IPPF

From choice, a world of possibilities

Qualitative research on legal barriers to young people's access to sexual and reproductive health services

Inception report

coram clc
Children's Legal Centre

Who we are

The International Planned Parenthood Federation (IPPF) is a global service provider and a leading advocate of sexual and reproductive health and rights for all. We are a worldwide movement of national organizations working with and for communities and individuals.

IPPF works towards a world where women, men and young people everywhere have control over their own bodies, and therefore their destinies. A world where they are free to choose parenthood or not; free to decide how many children they will have and when; free to pursue healthy sexual lives without fear of unwanted pregnancies and sexually transmitted infections, including HIV. A world where gender or sexuality are no longer a source of inequality or stigma. We will not retreat from doing everything we can to safeguard these important choices and rights for current and future generations.

Contents

1 Introduction and conceptual framework 3

Sexual and reproductive health

Child

Young person

Evolving capacities

Best interests

Protection and autonomy

2 Desk review 6

2.1 Introduction

2.2 Importance of access

2.3 Barriers to access

2.4 A global review – legal barriers to access

2.4.1 Access to services

2.4.2 Sexual freedom, equality and consent

2.4.3 Violence and the criminalisation of sexual activity

3 Concluding thoughts 28

Country selection

Sampling methods

4 Methodology 29

Primary data collection methods

Ethical guidelines

Endnotes 34

1 Introduction and conceptual framework

This inception report forms part of a pilot research project conducted by Coram Children's Legal Centre (CCLC) on behalf of the International Planned Parenthood Federation (IPPF). The research seeks to understand how law, as well as knowledge and perceptions of law, can create barriers to young people's access to sexual and reproductive health (SRH) services.

This report is intended to act as a tool to guide the content and process of the research project. The report has three sections as follows:

1 The first section of the report explores several terms and concepts relevant to the research question.
2 The second section reviews existing information concerning young people's access to SRH services. It contains a summary global mapping of the basic ways in which different legal systems impose restrictions on young people's access to SRH services both directly and indirectly.
3 On the bases of the information outlined in sections one and two, section three of the report sets out the methodology that the research team will use for primary data collection.

The following section will explore several terms and concepts relevant to the research question in order to frame research and findings.

Sexual and reproductive health

Sexual and reproductive health is fundamental to the general health and well-being of young people, women and men. SRH encompasses a magnitude of issues, including, but not limited to, contraception, family planning, abortion, pre-natal and postnatal care, maternal and infant mortality, sexually transmitted infections (STIs) and sexual violence.

This study takes a holistic view of SRH, as described in the following definitions from the World Health Organization:

Sexual health: "…a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled".[1]

Reproductive health: "implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this are the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant".[2]

Sexual and reproductive rights (SRR) are human rights that relate to sex, sexuality and reproduction. In a declaration on sexual rights, the International Planned Parenthood Federation identifies 10 such rights:

Article 1: The right to equality, equal protection of the law and freedom from all forms of discrimination based on sex, sexuality or gender;

Article 2: The right to participation for all persons, regardless of sex, sexuality or gender;

Article 3: The rights to life, liberty, security of the person and bodily integrity;

Article 4: Right to privacy;

Article 5: Right to personal autonomy and recognition before the law;

Article 6: Right to freedom of thought, opinion and expression; right to association;

Article 7: Right to health and to the benefits of scientific progress;

Article 8: Right to education and information;

Article 9: Right to choose whether or not to marry and to found and plan a family, and to decide whether or not, how and when, to have children;

Article 10: Right to accountability and redress.[3]

It is important to note that given that SRR include being free from discrimination based on sexuality, sexual orientation or gender identity, individual rights that protect SRR should not change or be compromised whether an individual is single, married or a member of a couple.

Child

For the purposes of this study a child is anyone between the ages of 0 and 18 years, in accordance with Article 1 of the UN Convention on the Rights of the Child (UNCRC).[4]

Young person

The terms 'young person' and 'young people' refer to anyone between the ages of 10 and 24 years, as defined in IPPF policy.[5]

Evolving capacities

As young people grow and develop, their capacities to make decisions and act independently evolve. This will happen at different rates for different young people in different contexts. Thus Article 5 of the UNCRC states that, while it is the responsibility of parents and caregivers to provide direction and guidance to children, they must do so in a way that accounts for the 'evolving capacities' of the child, and as a child gains skills, experience, judgment and other competencies, he or she will rely less on parental direction and take greater responsibility over his or her life.[6] As put by IPPF, when determining how to promote a safe and protective environment, "respect must be afforded to children's emerging autonomy".[7]

Best interests

The best interest principle, articulated in Article 3 of the UNCRC, states that in all decisions affecting children, "the best interests of the child shall be a primary consideration".[8] However determining the best interests of the child is rarely straightforward; the outcomes of potential decisions affecting children may be difficult to predict, highly contextual, and likely to impact on children's well-being in a variety of different ways, giving rise to a need to balance a range of competing values and interests.

Consider the issue of female genital mutilation (FGM); in contexts where FGM plays a critical role in a girl's acceptance into her community, marriage, and future, it is possible that not undergoing the process could result in social exclusion and suffering; whereas undergoing the procedure is likely to cause (extreme) physical, emotional, sexual and social harm.[9]

For these reasons, the principle of 'best interests' is highly elusive and subjective in nature; in practice it may be evoked to justify all manner of decisions or actions affecting children, which may have little or no relationship to rights.

Protection and autonomy

The balance between protection and autonomy is at the heart of the SRH and rights of children and young adults; understanding the interaction between these concepts is critical to conducting this study, and to the interpretation and analysis of findings. Protection is fundamental to a child's safety, well-being and physical, cognitive, social, emotional and moral development. As a child grows, and his or her capacities evolve, the child's autonomy develops and he or she will begin to experience greater freedom and privilege, but also greater responsibility.

As explored in the IPPF 'Understanding Young People's Right to Decide' series, broadly, protection can be approached in three ways:

1. Creation of a legal or policy framework which defines standard parameters in order to create a safe environment, for example, minimum legal ages for sexual consent, marriage and consent to medical treatment; content regulation of the media, Internet and entertainment industries, etc.
2. Controls and limitations on young people's behaviour imposed from outside or removing young people from access to harm, for example by caregivers enforcing behavioural rules regarding relationships, sexual activity and access to potentially inappropriate media content, etc.
3. Empowerment or capacity building of children and young people to protect themselves and their peers, for example, through developmentally appropriate comprehensive sexuality education from an early age; life skills on critical thinking, decision-making and confidence to negotiate consensual safe sex; technical skills such as use of condoms, contraceptives, etc.[10]

Approaches one and two are perhaps the most straight forward strategies for protecting young people, and often the most common approaches adopted by governments, as well as by families and caretakers, who establish rules to protect young people and limit and direct their behaviour. However it is necessary to utilise all three approaches in order to truly promote a young person's well-being. Empowering a child and building their capacity is critical to the fulfilment of that child's rights as an active and autonomous subject, and will contribute to their ability to make decisions that promote their own protection.

Furthermore, while protection and autonomy may seem to be conflicting principles since protective measures tend to restrict young people's autonomy, they are actually mutually reinforcing and should be understood as such. For instance, a young person will experience more difficulty developing the capacity to respond to a potentially dangerous or abusive situation or take appropriate action unless they are protected against harm; it is only within a safe and healthy environment that a young person can begin to experience freedom and choice. Similarly, protective measures are unlikely to function effectively where young people are not empowered: "all the externally imposed protective measures in the world, such as legislation, policies and professional codes of conduct, are not sufficient to keep young people safe if they themselves are not able to recognise potentially dangerous or abusive situations or take appropriate action to minimise risks".[11]

When considering the SRH of children and young adults and particularly their right to SRH, the ideal balance between approaching young people as vulnerable and in need of protection, and as autonomous individuals to be empowered to pursue their own decisions may be difficult to judge. SRH issues are sensitive in nearly every cultural context, and attitudes towards adolescent sexuality are very context specific. While in some societies, sex and relationships are viewed as part of a young person's normal development, in others, sexual activity by young people is

condemned, discouraged, or even denied. The later view often leads to an exclusive focus on restrictive forms of protection that deny the young person opportunities for agency or autonomy, with problematic implications for the rights of the child/young adult, and their right to SRH. This is particularly problematic when protective approaches serve to increase young people's vulnerability, disabling them from pursuing their rights or removing themselves from harmful situations. For instance, many societies, which condemn young people's involvement in any form of sexual activity, deny young people information about SRH, including contraceptives. As a result, when young people do become involved in sexual activity, they do so without the information necessary to make decisions in their own best interests or protect themselves, leading to early pregnancy and the transmission of STIs.

2 Desk review

2.1 Introduction

Access to family planning and SRH services for young people is limited to greater and lesser degrees in all countries around the world. Some barriers are prescribed by law; others derive from social, religious, moral or other beliefs and norms relating to young people's sexuality (which themselves both shape, and are shaped by, law). This research project examines the role that legislation plays in creating barriers to access of SRH services. This desk review forms the first part of the research, providing a mapping of legislation from around the world related to SRH. The review draws out commonalities and differences across jurisdictions in an attempt to understand the various ways in which legal systems are constructed to regulate young people's access to SRH services.[12]

The first section of the review provides a brief background and summary of basic information and statistics relevant to the research question, to provide crucial insights into the broader global contexts within which different legal systems are operating.

2.2 Importance of access

Limited access to SRH services has serious implications for a range of rights of young people, which have been well researched and documented. There are approximately 222 million women with an unmet need for contraception, 50 million of whom are under the age of 25.[13] The absence of SRH services including access to contraceptives results in higher rates of unwanted pregnancies.[14] The United Nations Population Fund has found that unwanted pregnancies are disproportionately high amongst young, unmarried girls who often lack access to contraception.[15] Further, an estimated 7.4 million adolescent girls across Sub-Saharan Africa, South Central and Southeast Asia, Latin America and the Caribbean experience unintended pregnancies per year, partly due to a lack of access to contraceptives.[16] An estimated 340 million cases of new bacterial STIs occur each year, in addition to many more viral infections, including 5 million HIV infections.[17] Access to SRH services both affects and is affected by (in)equality; women and young people experience particularly poor access to medical care in many countries. An estimated 356,000 women die annually during pregnancy or childbirth, primarily from preventable causes,[18] and nearly 8 million children under the age of five die each year (an indicator strong linked to maternal health and access to post-natal health care).[19] Most of these deaths could have been prevented through access to health care, including antenatal care, and the presence of a skilled attendant during childbirth and immediately after birth. Each year 20 million unsafe abortions lead to the death of an estimated 46,000 women.[20] Ninety-eight percent of abortion-related deaths occur in developing countries, mostly in Latin America and Asia.[21]

2.3 Barriers to access

There are a number of reasons why barriers to SRH services are particularly high in some country contexts. These include:

Economic and structural factors: Poverty plays a significant role in determining who can access SRH services in many countries, and may be the greatest barrier to access to SRH services around the world. The introduction of user fees, in particular, prevents many poor people from utilising health services; in India for example, evidence suggests that user fees discourage women from giving birth in formal institutions.[22] Furthermore, in many developing countries, governments do not have the capacity to provide universal access due to lack of human resources (trained doctors, nurses, midwives, etc), lack of technical expertise and scarce drug and contraceptive supplies.[23]

Gender roles: Gender norms that assign men decision-making power, particularly relating to sex, relationships and family life, restrict access to SRH services for both young men and women (particularly women). For example, men may associate masculinity with being 'macho' and consider seeking appropriate sexual health information or care as embarrassing, while women who play a subordinate role in relationships and are financially dependent on men may have limited power to negotiate the use of condoms during sex.[24] Gender norms that restrict women's sexual activity outside of marriage also restrict access to SRH services. In some contexts, unmarried women are often denied contraceptives, and married women may be restricted from using contraceptives without the permission of their husbands.[25]

Religious Conservatism: Religious norms which limit sexual activity or promote strong discretion and control around sex may also restrict SRH access for young people. Religious conservatives often argue that teaching young people information about sex or giving them access to contraception will encourage them to engage in intercourse when they otherwise would not. In the United States, for example, conservative Christian attitudes towards sex have led to government funding restrictions on services for sex workers, and have pushed schools to implement sexual education programmes that teach abstinence as the sole means of preventing STIs and pregnancy.[26] Rather than making young people less likely to have sex, these sorts of policy decisions are more likely to compromise young people's ability to make informed decisions about safe sexual practices and family planning.[27] As a result, policy and funding decisions that reflect conservative religious ideas restrict progress towards achieving universal access to SRH services and negatively influence legal frameworks surrounding access.

