The Center for Reproductive Law and Policy
Child and Law Foundation

State of Denial

Adolescent Reproductive Rights in Zimbabwe

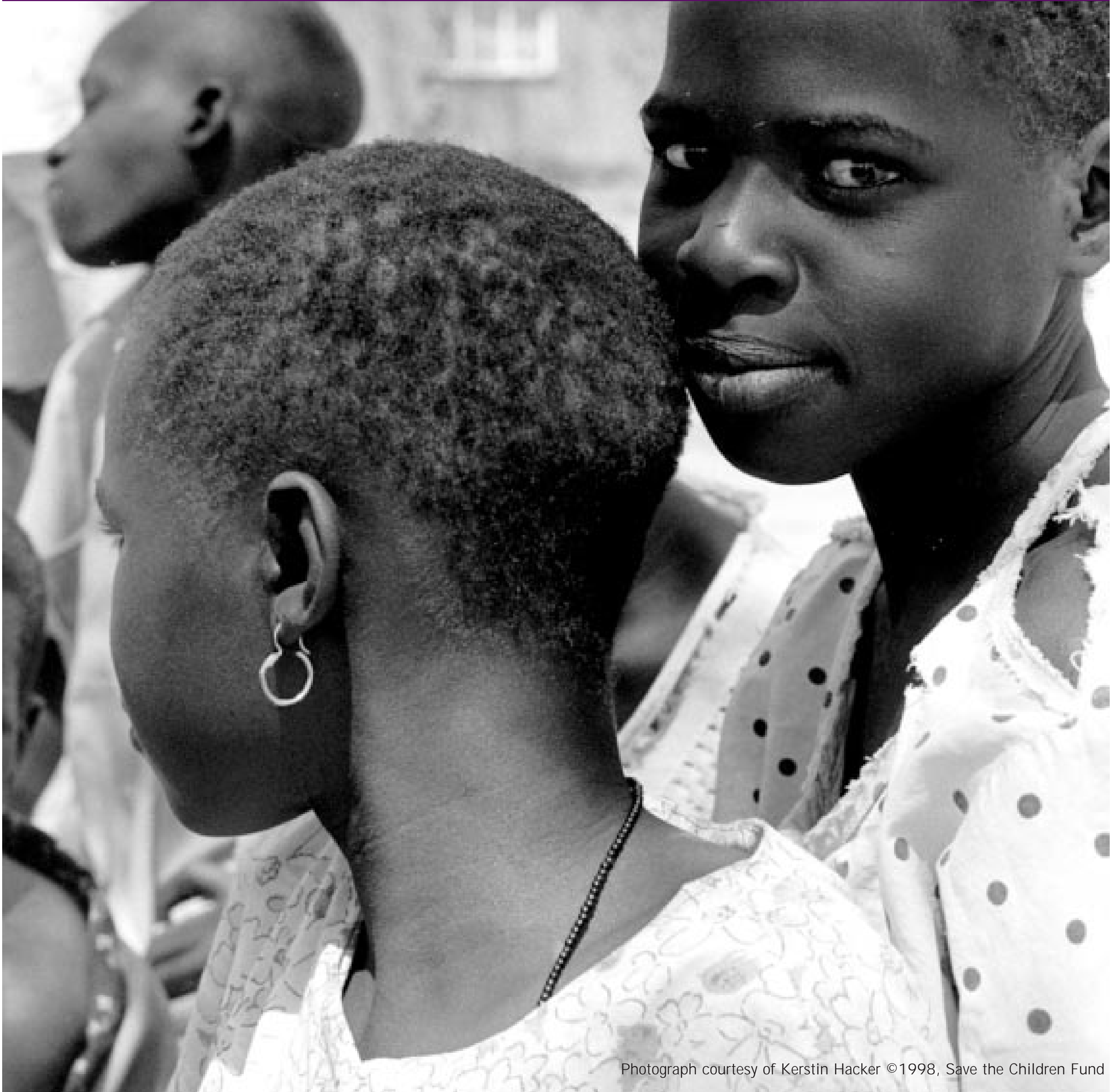

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TABLE OF ABBREVIATIONS AND GLOSSARY

Abbreviation	Complete Term and Definition
African Children's Charter	African Charter on the Rights and Welfare of the Child: Regional treaty codifying states' duties to protect and promote the rights of children
Banjul Charter	African Charter on Human and Peoples' Rights: Regional treaty codifying states' duties to protect human rights
Beijing Conference	1995 United Nations Fourth World Conference on Women: Global conference on women's human rights
Beijing Platform for Action	Beijing Declaration and Platform for Action, United Nations Fourth World Conference on Women: Consensus document adopted by nations participating in the Beijing Conference
Beijing+5	Women 2000: Gender Equality, Development and Peace for the 21st Century: United Nations General Assembly Special Session to examine states implementation of the Beijing Platform for Action
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women: International treaty codifying states' duties to eliminate discrimination against women
CEDAW Committee	Committee on the Elimination of Discrimination against Women: Treaty Monitory Body charged with monitoring states parties' implementation of the Convention on the Elimination of All Forms of Discrimination against Women
Committee on Economic, Social and Cultural Rights	Treaty Monitoring Body charged with monitoring states parties' implementation of the International Covenant on Economic, Social and Cultural Rights
Children's Rights Convention	Convention on the Rights of the Child: International treaty upholding the human rights of children
Children's Rights Committee	Committee on the Rights of the Child: Treaty Monitoring Body charged with monitoring states parties' compliance with the Convention on the Rights of the Child

Civil and Political Rights Covenant	International Covenant on Civil and Political Rights: International treaty protecting individuals' civil and political human rights
Dual Protection Methods	The means of preventing simultaneously unwanted pregnancy and sexually transmissible infections, including HIV/AIDS. Dual protection methods include use of a condom alone or a condom in combination with another contraceptive method
Dual Protection Information	Information, counseling and education regarding dual protection methods, offered as an element of comprehensive sexual and reproductive health care services and education
Economic, Social and Cultural Rights Covenant	International Covenant on Economic, Social and Cultural Rights: International treaty protecting individuals' economic, social and cultural human rights
Health Strategy	National Health Strategy of Zimbabwe
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
HIV/AIDS Policy	Zimbabwe's National Policy on HIV/AIDS
Human Rights Committee	Human Rights Committee: Treaty Monitoring Body charged with monitoring states parties' compliance with the International Covenant on Civil and Political Rights
ICPD	International Conference on Population and Development: United Nations Conference on population and development issues held in Cairo in 1994
ICPD Programme of Action	Programme of Action of the International Conference on Population and Development: Consensus document adopted by states participating in the International Conference on Population and Development
ICPD+5	21st Special Session of the UN General Assembly: Special session to review implementation of the International Conference on Population and Development Programme of Action
ICPD+5 Key Actions Document	Key actions for the further implementation of the Programme of Action of the International Conference on Population and Development: Consensus document adopted at ICPD+5
Ministry of Health	Ministry of Health and Child Welfare of Zimbabwe
NGO	Non-governmental organization

Population Policy	National Population Policy of Zimbabwe
STIs	Sexually Transmissible Infections
Treaty Monitoring Bodies	United Nations Human Rights Treaty Monitoring Bodies: Committees charged with monitoring states parties' fulfillment of their obligations under the six major international human rights treaties
UN	United Nations
UNDP	United Nations Development Programme: United Nations agency devoted to funding and supporting development initiatives in low- and middle-income countries
UNFPA	United Nations Population Fund: United Nations agency devoted to funding and supporting population and reproductive health programs in low- and middle-income countries
Universal Declaration	Universal Declaration of Human Rights: United Nations human rights instrument at the foundation of modern international human rights law
USAID	United States Agency for International Development: U.S. government body responsible for funding and overseeing U.S. foreign assistance programs worldwide
WHO	World Health Organization: United Nations agency devoted to researching and promoting public health worldwide
ZNFPC	Zimbabwe National Family Planning Council

EXECUTIVE SUMMARY

The reproductive rights of adolescents are protected under international human rights law. As stated at the 1994 International Conference on Population and Development (ICPD) the human rights that comprise reproductive rights rest on the recognition that everyone has "the right to attain the highest standard of reproductive and sexual health," "the right to make decisions concerning reproduction free of discrimination, coercion and violence," and the right to decide when and whether to bear children and to have the information and means to make such decisions.[1] Countries also agreed at ICPD that they must "protect and promote the rights of adolescents to reproductive health education, information and care. . . ."[2] The consequences of ignoring the rights of adolescents to reproductive and sexual health information and services can lead to loss of life, illness, the cessation of educational and economic opportunities, and other serious infringements of their human rights. This report focuses on one crucial aspect of adolescent reproductive rights in Zimbabwe: the right to access dual protection methods and information.

Adolescents constitute approximately 36% of the total population of Zimbabwe. The government of Zimbabwe faces the awesome task of meeting the crucial needs of this special group, including the prevention of unwanted pregnancies and STIs. The urgency of fulfilling adolescents' right to access dual protection methods and information is heightened by the fact that Zimbabwe ranks third in the world in the prevalence of HIV/AIDS, and also faces high rates of both teenage pregnancy and maternal mortality. These problems attest to the need for leadership by the Zimbabwean government in transforming existing cultural norms and stereotypes, which tend to promote parental control over adolescents and their sexuality.

This report documents legal, policy and social barriers to Zimbabwean adolescents' enjoyment of their international human right to access dual protection methods and information. Using a human rights fact-finding methodology, conclusions and recommendations are based upon an analysis of Zimbabwean laws and policies, as well as interviews conducted with over 800 adolescents, parents, family members, government officials and service providers. This investigation reveals a systematic denial of adolescents' right to access dual protection methods and information.

> In this report, the phrase **"dual protection methods"** refers to means of preventing simultaneously unwanted pregnancy and sexually transmissible infections (STIs), including HIV/AIDS. Dual protection methods include use of a condom alone or a condom in combination with another contraceptive method.[3] The phrase "dual protection information" refers to information, counseling and education regarding dual protection methods, offered as an element of comprehensive sexual and reproductive health care services and education. The "right to access dual protection methods and information" is a component of a broader set of internationally recognized reproductive rights, including the fundamental rights to reproductive self-determination, to non-discrimination, and to reproductive health care.

I. CONTEXT FOR ZIMBABWEAN ADOLESCENTS

The Zimbabwean government's denial of adolescents' concerns relating to unwanted pregnancy and STIs stems from cultural views regarding relations between parents and their children. Cultural values also promote sexual purity of young people to the extent that there are significant taboos against pre-

marital sex. Yet Zimbabwean youths face dramatic real-life problems as a result of their inability to obtain dual protection methods and information.

The government's failure to adopt an effective legislative and policy framework that ensures access to dual protection for adolescents has tremendous implications for their lives. In Zimbabwe, the onset of sexual activity generally begins before marriage, typically by the age of 17 and often as early as 12. Unfortunately, while it is clear that Zimbabwean adolescents are engaging in sexual activity both in and outside of marriage, they have a limited understanding of how to prevent pregnancy and reproductive health problems. Lack of access to dual protection methods and information leaves adolescents vulnerable to the grave health risks associated with early onset of sexual activity, including early pregnancy, unwanted pregnancies, unsafe abortions, and STIs, including HIV/AIDS. Moreover, such lack of access seriously affects adolescents' educational, occupational, and social opportunities.

In an attempt to navigate the conflict between cultural values and the reality of adolescents' lives, the government has issued inconsistent and confusing laws and policies in recent years. Moreover, outdated laws remain on the books, further complicating the situation. In addition to a lack of clarity in the relevant norms, there is also a general tendency for laws and policies to cast parents as gatekeepers for their children's access to reproductive and sexual health services and information, and favor parental control over adolescent reproductive choices. Given that the government is the primary provider of health care, including reproductive health care, the problems adolescents face are compounded when public health service providers interpret applicable laws and policies restrictively.

II. ADOLESCENTS' HUMAN RIGHT TO ACCESS DUAL PROTECTION METHODS AND INFORMATION

Adolescents' reproductive rights are firmly rooted in the most basic human rights principles, as enunciated in major international and regional human rights treaties as well as international conference documents. Adolescents' right to access dual protection methods and information is a component of the right to reproductive and sexual health, including the right to information and education, the right to reproductive self-determination, and the rights to equality and non-discrimination. According to international standards, adolescents are entitled to the same rights as adults with respect to services and information on contraception and STI prevention. Both the "evolving capacities of the child" standard and the "best interests of the child" standard resolve the apparent conflict between adolescents' rights and parental decision-making authority. In the context of reproductive and sexual health, the fact that a young person is engaged in or planning to engage in sexual activity and is seeking protection from unwanted pregnancy and STIs is evidence that his or her capacities have evolved. Moreover, adolescents who are sexually active and who seek dual protection methods and information are acting maturely in their own best interests to be informed and to protect themselves from serious health risks.

International human rights instruments obligate the Zimbabwean government to respect, protect and fulfill adolescents' right to access dual protection methods and information. As a signatory to these instruments, the government has a negative obligation to refrain from interfering with adolescents' ability to seek services and information on contraception and STI prevention, which means it may not implement laws or policies that violate these rights. Zimbabwe is also under a further obligation to protect adolescents' right to access dual protection methods and information from interference by private third parties, meaning that private individuals should not be permitted to interfere with another's ability to seek and receive services and information on contraception and STI prevention. In addition, the government is under a positive obligation to ensure that adolescents are able to enjoy all

their rights. Accordingly, the Zimbabwean government should introduce programs and implement laws and policies to ensure adolescents the effective enjoyment of their right to access dual protection methods and information. Finally, government-run programs should not discriminate in providing services and information on specified grounds that would interfere with adolescents' ability to exercise their rights. These prohibited grounds for discrimination include age, gender, marital status and socioeconomic status.

III. VIOLATIONS OF THE HUMAN RIGHTS OF ADOLESCENTS IN ZIMBABWE

Zimbabwe's legal and policy framework fails to ensure adolescents' human right to access dual protection methods and information. Certain laws and policies, both on their face and through official interpretations, violate adolescents' human rights. In addition, ambiguities and inconsistencies in national laws and policies appear to have laid the foundation for service providers to use their discretion to restrict adolescents' access to services and information on contraception and STI prevention; therefore adolescents' rights are also being violated in the application of laws and policies.

A. Certain Zimbabwean Laws and Policies Contravene International Standards

Zimbabwean national laws and policies do not meet international human rights standards regarding adolescents' right to access dual protection methods and information. There are inconsistencies between certain laws on the one hand, and certain policies, on the other hand, with the latter apparently more youth-friendly. Whereas policies often acknowledge the clash of cultural norms and traditions and the realities of adolescent sexuality, the laws generally do not.

- National-level laws and policies generally uphold parental consent requirements for adolescents below the age of 18 to access services and information on contraception and STI prevention. In practical terms, these laws and policies severely inhibit adolescents from seeking vital medical advice and services. In fact, they present almost insurmountable obstacles for adolescents seeking health services where sensitive and crucial issues regarding reproductive and sexual health are concerned. Therefore, these laws and polices violate adolescents' rights to health, to information and to education. Taken together, these laws and policies effectively deny adolescents under the age of 18 the legal capacity to control their bodies, thereby failing to ensure their rights to privacy and confidentiality and discriminating against them on the basis of age.

- National anti-discrimination provisions are insufficient to protect adolescents from discrimination on the basis of age, marital status and socioeconomic status in the exercise of their right to access dual protection methods and information. Most significantly, Article 23(3) of the Zimbabwe Constitution exempts both customary African law and laws relating to personal matters from anti-discrimination protections. In addition, there are no national legal instruments that explicitly prohibit discrimination on the basis of age, marital status or socioeconomic status.

- Complex and overlapping penal and civil law provisions pertaining to the legality of adolescent sex are contradictory and result in a denial of adolescent access to dual protection methods and information. This creates a gray zone where the law appears to prevent health care professionals from providing services and information regarding contraception and STI prevention to certain adolescents (ages 16–17) who are legally capable of consenting to sex.

- In addition to being inherently violatory, the laws and policies when taken as a whole fail to uphold international standards. Zimbabwe is not only obligated to eliminate legal and policy barriers to adolescents' full enjoyment of their rights, but the government also has a duty to affirmatively enact and implement laws and policies that will ensure their rights. However, the overall national legal and policy framework fails to do so. In its inconsistency and ambiguity, the national framework is insufficient, allowing for restrictive interpretation on the part of government officials and public health service providers.

B. Implementation of Zimbabwean Laws and Policies Results in Human Rights Violations

Public health service providers are left to navigate a complex, confusing maze of inadequate, conflicting laws and policies colored by cultural norms and attitudes. Our investigation reveals that service providers not only rigorously enforce parental consent requirements, but they also interpret national laws and policies very restrictively, implementing them in a way that denies access to and discriminates against adolescents.

- Our research results reveal that public health care providers rigorously enforce parental consent requirements. Health workers will not provide adolescents under 18 with services and information on contraception and STI prevention without parental consent. Our investigation also reveals that service providers routinely inform parents and obtain their consent before providing adolescents with such services and information. Even when a health care provider grants an adolescent entry to a clinic, he or she considers it part of his or her professional obligation to inform a parent of the adolescent child's reproductive health status. Thus, service providers give priority to parents' right to know over adolescents' right to treatment and to make autonomous decisions regarding their sexual and reproductive lives.

- The restrictive interpretation of legal and policy language on the part of public health service providers prevents adolescents from accessing dual protection methods and information through the public health care system, with potentially serious health consequences. Adolescents are forced to seek services and information from unreliable sources outside of public health care institutions and often use methods that are ineffective at preventing pregnancy or transmission of HIV/AIDS or other STIs. In fact, adolescents resort to a number of substitutes—such as empty "freezit" wrappers and traditional medicine such as "charms" and "guchu"—sometimes at great risk to their health.

- Adolescents are not receiving reliable information and education on contraception and STI prevention from government-sponsored institutions. Adolescents' firsthand reports of their lack of sexuality education reveal a widespread reliance on misinformation and miscon-

ceptions among Zimbabwe's young people. While the reasons for such lack of awareness are complex, and partly attributable to cultural norms and traditions, the government's promotion of abstinence rather than safe sex is certainly a factor.

- The investigation reveals that the rights to privacy and confidentiality are virtually non-existent for adolescents under 18. In enforcing the parental consent requirements, public health service providers share privileged information and involve parents at every step. Adolescents have very little faith in service providers' promises of confidentiality, and fear that they will be reported to parents, school officials and other members of the community. This failure to ensure adolescents' rights to privacy and confidentiality in reproductive health services inhibits their ability to make autonomous decisions regarding their reproductive and sexual lives and drives them away from getting the health services they need.

- The investigation reveals that public health service providers apply national laws and policies in a way that further discriminates against certain adolescents on the basis of gender, marital status and socioeconomic status. Cultural attitudes and expectations of girls create additional impediments for them in accessing dual protection methods and information, and they also suffer disproportionately from the lack of access. In addition, our interviews confirm that service providers grant married adolescents below the age of 18 access to services and information on contraception and STI prevention but are unreceptive toward unmarried adolescents. Rural adolescents also encounter more barriers to access than urban populations. Finally, low-income adolescents, primarily female sex workers, are routinely denied access to dual protection methods and information in part due to discriminatory attitudes and cultural stereotypes. These adolescents, who may be at greater risk of early and unwanted pregnancies and contracting HIV/AIDS or other STIs, have an even more urgent need to access dual protection methods and information.

The Zimbabwean government should take steps as soon as possible to provide adolescents with dual protection methods and information. The government should simplify its patchwork of inconsistent laws and policies to promote the ability of young people to obtain methods of contraception and STI prevention. An immediate opportunity is likely to be provided by efforts to develop a comprehensive national youth policy and by the efforts of the Zimbabwean National Family Planning Council (ZNFPC) to amend its Reproductive Health Guidelines, including policies dealing with adolescents. The government of Zimbabwe also should examine the way its current policies relating to adolescents are being implemented and enact changes to ensure that their human right to access dual protection methods and information is being upheld. It is time to end the state of denial that has undermined adolescents' ability to protect themselves from serious, potentially life threatening health risks.

RECOMMENDATIONS

The violations of adolescents' human rights that are exposed in this report are directly attributable to the actions or inaction of the government of Zimbabwe and its agents, including public health service providers and the public education sector. Recommended actions include legal and policy reform and changes in the way that public reproductive and sexual health services are provided to adolescents. Zimbabwean non-governmental organizations (NGOs), international donors and the Zimbabwean media also play a crucial role in ensuring adolescents' enjoyment of their human rights. The human rights of adolescents will only be realized where legal and policy reform is accompanied by a broader movement to address issues that affect their reproductive health and choices.

A. To the government of Zimbabwe:

1. Draft and adopt new laws, policies and guidelines that uphold international standards for ensuring adolescents' access to dual protection methods and information. In particular:

- Parliament should pass implementing legislation to harmonize national laws with international treaties that have been signed and ratified by the government, with a view to improving adolescents' access to dual protection methods and information.

- Adopt measures to reform cultural views of adolescents' needs for contraception and sexually transmissible infections (STI) prevention and address cultural taboos surrounding adolescents', particularly female adolescents', sexuality. Such government action should be consistent with the Convention on the Elimination of All Forms of Discrimination against Women, which asks states parties "[t]o modify the social and cultural patterns of conduct" in order to "eliminat[e] prejudices" as well as "practices which are based on the idea of the inferiority or the superiority of either of the sexes. . . ."[4]

- Take steps to address the gap in adequate legal protections for discrimination on certain specified grounds such as gender, age, socioeconomic status and marital status.

- Create public education campaigns and other policies addressing the cultural taboos surrounding adolescent sexuality, with an emphasis on encouraging parents to communicate with their children about sex.

- Incorporate specific language into the National Reproductive Health Guidelines, now being drafted, to provide adolescents with free access to dual protection methods and information.

- Provide guidelines, particularly to public health care providers, for interpreting ambiguous laws and policies to ensure uniform interpretation.

- Ensure that the Youth Policy currently being developed encourages adolescent access to dual protection methods and information free from parental consent requirements.

2. **Identify where existing laws and policies are inconsistent with international standards and amend the relevant provisions so that they conform to international reproductive rights standards. Specifically:**

   - Amend the Zimbabwean Constitution, Chapter III, Section 20, which renders the rights of adolescents under the age of 18 to receive or impart information subject to parental control, so that it guarantees the internationally recognized right of adolescents to seek and obtain information of all kinds.

   - Revise the Zimbabwean Constitution, Chapter III, Section 23(2), which prohibits discrimination on the bases of gender, race, tribe, place of origin, political opinions, color, or creed, so that it also prohibits discrimination on the basis of age, socioeconomic status, and marital status.

   - Amend the Zimbabwean Constitution, Chapter III, Section 23(3), which exempts customary laws and laws relating to personal matters from being subject to its anti-discrimination provisions, so that these laws may no longer discriminate.

   - Revise the Marriage Act and the Customary Marriages Act to establish 18 as the mandatory minimum age of marriage for both girls and boys.

   - Amend all policies, in particular the Patient's Charter, the National Population Policy and the National HIV/AIDS Policy, to require health care professionals to provide all adolescents with services and information on contraception and STI prevention without parental consent.

3. **Harmonize all domestic laws and policies to eliminate contradictions with respect to adolescents' access to dual protection methods and information. Specifically:**

   - Review laws and policies with a view to rendering language clear and consistent so that service providers may implement the laws and policies uniformly and in compliance with international obligations.

   - Clarify that laws that set the age of sexual consent do not prohibit public health care workers from providing services and information on contraception and STI prevention to adolescents under 16.

   - Supervise family planning policies to ensure that they are implemented uniformly throughout the country.

4. **Educate adolescents, parents and service providers about reproductive health issues and rights with a view to improving adolescents' access to dual protection methods and information. Specifically:**

   - Disseminate the Patients' Charter more widely to foster respect for its principles, especially confidentiality.

- Implement a national plan to train service providers to educate adolescents about the use of methods of contraception and STI prevention and to enable service providers to provide the same quality services to all adolescents.

- Encourage and implement comprehensive sexual education programs for adolescents, including the requirement of schools and other institutions to teach sexual education at the primary and secondary school level.

- Educate adolescents about methods of dual protection from unwanted pregnancies as well as HIV/AIDS and other STIs.

- Train service providers to respect adolescents' right to confidentiality over parents' right to control services for the adolescent; train them also to interact with adolescents with a view to encouraging access to dual protection methods and information.

- Adopt a policy that explicitly requires public and private schools to permit girls to attend school while pregnant and to return to school after giving birth.

B. To health care providers and associations:

- Provide dual protection methods and information to all adolescents, especially underserved groups, including out-of-school adolescents, sex workers, and adolescents residing in rural areas.

- Encourage legislative reform to ensure adolescents' access to dual protection methods and information. In this respect, contribute with studies on the relationship between access to dual protection methods and information and the HIV infection rate among adolescents. Assist in revising provisions that hinder adolescents' access to services and information on contraception and STI prevention.

- Uphold the right to privacy of adolescents who seek services and information on contraception and STI prevention by supporting professional confidentiality in the doctor-patient relationship.

- Create forums where health care providers who support adolescents' access to dual protection methods and information can speak out publicly on lack of access as a public health problem.

- Organizations that provide reproductive health services should advocate the creation of coalitions with medical associations, including local professional groups, to address the issue of adolescents' access to dual protection methods and information.

C. To Zimbabwean NGOs:

- Provide training to service providers to teach them to be more adolescent-friendly and non-judgmental, and to respect their clients' confidentiality. Organize workshops for service providers to ensure that they do not let their personal values interfere with their professional obligations.

- NGOs working in the area of human rights should join efforts to develop common legal and advocacy strategies to ensure adolescents' right to access dual protection methods and information and promote adolescents' reproductive autonomy. In particular, NGOs should:

  - Promote and disseminate the international framework for the protection of adolescents' right to access dual protection methods and information;

  - Document and investigate cases in which these rights are abused; and

  - Monitor Zimbabwe's compliance with recommendations of the Human Rights Treaty Monitoring Bodies.

- Engage in outreach to parents, church and traditional leaders on the need to provide services and information on contraception and STI prevention to adolescents.

- Work to change social norms by encouraging parents to communicate with their children about sex.

- Sensitize adolescent boys to ensure that they engage in responsible sexual behavior.

D. To international donors and international organizations working in Zimbabwe:

- Support government plans aimed at instituting sexuality education and access to reproductive health programs that promote reproductive rights. In particular, international donors should resume support of Zimbabwe National Family Population Council's radio program and magazine.

- Provide support to NGOs involved in advocacy on the issue of adolescents' access to dual protection methods and information, as well as support to specific projects aimed at increasing adolescents' access.

- Support projects proposed by NGOs and/or the state that involve studying the issue of adolescent access to dual protection methods and information from a public health perspective. Such projects should study the relationship between lack of access and HIV/AIDS prevalence among adolescents, maternal morbidity and mortality, and links to illegal and unsafe abortion. Priority should also be given to funding research on adolescents' access from a human rights perspective, particularly aimed at fostering respect for adolescents' autonomy and reproductive self-determination.

E. To the Media:

- Promote the human rights of adolescents by providing impartial information and opening forums for discussion on adolescents' sexual and reproductive rights, paying special attention to the impact of contradictory and confusing laws, policies, and guidelines.

INTRODUCTION

Adolescence is a period of transition from childhood to adulthood—a time when sexual and reproductive health concerns take on major significance in an individual's life. Many adolescents face choices that may have lifelong implications, including decisions to marry, form unions, engage in sexual relations, develop relationships, or bear children. The decisions boys and girls make during the early stages of their reproductive lives may shape their circumstances for years to come. Yet cultural taboos regarding adolescent sexuality persist. Because adolescence is a period of transition to sexual and reproductive maturity, it is essential to provide adolescents with the reproductive health services that will ensure their future. One of the key reproductive health needs of adolescents worldwide is the need to access dual protection from unwanted pregnancy and sexually transmissible infections (STIs), including HIV/AIDS.

While the international community has acknowledged adolescents' need for reproductive health care, it has not precisely defined terms applied to people in this transition to adulthood. For example, the international community defines "adolescents" as people between the ages of 10 and 19, "youth" as people between the ages of 15 and 24, and "young people" as people between the ages of 10 and 24 so as to encompass both "adolescents" and "youth."[6] The Convention on the Rights of the Child (Children's Rights Convention), defines a "child" as a person below the age of 18.[7] This report follows the international community's definition of the terms "adolescents," "youth" and "young people."[8]

In this report, the phrase "dual protection methods" refers to the means of preventing simultaneously unwanted pregnancy and STIs, including HIV/AIDS. Dual protection methods include use of a condom alone or a condom in combination with another contraceptive method.[5] The phrase "dual protection information" refers to information, counseling and education regarding dual protection methods, offered as an element of comprehensive sexual and reproductive health care services and education. The "right to access dual protection methods and information" is a component of a broader set of internationally recognized reproductive rights, including the fundamental rights to reproductive self-determination, to non-discrimination, and to reproductive health care.

Because young people constitute almost 36% of the population of Zimbabwe[9] and face critical reproductive health issues, this report focuses on Zimbabwean adolescents' human right to access dual protection methods and information. There appears to be a current opportunity to undertake legal and policy reform that would promote adolescents' reproductive rights in Zimbabwe. As this report is being published, the government and a para-statal agency that is a key provider of reproductive health services in Zimbabwe are in the process of jointly developing policies that aim to be youth-friendly.[10] Therefore, this report seeks to inform this process, and the formulation of policy documents, by identifying the legal, policy and social barriers to adolescent access to services and information on contraception and STI prevention.

