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
ACKNOWLEDGEMENT

SAT wishes to thank Jerome Amir Singh (lead author), Faadiela Jogee and Samantha Chareka (co-authors) from the 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 for working on the ethical, cultural and social review. The ESC research and editorial support was provided by Faadiela Jogee and Samantha Chareka, CAPRISA.

SAT also wishes to thank Civil Society Organisations and partners who attended the Age of Consent Validation Meeting that met to discuss and validate the draft Advocacy Toolkit. The meeting critically reviewed the draft reports, analysing the data collected for its accuracy and merits.

SAT is grateful to UNICEF for co-funding the review of the Age of Consent laws, policy frameworks, Ethical, Social and Cultural (ESC) impacts on sexual reproductive health and rights and HIV.
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## ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ASSAF</td>
<td>Academy of Science of South Africa</td>
</tr>
<tr>
<td>FGM</td>
<td>Female genital mutilation</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<tr>
<td>HCT</td>
<td>HIV Counselling and Testing</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>ILO</td>
<td>International Labour Organisation</td>
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<tr>
<td>LGBTI</td>
<td>Lesbian, gay, bisexual, transgender, intersexual</td>
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<tr>
<td>MMC</td>
<td>Medical male circumcision</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have sex with men</td>
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<tr>
<td>MSP</td>
<td>Multiple sexual partners</td>
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<tr>
<td>PrEP</td>
<td>Pre-exposure Prophylaxis</td>
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<tr>
<td>SRHR</td>
<td>Sexual and reproductive health rights</td>
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<td>SRHS</td>
<td>Sexual and Reproductive Healthcare Services</td>
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<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<tr>
<td>UNICEF</td>
<td>United Nations International Children’s Fund</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
</tbody>
</table>
# CONTENT PAGE

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>FOREWARD</td>
<td>i</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENT</td>
<td>iii</td>
</tr>
<tr>
<td>DISCLAIMER</td>
<td>iv</td>
</tr>
<tr>
<td>ACRONYMS</td>
<td>vi</td>
</tr>
<tr>
<td>Chapter One: Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Chapter Two: Age of Consent for sexual intercourse</td>
<td>3</td>
</tr>
<tr>
<td>Chapter Three: Homosexuality and transgender expression</td>
<td>6</td>
</tr>
<tr>
<td>Chapter Four: Access to sexual and reproductive health services</td>
<td>7</td>
</tr>
<tr>
<td>Chapter Five: Conclusion</td>
<td>10</td>
</tr>
<tr>
<td>References</td>
<td>11</td>
</tr>
<tr>
<td>Annex</td>
<td>17</td>
</tr>
</tbody>
</table>
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 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.

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%).

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% of young women are HIV positive, compared to 6.5% of young men.

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

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 an opportunity for ensuring that existing and new strategies and programmes on HIV prevention, treatment and care are effectively implemented to benefit young people. These include 2012 guidance on Pre-exposure oral Prophylaxis (PrEP) for sero-discordant couples, men and transgender women who have sex with men at high risk of HIV as well as the 2013 guidance for HIV testing and counselling and care for adolescents living with HIV and Young Key Population Policy Briefs.

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, HTC and to linkages to prevention, treatment and care.

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 at 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, acceptability, adherence and quality must inform these services.
SRHR Africa Trust 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 is to conduct research on “Age of Consent” laws, regulations, and policies, as well as ESC factors, in relation to adolescents. This will entail collecting country experiences to address Age of Consent laws / polices and ESC factors that serve as potential barriers to adolescents accessing sexual and reproductive healthcare services, including HIV prevention, care and treatment. This will include exploring implications for expanding SRHR services and HTC in adolescents aged 10 – 19 years.

Objective and methodology

This work 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 sex.
2. Homosexuality and transgender expression.
3. Access to Sexual and Reproductive Healthcare Services, including autonomous HIV counselling and testing (HCT) and contraception access.