Social taboos: In many cultures there is stigma attached to young people's sexuality, resulting in lack of discussion around sexuality or sex. For example, in many countries, engaging

in intercourse before marriage is viewed as unacceptable.[28] In these environments, young women's access to contraception and other SRH services is limited by social stigma or legal restrictions.[29] This in turn leads to unwanted pregnancy, STIs and unsafe abortions.[30] Young people may be hesitant to access treatment for STIs or HIV because they do not want to be seen as sexually active, sick or infected, particularly in contexts where services cannot be accessed in privacy and confidence. Unmarried adolescent girls are often denied SRH services even when vulnerable to violence and sexual abuse.[31] Social taboos surrounding young people's sexuality restrict healthy and helpful discussions about sexual health issues among young people, their parents and peers.[32]

Policy context: Policy in many countries and internationally often replaces an understanding of 'sexual and reproductive health' with 'reproductive health'.[33] Whilst the two are very much linked, reducing the former to the latter has the effect that the overwhelming focus of SRH services and information is limited to pregnancy. This fails to address broader personal, relationship and social contexts that form part of promoting sexual health (for example, the protection and promotion of sexual freedom and equality).Confused and restrictive political contexts often result in inconsistencies in law. For example, in Zimbabwe, whilst 16 year olds can legally consent to sex, they are not permitted to use services and information regarding contraception and STI prevention.[34]

Geographic inaccessibility: Poor transport infrastructure and other structural barriers can prevent access to services in rural areas. In many countries, isolated populations may have limited or no access to formal government provided SRH services, particularly in contexts where there are vast development and economic inequalities between urban and rural areas.[35][36]

Legislation: Finally, in many countries, legislation restricts access to SRH services, particularly for young people. Laws that make it difficult for young people to access SRH services are often (supposedly) derived from a protectionist approach to young people's sexuality; the belief that young people should be protected from harm that may result from sexual activity or exploitation.[37] An example of this is age-based consent laws that require minors to seek parental consent before they are able to access SRH care and information. Far from fulfilling their (presumed) protectionist objective, the practical impact of such laws may be that young people to engage in unsafe sexual behaviour, as they are unable to access the information, advice and medical support that they need to make informed, healthy and autonomous decisions.[38]

Whilst there is a strong body of research on the effect that gender, culture, religion and other social factors has on young people's access to SRH services, less in-depth research has been conducted on the legislative barriers that particularly affect young people. Furthermore, information databases concerning law that affects access to SRH often fail to consider how legal provisions may or may not be different in their application to young people, for example, access to contraception may be legal but only after an individual has reached a certain age.[39]

The following section contains a summary global mapping of the ways in which different jurisdictions impose legal restrictions in young people's access to SRH services.

2.4 A global review – legal barriers to access

This global review of law that affects access to SRH services comprises three sections. The first section reviews access to services including contraception, family planning services, pregnancy care, abortion, STI testing, treatment and others. The second section reviews legislation related to the protection and promotion of sexual freedom and equality (a fundamental part of sexual health). The final section reviews laws relating to sexual violence which have a significant impact on access to SRH services both directly and indirectly.

2.4.1 Access to services

SRH services vary widely around the world, and encompass many different services and projects. For example, there are over 15 different types of contraception, each with different levels of effectiveness and with different advantages and disadvantages.[40] There are also thousands of laws around the world that determine which contraceptives are available to whom in which contexts and where they are permitted to be distributed.

This review narrows the scope of inquiry to laws concerning **consent to accessing services**; one of the main ways in which states seek to regulate access to SRH services, particularly for young people. During the country-specific case study field research, further consideration will be made as to which services are actually available to those who are legally able to consent.

Access to abortion is one type of service that is regulated by law by all states around the world. Due to the significance of abortion services for ensuring protection and promotion of SRR, and the complex legislation that seeks to restrict and regulate these services, the issue of abortion is dealt with separately in this report, following a review of consent laws that affect access to other SRH services.

2.4.1a Consent for accessing contraception and sexual health services

No minimum age for accessing sexual and reproductive health services

In many countries around the world there is no age restriction for access to SRH services. No parental or other consent is required, although health care providers may contact parents or other authorities where they feel a minor is at risk (discussed below).[41] States in this category include **Austria**, **Denmark**, **Estonia**, **Finland**, **France**, **Hungary**, **Ireland**, **Iceland**, **Luxemburg**, **Portugal**, **Sweden** and the **UK**.

In other countries, the law imposes a minimum age for legally accessing SRH services. For instance, it is reported that in the **Central African Republic**, girls under the age of 18 are prohibited from accessing contraception.[42]

The ability of a young person to lawfully access services is often the result of the absence of an explicit restriction of access (for children or young people) in law. In other cases, a young person's right to access services is positively protected. For example, in the **USA**, all States allow minors to access STI testing and services, though 11 states establish a minimum age (usually 12–14) below which a minor cannot consent.[43] In 19 States, however, this does not include HIV testing.[44] The removal of restrictions for accessing (specifically) *contraception* is a somewhat recent development.[45]

Some laws allow room for discretion in determining whether a young person can receive a service or not. For example, in **South Africa**, a person over 12 years old can consent to an HIV test, and a person under 12 may consent to a test if they are "of sufficient maturity to understand the benefits, risks and social implications of such a test".[46] In the UK, a medical professional may provide SRH services to a child under the age of 16 years, but only in the case that (s)he is satisfied that a number of criteria are met. These criteria are known as the 'Gillick competency and Fraser Guidelines', derived from a 1985 House of Lords case specifically concerning contraception.[47]

Fraser Guidelines

A doctor could proceed to give advice and treatment provided he is satisfied in the following criteria:

1. That the girl (although under the age of 16 years of age) will understand his advice;
2. That he cannot persuade her to inform her parents or to allow him to inform the parents that she is seeking contraceptive advice;
3. That she is very likely to continue having sexual intercourse with or without contraceptive treatment;
4. That unless she receives contraceptive advice or treatment her physical or mental health or both are likely to suffer;
5. That her best interests require him to give her contraceptive advice, treatment or both without the parental consent.

Gillick Competency

"…it is not enough that she should understand the nature of the advice which is being given: she must also have a sufficient maturity to understand what is involved."

Even in places where there are no formal or direct legislative barriers related to consent, the law may serve as an indirect barrier to accessing services in practice. This is particularly the case for the contraceptive pill and for emergency contraception. For example, in the **UK**, emergency contraception is only available without prescription to persons over the age of 16 years.[48] Research has demonstrated that logistical constraints, lack of confidence, a sense of embarrassment or humiliation, and the inability to visit doctors without alerting parents (or other persons in positions of authority over young people), may result in such rules having a disproportionate effect on the willingness of young people to access these services.[49]

Social and cultural norms may influence a service provider to unilaterally decide to refuse a young person a particular service, or to inform their parent(s) or guardian(s). In other cases, law itself designates service providers with the discretion to determine the boundaries of confidentiality for young people. For example, in the **UK**, medical professionals have a positive duty (under a combination of the law and related statutory guidance and guidance issued by professional regulatory bodies) to report cases in certain circumstances where they have concerns for the young person's safety or welfare.[50] On the 'NHS Choices' website, advice to young people about access to contraceptives and confidentiality is provided thus:

> Contraceptive services are free and confidential, including for people under 16 years old. This means that the doctor or nurse won't tell your parents, or anyone else, as long as they believe that you're mature enough to understand the information and decisions involved. There are strict guidelines for healthcare professionals who work with people under 16 years. If they believe that there's a risk to your safety and welfare, they may decide to tell your parents.[51]

This, however, may leave young people in a state of uncertainty as to whether confidentiality will be ensured in practice, and as a

result may render them less confident to access services, especially where family and/or community norms are restrictive/ prohibitive regarding young people's sexuality.

Sexual and reproductive health services available to young people with parental consent

In many contexts, young people may only legally access sexual and reproductive health services with the consent of their parents. Many states set a minimum age for access to SRH services *without* parental consent. In Buenos Aires Province, **Argentina,** parental consent is required for any person under the age of 14 years to access these services.[52] In **South Africa**, while a child is able to access contraceptives without parental consent at 12 years of age, the law states that medical advice should be provided together with a medical examination determining whether a specific contraceptive should not be used.[53] In some cases, this is due to legal provisions that directly establish a minimum age for access to SRH services, while in other cases this minimum age is set out by other laws that regulate access to medical service and consent to sexual activity. Finally, in some states, parental consent may only apply to certain services. For example, in **Chile**, minors do not require parental consent for most sexual health services or to access contraception. However, HIV/AIDS tests require parental consent.[54]

In many states, parental consent is required before a young person can access contraceptive goods and services specifically. These states include **Lithuania** (under 16s), **Poland** (under 18s), **Slovakia** (under 15s), **Peru** (under 18s), **Argentina** (under 14s). Often these rules apply to prescription drugs, as opposed to goods such as condoms which may be available on purchase at retail outlets accessible to young people.

Consent to treatment and consent to sexual activity

There is often a distinct lack of clarity in the laws that regulate young people's access to SRH services. In particular, laws that determine the age at which one can consent to sexual activity may complicate (or be interpreted to complicate) laws concerning consent to access SRH services. For example, in 2006, the government of **Peru** amended Article 173(3) of its Criminal Code reportedly to protect young people from sexual abuse and violence, particularly sexual abuse committed by an adult against a minor.[55] However, the law also criminalised consensual sexual activity among adolescents between 14 and 18 years old, for which they could have received up to 30 years in prison.[56] In their submissions to the UN Committee on Economic, Social and Cultural Rights, a group of NGOs, including IPPF, highlighted that this law (although ostensibly concerned with the age of consent to sexual activity) negatively impacted on adolescents' access to SRH services and stigma surrounding sexual activity of young people. In particular, "the law left medical practitioners unclear of the treatment they should provide to adolescents … even jeopardizing pre-natal checkups, public institutional deliveries as the pregnancy is the evidence of the crime".[57] One young woman reportedly explained: "I was frightened to go to the hospital because I was scared [the government] would take away my baby or send me to communal housing where I could no longer care for him".[58]

The **UK** provides an example of legislation that attempts to provide more clarity on how to interpret young people's right to access SRH services in the light of laws on the age of consent to sexual activity. Section 73 of the Sexual Offences Act 2003 provides exceptions to the crime of aiding, abetting or counselling certain sexual offences against children where the person was acting to protect the child from an STI, protect their physical safety, protect them from becoming pregnant, or promote their emotional well-being by the giving of advice, provided that it was not carried out for the purpose of obtaining sexual gratification or causing or encouraging the offensive activity.[59] This provision can, in effect, exempt doctors from criminal liability for prescribing children under the age of consent with contraceptives should they ask for them, provided that the doctor is acting to protect the child's health under the conditions set out by the law.

SRH services only available to married people

In some states, the law prohibits the supply of contraceptives to *unmarried* women and/or men. One way in which such laws are constructed is for legislation to enshrine a right to contraception and family planning services, but only to mention married couples as recipients of such a right, such as is the case in **Indonesia**.[60] There are also reports in **Argentina** that unmarried women have been denied access to family planning services on the basis that, as they are unmarried, they do not have a spouse to provide the necessary spousal consent.[61]

There are references in online sources to African countries only making family planning services available to married couples, although the number of such sources is limited.[62] Given the lack of specific laws or policies on this issue, it is possible that these are contexts where informal convention or practice or customary legal principles are more significant in determining an individual's access to SRH services than formal, statutory law.

Interestingly, it is only as recently as 1972 that the **USA** made contraception legally available on the same terms to unmarried people as married ones.[63]

Availability of contraception with spousal consent

In some states, such as **Saudi Arabia**, traditional practice requires that women seek consent from a male spouse or guardian before decisions about health care, including accessing contraception and family planning services, are made.[64] In **Bahrain**, women are legally required to have their husband's consent should they wish to be sterilised and (perhaps more surprisingly) if they wish to undergo a caesarean section delivery (unless the surgery is urgent

or if the husband is absent).[65] They are, however, legally permitted to access contraception without spousal consent although spousal consent and religious advice is often sought in practice.[66]

Indeed, through this desk research, it has been difficult to obtain accurate information indicating where the requirement of spousal consent to access SRH services is the result of a legal obligation and where this is a matter of social custom. Many reviewed documents have been found to be contradictory and to contain an ambiguous blending of law and practice. In the case of **Senegal,** one source from 2001 claims that, "[u]se of contraceptives often depends upon the spouse's formal or tacit agreement"[67] but this review was unable to find a definitive reference to a specific legal rule setting out this requirement. Further, as of 2002, **Niger** and **Rwanda** reportedly required spousal consent for voluntary sterilisation, although it is not clear whether this restriction still applies today and whether it is/was imposed by law.[68] The lack of clarity and attention given to the difference in law and practice relating to this aspect of SRH is an important finding in itself, and one that it would be highly interesting to explore during the field research.

The review has noted a suggested gender imbalance in consent rules: laws may require a woman to obtain consent from her husband to access certain services, but not necessarily the other way around. This is an issue that should be looked at more carefully in the in-depth country case studies and during the field research. Are there contexts where a man must seek his wife's consent before accessing a vasectomy (for example)? More clarity on these issues would assist researchers to understand whether these types of laws are rooted in a notion that women lack capacity to make reasonable and appropriate decisions about such issues, an attempt to control women's sexuality, or whether the promotion of joint decision making is a significant factor.

Other factors that influence access to services

Cost and availability of service: In some countries, law and policy provides that access to (certain types of) SRH services are free. In others, no such provisions exist, and these services may be costly. High costs associated with accessing SRH services are likely to affect young people disproportionately; young people are less likely to be in positions of financial independence compared to older people, and may have difficulties paying for SRH services without parental or spousal support (which may not be available).

In **Peru**, for example, public funding is specifically not provided for emergency contraception making the service only available to better off members of society and less accessible to young people in general.[69] This is likely to be the result of a deliberate policy to limit access to emergency contraception.

Even where services are provided for free it may be that the difficulty or delay in actually obtaining them makes private, paid for services the only option. In **Poland** it is reported that crucial, time dependent antenatal services often have such lengthy waiting lists that private health services are the only sensible option resulting in some paying and some not obtaining access.[70]

The actual outcome of polices that require the free provision of contraceptive goods and sexual and reproductive health services is further complicated by commodity shortages. In **Peru** there is reported to be a constant shortage of 'modern contraceptives, including pills, injections and emergency contraception'.[71] It is also reported that 'although family planning services are free, [there is] a constant of undue and illicit charges' being made by medical centres.[72] In **Senegal**, where access to sexual health medical centres is legal in spite of the reluctance of such centres to admit adolescents,[73] access is further inhibited by the reportedly high cost of accessing quality medical care.[74] This high cost, driven in part by a shortage of trained medical staff, is a contributing factor to Senegal's high maternal mortality and morbidity rate.