A. Adolescence and Dual Protection: Critical Issues

The international community recognizes the human rights of adolescents to access dual protection methods and information. Providing adolescents with access to such services and information not only decreases their risk of exposure to serious health harms, but could also positively affect their educational, occupational and social opportunities. If adolescents are armed with appropriate services and information on contraception and STI prevention, they will be better able to guard themselves against

early and unwanted pregnancy and exposure to STIs, including HIV/AIDS. Moreover, preventing adolescents from facing these social and medical problems will enhance their ability to mature and to become productive citizens. Lack of information regarding reproductive health, including contraception, can also leave adolescents without the skills to protect themselves from potentially dangerous or abusive relationships.

Adolescent pregnancy is usually associated with serious social and medical consequences for young women. The social effects of such pregnancy for teenage mothers include lower educational attainment, decreased employment opportunities due to lack of skills, and reduced quality of life.[11] The medical effects of adolescent pregnancy, however, are even more far-reaching. Young adolescents, particularly those under 15, are far more likely to experience difficult and even tragic pregnancy outcomes than older adolescents and adult women. They are more likely than older women to experience premature labor, spontaneous abortion, and stillbirths, and they are up to four times more likely than women over 20 to die from pregnancy-related causes.[12] Moreover, lack of safe, legal abortion services for adolescents has particularly serious health implications for adolescent girls. Rates of maternal mortality and morbidity due to unsafe abortion are particularly high among adolescents.[13] In fact, adolescent girls worldwide are more likely to undergo unsafe abortions, in large part because their restricted access to high quality, confidential reproductive health services and information, including contraception, leaves them more susceptible to unwanted pregnancy.[14]

Adolescents also face increased exposure to STIs, particularly HIV/AIDS. Of the 40 million people living with HIV in 2001, at least one third were aged 15 to 24,[15] and half of all new HIV infections—almost 7,000 daily—occur among this age group.[16] In Africa, the HIV/AIDS prevalence rate among young women is almost twice the rate of young men.[17] Studies also reveal that there is an acute need to educate young people regarding HIV/AIDS. For example, in one survey of youths from more than a dozen low-income countries, UNICEF found that the majority of youth had either "never heard of HIV[/AIDS] or else "harbor[ed] serious misperceptions regarding its transmission."[18]

B. Reproductive Health Issues of Zimbabwean Adolescents

Zimbabwe's 1992 census indicated that the number of Zimbabweans between the ages of 10 and 24 years was over 3.7 million[19]—close to 36% of its total population.[20] With approximately 45% of young people under the age of 15, Zimbabwe's overall population is young.[21] Furthermore, the census indicated that the number of youth was growing faster than Zimbabwe's overall population. According to a 1999 survey carried out by the Zimbabwe National Family Planning Council (ZNFPC), while the country's population grew by 39% between 1982 and 1992, the number of youth increased by 47% during the same period.[22] The problems of the majority of Zimbabwe's adolescents are compounded by soaring national HIV/AIDS prevalence rates[23] and exceedingly high maternal mortality rates.[24] Although the government of Zimbabwe does not define the term "adolescents," it defines "youth" as anyone under 16 and a "minor" as anyone under 18.[25] Significant information regarding several key reproductive health issues confronting Zimbabwe's adolescents is presented below.

1. Early Onset of Sexual Activity

"[T]here are no virgins anymore, if the[re] are, they [are the] very odd ones."[26]

Zimbabwean traditional healer when asked about adolescents aged 11-18.

In Zimbabwe, the onset of sexual activity generally begins before marriage. The Ministry of Health and Child Welfare (Ministry of Health) has found that while the average age of first sexual activity is 17 years old, the average age of marriage is in the early 20s.[27] Certain groups begin having sexual relations even earlier.[28] Female adolescents, in particular, begin having sexual intercourse at an early age. Thirty percent of girls 15 to 19 years old reportedly have had sexual intercourse at least once.[29] It also appears that some sex workers[30] became sexually active as early as 13; the average age of first sex in this group was 14.8 years.[31]

2. Early and Unwanted Pregnancy

> ***"There is a big problem in the country with unsafe abortions. There are an estimated 60,000 to 70,000 unsafe abortions [performed each] year. But, this is just the tip of the iceberg, because most cases go unreported. Most of those who undergo illegal abortions are teenagers."***[32]
>
> ZNFPC Executive Director

There is a markedly high number of unplanned and early pregnancies among adolescents in Zimbabwe. Even though Zimbabwe has experienced a decline in adolescent fertility in recent years, studies continue to show that many adolescents have mistimed and unwanted pregnancies. Close to 40% of female adolescents in Zimbabwe are already mothers by the time they are 19 years old.[33] The mean age at which women have their first child is 18.9 years. However, it is not uncommon for girls to bear children as early as age 13.[34] According to a 1997 survey carried out by the ZNFPC, 18% of the young men and women who conceived a child were still in primary school. Eighty-two percent of the pregnancies reported in the survey ended in delivery and 7% ended in miscarriage or abortion.[35] Fortunately, pregnant young women use antenatal care despite their marital status: 91% of youth who have been pregnant reported receiving antenatal care. Thus, ensuring adolescents' access to health services associated with pregnancy appears to pose less of a challenge in Zimbabwe than preventing unwanted pregnancy.[36]

3. Exposure to STIs, including HIV/AIDS

> ***"We will deal with the problem (AIDS) when we get there."***[37]
>
> Zimbabwean adolescent

Sexually active adolescents in Zimbabwe are exposed to the risk of contracting STIs, including HIV/AIDS. Adolescent girls are at higher risk of contracting the virus for many reasons, including both biological[38] and economic factors.[39] Adolescent girls' heightened susceptibility is illustrated by the fact that HIV prevalence among 15–24-year-old females in 1999 was estimated to be between 23 to 26% whereas for males of the same age group it was only 10 to 13%.[40] One clinical study revealed that 30% of 15–19-year-old pregnant adolescents in Zimbabwe were HIV-positive.[41] Young women also face increased risk as they often develop sexual relationships with older men, or "sugar daddies," that provide them with economic support.[42] In fact, in a survey conducted by ZNFPC, an alarming 8% of the young women interviewed did not feel that they could avoid HIV/AIDS or other STIs.[43] Nor did they feel they could avoid relationships with older partners[44] who might already have had a number of sexual relationships and are, therefore, more apt to be carriers of a STI.

Adolescents' lack of knowledge regarding HIV/AIDS is particularly disturbing. According to a ZNFPC survey, 25% of adolescents did not know what STIs were, and young women from rural areas were the least informed. Just as distressingly, 38% of youth said that a man will always be able to tell when a woman has a STI.[45] Although adolescents interviewed for this report demonstrated some awareness of the HIV/AIDS pandemic, they lack knowledge on how to protect themselves and fail to do so for various reasons.[46] They believe that AIDS will never affect them, that post-sex rituals will prevent HIV/AIDS, and/or that AIDS is an inevitable occurrence.[47] These misunderstandings, coupled with a seemingly cavalier attitude towards the pandemic, translate into very few adolescents taking precautionary measures to prevent HIV/AIDS.

4. Lack of Use of and Knowledge Regarding Dual Protection Methods

> ***"Twenty-five percent of Zimbabwean youth do not think that a girl could get pregnant the first time she has sex."***[48]
>
> 1999 ZNFPC Survey

The early onset of sexual activity and Zimbabwean adolescents' high rates of unwanted pregnancy and STIs reflect *low usage* and *lack of information* regarding dual protection methods. According to a 1999 ZNFPC survey, "only 9% of unmarried youth reported ever using a method of contraception—15% of sexually active youth not using contraception did not know about it, and 11% could not obtain it."[49] Overall, the vast majority of adolescents do not use any method of contraception or STI prevention during their first sexual experience.[50] In addition, "most youth do not seek out reproductive health services until they have become pregnant or have contracted a [STI]."[51] Moreover, while it is clear that Zimbabwean adolescents are engaging in sexual activity both within and outside of marriage, they have a minimal understanding of reproductive biology and a limited knowledge of how to prevent pregnancy and reproductive health problems. For example, a 1999 ZNFPC survey found that "25% of youth do not think that a girl could get pregnant the first time she has sex," and 46% believe that a girl cannot get pregnant if she has sex standing up. A further 25% of respondents fear that the use of contraception can cause deformities in babies, and 37% believe that using oral contraceptives can cause infertility.[52]

Finally, it is relevant to point out that despite the prevalence of misinformation and the failure to use contraception, Zimbabwean adolescents would like to have access to dual protection methods and information. The large majority of adolescents hail the use of dual protection methods and would like free and adequate provision of services and information on contraception and STI prevention.[53] Unfortunately, for reasons discussed further in subsequent chapters, most Zimbabwean youth do not seek or are denied access to dual protection methods and information until they have become pregnant or have contracted a STI.

The grave public health concerns surrounding adolescent sexuality in Zimbabwe point to a critical need for adolescents to access methods of dual protection from unwanted pregnancy and STIs, including HIV/AIDS. The government of Zimbabwe is therefore faced with the formidable task of addressing the needs of this large segment of Zimbabwean society in light of prevailing socio-cultural norms and attitudes which stigmatize premarital sex among adolescents.

C. Scope of the Report

The researchers for this report employed a human rights fact-finding methodology to gather information from a broad range of sources. The objectives of this type of methodology differ from those of a social science study. By investigating whether or not particular human rights are being respected, a human rights report seeks to document whether a government is fulfilling its obligations under international law. If a government is not acting in a manner consistent with its international obligations, a human rights-based approach also establishes accountability on the part of the state and seeks to secure a remedy for violations.

Researchers attempted to monitor Zimbabwe's compliance with the international standards for adolescents' access to dual protection methods and information by examining concrete facts and by recording personal experiences of adolescents in Zimbabwe. This allowed the investigators to see first-hand how laws and policies affect the sexual and reproductive lives of Zimbabwean adolescents, as well as the real-life conditions that determine their impact. This methodology was used to evaluate the conduct of state representatives as well as private individuals, to analyze the facts in light of international human rights standards, and to formulate recommendations to address violations of adolescents' reproductive rights.

The research for this report was carried out by two staff members of the Child and Law Foundation (CLF), and one staff member of the New York-based Center for Reproductive Law and Policy (CRLP), from August to October 2000. The researchers covered the major cities of Zimbabwe—Harare, Mutare, Bulawayo, Chinoyi and Chitungwiza—and the rural schools surrounding these areas. The investigative techniques used in the fact-finding consisted of group discussions, one-on-one interviews, and questionnaires completed by individual interviewees. These methods were used with various groups of interviewees, including adolescents, parents, health care providers, government officials and United Nations (UN) and non-governmental organization (NGO) representatives.

1. Interviewees and Questionnaires

A total of 802 persons were interviewed during the course of the research. They included school-going adolescents, out-of-school adolescents, adolescent sex workers, parents, service providers, government officials, and representatives of NGOs and UN agencies. The young people interviewed were selected to represent a cross-section of the adolescent population of Zimbabwe, including various ethnic groups. School-going adolescents who participated in the study ranged in age from 14 to 19 years. Out-of-school young people ranged in age from 9 to 23 years. Adolescent sex workers ranged in age from 13 to 19 years. All groups included approximately the same number of adolescent girls and boys. Multiple-choice and open-ended questions were used to produce structured, self-administered questionnaires and also to stimulate more detailed interviews. However, it is important to note that, because of the sensitivity of the topic of this report, adolescents were often reluctant to provide information in one-on-one interviews. Group interviews yielded more information. See Appendix A, Table 5, for number of interviewees who responded to each type of questionnaire and Appendix A, Table 6, for a list of questions used. The interviewees were drawn from rural and urban communities within Zimbabwe. Appendix A, Table 1, summarizes the demographic characteristics of all participants.

School-Going Adolescents

The interviewees were selected from both rural and urban schools in Zimbabwe (see Appendix A, Table 2, for the names of schools visited). Permission was obtained from the Ministry of Education to interview the adolescents in their schools. A total of 292 adolescent girls and 355 adolescent boys were interviewed. Their ages ranged from 14 to 19 years with an average of 16.4 years.

Out-of-School Adolescents

A total of 94 out-of-school adolescents (59 boys and 35 girls) were interviewed. The interviewees were drawn from the Tsungirirai group, based in Norton, and the Chysap group, based in Chitungwiza. Out-of-school adolescents ranged in age from 16 to 19 years with an average age of 18.9. Adolescents living on the street were also interviewed at two centers: five boys and two girls were interviewed at the Streets Ahead Center in Harare; and 11 boys were interviewed at the Tutuga Center in Bulawayo, which is the second largest city located in south-west Zimbabwe. (See Appendix A, Table 3.)

Adolescent Sex Workers

A total of 30 adolescent sex workers who were arrested by police for soliciting for sex in the streets of Harare were interviewed. These adolescents, who spoke to interviewers voluntarily, range in age from 13 to 19 years, with the average age being 14.8 years. They were mostly school dropouts who were forced by economic circumstances into sex work. (See Appendix A, Table 3.)

Others

Information for this report was also obtained from parents, service providers, government officials and UN and NGO representatives. A group discussion was conducted with 11 parents, of whom five were men and six were women. They were all from Gweru, the third largest city in Zimbabwe, which is located in the Midlands province. At least 20 stakeholders from various governmental, non-governmental and inter-governmental organizations and professions were interviewed. They completed questionnaires and were then interviewed individually. (See Appendix A, Table 4, for the list of stakeholders.)

D. Structure of the Report

This report begins by setting forth recommendations regarding the manner in which the government of Zimbabwe can enhance adolescents' access to dual protection methods and information in accordance with international standards. This chapter introduces the importance of adolescence; underscores the gravity of adolescents' reproductive health concerns in Zimbabwe; and explains the objectives and methodology of the report. The report is then divided into three substantive chapters, which together demonstrate that the Zimbabwean government has failed to uphold its obligations under international human rights law. Chapter I provides a brief background to Zimbabwe and outlines Zimbabwean domestic laws and policies pertaining to adolescents' access to services and information on contraception and STI prevention. Chapter II outlines the international human rights framework for ensuring adolescents' right to access dual protection methods and information. Chapter III sets forth the manner in which adolescents' right to services and information is undermined both by national laws and policies and the application of those laws and policies. A brief conclusion sets forth the main findings of this report.

CHAPTER I: THE ZIMBABWEAN SETTING

There is little doubt that the Zimbabwean government is faced with serious challenges in ensuring the health and welfare of its growing adolescent population. Adolescents in Zimbabwe confront grave reproductive health issues such as disturbingly high rates of HIV/AIDS infection and maternal mortality. This chapter places these critical health concerns of Zimbabwean adolescents in a larger national setting It provides a brief overview of the demographic, historical, political and social context in Zimbabwe, with an emphasis on the health sector. This description is followed by a discussion of the Zimbabwean legal and policy framework, particularly those laws and policies that govern adolescents' ability to access dual protection methods and information. In general, these laws and policies reflect Zimbabwean socio-cultural traditions which stress the importance of marriage as a social institution and stigmatize sexual relations outside of marriage, particularly for adolescents. This chapter concludes with an analysis of the manner in which these laws and policies interact to effectively deny Zimbabwean adolescents' access to services and information on contraception and STI prevention.

A. General Background on Zimbabwe

This section briefly discusses the socioeconomic context and the basic political structure of Zimbabwe, with an emphasis on the health sector. It lays the foundation for understanding the manner in which laws and policies regarding health care may be enacted and provides a critical framework within which to examine the formal laws and policies affecting adolescents' access to dual protection methods and information.

According to 2001 estimates, there are approximately 12.9 million people living in Zimbabwe, with a population growth rate of 1.7%.[54] Approximately 35% of the population resides in urban areas.[55] Shona is the predominant ethnic group, comprising 77% of the population. The remainder of the population is Ndebele (14%), Kalanga (5%), white (2%), or from another ethnic group (2%).[56] Christian and traditional beliefs dominate; fewer than 1% of Zimbabweans are Muslim.[57] The official language is English, and a majority of Zimbabweans also speak Shona or Sindebele, the languages of the dominant ethnic groups.[58]

President Robert Mugabe has ruled Zimbabwe since the ousting of the white-minority government of Rhodesia in 1980.[59] Though a multiparty nation, Mugabe's party, the Zimbabwe Africa National Union–Patriotic Front (ZANU–PF) has dominated Zimbabwe's political scene. The June 2000 parliamentary election marked the first time that an opposition party garnered a sizable number of seats. Ongoing opposition has criticized President Mugabe's failure to remedy Zimbabwe's difficult economic situation.[60] The period leading up to this year's highly contested election between ZANU–PF and opposition party Movement for Democratic Change was marked by an increase in political violence and economic turmoil, particularly related to a controversial land redistribution program.[61] Despite international criticism,[62] President Mugabe was officially inaugurated for another six-year term on March 17, 2002.[63]

In 2000, Zimbabwe's rapidly declining gross national income per capita[64] was estimated at USD 480 (down from USD 710 in 1996).[65] According to 1998 estimates, women represented 44.5% of the total work force,[66] and provided at least 70% of all agricultural labor.[67] Zimbabwe's current economic difficulties are compounded by the demands of a population suffering from one of the highest HIV/AIDS infection rates in the world.[68]

Approximately 80% of the rural population and 90% of the urban population has access to health care.[69] The Ministry of Health is by far the largest provider of health care in Zimbabwe, employing 90% of all health personnel and providing financial support to other health care providers in the country.[70] It is responsible for providing nearly all family planning and reproductive health services.[71] Traditional and alternative medical care is provided by traditional practitioners,[72] midwives and "natural therapists."[73] Health facilities offer comprehensive services in promotive and preventive care, including: basic and essential preventive and curative care; immunization; maternal and child health services; family planning programming; health and nutrition education; and the control of communicable diseases.[74] Zimbabwe's recent wave of financial difficulties and political upheavals has undermined important gains in health care. In recent years, the government of Zimbabwe has significantly decreased spending on public health; between 1990 and 1998, its per-person health expenditures were cut in half.[75]

The ability of Zimbabweans to access health care is also limited by the unavailability of medicines and a shortage of qualified medical staff.[76] Statistics indicate that the national doctor-to-patient ratio from 1990–1998 was 1:10,000, whereas in European high-income countries the ratio is 37:10,000.[77] Rural areas suffer most from lack of access to health care, as evidenced by surveys that indicate that, in some remote rural areas, people have to walk about five kilometers to get to the nearest health care center because of problems associated with the lack of accessible roads and transport.[78] The inability to reach modern health centers has, in some instances, led to a greater dependence by Zimbabweans on traditional medicine.[79]

Zimbabwe faces crucial challenges in the arenas of maternal mortality and HIV/AIDS. The maternal mortality rate for Zimbabwe is approximately 610 deaths per 100,000 live births.[80] While this is better than most countries in the region of Eastern Africa, which averages approximately 1,300 deaths per 100,000 live births,[81] it is still tragically high. With the third highest HIV/AIDS prevalence rate in the world, the epidemic has hit Zimbabwe hard.[82] Among adults between the ages of 15 and 49, the HIV/AIDS prevalence rate is estimated at an astounding 25%.[83] Women account for 53% of the total number of cases.[84] To make matter worse, currency devaluation and cuts in government spending have placed many of the most effective drugs in treating HIV/AIDS beyond the means of a majority of Zimbabweans.[85]

In light of these poor health indicators, the Zimbabwean government is faced with serious challenges in ensuring the provision of quality health care services for its population. As the public health care sector is the primary provider of services, the government should answer these challenges through the enactment and application of laws and policies relating to the health sector. Those laws and policies relating directly to adolescents' access to services and information on contraception and STI prevention will be discussed in the section below.

B. National Legal and Policy Framework

Laws and policies are essential tools used to affect individual and societal behavior. While the passage of laws often involves specific formal procedures to be undertaken usually by a legislative body, policy enactments are generally not subject to such a process. Policies are usually issued by government entities that are part of the executive branch of government, such as ministries, administrative agencies and official councils or commissions. In Zimbabwe, there is neither a single law nor a single policy that determines adolescents' access to dual protection methods and information. Rather, there exists a patchwork of laws and policies, which, when taken together, provide the outline of a general framework governing provision of adolescent reproductive health services and information. The following

discussion highlights those legal and policy instruments with the greatest impact on adolescents' legal right to access dual protection methods and information.

1. National Laws Applicable to Adolescents

Adolescents' ability to access services and information on contraception and STI prevention is, to a large degree, determined by national laws. An overview of the country's key legal institutions and instruments is therefore crucial to a discussion of the role that the government of Zimbabwe can play in improving adolescents' access to needed services. The section below provides a brief outline of the national legal framework and proceeds to discuss laws that relate specifically to this analysis.

a. General Legal Framework

The Constitution,[86] which is the "supreme law of Zimbabwe,"[87] establishes a tripartite division of government consisting of the executive, the legislature, and the judiciary.[88] It contains a Declaration of Rights that articulates and seeks to protect "the fundamental rights and freedoms of the individual."[89] The Constitution also provides for the administration of a dual legal system[90] that includes African customary law on the one hand, and on the other, general law which follows the Roman-Dutch common law tradition. In case of a conflict between these two systems, statutory provisions specify the applicable regime,[91] and a unified court system integrates the oversight of both.[92] The Constitution does not explicitly provide for a hierarchical relationship between international law, the general law and customary law.

Although Zimbabwe has ratified numerous international human rights treaties, these treaties do not automatically become national law (See Appendix B). An international treaty or law is not automatically legally binding in Zimbabwe until it is approved by Parliament and has been incorporated into the national law under an Act of Parliament.[93] However, international laws create legal obligations on the part of the government of Zimbabwe to either undertake or refrain from certain actions at the national level.

Finally, it is important to note Zimbabwe's restrictive abortion law. While this law does not relate directly to adolescents' access to services and information on contraception and STI prevention, it serves to underline the difficulties that result from denying Zimbabwean adolescents access to contraception. The 1977 Termination of Pregnancy Act permits abortion only in cases of a serious threat to the woman's health, a strong probability of fetal impairment, or for pregnancy resulting from "unlawful intercourse."[94] As a result of this law, adolescents are unable to obtain safe and legal abortions.

b. Key Laws Relating to Adolescents' Access to Dual Protection Methods and Information

Zimbabwe has no laws that explicitly refer to adolescent reproductive health. However, specific provisions of various laws have been interpreted by service providers and law enforcement officials to limit adolescents' access to services and information on contraception and STI prevention. This section discusses the mosaic of national-level laws relating directly to adolescents' access to dual protection methods and information. Such laws include:

- Constitution of Zimbabwe;
- The Legal Age of Majority Act;
- The Marriage Act;
- The Customary Marriages Act; and
- The Sexual Offenses Act, as it amends the Criminal Law Amendment Act.

Constitution of Zimbabwe

The Zimbabwean Constitution provides little protection to adolescents. It contains three relevant provisions. First, the Constitution contains protection from discrimination on specified grounds. While the Constitution protects individuals from discrimination on the basis of their gender,[95] race, tribe, place of origin, political opinions, color, or creed,[96] it does not explicitly prohibit discrimination on the basis of age or socioeconomic status. Moreover, the Constitution exempts customary laws and laws relating to personal matters from being subject to its anti-discrimination provision.[97] Secondly, the Constitution limits adolescents' right to freedom of expression, including the freedom to "receive and impart ideas and information without interference." [98] Although the Constitution recognizes these general rights, it permits an exception for restriction by way of "parental discipline."[99] Finally, it is important to note that the Constitution recognizes "parental discipline" as an exception to the right to be free from arbitrary searches,[100] thereby permitting parents to consent to searches of their minor children. This constitutional provision provides the legal basis for requiring parental and/or guardian consent for adolescents in a number of contexts, including health care.

The Legal Age of Majority Act

The Legal Age of Majority Act reduced the legal age of majority from 21 to 18 for all legal purposes, including customary law.[101] It thereby gives those 18 and over contractual capacity to enter into any kind of agreement or to act without the consent of a guardian. This law is a critical part of the mosaic of laws governing adolescents' access to numerous services, including health care, since it implies that only adolescents who are 18 and over can obtain services without parental involvement.

The Marriage Act

The Marriage Act precludes boys under 18 years old and girls under 16 from being "capable of contracting a valid marriage. . . ."[102] While the age of marriage for boys is in conformity with the legal age of majority, this marriage law allows for the marriage of girls who have not achieved legal majority. While it does not appear that marriage bestows legal majority to adolescents below the age of 18, according to general interpretation, married adolescents are considered as adults for the purposes of access to services and information on contraception and STI prevention and are no longer subject to parental/guardian consent requirements for medical treatment. Therefore, the Marriage Act tends to provide a basis for permitting married adolescents access to dual protection methods free from parental instrument.

The Marriage Act also provides for an exception to the age requirement. Certain boys and girls below the specified age for first marriage are able to get married when the Minister of Justice, Legal, or Parliamentary Affairs "considers such marriage desirable. . . ."[103] The common interpretation of this exception is to permit a marriage to be solemnized when the adolescent girl is pregnant. Therefore a pregnancy, in effect renders an adolescent girl capable of contracting a valid marriage, which will grant her *de facto* majority regardless of her age. Thus, the effect of the pregnancy is to permit an adolescent to have access to services and information on contraception and STI prevention without parental consent.

The Customary Marriages Act

There is an apparent conflict between customary law and general law regarding the minimum age at which a woman may marry. Without specifying a minimum age of marriage, the Customary Marriages Act requires the consent of the woman's guardian or of a deputy appointed by that

guardian.[104] Since the Customary Marriages Act does not specify the same minimum age at first marriage as the Marriage Act, the former can be interpreted to permit marriages at ages earlier than those specified in the Marriage Act. Moreover, since the Constitution's protections from discrimination do not apply to laws relating to marriage,[105] it presumably permits different ages of marriage for boys and girls.

The Sexual Offenses Act, as it amends the Criminal Law Amendment Act

Statutory rape laws[106] make it a crime for anyone over 15 years of age to have extramarital sexual intercourse with anyone under the age of 16.[107] As will be further discussed below, the interpretation of this provision by service providers appears to prevent sexually active adolescents below the age of 18 from obtaining dual protection methods and information. It is also notable that a provision of the Sexual Offenses Act criminalizes the intentional transmission of HIV/AIDS.[108]

c. Legal Barriers to Adolescent's Access to Dual Protection Methods and Information

The above description of the laws applicable to Zimbabwean adolescents suggests that adolescents confront numerous legal barriers that impair their ability to access to services and information on contraception and STI prevention. These laws are problematic for four primary reasons. First, there are insufficient national legal protections from discrimination. Second, national-level laws appear to uphold parental consent requirements for adolescents below the age of 18. Third, several of these laws contradict each other. Finally, even where a law is not explicit about adolescents' access to contraception or STI prevention, the language allows for a restrictive interpretation by service providers. Taken together, these laws tend to reflect and also reinforce socio-cultural barriers which prevent adolescents from accessing dual protection methods.

National-level protections do not ensure adolescents' access to dual protection methods and information free from discrimination on specified grounds. The Zimbabwe Constitution does not contain protections from discrimination on the basis of age or socioeconomic status, both of which are particularly relevant in the case of adolescents and their right to access dual protection methods and information. Without explicit protections, the principle of freedom from age discrimination is not applied to parental consent requirements at the national level. Lack of explicit protection from discrimination on the basis of socioeconomic status tends to reinforce the barriers that certain groups, such as low-income or rural adolescents, confront in exercising their right to access dual protection methods and information. Moreover, protections from discrimination on specified grounds do not apply to laws relating to personal matters or customary African law, and this may tend to negatively affect women and girls, since these laws often place them in an inferior position to men and boys.

National laws establish parental consent and "adulthood" requirements when adolescents seek services and information on contraception and STI prevention. The national legal framework provides guarantees of individuals' rights to information,[109] to be free from arbitrary searches,[110] and to non-discrimination—all of which could be interpreted to protect the free flow of services and information on contraception and STI prevention. However, laws that permit exceptions in the case of parental discipline, that set a minimum age of consent and that require parental consent for medical procedures undercut adolescents' enjoyment of these rights. In practice, these legal restraints deny individuals under the age of 18 access to dual protection methods and information. They render adolescents below the age of 18 incapable of entering into any contract, including a contract for health services, and place their personal integrity and property under the authority of their parents despite the fact that 16 is the minimum age of consent for sex and marriage for girls.

There are several instances where national laws conflict with each other concerning issues relating to adolescent sexuality and access to services and information on contraception and STI prevention. First and foremost is the apparent conflict between the Legal Age of Majority Act and the Sexual Offenses Act. According to the Legal Age of Majority Act, an individual is deemed legally capable and responsible for one's life without the aid of a parent or guardian at the age of 18.[111] However, the Sexual Offenses Act deems a 16-year-old legally capable of consenting to sex. Thus, a gray zone emerges whereby all 16- and 17-year-old adolescents legally may have sex, but they may not access services and information on contraception and STI prevention without parental consent.[112] Similarly, there is a conflict between the law setting the legal age of majority and the Marriage Act regarding the ability of a pregnant adolescent to access dual protection methods. By the terms of the Legal Age of Majority Act, only persons 18 years of age and above can act without the consent of a guardian. Yet a government ministry's determination that a pregnant adolescent is capable of entering into a valid marriage pursuant to the Marriage Act has resulted in pregnant adolescents being able to access dual protection methods and information.