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

Country overview

Uganda’s population of approximately 35 million is largely young, with more than 50% of the population being under 15 years of age. While Uganda’s population is almost exclusively black, its people have considerable ethnic, cultural, religious and linguistic diversity. There are forty languages spoken in Uganda and they belong to four main groups: Bantu, Western Nilotic, Eastern Nilotic and Central Sudanic. Uganda’s main ethnic groups are comprised as follows: Baganda (16.9%), Banyakole (9.5%), Basoga (8.4%), Bakiga (6.9%), Iteso (6.4%), Langi (6.1%), Acholi (4.7%), Bagisu (4.6%), Lugbara (4.2%), Bunyoro (2.7%), and others (29.6%). 88% of Uganda’s population lives in rural areas. 82.3% of the Ugandan population identifies as Christian, of which 41.9% are Catholics, 35.9% Anglican and 4.5% are Pentecostal. 12.1% of Ugandans identify as Muslims.

Country overview

- Uganda is a low income country with a nominal GDP of $27 billion.
- Uganda’s population is approximately 35 million.
- Uganda is classified as a high burden HIV country with an estimated 1.5 million people living with HIV/AIDS.
- Men have lower HIV prevalence (6.1%) compared to women (8.3%).
- 3.7% of young men and women aged 15-24 are HIV-infected.
- Uganda accounts for 7% of new infections globally, placing it 3rd on the global rank.
- Uganda contributes 10% of new HIV infections in sub-Saharan Africa.
- HIV prevalence among adolescents between 15-19 years of age is an estimated 2.4%.
- Uganda is ranked 16th among 25 countries with the highest rates of early marriages.
Chapter Two: Age of Consent for sexual intercourse

The legal Age of Consent for heterosexual sex in Uganda is 18 years of age for males and females. Homosexual activity is criminalized and there is widespread homophobia amongst the Ugandan population. The average age of heterosexual sexual debut is 16.4 years for women and 18.1 years for men. Local culture and the country’s prevailing religions (Christianity and Islam) promote chastity until marriage. There are a number of cultural and social issues which lead to sexual debut amongst adolescents.

a. Child marriages and co-habitation

Child marriage is a reality for many adolescent girls in Uganda. It remains a common practice throughout the country. In traditional ethnic communities, child marriage is linked to preservation of family dignity by inhibiting girls from early debut and pregnancy. It provides a sense of security for girls because their education is not a priority to their families. Child marriage provides a means of securing wealth through bride price for some families. Especially poverty-stricken families where girls may pose a substantial economic burden. Child marriage may involve forcing girls to marry a much older partner. Conflict situations also perpetuate child marriage. Conflict results in loss and trauma. This coupled with a breakdown of family unit provide motivators for girls to marry early.

The country’s 2011 demographic and health survey yields interesting findings in relation to adolescents and marriage. Approximately 11.5% of Ugandan girls between the ages of 15-19 are married, divorced, separated, or widowed. In regard to 15-19 year olds female adolescents, 8.6% are married, of which 7.7% constitute customary marriages, 0.7% religious marriages, and 0.2% civil marriages. 82.4% of 15-19 year old female adolescents report being in monogamous unions, 11.1% report having one co-wife in their marriage, 2.6% report having 2 or more than co-wives, 11.4% report cohabiting, and 20% report being currently in a union. The corresponding statistics for 15-19 year olds males are starkly different: only 0.6% report being married, of which 0.4% are customary marriages, 0.2% are religious marriages, and none are civil marriages. 1.2% of adolescent boys 15-19 years of age report cohabiting, while 1.9% are currently in a union. No 15-19 year old male adolescents reported being married in the country’s 2011 demographic and health survey, and therefore none had wives/co-wives.