Even where laws regulating access to SRH services are broadly liberal and permissive, access may be compromised in practice due to a lack of affordable care. For example, whilst the Medical Termination of Pregnancy Act, 1971 in India, permits abortion on the grounds of health, many women in **India** continue to access unsafe abortion services.[75] This compares to **Nepal**, where legislation legalising abortion is understood to have contributed to the reduction in maternal mortality by 50% in the last decade, as it has been accompanied by an effort to ensure the availability of safe and affordable family planning care including abortion.[76]

Encouragingly, awareness of the problems caused by charging for SRH services is becoming more widespread, with countries all over the world introducing new laws to extend access to those without the means to pay. For instance, in 2004, **Colombia**'s Ministry of Social Protection issued Circular No. 18, which outlines goals, activities, and standards for the delivery of primary health-care services. The circular specifically addresses adolescents' access to contraception and requires the provision of emergency contraception to uninsured adolescents living in communities that are displaced, economically disadvantaged, and at risk.[77]

Freedom of movement: Even if a young person is able to legally access contraceptive goods and SRH, in some contexts a young person (particularly women and girls) may not be able to leave the house without their husband's or parents' permission. For example in **Morocco** it is reported that despite the unrestricted right of women to consent to their own family planning in practice, because women are often subject to a degree of traditional male control over their movements, they may need the consent of their husbands or male guardians to visit a doctor or go to the hospital.[78]

Awareness of services and rights: Even where services are legally accessible to young people, poor education and awareness may mean that people are unaware of their existence or how to access them. For instance in **China**, the National Family Planning Programme targets married couples (for awareness-raising and information provision). This means that young unmarried people often lack access to information or advice regarding contraception.[79] Research conducted in **Yemen**, for example, has found that few women are aware of their legal right to use contraception, and even fewer are in a position to make free and independent choices about their reproductive health. It is reported that in rural areas, provision of healthcare in general is very poor, including SRH healthcare, leading to very high rates of maternal mortality. Childbirth is the leading cause of death among women of reproductive age.[80]

Conclusions and further points for consideration
Law relating to the medical treatment of adolescents is generally vague and confusing. In many cases laws appear to be drafted without consideration of children, and the situation for under-18s or people under the age of majority is unspecified or unclear. This leaves a wide margin for healthcare providers to interpret the law, such that young people are in an uncertain position and may be subject to arbitrary or inconsistent imposition of restrictions. This is an issue that needs to be explored in more detail in the field research. Preliminary findings from this review suggest that more work needs to be done to help states draft legislation and guidelines for service providers that is explicit in intent and inclusive of young people, to avoid the unintended outcomes of vague and unclear legal provisions.

2.4.1b Access to abortion

This section considers how different jurisdictions around the world regulate access to legal (induced) abortion for young people. The analysis considers how young people's access to abortion may be affected by law in the following three ways:

- Restrictions on the circumstances in which an abortion is permitted
- Laws that govern who can consent to abortion
- Laws that regulate the cost of abortion.

This is followed by a quick summary of other barriers to accessing abortion, that interact with abortion law, to compromise access to abortion (particularly for young girls) in practice.

In general, detailed, current, collated information about abortion laws around the world is limited. Even UN state profiles often fail to mention key aspects of a state's legal position, and, crucially, many sources neglect to include details of the consent arrangement for minors, or (un)married women or girls. However, a comprehensive mapping by the Center for Reproductive Rights demonstrates broadly the range of laws and regulations on abortion around the world.[81]

A. Circumstances in which abortion is permitted

The circumstances in which abortion is allowed vary considerably in different jurisdictions around the world, ranging from states where there is a total prohibition on abortion, to states where abortion is 'available on request' within a restricted gestational period.

Abortion 'on request'
Roughly a quarter of states around the world permit abortion 'on request' within a restricted gestational period.[82] In some of these jurisdictions a woman/girl is not required to justify her decision to have an abortion, however, in some contexts she may be required to state that she is in a situation of distress or crisis.[83] Further, there are often additional procedural requirements which functionally limit the availability of abortion in practice, including waiting periods, third-party consent or authorisation, mandatory counselling, limited categories of health care workers permitted to perform abortions, and limited medical facilities where abortions may take place.[84]

Jurisdictions which permit abortion on request are numerous and include 69% of developed countries.[85] However, in many of these jurisdictions, abortion is only available in the early weeks of pregnancy. Examples of states that permit abortion on request include: **Austria**, **Australia**, **Belgium**, **France**, **Germany**, **Netherland**, **Switzerland**, **USA**, **South Africa**, **Turkey**, **China**, **Mongolia**, **North Korea**, **Kazakhstan**, **Kyrgyzstan**, **Nepal**, **Tajikistan**, **Turkmenistan**, **Uzbekistan**, **Cambodia**, **Singapore**, **Vietnam**, **Armenia**, **Azerbaijan**, **Bahrain**, **Georgia**, **Belarus**, **Bulgaria**, **Czech Republic**, **Hungary**, **Moldova**, **Romania**, **Russia**, **Slovakia**, **Ukraine**, **Denmark**, **Estonia**, **Latvia**, **Lithuania**, **Norway**, **Sweden**, **Albania**, **Bosnia and Herzegovina**, **Croatia**, **Greece**, **Italy**, **Macedonia**, **Montenegro**, **Portugal**, **Serbia**, **Slovenia**, **Spain.** Largely absent in this category are **African**, **Arab**, **Caribbean** and **South American states** with the exception of **Cape Verde**, **Tunisia**, **Cuba** and **Uruguay**.[86]

States in this category tend to have better contraceptive provision, and often have *lower* levels of abortion than countries where these services are heavily restricted.[87]

Abortion allowed for economic or social reasons
In practice, laws in this category can be nearly as permissive as 'on request' abortion laws. However, they give a higher level of discretion to doctors to decide if abortion is permissible, and place a heavier onus on the woman/girl to justify her decision to abort.

In practice, assessments as to whether abortion is permissible in a given circumstance may be highly subjective, and involve a complex, and a (potentially) non-transparent balancing of different considerations. For example, in **Belize**, 'economic and social considerations' are considered as part of a broader examination on the effect that carrying a foetus to term would have on a woman's health.[88] Furthermore, the 'justification' requirement is likely to influence broader social norms about the acceptability of abortion in general, and the circumstances in which it may be a 'legitimate' option. This issue would be very interesting to explore during the field research.

Other states which fall into this category include the **Japan**, **Mexico** and **India**.[89]

According to an analysis of 'World Abortion Policies' conducted in 2011 by the Population Division of the Department of Economic and Social Affairs, the **UK** falls into the category of countries which permit abortion for 'social and economic reasons'.[90] The law in the UK, however, focuses primarily on physical and mental health justifications.[91]

UK Abortion Act 1967

Section 1 of the Abortion Act 1967 states that a registered medical practitioner may lawfully terminate a pregnancy, in an NHS hospital or on premises approved for this purpose, if two registered medical practitioners are of the opinion that:

(a) the pregnancy has not exceeded its 24th week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family;

(b) the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman;

(c) the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater that if the pregnancy were terminated; or

(d) there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

The Abortion Act 1967 has a conscientious objection clause (Section 4) which permits a doctor to refuse to participate in terminations if he or she has a conscientious objection to performing an abortion, but which obliges the doctor to provide necessary treatment in an emergency when the woman's life may be jeopardised. The right to conscientiously object is limited to an objector who had to be required to actually take part in administering treatment in a hospital or approved centre. This seems to support the view that general practitioners cannot claim exemption from giving advice or performing the preparatory steps to arrange an abortion if the request for abortion meets the legal requirements. Such steps include referral to another doctor as appropriate. Section 4 is often cited as the reason why some doctors do not perform abortions on minors, in particular young adults under the age of 16.

Abortion permitted to preserve a woman's health

In the majority of states around the world abortion is permitted (at least) in order to preserve the health of a pregnant woman or girl.[92] The definition of 'health' varies widely between different jurisdictions. The laws of some states are broadly open to interpretation; others will list specific conditions/thresholds that must be met. In some states such as **Burundi**, **Mozambique**, **Rwanda**, **Uganda**, **Zambia**, **Nigeria**, **Sierra Leone**, **Malaysia** and **Saudi Arabia**, health is defined to include mental health. In others, such as **Lao PDR**, the **Maldives**, **Panama** and **Togo**, abortion is only permitted where it is a risk to the mother's physical health.[93]

Abortion to save the life of the woman

In many countries around the world abortion is only permitted in circumstances where carrying a pregnancy to term is understood to be life-threatening for a woman/girl. Arab and African countries are strongly represented in this group which includes states such as **Haiti**, **Malawi**, **Angola**, **Congo**, **Gabon**, **Niger**, **Bangladesh**, **Iran**, **Syria**, **Egypt**, **Sudan**, **Senegal and Ireland**.[94] Whilst many of these laws are driven by religious or moral convictions, justifications do vary. For instance, in **Gabon**, abortion is restricted, along with other family planning services, at least partly due to government concerns about the country's falling fertility and population growth rates.[95]

Abortion allowed due to foetal impairment

States that extend to circumstances in which abortion is allowed to include foetal impairment are **Botswana**, **Columbia**, **Ethiopia**, **Ghana**, **Guinea**, **Liberia**, **Seychelles**, and **Swaziland**, amongst others.[96]

Abortion allowed in cases of rape or incest
Many states extend circumstances under which abortion is permitted to include cases of rape or incest.[97]

The potential complication, delay and stigma involved in proving a case for abortion on these grounds may, in practice, significantly inhibit a survivor's access to abortion on this basis, particularly in the case of the rape of a minor. For example, in **Panama**, an abortion can only take place in circumstances where it has been identified as the consequence of the event of rape which has been detailed in Court proceedings.[98] Detailing the circumstances of a rape is likely to be a humiliating and traumatic process for a survivor of sexual violence; and this vulnerability is often accentuated in cases where the survivor is a young person.

Furthermore, there may be complications around ensuring confidentiality, and onerous procedural requirements may limit the availability of abortion (even where the legal condition is met) in practice. In **Bolivia** (as in many other states in this category) criminal action (for rape) must be pursued for this ground to apply, and until recently, abortion has required judicial consent.[99] Even for victims who are willing to go through proceedings, given the delays imposed by legal processes, by the time a legal decision is made it may be too late for the victim to get an abortion. Given low conviction and reporting rates surrounding rape and sexual abuse,[100] this will mean that a limited number of rape victims are able to access abortion. Indeed, the difficulty and delay in establishing this has resulted in only a very small number of legal abortions in **Bolivia**.[101]

This was exhibited in a case in **Poland** where a 14 year old rape victim struggled to access abortion services from resistant service providers, and was mistreated and poorly served by medical practitioners.[102] Though abortion is legal in cases of rape in **Poland**, the medical practitioners invoked conscientious objection and presented misinformation to avoid delivering services. This was likely more intense because the victim was a minor; she was accused of being pressured by her mother into seeking an abortion. The case was brought to the European Court of Human Rights, which found that where a woman is entitled to an abortion the state must guarantee that she is able to access one. The court also found that, "states must respect adolescents' person autonomy in the sphere of reproductive health".[103]

Abortion not allowed in any circumstances
There are a limited number of states in which abortion is not allowed on any grounds, including **Chile**, **Dominican Republic**, **El Salvador**, **Nicaragua**, and **Malta.**[104] [105] States in this category tend to have significant or majority populations of Roman Catholics. Many of these states are signatories to the Inter-American Convention on Human Rights, a largely South and Central American human rights instrument in which Article 4.1 states that the right to life begins at conception.[106]

In practice, this does not necessarily reduce rates of abortion in these jurisdictions, it does, however, compromise access to safe abortion, particularly for young people.[107] In the **Dominican Republic**, for example, despite a total prohibition on abortion, abortions are performed in private clinics as well as more clandestine and unsafe circumstances.[108] Such an environment makes access to financial resources a key element of accessing safe abortion. As young people often lack financial independence this has serious implications for both the autonomy and privacy of their access.

B. Laws of consent to abortion

Parental permission needed for those under the age of majority
In many states, although abortion is legal, those under the age of majority require parental consent to access an abortion. These states include **Iceland** (under 16s), **Italy** (under 18s), **Poland** (under 16s), **Slovakia** (under 16s), **Turkey** (under 18s), **and Cuba** (under 18s) amongst others.[109] This provision by definition means that young people are unable to act autonomously and have their confidentiality protected.[110] It creates an additional barrier affecting young people's ability to access legal abortion, and has the potential to place some young people at risk (depending on the values and attitudes of their family environment).

No age restriction but spousal/family permission needed at all ages
In these states, abortion is legal but consent is required from the spouse or family members regardless of age. By nature of the parental/spousal involvement, the service fundamentally lacks confidentiality, and compromises women and girls' ability to make an autonomous choice.[111] This may particularly limit access to abortion for young women and girls, who may have relatively less capacity to assert their independent wishes than older women. These states include the **Faroe Island**, **Maldives**, **Togo**, **Japan** (where the spouse is available) and **Saudi Arabia** amongst others.[112] In **Turkey** spousal consent is required for abortions taking place past the 10th week.[113]

No age restriction but adult support required
In these states, abortion is legal for young people, even those under the age of majority, without their parents' permission; however they must be accompanied by an adult of their own choosing. Such states include **France** amongst others.[114] In **Cuba** permission for abortion for under-16s is required from both parents and local medical councils.[115]

No age restriction, no parental permission required
In many states abortion is legal for young people, even those under the age of majority, without their parents' permission. Their parents will only be informed without their consent, subject to exceptions where the doctor believes that the young person

is at risk. States in this category include the **UK** (if the Gillick competency requirements are met), **New Zealand** and some states in the **USA.**[116]

Forced abortion

Not considered in detail here but relevant to the topic and of great importance is young people's right to not be forced to undergo an abortion.