Finally, it is important to point out the implications for health care providers of laws that set 16 as the minimum age of consent for sexual relations. Health service providers have interpreted such laws to imply that it is a crime for a provider to facilitate sexual activity with a person[113] below the age of 16 by providing such an adolescent with contraception.[114] Service providers thus erroneously fear that the government may prosecute them for providing adolescents with services and information regarding contraception and STI prevention.[115]

2. Policies Affecting Adolescents' Access to Dual Protection Methods and Information

The Zimbabwean government has made strong policy statements regarding the right to health in recent years and has recognized reproductive rights in its policy statements, particularly in the context of HIV/AIDS. Zimbabwe began to recognize the urgency of adopting laws and policies geared toward improving adolescents' access to reproductive health information and services primarily in response to the HIV/AIDS epidemic. There are currently numerous national policies that govern adolescents' access to dual protection methods and information. This section gives an overview of recent developments regarding the general health care policy framework, and then outlines those Zimbabwean policies which are particularly relevant to adolescents' access to dual protection methods and information.

a. General Health Care Policy Framework

The government of Zimbabwe has identified health as a human right and prioritized the improvement and extension of health services as "a necessary and primary condition of development."[116] All Zimbabweans have the right to access health care, regardless of their ability to pay.[117]

The Ministry of Health administers the national health policy, which establishes the framework for health services in Zimbabwe. The Ministry of Health has identified as its overall purpose the promotion of "the health and quality of life of the people of Zimbabwe."[118] Ministry of Health strategies have focused on integrating the delivery of basic health, as well as informational and educational services, and increasing access to health facilities.[119] The Ministry of Health consequently has outlined ten priority areas: HIV/AIDS and other STIs; tuberculosis; malaria; childhood illnesses; diseases associated with reproductive health; cardiovascular conditions; diarrheal diseases; nutritional deficiencies; injuries; and mental disorders.[120] The ZNFPC, a para-statal body under the purview of the Ministry

of Health, is responsible for implementing the national family planning service delivery programs[121] and is the leading provider of family planning and reproductive health services in Zimbabwe.

b. Key Policies Related to Adolescents' Access to Dual Protection Methods and Information

Although the Zimbabwean government has not yet enacted laws relating directly to adolescent reproductive rights, there are several national-level policies that have a direct bearing on adolescents' access to dual protection methods and information. In general, these policies reflect a commitment to improving the state of adolescents' reproductive health. This section discusses specific portions of the following policies:

- the National Population Policy;
- the National Health Strategy, 1997-2007;
- the National Policy on HIV/AIDS;
- the ZNFPC's Policies; and
- the Patient's Charter.

The National Population Policy

The National Population Policy (Population Policy),[122] issued in 1998, is one indication of Zimbabwe's express intent to guarantee conditions necessary to broaden access to family planning. In this policy, the government recognizes women's right to control their own fertility.[123] The Population Policy specifies that "individual rights to choose freely and responsibly the number, spacing and timing of children they want will be fully respected,"[124] and that it is essential to recognize the aspirations of women and youth in particular.[125] More specifically, the policy states that "[t]here . . . is need for a concerted effort to address [youths'] health, education and other needs"[126] because "their reproductive decisions and choices have much bearing on the future of the country in terms of population growth and other related issues."[127] Accordingly, the Population Policy includes two goals related to adolescents: to "reduce prevalence of high risk sexual behavior among the youth"[128] and to "[r]educe the proportion of adolescents who are becoming mothers below the age of 20 from 40% in 1994 to a lower figure by the year 2002."[129]

The Population Policy states that "[t]he family planning programme [is] to continue with ongoing efforts to increase contraceptive availability, accessibility, use and improve method mix."[130] The Population Policy specifies that the government is to "remove obstacles" in order "to make reproductive health services easily accessible and available to *all those who are sexually active*" (emphasis added).[131] This language reflects the government's departure from restricting reproductive health care to mothers only. However, by referring specifically to those who are sexually active, the Population Policy opens the possibility that non-sexually active adolescents will be excluded from awareness programs. In addition, according to the Population Policy, the government plans to "integrate STI management and family planning services."[132]

The Population Policy recognizes that adolescents have reproductive health needs, including the need for services and information on contraception and STI prevention. However, the language limiting service provision to sexually active adolescents, along with the emphasis on curative care for those with STIs and parental consent requirements for access, means that adolescents are not likely to receive dual protection methods and information until they are pregnant, have a child, or are infected with HIV or another STI.[133]

The National Health Strategy, 1997–2007

The Ministry of Health's National Health Strategy, 1997-2007 (Health Strategy), encompasses plans for developing the health sector's infrastructure and health services delivery.[134] The Health Strategy prioritizes HIV/AIDS/STIs[135] and has resulted in the creation of a Reproductive Health Services agency.[136] The Health Strategy has thus laid the foundation for a national agenda to improve access to reproductive health services and information. In this policy, the government has expressly articulated its goals to create a national reproductive health strategy, "make available information and produce materials to improve education on reproductive health, and carry out operational research for identifying and removing obstacles that hamper access to reproductive health care services."[137] One of the Ministry of Health's goals is to develop policies and strategies that guarantee rights to safe and accessible reproductive health services to men and women throughout their life cycle.[138] In particular, the Ministry of Health states that it will "[d]evelop programmes targeted at addressing reproductive health issues for the adolescent" and "[p]revent unwanted pregnancies."[139] Although the programs have not yet been developed, this policy demonstrates Zimbabwe's interest in providing improved reproductive health services to its citizens.

The Ministry of Health has set forth specific objectives intended to benefit adolescents, including "increas[ing] access for those of all ages to affordable, acceptable, comprehensive and quality reproductive health services."[140] The Ministry of Health's strategic interventions focus on adolescent children and youth to "inculcat[e] in them an understanding of the link between lifestyle, health and quality of life."[141] In addition, in light of Zimbabwe's growing youth and adolescent population, the Ministry of Health deems it "imperative to revisit a number of critical family planning and population control issues, such as teenage pregnancies, abortions, age of first pregnancy and age of marriage."[142]

The National Policy on HIV/AIDS

The National Policy on HIV/AIDS (HIV/AIDS Policy) upholds the human rights and dignity of people with HIV/AIDS and prohibits discrimination against them.[143] Generally, informed consent is required for HIV testing and notification.[144] In addition, the HIV/AIDS Policy promotes access to dual protection methods and information and seeks to remove barriers specific to young people.[145] The HIV/AIDS Policy states that "[c]hildren and young people have the right to information and to advice on means to protect themselves from early sex, unwanted pregnancies and HIV/AIDS."[146] Thus, the HIV/AIDS Policy strongly emphasizes improved access to dual protection methods and information, as well as guarantees of non-discrimination in this regard. These guarantees are potentially undermined, however, by ambiguous language regarding parental consent requirements for access to services.

Overall, the HIV/AIDS Policy supports adolescents' right to access dual protection methods and information. It contains language upholding the right to access the means of prevention (including condoms) and the right to access information regarding HIV/AIDS. The policy also seeks to combat gender discrimination. The relevant sections of the policy are discussed in more detail below.

Adolescents' Right to Access Methods of STI Prevention

The HIV/AIDS Policy states that quality-assured condoms should be made "available, accessible and affordable to all sexually active individuals"[147] to limit HIV transmission through sexual intercourse. The government plans to make condoms available through a variety of distribution channels.[148] In this respect, the HIV/AIDS Policy does not distinguish between sexually active individuals

on the basis of age. It can therefore be assumed that its stated commitment to make the means of prevention accessible applies to adolescents as well.

Adolescents' Right to Information

The HIV/AIDS Policy encourages assisting adolescents under 16 to develop the knowledge and life skills needed to avoid HIV infection;[149] it also encourages providing information to the increasing number of young people seeking advice on and/or care for STIs.[150] One strategy is to "[e]ducate the community and especially young people on STI health seeking behaviour."[151] In furtherance of this strategy, the government plans to "train health personnel and other youth practitioners in counseling young people to protect themselves from early sex, unwanted pregnancies and the prevention of HIV/STIs."[152] The HIV/AIDS Policy emphasizes that "[a]bstinence and deferment of sexual debut should be a major component of reproductive health advice to children and the youths."[153]

According to the HIV/AIDS Policy, the government plans to "[e]ducate women, men, girls and boys about male and female sexuality, HIV/AIDS and other sexually transmitted infections and the consequences of high-risk behaviour."[154] In particular the policy states that it plans to "[e]ducate women and men about the risks related to certain practices that may facilitate transmission of HIV, [such as] the adverse physical effects of herbs and chemicals [that] some women insert in the genital area."[155]

Gender Discrimination

The HIV/AIDS Policy reflects Zimbabwe's wish to eliminate differential treatment of men and women in terms of access to the means of preventing HIV/AIDS. It emphasizes that "[g]irls, in particular, should have equal access to education, training and employment."[156] In particular, "[i]ssues of gender imbalance and gender inequality need to be redressed in order to create a supportive environment for HIV/AIDS/STI prevention, control and care."[157] The HIV/AIDS Policy acknowledges that cultural norms impact men's and women's access to services and information on contraception and STI prevention, and emphasizes that "HIV/AIDS/STI should be viewed and dealt with in the context of sexuality and sexual relationships and socio-cultural perspective."[158]

Consent Requirements for Adolescents

The HIV/AIDS Policy itself contains contradictory statements regarding the legal right of adolescents below the age of 18 to consent to reproductive health care services. For example, it states that prior to the legal age of majority (18) "a child is considered a minor and consent is obtained from parents or a legal guardian [to be tested for HIV]."[159] However, the policy also states that "[c]hildren and young people below the age of 16 years who have concerns about and/or have an STI have the right to appropriate counseling and care services and advice on means to prevent HIV/STI. The counseling and professional advice given should depend on each young person's circumstances and potential risk of HIV/STI."[160] Thus, the policy allows a service provider to weigh the individual adolescent's circumstances and best interests against the rights of the parent to control access to services and information on contraception and STI prevention.

The ZNFPC's Policies

The ZNFPC's Family Planning Service Delivery Policies and Standards provide guidelines for eligibility for services, and it identifies priority service groups.[161] According to these guidelines, "all sexually active or potentially sexually active individuals" are eligible for family planning services[162] and special efforts will be made to provide youth—who are deemed a high priority group—with information, education, and services.[163] The service delivery policies also explicitly require full and informed consent concerning contraceptive methods.[164] However, "[i]n the case of a minor . . . consent will be obtained after receiving full information in accordance with legal practice, i.e., the guardian giving consent on behalf of the client."[165] Therefore, although services and information on contraception and STI prevention are purportedly available to all, access is restricted for adolescents below the age of 18.

The Youth Services division of the ZNFPC is under a mandate to "provide the young people of Zimbabwe with the information and services they need to enable them to develop responsible patterns of reproductive health behavior."[166] The division is further required to "convey to parents the skills and information that will enable them to effectively carry out their role as reproductive health educators, [c]reate a public environment that is supportive of the various youth reproductive health programs; [and] [i]ncrease the quantity and quality of services and materials used by youth."[167]

The Patient's Charter

The Patient's Charter[168] recognizes a right to health care. It guarantees patients the right to adequate information and consent about their medical problem,[169] the right to privacy,[170] the right to confidentiality of treatment, and the right to non-discrimination on the basis of age, economic status or social class.[171] However, the Patient's Charter incorporates general parental consent requirements, placing adolescents under the control of their parents,[172] thereby barring access to services and information on contraception and STI prevention without parental involvement. Moreover, the Patient's Charter recognizes exceptions to its general guarantee of confidentiality if it is in the patients' interest that confidentiality be broken,[173] or if the information is required by "due legal process."[174] These exceptions open the door to restrictive interpretations that adolescents' right to confidentiality is subject to parental discipline and control.

c. Policy Barriers to Adolescents' Access to Dual Protection Methods and Information

National-level policies in Zimbabwe generally demonstrate a commitment to the reproductive health concerns of adolescents; in many ways these policies attempt to address some of the cultural norms that undermine adolescents' access to dual protection methods and information.[175] However, both the manner in which policies are stated and their common interpretations reinforce many of the barriers confronting adolescents in accessing methods of contraception and STI prevention. Despite the government's stated intention to revisit important reproductive and sexual health issues affecting adolescents,[176] the current policies are problematic for three main reasons. First, national policies take a curative, rather than preventive, approach by encouraging access to services and information on contraception and STI prevention for sexually active individuals. Second, policies are inconsistent regarding parental consent requirements. Third, despite evidence of early sexual activity and high rates of unintended pregnancy, Zimbabwean policies also promote abstinence.

The language and interpretation of the relevant policies supports the provision of dual protection methods and information only to sexually active adolescents. The Population Policy calls for the gov-

ernment to facilitate access to reproductive health services to those who are "sexually active."[177] This phrase has been interpreted to mean adolescents who either have a child, are pregnant, or are infected with an STI or HIV. In addition, the ZNFPC policy states that "potentially sexually active individuals" are eligible for services,[178] but requires parental consent for adolescents below the age of 18 to access services.[179] Such restrictive policies effectively exclude the majority of Zimbabwean adolescents from access to dual protection methods and information.

Zimbabwean policies are also contradictory in terms of parental consent requirements for those regarded as minors under Zimbabwean law. Most notably, ZNFPC's service delivery policies explicitly require parental consent for adolescents under 18 to access family planning services. In addition, the Patients Charter also requires service providers to obtain parental consent for medical treatment in general. However, the HIV/AIDS policy appears to encourage the provision of services and information regarding STI/HIV/AIDS prevention, depending on "each young person's circumstances and potential risk of HIV/STI."[180] These policy inconsistencies serve to confuse service providers and deny adolescents below the age of 18 access to dual protection methods and information. For example, health care workers may continue to interpret this to allow access only after the adolescent demonstrates sexual activity—through pregnancy, parenthood, or infection with HIV/AIDS or another STI.

Zimbabwean policies also emphasize abstinence for adolescents rather than promoting their access to dual protection methods and information. For example, the major weakness of the HIV/AIDS policy is that it expressly emphasizes that abstinence and the deferment of sexual activity are to be the major components of reproductive health advice to children and youths.[181] Similarly, it is not clear whether the Population Policy intends to facilitate access to information and services or instead, if its goal is to encourage unmarried adolescents under 18 to abstain from having sex.

C. Conclusion

Zimbabwe's patchwork of rules undermines adolescents' access to dual protection methods and information. National-level laws and policies generally uphold parental consent requirements for adolescents below the age of 18. Yet, certain laws and policies are inconsistent with one another such that it appears that the policies are more youth-friendly than the laws. These ambiguities and inconsistencies in national laws and policies appear to have laid the foundation for service providers to use their discretion to restrict adolescents' access to services and information on contraception and STI prevention.

Generally, a Zimbabwean adolescent cannot access contraception without the consent of a parent or guardian. Laws setting the minimum age of consent and permitting parental discipline to inhibit adolescents from exercising their rights deny adolescents under the age of 18 access to dual protection methods and information. These legal barriers are reaffirmed by parental consent requirements found in both the Patient's Charter and ZNFPC's service delivery requirements. However, laws and policies implicitly allow married adolescents, regardless of their age, access to services and information on contraception and STI prevention. In addition, policies permit contraception access for those who are "sexually active"—a phrase which is interpreted to mean adolescents who either have a child, are pregnant, or are infected with HIV/AIDS or another STI.

Laws and policies are sometimes inconsistent. Overall, the different key laws relating to adolescents' access to dual protection methods and information are not generally as adolescent-friendly as recent policy pronouncements on adolescents' reproductive health. In addition, the policies tend to acknowledge the role of cultural norms and traditions regarding adolescent sexuality whereas, the laws generally do not. In this regard, it appears that the legal framework has not yet "caught up" with the

policy framework. For example, a number of Zimbabwean laws establish specific ages for majority, legal marriage, and legal sexual intercourse. The policy pronouncements of the Zimbabwean government, however, do not state explicit age guidelines for reproductive health care. Rather, the government's policy statements are generally youth-friendly, as exemplified by the Population Policy and the HIV/AIDS policy. Another example is the manner in which laws and policies deal differently with sexually active adolescents. Some service providers have interpreted the statutory rape law to apply to them if they provide a sexually active adolescent with services and information on contraception and STI prevention. Yet, the Population Policy explicitly calls for reproductive health care services to all those who are "sexually active."

This tangle of national-level laws and policies, which results in the denial of access to services and information on contraception and STI prevention to those regarded as minors under Zimbabwe's laws, should be viewed in light of Zimbabwe's obligations under international human rights treaties and consensus documents. As will be further examined in the next chapter, the government of Zimbabwe has a duty to respect, protect, and fulfill the internationally recognized rights of all adolescents to access dual protection methods and information.

CHAPTER II: INTERNATIONAL HUMAN RIGHTS FRAMEWORK FOR ADOLESCENTS' RIGHT TO ACCESS DUAL PROTECTION METHODS AND INFORMATION

In 1998, the Committee on the Elimination of Discrimination against Women openly criticized Zimbabwe for failing to provide teenage girls with information and access to appropriate, safe and affordable methods of contraception and STI prevention. The committee "urge[d] the Government to increase its efforts to combat the HIV/AIDS pandemic and to ensure that appropriate sexual and reproductive health information, education and services are provided to all women and, in particular, to adolescents."[182]

Over the course of the last three decades, the international community has come to acknowledge that the right to plan one's family, including the right to the means with which to do so, is a fundamental human right. While a number of UN-sponsored human rights conferences began to recognize the rights to reproductive health care and decision-making as early as the late 1960s, it was at the 1994 International Conference on Population and Development (ICPD) that the international community made its strongest acknowledgement that access to reproductive health care is an inviolable human right. At ICPD, 179 governments adopted by consensus an historic agreement recognizing that reproductive rights are an integral component of the human rights of all individuals, including adolescents.[183] The ICPD Programme of Action is explicit in recommending that "[p]rogrammes [for adolescents] should include support mechanisms for the education and counseling of adolescents in the areas of . . . responsible sexual behavior, responsible family-planning practice, family life, [and] reproductive health. . . . "[184]

The principle that adolescents are rights holders and therefore protected by universal human rights norms is well established. Section A of this chapter provides an overview of the sources of international law that are relevant to a discussion of adolescents' right to dual protection methods and information. It also discusses the obligations of governments under international law. Section B addresses special concerns raised in international human rights law that relate to adolescents' right to access dual protection methods and information. In particular, the "evolving capacities of the child"[185] and the "best interests of the child"[186] standards protect adolescents' decision-making capacity in matters affecting their reproductive health. These standards ensure that, in the context of access to services and information on contraception and STI prevention, adolescents' enjoy the same rights as adults.[187] Section C of this chapter demonstrates that adolescents' right to access dual protection methods and information derives from internationally recognized reproductive rights. It also defines the context of the right to health, the right to information and education, the right to privacy, and the right to reproductive self-determination and autonomy.

A. Sources of Law and Government Obligations

Governments have a duty to respect, protect and fulfill adolescents' right to access dual protection methods and information, pursuant to international human rights law. This section examines the governmental obligations arising under key international instruments:[188] the Universal Declaration of Human Rights (Universal Declaration);[189] the International Covenant on Economic, Social and Cultural Rights (Economic, Social and Cultural Rights Covenant);[190] the International Covenant on Civil and Political Rights (Civil and Political Rights Covenant);[191] the Convention on the Elimination

of All Forms of Discrimination against Women (CEDAW); [192] and the Children's Rights Convention.[193] Regional human rights treaties applicable to African governments such as Zimbabwe—the African Charter on Human and Peoples' Rights (Banjul Charter)[194] and the African Charter on the Rights and Welfare of the Child (African Children's Charter)—are also discussed.[195] In addition, the following analysis incorporates the statements of the UN Human Rights Treaty Monitoring Bodies,[196] which are charged with monitoring states parties' compliance with international human rights treaties.[197] These statements provide a more detailed interpretation of the provisions of each treaty with respect to adolescents' right to access dual protection methods and information.

States have also committed to ensure adolescents' right to access dual protection methods and information by signing international human rights conference and consensus documents, including the documents adopted at ICPD and the 1995 UN Fourth World Conference on Women (Beijing Conference).[198] Although conference documents are not binding on governments, they reflect international consensus on these issues and establish governmental commitments. They provide detailed guidance to governments on actions they should take to meet their commitments. Moreover, international conference documents provide an interpretation of international law and can serve as a basis for emerging international law standards.

The obligation to ensure the human rights of adolescents translates into an international responsibility on the part of governments. Among the obligations to which governments have committed are: to refrain from actively violating the human rights of adolescents; to refrain from enacting laws and policies with either the purpose or the effect of depriving adolescents of the ability to exercise their rights; and to eliminate legal and policy barriers preventing adolescents from exercising their rights. Moreover, states are required to prevent violations of adolescents' rights by third parties who may or may not be representatives of the state, including private individuals.[199] State responsibility to fulfill the human rights of adolescents creates a positive obligation on the part of governments to create the necessary conditions for the enjoyment of these rights. These affirmative obligations include the governmental responsibility to introduce programs and to implement laws and policies to ensure rights and to allocate adequate resources for their effective implementation.

In order to fully understand the nature of these governmental obligations in the context of adolescents, it is necessary to examine how this particular group has been treated under international human rights law. There are certain key human rights standards that serve to further clarify governments' obligations with respect to this group. To the extent that these standards are applicable to adolescents' rights to access dual protection methods and information, they will be discussed below.

B. Special Issues Relating to Adolescents

Historically, international pronouncements on children's rights have evidenced a tension between ensuring parents' rights to make decisions regarding their children, on the one hand, and children's rights to special protection and autonomy, on the other hand. Over time, there has been a notable movement towards embracing adolescents' decision-making capabilities.[200] The clearest international articulation reconciling parental decision-making rights with children's rights to protection and autonomy is found in the Children's Rights Convention, a treaty that has achieved nearly universal ratification. This treaty, which defines a child as anyone under the age of 18,[201] does not recognize exclusive autonomous decision-making power in either the child or the parent. Rather, the convention seeks to attain a balance between the decision-making rights of the adolescent and those of the parent in applying the "evolving capacities of the child" and the "best interests of the child" stan-

dards.[202] The following is a brief examination of these standards, in the context of adolescents' reproductive health and rights.

1. "Evolving Capacities of the Child" Standard

The Children's Rights Convention contains a clear articulation of children's right to autonomy as measured according to their capacities. Article 5 of the convention requires states parties to respect parents' responsibilities, rights, and duties, but the provision clearly limits parental rights in that they must be exercised consistently with "the evolving capacities of the child."[203] Article 12(1) of the convention provides that "the evolving capacities of the child" must be considered with "the views of the child being given due weight in accordance with the age and maturity of the child."[204] This standard emphasizes children's increasing decision-making capacity and offers a basis to guide the development of laws and policies which affect adolescents.[205]

The "evolving capacities of the child" standard informs the discussion of the conflict between children's right to health and parental decision-making authority[206] in the context of reproductive health. This standard is particularly relevant when determining an adolescent's right to make autonomous decisions about his or her reproductive life because it implies that there is a point at which an adolescent should have full responsibility for his or her own decisions. This standard also implies that the capacities of an adolescent should be determined on an individual basis through a "flexible," "gradient approach," rather than based solely on age.[207] International conference documents provide further support for such an interpretation of this standard. According to the ICPD Programme of Action, in the context of reproductive health care services and information, "the evolving capacities of the adolescent" should be balanced with the "rights, duties, and responsibilities of parents." [208] Therefore the question of what constitutes evidence of evolving capacity is crucial.

In the context of reproductive health, the very fact that a young person is engaged in or planning to be engaged in sexual activity *and* is seeking to access services and information on contraception and STI prevention can be taken as evidence that his or her capacities have evolved.[209] Adolescents who are sexually active and who seek dual protection methods and information are acting maturely in their own best interests to be informed and to protect themselves from health risks such as unwanted pregnancies and STIs, including HIV/AIDS. Moreover, certain nations permit adolescents under the age of 18 to marry,[210] thus facilitating their access to services and information on contraception and STI prevention.[211] This distinction between married and unmarried adolescents is presumably based on the sexual aspect of marriage and demonstrates that the state recognizes certain adolescents' right to access services and information on contraception and STI prevention due to their capacity to engage in sexual activity. In addition, adolescents who are not sexually active, but who seek information on dual protection methods demonstrate an evolved capacity and maturity level since the information they seek will prevent a harm.

The work of the Committee on the Rights of the Child (Children's Rights Committee) offers guidance on when a child has developed full decision-making capability in his or her reproductive life. The committee has repeatedly asked states parties to eliminate the requirement of parental consent for adolescents' access to reproductive health services and information.[212] These requests indicate an acknowledgement that adolescents possess the necessary judgment to control their reproductive lives, without adult oversight.

2. "Best Interests of the Child" Standard

Article 3(1) of the Children's Rights Convention states the principle that, in all actions concerning children, the "best interests of the child shall be a primary consideration."[213] Article 18(1) acknowledges potential conflict between parental rights and the children's interests by providing that as long as parents have the primary responsibility for the upbringing and development of the child, "the best interests of the child will be their basic concern."[214] In this way, the convention clearly demonstrates that parental rights are not without limit. This standard is echoed in the African Children's Charter.[215] The substantive interpretation of this principle varies, but it is clear that it contains elements of both parental protection and adolescent autonomy. In a number of circumstances, it may be in the best interests of the child to be granted autonomy in decision-making.

The application of the "best interests of the child" standard also helps to resolve the apparent conflict between adolescents' rights and parental decision-making rights in the context of reproductive health. Considering the serious potential risks to adolescents' health and lives if they are denied access to services and information on contraception and STI prevention, permitting adolescents access to these services without parental involvement must be in adolescents' best interests. Parental discipline that prevents adolescents from seeking and obtaining dual protection methods and information rarely prevents sexual activity altogether. This increases the health risks to the child and is in direct conflict with the best interests of the child.

International standards thus support the right of adolescents to access dual protection methods and information. Adolescents who demonstrate an evolved or adult-like capacity by seeking out information and services on contraception and STI prevention to prevent a potential harm are acting in their own best interests and should accordingly be granted the same rights as adults in this regard. Moreover, access to dual protection methods and information is in the best interests of adolescents, as it ensures that they will be in control of their reproductive future. Parental rights must be limited in as much as they inhibit adolescents' ability to exercise their rights. Hence, restrictions on adolescents' access to dual protection methods and information, including parental consent requirements, are in violation of international human rights standards.

C. Adolescents' Right to Access Dual Protection Methods and Information

Reproductive rights are firmly rooted in the most basic human rights principles. Adolescents' right to access dual protection methods and information is a component of the right to reproductive and sexual health, including the right to information and education, the right to reproductive self-determination, and the rights to equality and non-discrimination. This discussion will examine the content of the international human rights related to adolescents' access to dual protection methods and information. The scope of each right is analyzed with reference to the key applicable international and regional instruments. (See Appendix C for a guide to the relevant provisions of international legal instruments and conference documents.)

1. The Rights to Health, Information and Education

Enjoyment of the right to health requires access to health information. Therefore, provisions for the right to health, in particular the right to preserve health through preventive health care, imply a right to information and education. In the context of reproductive health, access to dual protection methods and information can prevent serious health problems such as STIs, including HIV/AIDS, and

unwanted pregnancy. Moreover, the ability to control one's fertility directly affects one's enjoyment of the right to health because pregnancy may have grave health consequences for adolescents. Therefore, access to dual protection methods and information is a key condition to fulfilling adolescents' right to health. For the purposes of this discussion, the right to reproductive health information is thus considered a component of the right to health. It is also, however, grounded in other internationally recognized human rights to education and information, which are guaranteed in the major international human rights treaties.

a. International Treaties

The international human rights instruments provide strong protections of adolescents' rights to health, information and education; the Treaty Monitoring Bodies have also interpreted the provisions of their respective treaties to ensure these rights in the context of access to dual protection methods and information. The following discussion incorporates the specific articles of the major international human rights treaties, as well as the general recommendations and concluding observations which provide further articulations of the treaty provisions.

Children's Rights Convention

The Children's Rights Convention provides the strongest legal support for the position that adolescents are entitled to all health services, including dual protection methods and information. Article 24 of the Children's Rights Convention recognizes the right of the child to the "enjoyment of the highest attainable standard of health" and provides that states "shall strive to ensure that no child is deprived of his or her right of access to . . . health care services."[216] Article 24 also establishes that states "shall take appropriate measures . . . [t]o develop preventive health care, guidance for parents and family planning education and services."[217] One interpretation of this article is that children, specifically adolescents, require family planning and education services in order to enjoy fully their right to health.[218] Even if the provision is interpreted as establishing the right of parents to family planning and education services, it still applies to adolescent parents who continue to enjoy the rights outlined in the Children's Rights Convention until the age of 18.[219]

Adolescents' right to seek and obtain information[220] and the right of all children to education[221] provide the basis for adolescents' right to information and education on family planning, including contraception and STI prevention methods. The Children's Rights Committee has taken a broad view of adolescents' right to health, recognizing that this right includes the right to reproductive health, which in turn includes access to services and information on contraception and STI prevention. While the committee has not issued a general comment on children's health, in its General Discussion on "Children Living in a World with AIDS," it has issued recommendations to states parties to remove barriers to "youth-friendly" health services. The committee stated that "[t]he formulation of comprehensive adolescent reproductive health policies should be based on the right of children to have access to information and services, including those designed to prevent sexually transmitted diseases or teenage pregnancy. . . ."[222] In addition, the committee has issued General Comment No. 1 on the Aims of Education,[223] which emphasizes a broad understanding of education to encompass the provision of certain life skills needed to, "develop a healthy lifestyle, good social relationships and responsibility, a critical way of thinking, creative talents, and other abilities which give children the tools needed to pursue their life options."[224]

The Children's Rights Committee has repeatedly voiced its concern about "the lack of sufficient reproductive health information and services for adolescents"[225] in its concluding observations to states

parties and has frequently criticized governments for failing to promote education on family planning for adolescents.[226] It has urged states parties to strengthen reproductive health education programs[227] and has recommended that they "provide access to information about sexual and reproductive health."[228]

CEDAW

CEDAW provides the clearest and broadest articulation of the general right to family planning information and services in the context of the right to health. While the focus of CEDAW is on women's and girls' right to be free from discrimination in the exercise of all their rights, including the right to health, it also sets standards with respect to the right to reproductive health information and services that are more broadly applicable.[229] Article 12 provides that "States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning."[230] CEDAW also acknowledges that information is a prerequisite of effective access to health services.[231]

In its interpretation of CEDAW, the Committee on the Elimination of Discrimination against Women (CEDAW Committee) has recognized that its provisions guarantee reproductive health information and services to adolescents, including services and information on contraception and STI prevention. In General Recommendation No. 24 on Women and Health, the CEDAW Committee asserts that states parties "should ensure, without prejudice and discrimination, the right to sexual health information, education, and services for all women and girls. . . ."[232] The committee also underscores that access to reproductive health education is an essential component and determinant of the right to health. This general recommendation obligates states to "ensure the rights of female and male adolescents to sexual and reproductive health education by properly trained personnel in specially designed programs that respect their rights to privacy and confidentiality."[233] The committee further states that "particular attention should be paid to the health education of adolescents, including information and counseling on all methods of family planning."[234]

In its concluding observations to states parties, the CEDAW Committee has repeatedly focused on the right of adolescents to reproductive health care and information.[235] Most notably, in its concluding observations to Zimbabwe in 1998, the committee openly criticized the government for failing to provide teenage girls with information and access to appropriate, safe, and affordable contraceptives.[236] In order to fulfill its obligations under CEDAW, Zimbabwe is expected to respond to the committee by implementing these recommendations at the national level.

