringe the rights of adolescents (12 to 16 year olds) to dignity and privacy, and further in that they violate the best-interests principle contained in Section 28(2) of the Constitution. Influenced by expert evidence before the court, it was further held that limiting the sexual activities of adolescents through criminal law may impair their development as human beings and negatively affect the very children the act seeks to protect.

In affirming the rights of children under the Constitution, Khampepe J explains as follows:

> I wish to explicate the manner in which courts should approach children's rights in general. In my view, the correct approach is to start from the premise that children enjoy each of the fundamental rights in the Constitution that are granted to "everyone" as individual bearers of human rights. This approach is consistent with the constitutional text, and gives effect to the express distinction that the Bill of Rights makes between granting rights to "everyone" on the one hand, and to adults only on the other hand. (*The Teddy Bear Clinic for Abused Children and Another v Minister of Justice and Constitutional Development and Another*, 2013)

Thus, the Court concluded that criminalizing consensual sexual acts among adolescents impugns their dignity and is inconsistent with the "best interests of the child" principle. While this decision does not specifically affirm that adolescent should engage in "uncontrolled" sexual acts, it does affirm that sexual expression and consensual sexual acts form part of developmental state of adolescents, which enhances their dignity. While the decision of the court in this case is commendable, it, however, falls short of addressing the specific needs of female adolescents. It was missed opportunity for the court not to engage with the lived realities of female adolescents in the context of the Sexual Offences Act. In short, the court failed to ask the female adolescent question by not specifically examining the impact of the impugned provisions of the Sexual Offences Act for adolescent girls.

Recognizing the Gender Dimension of Adolescents' Decision-Making Powers (Asking the Female Adolescent Question)

In matters relating to the sexual health of adolescents, courts can similarly play important roles in making inquiries into the female adolescent question with regard to cases brought before them. Courts have an important role to play in removing barriers to the enjoyment of sexual and reproductive health of adolescents. In doing this, courts will need to inquire to the situations or circumstances which often make it difficult for female adolescents to exercise their sexual choices, particularly with regard to access to contraception. Such inquiries are necessary essentially in a male-oriented society, such as Nigeria, where studies have shown that male sexuality is privileged over female sexuality (Odejide 2007). In some cases, barriers to access to contraception for adolescents are often masked by gender inequality and patriarchal tradition. Thus, courts will be required to "lift this veil" of patriarchy by analyzing the gender implications of cases involving adolescents. Such an analysis must take into cognizance the peculiar life circumstances of female adolescents in Nigeria. In essence, it must recognize that the low status of women and adolescent girls in the country constitutes a great threat to the realization of their sexual health and rights. This is evidenced by the high rates of unwanted pregnancies, STIs, including HIV/AIDS, and unsafe abortion (Sledgh et al. 2009). Pillard (2007) correctly observes that:

> Various forms of inequality and stereotyping contribute to a status quo in which many women get pregnant in circumstances in which they either do not want children, or want children yet feel they cannot have them. Girls and women disproportionately are taught to be in denial about their own sexual urges, and yet rely inappropriately on their sex appeal. The denial occurs both ways: Women are expected to deny the presence of their sexual desire (to guard chastity), and to deny its absence (to be sexually responsive to men). In a world in which such denial is the norm, women will lack the kind of agency and responsibility needed to meet their own desires for pleasure, well-being, support, and meaning in their lives.

Sometimes courts may need to demonstrate some degree of activism in order to strike down sociocultural or legal barriers to adolescents' access to contraception. In other words, courts will need to do more than mere formal application or interpretation of the law but where necessary "lift the veil of patriarchy" behind such laws, customs, or practices in order to address the root causes of discrimination against women and girls in society. This may require courts to demand evidence-based information and data rather than reliance on customary or religious beliefs. For instance, in *Axon* the court was prepared to go a step further in a bid to determine the propriety or otherwise of a girl under 16 to seek sexual advice, without the need for parental consent, by relying on available data and statistics on teenage pregnancy in the United Kingdom. The mere fact that the court in this case relied on a report showing an increase in teenage pregnancy among young girls under the age of 16 and low contraceptive use among young people in general in Great Britain is an indication of the court's willingness to base its judgments on established evidence rather than mere sentiment. This position of the court seems to coincide with the suggestion of Cook and Ngwena (2006) to the extent that any decision that must be taken in relation to sensitive issues, such as sexual health needs of adolescents, must be founded on empirical evidence rather than mere sentiment or morality. Indeed, as mentioned above, there is no evidence justifying such involvement as it may not mercenarily lead to good decisions for adolescents. Erdman (2009), therefore, suggests that in determining whether or not a third-party involvement in adolescents' decision-making is necessary, such a finding must be based on established evidence and fact rather than mere assumptions.