In Uganda, the trend has shifted toward fewer women marrying at very young ages (i.e., <15 years of age). The proportion of women married by age 15 has declined over time, from 19% among women currently aged 45-49, to 3% among women currently aged 15-19. Women aged 25-49 living in urban areas marry about two years later than rural women (20 years compared with 17.6 years). The median age at first marriage is highest in Kampala (20.7 years) and lowest in North region at 16.7 years. The median age at first marriage for women age 25-49 is higher among the better educated and the wealthier.

To increase their chances of marriage, 1.4% of Ugandan adolescent girls undergo Female Genital Mutilation (FGM). Most girls who undergo the procedure in Uganda are 10-15 years of age. FGM is practiced mostly in the country’s eastern regions amongst the Pokot, who comprise 0.3% of Uganda’s population (95% FGM prevalence amongst Pokot girls) and the Sabinyi who comprise 0.8% of Uganda's population (50% FGM prevalence amongst Sabinyi girls). There are regional variations in prevalence with the highest rates occurring in Karamoja (4.5%) and the Eastern Region (2.3%). All other regions in Uganda have prevalence rates of under 2%. Most eastern tribesmen would not marry an uncircumcised woman. After the performance of FGM, girls are eligible for marriage offers. Accordingly, FGM facilitates child marriages amongst some tribes in Uganda. Although declining, ‘wife inheritance’ also contributes to adolescents marrying young amongst some communities in Uganda. This practice occurs when a man loses his wife and acquires a young unmarried girl from the same clan or when an older woman who has failed to bear children for her husband, co-opts a young female relative (for example, a niece) to share her husband with.
b. Sexual debut

Among Ugandan women aged 25-49, 23% report having had their first sexual intercourse before age 15, 64% report having their first episode of intercourse before 18 years of age, while by 25 years of age, 90% of Ugandan women report having had sexual intercourse. The median age at first sexual intercourse for women age 25-49 is 16.8 years compared with the median age at first marriage of 17.9 years. This suggests that Ugandan women generally begin sexual intercourse about a year earlier than their first marriage. The median age at first sexual intercourse has increased over the past two decades, from 16.8 years for women currently age 45-49 to 17.5 years for women currently age 20-24. Significantly, 18.7% of 15-19 year olds were sexually active in the four weeks preceding the country’s 2011 Demographic and Health Survey. Approximately 14% of young women and 16% of young men in the age group 15-24 experience sexual debut before the age of 15. Approximately 58% of young women and 47% of young men report having had sex before age 18. 12.2% of 15-19 year old females and 17.9% of males experience sexual debut before 15 years of age.

As is the case with age at first marriage, men tend to initiate sexual activity later in life than women. The median age at first sex for men age 25-49 years is 18.6 years, approximately two years later than for women. The median age at first sexual intercourse for men age 25-49 years – 18.6 years – is approximately four years lower than the median age at first marriage, at 22.3 years.

Urban Ugandan women have their first sexual experience at older ages compared to their rural counterparts. To this end, women of the Eastern and East Central regions engage in sexual relations earliest (16.3 and 16.2 years respectively), while their counterparts in the Southwest region initiate sex about two years later, at age 18.7 years. Women with at least some secondary education start sexual relations almost two years later than less educated women. It does not seem that household wealth affects sexual debut.

As is the case with age at first marriage, men initiate sexual activity later in life than women. The median age for sexual debut for men age 25-49 years is 18.6 years, approximately two years later than for women. The median age at first sexual intercourse for men age 25-49 years, at 18.6 years, is about four years lower than the median age at first marriage, at 22.3 years. Men in the West Nile region and the Southwest region start sexual intercourse later than men in other regions (19.3 and 20.0 years, respectively).

c. Sexual partnering norms: age-differential relationships and multiple concurrent sexual partnering

