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Capacity of Adolescents to Consent to Sexual and Reproductive Health Services: The Case for Policy, Legal and Pragmatic Reform

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Uganda's laws prescribe 18 years as the age of adulthood,[1] at this age an individual is deemed to have the capacity to make their own decisions. The capacity of minors to consent is an area of contention with conflicting laws, policies and practices. While it is reasonable that parents should contribute in the making of major decisions for their under-age children, many adolescents have evolving capacities depending on their circumstances and environment which makes them mature and or emancipated before the age of 18 and requiring them to provide parental consent would instead hinder access to critical health care services.

Sexual and Reproductive Health needs of Adolescents

Adolescents (10-19 years) constitute about one quarter of Uganda's population.[2] Almost 22% of these have experienced sexual activity.[3] As a result, by the age of 15-19, up to 25% of the adolescents have started having children; 19% have given birth; and 5% are pregnant. At the age of 17, an estimated 22% have had children – a proportion that rises to 54% by the age of 19.[4] Hence, adolescents are sexually active and need SRH information and services.

The package of SRH services prescribed by the National Adolescent Health Policy 2004 includes: information on sexuality and sexually transmitted infections (STIs), family planning counselling and services, contraceptive use for sexually-active adolescents, HIV prevention and care services; maternal health services for adolescent mothers, post-abortion care, and psychosocial support. Current laws, policies and service guidelines on capacity to consent should be implemented in a manner that facilitates adolescent access to these services.

However to access these and other essential SRHR services is still inadequate, and adolescents continue to be disproportionately affected by sexual violence, STIs, unintended pregnancies, unsafe abortions, ill-health, disability and death.[5] For instance, estimates for 2015 show that adolescent girls and young women (AGYW) made up 22% of the 83,000 new HIV infections registered in that year, translating into an average of 50 infections in this age group on a daily basis.[6]

Hence, it is extremely critical that adolescents are supported, including through legal and policy frameworks, to access information and services they need to make informed decisions to realize their sexual and reproductive health and rights (SRHR).

1 Article 257(1)(c) of the Constitution of the Republic of Uganda, 1995 and Section 2 of the Children Act
2 Uganda Bureau of Statistics, 2016. *The National Population and Housing Census 2014 – Main Report.*
3 MoH (2016). Adolescent Health Risk Behaviors in Uganda: A National Cross-sectional Survey, 2016.
4 Uganda Demographic and Health Survey 2016
5 Guttmacher Institute (2009). Unintended pregnancy and abortion in Uganda.
6 Office of the President of Uganda (2017). Presidential fast track initiative on ending AIDS as a public health problem in Uganda; a five-point plan

The legal framework for capacity to consent and the doctrine of evolving capacities

Medical ethics and human rights require health care providers to obtain informed consent from a patient before they perform any test or procedure on them.[7] And for consent to be valid, it must be voluntary and informed, and the person consenting must have the capacity to make the decision. The majority of adolescents are below the age of 18 and legally regarded as minors (children) without capacity to understand medical information and make informed decisions.

However, national and international laws recognize the principle of evolving capacities[8] by prescribing different ages for different responsibilities:

- The **United Nations Convention on the Rights of the Child, 1989** (Art.12) requires Uganda to ensure that the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.
- The **Constitution of the Republic of Uganda, 1995** sets the age of consent to marry at 18 years (Art.31(1)), and that of employment at 16 years (Art.34). It also provides that no child shall be deprived by any person of medical treatment by reason of religious or other beliefs (Art 34(3)).
- The **Customary Marriage (Registration) Act, Cap 248** (Sec.11) provides that a female can consent to marry customarily if they are 16 years and above.
- The **Marriage Act, Cap 251** (Sec. 17, 19) provides for age of consent to marriage at 21 years.
- The **Evidence Act, Cap 6** (Section 117) provides that evidence from a person above tender years (14 years and older) is directly admissible in court hence recognizing minors' evolving capacities at different ages.
- The **Children's (Amendment) Act, 2016** (Sec.2) defines a child as a person below the age of 18 years, but sets (Sec.8) the minimum age of employment of a child at 16 years. Then it provides (Sec.47) that a child of at least 14 years shall give their consent to adoption. In addition, the Act (Sec.88) provides that the minimum age of criminal responsibility shall be 12 years.
- The **Employment Act, 2006** allows the employment of children from the age of 12 and above (Sec.32(1) and (2))..
- The **HIV Prevention and Control Act, 2014** (Sec.9 & 10) restricts consent to HIV testing to persons of 18 years and above.
- The **Penal Code Act, Cap 120** differentiates defilement into simple defilement for children aged 16-17 years, from aggravated defilement for sex with children below 16 years

These different provisions illustrate that the legal framework is inconsistent and contradictory on the issue of capacity to consent, and appears to peg maturity to age. Individual laws have inconsistencies within themselves, with other laws as well as with policies. Notably, the prescribed age of marriage (and by implication sexual intercourse) varies from 16 years in the Customary Marriage (Registrations) Act, to 18 years in the Constitution, to 21 years in the Marriage Act. These inconsistencies and differences between the statutory age of majority and the prescribed the ages for employment, participation in justice processes and criminal liability highlight the confusion in the legal framework that calls for legal review and reform. This should

7 Richard A. Wagner. Informed consent. *emedicinehealth.* https://www.emedicinehealth.com/informed_consent/article_em.htm#what_ is_informed_consent

8 This principle implies that parents should respect a child's right to make their own decisions on an expanding range of issues as they mature. For instance, older children or mature minors (16-17 years) are likely to comprehend more information and to make responsible decisions, when compared to younger children.

be read together with the Constitution that states that that no child shall be deprived by any person of medical treatment by reason of religious or other beliefs which presupposes that a child should not at any one time be denied health services provided the services are in their best interests.

