Female adolescents' evolving capacities in relation to their right to access contraceptive information and services: a comparative study of South Africa and Nigeria

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Abstract

Adolescents' early sexual debut contributes to their huge burden of sexual and reproductive ill-health, especially in sub-Saharan African countries. Reports continually reveal that adolescents in general, and female adolescents in particular, constitute a large portion of the 34 million people living with HIV worldwide. Other consequences associated with early adolescent sexuality include unplanned pregnancies, unsafe abortions, and sexually-transmitted infections. Whilst international human rights instruments and national legislation recognise the importance of considering the adolescent child's evolving capacities, this becomes contentious when adolescents' access to contraceptive information and services and other sexual and reproductive health issues are involved. The article examines Nigeria's and South Africa's national legislation regarding adolescent girls' right to independently access and consent to confidential contraceptive information and services in accordance with the recognition of their evolving capacities provided for under international human rights law. We argue that a major impediment to adolescent girls' contraceptive use relates to the assumption that they are incapable of making rational decisions or of consenting to sexual and reproductive health care services without parental Involvement. The article concludes that allowing adolescent girls to consent independently, especially when accessing contraceptive information and services, is a necessary step in achieving increased adolescent contraceptive use, so affirming their evolving capacity in decision-making.

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INTRODUCTION

Currently, the world's adolescent population stands at 1,2 billion, 88 per cent of whom reside in developing countries.[1] In sub-Saharan Africa, adolescents account for more than one in every five inhabitants.[2] The large adolescent[3] population presents an opportunity for economic development and a foundation for remodelling the future of countries in the African region.[4]

The period of adolescence is fraught with challenges associated with acquiring the necessary social interaction and sexual skills the adolescents will carry into adulthood.[5] Adolescence not only presents an opportunity to establish a foundation for a healthy and productive adulthood, but it is also a period of risk where sexual and reproductive health (SRH) problems which have immediate or future consequences occur.[6] Statistics indicate that adolescents worldwide are engaging in intimate sexual relations at a progressively younger age.[7] As the early commencement of adolescent

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1 UNICEF *Demographic trends for adolescents: Ten key facts*, available at: http://www.unicef.org/sowc2011/pdfs/Demographic-Trends.pdf (last accessed 31 August 2014).

2 UNICEF *Demographic trends for adolescents: Ten key facts*, available at: http://www.unicef.org/sowc2011/pdfs/Demographic-Trends.pdf (last accessed 30 August 2014). Statistics reveal that over 88% of adolescents reside in the developing world with the African region being home to over 220 million of them.

3 The WHO defines adolescents as persons between the ages of ten and nineteen; early adolescence is between ten years and fourteen years, while late adolescence is between fifteen and nineteen years. See Cook *et al Reproductive health and human rights, integrating medicine, ethics and law* (2003) 276.

4 Population Reference Bureau *The time is now: Invest in sexual and reproductive health for young people* (2012), available at: http://www.prb.org/pdf12/engage-youth-key-messages.pdf (last accessed 31 August 2014); Jimenez *et al World Development Report 2007: Development and the Next Generation* (2006) 26–28, available at: http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2006/09/13/000112742_20060913111024/Rendered/PDF/359990WDR0complete.pdf (last accessed 31 August 2014).

5 WHO *Strategic directions for improving adolescent health in South-East Asia Region* (2011) 1, available at: http://apps.searo.who.int/PDS_DOCS/B4771.pdf (last accessed 31 August 2014); WHO *Strengthening the health sector response to adolescent health and development* (2010) 2, available at: http://www.who.int/maternal_child_adolescent/documents/cah_adh_flyer_2010_12_en.pdf?ua=1 (last accessed 31 August 2014).

6 WHO *Strengthening the health sector response to adolescent health and development* (2010) 2, available at: http://www.who.int/maternal_child_adolescent/documents/cah_adh_flyer_2010_12_en.pdf?ua=1 (last accessed 31 August 2014).

7 Statistics reveal a drastic reduction in the current average age at first intercourse from the median age recorded in the early 1950s. For example, in France the average age at first

sexual relations has been linked to an increase in adolescent pregnancies and sexually transmitted infections (STIs),[8] it is vitally important that adolescents can access comprehensive contraceptive services and information that will reduce the threats occasioned by the expression of their sexuality.

However, access to comprehensive contraceptive services and information continues to elude adolescents in sub-Sahara Africa, and it is female adolescents, in particular, who bear the burden of sexual and reproductive ill health.[9] This is evidenced by the fact that of the 34 million people living with HIV worldwide, 23,5 million reside in Africa, and a substantial number of these are young women.[10] In addition, while unintended pregnancies among adolescents is a common public health problem worldwide,[11] the situation is particularly grave in sub-Sahara Africa where teenage fertility rates in 2013 peaked at a staggering 101 per 1 000 adolescents. In Africa, early pregnancy is a major cause of morbidity and mortality among adolescent girls between the ages of fifteen and nineteen.[12] Female adolescents also account for over fourteen per cent of unsafe abortions that occur annually as a result of unwanted pregnancies.[13]

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intercourse is now seventeen years, compared to being in the early twenties previously. See Madkour *et al* 'Early adolescent sexual initiation and physical/psychological symptoms: a comparative analysis of five nations' (2010) 39 *Journal of Youth and Adolescence* 1213; Nwankwo & Nwoke 'Risky sexual behaviours among adolescents in Owerri municipal: predictors of unmet family health needs' (2009) 13/1 *African Journal of Reproductive Health* 136.

8 French & Cowan 'Contraception' (2009) 23 *Best Practice & Research Clinical Obstetrics and Gynecology* 234.

9 Durojaye 'Access to contraception for adolescents in Africa: A human rights challenge' (2011) 44 *CILSA* 2.

10 UNAIDs *Special report: How Africa turned AIDS around* (2013) 6 & 7, available at: http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2013/20130521_Update_Africa.pdf (last accessed 31 August 2014); AGNATES *World AIDS Day Report* (2011) 10, available at: http://www.unaids.org/en/media/agnates/contentassets/documents/unaidspublication/2011/JC2216_WorldAIDSday_report_2011_en.pdf (last accessed 31 August 2014).

11 Ramos 'Interventions for preventing unintended pregnancies among adolescents' (2011) *WHO Reproductive Health Library Commentary*, available at: http://apps.who.int/rhl/adolescent/cd005215_ramoss_com/en/index.html (last accessed 31 August 2014).

12 In the same year, the global fertility rate among fifteen to nineteen-year-olds was fifty-two births per 1 000 adolescents. Population Reference Bureau *The world youth: 2013 data sheet* (2013) 11, available at: http://www.prb.org/pdf13/youth-data-sheet-2013.pdf (last accessed 31 August 2014). See also Ramos n 11 above.

13 Cook *et al* 'Respecting adolescents' confidentiality and reproductive and sexual choices' (2007) 98 *International Journal of Gynecology and Obstetrics* 183.

