FOREWORD

There is one barrier to health access and a major impediment to national and regional development across the globe that could be removed within a few days if only the policy decisions would be made. The removal of this barrier would promote gender equality, help end child marriage, reduce teenage pregnancy and girl dropout rates from secondary school, lower HIV incidence rates, and achieve the prerequisite for the demographic dividend. Let me explain.

As the Sustainable Development Goals (SDGs) become the world’s compass towards development and a better life for all people on the planet, sub-Saharan Africa faces a potential demographic disaster that could undermine many of the SDGs.

Many sub-Saharan countries have some of the highest fertility rates in the world which, if unaltered, will see those countries’ population, rising from 17 million to 43 million by 2050. Another country’s population that is currently at 27 million will more than double to 65 million by 2050, with yet another going from 53 million to 137 million. Not one of these countries will have reached the population turnaround required as an inescapable prerequisite for achieving a demographic dividend by 2050.

With increases like these on the same available land area, with the same or less access to drinking water, potentially less arable land available due to global warming, and services and GDP increasing at a far slower rate than population, it will be impossible to achieve the SDGs and improbable to even maintain the human development index achieved thus far by 2017. These are not scenarios or ‘maybes’. This is the inevitable future of the region unless something significant, such as the fertility rates, changes. Slowing and reversing population acceleration is essential to development in sub-Saharan Africa.

And yet, the world has a dark and shameful history of ‘population control’, legislating women’s rights to decide on having children away and forcing and coercing sterilisation. These restrictions on agency and autonomy have no place in a democratic, sustainable development world in the 21st century and the vast majority of nations achieving the demographic dividend have not resorted to such dark methods.

Increasing gender equality, keeping girls in safe schools for longer, reducing sexual and gender based violence, and increasing the sexual and reproductive health knowledge of young people are also factors. And of course, it is the increased access to modern contraceptives and women making choices about their own reproductive health that have turned the tide.

So this research report turns its attention to this access to modern contraceptive methods, as well as all other sexual and reproductive health (SRH) services. There are many barriers for adolescents around the globe - the majority of citizens in many countries – to access SRH services. Distance from services, lack of transport, lack of available commodities, poverty, inherited beliefs, harmful practices, and hostile staff attitudes can all be barriers to access. But only one barrier is self-inflicted by countries. And this barrier could disappear tomorrow, creating massive access for adolescents. It is the barrier of legal restrictions on adolescents’ access to SRH. The majority of countries in the region have placed arbitrary legal barriers to adolescent access by creating policies or laws with a number of parental consent and other restrictions, preventing adolescents from initiating their own healthcare.

In some cases, these have been gradually added to laws or policies with well-intentioned reasons to protect adolescents. In many cases, however, they reflect an idealised view of what older people think younger people should or should not be doing. Primarily, these idealised views revolve around sex. Older people, sometimes forgetting their own youth, think that the best protection for younger people is to abstain from sex until they are, perhaps 16, or even 18. Reality is, in many cases different, and by ignoring reality and locking adolescents out of the health system when it comes to sexual and reproductive health and rights (SRHR), adults are doing irreparable damage to their children and other children, as well as directly contributing to a looming demographic disaster for their nation.
Because this seems so obvious, recent global guidelines have called on countries to examine their current policies and consider revising them to reduce age-related barriers to access and uptake of all SRH services. To assist in this process, the SRHR Africa Trust (SAT) in collaboration with the Thomson Reuters Foundation, 20 global law firms, and UNICEF, has reviewed Age of Consent laws in 22 countries: Botswana, Kenya, Ivory Coast, Malawi, Morocco, Nigeria, South Africa, Swaziland, Tanzania, Zambia, Zimbabwe, Brazil, Jamaica, India, Indonesia, Thailand, Vietnam, Canada, United Kingdom, France, Sweden, and Ukraine. The range of countries was chosen to highlight a spread of geography, cultures, development status, nonachievement, in-transition and achievement of the demographic dividend, and adolescent health outcomes. In addition, SAT and UNICEF also undertook an Ethical, Cultural and Social review in nine countries (seven being from the 22 countries above, plus two others - Uganda and Philippines) to look at ethical cultural and social barriers impacting adolescent access to health and services including SRH services.

The data revealed some game-changing recommendations apparent to SAT:

1. Desexualise SRHR services and treat them as you would any other health system access;
2. Base both access and restriction decisions on child and adolescent development, competence and maturity to make decisions about their own health;
3. Do not make the age of sexual consent older than 16 years, and do not distinguish between young men and young women;
4. Have statutory rape provisions in place to protect adolescents from predatory adults;
5. Put ‘close in age’ exceptions to the age of sexual consent in place so that young adolescents having consensual sex with one another do not have to go to jail – a travesty affecting young men aged 13-16 years.

We offer this report and its insights to policymakers, legislators, development agencies, international cooperating partners, and activists wherever they may be. A thinking and action tool is currently being designed to accompany this report. If you wish to receive it or an electronic copy of this report, please send an e-mail to ageofconsent@satregional.org. Please also feel free to share ways in which you may have used this report or the action tool to create positive change with us and with one another.

Our hope is that these resources will create dialogue and action that will remove all legal barriers to adolescent access to SRH services and allow attention and resources to focus on the remaining and more intractable barriers.

Jonathan Gunthorp

Executive Director - SAT
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NIGERIA

AGE OF CONSENT
LEGAL, ETHICAL, CULTURAL
AND SOCIAL REVIEW
ACRONYMS

AIDS       Acquired Immune Deficiency Syndrome
ANC        Antenatal Care
ART        Antiretroviral Therapy
EHP        Essential Health Package
FSW        Female Sex Worker
GBV        Gender Based Violence
GDP        Gross Domestic Product
HCT        HIV Counselling and Testing
HIV        Human Immunodeficiency Virus
HPV        Human Papillomavirus
MMC        Medical Male Circumcision
MPR        Multiple-perpetrator Rape
MSP        Multiple Sexual Partners
MSW        Male Sex Worker
PLWA       People Living with HIV/AIDS
PLWHIV     People Living with HIV
PEP        Post-exposure Prophylaxis
PrEP       Pre-exposure Prophylaxis
SRH        Sexual and Reproductive Health
SRHS       Sexual and Reproductive Health Services
UNAIDS     Joint United Nations Programme on HIV/AIDS
UNICEF     United Nations International Children’s Fund
UNFPA       United Nations Population Fund
WHO        World Health Organization
YFS        Youth-friendly Services
EXECUTIVE SUMMARY

The Age of Consent for sexual intercourse in Nigeria is 18 years. Sexual intercourse with a person under the age of 18 years is illegal. Under the Nigerian law there is no specific definition for statutory rape. There is, however, a definition of "rape" under section 357 of the Criminal Code Act, which requires unlawful carnal knowledge of a woman or girl. There are, however, cultural practices that provide exceptions depending on the religion, ethnic, cultural beliefs and general customs of both or all parties to the act. It is, for instance, not uncommon in the Northern region of Nigeria that is predominantly Muslim and where Shariah Law is applicable for adult men to marry girls that are younger than 18 years.

There are no gay sex exceptions in formally recognised Nigerian laws.

There are no provisions under Nigerian law that regulate a young person’s access to, or purchase of, contraceptive products. Contraceptives are made available to everyone of all ages and whether or not a young person may access contraceptives would depend on whether a doctor or pharmacist is willing to give the contraceptive to that person and the availability of such contraceptive.