In **China**, for instance, the Government, under the One-Child Policy, has introduced considerable and, for many, unaffordable financial levies for having a second child.[117] Given widespread poverty in China, the result is to deprive many women of a real choice as to whether to terminate their pregnancy or not. This law has also provided an environment in which local family planning officials acting beyond their official remit have been implicated in coercive and aggressive demands for termination.[118] Where present, such laws represent a comparable restriction of young people's reproductive and contraceptive freedom as laws limiting their access to such services.

Forced abortion may also occur in the case where a pregnant woman is deemed not to have the mental capacity to consent to abortion, and a guardian is given the right to consent on her behalf. This nearly resulted in a forced abortion in the **US** state of Massachusetts, where, in a controversial ruling, the judge awarded guardianship for the purpose of consenting to abortion to the parents of a 31-year-old woman suffering from delusions and schizophrenia, despite the fact that the woman, who claimed to be Catholic, opposed the abortion. However an appeals court overturned the ruling.[119]

C. Laws concerning cost of abortion

As mentioned above, given that young people around the world often lack financial independence, where abortion requires the payment of a fee, there is likely to be a disproportionate increase in barriers to access for young people.[120] Even where abortion is provided free of charge, different healthcare provision models may result in different outcomes for a young person's autonomy and privacy. Further research might consider whether countries where healthcare is provided (for instance, through a private insurance policy controlled by a parent) suffer from a restriction in privacy or control of access.

States where abortion incurs a fee

In many states, health care, including abortion access, is not provided for free. In some states a distinction is made between abortion for medical reasons, and other reasons. For example in **Estonia**, abortion is more expensive for a client when it is not understood to be necessary on medical grounds.[121] In **Finland**, whilst the abortion itself is covered by national health insurance, clients must pay for their hospital fees.[122]

States where abortion is provided free of charge

In the **UK**, **Netherlands**, **Italy**, **Finland** and **South Africa** abortion is free of charge to all residents.[123][124] In **Cyprus** and **Germany** abortion is means tested providing that those on low incomes can access abortion.[125] Significantly in **France**, abortion is provided free of charge to minors.[126]

D. Other potential barriers to abortion access for young people

It is useful to briefly review other barriers which impact on young people's access to SRH services in order to understand how these may interact with legal barriers, or impact on young people's perceptions of them.

Bureaucracy

In some states the procedure for obtaining abortion services involves multiple steps and appointments presenting difficulties to young people who may have limited access to transportation and limited ability to travel independently of their parents. In **New Zealand**, for instance, a woman may have to travel to a second site to get a second certifying consultant's signature prior to going to a hospital or clinic.[127]

Counselling services

Many states offer women some form of counselling before and/or after having an abortion. In some **US** states (e.g. Texas) counselling is compulsory.[128] Whilst the process of counselling is usually required to be provided without judgement or bias (e.g. **New Zealand**[129]), there is scope for individuals with particular religious or political positions on abortion to use counselling as a forum to promote their agenda. There is an additional concern that counselling may not take into account the unique needs of young people. For these reasons (especially in contexts where counselling is compulsory) the process could be distressing for women and girls, particularly those that are young. This is a question that would be interesting to explore during field research.

Willingness of doctors to provide abortions

Even where abortion is legal, availability of abortion services can be restricted in practice, due to attitudes of doctors who are legally allowed to refuse to personally perform abortions on the grounds of 'conscientious objection'.[130] In **Bolivia**, for example, a judge ordered an abortion for a 12 year old girl raped by her stepfather but even with permission granted it took weeks to find a medical centre willing to perform the procedure.[131]

A recent survey by the Journal of Medical Ethics of the opinions of medical students in the **UK** found that almost half believe doctors should be allowed to refuse to perform any procedure to which they object on moral, cultural or religious grounds. Abortion provoked the strongest feelings among the 733 medical students surveyed: "*the survey revealed that almost a third of students*

would not perform an abortion for a congenitally malformed foetus after 24 weeks, a quarter would not perform an abortion for failed contraception before 24 weeks and a fifth would not perform an abortion on a minor who was the victim of rape".[132]

Waiting periods

Some states require women of all ages to wait a certain number of days between an initial consultation and any subsequent abortion. For example, the **Netherlands** has a 5 day waiting period, and **Germany** 3 days.[133] In the **USA**, 26 states have introduced laws requiring women to wait a specified period of time, usually 24 hours, between when she receives counselling and the procedure is performed.[134] The introduction of these laws has caused considerable controversy, particularly in the recent case of Utah where last year a 72 hour waiting period was introduced.[135]

Whilst countries such as the **UK** do not have a compulsory waiting period provided in law, the consequence of abortion being provided for free through the limited resources of the National Health Service, is that there is often a waiting period of considerable length simply to get an appointment.[136] This period of wait can be distressing for women and girls, and the physical consequences of pregnancy may interrupt education and other activities.

Prohibitions on frequency

Some countries limit the frequency with which a woman can have an abortion. For instance, in **Slovakia** a woman may not legally have an abortion unless a minimum of 6 months has passed since last having one.[137]

E. Punishments for illegal abortion

Penalties that are imposed for illegal abortion vary widely between states. In some states, e.g. **Bolivia**, it is the doctor/practitioner performing the abortion who is penalised.[138] In other states, more heavy-handed laws punish both women/girls seeking abortions and all those involved in assisting her.

Different types of laws that impose penalties, such as fines or jail time, for abortion are likely to impact on access in different ways. For example, laws that impose a penalty on the abortion provider are likely to raise the cost of accessing abortion (as the risk of prosecution is factored into the cost). Laws that impose penalties on women may directly impact on abortion-seeking behaviour (although, as mentioned, evidence shows that restrictive laws do not in practice reduce the numbers of abortions being performed). Women might choose to seek out particularly clandestine services regardless of safety, and such laws may discourage the likelihood that the woman will seek help for any subsequent complications that result.

A particularly problematic development in several countries is the use of abortion laws, or even homicide provisions, to prosecute women for 'spontaneous abortions' (miscarriages). This has occurred in **El Salvador**, one of the few countries in the world in which abortion is illegal under all circumstances, where numerous women have been imprisoned on charges of illegal abortion and even homicide after having miscarried.[139] Similarly, the US state of Utah recently passed a law which states that "the killing or attempted killing of a live unborn child in a manner that is not abortion shall be punished as … criminal homicide" and establishes the standard that the death of an unborn child which results from "intentional, knowing or reckless act of the woman" is punishable as criminal homicide.[140] This effectively makes a woman criminally liable for having a miscarriage if she knows she is pregnant. We hope to explore the direct and indirect impact of extreme provisions such of these on young people's access over the course of the research.

F. Conclusions

This review reveals that almost all states around the world intend to prescribe normative ideas about abortion through their law. This is clearly the case even for states that fall into the 'abortion on request' category. For example, compulsory waiting periods enforced in states such as **Germany** and the **Netherlands**, impose the normative position that abortion is a 'big decision' and, therefore, time *must* be taken to think about it carefully. The **UK** falls into the category of states where abortion is available either for health or for social and economic reasons. Whilst, in practice, there may appear to be very little difference in the availability of abortion in the **UK** compared to states in the 'abortion on request' category, it is significant that, according to law, abortion is not a matter of individual *right* or *choice*, but rather something that is rendered necessary under particular (unfortunate) circumstances.

In the majority of states around the world abortion is only permitted under very limited circumstances.[141]

In states where there is a total prohibition on abortion, this appears to largely derive from the absolute religious and moral position that human life begins at conception. It is significant, however, that this group only comprises a tiny fraction of states. A much wider number of states (the majority in the world) permit some abortions, but only in very specific circumstances: such as where the pregnancy threatens the mothers' health, or where the pregnancy has resulted from rape or incest. These laws are likely to be the result of a more complex process of moral reasoning, which involves balancing a variety of different concerns and interests. During the field research it would be interesting to gather young people's perspectives on these laws, to understand how they are interpreted and the grounds on which they are justified.

It is widely evidenced that strict abortion laws do not consistently translate into a reduction in the number of abortions. For example, in Africa and Latin America (regions where abortion is illegal under most circumstances in the majority of countries), abortion rates are estimated at 29 to 32 per 1,000 women of childbearing age in Africa and Latin America.[142] Comparatively in Western Europe, where abortion is generally permitted on relatively broader ground, the abortion rate is 12 per 1,000 women.[143]

In addition, liberalisation of abortion laws may not always improve access. For example, in **Cambodia** concerns about the high level of fatalities in illegal abortion lead to a 1997 law allowing abortion on request. Despite this change in law actual improvement in access remains limited due to a shortage of trained medical staff capable of performing the operation.[144]

Nevertheless, strict prohibitions on abortion are likely to impact on abortion seeking behaviour by encouraging individuals to turn to clandestine or unsafe services. In some states, concerns about health care problems caused by illegal abortion have led to a liberalisation in abortion law. **Barbados** is one of many states that initiated dramatic change of its law in response to large scale public health problems caused by dangerous illegal abortion.[145] **Nepal** provides an example of a country where liberal abortion laws have contributed to decreases in maternal morbidity and mortality. In 2002, the law was changed to allow all women access to legal abortion up to 12 weeks of gestation and up to 18 weeks for pregnancies resulting from rape or incest.[146] Since 2005, the maternal mortality ratio has halved in Nepal and since the law's introduction, the number of abortion-related complications recorded has also halved.[147]

The circumstances in which young people may need abortion services have different characteristics to those of adults. Young people may be less inclined to admit they're pregnant, more susceptible to external influence, less sure of their actions, less quick to realise they are pregnant, less independent both financially and in terms of their ability to leave their parents' company and fearful of family and societal reaction if they have become pregnant in taboo circumstances. For all these reasons laws that limit time frames, circumstances, autonomy, privacy, and affordability of services are likely to disproportionately affect the sexual health of young people.

2.4.2 Sexual freedom, equality and consent

The first principle of 'Sexual Rights: An IPPF Declaration' affirms the principle (enshrined in international human rights law) that the freedom to express ones sexuality is a fundamental part of personhood: *"sexual rights are universal human rights based on the inherent freedom, dignity and equality of all human beings"*.[148]

States have an obligation to individuals within their jurisdictions to protect their right to freely express their sexuality; this obligation has two essential components: the negative liberty to be free from state prosecution and the positive liberty to be protected from harassment and attack on the basis of one's sexuality or sexual activity.[149]

The ability to freely express one's sexuality is directly linked to sexual and reproductive health and access to services. In states where particular sexual identities or modes of behaviour are restricted, young people may be at risk of punishment, persecution or prosecution potentially exposing them to severe physical and mental harm. This harm may be the result of direct attack, correctional punishment or other 'treatment',[150] or the indirect effect of living a life of fear and repression. Access to services may be restricted either because the young person is afraid that their sexual identity may be revealed through contact with medical services, or because facilities are only available for married individuals (either through law or custom). Furthermore, individuals with homosexual or transgendered identity may have difficulty accessing sexual health education and information about services.

2.4.2a Law and LGBTI identity

Many states around the world seek to control the gender and sexual identity of individuals within their jurisdictions through a number of direct and indirect legal measures. It is beyond the scope of this review to consider all types of law that seek to describe and prescribe constructions of gender; in this section, however, we consider one of the most direct ways that states seek to regulate sexual expression: through the prohibition of specific forms of sexual activity.

Direct prohibitions on male same-sex sexual activity
Male homosexual acts are currently specifically prohibited in the legislation of 78 countries around the world.[151]

- 37 (almost half) of these states are in Africa, including **Angola**, **Botswana**, **Cameroon**, **Egypt**, **Kenya**, **Morocco**, **Nigeria**, **Senegal**, **Somalia**, **Uganda** and **Zimbabwe**.
- 21 such states are in Asia including **Afghanistan**, **Bangladesh**, **Kuwait**, **Iran**, **Lebanon**, **Pakistan**, **Saudi Arabia**, **Syria** and **Yemen**.
- In Oceania there are 11 states in this category including **Nauru**, **Papua New Guinea**, **Samoa** and **Solomon Islands**.
- The 5 remaining territories include **Gaza**, **South Sumatra** and the **Turkish Republic of Northern Cyprus.**

The 'offence' of same-sex male activity is framed in different ways in different states, although the outcome is broadly the same. In some states the offence specifically prohibits certain physical acts such as sodomy (e.g. **Malaysia**).[152] These definitions appear to cover heterosexual acts of the same nature, but in practice they

are only likely to be applied to same-sex couples. In other states (e.g. **Swaziland**) sexual acts are prohibited explicitly when they are enacted between two males: "sexual intercourse per anus between two human males".[153] Prohibitions in other states are framed more generally; for example **Egyptian** law prohibits 'shameless public acts' which include a wider category of sexual offences but have been regularly and successfully used to prosecute gay men.[154]

Direct prohibitions on female same-sex sexual activity

Lesbian activity is illegal in at least 49 states.[155] Definitions of the crime vary, but usually focus on genital contact between two females. **Iranian** law, for instance, states that "lesbianism is homosexuality of women by genitals".[156] Laws in many jurisdictions do not explicitly prohibit lesbianism, but more general rules have or may be used to prohibit lesbian acts. In **Botswana** lesbians have been convicted through judicial interpretation of the offence committed by anybody who "has carnal knowledge of any person against the order of nature".[157]

It is significant that many jurisdictions that previously had, or continue to have, prohibitions on male homosexuality never criminalised lesbian activity (e.g. **Ghana**, **Lesotho**, **Mauritius**, **Namibia**, **Seychelles**, **Sierra Leone**, **Swaziland**, **Zambia**, **Zimbabwe**, **Bangladesh**, **Brunei**, **Gaza**, **India**, **Indonesia**, **Kuwait**, **Pakistan**, **Singapore**, **Turkmenistan**, **Grenada**, **Guyana**, **Jamaica**, **Kiribati**, **Nauru** and **Tonga** amongst others).[158] This is reflective of the fact that lesbian sex does not appear to have been widely considered or acknowledged within law. Whilst lesbians in such contexts may not suffer the same direct legal persecution that men may suffer, these provisions are likely to be both reflective and prescriptive of strong gender-based prejudice, which may also serve to increase their vulnerability to sexual violence. They mirror the lesser visibility of women and girls in legal and public life generally, and the particular lack of visibility and legal/social status of lesbian women. Significantly, there are no countries in the world where lesbian activity is illegal but gay sexual activity is legal.