The link between good SRH practices by adolescents and their access to SRH care, especially contraceptive information and services, has received increased attention in the last few decades. International and regional bodies have pledged their commitment to the recognition of the right of adolescents to access SRH care as a means of fulfilling other rights[14] and meeting development needs. Apart from human rights instruments which guarantee adolescents' right to health care,[15] other consensus documents, led by the ICPD Programme of Action,[16] support the idea that a successful transition into adulthood requires the realisation of access to adolescent-friendly health services and access to health-promoting information on sexual and reproductive matters.[17] The necessity of investing in the SRH of adolescent girls is closely associated with the need to eradicate poverty and inequity which affect generations of girls who lack education and who bear the brunt of society's negligence by giving birth to unplanned children.[18] Further, the SRH of adolescents is a public health priority because preventing HIV transmission among this group can lead to a halt of the epidemic as 40 per cent of new HIV infections worldwide occur in young people.[19]

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14 Other rights that are fulfilled by guaranteeing adolescents' right to SRH care include the right to life, equality, information, education and dignity, among others.

15 ICESCR of 1966, CRC of 1989, African Charter of 1981, ACRWC of 1990 and the African Women's Protocol of 2003. Particularly, in relation to the right of everyone to enjoy the highest attainable standard of physical and mental health guaranteed in art 12(1) of the ICESCR, the ICESCR Committee has explained that the minimum core essentials that must be satisfied by state parties include those of availability, accessibility, acceptability and quality. See par 12 General Comment 14 of the ICESCR Committee (2000) available at: http://www.refworld.org/docid/4538838d0.html (last accessed 31 August 2014).

16 International Conference on Population and Development Programme of Action 1994, available at: http://www.unfpa.org/public/publications/pid/1973 (last accessed 31 August 2014). Other documents include the Beijing Platform of Action of 1995, Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development (ICPD +5) of 1999; and, most recently, the Bali Global Youth Forum Declaration of 2012, available at: http://icpdbeyond2014.org/uploads/browser/files/bali_global_youth_forum_declaration.pdf (last accessed 31 August 2014).

17 Jejeebhoy *et al* 'Meeting the commitments of the ICPD Programme of Action to young people' (2013) 21(41) *Reproductive Health Matters* 18.

18 UNICEF *The state of the world's children 2011: adolescence an age of opportunity* (2011) 3, available at: http://www.unicef.org/sowc2011/pdfs/SOWC-2011-Main-Report_EN_02092011.pdf (last accessed 31 August 2014).

19 Biddlecom *et al Protecting the next generation in sub-Saharan Africa: learning from adolescents to prevent HIV and unintended pregnancy* (2007) 6, available at: http://www.guttmacher.org/pubs/2007/12/12/PNG_monograph.pdf (last accessed 31 August 2014).

Regardless of the potential benefits associated with adolescents' access to contraceptive information and services, this group continues to face significant obstacles when accessing SRH services and information. Specifically, one of the most significant of these obstacles relates to the minimum age at which female adolescents are recognised as capable of making independent decisions regarding their SRH, and of consenting to SRH interventions. With this in mind, and in line with human rights guarantees of the right of access to health care, the article begins by examining the concept of the evolving capacities of children under international human rights law, particularly the Convention on the Rights of the Child (CRC) and the African Charter on the Rights and Welfare of the Child (ACRWC). We argue that the concept of the evolving capacities of children may be used to guarantee adolescent girls' access to contraceptive information and services, and we illustrate how this has in fact happened in the case law of the United Kingdom. Next we focus on the position taken in Nigerian and South African legislation regarding female adolescents' ability independently to access and consent to confidential SRH care services. Finally, we draw conclusions regarding the situation of female adolescents in the two countries in relation to their access to confidential SRH care services, as guaranteed in the human rights documents discussed at the beginning of the article, and as they relate to the evolving capacities of adolescents.

EVOLVING CAPACITY AS A CONCEPT UNDER INTERNATIONAL AND FOREIGN LAW

Introduction

In the past, children[20] were regarded as powerless and invisible beings who depended upon adult members of society for protection. Recognising children as right bearers with rational capabilities was unheard of and, far from being accepted as rational beings, children were regarded as a *species* of property, requiring adult protection and assistance in every decision-making process.[21] Although society has since clearly evolved in how it regards children, the recognition of the idea of children's evolving capacity to make decisions continues to be fraught with controversy, with the 'child

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[20] As a result of the definition of children in human rights instruments as persons below the age of eighteen years and the WHO's definition of adolescents as persons between the ages of ten and nineteen years, in this article the words children and adolescents are used interchangeably.

[21] Arnott 'Autonomy, standing, and children's rights' (2007) 33/3 *William Mitchell Law Review* 809.

liberationists' on the one side, and those who believe that children should be 'allowed to be children' on the other.[22]

Child liberationists argue that children as persons and right holders should not be discriminated against by exclusion from decision-making processes as they possess greater abilities for self-determination than society cares to admit.[23] Others, such as Campbell, are of the opinion that children require protection from the stresses of being required to make rational decisions for themselves.[24] This group views the liberationists as unrealistic and reckless in their incorrect perception of children's capacities, their ignorance of children's slow rate of physical and mental development, and their interference in parental rights and the structure of the family unit.[25] Regardless of which of these two views one supports, it is clear that while adults generally are recognised as capable of assuming responsibility for their actions, children, including adolescents, are understood to be in need of social and legal protection as a result of their immaturity.[26]

A view that over–emphasises the need to protect children, however, fails to take into account children's evolving capacities as they mature. Several writers have commented on this. For example, Fortin maintains that as children develop and become more mature, their capacity to take responsibility for their lives develops and demands encouragement.[27] Lansdown notes that adults' view of children and adolescents is influenced by their assumptions regarding children's competence and treatment.[28] The inclination to judge children using adult standards not only results in children being found lacking, but also leads to an unwillingness on the part

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22 Fortin *Children's Rights and the developing law* (2009) 4–5.

23 According to the liberationist theorists, there is no reason to prohibit children from enjoying the freedoms granted to adults, including the right to control their private sexual lives. See Fortin n 22 above at 4.

24 Campbell 'The rights of the minor: as person, as child, as juvenile, as future adult' (1992) 6/1 *International Journal of Law, Policy and the Family* 1 at 1–23.

25 Fortin n 22 above on children's rights and decision-making in England' (1999) 7 *The International Journal of Children's Rights* 150.

26 Lansdown 'Evolving capacities' explained' in Child Rights Information Network (CRIN) Review *Measuring maturity: understanding children's 'evolving capacities'* (2009) 7, available at: https://www.crin.org/docs/CRIN_review_23_final.pdf (last accessed 31 August 2014).