The National Agency for Control of AIDS (NACA), the agency of the Nigerian Government set up to fight HIV/AIDS discrimination, create public awareness and prevent the spread of the virus around the country, issued a National HIV Prevention Plan 2014-2015. The plan encourages use of and access to Antiretroviral Therapy (ART) for the purposes of HIV treatment and prevention, both between sexual partners and from mother to child. Neither the National Plan nor any other policy stipulates an Age of Consent to ART. However, parental consent for access to ART by children (under the age of 18 years) might be required. Where a young person or minor visits a clinic and requests ART, the medical personnel attending to the child would usually ask to speak to the child’s parents or guardians first, but where no such adult can be found, the child would not be denied access to ART.

The law does not specify an age at which the HIV status of an adolescent will be reported directly to his/her parents. Accordingly, children and adolescents are entitled to the same level of confidentiality as adults. Under the HIV Anti-Discrimination Act, it is provided that no body, person or institution shall require a person to disclose his/her HIV status or the status of any other person, by asking questions, orally or in writing, directly or indirectly.

There is no prohibition on Post-exposure Prophylaxis (PEP), young people are able to access PEP from healthcare centres or anywhere else where PEP is offered. In most Government-owned hospitals, special clinics within the hospitals specialising on HIV/AIDS testing and care offer free drugs to those infected.

There are no legal prohibitions on access to HIV Pre-exposure Prophylaxis (PrEP). In practice, the most common restriction to a person’s access to PrEP is lack of availability in the clinics, and this restriction is not limited solely to young persons. PrEP is not as common as contraceptives are in Nigeria, and it is still a fairly new technology for combating HIV/AIDS spread in the country. The National Plan seeks to encourage public access to PrEP as a new preventive technology with an effective result, for the prevention of HIV spread in the country.

Abortion is illegal in Nigeria. There is no Age of Consent access to Antenatal Care (ANC) specified in law, young persons’ access ANC in healthcare centres that offer same without any Age of Consent restriction. In practice, however, the healthcare officer attending to a child may require parental consent for the young person under 18 years to access ANC services even though it is not provided for by law.

The National Plan encourages access to Human Papilloma Virus (HPV) vaccines for every woman and girls. It does not deal with the Age of Consent.
Chapter One: Introduction

The world’s attention has moved beyond HIV and AIDS, yet it remains the leading killer of adolescents in Southern Africa, presenting a major impediment to healthy communities and a significant factor in the health and status of women and girls in the region.

According to a report by the Joint United Nations Programme on HIV/AIDS (UNAIDS) on prevention of HIV (2013), Eastern and Southern Africa is home to half the world’s population living with HIV, even if the region is only 5% of the world’s population. Today the region continues to be the most infected and affected by the HIV/AIDS epidemic, with 48% of the world’s new HIV infections among adults, 55% among children, and 48% of AIDS-related deaths.

Research conducted in many parts of the world shows that several legal and human rights barriers hinder access to, and uptake of, HIV services for adolescents. Key among these barriers are Age of Consent legislation and policies. Recent global guidelines have, therefore, explicitly called on countries to examine their current policies and consider revising them to reduce age-related barriers to access and uptake of the overall SRH services, HIV Counselling and Testing (HCT) and to linkages to prevention, treatment and care.

HIV is the most severe in the Southern Africa sub-region which includes Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe, with each having an adult HIV prevalence of over 10%. UNAIDS reports that Swaziland have the highest HIV prevalence in the world (26.0%), followed by Botswana (23.4%).

In 2011, there was an estimated 1.2 million adolescents aged 10-19 years old living with HIV, more than half of all HIV positive adolescents globally. Eastern and Southern Africa now have 10.5 million children who have lost one or both parents to AIDS.

The risk of becoming infected with HIV is higher for girls and young women and currently, HIV prevalence among young women aged 15-24 years stands at 4.8%, which is two and a half times higher than among men of the same age. In Swaziland, 15.6% of young women are HIV positive, compared to 6.5% of young men.

The advocacy campaign ‘All In To #EndAdolescentAIDS’ was launched as a global platform for action and collaboration for social change in February 2015 by global leaders and civil society partners. This global agenda provides opportunities for ensuring that existing and new strategies and programmes on HIV prevention, treatment and care are effectively implemented to benefit young people. These include the 2012 guidance on Pre-exposure Oral Prophylaxis (PrEP) for serodiscordant couples, men, and transgender women who have sex with men at high risk of HIV transmission, as well as the 2013 guidance for HCT and care for adolescents living with HIV and young key population policy briefs.

All In To #EndAdolescentAIDS works through four workstreams. As part of workstream 1, global partners have prioritised joint action to take stock of the current situation in countries with respect to Age of Consent for services including HIV prevention by carrying out a systematic desk review of Age of Consent laws and a mapping of the processes led and outcome of reforms undertaken by countries to address this barrier. Through the All In To #EndAdolescentAIDS, many agencies, and global partners including the United Nations Development Programmes (UNDP), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the PACT and AIDS Alliance have already initiated actions on data collection to inform their policy advocacy efforts globally and specifically within the 25 focus countries. This review will inform the development of a source or toolkit for learning on this theme and capacity building of experts and policymakers worldwide.

Why Age of Consent review?

Several global bodies, including UNICEF and WHO, are currently undertaking a number of initiatives to change the global guidelines with regard to adolescent access to a range of HIV prevention services, including Age of Consent and informed consent, confidentiality, availability, accessibility, and acceptability. Adherence and quality must inform these services.
The Southern African AIDS Trust (SAT) in collaboration with UNICEF worked with participating local law firms, and a consultant to conduct the Age of Consent research. The three areas of the research included the following:

1. **Age of Consent legal review**
2. **Ethical, Social, Cultural (ESC) desktop review**
3. **Youth attitudes survey**

Therefore, the main goal of the project was to conduct research on “Age of Consent” laws, regulations, and policies, as well as ESC factors, in relation to adolescents. This entailed collecting country experiences to address Age of Consent laws / policies and ESC factors that serve as potential barriers to adolescents accessing SRHS, including HIV prevention, care and treatment. The research explored implications for expanding SRHS and HCT in adolescents aged 10–19 years.

**Methodology**

The Nigeria legal, ethical, cultural and social review was prepared by SAT and is based on legal review research conducted by Udo Udoma & Belo-Osagie Law Firm and the ethical, cultural, and social review by Jerome Amir Singh, Centre for the AIDS Programme of Research in South Africa (CAPRISA), Durban, South Africa, and Dalla Lana School of Public Health, University of Toronto, Toronto, Canada.

The ethical, cultural and social review focuses on the norms and practices around the Age of Consent in relation to the various aspects relating to SRHR. The legal review looks at all the relevant national laws (including nationally recognised customary or religious laws), regulations, and policies exploring the ages for girls and boys separately where relevant, including where contradictions exist in laws, policies, and regulations on these issues.