Legal penalties for homosexuality

Penalties for violating prohibitions on same-sex activity usually involve a prison sentence, ranging from 2 months in **Algeria** to 10 years (maximum sentence) in **Ethiopia**.[159] Minimum sentences are a common feature in sexuality laws, reflecting the severity with which the state regards these types of sentences. Other penalties include:[160]

- The imposition of fines;
- Banishment from the state (in the **Maldives** men may be banished for 9–12 months for engaging in homosexual acts. In **Saudi Arabia** unmarried men engaged in homosexual activity may be banished for 12 months);
- In some countries (such as in **Saudi Arabia)** corporal punishment is imposed. This form of penalty might be particularly likely to be applied to lesbians. For example in **Nigeria**, the penalty for gay men is death but for lesbians is whipping. Women have also reportedly been whipped in the Maldives for same-sex activity;
- In some states, notably **Mozambique**, homosexuals' sentences may include a prohibition on their former economic activity;
- In the **Maldives** lesbians can be punished with house arrest;
- Some states, such as **Mozambique** and **Sao Tome and Principle**, may sentence individuals to a period in a labour camp. This law is remnant of Portuguese colonial regulation;
- In some countries convicted homosexuals are confined for a period within a mental health hospital (e.g. **Mozambique**).
- In ten states homosexuality is punishable by the death penalty (**Iran**, **Iraq Mozambique**, **Nigeria**, **Saudi Arabia**, **Sudan**, **United Arab Emirates**, **Uganda**, the southern states of **Somalia** and **Yemen**).
- In countries where there are both secular and religious laws/courts (e.g. **Pakistan**) a person charged with the crime of homosexuality might face separate secular and Islamic punishments.[161]

Insufficient protection for persons of homosexual identity

Many states in the world violate individuals' SRR by failing to take reasonable measures to protect individuals from gender-based harassment and attack. In some states, despite high reported incidents by relevant NGOs, governments have failed to officially monitor crime rates for homophobic hate crimes. Poor reporting of incidents leads to assumptions that homophobia is not a serious problem and results in states' failure to allocated sufficient resources to the protection of homosexuals. For example in **Brazil**, despite gender activists reporting a homophobic murder every two days, the Government does not record such incidents as hate crimes perpetrated on the grounds of sexuality, and scant resources are dedicated to preventing such crimes.[162] Similarly in **South Africa**, corrective rape (the rape of lesbians to 'turn them straight') incidents are not separated from general rape in Government reporting.[163]

Persecution or lack of action on the part of law enforcement personnel, inadequate training, unwillingness of prosecutors to bring cases, inadequate hate crime legislation and a failure to provide security on the streets are all common features of most states' failure to protect and promote freedom of sexuality within their borders.

Law and transsexualism/transgender identity

According to a study by Transgender Europe, out of the 72 countries selected for the study across the world, legal change of gender was found to be possible in 31 of them.[164] With the exception of **Argentina** and **India**, a psychological diagnosis is required before gender can be legally changed.[165] Additionally in most cases gender reassignment surgery or sterilisation is required for legal gender recognition. Other restrictions may also apply;

some states require that an individual wishing to legally change their gender has never been married and has no children. In other states legal marriages may be invalidated after a change of gender (e.g. the **United States**).[166]

Argentina has recently become an example of a state pioneering best practice in this area of law. Last year a new federal law was adopted allowing for gender to be self-defined and state-recognised without any medicalisation or pathologisation.[167]

A number of states criminalise transsexual identity. For example, in **Malaysia** sex reassignment surgery is prohibited for anyone who is not intersex.[168] Others pursue policies to limit and control transsexualism; in **Thailand**, sexual reassignment treatment is not covered in the government medical plan.[169] In **Algeria** and **Chile** transgenderism is legally classified as an illness.[170] Furthermore, in a number of countries, despite the fact that transsexualism is not criminalized, trans people have been prosecuted under laws that were designed for other purposes, for example prostitution. This has been the case in several states in Africa, Asia as well as in Central and South America and in one state in Europe; **Turkey**.[171]

In other countries sex reassignment surgery is considered a right. In an important step in 2007, a panel of judges in **Brazil** ruled that the public health system should provide sex reassignment surgery without charge.[172] The state of **Cuba** also allows sex reassignment surgery in 'appropriate' cases.[173]

Legal restrictions on gender reassignment treatment frequently make treatments unavailable to people under the age of eighteen, if they are available at all.[174] In the small number of countries which offer treatment to young people with gender dysphoria under the age of sixteen (the **Netherlands**, **Canada**, **Australia**, **Germany**, **UK** and **USA**), consent from both their legal guardian and physician is required.[175] In **Australia**, additional consent must be sought from the courts, the cost of which is borne by the family themselves.[176] In the **UK** only a handful of young people under-16 are currently receiving puberty suppressants (as part of a research study) and up until 2011, these could not be prescribed. UK citizens under 16 are also not legally permitted to obtain treatment from other European countries.[177]

The Endocrine Society[178] and WPATH[179] advocate that puberty suppressant treatment be made available to gender dysphoric young people in the early stages of puberty, since it can be psychologically and physically beneficial.[180] Allowing access to drugs, which slow or halt the physical developments of puberty, has a number of advantages,[181] including; alleviating the harm and distress caused by the physical development of an assigned gender in opposition to a young person's identified gender, prolonging the period during which a young person can explore their gender identity before their body begins to change, reducing the need for traumatic and invasive forms of sexual reassignment surgery in later life,[182] and lastly, preventing young people from seeking these drugs illicitly if denied access to them. According to the SRI, denying under-18s gender reassignment therapy is a violation of their SRR.[183] Even in countries where puberty suppressing treatment is available in the early stages of puberty, however, clinics offering the service are scarce and the high costs are potentially exclusionary. Furthermore, even though many young people feel they cannot (or do not wish to) disclose their gender variance to their families, the requirement for parental consent means they cannot access treatment (legally and safely) without doing so.

As in other areas of law related to SRH, this review has found that in many contexts there are significant discrepancies between existing legal provisions and the way these are implemented in practice. In **Denmark** and **South Africa**, for example, legal provisions exist to allow a change of gender and/or name. Nevertheless, in practice, applications are often delayed for months or even years.[184] Conversely, in some contexts legal provisions prohibiting trans-identity contrast with cultures and societies where trans-identity is highly visible and accepted largely without prosecution (e.g. in **Tonga** and **Samoa**).[185]

Prohibitions on heterosexual activity

Some states have sought to prohibit certain types of sexual activities regardless of whether they are practised within the context of a heterosexual or homosexual relationship. A number of states have laws that prohibit oral and anal sex and the possession and sale of sex toys (**Malaysia** is one of a number of countries internationally that has laws restricting oral and anal sex[186]). There are a limited number of countries, such as **Pakistan** and **Saudi Arabia**, where sex outside of marriage is a criminal offence.[187] Many Arab nations have rules restricting physical activity in public. **Dubai**, **Saudi Arabia** and the **UAE** all have public decency laws that in some manner prohibit kissing or other public displays of affections such as holding hands.[188]

Conclusions

There are severe restrictions on sexual freedom imposed on young people in many states around the world. These restrictions take the form of both direct and indirect forms of persecution: both through the active prosecution of individuals, and through the failure to protect individuals from discrimination and harm on the basis of their sexuality.

During the field research it may be interesting to consider how (the language of) laws relating to sexual behaviour and identity, and young people's perceptions of these both reflect and affect wider attitudes to sexuality and gender in society and, in turn, young people's access to SRH services. (For example in **Dominica** all sexual activity is defined by the Sexual Offences Act 1998 as 'gross indecency' and the law starts by essentially prohibiting all sexual activity before prescribing the limited circumstances in which it is allowed).[189]

2.4.2b Consent to sexual activity

The majority of states around the world prescribe the age at which a young person may legally consent to sexual activity. The different ages of consent, and the ways in which consent is understood within different jurisdictions have a significant impact on young people's ability to access sexual and reproductive health services. In many contexts there may be social, religious, economic (etc.) barriers in access to SRH services for young people under the age of consent. Furthermore, legal systems may directly align ages of consent to legal provisions that regulate access to SRH services (for example in many states where abortion is legal on request, an individual under the age of consent will require consent from an adult, usually their parents; in other countries an individual may not be able to legally access contraceptive services until they are over the age of consent).

Varying ages of consent

Establishing an age of consent is one of the many ways that states are understood to negotiate/balance the principle of protection of young people against a principle of autonomy and evolving capacities. Where the age of consent is set too low, young people may be exposed to rights violations such as rape, early/forced marriage and a range of risks to their physical and mental health including complications during pregnancy and heightened risk of HIV and other STI infection.[190] Where the age of consent is too high young people may face huge barriers to accessing their SRR, including their right to access vital sexual and reproductive health services.

Ages of consent vary widely in different countries around the world; ranging from 12 years in **Colombia**, **Mexico**, **Panama**, to 21 in **Cameroon**.[191] The vast majority of states set consent at between 14 and 16 years of age. In some states the age of consent is set at a specific age (e.g. the **UK** is 16), however in other states the age at which someone can consent to sex is defined as the point of someone having reached sexual maturity. Others combine the two. For instance, while the **Austrian** Penal Code sets the age of sexual consent at 14, it contains an exception which states that if one of the partners if younger than 16 years of age and "not sufficiently mature to understand the significance of the act" then it is punishable under law.[192] Finally, certain jurisdictions do not specifically set an age of consent, but an individual is only legally allowed to consent to sex within the context of marriage (e.g. **Saudi Arabia**, **Yemen**, **Bahrain** and **Bolivia**).[193]

Different ages of consent for boys and girls

Significantly in many states around the world there is a difference in ages of consent for men and for women. States in this category include **Bolivia**, **Hong Kong**, **China**, **Colombia**, **Guernsey**, **Indonesia**, **Lesotho**, **Mexico**, **Monaco**, **Pakistan**, **Panama**, **Philippines**, **Swaziland** and **Ireland**.[194] In **Mexico** the variation in ages of consent for girls and boys is the difference of 12 years (girls) and 18 years (boys).[195] In *every* state where there is an unequal age of sex for boys and girls, the age of consent is younger for girls as opposed to boys, never the other way around.[196]

These findings are surprising given the presumed protectionist purpose of age of consent laws. Due to the interplay of social gender inequalities and biological factors, in most contexts around the world girls are more vulnerable than boys to becoming victims of sexual exploitation and violence, and the (potentially onerous or harmful) social, emotional and physical consequences of sexual intercourse tend to fall more heavily on women/girls than men/boys. As such, rather than fulfilling a protectionist purpose, it would seem that these laws are more accurately understood as both reflecting and prescribing social and cultural constructions of gender.

Different ages of consent for heterosexual and homosexual activity

This understanding of age of consent laws also explains disparities in many jurisdictions between the ages that an individual can consent to heterosexual and homosexual sex. As mentioned above, many states around the world prohibit same-sex activity (especially between males). Other states set a higher age of consent to intercourse for homosexual couples either directly or indirectly (for males through setting a higher age for consent to anal sex); these countries include the **Bahamas**, **Bermuda**, **Chile**, **Indonesia**, **Madagascar**, **South Africa**, **India** (anal sex), **Canada** (anal sex between unmarried persons) and **Australia** (anal sex).[197] Many of the states in this category include those who have only recently legalised any degree of adult same-sex activity (**Chile**).[198] As such, the unequal age of consent may result from the transition period between condemnation of homosexual activity and acceptance.

In many states around the world the age consent is the same for same-sex couples as it is for different-sex couples. These states include **China**, **Costa Rica**, **Denmark**, **Guatemala**, **Hungary**, **Jordan**, **Montenegro**, **Serbia**, **South Korea**, **New Zealand**, **Thailand** and the **UK**.[199] This position is relatively recent in a number of these states (e.g. 2000 in the **UK**,[200] 2003 for **Hungary**, 2004 for **Lithuania**, and 2007 in the case of **Portugal**).

Unclear ages of consent for lesbians

In many states where specific legislation addresses gay homosexual activity there is no legislation addressing the age of consent for lesbians, e.g. **Armenia**, **Cyprus,** and **Senegal**[201] amongst many others. This appears to be universally the case until very recent times. For example in the **UK**, until the year 2000 (and the passing of the Sexual Offences Amendment Bill) there were no recognitions of consent for lesbian activity.[202] These laws reflect the failure of state legislation to address the needs of homosexual women, and to acknowledge their experiences and identity.