More importantly, in the *Axon* case, Justice Silber rejected the argument that permitting young people to seek treatment on sexual health without parental consent will encourage sexual immorality. Rather, he was of the view that if parents talk to their children about sexual health, they are less likely to engage in unprepared sex and less likely to conceive as young women (Erdman 2009). This reasoning seems to be sensitive to the plight of young girls who might be in need of sexual health services but might face challenges due to the need for parental consent. It particularly speaks to the plight of adolescent girls in Africa, where religious and cultural beliefs often undermine adolescents' right to seek information and services with regard to their sexuality.

By considering the implications of a lack of confidential sexual health treatment for an adolescent girl before arriving at its decision, the court in *Axon* is more or less asking the female adolescent question. It is an indication that the court is willing to put sexual health challenges facing adolescent girls at the center of its decision. More

importantly, the decision represents an affirmation of the right to sexual autonomy on the part of an adolescent girl with regard to seeking contraceptive services. In the view of Bridgeman (2006), the implication of the *Axon* case is that though parents are primarily responsible for the health and well-being of their young ones, such young people, however, can decide for themselves whether to seek advice, information, and services as regards their sexual health needs without the knowledge of their parents. The approach of the court to invoke human rights standards and principles contained in international human rights instruments such as the CRC is highly commendable. Such an approach provides greater opportunities to advance adolescents' sexual health and rights, particularly in relation to access to contraception.

Limitations to the autonomous decision-making of adolescents, especially female adolescents, in matters of sexual health, particularly as regards access to contraception, are often hinged on the fact that female adolescents are incapable of making a developed moral decision. In other words, female adolescents are "too immature," "irresponsible," and "too young" to engage in consensual sexual acts. This belief tends not only to undermine the sexual autonomy of women and girls but also subjugate their human rights to that of men. Erdman has observed that moral decision-making has always been situated within a gender framework based on "two hierarchically arranged standards of moral reasoning invariably associated with gender: the masculine glorified, the feminine designated" (Erdman 2009). Pillard (2007) has also criticized the different roles which society often assigns to women and men, noting that such different roles tend to compromise sexual choices of women and girls.

Africa remains highly patriarchal, and where gender inequality is often very pronounced and women's and girls' rights are given little attention, female adolescents are bound to encounter some challenges in exercising their sexual choices. Thus, in some cultures in the region, it is still believed that reproduction is the primary function of women and girls and that a woman is expected to sexually please her husband. This in turn limits women's and girls' autonomous decision-making powers as regards sexual health matters. Therefore, the decision in *Axon* constitutes a positive step toward "lifting the veil" of gender inequality which often masks as custom and tradition.

Recent developments have shown that courts are beginning to strike down the sex-biased "maternal wall" that has constrained women's sexual choices. Also, courts are beginning to demonstrate the willingness to question the gender implications of laws and policies limiting women's and girls' sexual choices. For instance, the Colombian Constitutional Court has delivered a judgment relating to the sexual autonomy of a young girl to consent to medical abortion. In that case, the Constitutional Court had been called upon to determine whether a 14-year-old girl could lawfully consent to an abortion and whether the provisions of the penal code criminalizing abortion were constitutional. The court had invoked principles and standards laid down under international human rights instruments and consensus statements to arrive at its decision. For example, the court relied extensively on the provisions of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Convention on the Rights of the Child, including

consensus documents such as the International Conference on Population and Development (ICPD) and the Beijing Platform for Action, to hold that a denial of abortion right to a girl under the age of 14 constitutes a gross violation of the sexual and reproductive rights of a woman. The court further held that criminalization of abortion violates the rights to health, equality, dignity, and liberty of a woman, all recognized in various human rights instruments and consensus statements such as the Cairo and Beijing Declarations (Women's Link Worldwide 2007).

In arriving at its decision, the Court had reviewed the challenges women in Colombia face in realizing their health needs, particularly with regard to safe abortion and sexual health services. According to the court, such challenges, often due to restrictive laws, are not only violations of women's rights but further reinforce the subjugation of women in society. More importantly, the Court reasoned that a girl of 14 who had exhibited a good understanding of the implications involved in a treatment could consent to an abortion. Beyond the fact that this landmark decision liberalizes abortion law in Colombia, one other significance of the decision is that the court tends to accord recognition to the right of a girl of 14 to exercise her autonomy with regard to issues relating to sexual health services, including seeking contraceptive services. Indeed, the court affirms the rights of all individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so. According to the Court, women, including girls, should not be treated merely as "reproductive instruments in human race"; rather they must be recognized as independent entity capable of making autonomous sexual and reproductive health decisions.