The review specifically looked at the following:

1. **Age of Consent to sexual intercourse including the age for statutory rape**
2. **Age of Consent to access modern contraceptives, with and without parental consent**
3. **Age of access to emergency contraceptives, with and without parental consent**
4. **Policy framework and legislation enabling or disenabling access to Pre-exposure Prophylaxis (PrEP) including Age of Consent, with and without parental consent**
5. **Policy framework and legislation enabling or disenabling access to Post-exposure Prophylaxis (PEP) including Age of Consent, with and without parental consent**
6. **Policy framework and legislation enabling or disenabling access to safe abortions and postabortion care including Age of Consent, with and without parental consent**
7. **Policy framework and legislation enabling or disenabling access to Antenatal Care (ANC) including Age of Consent, with and without parental consent**
8. **Policy framework and legislation enabling or disenabling access to HPV vaccines and cervical cancer screening and treatment, including Age of Consent, with and without parental consent**
9. **Age of Consent to access HIV testing without parental consent**

The Ethical, cultural and social component of the research seeks to highlight social and cultural factors, and the ethical dimensions thereof, that impact on adolescent health in the following contexts:

1. **Age of Consent for sexual intercourse.**
2. **Homosexuality and transgender expression.**
3. **Access to Sexual and Reproductive Healthcare Services, including autonomous HIV counselling and testing [HCT] and contraception access.**

Nigeria’s analysis was conducted through a desk review of publically accessible sources, including works published by international agencies such as UNICEF, WHO, UNAIDS, and the World Bank, Nigerian Government reports, and non-governmental research outputs.
Country overview

UNICEF estimates that by 2015, one fifth of Africa’s births will take place in Nigeria alone, which would account for 5 per cent of all global births.¹ Nigeria has an estimated 63 million youth (defined in Nigeria as individuals 15 – 35 years of age), of which females comprise 51.6 %.² Adolescents comprise approximately 41.4 million of Nigeria’s population.³ There are more females than males in all Nigerian age-groups, except in the age group 15-19 years of age, where females comprise 47.2 % of that component of the country’s population.⁴ Approximately 64% of Nigerian adolescents aged 15–19 years of age are in school while 21.3% of adolescents have never been to school. 47.4 per cent of youths in the country have access to, and used, public facilities, compared to 19.5% who have access to, and utilized private facilities.⁵ While Nigeria is virtually homogenous in respect to race, the country is home to a wide array of ethnicities. Estimates of Nigeria’s ethnic diversity range between 250-400 ethnicities.⁶ Nigeria’s three largest ethnic groups are the Hausa-Fulani (29% of the population), Yoruba (21%) and Igbo, or Ibo (18%).⁷ There are two predominant religions amongst the Nigerian population. An estimated 49.3% of Nigeria’s population are Christian and 48.8% are Muslim. African traditional religions constitute 1.4% of Nigeria’s population.⁸ Northern Nigeria is mostly Islamic and dominated by the Hausa-Fulani ethnic group. Southern Nigeria is more westernized and urbanized than the north, with the Yoruba predominant in the southwest and the Igbo in the southeast. It is estimated that about half the Yorubas are Christian and half Muslim, though many maintain traditional beliefs. The Igbo in the southwest tend to be Christian, with many being Roman Catholic.⁹

Country context

- Nigeria is classified as a lower-middle income country with a nominal GDP of $568.5 billion.¹⁰
- Nigeria’s population estimate as of March 2016 is approximately 179,430,139,¹¹ the largest in Africa.
- Females comprise approximately 49.5 percent of Nigeria’s population.¹²
- In 2013, the total fertility rate was 5.5 births per woman.¹³
- Nigeria has a national HIV prevalence rate of 3.4% with approximately 3.2 million people living with HIV.¹⁴
- The highest HIV prevalence in Nigeria is amongst 35-39 year olds at 4.4% and lowest amongst adolescents aged 15-19 at 2.9%.¹⁵
- Nigeria contributes 10% of new global HIV infections annually, and 15% of Sub-Saharan Africa’s total.¹⁶
- 9% of the global population of PLWHIV is Nigerian.¹⁷
- Of all AIDS-related deaths in the Sub-Saharan Africa region, 19% occur in Nigeria.¹⁸
- Nigeria contributes 14% of HIV/AIDS-related deaths globally, and 19% of the Sub-Saharan Africa region.¹⁹
- Nigeria accounts for one quarter of all new HIV infections amongst children in the Global Plan priority countries in 2013 – an estimated 51,000 cases.²⁰
- HIV prevalence among MSW and FSW is 19% and 25% respectively.²¹
- Prevalence is 8-fold higher in sex workers than the general population.²²
- It is estimated that there are over 236,416 sex workers in Nigeria, with an estimated prevalence of 24.5%.²³
Chapter Two: Age of Consent to sexual intercourse

The legal Age of Consent for heterosexual sex in Nigeria is 18 years of age.24 Same-sex sexual relationships are legally prohibited in Nigeria.25 According to national statistics, 15.6% of adolescent girls and 2.9% of adolescent boys aged 15-19 years of age had sexual debut before 15 years of age. 24% of Nigerian women had experienced sexual debut by 18 years of age, while 19% of Nigerian men experienced sexual debut by 18 years of age.26,27 One study conducted in South West Nigeria found that the average age at initiation into MSM was 19.3 (+1.2) years.28 The median age for sexual debut amongst adolescents that self-reported as being HIV-infected was 14.8 years of age, with a median of 15.4 years for females and 14.8 years of age for males.29 The median age for adolescents that self-reported as being HIV-negative was 15.2 years for age for males and 15.5 years of age for females.30 Given the above, sexual debut by approximately 15 years of age for both male and female adolescents seems to be the social norm amongst heterosexual Nigerian adolescents.31 Notwithstanding these statistics, discussing sex with adolescents is regarded as being culturally taboo in Nigeria. Sex education is rare.32 From a social perspective, differential standards apply in the Nigerian context in regard to sexual activity. Whereas young boys receive social recognition and praise from their peers33 for engaging in intercourse at an early age, young girls are expected to remain chaste and submissive.34

In Nigeria Section 31 of the Childs Rights Act, Cap C50, LFN 2004 (the “CRA”) makes it an offence to have sexual intercourse with a child. Under the CRA, a child is defined as any person under the age of 18 years. The Nigerian law makes no distinction in the Age of Consent for males and females.

Legislation on Age of Consent to sexual intercourse

Section 31 of the Childs Rights Act, Cap C50, LFN 2004 (the ‘CRA’):

1. No person shall have sexual intercourse with a child
2. A person who contravenes the provision of subsection (1) of this section commits an offence of rape and is liable on conviction to imprisonment for life.
3. where a person is charged with an offence under this section, it is immaterial that-
   a. the offender believed the person to be of or above the age of eighteen years; or
   b. the sexual intercourse was with the consent of the child.

Section 277 (Interpretation) of the CRA:

A ‘child’ means a person under the age of 18 years.

Child marriage

Nigeria is currently home to the largest population of child brides in Africa, with an estimated 23 million girls and women in that country who married during their childhood.35 Religious beliefs and morals often dictate early sexual behavior amongst adolescents in Nigeria.36 Nigeria’s national prevalence of adolescent girls married by 18 years of age is 39%.37 The prevalence of adolescent girls who married before turning 15 is greater than 10%.38 Child marriage between young girls and adult men remains prevalent amongst the Hausa-Fulani, an ethnic group inhabiting the northern regions of Nigeria. Child marriage is recognized as a traditional cultural practice in Northern Nigeria and has been greatly influenced by Islam, which has had a long presence in this region of Nigeria, and continues to be practiced in this region today.39 Child marriage in certain parts of Nigeria is predicated on the marriage between the Prophet Muhammad and his wife, Aisha. 40 Aisha was reportedly 9 years old when she married The Prophet.41 In Islam, the male is forbidden from consummating the marriage until the girl reaches puberty, as evidenced by the girl’s first menstruation.42 Likewise, traditional Christianity is opposed to premarital sex43 but regards marriage as permissible upon the attainment of puberty.44 Therefore, according to Nigeria’s two dominant religions, sexual intercourse is permissible below the country’s legal Age of Consent and the country’s socially acceptable age of sexual debut, provided the sex occurs within the confines of marriage.
This said, the Marriage Act, Cap M6, LFN 2004 sets the age at which a person may marry without the consent of his/her parents or guardians, at 21 years. Below this age, the consent of a parent or guardian is required. Marriage under the Marriage Act is prevalent in southern Nigeria and amongst the educated middle-class.