27 Fortin n 22 above at 7.

28 Lansdown *The evolving capacities of the child* (2005) xiii–xiv, available at: http://www.unicef-irc.org/publications/pdf/evolving-eng.pdf (last accessed 31 August 2014).

of adults to value children's evolving capabilities, thereby limiting future opportunities available to adolescents to become more competent.[29]

Whilst presumptions relating to the lack of the decision-making competence of adolescents persist, especially in sub-Saharan Africa, female adolescents are continually burdened and affected by gender inequalities. This allows for the stereotyping of adolescent girls as natural subordinates, who are not only incapable of making decisions on issues affecting their SRH, but who are also limited to satisfying the sexual needs of men with 'motherhood as their ultimate and ideal role', thereby making them victims of sexual and reproductive ill-health.[30]

Defining evolving capacities

The term 'capacity' denotes mental or intellectual power of reception, and involves the ability to comprehend or assimilate ideas and information.[31] Whilst the reasoning faculties which enable children to understand issues change over time as they develop in age and maturity, the capacity to understand is innate to human nature and already exists at birth in a rudimentary form.[32] In view of this, the concept of evolving capacities recognises the gradual phases of mental and psychological development that children undergo as they mature and allows for its consideration in issues relating to children.

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29 *Ibid*.

30 Human Rights Watch *This old man can feed us, you will marry him: Child and forced marriage in South Sudan* (2013) 48–49, available at: http://www.hrw.org/sites/default/files/reports/southSudan0313_forinsertWebVersion_0.pdf (last accessed 31 August 2014); Loaiza & Wong *Marrying too young: End child marriage* (2012) 39, available at: http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/MarryingTooYoung.pdf (last accessed 31 August 2014); Chaaban & Cunningham *Measuring the economic gain of investing in girls: The girl effect dividend* (2011) 4, available at: http://www-wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/2011/08/08/000158349_20110808092702/Rendered/PDF/WPS5753.pdf (last accessed 31 August 2014); Cusack & Cook 'Combating Discrimination Based on Sex and Gender' in Krause & Scheinin (eds) *International Protection of human rights: A textbook* (2009) 222; Bayisenge 'Early marriage as a barrier to girl's education: A developmental challenge in Africa' in Ikekeonwu (ed) Girl-Child Education in Africa (2010) 7–8.

31 Collins & Pearson 'What does the "evolving capacities of the child" mean?' (2002) 1, available at: http://www3.carleton.ca/landonpearson/htmfiles/hill/17_htm_files/Committee-e/Tara-Acapacity.pdf (last accessed 31 August 2014).

32 *Ibid*.

Evolving capacities in the CRC

The Convention on the Rights of the Child entered into force less than a year after its adoption[33] and is the most widely-ratified human rights treaty in history.[34] The adoption of the CRC was the result of several years of struggle for the recognition of children as fully-fledged human beings who require the protection of their rights as autonomous beings.[35] In addition to recognising the rights guaranteed under previous international human rights instruments to which children are already entitled, including the right to health care,[36] the CRC expressly provides that the fulfilment of the best interests of children should be a primary consideration in situations affecting children.[37]

Specifically in connection with the recognition of the evolving capacities of children, including adolescents, the CRC provides in article 5 that legal guardians or other persons legally responsible for the child, must 'provide, in a manner consistent with the *evolving capacities of the child*, appropriate direction and guidance in the exercise by the child of the rights recognised in the present Convention'.[38] This recognition of children's evolving capacities is further confirmed in articles 12(1) and 14(2) of the CRC which state:

> 12(1) States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.
> and
>
> 14(2) States Parties shall respect the rights and duties of the parents and, when applicable, legal guardians, to provide direction to the child in the exercise of his or her right in a manner consistent with the evolving capacities of the child.

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33 The Convention on the Rights of the Child was adopted by Resolution 44/25 of 20 November 1989 and entered into force on 2 September 1990.

34 Currently, only Somalia and the United States of America are not parties to the CRC. See http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-11&chapter=4&lang=en (last accessed 31 August 2014).

35 Vandenhole 'The Convention on the Rights of the Child' in Felipe & de Feyter (eds) *International human rights law in a global context* (2009) at 452–454.

36 Article 12(1) ICESCR, 12 CEDAW, arts 2, 6, 13, 16, 24 & 28 CRC.

37 Article 3(1) CRC.

38 Our emphasis.

The above provisions reiterate the need for parents and other persons *in loco parentis* to acknowledge the evolving capacities of children in the exercise of their rights generally, and specifically in relation to the right of children to participate in decisions affecting them. Accordingly, by using the word 'evolving capacities' in article 5, the CRC recognises the fact that though children are in the process of cognitive development, the extent of their acquisition of social, moral and reasoning skills that will ensure the development of their overall socio-economic advancement capacities, depends largely on the opportunities accorded to them.

Implications of article 5

As Lansdown explains, apart from directly challenging previous constructions of children and adolescents as 'properties' of their parents, the CRC's use of the concept 'evolving capacities' reveals a recognition that parental rights endure only while children are in a state of immaturity and therefore incapable of exercising their rights.[39] In other words, as children develop and mature, parents and guardians are to encourage the ability of their children not only to be involved in decisions affecting them, but also gradually to become capable of making independent decisions as active agents of their own destinies, while still protecting them when necessary. According to Hodgkin and Newell, by using the concept 'evolving capacities', the CRC has avoided setting arbitrary age limits or definitions of maturity for different issues, and recognises that each child develops and matures at a different pace.[40]

Another implication of article 5 relates to the dual role assumed by state parties to the CRC: while states are to respect parental rights and duties, they must at the same time ensure the protection of children's rights are guaranteed. This is based on the need to balance both respect for children's evolving capacities while concurrently seeking to realise their best interests.[41]

In General Comment 7, the CRS Committee explained that the concept of evolving capacities is an enabling principle in the sense that parents and

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39 Lansdown 'Evolving capacities and the exercise of rights' (2013) 4, available at: http://www.barnrattsdagarna.se/fileadmin/user_upload/dokument/2013/Presentationer/Gerison_seminarium.pdf (last accessed 31 August 2014).

40 Hodgkin & Newell *Implementation handbook for the Convention on the Rights of the Child* (2007) 77.

41 Lansdown n 39 above at 4.

others in positions of authority are vested with the mandate continually to adjust the level of support and guidance they offer children.[42] Parents are to take into account the child's best interest, wishes and capacity to make autonomous decisions. According to the Committee, the concept of evolving capacities[43]

> should be seen as a positive and enabling process, not an excuse for authoritarian practices that restrict children's autonomy and self-expression and which have traditionally been justified by pointing to children's relative immaturity and their need for socialization. Parents (and others) should be encouraged to offer 'direction and guidance' in a child-centred way.

Particularly in relation to adolescents, the Committee took note of the fact that in order to promote the health and development of adolescents, state parties are to respect the evolving capacities and maturity of adolescents by ensuring their access to private and confidential healthcare services. Especially, adolescents deemed mature enough to receive counselling without the presence of parents are entitled to privacy and may request confidential services and treatment.[44]

In line with the above, the concept of the evolving capacities of children is based on an understanding of three conceptual frameworks.[45] These frameworks are outlined briefly below.