In Uganda, early marriages are supplemented by high levels of intergenerational sexual partnering, which are driven by socio-economic and cultural norms. Gender inequality in Uganda limits adolescent girls’ economic options. Hence, transactional sex becomes a viable solution to their lack of financial resources. Adolescents may be coerced into such relationships by older partners. Additionally, they may seek out such relationships to achieve financial security, social status, or developmental objectives (such as using any gifts received towards furthering their education). Adolescent girls may also be pressured by their parents who require financial resources for the family household. In the rural context, impoverished adolescent girls are drawn into such relationships in the pursuit of stable marriage, protection, and/or better socio-economic conditions. Adolescent girls may also be forced into such relationships to meet basic needs, to avoid domestic violence, or because they are unaware of their options. In high-density urban settings, such as Kampala, adolescents engage in such relationships out of desperation to earn quick cash for daily survival. Moreover, to acquire material items and services that would be otherwise unaffordable to an adolescent. In both rural and urban contexts, girl-girl peer pressure also drive female adolescents to engage in such partnering. In all the above contexts, sexual social mores prevail despite Uganda’s legal Age of Consent for sex. 1.5% of 15-19 year old females and 5.4% of 15-19 year old males report having had two or more sexual partners in the past 12 months. Among female Ugandan adolescents aged 15-19 who report having had sexual intercourse in the past 12 months, 8.9% of those aged 15-17 years and 15.7% of those aged 18-19 years report having had sexual intercourse with a partner who was 10 or more years older than themselves.
Ethical implications and recommendations

While Uganda’s declining trend of fewer adolescents marrying at a very young age (15 years of age) is to be welcomed, the country’s average age of heterosexual debut (approximately 15 years for females and 18 years for males), as well as significant gender differentials in respect to marriage and cohabitation norms in relation to adolescents 15-19 years of age, highlight that the country is characterized by stark gender inequality. More efforts must be made in respect to encouraging adolescents to delay sexual debut, eradicating gender inequality, and facilitating adolescent access to SRHS. As evidence indicates that females with some level of secondary education have delayed sexual debut, the Ugandan Government should dedicate more efforts to retaining adolescent females in the secondary education system. Moreover, Uganda’s Government should do more to eradicate child marriages, particularly in the country’s North region. Since family income poverty and sociocultural factors have emerged as key underlying issues undermining the legal age of sexual intercourse in Uganda, poverty reduction should be prioritised to reduce the prevalence of underage sexual intercourse between adolescents and older sexual partners. Such interventions should ideally be both short and long term in nature, as well as preventative and responsive.

Country experiences in addressing the barriers

The Ugandan Government has focused on instituting a national legal and policy framework to end child marriage and under-age sex. To this end, the Ugandan Constitution sets the legal age of marriage for men and women at 18 years of age, and the country’s Penal Code sets Age of Consent for engagement in sexual acts at 18 years of age. Chapter 4 of the Ugandan Constitution provides specific provisions for the protection of women and girls in Articles 20, 21, 24, 33, 34 and 50. Article 31(3) of the Constitution prohibits forced marriage and requires free consent of the man and woman to enter into marriage. Significantly, article 33(6) of the Constitution prohibits laws, cultures, customs or traditions which are against the dignity, welfare or interest of women or which undermine their status. The country’s Penal Code stipulates that any person who performs a sexual act with another person under the age of 18 years commits an offence (defilement) and is liable to life imprisonment; or a death sentence if the offence is committed with a child under 14 years, is infected with HIV/AIDS, or the perpetrator is a parent or guardian, is a person in authority, a serial offender and where the victim is a person with disability (aggravated defilement). The country’s Prevention of Trafficking in Persons Act outlaws the exploitation of children which is defined as including sexual exploitation and child marriage, and criminalizes the facilitation of forced and arranged marriages. The country’s Domestic Violence Act also prohibits the abuse of individuals, including children. Despite these legislative measures, the enforcement of child marriage laws at local level is still low and child marriage amongst Ugandan adolescents is still common, illustrating the ineffectiveness of legislative measures to end these social practices.