Culturally, menstruation in some parts of Nigeria is indicative of a girl’s maturity and ability to bear children. In light of the immense pressure exerted on young girls, an estimated 45% of young Hausa-Fulani girls are married prior to turning 15 years of age. An additional 73% of Hausa-Fulani girls are wed by 18 years of age. There are a number of social reasons for the pervasiveness of this practice, the foremost being poverty. Nigeria’s poverty rate is estimated at 67%. The rates in Northern Nigeria is an alarming 80%. Child marriages relieve the financial burden of those families following the practice. Secondly, child marriage is viewed as a way to preserve young girls’ chastity and prevent pregnancies out of wedlock. Thus, it is not unusual for adolescent girls as young as 10 years of age to be married.

**Definition of statutory rape**

There is no specific definition of ‘statutory rape’ under Nigerian law. There is however a definition for ‘rape’ under section 357 of the Criminal Code Act which requires unlawful carnal knowledge of a woman or girl. Section 31 of the CRA provides that any person who has sexual intercourse with a child (i.e. any person under the age of 18 years) commits an offence of rape and is liable on conviction to imprisonment for life. Section 31 of the CRA differs from section 357 of the Criminal Code Act in that it does not require that force be used or the lack of true consent. In the case of the crime of rape under section 31 of the CRA, all that is required to prove the offence is that one of the parties to the sexual act is under the age of 18 years. Therefore, a young male (under 18) can constitute a victim under section 31 of the CRA. In contrast, Nigerian law does not recognize an offence of rape where the victim is a male adult (18 years or over).

**Legislation and Policy framework on statutory rape**

**Section 31 of the CRA**

Section 357 of the Criminal Code Act: Any person who has unlawful carnal knowledge of a woman or girl, without her consent, or with her consent, if the consent is obtained by force or by means of threats or intimidation of any kind, or by fear of harm, or by means of false and fraudulent representation as to the nature of the act, or, in the case of a married woman, by impersonating her husband, is guilty of an offence which is called rape. No contradiction and the recommended intervention is Law reform.

It is not uncommon in the predominantly Muslim Northern region of Nigeria for adult men to marry girls that are younger than 18 years. As a result, there is in practice a degree of prosecutorial discretion exercised under Section 31 CRA; in other words, prosecutors may decline to charge individuals with rape under s.31 CRA if customary practices provide for an exception to the offence of rape, e.g. in situations where adult males marry female children.

**Intergenerational Relationships**

Early sexual debut amongst adolescents is usually indicative of engagement in risky sexual practices. Risk of HIV acquisition increases with multiple and concurrent sexual partnering. According to Nigerian national statistics more than 1.1% of Nigerian adolescent males and 0.7% females aged 15-19 years had more than 2 sexual partners, while 2.1% of adolescent males 18-19 years of age and 1.3% of adolescent females 18-19 years of age had more than 2 sexual partners. In light of rising poverty levels in Nigeria, the prevalence of intergenerational relationships between adolescent girls and older men is rising. Intergenerational sexual relationships are widespread throughout sub-Saharan Africa, including Nigeria. According to the Nigerian Demographic and Health Survey (NDHS), 42.5% of adolescent girls 15-17 years of age and 37% of girls 18-19 years of age were sexually involved with men at least 10 years or older than themselves in the year leading up to the survey. Intergenerational sex was most prevalent amongst unmarried females who did not know how to access contraceptives; women residing in rural areas; and those in the North West. Poverty-stricken women without an education are susceptible to pursuing intergenerational relationships, as the likelihood of embarking on intergenerational relationships decreases with higher levels of education.
and increasing wealth. The high prevalence of intergenerational sexual relationships between adolescent girls and older men in Nigeria seems to indicate that such relationships are socially acceptable. Moreover, intergenerational relationships are culturally acceptable, given the traditional practices of early marriage, particularly in the Northern parts of Nigeria.

The practice of safe sex is less likely in intergenerational sexual partnerships. NDHS reports that of the 876 respondents participating in the survey, only 37.2% of female adolescent 15-19 years of age used a condom in their last sexual intercourse. Given inequitable power dynamics between the partners in intergenerational relationships, adolescent female partners are unlikely to be able to negotiate safe sexual practices. When adolescent females engage in transactional sex for economic reasons, their power to negotiate safe-sex diminishes. In such circumstances, female adolescents have less incentive to access SRHS and HCT services. Moreover, given the gainful nature of transactional sexual relations, adolescent girls may be less likely to access SRHS if the provision and use of HIV prevention and contraceptive interventions, such as condoms, could deter her older partner (who may prefer unprotected sex).

**Gender-based violence**

GBV, especially sexual violence, is pervasive in West Africa and it usually involves sexual slavery, mutilation and multiple-perpetrator rape of young girls and women. The most common form of gender-based violence that young girls and women in Nigeria endure is domestic violence. This usually takes the form of battering, intimate-partner violence such as marital rape, sexual violence and intimidation. Domestic violence is buttressed by cultural beliefs that it is permissible to beat a child or woman for disciplinary purpose without the intention to grievously harm them. This is legally permissible according to Section 55 (1) (d) of Nigeria's Penal Code which applies in Northern Nigeria, which permits a father or husband to discipline a child or woman in this manner. This cultural practice is not age discriminatory. It can occur at any age and although the Penal Code recognises a father and a husband, such violence is sometimes also carried out by other male relatives. Domestic violence is rife throughout Nigeria. Nigeria is experiencing a rape epidemic. More frightening still is the estimated child and baby rape prevalence. It is estimated that the prevalence of rape amongst adolescent females is between 11 and 55%. Previously, the prevalence rate sat between 4-6%. Still, underreporting by victims continues to mask the actual number of cases that are perpetrated in Nigeria. Nigeria is not immune to ethnic and religious conflict. It has been found that in the midst of armed struggle, young girls and women are at an increased risk of being subjected to sexual violence, especially sexual abuse and systematic rape as a terror tactic. This is owed to their gender and economic vulnerability. Nigeria has experienced several ethno-religious armed conflicts in recent years. For instance, major crises occurred in the city of Jos, Central Nigeria in 2001, 2004, 2008 and 2010. In one such example, 20 young girls and women were abducted by the Boghom people and taken to the Kangyal village in Kanam Local Government Area. There they were subjected to continuous sexual abuse, rape and torture. This abuse persisted every single night for three months. When they were finally rescued, a fifth of them had already contracted HIV and were pregnant.

Boko Haram is a militant Islamic fundamentalist group terrorizing Nigeria. The term 'Boko Haram' is derived from Hausa, the language spoken in Northern Nigeria and Arabic. 'Boko' is a Hausa term connoting 'sham, deceit, fraud'. It generally referred to the implementation of the British colonialist secular education system in Nigeria. Haram is an Arabic term connoting forbidden or sinful in God's eyes. Collectively the term Boko Haram means, 'Western education is sinful'. The group’s primary objective is to enforce Islamic or Sharia law throughout Nigeria. Boko Haram has been active in the crimes of kidnapping, suicide attacks and bombings, their initial targets being the United Nations, churches, and federal Government establishments. The abuse and victimization of young girls, especially attacks on the girls themselves and their education, is vastly becoming central to the groups dogmatic tactics. Boko Haram has consistently and systematically inflicted sexual violence on non-Muslim girls and women. Christian women and girls in the Yobe and Borno states of Nigeria are repeatedly raped, tortured and even murdered by the group. Nigeria's astounding adolescent rape prevalence impacts on sexual debut in that country. Considering that many adolescent girls are unwilling to report their sexual assaults, they are unlikely to attend SRHS, fearing they may be labelled promiscuous and accordingly, met with stigma, discrimination, and social sanction.
Ethical implications and recommendations