Economic, Social and Cultural Rights Covenant

The Economic, Social and Cultural Rights Covenant recognizes the right of all people to the enjoyment of the highest attainable standard of physical and mental health.[237] While the right to health does not guarantee perfect health for all people, it does encompass a governmental duty to ensure health care, by requiring states to take certain steps to assure access to medical services for all.[238] This guarantee encompasses the rights of adolescents to health services and information, including those relating to contraception and STI prevention. Consistent with this interpretation, the Committee on Economic, Social and Cultural Rights has issued General Comment 14 on the Right to the Highest Attainable Standard of Health,[239] explicitly obligating states parties to provide adolescents with "youth friendly health care, which respects confidentiality and privacy and includes appropriate sexual and reproductive health services."[240] The committee considers access to information on health issues, par-

ticularly sexual and reproductive health, as an underlying determinant of health. In fact, in its concluding observations to states parties, the Committee on Economic, Social and Cultural Rights has asked governments to fulfill adolescents' right to reproductive health information as a means of fulfilling their right to health, specifically in relation to the issue of teenage pregnancy, which is a threat to the health of adolescents.[241]

Article 13(1) of the Economic, Social and Cultural Rights Covenant protects the right to education, and in General Comment 13 on the Right to Education, the Committee on Economic, Social and Cultural Rights emphasizes that education must be accessible to all and must "adapt to the needs of changing societies and communities. . . ."[242] The Committee on Economic, Social and Cultural Rights has interpreted this provision of the covenant to include the right to sexual education and has been a strong advocate for sexual and reproductive health programs,[243] linking lack of reproductive health education to high rates of unwanted pregnancies and abortion.[244]

Other Key Treaties and Instruments

There are two other key international instruments that are relevant to a discussion of adolescent access to dual protection methods and information: the Civil and Political Rights Covenant and the Universal Declaration.

Civil and Political Rights Covenant

While the Civil and Political Rights Covenant does not contain provisions directly relating to adolescents' right to health, it establishes rights that are fundamental to the enjoyment of the right to health. For example, the Human Rights Committee has used both anti-discrimination and privacy provisions of the Civil and Political Rights Covenant to address the reproductive health needs of adolescents. The Human Rights Committee, in its interpretation of Articles 3 and 26 of the covenant that protect the rights to equality and privacy respectively, has recommended that states parties "adopt all necessary legislative and other measures to assist women, and particularly adolescent girls, faced with the problem of unwanted pregnancies to obtain access to adequate health and education facilities."[245] In monitoring state party compliance with Article 19(2) of the covenant, the Human Rights Committee has also asked governments to introduce sexual education into the public school curriculum.[246]

Universal Declaration

Article 25(1) of the Universal Declaration recognizes all individuals' right to health in order to attain well-being. It states that "[e]veryone has the right to a standard of living adequate for the health and well-being of himself and of his family, including . . . medical care and necessary social services. . . ."[247] The right to health information may be inferred from broader protections of the right to information and education.[248]

b. Regional Instruments

Like the international human rights treaties, the major regional human rights instruments also play a fundamental role in promoting and protecting adolescents' rights to health, information and education. Both the Banjul Charter and the African Children's Charter reinforce the universal human rights standards found in the international treaties. They are comprehensive, in that they encompass civil and

political as well as economic, social and cultural rights. These regional instruments also reflect the specific history and values of the region, including the relationship of the individual to society. In the context of reproductive health and rights, the tension between individual and group rights found in African human rights instruments is less pronounced in light of broadly articulated treaty provisions recognizing an individual's rights to health and education.

The Banjul Charter

At the regional level, the Banjul Charter ensures that "[e]very individual shall have the right to enjoy the best attainable state of physical and mental health,"[249] which would include sexual and reproductive health. The charter also guarantees the right of all people "to receive information"[250] and education,[251] which is applicable to sexual education and information on methods of contraception and STI prevention.

African Children's Charter

The African Children's Charter, which defines a "child" as "every human being below the age of 18 years,"[252] guarantees that "[e]very child shall have the right to enjoy the best attainable state of physical, mental and spiritual health."[253] As a means to fulfill "implementation of this right," states shall "develop preventive health care and family life education and provision of service."[254] Article 11 of the African Children's Charter ensures children's right to education.[255] The charter's holistic view of children's health and its protection of the right to education serves to ensure adolescents' right to access dual protection methods and information.

c. International Conferences

The agreements reached at international conferences, while not legally binding on governments, indicate consensus among members of the international community on the issues covered. International conference documents serve to underscore and elaborate upon principles found in international human rights law. Participating governments pledge themselves to translate the principles expressed in conference agreements into improvements in the lives of their citizens. The two conferences which dealt in greatest depth with the pressing need for governments to address the issue of access to dual protection methods and information were the ICPD, held in Cairo in 1994, and the 1995 Beijing Conference.

ICPD

The ICPD Programme of Action recognizes that "information and services should be made available to adolescents to help them understand their sexuality and protect them from unwanted pregnancies, sexually transmitted diseases and subsequent risk of infertility."[256] The document acknowledges that access to reproductive health information is a precondition to fulfilling the right to access family planning services, and it links adolescents' right to information on family planning, including contraception and STI prevention methods, to their rights to health and to education.[257] The 1999 five-year review of ICPD (ICPD+5) further emphasized the importance of providing adolescents with reproductive health care. [258]

Beijing Conference

The Beijing Platform for Action "[r]eaffirm[s] the right to the enjoyment of the highest attainable standard of physical and mental health" and promises to "protect and promote the attainment of this

right for women and girls. . . ."[259] Like the ICPD Programme of Action, the Beijing Platform for Action links reproductive health services and information to the right to health as well as the rights to education and information. It stresses the importance of proper dissemination of information to ensure adolescent girls' access to reproductive health.[260] The Beijing Platform for Action also calls for governments to "[r]ecognize the specific needs of adolescents and implement specific appropriate programmes, such as education and information on sexual and reproductive health issues and on sexually transmitted diseases. . . ."[261] In 2000, the five-year review of the Beijing Conference (Beijing+5) further encouraged governments to continue to address the reproductive health needs of adolescents.[262]

> The rights of adolescents to access dual protection methods and information are rooted in the international human rights instruments, regional treaties and conference documents that protect the rights to health, information and education. Accordingly, the UN Treaty Monitoring Bodies have interpreted their respective treaty provisions to ensure adolescents' right to access dual protection methods and information. These international, regional and conference documents reaffirm that reproductive health, particularly access to services and information on contraception and STI prevention, is a fundamental aspect of one's well-being. The right to reproductive health care thus gives rise to governmental duties both to ensure the availability of dual protection methods and information, and to remove existing legal barriers to access.

2. Rights Relating to the Right to Reproductive Self-Determination and Autonomy

The right to freedom from interference in reproductive decision-making relates to broader principles of bodily autonomy, often referred to as the right to physical integrity, which has its roots in the right to respect for human dignity, the rights to liberty and security of the person, and the right to privacy.[263] These rights are at the foundation of an individual's right to choose freely the number and spacing of his or her children. In essence, these principles afford adolescents the right to make decisions about their own reproductive capacity. They also support adolescents' right to confidentiality in accessing reproductive health services. Adolescents' rights to health, information, and education, as discussed above, are a prerequisite for the fulfillment of adolescents' right to reproductive autonomy and self-determination. The right to independent decision-making in the context of reproductive health services, in turn, directly impacts adolescents' ability to exercise their right to health.[264]

a. International Treaties and Instruments

The international instruments provide strong legal protections for the right to reproductive self-determination and autonomy, grounded in the right to plan one's family and the right to privacy. In addition, the Treaty Monitoring Bodies have interpreted the privacy provisions of the international human rights treaties to encompass the right to plan one's family, as it infers protection from interference in decision-making with respect to personal matters such as whether or not to have children, as well as the right to privacy (particularly as it covers patients' right to confidentiality).

The Universal Declaration

Article 3 of the Universal Declaration protects individuals' right to personal liberty, and Article 12 holds that "[n]o one shall be subjected to arbitrary interference with his [*sic*] privacy. . . ."[265] The Declaration's call for recognizing individuals' right to liberty and privacy thus extends to adolescents. Specifically, these rights lay the foundation for adolescents' access to confidential reproductive and sexual health services.

The Civil and Political Rights Covenant

The Civil and Political Rights Covenant protects the rights to individual liberty,[266] privacy,[267] and the right to marry and to found a family.[268] The individual's right to reproductive self-determination has been linked to an enumeration of rights found in the Civil and Political Rights Covenant.[269] In interpreting these provisions of the covenant, the Human Rights Committee has maintained that a government's refusal to enact a legislative and policy framework to facilitate access to dual protection methods and information constitutes a violation of the right to reproductive self-determination.[270] For example, in its concluding observations to Argentina, the committee recommended that the state party take measures to implement a law, "by which family planning counseling and contraceptives are to be provided, in order to grant women real alternatives."[271]

Protection of the right to privacy found in article 17(1) can be interpreted to give rise to a right to confidentiality in health services. To this effect, the Human Rights Committee has addressed violations of privacy and confidentiality in the health care context by asking states parties to take legislative measures to ensure confidentiality.[272]

The Children's Rights Convention

As discussed previously, the Children's Rights Convention does not recognize exclusive autonomous decision-making power of the child or the parent. Rather, the Convention seeks to attain a balance between the decision-making rights of the adolescent and those of the parent by applying the "evolving capacities of the child" and the "best interests of the child" standards.[273] Nonetheless, the Children's Rights Convention strongly supports children's right to privacy.[274] The Children's Rights Committee has closely linked the right to privacy with a right to access confidential family planning services and information. In a recent set of concluding observations, for example, the committee commented directly on the need for confidentiality in adolescent reproductive health services,[275] and it has also strongly advocated for adolescent health services that are accessible without parental consent.[276] The committee has also emphasized children's right to privacy and confidentiality in the context of HIV/AIDS.[277]

CEDAW

CEDAW contains the most direct articulation of reproductive autonomy of any human rights treaty. Article 16(1)(e) establishes women's right to "decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights."[278] The CEDAW Committee's General Recommendation 24 on Women and Health underscores women's and girls' right to reproductive self-determination by defining them as autonomous decision-makers, and asks states parties to "refrain from obstructing action taken by women in pursuit of their health goals."[279] The CEDAW Committee has been a strong advocate for the free and informed decision-making of adolescents by frequently recommending that states parties increase their access to reproductive health services and information.[280]

The CEDAW Committee has interpreted the convention's provisions on the right to health as protecting a right to confidentiality in the provision of reproductive health services.[281] In particular, the committee has recommended that "[s]tates parties should ensure the rights of female and male adolescents to sexual and reproductive health education by properly trained personnel in specially designed programs that respect their rights to privacy and confidentiality."[282] The committee has also asked states parties to eliminate parental consent for adolescents' access to contraception,[283] thus recog-

nizing the primacy of adolescents' right to confidentiality in reproductive health services over parents' right to consent.

Economic, Social and Cultural Rights Covenant

While the Economic, Social and Cultural Rights Covenant does not explicitly reference the principle of personal liberty, the Committee on Economic, Social and Cultural Rights has interpreted individuals' right to health to include the "freedom to decide if and when to reproduce and the right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice as well as the right of access to appropriate health-care services. . . ."[284] The Committee on Economic, Social and Cultural Rights has further emphasized the right of adolescents to "participate in decisions affecting their health"[285] and to "negotiate the health-behavior choices they make,"[286] with a strong emphasis on confidentiality and privacy in sexual and reproductive health services.[287]

Because the Economic, Social and Cultural Rights Covenant does not contain provisions explicitly protecting the right to privacy, Committee on Economic, Social and Cultural Rights has inferred adolescents' right to confidentiality in reproductive health services from the right to health. In General Comment 14 the committee outlines states parties' obligation to provide adolescents with "youth friendly health care, which respects confidentiality and privacy and includes appropriate sexual and reproductive health services."[288]

b. Regional Instruments

Regional treaties also protect the right to privacy and rights related to the dignity of a person. Article 5 of the Banjul Charter provides that "[e]very individual shall have the right to the respect of the dignity inherent in a human being. . . ."[289] In this context, inherent dignity should be interpreted to include the power to make important decisions regarding one's life. Moreover, the African Children's Charter protects children's right to privacy, subject to a reasonable level of parental supervision. Article 10 states: "[n]o child shall be subject to arbitrary or unlawful interference with his privacy, family home or correspondence, or to the attacks upon his honor or reputation, provided that parents or legal guardians shall have the right to exercise reasonable supervision over the conduct of their children. The child has the right to the protection of the law against such interference or attacks."[290]

c. International Conferences

ICPD

The relatively recent international conference documents provide a more comprehensive articulation of the right to reproductive autonomy. The ICPD Programme of Action articulates an obligation on the part of governments to respect and fulfill reproductive rights, including the right of all individuals to make reproductive decisions free from discrimination, in public and private health care institutions alike.[291] The Programme of Action explicitly references the need for confidential reproductive health services for adolescents in the context of sexual abuse where it states, "in order to, inter alia, address sexual abuse, [reproductive and sexual health] services must safeguard the rights of adolescents to privacy, confidentiality, respect and informed consent. . . ."[292] The ICPD+5 Key Actions Document further emphasizes adolescents' right to autonomous decision-making with respect to their reproductive lives. It calls for governments to provide "appropriate, specific, user-friendly and accessible services to address effectively [adolescents'] reproductive and sexual health needs, including reproductive health education, information, counseling and health promotion strategies," stressing that such services should respect adolescents' rights to privacy, confidentiality and informed consent.[293]

Beijing Conference

The Beijing Platform for Action reaffirms and adopts the principles established at the ICPD with regard to the need to address women's right to control their own fertility and to make decisions about their reproduction. With respect to adolescents in particular, the Beijing Platform for Action explicitly acknowledges children's right to privacy and confidentiality in the context of reproductive health services.[294] Beijing+5 also stresses the importance of providing reproductive health services and information to the equality and future of adolescent girls.[295]

Adolescents' rights to reproductive self-determination and autonomy are grounded in the internationally recognized rights to plan one's family and to privacy, including confidentiality, which are ensured in international and regional human rights instruments and in international conference documents. The right to reproductive self-determination and autonomy gives rise to an obligation on the part of governments to ensure that individuals have full access to the means with which to make decisions concerning their reproductive and sexual lives. Governments must also remove barriers that interfere with patients' rights to privacy and confidentiality. Moreover, reproductive self-determination implies the right to be free from all forms of discrimination that affect one's sexual or reproductive life. This right will be discussed in more detail below.

3. Right to be Free from Discrimination on Specific Grounds

Laws, policies, and social practices that prevent adolescents from accessing dual protection methods and information may discriminate against them based on various specified grounds. For example, such laws may be discriminatory in that they have a disproportionate impact on women and girls who alone risk unwanted pregnancy and who are more vulnerable to contracting HIV/AIDS and other STIs. In addition, when certain vulnerable groups, such as low-income and rural women, face greater barriers to accessing services and information on contraception and STI prevention, a pattern emerges of discrimination on socioeconomic grounds. Laws and policies that deny access only to certain age groups discriminate based on age. Finally, laws and policies that grant access solely based on adolescents' marital status deny adolescents their right to equal protection and to be free from discrimination based on marital status.

The right to equality and to be free from discrimination on prohibited grounds is a fundamental principle of international law. International and regional instruments—including the Universal Declaration,[296] the Economic, Social and Cultural Rights Covenant,[297] the Civil and Political Rights Covenant,[298] CEDAW,[299] the Children's Rights Convention,[300] the Banjul Charter,[301] and the African Children's Charter[302]—expressly proscribe discrimination based on prohibited grounds that would infringe upon one's ability to exercise the rights embodied in these instruments. These treaties protect all individuals from discrimination on the basis of a number of enumerated grounds, including sex and "other status." The Treaty Monitoring Bodies have made an effort to extend protection to particularly vulnerable groups and have interpreted the term "other status" to include discrimination on the basis of socioeconomic status, age and marital status.

International conference documents such as the ICPD Programme of Action[303] and the Beijing Platform for Action[304] also reiterate the rights to equality and to be free from discrimination, particularly in the context of reproductive health care. The ICPD Programme of Action articulates an obliga-

tion on the part of governments to guarantee the right of all individuals to make reproductive decisions free from discrimination, in public and private health care institutions alike.[305] The Beijing Platform for Action also specifically addresses the right of all women to make decisions about their reproductive lives without discrimination.[306]

It is important to recognize that these various prohibited grounds of discrimination do not manifest themselves in isolation from each other. In attempting to access dual protection methods and information, adolescents may at times experience multiple forms of discrimination simultaneously. Therefore, an intersectional analysis of the various factors at play is needed to understand fully the many reasons why adolescents may not be able to access services and information on contraception and STI prevention. While the international instruments and conference documents do not explicitly discuss simultaneous and multiple forms of discrimination, their provisions serve as tools with which to address it. To this end, the Treaty Monitoring Bodies have also begun to recognize the intersectional nature of discrimination faced by various groups.

Gender

CEDAW is the most comprehensive international instrument on gender. It defines discrimination against women as "any distinction, exclusion or restriction made on the basis of sex, which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the civil, political, economic, social, cultural, or any other field."[307] CEDAW is also the only international instrument to explicitly address gender discrimination in the field of health and specifically in family planning services and information.[308] Furthermore, it is the only international human rights treaty to explicitly ask states parties "to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices that are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women."[309]

In its interpretation of CEDAW, the CEDAW Committee has been a strong advocate for women's and girls' access to services and information on contraception and STI prevention,[310] and has characterized lack of access to such services as discriminatory against women and girls by applying the antidiscrimination provisions of CEDAW. Furthermore, the CEDAW Committee has recognized the disproportionately discriminatory impact of lack of access to dual protection methods on female adolescents. In this regard, the committee has linked lack of access to contraception to high rates of abortion among female teenagers, noting that lack of access disproportionately affects girls.[311]

Both the Committee on Economic, Social and Cultural Rights and the Human Rights Committee recognize states' obligation to uphold anti-discrimination provisions, particularly on the grounds of gender. The Committee on Economic, Social and Cultural Right's General Comment 14 "proscribes any discrimination in access to health care" on the grounds of sex[312] and outlines a strategy for eliminating gender discrimination in promoting women's and girls' right to health.[313] In General Comment 28, the Human Rights Committee links women's right to equality in exercising their privacy rights to reproductive health.[314] This committee has gone even further in its concluding observations by stating that women's lack of access to contraceptives is discriminatory,[315] and recommending that states parties increase that access.[316] The Human Rights Committee has specifically criticized Zimbabwe for failing to eliminate discrimination against women and has asked the state to take positive measures to promote their role in society.[317]

The Children's Rights Committee has applied anti-discrimination provisions of the Children's Rights Convention to address the discrimination that female adolescents suffer in accessing reproductive health services and information, showing particular concern over the link between adolescent

pregnancy and lack of access.[318] In particular, this committee has emphasized the important connection between gender discrimination, access to health services and information, and the spread of HIV/AIDS.[319]

With respect to the regional instruments, Article 18(3) of the Banjul Charter specifically guarantees that "the [s]tate shall ensure the elimination of every discrimination against women and also ensure the protection of the rights of the woman and the child as stipulated in international declarations and conventions."[320] The charter thus recognizes the importance of eliminating gender discrimination.

International conference documents further affirm the right to be free from discrimination on the basis of gender. The ICPD Programme of Action explicitly calls for the eradication of all forms of gender discrimination.[321] As noted earlier, the Beijing Platform for Action reiterates the equal rights of men and women found in all the major international human rights treaties,[322] and specifically underscores the right of all women to make decisions about their reproductive lives without discrimination.[323]

Socioeconomic Status

The anti-discrimination provisions of the international instruments have consistently been interpreted to prohibit discrimination on the basis of socioeconomic status, particularly with respect to access to services and information on contraception and STI prevention. For example, the CEDAW Committee has recognized that poor women, rural women and sex workers are particularly vulnerable to discrimination and in General Recommendation 24 on Women and Health, the Committee prohibits discrimination against these groups of women in accessing health services.[324] In its concluding observations to states parties, the CEDAW Committee has further recommended that states parties address the needs of these groups in gaining access to reproductive health services and information.[325]

Likewise, the Committee on Economic, Social and Cultural Rights General Comment 14 proscribes any discrimination in access to health care on the grounds of any status that has the effect of nullifying or impairing the exercise of the right to health.[326] In its concluding observations to states parties, the Committee on Economic, Social and Cultural Rights has interpreted the provisions of the covenant and General Comment 14 to prohibit discrimination on the basis of socioeconomic status in exercising one's right to health.[327]

International and regional instruments, as well as international conference documents, prohibit discrimination on the basis of gender, age, marital, or socioeconomic status. The anti-discrimination and equality provisions of these instruments have consistently been interpreted to protect all individuals from discrimination in the exercise of all of their human rights. In this regard, governments are obligated to protect, promote and fulfill the rights of *all* adolescents to access dual protection methods and information.

Age

While international instruments do not explicitly refer to discrimination on the basis of age, references to "other status" often have been interpreted to extend protection to particularly vulnerable groups.[328] Adolescents have frequently been identified as a particularly vulnerable group with respect to health services in general and reproductive health services specifically.

The Treaty Monitoring Bodies have interpreted anti-discrimination provisions of the various international instruments to prohibit age discrimination, particularly with respect to access to family planning information and services. For example, in General Recommendation 24 on Women and

Health, the CEDAW Committee addresses discrimination against women in the health sector, emphasizing the needs of particularly vulnerable groups, including female adolescents.[329] In its concluding observations to states parties, the CEDAW Committee has frequently advocated for the rights of female adolescents to reproductive health services and information.[330]

The Human Rights Committee has recognized adolescents' right to be free from discrimination based on age in exercising the rights protected in the Civil and Political Rights Covenant. The Human Rights Committee has applied the anti-discrimination provisions of this treaty in recognizing the particular needs of adolescent girls who are faced with unwanted pregnancies.[331]

The Committee on Economic, Social and Cultural Right's General Comment 14 specifically establishes that principles of non-discrimination protect children's right to health, guaranteeing equal access to health services.[332] It also proscribes discrimination in access to health care on the grounds of any "status," that has the effect of "nullifying or impairing" the "exercise of the right to health."[333] The comment underscores state parties' obligations to respect, protect and fulfill the right to health of particularly vulnerable groups, which specifically includes adolescents.[334]

Finally, the Children's Rights Committee has been a strong advocate for adolescents' access to reproductive health information and services.[335] In its General Day of Discussion on "Children Living in a World with AIDS," the committee emphasized the need for all adolescents to have access to health services and information without age restrictions by asking states parties to "review existing laws or enact new legislation to regulate the minimum age for access to health counseling, care and welfare benefits."[336]

Marital Status

While discrimination on the basis of marital status is not explicitly prohibited in the international instruments, this unequal treatment violates principles of equal protection found in all the major international human rights documents. The Treaty Monitoring Bodies have consistently interpreted discrimination provisions of their respective instruments to prohibit discrimination based on marital status. In General Recommendation 24 on Women and Health, the CEDAW Committee addresses discrimination against women in the health sector, specifically referring to the problem of discrimination based on marital status in accessing health services.[337] Furthermore, in its concluding observations to states parties, the CEDAW Committee has explicitly identified discrimination on the basis of marital status as a barrier to accessing family planning services and information.[338] The Human Rights Committee, for its part, has interpreted the anti-discrimination and equal protection provisions of the Civil and Political Rights Covenant to prohibit discrimination on the basis of marital status. The Human Rights Committee has specifically criticized Zimbabwe for contradictions between statutory law and customary law regarding marriage—contradictions that lead to unequal treatment among individuals.[339]

D. Conclusion

International human rights instruments obligate states to respect, protect, and fulfill adolescents' right to access dual protection methods and information. According to these instruments and their interpretation, when adolescents are denied access to services and information on contraception and STI prevention, their rights to health, reproductive self-determination, and non-discrimination are violated. Furthermore, international standards guarantee adolescents the same rights as adults with respect to accessing services and information on contraception and STI prevention.

Having established that adolescents' right to access dual protection methods and information is upheld in international human rights law, this report next turns to examining how Zimbabwe is fulfilling its obligations to respect, protect, and fulfill these rights. States are clearly under a negative obligation to refrain from interfering with an adolescents' ability to seek information and services, which means they may not implement laws or policies that violate these rights. States have a further obligation to protect adolescents' right to access dual protection methods and information from interference by private third parties. This means that the state should not allow a private individual, such as a parent, to interfere with another's ability to seek and receive services and information on contraception and STI prevention. Finally, the state is under a positive obligation to ensure that adolescents are able to enjoy all their rights. The state must accordingly introduce programs and implement laws and policies to ensure adolescents the effective enjoyment of their rights. This means that state-run programs should not discriminate in providing information and services on the basis of age or marital status as that would interfere with adolescents' ability to exercise their rights. These obligations on the part of states must be taken into account when examining Zimbabwe's laws and policies. The following chapter will evaluate whether Zimbabwe's laws and policies uphold the international human rights legal standards, and will examine the impact of the application of the laws and policies on adolescents' reproductive lives.

CHAPTER III: VIOLATIONS OF THE INTERNATIONAL HUMAN RIGHTS OF ADOLESCENTS

This chapter demonstrates the manner in which the government of Zimbabwe has fallen short of its international obligations to respect, protect, and fulfill adolescents' right to access dual protection methods and information. Section A examines the existing patchwork of conflicting and confusing Zimbabwean laws and policies through a human rights lens. It is limited to a discussion of the laws and policies that either on their face or through official interpretations violate international human rights standards. Section B presents the results of the research that investigates the human rights violated by the application of such laws and policies. For the purposes of this analysis, it is important to underscore the fact that the government of Zimbabwe is the primary provider of health services, including services and information on contraception and STI prevention. Public health care providers are agents of the government in this regard and their actions are therefore attributable to the government as they are primarily responsible for implementing the relevant laws and policies.

A. Certain Zimbabwean Laws and Policies Contradict International Standards

There are two categories of national laws and policies that inhibit adolescents' access to dual protection methods and information. The first includes those provisions of laws and policies that mandate parental consent; the second is comprised of laws that, when taken together, fail to provide adequate legal protections from discrimination. The following discussion will show how these laws and policies fail to respect, protect and fulfill adolescents' human rights to health, to education and information, to confidentiality and privacy, and to be free from discrimination.

1. Parental Consent Requirements for Adolescents

As discussed in Chapter I, Zimbabwe's mosaic of laws and policies generally prevent adolescents below the age of 18 from accessing services and information on contraception and STI prevention without the consent of a parent or guardian. Although two main groups of adolescents are *de facto* exempt from this requirement—married adolescents or those who already have children—the vast majority of Zimbabwean adolescents are subject to this requirement. While parental consent requirements are, in part, based on a fear that granting access to adolescents will encourage sexually promiscuous and potentially risky behavior, in fact they do little to either encourage or discourage sexual behavior *per se*. Rather, they discourage sexually responsible behavior that would improve adolescents' health status. In addition, Zimbabwe's parental consent requirement fails to respect adolescents' rights to information, education, reproductive autonomy, and freedom from age discrimination.

a. The Rights to Health, Information, and Education

Zimbabwean laws and policies that require parental consent for the provision of contraception fail to respect adolescents' human rights to health, information, and education. Not only do such restrictive norms expose adolescents to serious health problems, but they also inhibit adolescents' ability to seek and receive critical information. Because of the detrimental effect on adolescents' health, these laws and policies run counter to the "best interests of the child" standard.

Parental consent requirements constitute a serious barrier to adolescents' access to health services, specifically services and information on contraception and STI prevention, which is an integral and essential element of the right to health.[340] In practical terms, an insistence on notification to parents inhibits adolescents from seeking medical services and advice where sensitive and crucial issues—like the interest in commencing a sexual relationship—are involved. Yet, this lack of reproductive health information does not prevent adolescents from becoming sexually active. As discussed previously, sexual activity commences early in Zimbabwe; 30% of adolescents between the ages of 15 and 19 reportedly have had sexual intercourse at least once.[341]

Laws and policies requiring parental consent for adolescents' access to information on contraception and STI prevention also inhibit adolescents' ability to seek, receive, and impart information. A requirement of parental involvement constitutes an almost insurmountable obstacle for adolescents seeking access to dual protection methods and information.[342] Moreover, parental consent requirements fail to respect and ensure adolescents' right to education, which encompasses a right to be taught certain necessary life skills.[343] Parental consent requirements for provision of information on dual protection methods restrict and ultimately deny adolescents the ability to develop important life skills and capacities.