Evolving capacities as a developmental concept

The evolving capacities of children as a developmental concept means that the CRC can be viewed as an instrument for promoting and encouraging the development of children's emerging autonomy and competence.[46] This is achieved by state parties taking steps to ensure that parents and gate-keepers recognise that children possess rights, including the right to access

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42 Paragraph 17 CRC Committee General Comment 7 (2006) *Compilations of General Comments and Recommendations Adopted by Human rights Treaty Bodies, Vol II*, available at: http://www.bayefsky.com/general/hri_gen_1_rev9_vol_ii.pdf (last accessed 6 April 2014).

43 Paragraph17 CRC Committee General Comment 17.

44 Pars 5 & 7 CRC Committee General Comment 4 (2003) *Compilations of General Comments and Recommendations Adopted by Human rights Treaty Bodies, Vol II*, available at: http://www.bayefsky.com/general/hri_gen_1_rev9_vol_ii.pdf (last accessed 6 April 2014).

45 Lansdown n 39 above at 8.

46 *Ibid*.

contraceptive information and services. Thus, states must ensure that adolescents enjoy and access their guaranteed rights.

Evolving capacities as an emancipatory concept

As an emancipatory concept,[47] recognising the evolving capacities of children in relation to the right to healthcare means that children and adolescents need to be respected as bearers of rights[48] who possess the ability to access relevant information important for the promotion of their health. It also denotes that adolescents are allowed to consent to healthcare services, including those related to accessing contraceptives according to their levels of competence and maturity.

Evolving capacities as a protective concept

Considering the fact that children and adolescents are still developing and their reasoning faculties are still evolving, the CRC recognises that children still require the protection of their parents and the state from activities that may result in their being harmed. Examples include instances where female adolescents are the victims of sexual abuse and violence.[49]

Evolving capacities in the ACRWC

Like its counterpart at the global level, the African Charter on the Rights and Welfare of the Child adopts the approach that a child is a bearer of rights.[50] Apart from placing an obligation on state parties to take the necessary steps that will give effect to the provisions of the Charter,[51] the ACRWC provides that the best interests of the child shall be the primary consideration in all actions concerning the child.[52] In relation to the evolving capacities of children, the ACRWC provides:[53]

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47 *Ibid*.

48 Hodgkin & Newell n 40 above at 75.

49 Lansdown n 28 above at x.

50 This approach involves the specific allocation of rights to every child. Getachew *The contribution of the African Children's Charter and its monitoring committee in the advancement of children's rights in Africa: A critical reflection'* (2011) 6–7, available at: http://www.academia.edu/996820/The_contribution_of_the_African_Childrens_Charter_and_its_monitoring (last accessed 31 August 2014).

51 A 1(1) ACRWC.

52 A 4 ACRWC.

53 A 9(2) ACRWC. Also, the right of the African child to participate in decisions is recognised in a 4(2) ACRWC.

> Parents and where applicable, legal guardians, shall have a duty to provide guidance and direction in the exercise of these rights having regard to the evolving capacities, and best interests of the child.

As is the case with the CRC, with the insertion of a provision mandating parents and legal guardians to consider the evolving capacities of children, the ACRWC recognises the proposition that children and adolescents acquire different levels of competence and maturity as they develop. It is the acquisition of these competences that should be respected in situations where female adolescents need to access confidential contraceptive information and services.

Evolving capacities in UK case law: The *Gillick* and *R (Axon)* cases

Until recently, medical practitioners ignored the capacity of children to choose or participate in decisions affecting them as it was assumed that parents were the appropriate people who had the capacity to determine what happened to their children's health.[54] However, in the United Kingdom (UK) a change in the position in respect to female adolescents' consenting to and accessing confidential contraceptive information and services was brought about by the decision in the case of *Gillick v West Norfolk and Wisbech Area Health Authority and Another* (*Gillick* case).[55]

Mrs Gillick, a mother with five daughters under the age of sixteen, instituted the case following the UK Department of Health and Social Security's guidelines which allowed doctors in 'exceptional' cases lawfully to prescribe contraception for girls younger than sixteen years without their parents' consent. Arguing that adolescents under the age of sixteen were incompetent to consent to contraceptive advice and treatment, Mrs Gillick sought a declaration that it would be unlawful for a doctor to prescribe contraceptives to her daughters without her knowledge or consent.[56]

Rejecting her argument, the British House of Lords held that a doctor would not be acting unlawfully where he gives advice or treatment to an adolescent who has sufficient understanding and intelligence to comprehend the nature

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54 Fortin n 22 above at 147.

55 *Gillick v West Norfolk and Wisbech Area Health Authority and Another* (1986) 1 AC 112, (1985) 3 All ER 402 par 17, available at: http://www.hrcr.org/safrica/childrens_rights/Gillick_WestNorfolk.htm (last accessed 31 August 2014).

56 *Ibid*.

of the proposed treatment.[57] According to the court, a doctor would be justified in providing contraceptive advice and treatment to a girl under the age of sixteen without parental consent if the doctor is satisfied that the girl will understand the advice. The doctor cannot persuade the girl to inform her parents or to allow the doctor to inform her parents that she is seeking contraceptive advice. As she is likely to begin or to continue having sexual intercourse with or without contraceptive treatment, her best interests require a doctor to give her contraceptive advice or treatment, or both, without parental consent.[58] Particularly, Lord Fraser declared that it was contrary to the moral convictions of present-day society to say that a child or young person remains under the complete control of his or her parents 'until he [or she] attains the definite age of majority … in practice most wise parents relax their control gradually as the child develops and encourage him or her to become increasingly independent'.[59] A clearer articulation in case law of the evolving-capacities concept will be hard to find.

As regards female adolescents accessing confidential SRH care services, the court stated (per Lord Scarman):[60]

> In my judgment the guidance clearly implies that in exceptional cases the parental right to make decisions as to the care of their children, which derives from their right of custody, can lawfully be overridden, and that in such cases the doctor may without parental consultation or consent prescribe contraceptive treatment in the exercise of his clinical judgment and the guidance reminds the doctor that in such cases he owes the duty of confidentiality to his patient, by which is meant that the doctor would be in breach of his duty to her if he did communicate with her parents.

In *R (Axon) v Secretary of State for Health*[61] the right of adolescents capable of giving informed consent to access confidential SRH care services was confirmed. In this case, the UK High Court clarified that the nature of information received by a doctor on the SRH of any patient, irrespective of

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57 *Id* 186. Children who are mature enough to comprehend the nature of the treatment that they have requested are sometimes referred to as 'Gillick-competent minors'.

58 These requisites later became known as the Fraser guidelines.

59 *Gillick* case n 55 above at 171. See also Fortin n 22 above at 95.

60 *Gillick* case n 55 above at 417–418.

61 *R (Axon) v Secretary of State for Health* (2006) EWHC 37, available at: http://www.slatergordon.com.au/files/editor_upload/file/medicalnegligence/healthlawbulletin/art%201%20hlb_14_5.pdf (last accessed 31 August 2014).

age, deserves the highest degree of confidentiality.[62] Explaining that the issue that deserves pre-eminence is the welfare of the patient, the court noted that[63]

> there is clear evidence that confidentiality increases the use of contraceptive and abortion services for those under the age of sixteen and that conclusion corresponds with common sense. The use of contraceptives will also reduce the risk of the need subsequently for treatment for sexually transmitted diseases and for abortion. By the same token, in the case of sexually transmissible diseases, it is much more likely that a young person, who does not want his or her parents to know of his or her sexual activities, would go and obtain advice from a medical professional if that young person knew that his or her parents would not be notified of the advice or of the young person's condition by a medical professional.