To counter the practice of FGM, Uganda’s legislature passed the Prohibition of Female Genital Mutilation Act in 2010. The Government is also a signatory to several international human rights conventions such as the Convention on the Rights of Children. However, notwithstanding these legislative measures, FGM is still practiced amongst some Ugandan communities in remote areas, or even in Kenya, in an attempt to avoid prosecution. Such behaviour illustrates the resilience of social and cultural practices, regardless of the enactment of law, and speaks to the need for ongoing community engagement and education to end such practices.
Chapter Three: Homosexuality and transgender expression

Approximately 500,000 Ugandans identify as homosexual. However, few are openly gay since homosexuality is essentially prohibited. Religion and culture in Uganda propagate homophobia. Homosexuality is thought of as ‘unnatural’ and ‘unAfrican’, and an upshot of western colonization. This, despite Uganda’s Presidential Scientific Committee on Homosexuality panel concluding: “Homosexual behaviour has existed throughout human history including in Africa... Homosexuality existed in Africa way before the coming of the white man.”

Religion plays a central role in homosexuality debates in Uganda. Christian morals deem homosexuality to be a sin. It has been alleged that Christian evangelical groups from the United States, in particular, have been increasingly manipulating and influencing Uganda’s anti-gay policies to suit their religious agenda. According to a global poll, 96% of Ugandans believe that homosexuality is unacceptable. Such views have sparked intolerance, hate, discrimination, and violence against the Ugandan gay, lesbian, bi-sexual, and transgender communities, culminating in the enactment of the country’s Anti-Homosexuality Act of 2014. Following the passage of the law, a Ugandan tabloid published the names of 200 alleged Ugandan gays. The passage of the country’s anti-gay law also led to an immediate tenfold rise in attacks on LGBTI people in Uganda, and resulted in the suicide of at least one adolescent boy. This law was subsequently overturned by the country’s Constitutional Court on technical grounds. These social, cultural and religious norms intensify the exclusion of homosexuals and transgender adolescents from accessing SRHS and HCT services.

Ethical implications and recommendations

Uganda’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 against all persons, including the LGBTI communities. Shortly after the passage of Uganda’s anti-homosexuality law, 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.” Uganda’s Government and policymakers should heed this sage advice. Uganda is also a secular democracy and policymakers and officials should be alert to the influence and agendas of religious leaders of all faiths, local or foreign. 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 their personal moral biases regarding sexual orientation and lifestyle choice. Furthermore, that health professionals (and officials) 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

The Ugandan Government has come under tremendous international pressure to ease its official stance against homosexuality. This has had limited success, with the country’s President since claiming that the re-enactment of the country’s anti-homosexuality law – after it had been struck down by the courts on technical grounds - was “not necessary” because the country’s existing colonial-era laws. Despite this stance, the persecution of the country’s LGBTI community continued in 2015, although officials permitted a gay pride rally in nation’s capital, Kampala, in August 2015. In the absence of the Government affirming the rights of the LGBTI communities in Uganda, the continued work, and support of, pro-LGBTI groups, such as Sexual Minorities Uganda (SMUG), Spectrum Uganda, and Civil Society Coalition on Human Rights and Constitutional Law, will be essential in promoting, protecting, and realizing the rights of LGBTI persons in the country.
Chapter Four: Access to sexual and reproductive health services

Uganda’s Health Policy Guidelines and Service Standards, National Minimum Healthcare Package, and the Health Sector Strategic and Investment Plan, give attention to adolescent development and health. Yet, several barriers impede adolescents from accessing SRHS. Uganda society is predominantly conservative. Discussions on sex and sexuality is considered taboo. Traditionally, the senga (paternal aunts) facilitates discussion on topics related to sexuality with their nieces. However, due to socio-cultural transitions, such interactions have become increasingly rare. Accordingly, information concerning SRHS is relatively limited amongst Ugandan adolescents. This translates to, amongst other implications, poor risk perceptions regarding HIV/AIDS. Alternatively, adolescents can obtain information on the accessibility and availability of SRHS from school, peers, NGO’s, churches and health workers.