It is also important to underscore that a parental consent requirement runs counter to the "best interests of the child" standard, particularly with respect to children's right to health. To comply with this standard, the tension between parental decision-making rights and adolescents' right to access dual protection methods and information must be resolved in favor of the rights of the adolescents. Some policymakers may regard consent requirements as being in the "best interests of the child" because they are intended to protect adolescents from their own actions, thereby delaying sexual activity and all its consequences. However, the prevalence of early sexual activity, unwanted pregnancy, and high HIV/AIDS rates among Zimbabwean adolescents testifies to an alternative reality—one in which methods of contraception and STI prevention are necessary to promote adolescent health.

b. The Right to Reproductive Autonomy: Privacy and Confidentiality

Parental consent requirements for access to dual protection methods and information violate adolescents' rights to privacy and confidentiality and thus inhibit their ability to make autonomous decisions regarding their sexual and reproductive lives. Consent requirements erase any expectation of privacy for the adolescent. Moreover, Zimbabwean policies do not consistently ensure adolescents confidential services.[344] The result of a legal and policy framework that mandates parental consent is weak formal protection for adolescents' confidentiality and an infringement on their reproductive self-determination and autonomy.

Laws and policies requiring parental consent for access to services and information on contraception and STI prevention fail to recognize adolescents as capable of making decisions regarding their sexual and reproductive lives and thereby do not meet the "evolving capacities of the child" standard set forth by the international community. This standard implies that adolescents who display a mature or adult-like capacity by attempting to access methods of contraception or STI prevention be afforded the means to make autonomous decisions regarding their reproductive and sexual lives.[345] Instead, parental consent requirements subjugate adolescents' rights to privacy and confidentiality to parental control, denying that adolescents evolve to the point where they are capable of making such decisions.

c. The Right to be Free from Age Discrimination

Parental consent requirements also violate the right of adolescents under 18 to be free from unreasonable discrimination on the basis of age. Legal and policy instruments in Zimbabwe expressly limit access to services and information based on age, and therefore violate the right to be free from unreasonable discrimination on this basis.[346]

2. Insufficient Legal Protections for the Right to be Free from Discrimination

In addition to parental consent requirements that violate adolescents' right to be free from discrimination on the basis of age, certain national legal provisions fail to protect adolescents' right to be free from discrimination on other specified grounds. Most significantly, Article 23(3) of the Zimbabwe Constitution has the effect of denying adolescents legal protections from discrimination.[347] According to this provision, laws pertaining to personal matters and customary African law are not subject to Article 23(2) which prohibits discrimination on the basis of gender, race, tribe, place of origin, political opinions, color, or creed.[348] Hence, personal and African customary law may explicitly discriminate on the basis of gender or any of the other prohibited grounds. Since laws and policies that impact adolescents' access to services and information on contraception and STI prevention are inextricably tied to the socio-cultural context regarding marriage and the stigmatization of premarital sex, they are very likely to be considered 'personal matters' for these purposes.[349] Moreover, African customary law frequently puts women and girls in an inferior position to boys and men and therefore discriminates on the basis of gender.[350] In particular, African customary law that impedes women's ability to enter into even the most basic contracts may affect their ability to access services and information on contraceptive and STI prevention. However, such discrimination in customary law is permissible under the Zimbabwean Constitution.[351]

There is also a marked lack of protection from discrimination on the bases of age, socioeconomic status and marital status in Zimbabwean legal and policy instruments. The Zimbabwe Constitution does not explicitly prohibit discrimination based on age, socioeconomic status, or marital status.[352] Nor do policy documents explicitly protect adolescents from discrimination on these bases. The Zimbabwean government therefore is failing to uphold its positive obligation to enact an effective legal and policy framework that ensures adolescents' right to be free from discrimination.

Finally, under the national legal and policy framework, married adolescents under the age of 18 receive preferential treatment, resulting in discrimination against unmarried adolescents under the age of 18. In light of cultural norms that sanction adolescent sexual relations exclusively within the institution of marriage, the Marriage Act and the Customary Marriages Act *de facto* grant married adolescents under age 18[353] access to dual protection methods and information. This results in preferential treatment of married adolescents and discrimination against unmarried adolescents at the level of service provision. Furthermore, since laws regarding marriage relate to personal matters,[354] they are not subject to the non-discrimination provisions of the Constitution.[355]

Zimbabwe's laws and policies fall short of fulfilling its obligations to respect, protect and guarantee adolescents' internationally recognized human rights. Laws and policies requiring parental consent for access to dual protection methods and information inherently violate adolescents' human rights to health, information and education, confidentiality and privacy, and non-discrimination on the basis of age. Moreover, these laws and policies do not rise to the "best interests of the child" and "evolving capacities of the child" international standards. In addition, national laws and policies fail to respect and fulfill adolescents' right to be free from discrimination based on age, socioeconomic status, and marital status. The exemption of certain laws from constitutional non-discrimination provisions, and a lack of explicit legal provisions prohibiting discrimination on these bases, constitute violations of international standards. Finally, legal provisions that *de facto* exempt married adolescents of any age from parental consent requirements discriminate against unmarried adolescents. Zimbabwe is not only obligated to eliminate legal and policy impediments to adolescents' full enjoyment of their rights, but the government also has a duty to affirmatively enact and implement laws and policies that will ensure their rights.

It is important to underscore that, in addition to being inherently violatory, the laws and policies when taken as a whole fail to uphold international standards. The national framework is insufficient in that it is inconsistent and ambiguous and therefore allows for restrictive interpretation on the part of government officials and public health service providers.

B. Implementation of Zimbabwean Laws and Policies Results in Violations of International Standards

The enforcement of Zimbabwe's restrictive laws and policies on adolescents' access to dual protection methods and information results in a number of human rights violations. Our investigation confirms that the human rights problems associated with the existence of parental consent requirements are compounded by strict enforcement. Moreover, the implementation of Zimbabwe's patchwork of laws and policies governing adolescents' ability to obtain services and information on contraception and STI prevention inhibits their enjoyment of the right to health, deprives them of their rights to privacy and confidentiality and is discriminatory in a variety of ways.

It should be noted at the outset that public sector service providers act as gatekeepers to services and information on contraception and STI prevention. At least partially due to the lack of clear guidance from laws and policies, Zimbabwean health care workers use their discretion to interpret laws and policies in a restrictive manner. For example, service providers interpret criminal law in a manner that results in denial of services to adolescents under 18 years old. The Criminal Law Amendment Act and the Sexual Offenses Act, which make it a crime for anyone over 15 years of age to have extramarital sexual intercourse with anyone under the age of 16,[356] have been interpreted by providers to prevent sexually active adolescents from obtaining dual protection methods and information. Accordingly, public health service providers are reluctant to provide methods of contraception or STI prevention to anyone who is under the legal age of consent without parental consent, because they fear that they will be found criminally liable as an accomplice to statutory rape.[357] Such restrictive interpretations of the law by service providers violate adolescents' right to access dual protection methods and information.

1. Parental Consent Requirements Are Enforced

> ***"We sometimes receive adolescents at the clinic, but the law of the country dictates that the parents must be informed. . . . We are legally bound to tell parents when the adolescents come into the clinic."***[358]
>
> Service Provider

Our research results reveal that public health care workers very rarely provide adolescents under 18 services and information on contraception and STI prevention without parental consent.[359] Our investigation also reveals that service providers routinely inform parents and obtain their consent before providing adolescents with services and information on contraception and STI prevention. As we were told at a clinic in Belvedere: "We do receive some adolescents at the clinic. Those who come are older than 16. In order to receive the services, they must be accompanied by their parents. . . . Once the adolescents are older than 18, they need not be accompanied by their parents."[360]

Even when a health care worker grants an adolescent entry to a clinic, that service provider considers it part of his or her professional obligation to inform parents of the adolescent child's reproductive health status. For example, one service provider told us, "[w]e sometimes receive adolescents at the clinic, but the law of the country dictates that the parents must be informed. . . . We are legally bound to tell parents when the adolescents come into the clinic."[361] Service providers generally give priority to parents' right to know about treatment over adolescents' rights to health and to make autonomous decisions regarding their sexual and reproductive lives.

2. Violations of the Right to Health

> ***"[M]y parent, who is a village health worker, tells me I am still young, but my feelings are forcing me to have 'dry sex'***[362] ***for there is nowhere I can get contraceptives from."***[363]
>
> 17-year-old rural boy

Our research reveals that the enforcement of the profusion of confusing laws and policies by service providers denies adolescents' access to dual protection methods and information and thus violates their right to health. As discussed above, public health service providers enforce the parental consent requirements. This constitutes a serious barrier to access to health care for adolescents. According to the adolescents we interviewed, the reality is that the parental consent requirements bar them from accessing services and information because they are unable or unwilling to involve their parents in their sexual lives. The findings confirm that adolescents under the age of 16 routinely are refused access to services and information on contraception and STI prevention. Sixty-three percent of the girls and 47% of the boys interviewed stated that they have encountered this problem.[365]

Adolescents' lack of access to services and information on contraception and STI prevention has a direct impact on their ability to protect themselves from unwanted pregnancy and STIs, including HIV/AIDS, further threatening their right to health. Our research reveals that, because of their experience being turned away by public health care providers, adolescents seldom try to access methods of contraception and STI prevention from governmental institutions, such as schools, clinics, or youth centers. Instead, the adolescents with whom we spoke seek contraception from various and unreliable sources.[366] These alternative sources often provide adolescents with products that are ineffective at preventing pregnancy and STIs or they fail to administer these methods properly. This means that

adolescents either use no method at all,[367] use traditional methods, or use unreliable or substitute methods. In each case, adolescents are exposing themselves to serious and potentially life-threatening health risks. The results of our investigation provide further evidence that HIV/AIDS is a major threat to their health.[368]

Our investigation demonstrates that adolescents often use traditional and ineffective methods of contraception which seriously jeopardize their health. The group discussions revealed that the family planning methods that adolescents use include identifying "safe" periods for having sex, the withdrawal method, and traditional medicine, such as "charms" by girls and "guchu" [369] by boys. Moreover, adolescents, particularly from rural areas, reported using ineffective and unsafe methods, such as substituting for condoms empty "freezit" packs and plastic bread-wrapping. The adolescents reported that these items break easily and that they are rough and abrasive on their genitalia. Moreover, none of these methods protect against HIV/AIDS and other STIs and they may be unreliable or completely ineffective at preventing pregnancy. In addition, these methods may tend to promote local infections.

Even in cases where adolescents report using a modern method of contraception or STI prevention, it is impossible to determine the quality of products that adolescents obtain from inevitably unreliable sources. For example, young people may depend upon expired condoms or oral contraceptives, which may be ineffective in preventing unwanted pregnancies and STIs, including HIV/AIDS. In an interview at ZNFPC, a representative told us that contraceptive drugs are often brought into Zimbabwe illegally from other countries, such as Malawi, Botswana, and South Africa, and then sold on the streets. Individuals who do not have the necessary training to provide services and information on contraception and STI prevention sell the unauthorized products.[370] In addition, group discussions revealed that at times girls are given aspirins and are then convinced that these pills are really birth control pills.[371]

3. Violations of the Right to Information and Education

> ***"We teach students how to abstain, how to put off sex until after marriage. We never talk about condoms."***[372]
>
> Representative of the Ministry of Education

> ***"[The first time I had sex] I was only 14 years and I knew nothing about condoms."***[373]
>
> 17-year-old boy in Igusi

Our investigation revealed that adolescents do not receive adequate information and education about contraception. Firsthand reports from adolescents of their lack of sexuality education indicate the stark realities of the poor state of reproductive health knowledge amongst Zimbabwe's young people. While the reasons for such ignorance are complex, and partly attributable to cultural norms and traditions, one additional and complicating reason for this lack of information is the government's promotion of abstinence rather than safe sex.

The government requires schools and health care professionals to teach adolescents about abstinence rather than safe sex. Adolescents reported that they had learned very little, if anything, about contraception or STI prevention from their teachers. A representative of the Ministry of Education acknowledged the limitations of the current sexuality education program, referring to it as "rudimentary" and criticizing it for focusing primarily on abstinence. These lessons begin in grade four, when students take classes on HIV/AIDS under the "Education for Living" program.[374] In an interview at

the Ministry of Education, we were told: "We teach students how to abstain, how to put off sex until after marriage. We never talk about condoms. We try to empower students to say 'no.' Some of the churches are unhappy even about this limited sexuality education."[375] Students are taught neither about reproductive health (except in biology classes), nor about the availability of dual protection methods.

It is clear that promotion of abstinence rather than effective dual protection alternatives has failed to keep adolescents from engaging in sex. [376] Rather, as a result of such policies, adolescents are pitifully misinformed and fail to use contraception.

The majority of adolescents particularly in the study reported that they had not received any sexuality education information prior to their first sexual experience, and most of the respondents had never received any information. Approximately 42% of the adolescents reported a lack of information on the availability of methods of contraception and STI prevention, including where one can get them and how to use them.[377] Adolescents are generally not aware of the variety of safe and effective methods of dual protection. Methods such as the diaphragm, the intra-uterine device and emergency contraception are only remotely familiar to adolescents, if not totally unknown to them. In fact, during our interviews, adolescents were unable to differentiate between modern, effective types of contraception and ineffective methods.[378] A 17-year-old boy in Igusi reported: "[The first time I had sex] I was only 14 years and I knew nothing about condoms."[379] The majority (60%) of sex workers we interviewed reported not using a method of contraception or STI prevention during their first sexual encounter because they lacked any information about dual protection methods. (See Appendix D, Table 2.)

Our research also indicates that adolescents are learning about sex more often from unreliable sources than from reliable ones. When we asked adolescents from whom they had learned about family planning, the vast majority had not learned in school or through government-sponsored programs. Most interviewees reported receiving information from the media and from friends, as shown in Appendix D, Table 3. In rural areas, family planning information is disseminated mostly through people within an adolescent's immediate circle, such as friends or a family member. Appendix D, Table 4 compares the influence of various sources of information on contraception and STI prevention in urban areas as opposed to rural areas.

Given the low rate of knowledge regarding dual protection amongst Zimbabwean adolescents, and the fact that they obtain such information from unreliable sources, it is no surprise that young people have a lot of misinformation. Not only are they generally unaware of different types of dual protection methods, but they also harbor many misconceptions regarding contraception and STI prevention.

Stakeholders that were interviewed stated that adolescents' access to dual protection methods and information was impeded by myths and misconceptions surrounding the use of contraception, its effectiveness, and any possible side effects.[380] Our research confirmed this, with 60% of adolescent interviewees responding that family planning methods can lead to infertility.[381] One 16-year-old responded that "[contraceptives] may damage my womb and I may fail to bear children forever."[382] Similarly, males were afraid that consistent use of condoms would "weaken" one's sperm, thus leading to infertility. Another common myth is that rather than preventing diseases, contraceptives actually cause viruses. This was reported in both urban and rural areas, most commonly by males.[383]

These prevailing misconceptions result in many adolescents shunning contraception. For example, some interviewees reported a personal preference for not using methods of contraception and STI prevention. Almost 35% (mostly male respondents) reported that they prefer "dry sex"—having unprotected sex.[384] A 17-year-old reported: "My brother told me sex is not enjoyable when you

have a condom."[385] One boy said, "One cannot eat sweets in their plastic wrappers,"[386] while another respondent stated that he wanted to have unprotected sex so as to get the "real taste of it."[387]

4. Violations of the Right to Reproductive Autonomy

> ***"I do not think that health care workers actually realize how judgmental they are with respect to adolescents asking for family planning services. The wors[t] part is that [the service providers] do not keep the information to themselves. It is bound to be passed on in the community or to the family of the adolescents."***[388]
>
> Employee of the Ministry of Health

Our research results demonstrate that the government fails to ensure adolescents' rights to privacy and confidentiality in the provision of services and information on contraception and STI prevention, and thus inhibits their ability to make autonomous decisions. Laws and policies that require parental consent foster a climate of disrespect for confidentiality and one in which providers freely share information about those seeking reproductive health services. The results confirm that service providers share privileged information. Service providers interpret laws and policies to mean that an adolescent's right to confidentiality is superceded by the parents' right to know about and consent to services for their child. Thus, the rights to privacy and confidentiality are virtually nonexistent for adolescents under 18.

The adolescents we interviewed identified lack of trust in service providers' promises of confidentiality as a significant deterrent to obtaining services and information on contraception and STI prevention. Participants were nervous that the staff would report them to the headmaster or to their parents. A number of respondents also reported that service providers "gossiped" in their communities, revealing the names of adolescents who requested services and information. For example, a 17-year-old girl claimed: "Mostly the people who are responsible (service providers) went on publishing our names."[389]

The government is aware that service providers fail to respect the confidentiality of adolescents. For example, one employee of the Ministry of Health admitted, "I do not think that health care workers actually realize how judgmental they are with respect to adolescents asking for family planning services. The wors[t] part is that [the service providers] do not keep the information to themselves. It is bound to be passed on in the community or to the family of the adolescents."[390] Despite the government's recognition of service providers' failure to ensure confidential treatment of adolescents, the results did not indicate the government was taking any steps to address this problem.

5. Violations of the Right to be Free from Discrimination

In enforcing Zimbabwe's restrictive laws and policies regarding access to services and information on contraception and STI prevention, service providers treat certain groups of adolescents differently. The following section will illustrate that public health service providers are applying national laws and policies in a way that further discriminates on the basis of gender, marital status, and socioeconomic status. This discrimination may take the form of denial of services only to particular groups, favoring of certain groups, or it may manifest itself through a disproportionate impact on a particular population.

Gender

> ***"Parents deny that their children can be sexually active. Sometimes parents come in to the clinic and ask us to check if their girl is still a virgin."***[391]
>
> Service Provider

> ***[I am not concerned about pregnancy] because I do not get pregnant and I can deny [that I am the father]."***[392]
>
> Urban Zimbabwean male adolescent

Our research indicates that, in its application of laws and policies, the government of Zimbabwe fails to respect, protect and guarantee girls' right to be free from discrimination in exercising their right to access dual protection methods and information. Not only do girls face additional obstacles in obtaining contraception, but they suffer more acutely as a result of this failure of access. Cultural attitudes and expectations of girls lie at the heart of the problem.

Our results suggest that girls have more difficulty accessing contraception than boys do. The investigation reveals that more boys than girls reported using a method of contraception or STI prevention on their first sexual encounter, and that when a method was used, the male partner provided it.[393] Overall, boys reported less difficulty in accessing condoms than girls. Girls reported a number of reasons for not being able to access and carry condoms, including:

- a girl would face severe censure from her parents if they discovered condoms in her possession;
- a girl with condoms is often stigmatized as a prostitute and she encounters mistrust even from her boyfriend; and
- boys tend to dominate in sexual matters, taking advantage of girls' subordinate position in society. The girls stated that a girl often does not anticipate having sex when she goes out, but a boy will anticipate and plan on it.[394]

The disproportionate effect on girls of denial of access to dual protection methods and information reflects cultural stereotypes and discriminatory attitudes toward girls. Society, and hence parents, place a high premium on sexual purity for girls. At one clinic, we were told that "[p]arents deny that their children can be sexually active. Sometimes parents come in to the clinic and ask us to check if their girl is still a virgin."[395] Service providers also ridicule or admonish girls who request contraceptives and means of STI prevention. One girl reported that "at clinics they were asking many questions and sometimes scolded us as prostitutes."[396] One traditional healer stated, "We should use our traditional methods of inspecting the girl's virginity rather than teaching them family planning as if they are married."[397]

Marital Status

> ***"As soon as adolescents are married, they are considered as adults. They can have access to contraceptives without any difficulties. . . ."***[398]
>
> Nurse at the ZNFPC Clinic in Bulawayo

Our research confirms that married adolescents under 18 are granted access to services and information on contraception and STI prevention because of their marital status. Because service providers view married adolescents as adults, they are no longer required to obtain parental consent. This

restrictive interpretation of ambiguous national laws and policies is in part due to cultural norms that approve of adolescent sexuality exclusively within the social institution of marriage.

Interviews with service providers demonstrate that they grant married adolescents below the age of 18 access to services and information on contraception and STI prevention but are unreceptive toward unmarried adolescents. A Ministry of Health representative pointed out that the nurses always ask whether a patient is married and become willing to provide dual protection methods and information only to adolescents who answer affirmatively.[399] As a nurse at the ZNFPC clinic in Bulawayo told us: "[a]s soon as adolescents are married, they are considered as adults. They can have access to contraceptives without any difficulties. . . ."[400]

Socioeconomic Status

> ***"What choice did I have, both my parents died of AIDS, how was I going to feed the other children?"***[401]
>
> Zimbabwean adolescent sex worker

Our research reveals that the Zimbabwean government violates the rights of socioeconomically disadvantaged adolescents to be free from discrimination in the exercise of their right to access dual protection methods and information. The government fails to protect this right when service providers refuse or inhibit access to services and information on contraception and STI prevention to groups on the basis of their socioeconomic status—specifically rural adolescents and low-income adolescents who are sex workers. The government also fails to guarantee the conditions necessary for these groups to enjoy their rights. It should be further noted that this denial of access to dual protection methods and information affects certain groups disproportionately. For example, due to their frequent sexual activity, adolescent sex workers are more likely to suffer severe health harms when denied dual protection methods and information.

Rural Adolescents

Our investigation indicates that rural adolescents encounter greater obstacles to access than adolescents from urban areas do. According to the respondents, service providers in rural areas tended to restrict access more than do those in urban areas. In fact, 61% of the adolescents interviewed in rural areas reported having had problems accessing services and information on contraception and STI prevention from service providers, whereas only 49% of adolescents interviewed in urban areas reported facing obstacles.[402] Adolescents from rural areas are denied access to dual protection methods and information and often do not seek services and information from clinics because of the likelihood that providers know their family members. For example, one 17-year-old rural boy wrote: "My parent, who is a village health worker, tells me I am still young, but my feelings are forcing me to have 'dry sex' for there is nowhere I can get contraceptives from."[403] In rural settings, there are fewer alternative sources for adolescents. As a result, the rural group seems to resort more often to using empty "freez-it" packs or plastic wrappers as alternatives to condoms.

Low-Income Adolescents/Female Sex Workers[404]

> ***"[R]arely some men put on condoms, others offer an attractive amount of money to do without. If the amount is good you just take the risk."***[405]
>
> Zimbabwean adolescent sex worker

The interviews demonstrate that low-income girls face heightened obstacles to access to dual protection methods and information. According to our research, low-income female adolescents are more likely than other adolescents to exchange sex for money or material items.[406] Accordingly, this culture of sex as a commodity results in girls entering into inherently coercive relationships with more powerful men with money or commodities to trade. Because of the "sugar daddy's" more powerful position in these relationships, the socioeconomically disadvantaged girl faces special obstacles in accessing methods of contraception and STI prevention, since it is usually left to the older man to decide whether or not to use a method. Sometimes these low-income girls turn to more regular sex work to feed themselves or their families. For example, one 16-year-old sex worker told us, "[m]y family needs the money. They know I must be prostituting myself because I am not home at night but no one mentions it. No one asks me where I get the money from."[407] Those low-income girls who resort to sex work confront particular barriers when attempting to access dual protection methods and information.

Adolescent sex workers are routinely denied access to dual protection methods and information despite the fact that they are obviously sexually active and therefore, under certain policy statements, should be granted access without parental consent requirements.[408] Thirty-two percent reported that they were denied access from service providers because of the staff's attitudes regarding sex work and 40% reported that they were denied access because service providers discriminate against them on the basis of their age. (Appendix D, Table 5) Such denial of access is particularly dangerous for this group of adolescents since they are at high risk for a host of problems related to their sexual activities, including unwanted pregnancies and infection with STIs, including HIV/AIDS.[409]

In addition, the research shows that adolescent sex workers are unable to negotiate condom use among their clients. Approximately 86% of the sex workers interviewed acknowledged that the responsibility to use a method of contraception or STI prevention is usually left to their clients. Approximately 10% of sex workers that we interviewed reported that they do not want to initiate the use of contraception with their clients for fear of rejection. Accordingly, only 20% of the interviewees stated that they have initiated the use of a dual protection method.[410]

Our investigation reveals that the enforcement of Zimbabwe's patchwork of restrictive laws and policies relating to adolescents' access to dual protection methods and information results in a violation of their rights. The implementation of parental consent requirements results in curtailing young people's ability to obtain services and information on contraception and STI prevention. In addition, because of their inability to access reliable methods contraception and STI prevention, adolescents turn to unreliable methods and thus further jeopardize their health. Adolescents' lack of information regarding dual protection methods, particularly the myths associated with contraception, has effectively limited their use of dual protection methods. In addition, Zimbabwe's laws and policies discriminate against girls, rural adolescents, and such vulnerable social groups as sex workers.

C. Conclusion

Zimbabwe's patchwork of laws and policies restricting adolescents' access to dual protection methods and information violate international human rights standards. The parental consent requirement mandated by the government contravenes international norms, and the problems it creates in the lives of adolescents are only compounded by its strict application and enforcement. Insufficient legal pro-

tections from discrimination fail to protect adolescents from discrimination on specified grounds, further restricting their access to vital dual protection methods and information. Zimbabwe has failed to uphold its international obligations to adopt an adequate legal and policy framework that would ensure adolescents' access to services and information on contraception and STI prevention. Our research documents that, as a result, adolescents' rights to health, to education and information, to privacy and confidentiality, and their right to be free from discrimination are violated.

One of the most serious consequences of Zimbabwe's current laws and policies is that they prevent adolescents from obtaining reliable information and services regarding contraception and STI prevention. Myths and misinformation result in minimal usage of dual protection and therefore expose young people to health hazards. Moreover, the failure of public health service providers to respect adolescents' confidentiality and privacy prevents them from seeking out such care. There is also evidence of a pattern of discrimination in certain national laws and policies on the basis of age, marital status, and socioeconomic status. The results of the investigation confirm that service providers discriminate against rural and low-income adolescents, particularly sex workers. To the extent that there are legal protections against gender discrimination, laws and policies are nonetheless being interpreted and implemented in a way that fails to address the particular obstacles faced by girls.

Laws and polices that hinder or fail to ensure adolescents' access to dual protection methods and information reflect a denial of the realities of adolescent sexuality on the part of the government as well as by society as a whole. As a result, public health service providers systematically prevent adolescents from accessing vital services and information. This pattern of denial inhibits adolescents from exercising their international human rights to access dual protection methods and information. Considering the gravity of the health risks at stake, it is clear that the time has come for the government to make an affirmative commitment to promote and protect the reproductive rights of adolescents.

CONCLUSION

This report documents legal, policy, and social barriers to Zimbabwean adolescents' enjoyment of their international human rights to access dual protection methods and information. Certain Zimbabwean laws and policies restricting adolescents' ability to obtain services and information on contraception and STI prevention are inconsistent with international norms. In particular, this publication highlights those Zimbabwean laws and policies mandating parental consent for access to services and information on contraception and STI prevention, as well as national laws that do not provide adequate protection against discrimination on the basis of gender, age, and marital and socioeconomic status. Our investigation reveals that the application of this complex mosaic of inconsistent and contradictory laws and policies results in human rights violations.

First, service providers rigorously enforce the parental consent requirements, severely inhibiting adolescents from seeking medical advice and services. Moreover, they interpret national laws and policies very restrictively, implementing them in a way that denies access to dual protection methods and information and discriminates against particular groups of adolescents. This denial of access is a violation of adolescents' right to health, as they will therefore either fail to use any method of protection or they will resort to unreliable, ineffective methods, which may fail to prevent pregnancy or the transmission of HIV/AIDS and other STIs. Restricted access to information on dual protection violates adolescents' rights to information and education, leaving them to make decisions based on myths and misconceptions. The lack of respect for adolescents' rights to privacy and confidentiality further inhibits their ability to make key decisions regarding their reproductive and sexual lives. Finally, while all adolescents face discrimination on the basis of age when accessing dual protection methods and information, certain groups of adolescents confront particular barriers. This report documents a pattern of discrimination based on gender, marital status, and socioeconomic status, which further inhibits certain adolescents' ability to exercise their rights.

Denial of access to dual protection methods and information inhibits Zimbabwean adolescents' participation in economic, political, and social life. Adolescents' inability to protect themselves from the grave risks associated with early sexual activity—early and unwanted pregnancies, unsafe abortions, HIV/AIDS, and other STIs—may seriously affect their educational, occupational, and social opportunities. Considering that this age group constitutes a large and growing segment of the population, this pattern of denial may have serious consequences for Zimbabwean society as a whole.

The Zimbabwean government should take immediate steps to rise to the considerable challenge of addressing the reproductive health needs of adolescents and ensuring their human rights. As important policy developments are now underway, the government is presented with a tremendous opportunity to affirm its commitment to ensuring adolescents' access to dual protection methods and information and to bolster its efforts to address traditional cultural and religious values in this respect. Moreover, the government must take measures to harmonize both laws and policies at the national level with international human rights standards. In the face of the grave reproductive health risks confronting Zimbabwean adolescents, the Zimbabwean government can no longer afford to maintain its current state of denial.