Conversely, many young people who need to access SRH care services would be deterred from obtaining such advice and treatment if their parents have to be notified.[64] The decisions in the *Gillick* and *R (Axon)* cases are welcomed as they succeeded in laying a foundation and further cementing the importance of allowing intellectually mature adolescent girls access to contraceptive information and services in private settings, as complementary to the adoption of safer sexual practices which are required to promote the health and development of adolescents.

Conclusion

Our analysis shows that both the CRC and the ACRWC include the concept of the evolving capacities of children, highlighting the recognition of this concept in international human rights law. It further underscores the importance that should be attached to recognising the need of adolescents to arrive at independent decisions as they grow older and mature. To this end, the comment of the CRC Committee that state parties are to respect the evolving capacities and maturity of adolescents by ensuring their access to private and confidential healthcare services is instructive, as it nurtures and encourages them to seek access to contraceptives and other SRH care services instead of engaging in risky sexual practices.

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62 *Id* at par 62.
63 *Id* at par 142.
64 *Id* at par 142.

Our examination in this section of the *Gillick* and *R (Axon)* cases illustrates how the courts can give substance to the concept of evolving capacities and reveals the change in the attitudes of courts in the UK towards recognising the evolving capacities of adolescents to consent to and access confidential contraceptive information and services.

In the next section we examine the recognition of female adolescents' evolving capacities in relation to their ability to access and consent to contraceptive information and services in South African and Nigerian legislation.

RECOGNISING FEMALE ADOLESCENTS' EVOLVING CAPACITIES IN SEXUAL AND REPRODUCTIVE HEALTH MATTERS IN SOUTH AFRICA AND NIGERIA

Introduction

Despite the modern inclination to view adolescents as beings possessing rights separate from those of their parents, and the obligations imposed by the CRC and the ACRWC to recognise the evolving capacities of children in decision-making processes,[65] the capacity of female adolescents to consent to and access confidential contraceptive and other SRH care information and services remains a tug of war between the adolescents on one hand, and their parents and various other stakeholders concerned with promoting the health and well-being of adolescents, on the other.[66]

In African societies, in particular, the decision-making capacities of children and adolescents are seldom recognised. Instead of acknowledging that children become gradually more mature as they grow older or accepting the notion that adolescents possess rights, in many African societies the emphasis is placed on ensuring the protection of children and their obedience to the authorities and the dictates of parents and guardians.[67] In

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65 A 5, 12(1) & 14(2) CRC and a 9(2) ACRWC.

66 Goodwin & Duke 'Capacity and autonomy: a thought experiment on minors' access to assisted reproductive technology' (2011) 34 *Harvard Journal of Law & Gender* 507.

67 Owasonoye '*Implementation of the United Nations Convention on the Rights of the Child in Nigeria'* (2001) 2 &3, available at: http://www.google.co.za/url?sa=t&rct=j&q=speaker+presentations+-+bolaji+owasanoye+&source=web&cd=1&cad=rja&ved=0CCoQFjAA&url=http%3A%2F%2Fwww.childjustice.org%2Findex.php%2Fcomponent%2Fedocman%2F%3Ftask%3Ddocument.download%26id%3D32%26Itemid%3D470&ei=82qjUZC8J8u2hAe0xIGwBg&usg=AFQjCNEcAgqHYvG5y1hEzTSPjz6bv6XIZw&bvm=bv.47008514,d.d2k (last accessed 31 August 2014).

fact, in relation to SRH matters, the competence of adolescents to make decisions on whether to access health care services, including contraceptives, is not encouraged because premarital sex is frowned upon in most of these societies.[68] The situation of adolescent girls in African settings is particularly precarious as a result of cultural and religious practices that foster gender inequality and the belief that adolescent girls engaging in premarital sexual relationships are promiscuous.[69] This situation is summarised aptly by Haider who states: [70]

> Because adolescence is a borderline stage of life, it often becomes a legal battleground for control over provocative issues, such as sex, contraception, abortion, and sexually transmitted diseases. Despite the critical health issues at stake, discussing the sexuality of young persons typically sparks controversy. Sometimes the issue is age or maturity level. The charge is that talking to teens about sex is tantamount to pushing them into sexual encounters.

Haider further notes that, in some instances, advocates for the recognition of adolescents' right to access SRH health care come up against culture as a justification or a defence for violations of adolescents' rights. When these advocates for adolescents' rights attempt to defeat the cultural relativist arguments, they are confronted with charges of human rights imperialism and a lack of respect for local culture.[71]

The inequalities faced by the girl child in African societies, including those of Nigeria and South Africa, emphasise the importance of using the provisions in the CRC and ACRWC on evolving capacities, as well as provisions in other human rights instruments, to advance the recognition of the autonomy of adolescents in accordance with their level of maturity and

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68 Enuameh *et al* 'Perceived facilitators and barriers to interventions aimed at reducing unintended pregnancies among adolescents in low and middle income (developing) countries: a systematic review of qualitative evidence' (2012) 10 (52) *Joanna Briggs Institute (JBI) Library of Systematic Reviews* 3351 & 3354; Izugbara 'The socio-cultural context of adolescents' notions of sex and sexuality in rural South-Eastern Nigeria' (2005) 8/5 *Sexualities* 607–609; Varga 'How gender roles influence sexual and reproductive health among South African adolescents' (2003) 34/3 *Studies in Family Planning* 160–172.

69 Adjetey 'Reclaiming the African woman's individuality: the struggle between women's reproductive autonomy and African society and culture' (1995) 44 *American University Law Review* 1353.

70 Haider 'Adolescents under international law: Autonomy as the key to reproductive health' (2008) 14(3) *William & Mary Journal of Women and the Law* 607.

71 *Ibid*.

competence. According to Temin and Levine,[72] using human rights to advance recognition for the evolving capacities of the girl-child is vitally important as practices of unequal gender relations between the sexes continue to be a factor that allows the coercion of girls into initiating sexual relations, and also prevent them from accessing SRH information and services, thereby exposing them to infection with HIV and other STIs.

In its General Comment on HIV/AIDS and the Rights of the Child, the CRC Committee notes that access to information and education on sexuality is a crucial aspect of preventing the spread of HIV.[73] According to the CRC Committee, effective HIV and AIDS prevention requires state parties to refrain from censoring, withholding, or intentionally misrepresenting health-related information, including that related to SRH.[74] In relation to female adolescents' access to SRH care, including contraceptive services, the Committee explains that having regard to the evolving capacities of the child, state parties are to ensure that health providers fully respect the rights of adolescents to privacy and non-discrimination when accessing HIV-related information and other SRH services, including those involving contraception.[75]

Below we consider the Nigerian and South African positions on the recognition of female adolescents' evolving capacities in relation to their access of contraceptive information and services.