In such reform process, the principle of evolving capacities of children, which is only implied in the current legal framework, should be the basis for the new legal framework for obtaining informed consent from minors to medical treatment. This principle recognizes that adolescents live in different environments and are in different situations and therefore their level of understanding and appreciating information is different. Capacity to consent should not therefore only be based on age but also on the level of maturity and emancipation of the minor.

It is notable that the current framework already requires states parties to respect the views of the child in making decisions that affect them, and recognizes the concept of evolving capacities and different situations of minors. The framework clearly shows that in considering the views of children, age should be considered alongside maturity, implying that a lower age does not necessarily mean that an individual has no capacity to understand and make decisions. This is a recognition that some children mature earlier than others, and earlier or later than 18 years. The requirement by the Convention on the Rights of the Child to consider the views of a child who can form and express an opinion on any matter that concern them should be concretized in the new legal framework, including clear regulations on assessing maturity.

The policy framework for capacity to consent

In comparison to the legal framework, the policy framework is relatively more progressive on capacity to consent to SRHR services by minors:

- The **National guidelines for research involving humans as research participants (2014)** give the best guidance on capacity of minors to consent and provide that all children 8 years and above shall assent to participate in research, and their decision will take precedence over parental/guardian consent. They further provide that mature and emancipated minors can consent to research without guardians. The guidelines define mature minors as individuals aged 14-17 years who have drug or alcohol dependency or an STI; while emancipated minors are those who are pregnant, married, have a child or cater for their own livelihood.

- The **National Adolescent Health Policy (2004)** which is specific to minors on SRHR prioritizes safe sex and contraceptive use among sexually-active adolescents; abstinence before marriage, delaying sexual debut in females to 18 years, integration of emergency contraception into adolescent family planning programs, etc. The policy is however silent on whether service providers will obtain assent/consent from adolescent client and/or third parties for these interventions but health workers in practice use this policy to provide SRH services to minors.

- The **Adolescent Health Policy Guidelines and Service Standards (2012)** encourage adolescents to involve their parents "if they choose to" in the process of accessing SRH services, including clinical care for sexual violence; antenatal and maternity care; HPV immunization; HIV testing; cervical and breast cancer examination; information on HIV prevention; and information on their rights and responsibilities, etc. This policy is also silent on when and how to obtain assent/consent from a minor.

- The **National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights (2006)** have the most progressive, detailed and bold guidelines on obtaining consent from adolescents to different categories of services. The guidelines state that "No verbal or written consent is required from

parent, guardian or spouse before a client can be given family planning service except in cases of incapacitation (intellectual disability)", and recommends written consent only in cases of long-term and permanent family planning methods. They further prescribe consent from the patient or legal guardian for post-abortion care (PAC) services, including evacuation for incomplete abortion; examination under general anesthesia; and any surgical interventions.

- The **National Adolescent Health Strategy (2011-2015)** commits to ensuring that services provided are conducive to young people by making them private and confidential, etc. The strategy does not set the requirement of informed consent/assent for adolescents to access SRHR services, but its use of the requirements of "private" and "confidential" can be interpreted to mean that adolescents do not need the consent of their parents or guardians to access the services.

- The **National Sexuality Education Framework (2018)** does not provide for consent of the learners to sexuality education in school settings, but acknowledges the Eastern and Southern African (ESA) Ministerial Commitment on Sexuality Education of 2013, in which ministers of education and health from 20 countries in the region committed to "Urgently review – and where necessary amend – existing laws and policies on age of consent, child protection and teacher codes of conduct to improve independent access to SRH services for adolescents and young people and protect children".

- The **Consolidated guidelines for prevention and treatment of HIV in Uganda 2016** provide that all persons 12 years and above can consent to HIV testing services (HTS) on their own. This includes minors (12-17 years).

From the foregoing, the policy framework is more progressive, but its provisions need to be harmonized across the different policies, strategies, standards and guidelines, and with the legal framework. One notable inconsistence is between the age of consent to HIV testing between the HIV Prevention and Control Act 2014 (18 years) and the consolidated guidelines for prevention and treatment of HIV in Uganda 2016 (12 years). The service guidelines and standards should provide clear guidance on how service providers will assess the maturity of a minor within the context of evolving capacities.

Conclusion

The legal and policy frameworks are inconsistent in their provisions on the age of consent on different responsibilities, the policy framework is clearly more progressive on the critical issue of adolescent access to SRHR information and services. An overhaul of the laws and policies regarding obtaining informed consent from minors is urgently needed to address the current SRHR challenges facing young people. Confidentiality and privacy are critical in the provision of SRHR information and services to adolescents since many young people would not wish their parents to know that they are sexually active.

In the provision of SRHR, the capacity of adolescents to consent needs to be assessed not only on the basis of age, but more so on the basis of maturity, in line with the concept of evolving capacities of the child as recognized by the Convention on the Rights of the Child. This notion has been used to good effect by courts of law, in assessing the capacity of minors to testify. It has also been used to good effect in the case of mature and emancipated minors.