APPENDIX A: Details Regarding Scope of Report

Table 1: Demographic Characteristics of the Participants[411]

Group	Males	Females	Mean Ages	Total
School-going Adolescents	355	292	16.4	647
Out-of-school Adolescents	59	35	18.9	94
Adolescent Sex Workers	-	30	14.8	30
Parents	5	6	-	11
Policy-makers and Other Stakeholders, including: Government Officials, NGO and UN Representatives, and Service Providers	7	13	-	20
Total	**426**	**376**	**16.7**	**802**

Table 2: Names of Schools Visited

Area	School
Mutate	Dangamvura
Mutare	Inyangani
Bulawayo	Saw Mills
Bulawayo	Ihlathi
Chinhoyi	Nyamasanga
Banket	Kuwadzana
Mazoe	Shingirirai
Chitungwiza	Seke High 1
Harare	Prestige
Harare	Mount Pleasant

Table 3: Out-of-school Children Interviewed

Area	Group
Norton	Tsungirirai
Chitungwiza	CHYSAP

Adolescent Street Children

Place of Interview	No. of Subjects
Streets Ahead Center, Harare	7
Tutuga Center, Bulawayo	11

Adolescent Sex Workers

Area	No. of Subjects
Harare	19
Chitungwiza	11

Table 4: List of Stakeholders

Organization	Geographical Area
Health Sector	• Ministry of Health (Harare) • Belvedere Satellite Clinic (Belvedere) • Hatcliffe clinic (Harare) • Msipani clinic (Zvishavanne) • Majada clinic (Gutu) • Well Women Clinic
UNICEF	• Harare • Harare
ZINATHA	ZINATHA Offices (Harare)
Matabeleland AIDS Council	Bulawayo
Ministry of Education	Harare
Ministry of Justice	Harare
Thuthuka Street Children Centre	Bulawayo
ZNFPC	Bulawayo
Department of Social Welfare	Bulawayo
SAFAIDS	Harare
UNFPA	Harare
Ministry of Youth	Harare

Table 5: Number of Interviewees Who Provided Various Forms of Feedback

Group	Self Report Questionnaire	One-on-one Interview	Group Discussion	Total
School-going Adolescents	302	15	330	647
Out-of-school Adolescents	38	-	56	94
Adolescent Sex Workers	30	-	-	30
Parents	-	-	11	11
Policy-makers and Other Stakeholders	5	15		20
Total	**375**	**30**	**397**	**802**

Table 6: Questionnaire

Section I: Biographical data

1) Age
2) Place of birth
3) Ethnic group
4) Marital status
5) In school or out of school
6) Living with parents or not

Section II: Establishing the Need for Dual Protection Methods and Information for Adolescents

1) Have you ever had sexual relations?
2) Are you currently sexually active?
3) Have you heard about STIs or HIV/AIDS
4) If so, what do you do to protect yourself from contracting these infections?
5) For the girls, do you worry about getting pregnant?
6) For the boys, do you worry about getting a girl pregnant?
7) If so, what do you do to avoid an unwanted pregnancy?

SectionIII: Experiences of Adolescents in Family Planning Clinics

1) Have you ever heard of family planning methods?
2) If so, where did you get this information?
3) Have you ever been to a family planning clinic?
4) If so, what was your experience there?
5) Was the staff friendly?
6) Did the staff ask you for your parents' consent before providing services?

APPENDIX B: Zimbabwe's Ratification of International Human Rights Instruments

Human Rights Instrument	Date of Ratification
International Instruments	
Convention on the Rights of the Child	September 11, 1990
International Covenant on Economic, Social and Cultural Rights	May 13, 1991
International Covenant on Civil and Political Rights	May 13, 1991
International Convention on the Elimination of Racial Discrimination	May 13, 1991
Convention on the Elimination of All Forms of Discrimination Against Women	May 14, 1991
Regional Instruments	
African Charter on Human and People's Rights	May 30, 1986
African Charter on the Rights and Welfare of the Child	January 19, 1995

APPENDIX C: International Legal Instruments Concerning Adolescents' Right to Access Dual Protection Methods and Information

	International Legal Instruments					Regional Legal Instruments		Conference Documents	
Human Rights Protected	Universal Declaration[412]	Civil and Political Rights Covenant[413]	Economic, Social and Cultural Rights Covenant[414]	CEDAW[415]	Children's Rights Convention[416]	Banjul Charter[417]	African Children's Charter[418]	ICPD Programme of Action[419]	Beijing Platform for Action[420]
The right to health and reproductive health	Art. 25.1		Art. 10.2 Art. 12	Art. 12 Art. 14.2(b)	Art. 24	Art. 16.1	Art. 14	Principle 8 Para. 4.20 Para. 7.2 Para. 7.41 Para. 7.46	Para. 106(b) Para. 89
The right to receive and impart information	Art. 19	Art. 19		Art. 10(h) Art. 14.2(b) Art. 16.1(e)	Art. 13	Art. 9		Para. 4.20 Para. 7.37 Para. 7.41 Para. 7.46	Para. 107(e) Para. 107(g)
The right to education	Art. 26		Art. 13	Art. 10 Art. 14.2(d) Art. 16.1(e)	Art. 28	Art. 17	Art. 14.2 (f) Art. 59	Para. 4.20 Para. 7.46 Para. 7.47	Para. 107(g)
The right to liberty and security	Art. 3	Art 9.1		Art. 16.1(e)		Art. 5		Para. 7.3	Para. 96
The right to privacy	Art. 12	Art. 17.1			Art. 16.1		Art. 10	Para. 7.45	Para. 106(f) Para. 107
The right to be free from discrimination on specified grounds	Art. 2	Art. 2	Art. 2.2	Art. 1 Art. 3 Art. 14.2	Art. 2	Art. 2 Art. 18(3)	Art. 3	Principle 1 Principle 4 Principle 7.3	Para. 232(a) Para. 214 Para. 95

APPENDIX D: Zimbabwean Adolescents' Access to Services and Information on Contraception and STI Prevention

Chart 1: Sources of Methods of Contraception and STI Prevention for Adolescents

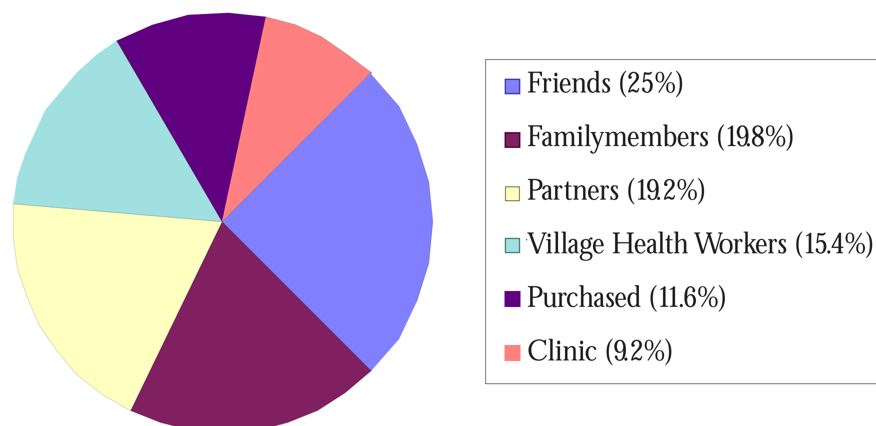

Table 1: Methods of Contraception or STI Prevention Used by Sexually-Active Adolescents[421]

Method	Percentage
Condoms	60%
Pills	30%
Other	10%

Table 2: Reasons Cited for the Minimal use of Methods of Contraception or STI Prevention Among Sex Workers on First Sexual Encounter

Reason	Percentage of Sex Workers
Lack information about family planning methods and services	60%
Forced into sex/raped	30%
Didn't want to bother the boyfriend	10%

Table 3: Sources of Information on Contraception and STI Prevention for Adolescents

The total percentage is cumulative, as adolescents mentioned more than one source of family planning information.

	Media	Friend	Family Members	Clinic	Village Health Workers	Partner	School
Girls (%)	8	6.9	3.9	2.2	2.5	1.3	5
Boys (%)	7.7	7.2	6.5	3	4.5	-	4
Total %	**50**	**45**	**30**	**12**	**13**	**4**	**27**

Table 4: Adolescents' Sources of Information on Contraception and STI Prevention in Urban v. Rural Areas

The total percentage is cumulative, as adolescents mentioned more than one source of family planning information.

Source of Information	% Urban Areas	% Rural Areas
Media	73	27
Friends	49	41
Family Members	24	36
Clinics/Hospitals	16	9
Schools	12	15
Partner	3	5
Village Health Workers	5	21
Youth Centers	2	-
Pharmacies/Doctors	1	-

Table 5: Obstacles Faced by Sex Workers in Accessing Services and Information on Contraception and STI Prevention

Problem	Percentage
Age restrictions	40%
Staff attitude	32%
Lack of confidentiality	22%
Few clinics	6%

Endnotes

1 *Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, Sept. 5-13, 1994, para. 7.3, U.N. Doc. A/CONF.171/13/Rev.1 (1995) [hereinafter *ICPD Programme of Action*].
2 *Id.* at para. 7.46.
3 Dual Protection can also include avoidance of all types of penetrative sex and mutual monogamy between uninfected partners using one form of contraception. However, these practices are considered impractical, particularly for women and adolescent girls. Center for Health and Gender Equity, Prevention Now: Promoting Gender Sensitive Dual Protection Strategies (on file at CRLP) [hereinafter Center for Health and Gender Equity].
4 Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec. 18, 1979, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, art. 5(a), U.N. Doc. A/34/46 (1979) (*entered into force* Sept. 3, 1981) [hereinafter CEDAW].
5 *See* Center for Health and Gender Equity, *supra* note 3.
6 United Nations Population Fund (UNFPA), The Sexual and Reproductive Health of Adolescents, Technical and Policy Division Draft Report 2 (1998) [hereinafter Technical Report].
7 Convention on the Rights of the Child, *adopted* Nov. 20, 1989, G.A. Res. 44/25, U.N. GAOR, 44th Sess., Supp. No. 49, at 166, art. 1, U.N. Doc.A/44/49 (1989) (*entered into force* Sept. 2, 1990) [hereinafter Children's Rights Convention].
8 The young people interviewed for this report were between the ages of nine and 23. For further details, see Section C of the "Introduction."
9 *See* Central Statistical Office & Macro International Inc., Zimbabwe Demographic and Health Survey 1994 10 (1995) [hereinafter Demographic Survey 1994].
10 *See* National Economic Planning Commission, Zimbabwe National Population Policy 46, 52 (1998) [hereinafter Population Policy]. Although the Ministry of National Affairs has responsibility for the development of a National Youth Policy, the timeframe for its development remains unclear; *See also* A. Klofkorn, Family and Child Health of the Ministry of Health and Child Welfare Dep't & United Nations Population Fund (UNFPA), Assessment of Adolescent Reproductive Health Needs in Zimbabwe 18 (1999) [hereinafter Assessment of Adolescent RH Needs].
11 *See* Alan Guttmacher Institute, Issues in Brief: Risks and Realities of Early Childbearing Worldwide (1997), *available at* http://www.guttmacher.org/pubs/ib10.html (last visited Mar. 19, 2002).
12 *See* Alan Guttmacher Institute, Into a New World 32 (1998), *citing* AP McCauley & C. Salter, *Meeting the Needs of Young Adults*, J:141 Population Reports 14-15 (1995).
13 In Chile and Argentina, for example, more than one-third of maternal deaths among adolescents are a direct result of unsafe abortions. Aruna Radhakrishna et al., *Adolescent Women Face Triple Jeopardy: Unwanted Pregnancy, HIV/AIDS and Unsafe Abortion*, 2/97 Women's Health J. 58 (Latin American and Caribbean Women's Health Network, 1997), *citing* Jeanne Noble et al., Population Reference Bureau, The World's Youth 1996 (1996). The World Health Organization has estimated that in many African countries, up to 70% of all women hospitalized for abortion complications are under age 20. Family Care International (FCI) & the Safe Motherhood Inter-Agency Group (IAG), Safe Motherhood Factsheet: Address Unsafe Abortions 1-2 (1998), *citing* World Health Organization, The Health of Young People: A Challenge and a Promise (1993).
14 *See* The Center for Reproductive Law and Policy (CRLP), Adolescent Reproductive Rights: Laws and Policies to Improve their Health and Lives 11 (1999).
15 *See* Joint United Nations Programme on HIV/AIDS (UNAIDS) & World Health Organization (WHO), AIDS Epidemic Update: December 2001 2 (2001), *available at* http://www.unaids.org/worldaidsday/2001/Epiupdate2001/Epiupdate2001_en.pdf (last visited Apr. 2, 2002) [hereinafter AIDS Epidemic Update: December 2001].
16 *See* Joint United Nations Programme on HIV/AIDS (UNAIDS) & World Health Organization (WHO), Children and Young People in the World of AIDS 2 (2001), *available at* http://www.unaids.org/publications/documents/children/children/JC656-Child&Aids-E.pdf (last visited Apr.

2, 2002).

17 *See* Joint United Nations Programme on HIV/AIDS (UNAIDS) & World Health Organization (WHO), Report on the Global HIV/AIDS Epidemic-June 2000 (2000), *available at* www.unaids.org/epidemic_update/report/Final_Table_Eng_Xcel.xls (last visited Apr. 2, 2002) [hereinafter Report on the Global HIV/AIDS Epidemic].

18 *See* AIDS Epidemic Update: December 2001, *supra* note 15, at 6.

19 *See* Assessment of Adolescent RH Needs, *supra* note 10, at ii.

20 *See* Demographic Survey 1994, *supra* note 9, at 10.

21 *See* United Nations Population Division (UNDP), World Population Prospects Population Database: Zimbabwe Demographic Profile, *available at* http://esa.un.org/unpp/p2k0data.asp (last visited Mar. 27, 2002).

22 *See* Assessment of Adolescent RH Needs, *supra* note 10, at 1.

23 The adult HIV/AIDS prevalence rate is approximately 25%. *See* Joint United Nations Programme on HIV/AIDS (UNAIDS) & World Health Organization (WHO), Epidemiological Fact Sheet on HIV/AIDS and Sexually Transmitted Infections 2000 Update (Revised): Zimbabwe 3 (2000), *available at* http://www.unaids.org/hivaidsinfo/statistics/june00/fact_sheets/pdfs/zimbabwe.pdf (last visited Mar. 13, 2002) [hereinafter Epidemiological Fact Sheet on HIV/AIDS].

24 The maternal mortality rate for Zimbabwe is approximately 610 deaths per 100,000 live births. *See* World Health Organization (WHO), Maternal Mortality in 1995: Estimates Developed by WHO, UNICEF, UNFPA 38 (2001), *available at* http://www.who.int/reproductive-health/publications/RHR_01_9_maternal_mortality_estimates/index.en.html [hereinafter WHO Maternal Mortality]; *See also* United Nations Population Fund (UNFPA), The State of the World Population 2001 67 (2001).

25 General Law Amendment Act (commonly referred to as the Legal Age of Majority Act), ch. 8:07, § 15 (1982).

26 Interview with Zimbabwean traditional healer, Zimbabwe (Sept. 1, 2000) (on file with CLF & CRLP).

27 *See* Assessment of Adolescent RH Needs, *supra* note 10, at 8.

28 In fact, of adolescents interviewed for this report, slightly more than 50% of both boys and girls have their first sexual encounter at the age of 12; more than 85% of both sexes have sexual relations by 16. Stakeholders also concurred that often adolescents have their first sexual experience as early as 12. *See Child and Law Foundation (CLF) & Center for Reproductive Law and Policy (CRLP), Survey of 802 Adolescents, Parents, Sex Workers, Service Providers and Various Stakeholders* (Aug.– Oct. 2000) (on file with CLF & CRLP) [hereinafter *CLF & CRLP Survey*].

29 *See* Ministry of Health and Child Welfare, National Health Strategy for Zimbabwe 1997-2007 20 (1999) [hereinafter National Health Strategy], *citing* Central Statistics Office (DHS-CSO), 1994 Demographic Health Survey (1994).

30 For the purposes of this report, the term 'sex workers' means those who support themselves almost exclusively by providing sexual services for money or things of value. It does not include those who occasionally exchange sex for money. We interviewed 30 sex workers, all adolescent girls between the ages of 13 to 19 years. The interviews were conducted in Harare and Chitungwiza with volunteer child sex workers who were arrested by the police. *See CLF & CRLP Survey, supra* note 28; *See also* Appendix A, Table 1, 3 & 5.

31 A big demand for teenage sexual partners has incited many adolescent girls, as young as 14 years, to become sex workers. Their clients are much older men. *See CLF & CRLP Survey, supra* note 28.

32 Interview with Mr. Godfrey Tinarwo, Executive Director, ZNFPC, Bulawayo, Zimbabwe (Aug. 8, 2000) (on file with CLF & CRLP).

33 *See* Population Policy, *supra* note 10, at 22.

34 *See* Assessment of Adolescent RH Needs, *supra* note 10, at 12.

35 *See id.* at 12-13.

36 *See id.* at 13.

37 Interview with Zimbabwean adolescent, Zimbabwe (Aug.-Oct. 2000) (on file with CLF).

38 *See* Joint United Nations Programme on HIV/AIDS (UNAIDS), Gender and HIV/AIDS: Taking stock of research and programmes 5 (1999), *available at* http://www.unaids.org/publications/documents/human/gender/una99e16.pdf (last visited Mar. 13, 2002).

39 *See id.* at 14.

40 *See* Report on the Global HIV/AIDS Epidemic, *supra* note 17.
41 They only learned of their condition when they sought prenatal care. *See* Joint United Nations Programme on HIV/AIDS (UNAIDS), Force for Change: World AIDS Campaign with Young People: 1998 World AIDS Campaign Briefing Paper 3 (1998), *available at* http://www.unaids.org/wac/1998/force-e.pdf (last visited Mar. 13, 2002).
42 Patrice Engle, UNICEF, Men in Families: Report of a Consultation on the Role of Males and Fathers in Achieving Gender Equality pt. 2, *at* http://www.unicef.org/reseval/malesr.html#exec (last visited Mar. 13, 2002).
43 *See* Assessment of Adolescent RH Needs, *supra* note 10, at 15.
44 *See id.*
45 *See id.* at 5.
46 Interviews revealed a disturbing disconnect between adolescent awareness of the HIV/AIDS pandemic and their failure to take protective measures. While the adolescents interviewed were aware of the issue of HIV/AIDS and other STIs, they did not know how to prevent infection. The adolescents interviewed understand HIV/AIDS to be an incurable disease that affects many people. For example, some adolescents identified it as a "deadly virus" and a "killer disease" that claims many lives daily. Approximately 66% of the adolescents expressed great concern and reported being scared about HIV/AIDS in responding to the questionnaire. *See CLF & CRLP Survey, supra* note 28.
47 For example, some adolescents believed that a bath after sex prevented infection. Others believed that AIDS is witchcraft. Many adolescents said that if the boy or girl is well-behaved and looks fit, he or she was necessarily AIDS-free. Many adolescents distance the HIV/AIDS issue from themselves—both by speaking about other adolescents, not themselves, and by expressing the view that it only happens to other people. For example, many believed that HIV/AIDS affects the aged and sex workers, but not them. *See id.*
48 Assessment of Adolescent RH Needs, *supra* note 10, at 5.
49 *Id.* at iii. The results of our research also show very low contraception usage rates among adolescents. Only 14% of female adolescents interviewed reported that they had ever used any method of contraception or STI prevention and only 6.2% of the 340 adolescents interviewed reported using a method of contraception or STI prevention during their first sexual experience. *See CLF & CRLP Survey, supra* note 28.
50 Only 6.2% of the 340 adolescents interviewed reported using methods of contraception or STI prevention during their first sexual experience. The adolescents interviewed reported a variety of reasons for not using dual protection methods during the first sexual encounter, including lack of accurate information, reliance upon myths, personal preference, and lack of control over the situation, including rape. Only 14% of female adolescents interviewed reported that they had ever used any method of contraception or STI prevention. *See id.*
51 Assessment of Adolescent RH Needs, *supra* note 10, at iv.
52 *See id.* at 5.
53 Some expressed the view that this would reduce the spread of STIs including HIV/AIDS, guard against unwanted pregnancies that often result in unsafe abortions, infanticide and suicide, regulate childbirth, and reduce the number of street children. These interviewees felt that if adolescent girls used contraceptives, fewer girls would fall pregnant and be chased away from their homes by their parents. *See CLF & CRLP Survey, supra* note 28.
54 *See* UNFPA, *supra* note 24, at 70.
55 *See id. See also* The World Bank Group, World Development Indicators Database: Zimbabwe Data Profile (2000), *available at* http://devdata.worldbank.org/external/CPProfile.asp?SelectedCountry=ZWE&CCODE=ZWE&CNAME=Zimbabwe&PTYPE=CP (last visited Apr. 2, 2002) [hereinafter Zimbabwe Data Profile].
56 *See* Bureau of Democracy, Human Rights, and Labor, U.S. Dep't of State, Zimbabwe Country Report on Human Rights Practices for 1999 § 5 (2000), *available at* http://www.state.gov/www/global/human_rights/1999_hrp_report/zimbabwe.html (released Feb. 25, 2000).
57 *See* Central Intelligence Agency (CIA), The World Factbook 2000 – Zimbabwe, *available at* http://www.cia.gov/cia/publications/factbook/geos/zi/html (last visited Apr. 2, 2002) [hereinafter CIA World Factbook]. There is an official separation of church and state, and Islamic law and institutions are generally not

a part of the legal or political landscape. Women in Law & Development in Africa (WiLDAF), Reproductive Health Rights in Zimbabwe 1 (1996) (unpublished paper on file at CRLP).
58 *See* CIA World Factbook, *supra* note 57.
59 *See* National Democratic Institute (NDI), *NDI Reports: A Review of Political Development in New Democracies – Southern Africa* (Winter 2000), *available at* http://www.ndi.org/ndi/about/reports/ndireportswinter2000/ndireportswinter2000.htm [hereinafter NDI].
60 *See, e.g, id;* The Economist Intelligence Unit, *Latest Country Analysis – Zimbabwe: Mug's Game* (July 27, 2000), *available at* http://www.eiu.com/latest/389257.asp (last visited July 18, 2001).
61 *See* BBC News, *Zimbabwe: An election observer's tale* (Mar. 13, 2002), *at* http://news.bbc.co.uk/hi/english/world/africa/newsid_1868000/1868790.stm.
62 *See* Edmund L. Andrews, *Denunciation of Mugabe by Europeans Intensifies*, N.Y. Times, Mar. 16, 2002, *available at* http://www.nytimes.com/2002/03/16/international/afirca/16ZIMB.html.
63 *See* Henri E. Cauvin, *Mugabe Takes Office Again, Appealing for National Unity*, N.Y. Times, Mar. 18, 2002, *available at* http://www.nytimes.com/2002/03/18/international/afirca/18ZIMB.html.
64 *See* The World Bank, World Development Indicators 2001 377 (2001), *available at* www.worldbank.org/data/wdi2001/pdfs/acronyms.pdf (last visited Apr. 1, 2001).
65 *See* Zimbabwe Data Profile, *supra* note 55.
66 *See* The World Bank, World Development Indicators 2000 48 (2000) [hereinafter Indicators 2000].
67 *See* Women's Environment and Development Organization (WEDO), Risks, Rights and Reforms 74 (1999).
68 *See* NDI, *supra* note 59.
69 *See* United Nations Development Programme (UNDP), Human Development Report 1994 149 (1994).
70 *See* Dep't of Health Services Planning & Management, Ministry of Health [Zimb.], Planning for Equity in Health: 1992 *Revision*, art. 4, at 7 (1992 [hereinafter Planning for Equity in Health].
71 Family planning and reproductive health services are provided primarily through the para-statal organization Zimbabwe National Family Planning Service. *See* Zimbabwe National Family Planning Council, Zimbabwe National Family Planning Programme Service Delivery Policies and Standards: November 1994 1 (1995) [hereinafter Service Delivery Policies].
72 The practice of a traditional medical practitioner is defined to be "every act, the object of which is to treat, identify, analyze or diagnose, without the application of operative surgery, any illness of body or mind by traditional methods." Traditional Medical Practitioner Act, ch. 27:14, § 2(2)
73 Natural therapists include homeopaths, naturopaths and osteopaths. Natural Therapists Act, No. 31, § 2(1) (1981). Natural therapists are usually white Zimbabweans or foreigners. WiLDAF, *supra* note 57, at 3.
74 *See* Demographic Survey 1994, *supra* note 9, at 4.
75 *See* WEDO, *supra* note 67, at 72.
76 *See* The Center for Reproductive Law and Policy (CRLP) & Women in Law and Development in Africa (WiLDAF), Women's Reproductive Rights in Zimbabwe: A Shadow Report 4 (1997) [hereinafter CRLP & WiLDAF].
77 *See* Indicators 2000, *supra* note 66, at 92.
78 *See* CRLP & WiLDAF, *supra* note 76, at 4.
79 *See* WEDO, *supra* note 67, at 72.
80 *See* WHO Maternal Mortality, *supra* note 24, at 38. *See also* UNFPA, *supra* note 24, at 67.
81 *See* UNFPA, *supra* note 24, at 67.
82 Only Botswana and Swaziland surpass Zimbabwe in terms of total prevalence rates of HIV/AIDS among the adult population between the ages of 15-49. *See* Report on the Global HIV/AIDS Epidemic, *supra* note 17.
83 *See* Epidemiological Fact Sheet on HIV/AIDS, *supra* note 23, at 3.
84 *See id.*
85 *See* National AIDS Coordination Programme, Ministry of Health and Child Welfare, HIV/AIDS in Zimbabwe: Background, Projections, Impact, Interventions 34 (1998).
86 The government of Zimbabwe is heading an effort to replace the country's colonial-era constitution with a new set of national laws. Zimbabwe is presently governed under the Lancaster House Agreement, the document

that established the 1979 cease-fire between Zimbabwean Nationalists and the ruling European minority. *See* Lewis Machipisa, Inter Press Service, *Jubilation as Constitution is Rejected* (Feb. 15, 2000), WL 4089862.
87 Zimb. Const. (revised ed. 1996) § 3.
88 Zimb. Const. § 27-63, 79-92.
89 Zimb. Const. § 11.
90 Zimb. Const. § 89; *See also* Zimb. Const. § 113(1) (defining "law" for the purposes of constitutional interpretation); Customary Law & Local Courts Act, ch. 7:05, § 2 (revised ed. 1996) (defining "the general law of Zimbabwe").
91 African customary law in Zimbabwe is diverse, often differing from tribe to tribe, and different systems of customary law may be implicated by a single claim. Zimb. Const. § 89.
92 *See generally* Customary Law & Local Courts Act, ch. 7:05 (revised ed. 1996). The colonial judicial system had two court hierarchies, one for Africans and the other for non-Africans. Development, Innovations and Networks (IRED), Women, Law, Development (1996) (unpublished paper on file at CRLP). A highly criticized draft constitution was proposed by a presidential-appointed commission in 1999 and rejected by voters during a February 2000 national referendum. *See* M2 Presswire, *Constitutional Reform* (Feb. 2, 2000), WL 4799118.
93 *See* Zimb. Const. § 111B(1)(B).
94 Termination of Pregnancy Act, ch. 15:10, § 4(c) (1978). Under the Sexual Offenses Act, "unlawful intercourse" includes extra-marital sexual intercourse, immoral acts or indecent acts committed with a young person or with and intellectually handicapped person. Sexual Offenses Act, ch. 9:21, § 3-4 (2001).
95 The constitution was amended to add gender as an impermissible grounds for discrimination in 1996. Zimb. Const. § 23(2), (3), *as amended by* Zimb. Const., amend. 14, § 9 (a), (b) (1996). However, Section 23, as amended, does allow laws or constitutional provisions, which take "due account of physiological differences between persons of different gender," or which are "in the interests of defence, public safety or public morality" to discriminate on the basis of gender. Zimb. Const. § 23(5), *as amended by* Zimb. Const., amend. 14, § 9(d) (1996) The only exception to this general rule is if that law or action "is shown not to be reasonably justifiable in a democratic society." Zimb. Const. § 23(5), *as amended by* Zimb. Const., amend. 14, § 9(d) (1996).
96 The Zimbabwean Constitution includes a prohibition against laws that discriminate on their face or in effect on the basis of "race, tribe, place of origin, political opinions, colour, or creed." Zimb. Const. § 23 (2). Section 23 (1) (a) and (b) states that "no law shall make any provision that is discriminatory either of itself or in its effect; and no person shall be treated in a discriminatory manner by any person acting by virtue of any written law or in the performance of the functions of any public office or any public authority." Zimb. Const. § 23 (1) (a-b).
97 Article 23(3) states that "Nothing contained in any law shall be held to be in contravention of subsection (1)(a) to the extent that the law in question relates to any of the following matters—(a) adoption, marriage, divorce, burial, devolution of property on death or other matters of personal law; (b) the application of African customary law. . . ." Zimb. Const. § 23 (3) (a-b). In reality this exemption from the prohibition on discriminatory laws may undermine women's right to be free from gender discrimination as laws involving personal matters tend to negatively affect women and girls. If these laws are not subject to the non-discrimination provisions of the Constitution, girls will be more likely to be adversely affected.
98 Section 20 (1) states that "Except . . . by way of parental discipline, no person shall be hindered in the enjoyment of his freedom of expression, that is to say, freedom to hold opinions and to receive and impart ideas and information without interference, and freedom from interference with his correspondence." Zimb. Const. § 20 (1)
99 *Id.*
100 Section 17 (1-3) states that "[e]xcept with his own consent or by way of parental discipline, no person shall be subjected to the search of his person or his property or the entry by others on his premises. . . . Nothing . . . shall be held to be in contravention of subsection (1) to the extent that the law in question makes provision—in the interests of defence, public safety, public order, public morality, public health or town and country planning. . . ." Zimb. Const. § 17 (1-3)
101 General Law Amendment Act (commonly referred to as the Legal Age of Majority Act), ch. 8:07, § 15 (1-3) (1982).
102 Marriage Act, ch. 5:11, § 22 (1) (revised ed. 1996).