South Africa

As a party to both the CRC and the ACRWC, South Africa supports the approach in international human rights law that sees the child as a bearer of rights. The Constitution of the Republic of South Africa, 1996,[76] in addition to recognising children's right together with adults to access healthcare services, including reproductive health care services,[77] also recognises the

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72 Temin & Levine *Start with a girl: A new agenda for global health* (2009) at 22–24, available at: http://www.cgdev.org/files/1422899_file_Start_with_a_Girl_FINAL.pdf (last accessed 31 August 2014).

73 CRC Committee General Comment 3 (2003) *Compilations of General Comments and Recommendations Adopted by Human rights Treaty Bodies, Vol. II*, available at: http://www.bayefsky.com/general/hri_gen_1_rev9_vol_ii.pdf (last accessed 31 August 2014).

74 CRC Committee General Comment 3 par 13.

75 *Id* at par 17.

76 Constitution of the Republic of South Africa, 1996.

77 Sec 27(1) Constitution of the Republic of South Africa, 1996.

right of children to basic healthcare services in section 28(1)(c). Children's right to basic healthcare services is guaranteed without the internal qualifiers of availability of resources and progressive realisation that are found in section 27.[78]

Provisions relating to the recognition of the evolving capacities of female adolescents in accessing contraceptive information and services, as well as other healthcare services, can be gleaned from various sections of South Africa's Children's Act.[79] Providing for the consideration of the child's best interests, which is of paramount importance when making decisions affecting the child,[80] the Children's Act stipulates that consideration should be had to the child's age, maturity, gender and stage of development.[81] The South African Children's Act further recognises the right of adolescents to participate in the decision-making process in issues that concern them.[82]

It is argued by many writers that serving the best interests of children includes respecting their evolving capacities, especially their right to be involved in decision-making processes in issues affecting them. Interpreting the 'best interest of the child' principle, the Constitutional Court in *Minister of Welfare and Population Development v Fitzpatrick*[83] explained that the 'best interest' of the child principle extends beyond the rights listed in section 28(1), and creates a separate right.[84] This was supported in *Van Deijl v Van Deijl*,[85] when the court acknowledged the concept of evolving capacities of children and explained that serving the best interests of children includes protecting their welfare. For older children, according to the court, the protection of their best interests includes allowing them to express their views which cannot be ignored.[86]

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78 For discussions relating to the difference between the provisions of s 26, s 27 and s 28 of the South African Constitution, see Robinson 'Children's rights in the South African Constitution' (2003) 6 *Potchefstroom Electronic Law Journal* 1–58; and Skelton 'Girls socio-economic rights in South Africa' (2010) 26 *South African Journal on Human Rights* 146–148.

79 Sections 7(1)(g), 9, 10, 13, 129 and 134 Children's Act 38 of 2005.

80 Section 9 Children's Act.

81 Section 7(1)(g) Children's Act.

82 Section 10 Children's Act.

83 *Minister of Welfare and Population Development v Fitzpatrick* 2000 (3) SA 422 (CC).

84 *Id* at par 17.

85 *Van Deijl v Van Deijl* 1966(4) SA 260 (R).

86 *Id* 261 H. See also *McCall v McCall* 1994 (3) SA 201 (C) where King J set out factors to be borne in mind when determining children's best interests – at 205 B–G; *Krasin v Ogle* [1997] 1 All SA 557 (W) 567I–569E.

In South Africa, in line with the concept of evolving capacities, the current threshold for children to be able to consent independently to medical treatment is the age of twelve. In terms of the Children's Act, children can consent independently to their medical treatment if they are above the age of twelve and are of sufficient maturity and mental capacity to understand the benefits, risks, social, and other implications associated with the proposed treatment.[87] Additionally, South Africa's acknowledgment of the evolving capacities of adolescents includes its insertion into the Children's Act of a provision allowing children access to information on their healthcare in an easily-understandable format.[88]

In relation to the right of adolescent girls to access contraceptive services, South Africa's Children's Act also guarantees access to contraceptives in confidential settings on request and without parental consent from the age of twelve and after the necessary medical examination.[89] In fact, the Children's Act provides that 'no person may refuse to grant a child's request to access contraception'.[90] South Africa's recognition of the evolving capacities of adolescent girls through the implementation of a legislative framework that recognises their need to access contraceptive services and information in private, is an important step in response to the country's high adolescent pregnancy[91] and HIV infection rates. Panday *et al* maintain that the high HIV infection rates in the country are now recognised as the

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87 Section 129 Children's Act. In relation to the termination of pregnancy, the age of twelve does not apply as s 5 of the Choice on Termination of Pregnancy Act 92 of 1996 allows a woman of any age to consent to the termination of her pregnancy. See generally Mahery *et al A guide to the Children's Act for health professionals* (2010) 9, available at: http://www.ci.org.za/depts/ci/pubs/pdf/resources/general/ca_guide_health%20prof_2010.pdf (last accessed 31 August 2014). Also, consent provisions relating to health services users (including female adolescents) are contained in s 6 – s 8 of the National Health Act 61 of 2003.

88 The right to access information on health care includes those associated with the promotion of reproductive health and the prevention of ill health; see ss 13(1) & 13(2) Children's Act.

89 Section 134 Children's Act.

90 *Ibid*.

91 According to the WHO, the adolescent birth rate in the country stands at 54 for every 1 000 live births among girls aged fifteen to nineteen years. As well, research reveals that Mpumalanga, Northern Cape, Limpopo and the Eastern Cape Provinces are the worst hit by the high levels of adolescent pregnancies. See Willan *A review of teenage pregnancy in South Africa: Experiences of schooling, and knowledge and access to sexual & reproductive health services* (2013) 7, available at: http://www.hst.org.za/sites/default/files/Teenage%20Pregnancy%20in%20South%20Africa%20Final%2010%20May%202013.pdf (last accessed 31 August 2014).

primary reproductive health concern of adolescents, overtaking the long-standing emphasis on adolescent fertility.[92]

South Africa further guarantees abortion on demand until the twelfth week of gestation for all women, including adolescents.[93] In *Christian Lawyers Association v Minister of Health and Others (Reproductive Health Alliance as Amicus Curiae)*,[94] the plaintiffs sought an order declaring sections 5(2) and 5(3) of the Choice on Termination of Pregnancy Act unconstitutional on the ground that it allowed girls under eighteen years of age to have abortions without parental consent or knowledge. In refusing the application, the court found that while the provisions of the Choice on Termination of Pregnancy Act provide that minors should be advised to consult with their parents before the termination of a pregnancy, the termination should not be denied because a minor refuses to seek parental consent.[95] The judge also took note of the fact that the legislature had not left the area of the termination of pregnancy totally unregulated. According to the court, requirements have been put in place to ensure that informed consent is obtained before a pregnancy is terminated, and that no woman – regardless of her age – can have her pregnancy terminated unless she is capable of giving informed consent and actually does this.[96] According to the court, valid consent can only be given by a person who has the intellectual and emotional capacity to appreciate the nature of the medical treatment requested.[97] This will automatically dissuade or prevent 'immature' adolescents from assessing these services without parental knowledge.[98]

By allowing legislative provisions dealing with the protection of the reproductive health of its citizens also to be applied to children, the South African government has taken progressive steps to enhance the rights of

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92 Panday *et al* Teenage *pregnancy in South Africa: With a specific focus on school-going learners* (2009) 20, available at: http://www.education.gov.za/LinkClick.aspx?fileticket=uIqj%2BsyyccM%3D& (last accessed 31 August 2014).