In Uganda, adolescents aged 12 and over can autonomously consent to HIV testing. However, most adolescents avoid testing due to the socio-cultural injunction on premarital sex. Further, HIV testing is considered synonymous with sexual activity. Studies show that most people are reticent about HCT given the HIV-related stigma and discrimination that usually accompanies HCT. Health providers are also disinclined to test adolescents. Furthermore, given the high rates of child marriage, adolescent brides are unlikely to make autonomous SRHR decisions, including decisions related to HCT. Despite these barriers, approximately 49% of female adolescents aged 15-19 years report having accessed HCT in the past 12 months while approximately 26% of male adolescents 15-19 years of age report having accessed HCT in the same period.

Culturally scripted notions of fertility and masculinity

Uganda’s estimated contraception prevalence rate is 30% in married women aged 15-49 while awareness of at least one method of contraception in Uganda is “nearly universal”. Injectables remain the most commonly used method of contraception among currently married women (14%). The Government sector remains the major provider of contraceptive methods for nearly half of the users of modern contraceptive methods (47%). Forty-three percent of family planning users in Uganda discontinue use of a method within 12 months of starting its use. Fear of side effects is the main reason for discontinuation (16%). The pill has the highest discontinuation rate (54%). Given the above, it is alarming, but, perhaps, not surprising, that 24% of female adolescents in the country are already mothers or pregnant with their first child, while 13.5% of adolescents 15-19 years of age have given birth.

Ethical implications and recommendations

Uganda has the world’s 5th highest rate of population growth (3.2%), and the world’s 2nd highest fertility rate (6.2 children/woman). Research conducted in one rural area of Uganda showed that although the respondents were knowledgeable about family planning methods, the majority were not using them. Among the cultural practices relating to fertility in Ntungamo are cultural beliefs in extending the family lineage, polygamy, producing children of the same sex, early marriages, extra marital sex and sexual rituals. Other cultural beliefs and practices that affect fertility in Uganda include women subordination, women economic dependence, women’s lack of control over information sources, women’s low status, and multiple roles in a home. Other factors that were identified as affecting fertility included distance to health facilities, availability of health facilities and services, education, awareness, financial ability, and religion. These findings highlight that “cultural values are inextricably woven in decisions that favor or oppose programmes affecting sexual activity and fertility.”
Female adolescents must be encouraged to access SRHS and adequately counseled on contraception use to allay potentially misguided concerns regarding safety. Such measures could help mitigate contraception discontinuation. The promotion of gender equality will be central to facilitate adolescent access to SRHS and the effective adoption of birth control methods. To this end. It has been suggested that messaging should focus on the promotion of gender equity, "particularly the promotion of education of a girl child, women entrepreneurship and enterprise development, so as to enable them acquire economic potential to take their own decisions and afford birth control methods without having to first beg the men.” Male adolescents should also be encouraged to access SRHS. Strategies should be devised to counter male adolescent perception that accessing health services undermines their culturally scripted masculine identity as resilient and strong individuals. Furthermore, strategies should be devised to counter patriarchal cultural beliefs that hold that females have lower status and should accordingly be subordinate, economically dependent, and lack control over information sources.

Child labour

Despite Uganda having ratified the Minimum Age Convention, and having committed to a minimum labour age of 14 years of age, an alarming 51% of children aged 5-17 years in Uganda work. Across all regions, more males (52%) than females (49%) work. The Western region (56%) followed by the Central region had the highest proportion of working children.

Ethical implications and recommendations

If adolescents are engaged in labour practices, it follows that they will likely be unable to access SRHS, especially if their working hours and the operating hours of SRHS correspond. Uganda’s prevalence of child labour may accordingly serve as a major barrier to adolescents accessing SRHS. While it may be argued that household poverty underpins child labour in Uganda and that such practices are unavoidable in a country with high levels of poverty, authorities should consider ways to facilitate access to SRHS for adolescent labourers. This may include the provision of community-based youth friendly SRHS mobile clinics with extended operating hours to cater for adolescent laborers.