Conclusion
Laws that regulate ages of consent are likely to have significant impact on young people's access to sexual and reproductive health services, and sexual and reproductive health more broadly. Where ages of consent are low, particularly for girls, young people could be more vulnerable to sexual violence and health risks associated with early sexual activity. Alternatively, where the age of consent is set too high young people may be denied the education and services that they need to make healthy and autonomous decisions about their sexual and reproductive health, which could also have serious emotional, social and health implications. This may result from the direct impact of the law in restricting young people's access to rights and services, or the indirect impact of laws on sexual consent, which shape norms about appropriate sexual behaviour that then restrict access to services. A high age of sexual consent particularly problematic in contexts where the age of consent is linked to the age of marriage, which is in turn tied to sexual and reproductive health services. In these contexts many young, unmarried men and women face legal barriers to accessing services which protect and promote their right to sexual and reproductive health.

The imbalances in ages of consent for men/boys vs. women/girls and homosexual vs. heterosexual couples, as well as for different types of sexual activity in many states suggest that states' laws of consent are not solely derived for a protection purpose. Rather, and perhaps, more importantly, they are intended to describe and prescribe value-based norms concerning gender/childhood/adulthood, and serve as a means for controlling young people's sexual activity, identity and behaviour.

2.4.3 Violence and the criminalisation of sexual activity

Most countries have laws which criminalise certain sexual activity, particularly activity that is violent, causes harm, or is a violation of an individual's SRR. Other countries criminalise consensual sexual activity, such as same-sex sexual activity[203] (see previous), transactional or commercial sex work,[204] or adultery.[205] Legal frameworks on sexual violence and criminalisation of certain sexual activities impact on access to sexual and reproductive health services both directly and indirectly.

Direct relevance
In countries where sex crimes are not recognised in the law, practitioners are less likely to provide SRH services required by the victim, while the victim may not consider themselves eligible or in need of care. For instance, where the law does not recognise that a man can be a victim of rape, prevention and recovery services are unlikely to exist and victims will struggle to explain or present their experiences.[206] In particular, laws which incriminate victims of sexual violence (as well, or even to a greater extent than perpetrators[207]) have a serious negative impact on access to services. Young people who have been sexually abused are unlikely to seek the care or other services that could help them recover physically and emotionally from the experience.[208] This is a violation of young people's sexual and reproductive rights, including the rights to health, autonomy, accountability and redress, and bodily integrity and personal security.[209]

Indirect relevance
When a country's government fails to prohibit, or even endorses violations of sexual and reproductive rights, this is likely to impact young people's access in a number of less direct ways. When an authority fails to protect or acknowledge victims' experiences, victims (and young people more broadly) are less likely to trust and access the information and services that the authority provides.[210] The failure to criminalise sexual violence also has gendered implications. Sexual violence is a deeply gendered phenomenon, which often reflects and serves to solidify existing power dynamics within a society, with women, girls, and gender non-conforming individuals by far the greatest victims of abuse.[211] Thus the failure to legally prohibit forms of sexual violence disproportionately experienced by these individuals, may serve to limit their access to SRH services by normalising and legitimising male dominance regarding sexuality, reproduction and SRH.

Laws on sex crimes also have important implications for the notion of sexual consent and choice regarding SRH, which lies at the core of SRR. For example, in countries where consent is assumed as part of a marriage contract (expressed through the failure to criminalise rape within marriage) a person's choices with regard to sex and reproduction become a function of laws, power structures and social norms rather than of individual autonomy and choice.

The relationship between violence and access to SRH services will be explored in greater detail through the following analysis of laws criminalising sexual violence or other sexual activity.

2.4.3a Sexual violence and abuse

This section comprises a broad overview of laws on sexual violence and abuse around the world. Laws on sexual violence vary significantly among countries, partially due to cultural norms and attitudes regarding sexual abuse. Commonly known sex crimes include the following categories: rape, (child) molestation, sexual battery, sexual harassment, pornography production or distribution, and prostitution.

As noted by the UN Special Rapporteur on Violence Against Women, sexual violence is a universal issue.[212] In nearly every national jurisdiction, however, sexual assault is an underreported crime with low conviction rates.[213] Developing robust legislation concerning sexual abuse is one method of addressing the issue, which has the potential to impact on social and cultural norms and values, through encouraging survivors to have the confidence to

report incidents of assault. This has the potential to have a positive cyclical effect: as law increases victims' confidence and reporting, permissive norms about sexual violence begin to shift, which in turn will increase victims' confidence and reporting, and also deter future acts of sexual violence or abuse.

Sexual violence and abuse and the laws that criminalise them have important implications for gender. While individuals of all genders can be victims of sexual violence, women and girls (and particularly LBT women and girls) and men of GBT identity are the most vulnerable.[214] Thus legal frameworks, or the absence of legal frameworks, that seek to protect individuals from sexual violence have significant implications for equality and access to SRH services.

Domestic violence

Domestic violence is one of the most pervasive forms of violence that affects young people, occurring in all cultures and societies in the world. As well as being one of the most common types of violence, it is also historically one of the most unrecognised and unreported crimes.[215] Domestic violence is widely understood to be a form of gender-driven violence that is primarily directed at women and girls.[216] As such, laws that specifically address violence within intimate relationships, family and household settings generally refer exclusively to women and girls. It is important to recognise, however, that boys (especially young boys) are also highly vulnerable to domestic violence. In rarer cases, adult men may be victims; some evidence suggests, for example, that domestic violence occurs as frequently within homosexual relationships as it does within heterosexual ones.[217] Laws against domestic violence which indicate that women and girls are the only victims contribute to harmful gender norms and render violence directed towards men or in LGBT relationships invisible.

Domestic violence often includes sexual violence and for many individuals is a threat to their sexual and reproductive health.[218] It also affects victims' access to sexual and reproductive health services as violence and oppressive forms of (gendered) dominance within a relationship are often associated with control by the violent spouse over their partner's sexual and reproductive agency and choice. In **Senegal**, for example, research has shown that husbands may ask providers of SRH services not to provide contraceptives to their spouses, leading women to access forms of contraception in secret often using less safe methods.[219]

Domestic violence is prohibited by law in 125 countries, but the following countries, many of which are in Africa, do not have laws against domestic violence.[220] These include, **Afghanistan**, **Algeria**, **Angola**, **Armenia**, **Azerbaijan**, **Bahrain**, **Belarus**, **Benin**, **Bhutan**, **Brunei Darussalam**, **Burkina Faso**, **Cameroon**, **Congo**, **C'ôte D'Ivoire, the DRC**, **Djibouti**, **Equatorial Guinea**, **Eritrea**, **Gabon**, **Gambia**, **Guinea**, **Guinea Bissau**, **Haiti**, **Hungary**, **Iraq**, **Kenya**, **Kiribati**, **Kuwait**, **Lebanon**, **Liberia**, **Lesotho**, **Lithuania**, **Maldives**, **Mali**, **Marshall Islands**, **Mauritania**, **Micronesia**, **Myanmar**, **Nauru**, **Niger**, **Nigeria**, **Occupied Palestinian Territory**, **Oman**, **Pakistan**, **Palau**, **Papua New Guinea**, **Qatar**, **Russia**, **Samoa**, **Saudi Arabia**, **Salomon Islands**, **Sudan**, **Swaziland**, **Syria**, **Togo**, **Togo**, **Tunisia**, **Turkmenistan**, **Tuvalu**, **United Arab Emirates**, **United Republic of Tanzania**, **Uzbekistan**, **Yemen**, **Zambia**.[221] The failure to legislate against domestic violence indicates an endorsement by the state of gender inequality, power and violence, and a failure to protect the autonomy and agency of women and girls in particular, and their right to access to SRH services.

Sexual harassment

Sexual harassment is another form of sexual abuse, which has disproportionate effects on women and girls, and may also occur based on sexual orientation or gender identity. In different legal contexts, sexual harassment is generally considered to be unwanted sexual attention, which causes harm to the victim. General Recommendation 19 to the Convention on the Elimination of all forms of Discrimination Against Women defines sexual harassment as including:

> Such unwelcome sexually determined behaviour as physical contact and advances, sexually coloured remarks, showing pornography and sexual demands, whether by words or actions. Such conduct can be humiliating and may constitute a health and safety problem; it is discriminatory when the woman has reasonable ground to believe that her objection would disadvantage her in connection with her employment, including recruitment or promotion, or when it creates a hostile working environment.[222]

The failure to create legal prohibitions on sexual harassment may serve to legitimise forms of sexual abuse and promote gendered perceptions objectifying female sexuality. The following countries lack laws against sexual harassment: **Afghanistan**, **Antigua and Barbuda**, **Bahrain**, **Barbados**, **Belarus**, **Bolivia**, **Cameroon**, **Chad**, **Djibouti**, **Dominica**, **Egypt**, **Gabon**, **Georgia**, **Ghana**, **Guatemala**, **Guinea**, **Guinea-Bissau**, **Haiti**, **Hungary**, **Indonesia**, **Jamaica**, **Japan**, **Jordon**, **Kazakhstan**, **Kiribati**, **Kuwait**, **Kyrgyzstan**, **Lao People's Democratic Republic**, **Lebanon**, **Liberia**, **Malawi**, **Malaysia**, **Maldives**, **Mali, the Marshall Islands**, **Mauritania**, **Micronesia**, **Mongolia**, **Nepal**, **Nigeria**, **Occupied Palestinian Territory**, **Oman**, **Saint Kitts and Nevis**, **Saint Vincent and the Grenadines**, **Samoa**, **Sierra Leone**, **Singapore, the Salomon Islands**, **Suriname**, **Syrian Arab Republic**, **The former Yugoslav Republic of Macedonia**, **Togo**, **Trinidad and Tobago**, **Turkmenistan**, **Tuvalu**, **Uzbekistan**, **Vanuatu** and **Yemen**.[223]

Legislating on gender based violence

Gender based violence is commonly understood as violence that is perpetrated against an individual because of their (ascribed) gender and violence that disproportionately affects a particular

gender group.[224] Because women and girls constitute the majority of victims of gender based violence around the world, the term 'gender based violence' is often conflated with the term the term 'violence against women and girls'. In fact, violence against women and girls is one (narrow) type or manifestation of gender based violence,[225] which can also affect men, boys and others who do not fit into hetero-normative understandings of what it is to be 'male'.

(Somewhat problematically) international legal standards and policy tends to be focused on exclusively addressing violence against women and girls. More international attention needs to be brought to acknowledging the experiences of LGBT identified individuals and their vulnerability to violence.[226] Many of the international legal principles that are understood to address violence directed against women and girls could be expanded to include violence directed against men, boys and individuals who don't indentify within a gender-binary.

A United Nations Expert Group Meeting on good practices in legislation on violence against women identified several legislative elements that are necessary to effectively prevent violence against women,[227] including the following:

- Penal codes must include provisions criminalise all forms of violence against women, and the state must play an active role in enforcing these provisions through prosecuting all acts of violence.
- Police and courts must take preventative legal measures such as: "issue barring orders, detain perpetrators or order them to stay away from the victim's vicinity or forbid them to go to certain places."
- It is essential for the state to provide information, education and awareness-raising on domestic violence.
- Victims of sexual violence should have the right to professional help.
- "Women who are victims of sexual violence should have the right to live safely in their own homes and to be protected from the perpetrator (e.g., on the basis of expulsion or barring orders by the police or protection orders by the court)."
- All women who are victims of violence should have the right to a women's shelter or other protective environment (a standard that has yet to be achieved in many countries, including European countries).
- Women's social and economic rights are relevant to domestic violence, and must be promoted; women who are financially dependent are at greater risk of suffering violence or staying in a violent relationship to maintain economic security.

2.4.3b Rape

Rape is perhaps the most severe form of sexual violence, and an analysis of different forms of rape legislation reveals important distinctions between states' laws on sexual violence. The following section will explore these different legal forms in detail, with particular attention on the implications for access to SRH services.

Definitions of rape

Most national laws define rape as forced (or non-consensual) sexual intercourse or other forms of sexual penetration (no matter how slight). The United Nations Office on Drugs and Crime defines rape as sexual intercourse without valid consent, and the World Health Organization has defined it as "physically forced or otherwise coerced penetration – even if slight – of the vulva or anus, using a penis, other body parts or an object".[228] However this may miss some important forms of forced sexual intercourse such as oral penetration. Some countries, such as **Germany**, take a broader definition of rape as entailing other forms of sexual violence, which do not require penetration.[229] The International Criminal Tribunal for Rwanda developed one of the first definitions of rape using the concept of coercion rather than consent: "a physical invasion of a sexual nature committed on a person under circumstances which are coercive".[230] This is an important step, as it recognises that rape often reflects inequities in power within societies.

In other countries, such as **Tajikistan** the definition of rape includes physical violence. The crime of rape is defined as; "Sexual intercourse using violence or threats of violence against the victim or her close relatives while taking advantage of the victim's helplessness".[231] Laws that take this form are problematic because they fail to address the crucial issue of consent, and therefore fail to address the wide variety of contexts and circumstances within which rape may occur. It is especially common for rape of young people to occur without (evidence of) physical assault.

Consent

As mentioned, consent is a key element of laws on rape: lack of consent on the part of the victim is integral to the definition of rape and determining whether or not rape occurred. However it is important that laws do not necessarily interpret the absence of objection as consent; lack of consent may be demonstrated by an act of force on the part of the perpetrator. Lack of consent may also be determined by the victim's inability to give consent, for instance if a victim is sleeping, intoxicated, or lacks the mental capacity to give consent.