93 Ss 5(2) & 5(3) Choice on Termination of Pregnancy Act.

94 *Christian Lawyers Association v Minister of Health and Others (Reproductive Health Alliance As Amicus Curaie)* 2005 1 SA 509 (T).

95 Section 5(3) Choice on Termination of Pregnancy Act.

96 *Christian Lawyers* n 94 above at 515.

97 The requirement of informed consent relies on the principles of knowledge, appreciation and consent that must be fulfilled by adolescents intending to access abortion termination procedures. See *Christian Lawyers* n 94 above at 515.

98 *Id* 516.

children to access confidential contraceptive and other SRH care services. Further, the country's inclusion of provisions on access to SRH care information[99] and consent to medical treatment in the Children's Act reveals its understanding of the steps that need to be taken in order to prevent the occurrence of unplanned pregnancies and to combat the spread of HIV and other STIs among the adolescent population.

The twelve-year age limit at which contraceptives can be last accessed, however, is not supported. Our objections to this are in line with those of Dickens and Cook who observe that setting fixed ages for consent may prejudice adolescent health and create a barrier to care as adolescents generally do not all mature at the same pace,[100] and mature minors under the age of twelve are therefore denied access to contraceptives.

Whist it is true that, on the whole, the legislation adopted by South Africa to ensure female adolescents' access to contraceptive information and services has been successful, ignorance and the fear of lack of privacy remain as major obstacles affecting adolescent contraceptive use in the country.[101]

Nigeria

Like South Africa, and in line with international and regional human rights instruments, Nigeria regards the child as the bearer of rights, as is borne out by its specific allocation of rights[102] to children under the Child Rights Act of 2003.[103] In addition to providing specifically that in actions concerning

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99 Section 13(1)(a) Children's Act.

100 Dickens & Cook 'Adolescents and consent to treatment' (2005) 89 *International Journal of Gynaecology and Obstetrics* 182–183. According to the authors, since adolescents do not mature at the same pace, fixing 'ages of medical consent' instead of 'conditions of consent' may result in barriers to adolescent sexual and reproductive health being imposed unintentionally as, sometimes, there may be mature minors, who though below twelve years, already understand the reason for their need of access to contraceptive services and information.

101 The issues of adolescents' ignorance and fear of lack of privacy fall outside the scope of this article. For an exhaustive discussion on these issues, see Savage-Oyekunle 'Female adolescents' reproductive health rights: Access to contraceptive information and services in Nigeria and South Africa' (2014) Unpublished LLD thesis, University of Pretoria.

102 The right of the Nigerian child to enjoy the best attainable state of physical mental and spiritual health is provided for in s 13 of the Child Rights Act of 2003.

103 See generally ss 3–15 Child Rights Act. A major shortcoming of the Child Rights Act relates to the fact that the Act is not applicable to the entire country as the various state legislatures need to pass corresponding laws.

the child, his or her best interest must be the primary consideration,[104] the Child Rights Act recognises the evolving capacities of children and its importance in fulfilling the best interests of children with the mandate that parents and legal guardians are to provide guidance and direction to children having regard to their evolving capacities and best interests.[105] Likewise, even though the right of adolescents to participate in decisions affecting them is not expressly provided for in the Child Rights Act, it can be inferred from the guarantee of the right of children to freedom of thought, and can be used to advance the right of adolescents to access contraceptive information and services.[106]

In spite of the laudable provisions outlined above, the Child Rights Act does not provide for the right of children to consent independently to medical treatment. Also, while the Child Rights Act guarantees the right of children to privacy[107] which is especially welcome since it can be used to further the need of adolescent girls to access confidential contraceptive health care services, the gains achieved are reversed by the subsequent insertion of a blanket limitation clause in the form of the provision in section 8(3). This provision stipulates that 'nothing in the provision of subsections (1) and (2) of this section shall affect the rights of parents and, where applicable, legal guardians, to exercise reasonable supervision and control over the conduct of their children and wards', without providing for exceptional situations, such as when competent and intellectually mature adolescent girls need to obtain confidential contraceptive services and information.

Nigeria's position in relation to the general limitation of the privacy rights of adolescents without providing for exceptions, is somewhat unfortunate since the country's adolescent population contributes substantially to its high HIV infection rate[108] and high teenage fertility rate.[109] In our view, the

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104 Section 1 Child Rights Act.

105 Section 7(2) Child Rights Act.

106 Section 7(1) Child Rights Act.

107 Section 8(1) Child Rights Act.

108 NACA *Key statistics on HIV in Nigeria*, available at: http://naca.gov.ng/index2.php?option=com_docman&task=doc_view&gid=110&Itemid=268; UNICEF Nigeria HIV/AIDS, available at: http://www.unicef.org/nigeria/children_1940.html (last accessed 31 August 2014).

109 Adolescent fertility rates have been estimated to be between 121–123 live births per1 000 births. See UNFPA country indicators – Nigeria in *The state of the world's midwifery 2011*, available at: http://www.unfpa.org/sowmy/resources/docs/country_info/profile/en_Nigeria_SoWM

limitation of adolescents' right to privacy is a shortcoming that will dissuade adolescent girls from accessing the required contraceptive services, thereby exposing them to risks occasioned by engaging in unprotected sex.[110] Moreover, the provision negates the intention of the Act to ensure that parents and persons *in loco parentis* provide guidance and direction to their children or wards while taking note of their evolving capacities and best interests.[111]

By inserting provisions in the Child Rights Act on the protection of children in accordance with their best interests and evolving capacities, a far-reaching obligation has been imposed on parents and persons *in loco parentis* as those who take decisions on issues affecting children are required to weigh the potential effects and outcome of their decisions before implementing them. Also, in accordance with the obligations created under international and regional human rights treaties on the right of the child,[112] governments, parents, and guardians are to ensure adolescent girls access to contraception when required in accordance with their level of maturity and ability to give informed consent, rather than raising idealist arguments as to why this group of persons should be denied access to contraception. This reasoning tallies with that of the CRC Committee which explained that the judgment of adults on what is in the child's best interests cannot override the obligation to respect the rights of the child guaranteed under the CRC, and that no right should be compromised by a restrictive interpretation of the child's best interests.[113]

As we have indicated, the Child Rights Act is silent on the right of children to consent independently to medical treatment. Whereas the right of adults

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110 Cook *et al Reproductive health and human rights: Integrating medicine, ethics and law* (2003) 167; Cook & Dickens 'Recognising adolescents' "evolving capacities" to exercise choice in reproductive healthcare' (2000) 70 *International Journal of Gynaecology & Obstetrics* 17; CRR and UNFPA 'The Right to Contraceptive Information and Services for Women and Adolescents' (2010) available at: http://www.unfpa.org/webdav/site/global/shared/documents/publications/2011/Contraception.pdf (last accessed 31 August 2014).