Orphanhood

Uganda is characterized by a large population of orphans. An estimated 1.2 million Ugandan children have been orphaned by AIDS. The proportion of orphans in the country increased from 11.5% in 1999/00, to 13.4% in 2002/03, and peaked at 14.6% in 2005/06, before declining to 12.3% in 2009/10. The country’s Orphans and Vulnerable Children Situation Analysis Report, 2009 estimated that 48% of all Ugandan orphans are a result of HIV/AIDS. Up to 43% of all children (7.3 million) live in a moderately vulnerable situation, while 8% (1.3 million) live in a critically vulnerable situation. Approximately 14 percent of children in Uganda under 18 years of age are orphans. Among those, 20 percent of children 6–17 years are orphans.

Ethical implications and recommendations

Orphaned children are forced to live on the streets or under exploitative conditions of labour, sexual abuse, prostitution and other forms of abuse. It has been reported that female maternal orphans are particularly susceptible to being sexually active, contracting STIs, getting pregnant and being infected with HIV, as opposed to paternal orphans who are more prone to being homeless and leaving school. Adolescent orphan girls are more likely to contract HIV than non-orphans. This is due to early exposure to HIV risk factors. To this end, orphan girls may be more susceptible to engaging in transactional sex and intergenerational sex for basic survival, thus increasing their risk to contracting HIV. Since adolescent orphans lack the benefit of parental income, they are much more likely to drop out of school. Lower levels of education have been linked with higher risk acquisition to HIV/AIDS and other sexually transmitted infections. These factors necessitate orphaned adolescents accessing SRHS, including HCT, contraception, and MMC. However, orphan status may present a significant barrier to autonomously accessing SRHS, especially as orphans lack parental or guardian consent to access such services.
Country experiences in addressing the barriers

Several initiatives have been undertaken in Uganda to provide and educate the community about contraceptive use. Initiatives such as ‘Vijana’ provide youth with up to date information about contraception and where it may be accessed. The Ministry of Health also increased the procurement and distribution of contraceptives to adolescents. However, such projects have faced challenges in regard to disseminating contraceptive information in schools because institutions are resistant to such initiatives. This speaks to the disconnect between national policies and grassroots implementation at a local level, and the need for prospective community engagement to ensure community-level buy-in.

The Constitution of Uganda gives special protection to orphans and vulnerable children. The Constitution states that children should have access to medical treatment, protected from fall forms abuse and exploitation. Article 34 (4) advocates for the protection of children from exploitation. It restricts children from work which interferes with their education or which may be harmful to their mental, spiritual, physical, moral and social development. Despite the Constitution making provisions for orphans to access health services and against exploitation, the vast majority of orphans live in poverty, thus making it impossible for them to access health services and to stop working in exploitative organisations. The Ugandan Government in collaboration with the International Labour Organisation and other stakeholders, should do more to address the SRHS health needs of Ugandan adolescents.

In response to youth shying away from health services which are offered in ‘open-to-all’ clinics, several initiatives have been implemented by both national and international policy makers. The Ministry of Health offers training to health workers to equip them with professional skills to work with young people. The training offers health workers skills in family planning, STI/HIV testing, male involvement and gender violence among adolescents. The WHO also established Youth Friendly Corners at select health units in the country. Youth meet at these corners to play and learn about health. Furthermore, community groups such as Adolescent Friendly Services, Male Action Groups, Alliance of Parents, Adolescent and Community for Adolescent Health have been established. These community groups bring together adolescents, parents, teachers and religious leaders to deal with adolescent health problems.
Chapter Five: 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 his 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 SRHS access to adolescent labourers and particularly vulnerable adolescents, such as orphans. 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 Uganda 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 publically-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.
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Annex

KEY QUESTIONS IN ESC REVIEW

1. 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).

2. 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.

3. 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.

4. 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).

5. 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:

6. 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.