Not only is child marriage a violation of the child bride’s basic human rights, it also increases vulnerability to HIV infection. Given the typical age-disparate power imbalance between both genders in such relationships, the female adolescent is vulnerable to domestic violence, sexual abuse, and will likely be unable to negotiate condom use. Given the above, the prevalence of child marriages in certain parts of Nigeria undermines that country’s legal Age of Consent for sexual intercourse. More efforts must be made in respect to encouraging adolescents to delay sexual debut, eradicating gender inequality, and facilitating adolescent access to SRHS. Moreover, Nigeria’s Government should do more to eradicate child marriages, particularly in the country’s Northern states. Poverty reduction and the education of adolescent females should be prioritised to reduce the prevalence of underage sexual intercourse between female adolescents and older sexual partners. The systematic extolling of male supremacy, dominance and authority is imposed over females in all aspects of human life. Patriarchy is systemic throughout all cultural communities in Nigeria. Several cultural and traditional practices are predominantly humiliating, derisive and cruel towards females. These practices are predominantly reinforced and perpetuated by religions, specifically Christianity and Islam. The Nigerian Government must commit to doing all it can to address gender inequality and to discourage intergenerational sex couplings. To this end, the Nigerian Government should engage with religious leaders to change social and religious beliefs and practices that are harmful to adolescents. Nigerian authorities should also do more to prevent the illegal abduction of adolescents by radical elements, such as Boko Haram.

Country experiences in addressing the barriers

Nigeria enacted the Violence Against Persons Prohibition Act in May 2015. This piece of legislation is considered a milestone for Nigeria as it strives to protect women and girls from all forms of violence, including sexual violence such as rape and sexual assault, and physical, psychological, and domestic violence. It even extends its protection to harmful traditional practices, which could arguably include child marriages. According to the Act, rape, harmful traditional practices, political violence, forced dependence/economic abuse, forced isolation and separation from family and friends, and violence by state actors are all offenses. The Act entitles victims to comprehensive legal medical, psychological, and social assistance either provided by the Government of non-governmental agencies. The Act further entitles victims to be informed of the assistance available and immediate access to such services, as well as to rehabilitation and re-integration programmes at the expense of the State.

Aside from Government initiatives, a number of NGOs focused on empowering adolescent girls and young women are active in Nigeria. Groups such as the Adolescent Health & Information Projects (AHIP) endeavor to empower young women and girls, particularly in Northern Nigeria, to make responsible decisions concerning their health and well-being. AHIP aims to do so by providing young women and girls with information, knowledge and life skills that will enable them to make such decisions. Similarly, the WomenAid Collective (WACOL), a non-profit and non-governmental organisation in Nigeria, seeks to assist young people, especially young women and children who are victims of physical, psychological and sexual abuses, and to ensure they are afforded increased legal protection. Likewise, Women United for Economic Empowerment (WUEE) is dedicated to empowering poor and marginalized young women and children in urban and rural areas. The object of WUEE is to help young girls and women fight for their rights, encourage self-reliance and foster stability.

Homosexuality and transgender expression

Nigerian society is intolerant towards homosexuality and transgender expression. Homosexuality has been outlawed in Nigeria since its colonization by Britain and the introduction of British penal codes in the country. Subsequently, the country’s Criminal Code Act made homosexuality punishable. Twelve of Nigeria’s northern states – Bauchi, Borno, Gombe, Jigawa, Kaduna, Kano, Katsina, Kebbi, Niger, Sokoto, Yobe and Zamfara – have implemented Islamic Sharia law. Sharia law strictly prohibits homosexual activity. These prohibitions are codified in scripture. Homosexual activity may be punishable by death. The above twelve states have adopted Sharia-based death penalties for same-sex sexual activities between men. Same-sex sexual activities among women often ends in either whipping or imprisonment.

Cultural values have significant influence and commonly determine what is permissible in society. Such cultural norms dictate Nigeria’s societal perception of sexuality to a great extent. In Nigeria, homosexuality
is considered a western construct which does not belong in African society. Although, homoerotic activity is practiced, as evidenced by the presence of the yan daudu (Hausa MSM), homosexuality is still considered immoral. Violence and abuse is encouraged against the yan daudu. Homosexuality and lesbianism is deemed un-Islamic and satanic. Likewise, Christianity, which is Nigeria’s most prevalent religion, considers homosexuality sinful and church leaders are unwilling to accept LGBT parishioners in Churches. Attitudes towards transgender expression correlates with attitudes regarding homosexuality. Transgender and homosexual individuals suffer a myriad of human rights violations. They endure abuse and death threats regularly because of their sexual identity. Therefore, homosexuality is deemed socially, culturally, and morally reprehensible in Nigeria.

Exceptions for gay sex

There are no exceptions in the CRA or any other formally recognized Nigerian laws. There are, however, cultural practices that provide exceptions depending on the religion, ethnic, cultural beliefs and general customs of both or all parties to the act.

The relevant customary practices are not expressly set out as written laws. The nature of Nigerian customary law is that it is not usually written and is derived from the cultures and peculiar traditions in the relevant part of the country, but nevertheless is treated as if it had the effect of law in those areas.

Ethical implications and recommendations

Nigeria’s Government is a signatory to the Universal Declaration of Human Rights, the African Charter of Human Rights, and the UN Convention on the Rights of the Child. All these instruments prohibit unfair discrimination. In 2014, the African Commission on Human and Peoples’ Rights passed a resolution condemning “the increasing incidence of violence and other human rights violations, including murder, rape, assault, arbitrary imprisonment and other forms of persecution of persons on the basis of their imputed or real sexual orientation or gender identity; Specifically condemns the situation of systematic attacks by State and non-state actors against persons on the basis of their imputed or real sexual orientation or gender identity”. The Commission called on State Parties to “ensure that human rights defenders work in an enabling environment that is free of stigma, reprisals or criminal prosecution as a result of their human rights protection activities, including the rights of sexual minorities” and strongly urged States to “end all acts of violence and abuse, whether committed by State or non-state actors, including by enacting and effectively applying appropriate laws prohibiting and punishing all forms of violence including those targeting persons on the basis of their imputed or real sexual orientation or gender identities, ensuring proper investigation and diligent prosecution of perpetrators, and establishing judicial procedures responsive to the needs of victims.”

Nigeria’s Federal and State Governments should heed this sage advice. Healthcare workers should be given sensitivity-training and reminded that they have an ethical (and legal) duty to provide care to any person in need and that this duty supersedes the healthcare professional’s personal moral biases regarding sexual orientation and lifestyle choice. Furthermore, policymakers, officials, and health professionals ought to note that they have a legal and ethical obligation to always act in the best interests of a child, regardless of that child’s sexual orientation.

Country experiences in addressing the barriers

Despite the overwhelming majority of Nigerians condemning homosexuality and the country’s draconian laws against homosexuality, there remains minor beacons of hope for the country’s LGBT community. To this end, non-state actors are taking the lead. For instance, the “No Strings” podcast operating out of Port Harcourt, Nigeria, seeks to inform, educate and provide a listening ear and shoulder to lean on for the LGBTI community. The Initiative for Equal Rights (TIERs), based in Lagos, supports the rights of the country’s LGBTI community by engaging with human rights bodies at a national and international levels to ensure the protection of LGBTI rights. TIER has founded the “Where Love Is A Crime” website. It provides vital information concerning LGBTI advocacy, health, human rights, law, and relationships. Additionally, TIER has established a toll-free line for the LGBTI community in need of counselling, legal aid, and an array of services including LGBTI-friendly health centers and HCT. TIER has also developed a 24-hour line which is accessible via the WhatsApp application, thus making it easier for LGBTI to access these services.
Chapter Three: Access to contraception services and commodities

There are no provisions under the Nigerian law that regulate a young person’s access to contraception services, commodities or purchase of contraceptive products and emergency contraception such as the morning after pill.