111 Section 7(2) Child Rights Act.

112 Article 3(1) & A 5 CRC & A 4(1) & A 9(2) ACRWC.

113 CRC Committee General Comment 14 (2013) par 4, available at: http://www2.ohchr.org/English/bodies/crc/docs/GC/CRC_C_GC_14_ENG.pdf (last accessed 31 August 2014).

to consent to medical treatment can be inferred from numerous sources,[114] the situation in relation to adolescents' consent to medical treatment is different as the consent of their next of kin or, in special circumstances, an order of the court, must be obtained.[115] This position is similar to the stance adopted under the Nigerian Constitution where section 35(1)(d) expressly limits the liberty of adolescents for 'welfare purposes', which may be interpreted to include their access to healthcare generally.

Nigeria's stance in not allowing adolescents under the age of eighteen to consent independently to medical treatment is disappointing and concerning. This is especially so as Nigeria is not only a party to international and regional human rights instruments protecting the rights of children which mandate state parties and persons *in loco parentis* to take cognisance of the wishes of children and respect their evolving capacities[116] as they increase in maturity, but it has domesticated the CRC and ACRWC in the Child Rights Act,[117] which acknowledge the importance of parents and guardians giving 'direction' to their children while having regard for their evolving capacities and best interests.

In fact, Nigeria's position regarding adolescents' consent to treatment and access to confidential healthcare services (especially in relation to contraceptive services) further entrenches cultural and paternalistic views that adolescent girls in particular, and children generally, have no say in their affairs or whatever course their healthcare treatment may take. This position is in stark contrast to the situation in South Africa where the country's legislative framework allows adolescent consent to medical treatment based on the adolescent's maturity and capacity to understand and

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[114] Sections 34, 35, 37 & 38 Nigerian Constitution 1999 and s 19 Code of Ethics of Medical and Dental Professionals. Also, the law of torts under the received English law encourages the obtaining of informed consent before the commencement of treatment. See *Apampa v The State* (1982) 6 SC 22 pars C–A; *Salisu Yahaya v The State* (2002) 3 NWLR (Pt 754) 289 pars B–C.

[115] Section 19 Code of Ethics of Medical and Dental Professionals. Special circumstances here includes where parents refuse to consent to the treatment of their children as a result of their religious beliefs. See *Esabunor v Fayewa* [2008] 12 NWLR (pt 1102) 794, available at: http://www.lawpavilionpersonal.com/lawreportsummary_ca.jsp?suite=olabisi@9thfloor&pk=CA/L/226/2003&apk=42587 (last accessed 31 August 2014).

[116] Article 3(1) & A 5 CRC & A 4(1) & A 9(2) ACRWC.

[117] Section 7(2) Child Rights Act.

comprehend the nature of treatment requested, rather than strictly on the basis of age.[118]

More importantly, the restrictive position adopted in Nigeria's legislation defeats the government's intention, as advanced in its reproductive health policies,[119] to promote adolescent reproductive health and ensure increased contraceptive use among this group of the population in order to combat the spread of HIV and high teenage pregnancy rates.[120]

CONCLUSION

Recognising the right of female adolescents to access and consent to private contraceptive information and services is not only a necessary step towards reducing their engagement in risky sexual practices, but it is also a step towards reducing the high teenage pregnancy and HIV infection rates plaguing Nigeria and South Africa.[121]

From the above it is clear that, although both South Africa and Nigeria have adopted legislation recognising the evolving capacities of adolescents, their legislative frameworks and commitment to ensuring adolescent girls' privacy to consent to and access contraceptive information and services, differ. While in various statutes South Africa specifically provides for the right of adolescents to access and consent to confidential contraceptive services and other SRH care services in accordance with their level of maturity and intellectual capacity, Nigeria adopts an inconsistent stance in this regard. This conclusion is reached based on the fact that, although Nigeria recognises the evolving capacities of adolescents in section 7(2) of the Child Rights Act and proclaims its intention to promote adolescent reproductive health, it introduces blanket limitations to the privacy rights of adolescents in section 8(3) of the same Act. This it does without considering that children may need to access confidential contraceptive and other SRH care services without their parents' knowledge. An express provision which

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118 Section 129 Children's Act, s 1(ix) Choice on the Termination of Pregnancy Act.

119 Nigerian National Reproductive Health Policy 2001 and National Policy on Health and Development of Adolescents and Young People 2007.

120 Paragraph 3.2.8 National Reproductive Health Policy; pars 4.1.1, 4.1.2 & 4.2 National Adolescent Policy.

121 According to current reports and statistics, South Africa and Nigeria are seriously affected by the HIV epidemic with a large number of the citizens already infected. See AGNATES Special report *How Africa turned AIDS around* (2013) 7, available at: http://www.unaids.org/en/media/agnates/contentassets/documents/unaidspublication/2013/20130521_Update_Africa.pdf (last accessed 31 August 2014).

disregards the evolving capacities of adolescents in relation to consent to medical treatment in the Nigerian Code of Ethics,[122] and the failure of the Child Rights Act to provide for the right of children to consent independently to medical treatment, are further instances of Nigeria's failure to recognise the right of female adolescents to access and consent to contraceptive information and services.

By extending the provisions dealing with the protection of the reproductive health of its citizens to its children, South Africa has not only adopted progressive steps to enhance the rights of children in relation to their access to contraception and reproductive health care, but its position supports current international recommendations that age should not be used as a barrier to prevent children (in this case, adolescent girls) from participating in decision-making processes on matters affecting their health and, particularly, when these decisions relate to their ability to consent to and exercise choice in contraception and other relevant reproductive health care services.[123] By contrast, Nigeria's contradictory position in this regard betrays its refusal to accept the reality of adolescent sexuality. It fails to take genuine measures that reflect the evolving capacities of adolescents and merely enacts laws that 'purportedly' protect children's best interests and guarantee their right to access contraceptive information and services, while denying children's rights.

Finally, although the article proposes that allowing adolescent girls access and independent consent to confidential contraceptive information and services is a necessary step towards achieving increased adolescent contraceptive use, it must be kept in mind that the recognition of adolescents' evolving capacities is but a first step towards achieving this goal as other measures, such as altering society's negative perceptions towards adolescent sexuality, must be taken to increase adolescent girls' access.[124]

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[122] Section 19 Code of Ethics of Medical and Dental Professionals.

[123] Ngwena 'Health care decision-making and the competent minor: the limits of self-determination' 1996 *Acta Juridica* 137; *Gillick* case n 55 above; *R (Axon)* n 71 above.

[124] In this regard, see Savage-Oyekunle n 101 above.