103 *Id.*
104 Customary Marriages Act, ch. 5:07, § 4 (revised ed. 1996).
105 Zimb. Const. § 23 (3)(a).
106 Sexual Offences Act, ch. 9:21, § 23 (2001) amends the Criminal Law Amendment Act, ch. 9:05 (revised ed. 1996) in part. The Sexual Offenses Act was passed by parliament in May 2001, and amended the Criminal Law Amendment Act. *See* The Center for Reproductive Law and Policy (CRLP) et. al., Women of the World: Laws and Polices Affecting Their Reproductive Lives Anglophone Africa, 2001 Progress Report 138 (2001) [hereinafter Women of the World].
107 Sexual Offences Act, ch. 9:21, § 3 (2) (2001). Part I, Section 2 (1) defines "young person" as a boy or girl under the age of sixteen years. *Id.* § 2 (1).
108 Under the act, it is an offense for a person who "having actual knowledge that he is infected with HIV, intentionally does anything or permits the doing of anything which he knows or ought reasonably to know" will transmit or is likely to transmit HIV infection to another person. Sexual Offenses Act § 15 (1) (2001). This provision was passed as law by Zimbabwe's parliament in mid-May 2001. UN Wire, *Zimbabwe To Punish Those Who Knowingly Spread Virus,* (May 23, 2001), *at* http://www.unfoundation.org/unwire/archives/UNWIRE010523.asp.
109 Section 20 (1) states that "no person shall be hindered in the enjoyment of his freedom of expression, that is to say, freedom to hold opinions and to receive and impart ideas and information without interference, and freedom from interference with his correspondence." Zimb. Const. § 20(1).
110 Zimb. Const. § 17.
111 General Law Amendment Act (commonly referred to as the Legal Age of Majority Act), ch. 8:07, § 15 (1-3) (1982).
112 Sexual Offences Act, ch. 9:21, § 3 (2)(a) (2001).
113 The Preamble of the Sexual Offences Bill states that the Criminal Law Amendment Act was "outdated in many respects and discriminatory against women." Sexual Offences Bill (2000), memorandum at 1. The Sexual Offences Act eliminated any distinction between the minimum age for statutory rape against women and men.
114 Section 2 (1) defines "young person" as a boy or girl under the age of sixteen years. Sexual Offences Act, § 2 (1) (2001). However, the law does permit sexual intercourse between two minors between the ages of 12 and 16, since one defense to the charge of statutory rape is if the accused is under the age of sixteen at the time of the offense. Sexual Offences Act, ch. 9:21, § 3 (2)(a) (2001).
115 This is based on feedback obtained from service providers as well as an analysis of the relevant laws. *See CLF & CRLP Survey, supra* note 28.
116 Growth with Equity: An Economic Policy Statement ¶ 85, at 12 (Republic of Zimbabwe 1981).
117 Ministry of Health & Child Welfare, Patient's Charter: Zimbabwe 1996 § 1.2 (1996) [hereinafter Patient's Charter].
118 Ministry of Health & Child Welfare, Health Human Resources Master Plan: Part I, 1993-1997, at 1 (unpublished paper on file at CRLP).
119 *See* Planning for Equity in Health, *supra* note 70, art. 2.1, at 3.
120 National Health Strategy, *supra* note 29, xv.
121 Service Delivery Policies, *supra* note 71.
122 National Economic Planning Commission, Gov't of Zimb., Zimbabwe National Report on Population, in preparation for the International Conference on Population and Development (1994).
123 Population Policy, *supra* note 10, 15 § 1.1. It further states that "[t]he Government realises that unless women are fully integrated into the main stream of development, efforts to improve their standards of living cannot be realised." *Id.* at 15 § 1.10.
124 *Id.* at 6-7; *See also id.* at 39 § 4.2.2.
125 *Id.* at 15 § 1.10-1.11.
126 *Id.* at 15 § 1.11; *See also id.* at 15 § 1.11 & 21 § 2.3.1 where the policy acknowledges that the government has failed to adequately address youths' problems in many development plans, even though youth constitute 37 % of the total population (1997 ICDS), with 43% of the youth population below 15 years (1997 ICDS).
127 *Id.* at 15 § 1.11.
128 *Id.* at 43 § 4.3.6.6.

129 *Id*. at 47 § 4.4.14.
130 *Id*. at 55 § 5.10.1.
131 *Id*. at 55 § 5.10.4.
132 *Id*. at 55 § 5.10.5.
133 *See infra* Chapter III: Violations of the International Human Rights of Adolescents, Section B.
134 "The Government of Zimbabwe envisions achievement of the highest possible level of health and quality of life for all its citizens through the combined efforts of individuals, communities, organisations and the government." National Health Strategy, *supra* note 29, at xi.
135 *Id.* at xiii, 52.
136 "Maternal health, child health and family planning will now fall under Reproductive Health Services, which cover the health needs of both women and men." *Id.* at 57.
137 *Id.* at 47, Action 5.
138 *Id.* at 57.
139 *Id.* at 57, Objective 2 & corresponding Actions.
140 *Id.* at 47, Objective 5.
141 *Id.* at 46.
142 *Id.* This Strategy sets forth an agenda geared to improving adolescent's access to reproductive health services, and, at the same time, the country's socioeconomic development. *Id.*
143 Republic of Zimbabwe, National Policy on HIV/AIDS for the Republic of Zimbabwe 20 (1999) [hereinafter HIV/AIDS Policy].
144 Specifically, consent for testing is given to the parent or legal guardian of a child under 16 and accused sex offenders are tested regardless of their wishes. *Id.* at 16, 19. In addition, the HIV/AIDS Policy encourages "shared confidentiality," in which health practitioners may reveal the HIV-positive status of a patient to his or her partners, overriding traditional doctor-patient confidentiality. *Id.* at 6, 20-21.
145 The President of the Republic of Zimbabwe states that "previous and current actions against HIV/AIDS have proved to be inadequate with limited scope and effectiveness as evidenced by the rising levels of HIV infections especially among young people. . . ." *Id.* at v.
146 *Id.* at 23, § 6.5.
147 *Id.* at 9, § 4.3 (guiding principle 9).
148 *Id.* at 10, § 4.3.
149 *Id.* at 22, § 6.5.
150 *Id.* at 24, § 6.5.1.
151 *Id.* at 8, § 4.1.
152 *Id.* at 23, § 6.5.
153 *Id.* at 23, § 6.5 (guiding principle 27).
154 *Id.* at 30, § 7.1. As part of its educational plan, it will discourage individuals "from high-risk behaviour such as multiple partners, unprotected sex, alcohol and drug abuse." *Id.*
155 *Id.*
156 *Id.* at 23, § 6.5 (guiding principle 27).
157 *Id.* at 32, § 8.1.
158 *Id.*
159 *Id.* at 16, § 5.3.2.
160 *Id.* at 24, § 6.5.1.
161 Service Delivery Policies, *supra* note 71, at 1.
162 *Id.* at 10. § 3.1.
163 *Id.* at 10, § 3.2.
164 *Id.* at 10, § 3.3.
165 *Id.* at 10.
166 *Id.* at 8.
167 *Id*.
168 This document was produced by the Ministry of Health and Child Welfare in collaboration with the

Consumer Council of Zimbabwe.

169 The Patient's Charter section 6.1 provides that patients have a right to know their prognosis and everything about their medical problem and that, "[a] patient shall have the right to know the identity and professional status of the individuals providing service to the patient and to know which health professional is primarily responsible for the patient's care including the right to adequate and coherent information on prescribed and purchased medicines." Patient's Charter, *supra* note 117, at § 6.1.

170 Section 3.1 states that, "[p]atients shall be interviewed, examined and treated in surroundings designed to ensure reasonable privacy and shall have the right to be accompanied during any physical examination or treatment if one so wishes." *Id.* at § 3.1.

171 *Id.* at § 2.1. Patients have a "right to have the details of [their] condition, treatment (including the use of new technology) prognosis and all communication and other records relating to the patient's care to be treated as confidential." *Id.* at § 3.1.

172 Section 6.1 states "[i]n the case of a child the informed consent shall be obtained from the parent or guardian." *Id.* at § 6.1.

173 *Id.* at § 2.1.

174 *Id.*

175 *See, e.g,* HIV/AIDS Policy, *supra* note 143, at 32, § 8.1.

176 *See, e.g,* Population Policy, *supra* note 10, at 15, § 1.11 & 10, § 3.2.

177 Service Delivery Policies, *supra* note 71, at 10, § 3.1.

178 *Id.* at 10, § 3.1.

179 *See id.* at 10, § 3.3.

180 HIV/AIDS Policy, *supra* note 143, at 24, § 6.5.1 (guiding principle 6.5.1).

181 *Id.* at 23, § 6.5.

182 *Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Zimbabwe*, 336-367th, 372nd mtgs., para. 160, U.N. Doc. A/53/38, paras. 120-166 (1998) [hereinafter *Concluding Observations CEDAW: Zimbabwe*].

183 *ICPD Programme of Action, supra* note 1.

184 *Id.* at para. 7.47.

185 *See, e.g,* Article 5 of the Children's Rights Convention maintains: "States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention." Children's Rights Convention, *supra* note 7, art. 5. The "evolving capacities" standard is also specifically referenced in relation to the child's right to express "his or her own view" (Article 12(1)) and "the child's right to freedom of thought"(Article 14.1). *Id.* at art. 12(1), 14(1). Article 9 (on the right to freedom of Thought, Conscience and Religion) of the African Charter on the Rights and Welfare of the Child requires parents "to provide guidance and direction" with "regard to the child's evolving capacities, and best interests of the child." African Charter on the Rights and Welfare of the Child, art. 9(2), OAU Doc. CAB/LEG/24.0/49 (1990) (*entered into force* Nov. 29, 1999) [hereinafter African Children's Charter]. Article 11 (4) (on the right to education) requires states parties to guarantee "the rights and duties of parents" and "to ensure, the religious and moral education of the child in a manner consistent with the evolving capacities of the child." *Id.* at art. 11(4).

186 *See, e.g,* Article 3 (1) states: "In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration. " Children's Rights Convention, *supra* note 7, art. 3 (1). At the regional level, Article 4 (1) holds that "[i]n all actions concerning the child undertaken by any person or authority the best interests of the child shall be the primary consideration." *African Children's Charter, supra* note 185, art. 4(1).

187 *See* Corinne A.A. Packer, *Preventing adolescent pregnancy: the protection offered by international human rights law*, 5 The Int'l J. of Child. Rts. 47, 64 (1997) [hereinafter Packer].

188 International laws are not included as sources of law in the Constitution; they must be enacted by Parliament in order to become domestic law. Zimb. Const. § 111B(1)(b)

[189] The Universal Declaration is regarded as the primary human rights instrument from which later human rights treaties are derived, an it is binding on all nations. Universal Declaration of Human Rights, *adopted* Dec. 10, 1948, G.A. Res. 217A (III), at 71, U.N. Doc. A/810 (1948) [hereinafter Universal Declaration].
[190] International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, at 49, U.N. Doc A/6316 (1966), 999 U.N.T.S. 3 (*entered into force* Jan. 3, 1976) [hereinafter Economic, Social and Cultural Rights Covenant].
[191] International Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc A/6316 (1966), 999 U.N.T.S. 171 *(entered into force* Mar. 23, 1976) [hereinafter Civil and Political Rights Covenant].
[192] CEDAW, *supra* note 4.
[193] Children's Rights Convention, *supra* note 7.
[194] African [Banjul] Charter on Human and People's Rights, OAU Doc. CAB/LEG/67/3 rev.5, 21 I.L.M. (1982) (*entered into force* Oct. 21, 1986) [hereinafter Banjul Charter].
[195] African Children's Charter, *supra* note 185.
[196] The major international human rights treaties provide for the establishment of bodies whose primary mandate is to examine country reports which are submitted on a periodic basis by states parties regarding their efforts to respect, protect, and fulfill the human rights enshrined in the each particular treaty. Their response to states parties country reports is in the form of recommendations found in the concluding observations or comments of the treaty body. See, e.g., CEDAW, *supra* note 4; Children's Rights Convention, *supra* note 7; Civil and Political Rights Covenant, *supra* note 191; Economic, Social and Cultural Rights Covenant, *supra* note 190; International Convention on the Elimination of All Forms of Racial Discrimination, 660 U.N.T.S. 195 (*entered into force* Jan. 4, 1969); and Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *adopted* Dec. 10, 1984, G.A. Res. 39/46, UN GAOR, 39th Sess., Supp. No. 51, at 197, UN Doc. A/39/51 (1984), 1465 U.N.T.S. 85 (*entered into force* June 26, 1987). In addition, some treaty monitoring bodies have the authority to issue general comments or recommendations to elaborate on broadly worded human rights guarantees found in the treaty, providing states parties with a guide to their interpretation. *See* Andrew Byrnes, *Toward More Effective Enforcement of Women's Human Rights Through the Use of International Human Rights Laws and Procedures, in* Human Rights of Women 218 (Rebecca Cook ed., 1994). Some treaty monitoring bodies have also been empowered to examine individual complaints of human rights violations. The following treaties have either an additional optional protocol empowering the treaty monitoring body to hear individual complaints, or a similar mechanism found in the treaty itself: CEDAW, Civil and Political Rights Covenant, International Convention on the Elimination of All Forms of Racial Discrimination, and the Convention against Torture, Inhuman, Cruel and Degrading Treatment.
[197] The Human Rights Committee monitors states parties' compliance with the Civil and Political Rights Covenant; the Committee on Economic, Social and Cultural Rights monitors states parties compliance with the Economic, Social and Cultural Covenant; the Committee on the Elimination of All forms of Discrimination Against Women monitors states parties' compliance with the CEDAW; the Committee on the Rights of the Child monitors states parties' compliance with the Children's Rights Convention.
[198] *Beijing Declaration and Platform for Action, Fourth World Conference on Women*, Beijing, China, Sept. 4-15, 1995, U.N. Doc. DPI/1766/Wom (1996) [hereinafter *Beijing Declaration and Platform for Action*].
[199] *See* Rebecca J. Cook & B.M. Dickens, *Recognizing adolescents' "evolving capacities" to exercise choice in reproductive healthcare*, 70:1 Int'l J. of Gynecology & Obstetric 13,18 (2000) [hereinafter Cook & Dickens].
[200] *See* Bruce C. Hafen & Jonathan O. Hafen, 37 Harv. Int'l L.J. 449, 449 (1996); *See also* Rhonda Gay Hartman, *Adolescent Autonomy: Clarifying an Ageless Conundrum*, 51 Hastings L.J. 1265, 1270 (2000) [hereinafter Hartman].
[201] Children's Rights Convention, *supra* note 7, art. 1.
[202] *See* Packer, *supra* note 187, at 64-65.
[203] Children's Rights Convention, *supra* note 7, art. 5.
[204] *Id.* at art. 12.1.
[205] *See* Hartman, *supra* note 200, at 1270.
[206] *See, e.g,* Article 5 states, "States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or

other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention." Children's Rights Convention, *supra* note 7, art. 5.

207 *See* Packer, *supra* note 187, at 67.

208 *ICPD Programme of Action, supra* note 1, para. 7.45.

209 *See* Packer, *supra* note 187, at 74.

210 *See, e.g* For example, in Ethiopia, the Civil Code bars marriage contracts between men under the age of 18 years and women under the age of 15 years. Women of the World, *supra* note 106, at 22, citing Civ. Code art. 581.

211 Once married, adolescents are often considered to have attained majority and are thus allowed to enter into contracts on their own accord.

212 *See, e.g, Concluding Observations on the Committee on the Rights of the Child: Austria*, 20th Sess., 531st mtg., para. 15, U.N. Doc. CRC/C/15/Add.98 (1999) [hereinafter *Concluding Observations CRC: Austria*]; *Concluding Observations on the Committee on the Rights of the Child: Barbados*, 21st Sess., 534-536th mtgs., para. 25, U.N. Doc. CRC/C/15/Add.103 (1999) [hereinafter *Concluding Observations CRC: Barbados*]; *Concluding Observations on the Committee on the Rights of the Child: Benin,* 21st Sess., 543rd -544th mtgs., para. 25, U.N. Doc. CRC/C/15/Add.106 (1999) [hereinafter *Concluding Observations CRC: Benin*]; *Concluding Observations on the Committee on the Rights of the Child: Georgia*, 24th Sess., 619-620th mtgs., para. 22, U.N. Doc. CRC/C/15/Add.124 (2000) [hereinafter *Concluding Observations CRC: Georgia*]; *Concluding Observations on the Committee on the Rights of the Child: Mali*, 22nd Sess., 570th-572nd mtgs., para. 27, U.N. Doc. CRC/C/15/Add.113 (1999) [hereinafter *Concluding Observations CRC: Mali*]; *Concluding Observations on the Committee on the Rights of the Child: Malta*, 24th Sess., 633rd-634th mtgs., para. 21, U.N. Doc. CRC/C/15/Add.129 (2000) [hereinafter *Concluding Observations CRC: Malta*]; *Concluding Observations on the Committee on the Rights of the Child: Marshall Islands*, 25th Sess., 659-660th mtgs., para. 51, U.N. Doc. CRC/C/15/Add.139 (2000) [hereinafter *Concluding Observations CRC: Marshall Islands*]; *Concluding Observations on the Committee on the Rights of the Child: South Africa*, 23rd Sess., 609-611th mtgs., para. 31, U.N. Doc. CRC/C/15/Add.122 (2000) [hereinafter *Concluding Observations CRC: South Africa*]; and *Concluding Observations on the Committee on the Rights of the Child: Vanuatu*, 22nd Sess., 566th-567nd mtgs., para. 20, U.N. Doc. CRC/C/15/Add.111 (1999) [hereinafter *Concluding Observations CRC: Vanuatu*].

213 Children's Rights Convention, *supra* note 7, art. 3(1).

214 *Id.* at art. 18(1).

215 Article 4 of the charter provides that "[i]n all actions concerning the child undertaken by any person or authority the best interests of the child shall be the primary consideration." *African Children's Charter*, *supra* note 185, art. 4.

216 Children's Rights Convention, *supra* note 7, art. 24 (1).

217 *Id.* at art. 24 (2)(f).

218 *See* Packer, *supra* note 187, at 60.

219 *See id.* at 60-61. However, the Children's Rights Convention does acknowledge that age of majority may be reached before 18 in some states, which could exclude certain populations of children from benefiting from the protection of the Convention. The Committee on the Rights of Children should consider the legality of national laws granting majority to children below the age of 18 who marry under international law. Many advocates have argued that neither the child, nor any adult such as the child's parents, should be able to agree to marriage. Where there is any evidence of force, coercion or undue influence on a child, the marriage should be nullified. In fact the Committee should adopt the position that children who do marry merit special protection since the potential for abuse of their rights is particularly high.

220 Guaranteed by Article 13 which states that "[c]hild shall have the right to . . . receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of the child's choice." Children's Rights Convention, *supra* note 7, art. 13.

221 Guaranteed in Article 28 which holds that "States Parties recognize the right of the child to education." *Id.* at art. 28(1).

222 *Committee on the Rights of the Child, Report on the nineteenth session* (Geneva, Sept. 21- Oct. 9 1998), 19th Sess., para. 243 (n), U.N. Doc CRC/C/80 (1998) [hereinafter *CRC, Report on the 19th Session*].

223 Committee on the Rights of the Child, General Comment 1, The Aims of Education, U.N.Doc. CRC/GC/2001/1 (2001). [hereinafter CRC General Comment 1].
224 *Id.* at para. 9.
225 *Concluding Observations on the Committee on the Rights of the Child: Paraguay*, 15th Sess., 167-168th mtgs., paras. 23, 45, U.N. Doc. CRC/C/15/Add.75 (1997) [hereinafter *Concluding Observations CRC: Paraguay*]; *See also Concluding Observations on the Committee on the Rights of the Child: Hungary*, 18th Sess., 455-457th mtgs., para. 36, U.N. Doc. CRC/C/15/Add.87 (1998) [hereinafter *Concluding Observations CRC: Hungary*].
226 *Concluding Observations on the Committee on the Rights of the Child: Belarus*, 5th Sess., 124-125th mtgs., para. 14, U.N. Doc. CRC/C/15/Add.17 (1994); *Concluding Observations on the Committee on the Rights of the Child: Cuba*, 15th Sess., 374 -375th mtgs., para. 37, U.N. Doc. CRC/C/15/Add.72 (1997); *Concluding Observations on the Committee on the Rights of the Child: Holy See*, 10th Sess., 255-266th mtgs., para. 9, U.N. Doc. CRC/C/15/Add.46 (1995); *Concluding Observations on the Committee on the Rights of the Child: Pakistan*, 6th Sess., 132nd-134th mtgs., para. 29, U.N. Doc. CRC/C/15/Add.18 (1994); and *Concluding Observations on the Committee on the Rights of the Child: Ukraine*, 10th Sess., 239th-242nd mtgs., para. 23, U.N. Doc. CRC/C/15/Add.42 (1995).
227 *See, e.g, Concluding Observations CRC: Hungary, supra* note 225, paras. 21, 36.
228 *Concluding Observations of the Committee for the Rights of the Child: Djibouti*, 24th Sess., 637-638th mtgs., para. 46, U.N. Doc. CRC/C/15/Add.131 (2000) [hereinafter *Concluding Observations of the CRC: Djibouti*].
229 *See* Packer, *supra* note 187, at 62.
230 CEDAW, *supra* note 4, art. 12(1).
231 Article 10(h) of the Convention articulates very clearly the right of all women to have "access to specific educational information to help ensure the health and well-being of families, including information and advice on family planning." *Id.* at art. 10(h).
232 Committee on the Elimination of Discrimination Against Women, General Recommendation No. 24, Women and Health, 20th Sess., para. 18 (1999) [hereinafter CEDAW, General Recommendation No. 24].
233 *Id.*
234 *Id.* para. 23.
235 *See, e.g, Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Chile,* 21st Sess., 442nd-443rd mtgs., para. 227, U.N. Doc. CEDAW/A/54/38 (1999) [hereinafter *Concluding Observations CEDAW: Chile*]; *Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Dominican Republic*, 379-380th mtgs., para. 349, U.N. Doc. CEDAW/A/53/38 (1998).
236 *Concluding Observations CEDAW: Zimbabwe, supra* note 182, para. 148.
237 Economic, Social and Cultural Rights Covenant, *supra* note 190, art 12. While the Economic, Social and Cultural Rights Covenant does qualify the obligation of states parties to take steps "to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized." *Id.* art 2(1). This provision has been interpreted to require states "to begin immediately to take steps to fulfill their obligations under the Covenant." *The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights*, *adopted* Jan. 8, 1987, U.N. ESCOR, 43rd Sess., para. 21, U.N. Doc E/CN.4/1987/17/Annex (1987). The Limburg Principles were approved by a group of experts on human rights at Maastricht in 1986. They also recognized that states must ensure a minimum essential level of each right "regardless of the level of economic development." *Id.* at para 25.
238 Economic, Social and Cultural Rights Covenant, *supra* note 190, art. 12(2).
239 Committee on Economic, Social and Cultural Rights, General Comment 14, The right to the highest attainable standard of health, 22nd Sess., U.N. Doc. E/C.12/2000/4 (2000) [hereinafter CESCR, General Comment 14].
240 *Id.* at para 23.
241 *See, e.g, Concluding Observations of the Committee on Economic, Social and Cultural Rights: Cameroon,* 41st-43rd mtgs., para. 45, U.N. Doc.E/C.12/1/Add.40 (1999) [hereinafter *Concluding Observation CESCR: Cameroon*].
242 Committee on Economic, Social and Cultural Rights, General Comment 13, The right to education (Art. 13), 21st Sess., para. 6(d), U.N. Doc. E/C.12/1999/10 (1999) [hereinafter CESCR, General Comment 13].
243 *See, e.g, Concluding Observations of the Committee on Economic, Social and Cultural Rights: Armenia,* 21st Sess., 38-40th mtgs., para. 15, U.N. Doc.E/C.12/1/Add.39 (1999) [hereinafter *Concluding Observation CESCR: Armenia*];

Concluding Observation CESCR: Cameroon, supra note 240, para. 45; *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Mexico,* 21st Sess., 44–46th mtgs., para. 43, U.N. Doc.E/C.12/1/Add.41 (1999); *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Poland,* 18th Sess., 26th mtg., para. 20, U.N. Doc.E/C.12/1/Add.26 (1998); *Review of the implementation of the Committee on Economic, Social and Cultural Rights: Saint Vincent and the Grenadines,* 45th mtg., para. 10, U.N. Doc.E/C.12/1/Add.21 (1997).

244 *See, e.g, Concluding Observation CESCR: Armenia, supra* note 243, para. 15.

245 *Concluding Observations of the Human Rights Committee: Ecuador*, 63rd Sess., 1673rd-1674th mtgs., para. 11, U.N. Doc. CCPR/C/79/Add.92 (1998) [hereinafter *Concluding Observations HRC: Ecuador*].

246 Civil and Political Rights Covenant, *supra* note 191, art. 19.2. For example, in its concluding observations to Poland, the committee asked the state party to, "introduce policies and programmes promoting full and non-discriminatory access to all methods of family planning and reintroduce sexual education at public schools." *Concluding Observations of the Human Rights Committee: Poland,* 66th Sess., 1764-1765th mtgs., para. 11, U.N. Doc. CCPR/C/79/Add.110 (1999) [hereinafter *Concluding Observation HRC: Poland].*

247 Universal Declaration, *supra* note 189, art. 25(1).

248 *See, e.g,* Article 19 states that "everyone has the right . . . to seek, receive and impart information and ideas through any media and regardless of frontiers." *Id.* at art. 19. Article 26 on the right to education ensures that "[e]ducation shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms." *Id.* at art. 26(2).

249 Banjul Charter, *supra* note 194, art. 16(1).

250 *Id.* at art. 9.

251 *Id.* at art. 17.

252 African Children's Charter, *supra* note 185, art. 2.

253 *Id.* at art.14(1).

254 *Id.* at art. 14(2)(f).

255 *Id.* at art. 11.

256 *ICPD Programme of Action, supra* note 1, para. 7.41.

257 The ICPD Programme of Action recommends that "programmes [for adolescents] should include support mechanisms for the education and counseling of adolescents in the areas of . . . responsible sexual behavior, responsible family-planning practice, family life, [and] reproductive health. . . . Sexually active adolescents will require special family-planning information, counseling and services. . . ." *Id.* at para. 7.47.

258 *Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development*, U.N. GAOR, 21st Special Sess., New York, United States, June 30 – July 2, 1999, para. 10, U.N. Doc.A/S-21/5/Add.1 (1999) [hereinafter *ICPD+5 Key Actions Document*].

259 *Beijing Declaration and Platform for Action, supra* note 198, para. 106(b).

260 Paragraph 107 calls for signatories to "[p]repare and disseminate accessible information, through public health campaigns, the media, reliable counseling and the education system, designed to ensure that women and men, particularly young people, can acquire knowledge about their health, especially information on sexuality and reproduction. . . ." *Id.* at para. 107(e).

261 *Id.* at para. 107(g).

262 *Further actions and initiatives to implement the Beijing Declaration and the Platform for Action*, U.N. GAOR, 23rd Special Sess., New York, United States, June 5-9, 2000, para. 12, U.N. Doc. A/Res/S-23 (2000) [hereinafter *Beijing +5 Review Document*].

263 Privacy and family life are protected by Article 12 of the Universal Declaration, *supra* note 189; Article 17 of the Civil and Political Rights Covenant, *supra* note 191; Article 11 of the American Convention on Human Rights, *signed* Nov. 22, 1969, O.A.S. Treaty Ser. No. 36, OEA/Ser.L./V/II.23.doc.21, rev. 6 (1979), 9 I.L.M.673 (1970) (*entry into force* July 18, 1978); and Article 8(1) of the European Convention for the Protection of Human Rights and Fundamental Freedoms, *signed* Nov. 4, 1950, 214 U.N.T.S. 222 (*entry into force* Sept. 3, 1953).

264 *See* Cook & Dickens, *supra* note 199, at 20.

265 Universal Declaration, *supra* note 189, art. 3, 12.

266 Civil and Political Rights Covenant, *supra* note 191, art 9(1).

267 *Id.* at art. 17(1).