In practice, contraceptives are made available to everyone of all ages and whether or not a young person may access contraceptives would depend on whether a doctor or pharmacist is willing to give the contraceptive to that person and the availability of such contraceptive.

Numerous cultural norms and social practices impact on contraception use in Nigeria. These include education and occupation of women, number of living children, rural-urban and region of residence. It has been reported that only 10.5% of Nigerian adolescents make use of contraception, including condoms. The rate of married teens and young women using contraception is much lower. Four percent of married teen women and fewer than 10% of married young women use modern contraception.

Adolescents listed fear of parent’s disapproval as a barrier to accessing contraception. This along with fear of negative side-effects of contraception; lack of knowledge; unexpected timing of sexual intercourse; embarrassment, and unfriendly unwelcoming service providers were some of the social barriers to access amongst adolescents. In the absence of being able to procure proven contraceptives, Nigerian adolescents sometimes procure traditional contraceptives, such as herbs, charms, potash, and tobacco.

The relative absence of adolescent-friendly clinics in Nigeria may also be contributing to Nigeria’s poor contraception adoption rate amongst female adolescents. To this end, the number adolescent-friendly centres administered by NGOs pale in comparison to the unmet needs of Nigeria’s large adolescent population. Despite these factors, condoms are freely available for use in clinics. Not only is condom use promoted in parts of Nigeria, condoms are also distributed freely too. As religious mores prohibit premarital sex amongst adolescents, religious messaging also serve as barriers to adolescents accessing contraceptives and condom use.

Research indicates that religious beliefs have an influence on contraceptive use in Nigeria. Religious disapproval of adolescents accessing contraceptives and the availability of traditional contraceptives serve as social and cultural barriers to adolescents accessing safe and proven contraceptives. In 2008, women of Islam and traditional religions were more likely to have never used, or not to be using, modern contraceptives compared with Catholics and Protestants. This can be attributed to their poorer socioeconomic status relative to Catholics and Protestants. Therefore, improving women’s socioeconomic status is an imperative in the promotion of modern contraception in Nigeria. Education and employment are critical in this regard and adherents of Islam and Traditional religions require special attention. Efforts to increase contraceptive usage in Nigeria should target religious leaders and put more emphasis on raising the status of women and promoting region specific programmes. Anecdotal evidence seems to indicate that an apparent rise in contraceptive use in Nigeria since 2008 stems largely from a willingness by traditional and religious leaders in some regions to use their influence in promoting reproductive health. This speaks to the value of engaging with religious leaders. The same should occur in relation to adolescent health. This is crucial in Nigeria, where 54% of people polled in that country stated that they believe contraceptive use to be morally unacceptable (this was the second highest total in the world, after Pakistan). Moreover, health authorities at state level should work towards establishing more YFS and getting the endorsement of religious leaders to do so.
In regard to MSM, despite the HIV-acquisition risks they face, condom use amongst Nigerian MSM remains low. This is partially due to a number of misconceptions concerning condom use amongst Nigerian MSM. For instance, some believe that condoms are ineffective and they should rather use the toilet to flush out ejaculation. Others believe condoms are an unreliable western invention. Some MSM were ashamed and thought buying a condom would 'out' them, especially, if they had never been publicly out with females. These socio-cultural factors cumulatively serve as barriers to Nigerian MSM accessing SRHS. This is particularly problematic as a number of Nigerian MSM engage in sex work. As a result of the highly stigmatized attitudes towards homosexuality, MSM engaged in sex work are deterred from accessing SRHS and HIV testing. Besides the constant abuse and death threats, MSM and MTF transsexuals suffer stigma and discrimination from health services providers to the extent that it directly precludes them from accessing basic SRHR. The same applies to adolescent MSM in Nigeria.

Ethical implications and recommendations

Provision of HIV treatment services is meagre in Nigeria. Between 79-82% of HIV-infected Nigerians do not have access to ARVs. Therefore, only about 20% of people have access to ARVs in the country. This is alarming considering that Nigeria accounts for 19% of all HIV/AIDS related deaths in sub-Saharan Africa and 14% globally. Currently, HIV service sites have increased dramatically. The number of sites providing HIV services rose from 516 in 2012 to 820 across Nigeria’s 36 states in 2013. In spite of the dramatic increase of sites providing treatment services in the country, there is a substantial amount of people that are incapable of accessing ART and HIV preventative services including HTC and PrEP. These issues are compounded by the lack of economic and human resources; lack of quality care and treatment services; and it is not uncommon for stocks of HIV treatment to run out when they are available. The public are incapable of accessing sites for preventative treatment due to socio-economic barriers such as restricted financial resources that prevent them from accessing transport. They are unable to miss work to visit sites. Institution-related barriers such as long waiting queues and stigma and discrimination from staff also prevent them from utilizing services.

According to UNAIDS, 44 low-middle income countries are reliant on international donors for 75% of their AIDS funding. Nigeria is one of the countries that predominantly relies on international agencies to fund its HIV/AIDS programme. Consequently, it is these donor agencies that fund ARV and HIV preventative services and treatment in the country. Since the donor agencies are beginning to steadily withdraw from Nigeria, it is up to the national Government to fund their HIV/AIDS programme. Nigeria is already in steep debt and is now trying to find suitable ways in which to keep HIV treatment and services sites afloat and provide drugs to the public.

Country experiences in addressing the barriers

Nigeria’s non-Government sector is taking the lead in regard to empowering women and facilitating their access to SRHS. For example, the Isa Wali Empowerment Initiative (IWEI), a non-profit NGO, seeks to improve the lives of young Nigerian women and children by providing them with access to better healthcare services, educational and economic empowerment programmes. The object of IWEI is to motivate young women and children to become independent and self-sufficient. Similarly, the Women’s Initiative for Self-Actualization (WISA) is a Nigerian NGO promoting women’s rights. It places emphasis on reproductive health and child health as well as reducing HIV/AIDS in the country. Further, it seeks to provide greater non-formal educational programmes for young women and orphans thereby striving to encourage girls to delay childbearing and early marriage in favor of completing their education and earning their own living. Likewise, Girl Child Concerns (GCC) is dedicated to enhancing the lives of young girls through education, general life skills, and sexual education, as well as promoting and protecting women’s human and reproductive health rights. It does so by disseminating information on reproductive health topics and enrichment programmes aimed at young girls and adolescent mothers. The Advocates for Youth Organisation in partnership with youth leaders, adult allies and youth-serving organisations, promotes and supports programmes aimed at recognizing the right to information on sexual health and accessible, affordable and confidential SRHS for adolescents. In 2012 it launched a programme focusing on the health and rights of LGBTI youth in Nigeria. Advocates for Youth could be vital in addressing some of the barriers facing MSM adolescents and access to SRHS.
Chapter Four: Age of Consent and HIV testing

Nigeria does not have an Age of Consent limit to access HIV testing specified in law. According to the research young persons may access HIV testing in healthcare centres without any Age of Consent restriction. In practice, however, the healthcare officer attending a child may require parental consent for HIV testing of children (i.e. a person who is younger than 18 years), but this is not provided for by law.