Evidence of *duress* (in which the victim was subject to threats or force) constitutes lack of consent in some countries. Evidence of coercion, which take account of power dynamics between the victim and perpetrator, may also constitute a lack of consent. For instance, in the **Philippines**, a man commits rape if he engages

in sexual intercourse with a woman "by means of fraudulent machination or grave abuse of authority".[232]

Statutory rape

Many states have an offence in their criminal laws of 'statutory rape' or 'unlawful carnal knowledge', which is committed when a person engages in sexual activity with a young person below a certain age. Laws on statutory rape vary significantly between countries; ranging from 12 to 18 years[233] with most countries setting the age at between 14 and 16 years.[234] In certain jurisdictions it is not the absolute age of the minor, but the age difference between sexual partners that determines whether an act of sex is legally considered to be rape. Further, the range of sexual acts which are defined as statutory rape vary, from kissing to sexual intercourse.[235]

It is considered best practice for states to have an exemption for prosecution where the sexual activity involves acts between two young people who are close in age[236] as the purpose of these provisions should not be to criminalise sexual exploration between young people. The aim should be to protect young people from sexual exploitation and abuse, rather than to criminalise factually consensual, non-exploitative, sexual behaviour between young people. Accordingly, the law should make a distinction between (1) factually consensual sexual activity taking place in the context of a young person's sexual development; and (2) sexual activity that by its very nature is exploitative.[237] The age of consent should not be set too low, to ensure that young people are protected from sexual abuse and exploitation. At the same time, it should not be too high, so that it is commensurate with the autonomy and evolving capacities of young people. Where the age is set very low, young people will not be adequately protected from sexual abuse and exploitation, but where it is set too high, it may not reflect the reality of young people's sexual relationships and may deny them access to advice, and services relating to sexual and reproductive health.

Rape within marriage

Historically, rape within marriage did not exist as a criminal act in national laws, but a number of countries have criminalised it over the past three decades. The first **US** state to criminalise rape within marriage did so in 1975 and it did not become a crime in the **UK** until 1991.[238] Marital rape is still not legally prohibited in 127 countries,[239] however in many of these countries, it remains unclear whether a perpetrator could be charged with marital rape under normal rape laws. In other countries, including **India**, **Indonesia** and **Vietnam**, marital rape is considered to be a form of domestic violence, but is not criminalised as rape.[240]

In certain countries, including **Sri Lanka**, **India** and **Tanzania,** rape between a married couple is only criminalised once they have been legally separated.[241] This is problematic as it indicates that either the state views marriage as entailing sexual obligations, or that laws on rape are intended to restrict extramarital sex. As demonstrated below, in several of these countries individuals charged with marital rape receive more mild sentences than those charged with rape outside of marriage. In the **Bahamas**, spousal sexual assault is eligible for less jail time than charges of rape, and cannot be prosecuted without the permission of the Attorney General.[242] In **India**, Penal Code Section 376(A) states that "Whoever has sexual intercourse with his wife, who is living separately from him under a decree of separation or under any custom or usage without her consent shall be punished with imprisonment of either description for a term which may extend to two years and shall also be liable to a fine".[243]

Marriage as a solution to rape

It is particularly problematic that in certain countries (particularly in Africa and the Middle East) marriage can be used to resolve criminal prosecution for rape, and criminal charges against a rapist will be dropped if he agrees to marry his victim.[244] This practice, which is written into the law in several countries, including **Algeria**, **Bolivia**, **Cameroon**, **Guatemala**, **Morocco**, **Philippines**, **Tajikistan** and, until recently, **Peru**, **Brazil** and **Egypt**[245] and emerges from customary law in many East and West African countries, serves to normalise sexual and gender based violence, and constitutes a pervasive violation of women and girls' right to consent to sexual activity.

Some legal systems place a heavy burden of proof upon the victim: in many Muslim countries, Sharia law requires a confession from the rapist or four male witnesses in order to prove an act of rape has occurred.[246] In a number of countries, such as **Bangladesh** and **Somalia**, victims of rape may be punished for their involvement in 'illegal' sexual activity, such as sex outside of marriage.[247] In deeply conservative societies, where sexual activity before marriage is condemned, honour killings are practiced. This is a practice where women (often adolescents and young women) are killed by family or community members for bringing dishonour to the family, usually through sexually related behaviour or engagement in a sexual act. Honour killings are a severe problem in a number of states including **Pakistan**, **India**, **Egypt**, **Saudi Arabia**, **Syria**, **Yemen** and others, and, particularly in the Middle East and Southeast Asia, governments have failed to effectively regulate the practice.[248]

Implementation of the law

In all countries in the world rape is under reported and under prosecuted.[249]

This may be a function of a lack of awareness among victims of their rights, or social pressure against sexual activity outside of marriage. For instance, victims may feel "too ashamed to discuss rape with a stranger; they may not want family and friends to find out about the assault; they fear they will not be believed, [due to] the societal presumption that the victim deserved it or is lying;

they fear they will be faced with hostile police officers, prosecutors and judges; they desire to hide something in their past (drug use or promiscuity); or they fear facing their attacker. Acquaintance rape is the most frequent rape to go unreported. In addition to the aforementioned concerns, acquaintance rape victims may want to maintain a relationship with their rapist. Also, societal attitudes foster the idea that acquaintance rape is not real rape and that the victim most likely consented".[250]

In some contexts where women are perceived as sexual objects without agency or desire, women's resistance to sex is normalised or encouraged, creating the perception that force or lack of consent is a natural part of sexual relationships. This may be the case even in countries with thorough and comprehensive laws on rape. For instance, in **South Africa** rape is defined in the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2007 as a statutory offence including all forms of sexual penetration without consent, irrespective of gender. Yet four out of ten women in **South Africa** characterised their first sexual experience as rape.[251]

Gender and rape

The definition of rape in some countries dictates that it is always perpetrated by a man. In **Scotland**, for example, the law defines rape as sexual assault committed with a penis.[252] While statistically rape is predominantly an act committed by males against females, rape can be committed by a person of any gender against a person of any gender. Attacks on men by other men are particularly prevalent, for instance a study by the **US** Federal Government revealed that 70,000 American male prisoners are raped each year.[253]

However women have been prosecuted for rape in several countries; In "**Zimbabwe** last year three women, said by police to be part of a nationwide syndicate, were put on trial for allegedly kidnapping and drugging men and then forcing them to have sex in order to collect their semen in condoms for use in rituals that claimed to make people wealthy. This year a woman in the **Australian** city of Adelaide was charged with rape after breaking into a man's home and forcing him to perform oral sex".[254]

Emerging standards in rape law

As the preceding analysis reveals, it is critical that rape laws are redrafted in a way that the legality of the act does not depend on the victims' behaviour, but instead on the perpetrator's failure to get consent.[255]

- Definitions of rape must be comprehensive; rape should never depend on the relationship between the victim and the perpetrator and anal and oral rape should be included in definitions.
- Where possible, any practice that stigmatise the victims (such as consideration of the victims' sexual history by the defence) should be avoided.
- Laws should also include training for officials involved in investigation and prosecution to ensure that victims are protected and cases prosecuted effectively.

Recent improvements in legal frameworks on violence against women, including rape, promise to improve accountability for victims and contribute to a shift in social norms. In Latin America, where violence against women is particularly widespread, a number of countries have made improvements to legislation on rape.[256] In 1979 **Puerto Rico** removed a provision which requires the victim to give evidence of previous sexual activity.[257] Additionally, **Mexico** (1989), **Peru** (1991), **Guatemala** (1997), **Colombia** (1997), **Dominican Republic** (1997), **Honduras** (1997), **Bolivia** (1997), **Ecuador** (1998), **El Salvador** (1998) and **Chile** (1999) changed legal frameworks regarding sexual crimes by "eliminating cultural concepts that operated to the detriment of the victim such as references to (i) the honour of the victim; (ii) her previous conduct; (iii) sanctions for these crimes were increased; and (iv) sexual crimes were typified, among them marital rape".[258] As noted by Flor de Maria Meza Tanata, what is particularly important about these legal changes in relation to SRH and access to SRH services is that sexual crimes are increasingly being considered as crimes against the sexual integrity and freedom of the victim, rather than crimes against moral conventions about sex and sexuality.[259]

2.4.3c Molestation and child sexual abuse

Sexual abuse of children, sometimes referred to as molestation, is a crime in most countries. Child sexual abuse may impact young people's access to SRH services by normalising abusive and harmful sexual relationships and instilling young people with misinformed ideas about SRH and causing them to feel shame and mistrust related to sexual activity. Legal definitions of molestation may include engaging in any sexual act with children under the age of 18, including rape, sexual or unwanted touching, taking pornographic pictures, or inducing sexual acts (including with other children). The definition of molestation may be broader in a case where the perpetrator has a history of paedophilia.

Most countries have laws prohibiting child sexual abuse, focussing on prevention, protection and rehabilitation. However in some countries, such as **Yemen**, laws prohibiting child sexual abuse do not exist.[260] Even where child sexual abuse is criminalised, implementation is difficult, particularly in many African countries, due to limited knowledge of the laws, reluctance to report among children and parents, lack of trust in formal legal systems lack of knowledge about how to respond to cases of child sexual abuse among practitioners and slow and ineffective systems.[261]

Mandatory reporting

Laws on child sexual abuse may impact access to SRH services when they include mandatory reporting requirements. Mandatory reporting requirements place a legal obligation on practitioners who discover or suspect that a child has been a victim of abuse to report the facts to a legal authority. While health practitioners are often in the best position to identify a child protection concern, mandatory reporting may create barriers for young people accessing SRH services where they do not want to disclose abuse. For example, a young person who has been a victim of sexual abuse but does not wish to disclose the abuse may avoid seeking out reproductive health services. Given that the first priority under the law should be the health and wellbeing of the victim, it is important that the law protects the confidentiality of the victim.

2.4.3d Female genital mutilation (FGM)

FGM is a form of gender-based violence which is criminalised in some countries yet remains a legal and prevalent practice in others. Female genital mutilation (FGM) is defined by WHO and the United Nations (UN) agencies as "the partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons".[262] FGM is a violent procedure, which severely compromises the victim's sexual and reproductive health, and leads to serious SRH complications.[263] FGM is also harmful to SRH by destroying women and girls' capacity to experience sexual pleasure.[264] FGM has been categorised into four types:

Type I: Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).

Type II: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).

Type III: Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).

Type IV: All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterisation.[265]

FGM is prohibited by law in over 25 countries including **Australia**, **Belgium**, **Canada**, **Denmark**, **New Zealand**, **Norway**, **Spain**, **Sweden**, **United Kingdom**, **United States** (federal law, and specific state laws). It has also been banned in the following **African countries: Benin**, **Burkina Faso**, **Central African Republic**, **Chad**, **Cote d'Ivoire**, **Djibouti**, **Egypt** (ministerial decree), **Ghana**, **Guinea**, **Kenya**, **Niger**, **Nigeria** (multiple states), **Senegal**, **Tanzania** and **Togo**.[266] Penalties for FGM may range from six months to life in prison, and include monetary fines in some countries. In June of 2000, prosecutions or arrests had been held in **Burkina Faso**, **Egypt**, **Ghana**, **France** and **Senegal**.[267]

Constitutional law and FGM

Some national constitutions include provisions designed to uphold women and girls' rights, which may require governments to take legal action against FGM. For example, provisions on 'women's protection from harmful practices'; prohibition of customs or traditions that are 'against the dignity, welfare or interest of women or which undermine their status', and abolition of 'traditional practices' injurious to people's health and well-being may create a legal requirement for the revision or abolition of laws and policies that are not compatible with these principles.[268] The Constitution of **Ethiopia** states that women shall have equal rights with men and supersedes customary law allowing practices that oppress or cause bodily or mental harm to women.[269] Despite this, a study involving over 10,000 young people in **Ethiopia** found that 58% of the young women and girls surveyed had experienced female genital mutilation (FGM).[270]

Criminal laws

Several governments have enacted criminal laws which specifically prohibit FGM and distinguish certain roles which may make a person liable for prosecution, including; traditional practitioners, medical personnel, parents, guardians and persons who fail to report a potential or already committed crime. Penalties include imprisonment, fines and medical disqualification depending on the form of mutilation or level of harm suffered by the victim. In some countries, existing provisions of criminal codes have been applied to FGM, such as provisions which prohibit: 'intentional wounds or strikes', 'assault occasioning grievous harm', 'attacks on corporal and mental integrity' or 'violent acts that result in mutilation or permanent disability'.[271]

Child protection laws

Child protection laws have been applied to FGM practices in several countries. As child protection laws call for the state to intervene in any case where there is reason to believe that child abuse has or may occur, authorities may have grounds to remove a girl from her family or community "if there is reason to believe that she will be subjected to female genital mutilation," and when this is in the child's best interests.[272]

FGM and young people's access to services

Laws and social practice regarding FGM impact young people's access to services on a number of levels. FGM is often associated with imposing a restrictive morality on women's sexual activity; the clitoris is removed in order to reduce women's sexual drive and desire, which is intended to control sexual activity and 'ensure marital fidelity' and 'decent behaviour'.[273] These forms of oppression, and the related signals that women should not

be sexually active, or have sexual agency may serve as barriers to women and girls in seeking out or accessing SRH services.

Women who have experienced FGM also often experience serious and unpleasant symptoms that cause them to undergo social isolation and great shame. Shame associated with their bodies and alienation from their sexuality is likely to reduce girls and women's level of comfort in accessing SRH services, or approaching practitioners about sexual health problems or needs.[274]

2.4.3e Commercial sex work

Despite being a prevalent global industry, sex work is outlawed in many countries. According to an analysis of laws on sex work in 100 countries across the globe, it is legal in 50% of countries, has limited legality in 11% and is illegal in 39% of countries.[275] Laws regulating sex work can take several forms.

1. In several countries, sex work is legal but owning a brothel or pimping is not;
2. In others sex work and brothel ownership is legal, but pimping is not;
3. Finally, a number of countries have legalised brothels, pimping and sex work.