268 *Id.* at art. 23(2).
269 Rebecca J. Cook, *Human Rights and Reproductive Self Determination*, 44:4 Am. U.L. Rev. 975, 993 (1995).
270 *See, e.g, Concluding Observations of the Human Rights Committee: Argentina,* 17th Sess., 1883rd-1884st mtgs., para. 14, U.N. Doc. CCPR/CO/70/ARG (2000) [hereinafter *Concluding Observation HRC: Argentina*]; *Concluding Observations of the Human Rights Committees: Colombia,* 1568th-1571st mtgs., para. 37, U.N. Doc. CCPR/CO/79/Add.76 (1997) [hereinafter *Concluding Observation HRC: Colombia*]; *Concluding Observation HRC: Poland, supra* note 246, para. 11.
271 *Concluding Observation HRC: Argentina, supra* note 270, para. 14.
272 *See, e.g, Concluding Observations of the Human Rights Committee: Chile,* 65th Sess., 1733rd-1734th mtgs., para. 15, U.N. Doc. CCPR/CO/79/Ad.d.104 (1999).
273 *See* Packer, *supra* note 187, at 64-65.
274 Children's Rights Convention, *supra* note 7, art. 16(1).
275 *See, e.g, Concluding Observations of the CRC: Djibouti, supra* note 228, para. 46.
276 *See, e.g, Concluding Observations CRC: Austria, supra* note 212, para. 15*; Concluding Observations CRC: Barbados, supra* note 212, para. 25; *Concluding Observations CRC: Benin, supra* note 212, para. 25; *Concluding Observations CRC: Georgia, supra* note 212, para. 22; *Concluding Observations CRC: Mali, supra* note 212, para. 27; *Concluding Observations CRC: Malta, supra* note 212, para. 21*; Concluding Observations CRC: Marshall Islands, supra* note 212, para. 51; *Concluding Observations CRC: South Africa, supra* note 212, para. 31; and *Concluding Observations CRC: Vanuatu, supra* note 212, para. 20 and, in context of abortion, *Concluding Observations of the Committee on the Rights of the Child: Kyrgyzstan*, 24th Sess., 627-628th mtgs., para. 45, U.N. Doc. CRC/C/15/Add.127 (2000) [hereinafter *Concluding Observations CRC: Kyrgyzstan*].
277 *See CRC Report on the 19th Session, supra* note 222, para 243(n).
278 CEDAW, *supra* note 4, art. 16(1)(e).
279 CEDAW, General Recommendation No. 24, *supra* note 232, para. 14.
280 *See e.g, Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Belize*, 21st Sess., 432nd-433rd, 438th mtgs., paras. 56-57, U.N. Doc.CEDAW/A/54/38, paras. 31-69, (1999); *Concluding Observations CEDAW: Chile, supra* note 235, para. 227; *Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Greece*, 20th Sess., 415-416th mtgs., para. 207, U.N. Doc. A/54/38, paras. 172-212 (1999) [hereinafter *Concluding Observations CEDAW: Greece*]; *Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Ireland*, 21st Sess., 440th-441st mtgs., para. 186, U.N. Doc. A/54/38, paras. 161-201 (1999) [hereinafter *Concluding Observations CEDAW: Ireland*]; *Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Mauritius*, 268th & 271st mtgs., para. 211, U.N. Doc. A/50/38, paras. 160-217 (1995) [hereinafter *Concluding Observations CEDAW: Mauritius*]; *Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Paraguay*, 289 & 297th mtgs., para. 123, U.N. Doc. A/51/38, paras. 105-133 (1996) [hereinafter *Concluding Observation CEDAW: Paraguay*]; *Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Peru*, 19th Sess., 397-398th mtgs., para. 341, U.N. Doc. A/53/38/Rev.1, paras.292-346 (1998) [hereinafter *Concluding Observation CEDAW: Peru*]; *Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Venezuela*, 16th Sess., 323rd-324th mtgs., para. 236, U.N. Doc. A/52/38/Rev.1, paras. 207-247 (1997) [hereinafter *Concluding Observation CEDAW: Venezuela*]; and *Concluding Observations CEDAW: Zimbabwe, supra* note 182, para. 148.
281 *See, e.g, Concluding Observations CEDAW: Chile, supra* note 235, para. 228-229; *Concluding Observation s of the Committee on the Elimination of Discrimination Against Women: Indonesia,* 377th mtg., para. 284(c), U.N. Doc. A/53/38 (1998); and *Concluding Observation s of the Committee on the Elimination of Discrimination Against Women: Turkey,* 16th Sess., 318-319th mtgs., paras. 184, 196, U.N. Doc. A/52/38/Rev.1, paras. 151-205 (1997).
282 CEDAW, General Recommendation No. 24, *supra* note 232, para. 18.
283 *See, e.g, Concluding Observation s of the Committee on the Elimination of Discrimination Against Women: Australia,* 251st mtg., para. 404, U.N. Doc. A/49/38, paras. 370-412 (1994).
284 CESCR, General Comment 14, *supra* note 239, para. 12.
285 *Id.* at para. 23.
286 *Id.*
287 *Id.*

288 *Id.* at para. 23.
289 Banjul Charter*, supra* note 194, art. 5.
290 African Children's Charter, *supra* note 185, art. 10.
291 *ICPD Programme of Action, supra* note 1, para. 7.3.
292 *Id*. at para. 7.45.
293 *ICPD+5 Key Actions Document, supra* note 258, para. 73(a).
294 *Beijing Declaration and Platform for Action, supra* note 198, para. 93.
295 *Beijing +5 Review Document, supra* note 262, para. 79(f).
296 The Universal Declaration contains a non-discrimination provision which provides that, "[e]veryone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status." Universal Declaration, *supra* note 189, art. 2.
297 The Economic, Social and Cultural Rights Covenant obligates states parties to "undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status." Economic, Social and Cultural Rights Covenant, *supra* note 190, art. 2(2).
298 The Civil and Political Rights Covenant provides that all of the rights recognized in the Covenant are to be accorded without distinction on the basis of race, sex, social origin, or other status. Civil and Political Rights Covenant, *supra* note 191, art. 2.
299 Article 1 of CEDAW defines discrimination against women as "any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women . . . of human rights and fundamental freedoms. . . ." CEDAW, *supra* note 4, art. 1. Article 3 holds that "States Parties shall take in all fields, in particular in the political, social, economic and cultural fields, all appropriate measures, including legislation, to ensure the full developments and advancement of women, for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality with men." *Id*. at art. 3.
300 The Children's Rights Convention states that its provision are to be applied without discrimination on the basis of sex, race, social origin, or any other reason. Children's Rights Convention, *supra* note 7, art. 2.1.
301 Article 2 holds that "[e]very individual shall be entitled to the enjoyment of the rights and freedoms recognized and guaranteed in the present Charter without distinction of any kind such as race, ethnic group, color, sex, language, religion, political or any other opinion, national and social origin, fortune, birth or other status." Banjul Charter*, supra* note 194, art. 2.
302 Article 3 holds that, "Every child shall be entitled to the enjoyment of the rights and freedoms recognized and guaranteed in this Charter irrespective of the child's or his/her parents' or legal guardians' race, ethnic group, colour, sex, language, religion, political or other opinion, national and social origin, fortune, birth or other status." African Children's Charter*, supra* note 185, art. 3.
303 *ICPD Programme of Action*, *supra* note 1, principle 1.
304 *Beijing Declaration and Platform for Action, supra* note 198, para. 214 which specifically reaffirms the equal rights of men and women.
305 *ICPD Programme of Action*, *supra* note 1, para. 7.3
306 *Beijing Declaration and Platform for Action, supra* note 198, para. 95.
307 CEDAW, *supra* note 4, art. 1.
308 Article 12 provides that states must "eliminate discrimination against women in the field of health care" to ensure equal "access to health care services, including those related to family planning." *Id.* at art. 12. Article 10 of the Convention obligates states parties to ensure, on the basis of equality of men and women "[a]ccess to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning." *Id*. at art. 10(h).
309 *Id*. at art. 5.
310 *See, e.g, Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Burkina Faso*, 22nd Sess., 458-459th mtgs., para. 274, U.N. Doc. A/55/38, paras. 239-286 (2000); *Concluding Observations CEDAW: Greece, supra* note 280, para. 207; *Concluding Observations of the Committee on the Elimination of*

Discrimination Against Women: Guyana, para. 621, U.N. Doc. A/50/38, paras. 616-626 (1995); *Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Iraq*, 23rd Sess., 468-469th mtgs., para. 203, U.N. Doc. A/55/38, paras. 166-210 (2000); *Concluding Observations CEDAW: Ireland, supra* note 280, para. 186; *Conduding Observations of the Committee on the Elimination of Discrimination Against Women: Lithuania*, 23rd Sess., 472nd-473rd, 480th mtgs., para. 158, U.N. Doc. A/55/38, paras. 118-165 (2000); *Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Madagascar*, 236-237th mtgs., para. 216, U.N. Doc. A/49/38, paras. 186-244 (1994); *Concluding Observations CEDAW: Mauritius, supra* note 280, para. 196; *Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Morocco,* 16th Sess., 312-313th, 320th mtgs., para. 68, U.N. Doc. A/525/38, paras. 45-80 (1997); *Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Namibia*, 17th Sess., 336-337,th 342nd mtgs., para. 79, U.N. Doc. A/52/38/Rev.1, Part II paras. 69-131 (1997); *Concluding Observation CEDAW: Paraguay, supra* note 280, para. 123; *Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Russian Federation*, 274th mtg., para. 523, U.N. Doc. A/50/38, paras. 496-552 (1995); *Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Tunisia*, 269th & 273rd mtgs., para. 245, U.N. Doc. A/50/38, paras. 218-277 (1995); *Concluding Observation CEDAW: Venezuela, supra* note 280, para. 236; and *Conduding Observations of the Committee on the Elimination of Discrimination Against Women: Zambia*, 241st-246th mtgs., para. 374, U.N. Doc. A/49/38, paras. 318-368 (1994).

311 *See Concluding Observations CEDAW: Greece, supra* note 280, para. 207.

312 CESCR, General Comment 14, *supra* note 239, para. 18.

313 *Id.* at paras. 21 & 23.

314 Human Rights Committee, General Comment 28 (Art. 3), Equality of rights between men and women, para. 20, U.N. Doc. CCPR/C/21/Rev.1/Add.10 (2000).

315 *See, e.g, Concluding Observation HRC: Argentina, supra* note 270, para. 14; *Concluding Observation HRC: Colombia, supra* note 257, para. 37; *Concluding Observations of the Human Rights Committee: Georgia*, 1564-1566th mtgs., para. 12, U.N. Doc. CCPR/C/79/Add.75 (1997); *Concluding Observation HRC: Poland, supra* note 246, para. 11.

316 *See, e.g, Concluding Observation HRC: Argentina, supra* note 270, para. 14; *Concluding Observation HRC: Colombia, supra* note 257, para. 37; *Concluding Observation HRC: Poland, supra* note 246, para. 11.

317 *Concluding Observations of the Human Rights Committee: Zimbabwe,* 62nd Sess., 1650th-1651st mtgs., para. 15, U.N. Doc.CCPR/C/79/Add.89 (1998) [hereinafter *Concluding Observations HRC: Zimbabwe*].

318 *See, e.g, Concluding Observations of the Committee on the Rights of the Child: Central African Republic*, 25th Sess., 657-658th mtgs., para. 61, U.N. Doc. CRC/C/15/Add.138 (2000) [hereinafter *Concluding Observations CRC: Central African Republic*]; *Concluding Observations CRC: Paraguay*, *supra* note 225, para. 45; *Concluding Observations of the Committee on the Rights of the Child: Russian Federation*, 22nd Sess., 564-565th mtgs., U.N. Doc. CRC/C/15/Add.110 (1999); and *Concluding Observations of the Committee on the Rights of the Child : Uruguay*, 13th Sess., 325-327th mtgs., U.N. Doc. CRC/C/15/Add.62 (1996).

319 *See CRC, Report on the 19th Session, supra* note 222, para 243(k).

320 Banjul Charter*, supra* note 194, art. 18(3).

321 *ICPD Programme of Action*, *supra* note 1, principle 4.

322 *Beijing Declaration and Platform for Action, supra* note 198, para. 214.

323 *Id.* at para. 95.

324 CEDAW, General Recommendation No. 24, *supra* note 232, para 6.

325 Sex workers: *See, e.g, Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Armenia,* 17th Sess., 344-345th, 349th mtgs., para. 59, U.N. Doc. A/52/38/Rev.1 Part II paras. 35-68 (1997); *Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Cameroon*, 23rd Sess., 476-477,th 483rd mtgs., para. 52, U.N. Doc. A/55/38, paras. 30-66 (2000); *Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Cuba*, 294-295th mtgs., para. 224, U.N. Doc. A/51/38, paras. 197-228 (1996); and *Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Democratic Republic of Congo*, 22nd Sess., 454-455th, 463rd mtgs., para. 219, U.N. Doc. A/55/38, paras. 194-238 (2000). Poor women: *See, e.g, Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Mexico*, 376-377th mtgs., para. 391, U.N. Doc. A/53/38, paras. 354-427 (1998); and *Concluding Observation CEDAW: Peru, supra* note 280, para. 341.

326 CESCR, General Comment 14, *supra* note 239, para. 18.
327 *See, e.g, Concluding Observations of the Committee on Economic, Social and Cultural Rights: Belgium*, 10th Sess., 15-17th mtgs., para. 10, U.N. Doc. E/C.12/1994/7 (1994); *Concluding Observation CESCR: Cameroon, supra* note 241, para. 421 ; and *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Philippines*, 12th Sess., 11-12, 14th mtgs., para. 20, U.N. Doc. E/C.12/1995/7 (1995).
328For example, the term "discrimination on the basis of . . . other status" has been interpreted to prohibit discrimination on the basis of disability, sexual orientation, as well as age. Disability: *See, e.g, Concluding Observations of the Committee on the Rights of the Child: Chad,* 21st Sess., 546-548th mtgs., para. 26, U.N. Doc. CRC/C/15/Add.107 (1999) [hereinafter *Concluding Observation CRC: Chad*]; *Concluding Observations of the Committee on the Rights of the Child: Cambodia,* 23rd Sess., 595-596th mtgs., para. 15, U.N. Doc. CRC/C/15/Add.117 (2000); *Concluding Observations of the Committee on the Rights of the Child: Ethiopia,* 14th Sess., 349th–351st mtgs., para. 14, U.N. Doc. CRC/C/15/Add.67 (1997); *Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Israel*, 17th Sess., 350th–351st, 353rd mtgs., para. 182, U.N. Doc. A/52/38Rev.1, Part II paras. 132-183 (1997); and *Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Libyan Arab Jamahiriya*, 237 & 240th mtgs., para. 166, U.N. Doc. A/49/38, paras.126-185 (1994). Sexual Orientation: *See, e.g, Concluding Observations of the Committee on the Rights of the Child: United Kingdom of Great Britain and Northern Ireland,* 25th Sess., 647-649th mtgs., paras. 25-26, U.N. Doc. CRC/C/15/Add.135 (2000); *Concluding Observations of the Human Rights Committee: United Kingdom of Great Britain and Northern Ireland*, 68th Sess., 1818-1819th mtgs., para. 14, U.N. Doc. CCPR/C/79/Add.119 (2000); *Concluding Observations of the Human Rights Committee: Trinidad and Tobago*, 17th Sess., 1870th–1871st mtgs., para. 11, U.N. Doc. CCPR/CO/70/TTO (2000) [hereinafter *Concluding Observations HRC: Trinidad and Tobago*]. Age: *See, e.g, Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Spain*, 21st Sess., 436– 437th mtgs., paras. 269-270, U.N. Doc. A/54/38, paras. 236-277 (1999); *Concluding Observations of the Committee on the Elimination of Discrimination Against Women: United Kingdom of Great Britain and Northern Ireland*, 21st Sess., 429-430th mtgs., para. 315, U.N. Doc. CEDAW/C/1999/L.2/Add.7 (1999); *Concluding Observations HRC: Trinidad and Tobago, supra* note 328, para. 11; and *Concluding Observations HRC: Ecuador, supra* note 245, para. 11.
329 CEDAW, General Recommendation No. 24, *supra* note 232, para 6.
330 *See, e.g, Concluding Observations CEDAW: Chile, supra* note 235, para. 227; *Concluding Observations CEDAW: Venezuela, supra* note 280, para. 243; and *Concluding Observations CEDAW: Zimbabwe, supra* note 182, paras. 148,160-161.
331 *See, e.g, Concluding Observations HRC: Ecuador, supra* note 245, para. 11.
332 CESCR, General Comment 14, *supra* note 239, para. 23.
333 *Id.* at para. 18.
334 It holds that "[s]tates are also obliged to . . . take measures to protect all vulnerable or marginalized groups of society, in particular women, children, adolescents and older persons, in the light of gender-based expressions of violence. States should also ensure that third parties do not limit people's access to health-related information and services." *Id.* at para. 35.
335 *See, e.g, Concluding Observations of the Committee on the Rights of the Child: Cambodia,* 24th Sess., 629-630th mtgs., para. 52, U.N. Doc. CRC/C/15/Add.128 (2000); *Concluding Observations CRC: Central African Republic, supra* note 318, para. 60;*Concluding Observation CRC: Chad, supra* note 328, para. 30; *Concluding Observations of the Committee on the Rights of the Child: Colombia,* 25th Sess., 655-656th mtgs., para. 48, U.N. Doc. CRC/C/15/Add.137 (2000); *Concluding Observations of the CRC: Djibouti, supra* note 228, para. 45-46; *Concluding Observations of the Committee on the Rights of the Child: Ecuador,* 19th Sess., 479th-481st mtgs., para. 23, U.N. Doc. CRC/C/15/Add.93 (1998); *Concluding Observations of the Committee on the Rights of the Child: Fiji,* 18th Sess., 461st–462nd mtgs., para. 20, U.N. Doc. CRC/C/15/Add.89 (1998); *Concluding Observations CRC: Georgia, supra* note 212, paras. 46-47; *Concluding Observations of the Committee on the Rights of the Child: Guinea,* 20th Sess., 515-517th mtgs., para. 27, U.N. Doc. CRC/C/15/Add.100 (1999); *Concluding Observations of the Committee on the Rights of the Child: Iraq,* 19th Sess., 482nd–484th mtgs., para. 23, U.N. Doc. CRC/C/15/Add.94 (1998); *Concluding Observations of the Committee on the Rights of the Child: Japan,* 18th Sess., 465-467th mtgs., para. 21, U.N. Doc. CRC/C/15/Add.90 (1998); *Concluding Observations CRC: Kyrgyzstan, supra* note 276, para. 45; *Concluding Observations CRC: Malta, supra* note 212, para. 39; *Concluding Observations CRC: Marshall Islands, supra* note 212, para. 50; *Concluding Observations of the Committee*

on the Rights of the Child: Nicaragua, 9th Sess., 211-213th mtgs., para. 35, U.N. Doc. CRC/C/15/Add.36 (1995); *Concluding Observations CRC: Paraguay*, *supra* note 225, para. 23; *Concluding Observations of the Committee on the Rights of the Child: Peru,* 4th Sess., 82nd-84th mtgs., para. 24, U.N. Doc. CRC/C/15/Add.8 (1993); and *Concluding Observations of the Committee on the Rights of the Child: Saint Kitts and Nevis,* 21st Sess., 537-538th mtgs., para. 26, U.N. Doc. CRC/C/15/Add.104 (1999).

336 *CRC, Report on the 19th Session, supra* note 222, para 243(n).

337 CEDAW, General Recommendation No. 24, *supra* note 232, para 14.

338 *See, e.g, Concluding Observations CEDAW: Mauritius*, *supra* note 280, para. 211.

339 *Concluding Observations HRC: Zimbabwe, supra* note 317, para. 12.

340 Accessibility includes the four overlapping dimensions of: discrimination, physical accessibility, economic accessibility, and information accessibility. CESCR, General Comment 14, *supra* note 239, para. 12.

341 *See* National Health Strategy, *supra* note 29, at 20. In fact, of adolescents interviewed for this report, slightly more than 50% of both boys and girls have their first sexual encounter at the age of 12; more than 85% of both sexes have sexual relations by 16. Stakeholders also concurred that often adolescents have their first sexual experience as early as 12. S*ee CLF & CRLP Survey, supra* note 28.

342 *See* Packer, *supra* note 187, at 55, *citing* Geraldine Van Bueren, The International Law on the Rights of the Child 312 (1995).

343 *See* CRC General Comment 1, *supra* note 223.

344 Neither the HIV/AIDS Policy nor the Patient's Charter contain absolute guarantees of confidentiality. The HIV/AIDS Policy states "Excessive emphasis on confidentiality may lead to increased stigma, discrimination and perpetuate denial of the epidemic. "Shared confidentiality" where medical information about one's HIV status may be shared with spouse/partner and care giver(s) has been recommended." HIV/AIDS Policy, *supra* note 143, at 5 § 3.1. The Patient's Charter permits a doctor to break confidentiality if, " it is in the patient's own interest that confidentiality should be broken." Patient's Charter, *supra* note 117, § 2.1.

345 *See infra* Chapter II: International Human Rights Framework for Adolescents' Right to Dual Protection Methods and Information, Section B.

346 For example, despite the fact that the Patients' Charter contains language ensuring access to health care regardless of one's age, it defers to parental rights when the adolescent is a minor, requiring parental consent for services. Patient's Charter, *supra* note 117, § 1.1 & 6.1. In this way, it contradicts and negates the protections from age discrimination found in the same document and reinforces the barriers that keep minor adolescents from accessing contraceptive services and information.

347 Zimb. Const. § 23 (3)(3).

348 The Zimbabwean Constitution includes a prohibition against laws that discriminate on their face or in effect on the basis of "race, tribe, place of origin, political opinions, colour, or creed." Zimb. Const. § 23 (2). Section 23 (1) (a) and (b) states that "no law shall make any provision that is discriminatory either of itself or in its effect; and no person shall be treated in a discriminatory manner by any person acting by virtue of any written law or in the performance of the functions of any public office or any public authority." Zimb. Const. § 23 (1) (a-b).

349 *See generally* International Women's Rights Action Watch (IWRAW), *Two Steps Back: Customary Law and* the *Zimbabwe Constitution*, 12:3/4 The Women's Watch, Sept. 1999.

350 Examples include African customary law relating to inheritance, property and marriage. *See id.*

351 *See Supreme Court ruling leaves women exposed*, The Daily News, May 17, 1999, at 17 [hereinafter The Daily News].

352 According to the Constitution, age, socioeconomic status and marital status are *not* explicitly prohibited grounds for discrimination. Zimb. Const. § 23 (2), as amended by Zimb. Const. amend. 14, § 9 (1)(a).

353 The Marriage Act specifies different age of marriage for girls, 16, and boys, 18. Marriage Act, ch. 5:11, § 22 (1) (revised ed. 1996).

354 Zimb. Const. § 23 (3), as amended by Zimb. Const. amend. 14, § 9 (1)(a).

355 *See* The Daily News, *supra* note 351, at 17.

356 Sexual Offences Act, ch. 9:21, § 3 (2) (2001). However, the law does permit sexual intercourse between two minors between the ages of 12 and 16, since one defense to the charge of statutory rape is if the accused is under the age of sixteen at the time of the offense. Sexual Offences Act, ch. 9:21, § 3 (2)(a) (2001).

357 This was revealed during interviews with service providers. *See CLF & CRLP Survey, supra* note 28.
358 Interview with Mrs. Pauline Makonen, Service Provider, Well Woman Clinic, Zimbabwe (Aug. 3, 2000) (on file with CLF & CRLP).
359 The research results confirm that adolescents under the age of 16 routinely are refused access to information and services on contraception and STI prevention. Sixty-three percent of the girls interviewed and 47% of the boys interviewed stated that they have encountered this problem. *See CLF & CRLP Survey, supra* note 28.
360 Interview with Service Provider, Belvedere Satellite Clinic, Belvedere, Zimbabwe (Aug. 3, 2000) (on file with CLF).
361 Interview with Mrs. Pauline Makonen, *supra* note 358.
362 In fact, "dry sex" is the practice of using vaginal drying agents for tightening the vagina and drying out lubrication prior to sexual intercourse. A study in Zimbabwe concluded that 93% of women had practiced dry sex. And, some studies suggest an association between this practice and increased risk of reproductive tract and HIV infections among women. *See* Daniel T. Halperin, *So Dry Sex Practice Does Not Only Happen in Africa!* 33 Women's Health Project Newsletter, Feb. 2000, at 22.
363 Interview with Adolescent Rural Boy, Zimbabwe (Aug.-Oct. 2000) (on file with CLF).
364 This information was revealed during various group interviews with adolescents. *See CLF & CRLP Survey, supra* note 28.
365 *See id.*
366 For example, girls reported stealing from their mothers and sisters, while boys reported that they steal from their brothers, uncles and fathers. A large number of adolescents appear to rely on their friends (25%), and their partners (19.2%) for the provision of contraceptives. (Boys seem to obtain contraceptives mostly from friends, while girls obtain them primarily from their partners.) Rating second, both boys and girls receive information and services on contraception and STI prevention from family members (19.8% overall). *See id.*
367 For example, the adolescents we interviewed used dual protection methods very minimally, with only 61 boys and 27 girls (25.8% of 340 adolescents) who responded to the self-administered questionnaire stating that they have ever used contraceptives. These were mainly older adolescents from 17 to 19 years of age. *See id.*
368 Stakeholders that we interviewed expressed concern over the increasing and recurrent adolescent STI and HIV/AIDS cases. At the Thuthuka Street Children Center in Bulawayo, we were told that "there are a lot of cases of STIs among the street children." We were also informed by SAFAIDS that 88% of the sex workers in Harare are HIV positive. But STIs are prevalent even among the school-going children. At a private clinic in Harare, we were told that a number of adolescents who come in for a check-up also test positive for STIs. *See id.*
369 "Guchu" is a calabash or container of a traditional variety usually with a long narrow neck attached to a round orb. It is usually used to store beer, water or charms. E-mail from Ms. Naira Khan, Executive Director, Child and Law Foundation, Zimbabwe, to Ms. Julia Zajkowski, Consulting Legal Advisor for Global Projects, The Center for Reproductive Law and Policy (Apr. 9, 2002) (on file with CRLP).
370 Interview with Mr. Godfrey Tinarwo, *supra* note 32.
371 *See CLF & CRLP Survey, supra* note 28.
372 Interview with Representative, Ministry of Education, Harare, Zimbabwe (Aug. 15, 2000) (on file with CLF & CRLP).
373 Interview with Adolescent Boy, Igusi, Zimbabwe (Aug.-Oct. 2000) (on file with CLF).
374 Interview with Representative, Ministry of Education, *supra* note 372.
375 *Id.*
376 *See infra* Introduction, Section B.
377 *See CLF & CRLP Survey, supra* note 28.
378 *See id.*
379 Interview with Adolescent Boy, Igusi, *supra* note 373.
380 S*ee CLF & CRLP Survey, supra* note 28.
381 *See CLF & CRLP Survey, supra* note 28.
382 Interview with Adolescent, Zimbabwe (Aug.-Oct. 2000) (on file with CLF).
383 *See CLF & CRLP Survey, supra* note 28.
384 *See* note 362 and accompanying text.

385 Interview with Adolescent Boy, Zimbabwe (Aug.-Oct. 2000) (on file with CLF).
386 Interview with Adolescent Boy, Zimbabwe (Aug.-Oct. 2000) (on file with CLF).
387 Interview with Adolescent Boy, Zimbabwe (Aug.-Oct. 2000) (on file with CLF).
388 Interview with Employee, Ministry of Health, Harare, Zimbabwe (Aug.-Oct. 2000) (on file with CLF).
389 Interview with Adolescent Girl, Zimbabwe (Aug.-Oct. 2000) (on file with CLF).
390 Interview with Employee, Ministry of Health, *supra* note 387.
391 Interview with Mrs. Pauline Makonen, *supra* note 358.
392 Interview with Urban Adolescent Boy, Zimbabwe (Aug.-Oct. 2000) (on file with CLF).
393 Sixteen boys and only 5 girls reported having used a method of contraception or STI prevention on their first sexual encounter. In all cases, the male partner provided the contraceptives. *See CLF & CRLP Survey, supra* note 28.
394 *See id.*
395 Interview with Mrs. Pauline Makonen, *supra* note 358.
396 Interview with Adolescent Girl, Zimbabwe (Aug.-Oct. 2000) (on file with CLF).
397 Interview with Traditional Healer, Zimbabwe (Sept. 1, 2000) (on file with CLF & CRLP).
398 Interview with Nurse, ZNFPC Clinic, Bulawayo, Zimbabwe (Aug. 8, 2000) (on file with CLF & CRLP).
399 Interview with Mrs. Dete, Representative, Ministry of Health, Harare, Zimbabwe (Aug. 3, 2000) (on file with CLF & CRLP).
400 Interview with Nurse, ZNFPC Clinic, *supra* note 397.
401 Interview with Adolescent Sex Worker, Harare/Chitungwiza, Zimbabwe (Aug.-Oct. 2000) (on file with CLF).
402 *See CLF & CRLP Survey, supra* note 28.
403 Interview with Adolescent Boy, Zimbabwe (Aug.-Oct. 2000) (on file with CLF).
404 For the purposes of this report, the term 'sex workers' means those who support themselves almost exclusively by providing sexual services for money or things of value. It does not include those who occasionally exchange sex for money.
405 Interview with Adolescent Sex Worker, Harare/Chitungwiza, Zimbabwe (Aug.-Oct. 2000) (on file with CLF).
406 Unlike boys in Zimbabwe, girls are discouraged from working and their parents do not provide them with spending money. Largely due to this economically disadvantaged position of Zimbabwean girls, they may engage in sexual activities in order to get material support such as food at school, books, hairstyles and other items. *See CLF & CRLP Survey, supra* note 28.
407 Interview with Adolescent Sex Worker, Harare/Chitungwiza, Zimbabwe (Aug.-Oct. 2000) (on file with CLF).
408 The HIV/AIDS Policy states that quality-assured condoms should be made "available, accessible and affordable to all sexually active individuals." HIV/AIDS Policy, *supra* note 143, at 9, § 4.3 (guideline 9).
409 *See infra* Appendix C, Table 5.
410 *See CLF & CRLP Survey, supra* note 28.
411 Mean ages exclude parents and stakeholders.
412 Universal Declaration, *supra* note 189.
413 Civil and Political Rights Covenant, *supra* note 191.
414 Economic, Social and Cultural Rights Covenant, *supra* note 190.
415 CEDAW, *supra* note 4.
416 Children's Rights Convention, *supra* note 7.
417 Banjul Charter, *supra* note 194.
418 African Children's Charter, *supra* note 185.
419 *ICPD Programme of Action, supra* note 1.
420 *Beijing Declaration and Platform for Action*, *supra* note 198.
421 This refers to those sexually active adolescents who have used a method of contraception or STI prevention. *See CLF & CRLP Survey, supra* note 28.