Age of Consent to report the HIV status direct to adolescents

The law does not specify an age at which the HIV status of an adolescent will be reported directly to his/her parents. Accordingly, children and adolescents are entitled to the same level of confidentiality as adults. Under the HIV Anti-Discrimination Act 2014, it is provided that no body, person or institution shall require a person to disclose his/her HIV status or the status of any other person, by asking questions, orally or in writing, directly or indirectly. The only exception to this rule under this Act is for a partner in marriage or a cohabiting relationship having the right to be informed of his or her partner’s HIV status, but only in a situation where he or she considers himself or herself at risk of being infected by the other person.

Section 11 of the HIV Anti-Discrimination Act also prohibits the disclosure of another person’s HIV status without the written consent of such individual to whom the information relates, unless required by law. A person who breaches this confidentiality requirement commits an offence and is liable to a fine of not less than =N=500,000 for an individual and =N=1,000,000 for an institution.

Legislation and policy framework on HIV testing

The HIV anti-discrimination act:

Section 8: (1) Prior to accessing any public or privately delivered services, employment and any other opportunity, no individual, institutions or bodies shall require a person to disclose his or her HIV status or the status of any other person, by asking questions, orally or in writing, directly or indirectly.

(2) Notwithstanding the provisions of this section, any partner in a marriage or co-habiting relationship has the right to be informed of his or her partner’s HIV status in a situation where he or she considers himself or herself at risk of being infected by a partner.

Section 11: (1) No person shall, except with the written consent of the individual to whom the information relates, disclose any information relating to the HIV status of that individual unless the disclosure is required by law.

(2) Testing will not be considered anonymous if there is a reasonable possibility that a person’s name or personal identifying features can be linked to the test.
Chapter Five: Age of Consent and access to Anti-retroviral Therapy (ART)

Age of Consent on ART is of children below the age of 18 years. The National Agency for Control of AIDS (NACA), which is the agency of the Nigerian Government set up to fight HIV/AIDS discrimination, create public awareness and prevent the spread of the virus around the country, issued a National HIV Prevention Plan 2014-2015 (the ‘National Plan’).

The objective of the National Plan is to focus on the different approaches and methods of preventing and dealing with the spread of HIV in the country. The National Plan was developed as a result of research-based surveys conducted in Nigeria over time and it provides for preventive technologies.

The National Plan encourages use of and access to ART for the purposes of HIV treatment and prevention, both between sexual partners and from mother to child. Neither the National Plan nor any other policy stipulates an Age of Consent to ART, however, parental consent for access to ART by children (below the age of 18 years) might be required. Where a person who is a very young minor (e.g. a child who is younger than a teenager) visits a clinic and requests ART, the medical personnel attending to the child would usually ask to speak to the child’s parents or guardians first, but where no such adult can be found, the child would not be denied access to ART.

Legislation and policy framework

Policy is the recommended category of regulation.

Clause 3.6.4.1 of the National HIV Prevention Plan 2014-2015 (the ‘National Plan’) provides for preventive technologies including:

1. the use of ARTs, for the treatment of HIV and as a preventive measure to limit the risk of a HIV positive person being able to transfer the virus to his/her sexual partner; and

2. the increased access to ARTs by individuals and pregnant women over the years, in order to reduce the risk of mother-to-child transmission.
Chapter Six: Age of Consent and access to Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP)

There are no legal prohibitions on access to HIV Pre-exposure Prophylaxis (PrEP) medication. The general understanding is that, in practice, the most common restriction to a person’s access to PrEP is lack of availability in the clinics, and this restriction is not limited solely to young persons. PrEP is not as common as contraceptives are in Nigeria, and PrEP is still a fairly new technology for combating HIV/AIDS spread in Nigeria.

On the other hand there are no legal prohibitions on access to HIV Post-exposure Prophylaxis (PEP). Young people are able to access PEP from healthcare centres or anywhere else where PEP is offered. In most Government-owned hospitals, special clinics within the hospitals that specialise in HIV/AIDS testing and care offer free drugs to those infected.

Parental consent for the receipt of PEP by children (under the age of 18 years) might be required. Where a person who is a very young minor (e.g. a child who is younger than a teenager) visits a clinic and requests PEP, the medical personnel attending the child would usually ask to speak to the child’s parents or guardians first, but where no such adult can be found, the child would not be denied access to PEP.

The researchers’ understanding is that, in practice, the most common restriction to a person’s access to PEP is lack of availability in the clinics, and this restriction is not limited solely to young persons. PEP is not as common as contraceptives are in Nigeria, and PEP is still a fairly new technology for combating HIV/AIDS spread in Nigeria.

Young people’s access to PrEP and PEP

Young people are able to access Pre-exposure Prophylaxis (PrEP) from healthcare centres or anywhere else where it is offered. In most Government owned hospitals, special clinics within the hospitals that specialise in HIV/AIDS testing and care offer free PrEP to those who request it.

Parental consent for the receipt of PrEP by children (under the age of 18 years) might be required. Where a very young minor (e.g. a child who is younger than a teenager) visits a clinic and requests PrEP, the medical personnel attending the child would usually ask to speak to the child’s parents or guardians first, but where no such adult can be found, the child would not be denied access to PrEP.
Legislation and policy framework on PrEP

The National Plan seeks to encourage public access to PrEP as a new preventive technology with an effective result, for the prevention of HIV spread in the country. It provides for access by all in need and does not specify Age of Consent requirements for access to PrEP.

National Plan

Clause 3.6.4.2: The National Plan: encourages public access to PrEP as a new preventive technology with effective results for the prevention of HIV spread in the country through sexual exposure.

Access to PEP

The HIV & AIDS (Anti-Discrimination) Act 2014 (the ‘HIV Act’) stipulates that employees should have access to PEP in their workplace.

The National Plan also seeks to encourage public access to PEP for nationwide HIV prevention.

Neither the HIV Act nor the National Plan specify any Age of Consent requirements for access to PEP.

Section 16 (c) of the HIV & AIDS (Anti-Discrimination) Act 2014:
“Every employer engaged in business where there is a risk of occupational transmission of HIV within the workplace shall ensure that it adopts safety procedures that provide for steps to be taken following an occupational exposure to HIV, including access to PEP.”

National Plan, section 3.4.1 - Blood Safety:

As part of its strategic focus in combating the spread of HIV/AIDS through blood transmission, one of the NACA’s focus is to “increase access to Post-Exposure Prophylaxis (PEP) for HIV prevention.”

There are no contradictions and the recommended interventions include Law Reform, Government to pass new regulations and/or policies and Ministerial sign off to new practice.
Chapter Seven: Age of Consent and access to safe abortions and/or post abortion care

Abortion is illegal in Nigeria and there is no policy or legislation enabling or disenabling post abortion care.

Legislation and policy framework

The Criminal Code Act

Section 228: Any person who, with intent to procure miscarriage of a woman whether she is with or not with child, unlawfully administers to such person or causes such person to take any poison or other noxious thing, or uses force of any kind or uses any other means whatsoever, is guilty of a felony and is liable to imprisonment for fourteen years.

Section 229: Any woman who, with intent to procure her own miscarriage, whether she is with or not with child, unlawfully administers to herself or causes herself to take any poison or other noxious thing, or uses force of any kind or uses any other means whatsoever, is guilty of a felony and is liable to imprisonment for seven years.
Chapter Eight: Age of Consent on access to Antenatal Care (ANC)

The Nigerian Primary Healthcare Development Agency (‘NPHCD’), an agency of the Federal Government, has a policy on the minimum standards of primary healthcare in Nigeria and provides that as a minimum requirement, all primary healthcare centres and institutions must have sufficient rooms, facilities, space, personnel and equipment for ANC. There is no specific section of the NPHCD policy that provides for the enabling or dis-enabling of access to ANC. Some states in Nigeria, through their public hospitals, also offer free ANC although there is no written policy to this effect.