This is a radical challenge to the patriarchal notion referred to above, which generally subordinates women's rights to that of men and assigns reproductive roles as women's primary responsibility. Thus, denial of abortion right or access to contraception is merely a means of perpetuating the status quo. Due to gender inequality, women and girls are usually unable to negotiate safe sex with their partners. This situation usually poses grave implications for women's and girls' health. Therefore, the recognition by the Colombian Constitutional Court of the right of a girl under 14 to seek sexual health services, including abortion and contraceptive services, is a bold attempt by the court to "lift the veil" of patriarchy, which the Colombian criminal law represents. The court inquired into the logic behind this restrictive law and found that it is meant to limit sexual choices of women and girls. It then proceeded to affirm the sexual autonomy of a girl under 14 to make "responsible" and "reasonable" decisions relating to her sexuality.

More importantly, the Court invoked the provisions of the CRC by upholding respect for parental rights, but subject to the evolving capacities of a girl of 14 to make decisions relating to her human rights, including the right to health and sexual autonomy. By so doing, the court seems to be asking the female adolescent question. Rather than acting in abstraction, the court seems to have contextualized the peculiar challenges confronting young women with regard to their sexual health needs in Colombia. Given the fact that the Colombian society is an essentially conservative and male-oriented one, this bold decision by the Constitutional Court symbolizes a new dawn in the recognition of women's and girls' sexual autonomy.

This decision by the Colombian Constitutional Court represents one of the most important roles of the court in carrying out legal reforms. According to Cook, the decision is an unequivocal recognition of all women's rights, particularly pregnant women, adolescent girls, rural women, poor women, and indigenous women (Cook 2007). She notes further that the decision has set a new standard in the recognition of women's rights as human rights internationally. Perhaps what is highly commendable about this decision is the ability of the court to invoke human rights principles and standards contained in international and regional human rights instruments such as the CEDAW, CRC, and the Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women (Convention of Belem do Para) to reach its decision.

In addition, the Court also relied extensively on interpretations provided by treaty monitoring bodies such as the CEDAW Committee and the Committee on the CRC. The Court particularly cited General Recommendation 24 of CEDAW on Women and Health (UNCEDAW 1999) to affirm that laws and policies which inhibit women and girls from expressing their sexual autonomy are not only discriminatory but also violate women's and girls' human rights. By so doing, the Court has demonstrated the relevance of "soft law" in advancing the sexual autonomy of adolescent girls to seek sexual health services. While "soft law" is not legally binding on states, it remains an important source in clarifying the nature of a state's obligations under international human rights law. In particular, it can be invoked to determine the commitment of a state to realizing the sexual health needs of female adolescents. This decision is a testament that courts can play a crucial role in freeing women and girls (by advancing their sexual autonomy) from "historically routine conscription into maternity or motherhood" (Pillard 2007).

As seen from above, it would appear that the essence of the Lord Fraser's guidelines laid down in *Gillick*, which was adopted wholly in *Axon*, is to put a female adolescent at the center of any decision to be taken with regard to her seeking contraceptive treatment. Rather than placing emphasis on parental power to consent on behalf of a girl under 16, the guidelines seem to prioritize the interests of such a girl over her parents. This approach seems to coincide with asking the female adolescent question. It would be important for national courts to adopt similar position should a case of similar nature come before them.

Given the serious threats to the sexual health needs of adolescent girls in the region, one would expect that any interpretation that will be provided by the courts, as regards a female adolescent seeking sexual health treatment, will favor the girl and not unduly give regard to parental powers to exercise control. Bartlett (1990) has emphasized this when she asserts that the "woman question" must aim not only to question existing wrongs but must also anticipate the remedy that will be brought through raising this question. Cook (1995) has similarly noted that applying the woman question in judicial decisions involved understanding the disadvantaged position of women in society and reflecting this in the judgment of the court. It is one thing to acknowledge the challenges facing women in society; it is another thing for this to be reflected in any action taken to address this situation. Perhaps a remarkable distinction between the anti- and pro-*Gillick* judges is the fact

that the former represent conservatism, paternalism, and the "welfarist approach," whereas the latter represent pragmatism, liberalism, and a recognition of the evolving capacities of the child.

Conclusion

This chapter has shown the important role of the courts in advancing the sexual and reproductive health of adolescent in Africa. It argues that through progressive interpretation of laws and policies, courts can strike down discriminatory laws and facilitate access to sexual and reproductive health to adolescents in general and female adolescents in particular. Although issues relating to adolescent consent to sexual and reproductive health services remain controversial, the courts can play an important role in affirming the sexual autonomy of adolescents. In considering whether adolescents should be allowed to consent to sexual and reproductive health services, fundamental principles relating to the rights of adolescents and children should be taken into consideration. In essence, the best interests of the child principle, the evolving capacities of children, nondiscrimination and gender-sensitivity, life and survival as well as the right to dignity of children and adolescents.

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