There is no Age of Consent to access to ANC specified in law, and according to local counsel young persons may in practice access ANC in healthcare centres that offer same without any Age of Consent restriction. In practice, however, the healthcare officer attending a child may require parental consent for the child’s access to ANC (i.e. a person who is younger than 18 years), but this is not provided for by law.

Legislation and policy framework

The Nigerian Primary Healthcare Development Agency (‘NPHCD’)

Clause 5.1 of the NPCHD policy provides that the building of any Primary Healthcare Centre must have as minimum infrastructure, enough rooms and space to accommodate Waiting/Reception Areas for Child Welfare, ANC, Health Education and ORT Corner.

Local counsel made enquiries with various professionals and workers in the Nigerian healthcare sector, including doctors and specialists in both private and public hospitals, clinics and other healthcare centres. No contradictions and the interventions are Government to pass new regulations, ministerial sign off to new practice and Law Reform.
Chapter Nine: Access to HPV vaccine, and cervical cancer screening and treatment

The National Plan seeks to encourage public access to Human Papillomavirus (HPV) Vaccines as a new preventive technology being made available in primary healthcare centres for the prevention of HIV spread in Nigeria.

It provides for the provision of HPV vaccines to prevent genital and liver cancers and promotes access by all in need. The National Plan does not specify any Age of Consent requirements for access to HPV vaccine. The National Plan also does not prescribe whether parental consent would be required for a young person to access the HPV vaccine. In practice HPV vaccine may be administered to a young person without the requirement to obtain parental consent.

Legislation and policy framework

The National Plan

Clause 2.8.3: The strategic focus is to expand the provision of good quality STI care into primary healthcare, sexual and reproductive health services and HIV services. Comprehensive STI services should include: Provision of hepatitis and human papillomavirus (HPV) vaccines to prevent genital and liver cancers;

Local counsel made enquiries with various professionals and workers in the Nigerian healthcare sector, including doctors and specialists in both private and public hospitals, clinics and other healthcare centres.
Chapter Ten: Conclusion

Authorities, policymakers, scientists, civil society should engage with communities on the social and cultural factors that facilitate early sexual debut and child marriages, and the health risks implicit therein. Such engagement should include focused campaigns in communities where early sexual debut and multiple concurrent sexual partnerships is deemed socially acceptable, with the aim being to change such norms and values. Furthermore, authorities should take tangible measures to sensitize health professionals regarding their ethical duties in respect of all patients, including homosexual and transgender adolescents. To this end, health professionals should be reminded that their professional ethics duties supersede personal moral biases. Authorities should work towards gender equality, and devise strategies to encourage and facilitate adolescent access to SRHS. Authorities, civil society actors, and community leaders must actively work towards increasing awareness amongst adolescents to the dangers posed by intergenerational / age-disparate sexual partnerships. Authorities should also work towards reducing institutionalized discrimination against MSM. To this end, they should actively work towards dispelling the myth that homosexuality and transgender expression is “un-African”. They should recall that Nigeria is bound by international human rights instruments and obliged to uphold the rights of all people, including MSM.

A limitation of this work is that data sources were limited to publicly accessible documents, and not based on original qualitative or quantitative research. Relevant studies may have been missed if they were not included in the databases searched for this review.
Chapter Eleven: Recommended intervention on legal and policy framework

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<td>Legislation policy on PrEP use in the country.</td>
<td>P</td>
<td>LR NR NP RP</td>
</tr>
<tr>
<td>Policy framework and/or legislation of access to safe abortion and/or post abortion care.</td>
<td>L</td>
<td>LR</td>
</tr>
<tr>
<td>Policy framework on access to Ante Natal Care (ANC).</td>
<td>P</td>
<td>LR NR NP RP</td>
</tr>
<tr>
<td>Policy framework and legislation on access to HPV vaccine and Clinical cancer screening and treatment.</td>
<td>P</td>
<td>LR NR NP RP</td>
</tr>
<tr>
<td>Age of Consent to access HIV testing without parental consent.</td>
<td>N/A</td>
<td>LR NR NP RP</td>
</tr>
<tr>
<td>Legal and policy Framework on Age of Consent HIV status will be reported directly to an adolescent.</td>
<td>L</td>
<td>LR</td>
</tr>
<tr>
<td>Address of various policy and legislation inconsistencies.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
References


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Annex 1

KEY QUESTIONS IN ESC REVIEW

i. Age of Consent for sexual intercourse: From an ESC perspective, what is considered to be the permissible Age of Consent for sexual intercourse / activities, and/or what are the permissible circumstances for adolescents to engage in sexual intercourse / activities? Indicate if different ages for heterosexual adolescents (males and females), and if applicable, homosexual adolescents (males and females).

ii. Adolescent homosexuality and transgender expression: From an ESC perspective, how is (i) adolescent homosexuality, and (ii) transgender expression, viewed in the local context? Specify if different for males and females.

iii. Contraception access and use: From an ESC perspective, how is contraception access / use amongst adolescents viewed in the local context? Specify if different for males and females.

iv. Access to sexual and reproductive health services: What are the potential ESC factors that hinder or facilitate adolescents accessing sexual and reproductive health services? Specify if different for heterosexual adolescents (males and females), and/or homosexual adolescents (male and female).

v. Autonomous HIV testing: What are the potential ESC factors that hinder or facilitate adolescents accessing HIV testing without parental consent? Specify if different for male and female. In each country-specific case study, research will focus on:

vi. How ESC factors impact on adolescent health in the above contexts, regardless of the enactment of relevant national laws (including nationally recognized customary or religious laws), regulations, and policies in relation to the respective contexts.
Annex 2

KEY QUESTIONS FOR THE LEGAL REVIEW

1. At what age may sex between consenting individuals legally take place? (Age of Consent to sexual intercourse) Indicate if there are different ages for males and females?

2. Is there a definition of statutory rape? Please define.

3. Are there exceptions to question (1)? For example gay sex?

4. At what age may a young person access contraceptive services including contraceptive commodities? Please specify with and without parental consent if the answers are different.

5. May a young person access emergency contraceptives (e.g. the ‘Morning-after pill’) At what age? Please specify if there are different ages with and without parental consent.

6. Specify whether there is any prohibition on HIV Post-exposure Prophylaxis (PEP), including Age of Consent, with and without parental consent.

7. If there is no prohibition in question 7, would young people be legally able to access PEP if it was offered? At what ages? Please specify if there are different ages with and without parental consent.

8. Is there any legislation or policy specifically enabling PEP use in country? Please specify if it deals with Ages of Consent and give details.

9. Specify whether there is any prohibition on HIV Pre-exposure Prophylaxis (PrEP), including Age of Consent, with and without parental consent.

10. If there is no prohibition in question 10, would young people be legally able to access PrEP was offered? At what ages? Please specify if there are different ages with and without parental consent.

11. Is there any legislation or policy specifically enabling PrEP use in the country? Please specify if it deals with Ages of Consent and give details.

12. Please state whether there is policy framework and/or legislation enabling or disenabling access to safe abortions and/or postabortion care, including Age of Consent, with and without parental consent.

13. Policy framework and legislation enabling or disenabling access to Antenatal Care (ANC), including Age of Consent, with and without parental consent.

14. Policy framework and legislation enabling or disenabling access to HPV vaccines and cervical cancer screening and treatment, including Age of Consent, with and without parental consent.

15. What is the Age of Consent to access HIV testing without parental consent?

16. What is the Age of Consent at which the HIV status will be reported directly to an adolescent and legal/policy requirements to report the status to her/his parents?

17. Please explain any inconsistencies between the answers above.