Laws which prohibit sex work as a sexual crime or offence (for example **Antigua and Barbuda**, **Dominica**, **Liberia**, **Slovenia**, **South Africa** and many others[276]) risk violating the SRR of women engaged in sex work. Where sex work is criminalised, women are unlikely to access SRH services such as health checks, treatment and contraception, which has serious repercussions on their health.[277] Laws that focus criminalisation on the buying of sex rather than the selling of sex can avoid creating some SRH risks, though they frequently create other risks for sex workers. For example, in **Sweden**, sex work is criminalised, but only the buying of sex is a crime – selling sex is not. Thus the law treats sex work as a form of sexual violence and focuses on addressing the demand which lies at the root cause of the practice.[278]

Enforcing criminal laws that target sex workers may also be an ineffective approach to crime control. A study on enforcement strategies by the Home Office found that enforcement operations were "resource intensive with no long term gain as they lead to a temporary reduction in prostitution activity only, displacement of activity is more likely and simply shifts the problem of crime to another functional area e.g. shoplifting. It was found that arresting and fining women tends to drive them back onto the streets to pay their fine and that arresting women compounds their social disadvantage as regular arrest becomes part of their lives".[279]

However, laws that criminalise the buying of sex rather than the selling of sex (exemplified by the 1999 **Swedish** Law which is widely known as the 'Swedish model') have also been criticised, especially by advocates for sex workers rights, who claim that this drives sex workers underground,[280] thus exacerbating SRH risks.

Reports demonstrate that the Swedish Model has increased the risk of violence faced by sex workers and, by criminalising the industry, has decreased sex workers' ability or likelihood to access health services.[281] According to critics, the Swedish model also conflates the situation of migrant sex workers, domestic sex workers, and women trafficked into sex work, viewing all women selling sex as 'victims' and denying them access to labour rights enjoyed by other workers.[282] The criminalisation of the client also reduces the likelihood of them coming forward with information about instances of trafficking.[283] This problem is exhibited by laws in **Iceland** and **Norway**, which follow the Swedish, or 'Nordic' Model,[284] as well as in other European countries (such as **Finland** and the **UK**) and **US states** (such as Illinois and New York), where laws seek to further criminalise the 'end buyer'.[285] Trafficking laws in several countries, such as; **Guatemala**, **Cambodia and South Korea**, also treat trafficked sex workers and voluntary sex workers identically, inhibiting the latter from working.[286] The 1998 Law on the Suppression of Human Trafficking and Sexual Exploitation in **Cambodia** is an example of where, "the conflation of consensual sex work and sex trafficking in such legislation leads to, at best, the implementation of inappropriate responses that fail to assist either of these groups in realizing their rights, and, at worst, to violence and oppression".[287]

There has been a recent push from UN agencies towards the decriminalisation of sex work in order to guarantee the rights of sex workers. In 2010, the UN Special Rapporteur on the right of everyone to the highest standards of health stated that "the failure of legal recognition of the sex-work sector results in infringements of the right to health, through the failure to provide safe working conditions, and a lack of recourse to legal remedies for occupational health issues".[288] WHO released guidelines in 2012, which advocate for all countries to decriminalise sex work and pursue antidiscrimination laws and policies to protect sex workers' rights to social, health, and financial services.[289] In 2010, UNDP released a report that also called for governments and international bodies to decriminalise voluntary sex work, and "ensure safe working conditions and offer sex workers and their clients' access to effective HIV and health services and commodities".[290] It is thought that through decriminalisation of voluntary sex work, workers in this industry will be better able (and more likely due to reduced stigma) to exercise their SRR.

2.4.3f Conclusions

An examination of legal frameworks on sexual violence and their implications for young people's access to SRH services reveals that laws on sexual violence (or the lack thereof) may create barriers to access, particularly for women and girls. When states fail to criminalise sexual violence within the home (domestic

violence) and sexual harassment, this serves to legitimate male dominance, reduce female decision making power and reinforce messages that women are sexual objects with limited agency. The implications may be social stigma around women and girls' access to SRH services or male control of decisions regarding SRH. When conducting research, we will consider laws on sexual violence (and particularly violence against women) in order to understand the legal context on gender and power relations, and determine how laws on violence may serve as direct or indirect barriers to access.

This relates to another critical characteristic of laws on sexual violence as they relate to access; laws which are developed in order to enforce moral codes on sexuality are likely to create barriers to access, where laws that focus on protecting the sexual autonomy and integrity of the individual are more likely to promote access, and sexual and reproductive health more broadly. Laws focused on enforcing moral codes attach stigma to sexual activity and may apply punitive measure to victims of sexual violence creating barriers to access (consider legal frameworks that fail to protect, or even punish, victims of rape). Conversely, laws that target the root cause of sexual violence, exploitation, and trafficking, whilst simultaneously promoting and protecting the rights of voluntary sex workers, will be more effective at both reducing sex crimes and promoting SRH.

3 Concluding thoughts

This inception report has reviewed different areas of law that relate to access to sexual and reproductive health services, particularly for young people. In particular, the review considered legal provisions that relate to access to services; access to abortion; sexual freedom, equality and consent; violence and the criminalisation of sexual activity. While the review was not comprehensive, it identified the range of ways in which countries do and do not legislate in the areas listed above, and explored the impact of different legal models on access. One of the central themes emerging from the review is that a vast range of laws impact on access to sexual and reproductive health services. Many of these laws are intended to regulate access to SRH services on the basis of age, particularly through establishing who has, or does not have, the 'capacity' to legally 'consent' to different activities and services. The review revealed that the meanings of different laws, and the interactions between them, are complex. Given this, the research will focus on determining young people and service providers' knowledge and understanding of the law, as well as how that knowledge and understanding relates to decisions to seek and access services. The methodology designed to address these issues is outlined below.

4 Methodology

We will structure our approach to data collection around two central questions:

1. *What are young people's and service providers' knowledge, perceptions, understandings and interpretations of law related to sexual and reproductive health (SRH) and gender and sexuality more broadly?*
2. *And how do these factors shape young people's experiences, expectations, choices and practices related to seeking of and access to SRH services?*

Country selection

We propose to conduct research for the study in three locations based on analysis of the desk review and in consultation with IPPF. Regions will be chosen according to the following criteria in order to ensure that findings are relevant to a broad range of IPPF member associations, include a range of socio-legal forms, and have some comparative value:

1. Laws regulating access: We will choose one country with highly restrictive laws regulating access to SRH, one with relatively permissive laws, and one where the situation is more mixed. Of the two more restrictive legal systems we will choose one country with a strong and comprehensive rule of law, and another where customary or informal legal systems are strong.
2. Specific legal barriers: Of our three selected countries we will ensure that the following restrictive laws are represented: a high age of sexual consent which is legally (or practically) associated with access; a restrictive law on abortion; a restrictive law on abortion that includes exceptions; a restrictive law on access to contraceptives (for examples requiring parental consent for under 18s); and other laws with interesting implications for gender, access to SRH services, forms of sexual, gender based violence, etc.
3. Religious and cultural environment: We will choose one country with a strong Islamic influence on law and society; a second country with a strong conservative Catholic tradition; and a third with a secular state and largely secular population.
4. Other cultural practices: We will choose countries with other relevant cultural practices such as FGM and traditional forms of medicine.
5. Global regional diversity: We will choose one country from the European region, one from Africa, and a third from Latin America.
6. We will choose a country (countries) with diverse populations facing different barriers to access. This will provide a valuable opportunity to compare how legal barriers interact with other barriers to impact young people's (perceptions of) access to SRH services.

Sampling methods

We will access a range of different groups during the field research with a focus on reaching out to young people and service providers from both urban and rural communities, and from diverse economic, ethnic (where relevant), religious and geographical contexts. We will also include parents and care givers in research, and (in some cases) legal representatives and policy makers. Selection of communities and research participants will be conducted in close consultation with input and support from IPPF member associations.

We plan to include young people between the ages of 12–25, although the minimum age limit will be determined after a thorough risk analysis and evaluation of ethical considerations in light of the norms and culture of each country context. With the help of IPPF member associations, and CCLC's institutional contacts in each country, we will ensure that our sample includes vulnerable or marginalised groups where it is safe to do so, including homeless young people, homosexual and transgender communities, refugees, sex workers, young people living in extreme poverty, and those with different forms of disability.

We will identify 5 communities to include in the study in each research locations. Of these five, two will be urban communities; one, which is economically advantaged with access to resources, and one, which is disadvantaged with limited access. Of the three rural communities we will select one with a particularly strong religious influence and another with a less strong religious influence.

We will spend 2 days conducting research in each community, to reach a total of 10 days of research within each country (assuming that resources allow). The first day of research will be spent with young people: we will conduct four individual interviews in the morning and two focus group discussions in the afternoon, one with boys and another with girls (data collection methods are described in more detail below). If we are working in communities that include a marginalised group of young people, we will arrange a separate FGD so that members of the group can discuss their issues in a protective environment. We will organise focus group discussions with young people in a similar age range to ensure that discussions are not intimidating and are age appropriate. We anticipate that groups will be broken down by the following ages: 12–15, 16–18 and 19–25.

On the second day of research we will spend half a day interviewing 3–4 sexual and reproductive health service providers. Individual interviews will be conducted to ensure privacy so that service providers are not subject to professional pressure to conform to certain standards or positions. In the afternoon we will conduct two focus group discussions with parents and carers.

Depending on the legal context in which the research is carried out, the CCLC team, in careful consultation with IPPF, and with regard to any risks and ethical considerations, may attempt to access providers of clandestine or illegal SRH services. For instance, given the prevalence of such activity in Senegal, this would provide critical information on young people's demand for and access to certain SRH services and the (legal) barriers surrounding these services.

Primary data collection methods

The CCLC team will carry out direct, primary field research in three locations with regard to the following questions:

- *What are the direct and indirect legal barriers that impact on young people's access to SRH services?*
- *How do different legal principles and provisions facilitate or inhibit access to SRH services for young people both directly and indirectly?*
- *What do young people know about the law as it applies to SRH services?*
- *What do they know about the law as it applies to sexuality and sexual activity?*
- *How do young people perceive or interpret such laws as applying to themselves or their peers?*
- *How does this knowledge and perception impact on their access to SRH services?*
- *What are their experiences accessing SRH services and information? How do they expect this process to occur?*
- *What are the gaps in their information and access?*
- *How do legal barriers interact with social, cultural or other barriers to accessing SRH services?*

Data collection tools, designed to answer each of these questions, have been developed alongside the methodology and submitted as an annex to this document. Tools were designed to ensure that concepts are clearly explained and developed in a way that is engaging and 'young-person-friendly'. We will also conduct group discussions and participatory activities with young people in a way that is sensitive to protecting their anonymity and acknowledges the sensitive nature of the subject matter. Our research will be primarily conducted through individual interviews, focus group discussion and participatory learning and action methods. The value of these methods, and what we hope to achieve through them is described in greater detail below.

Individual interviews

Given the sensitive nature of the research, and the fact that it will involve speaking to young people about their behaviour, choices, perceptions and experiences related to access to sexual and reproductive health services, it is important that individual interviews are carried out so respondents are given a private and confidential setting in which to respond. Interviews will be qualitative and semi-structured in nature: data collection tools were developed to facilitate a level of standardisation in data collection, however, the tools will be used as guides, rather than being followed religiously. Instead, interviews will be conducted in a participatory manner; the researcher will be guided by the young person's responses within the broader frame of the research questions. Questions will be asked based on the respondents' experiences and with a view to encouraging the most *authentic* and responsive data.

Interviews will aim to collect data on:

1. Respondents' knowledge, understandings and attitudes towards relevant law relating to gender, sexuality and health, on the part of both young people and service providers;
2. How these perceptions are linked to individual's practices, choices and experiences concerning access to (*or in the case of service providers, provisions of)* SRH services.

Interviews will include a mix of life history questions and questions that focus on perceptions of law and access to SRH services. This will allow us to link demographic data (e.g. gender, age, ethnicity, sexuality etc.) and data on participants' backgrounds and life circumstances, to particular perceptions about the law (and gender, sexuality and health more broadly) and experiences relating to seeking of and access to SRH services. It will allow us to examine how participants' social environments and lived experiences have shaped their understandings of law and experiences relating to access. This will facilitate our understanding of whether the legal environment impacts young people's seeking of and access to SRH services differently depending on other social and environmental factors, and to determine how other factors that influence access and service seeking behaviour interact with the legal environment. Following a 'life history' structure through interviews, will also allow us to access information about how (and why) perceptions of law and access to SRH services might change over time.

Focus groups

We will conduct focus group discussions (FDG) with both service providers and young people (questions asked will depend on the legal contexts, the nature of the services, and issues surrounding anonymity).

FDGs will consist of groups of 6–8 individuals. During focus groups with young people, we will separate individuals according to gender due to the sensitive nature of the issues under discussion (in consultation with Member Associations; particularly in the more legally 'permissive' country, we may deviate from this in some cases, as interactions between different genders may provide meaningful inputs to research). Data collection tools for focus group discussions will be designed such that participants are encouraged to discuss issues in a general, hypothetical, or

scenario-based format, so that they do not feel the need to reveal information about personal experiences.

Focus group discussions will provide a useful method for exploring issues concerning different contexts of access to SHR services. For example, participants will be presented with a series of 'scenarios' and asked to discuss/debate how they view the situation, as well as their perceptions of how the law applied to the situation (e.g. different circumstances in which an individual may seek contraceptive or abortion services). Exploring these issues through a focus group discussion will be particularly useful as participants will have the opportunity to respond to each others' ideas and opinions; this has the potential to stimulate discussion and debate. Focus group discussions are generally more interesting for participants than individual interviews, and can provide for a more fun and relaxed environment for young people than a one-to-one setting. Also, as focus groups take the pressure off individual respondents, they can sometimes result in more natural and spontaneous answers than individual interviews. On the other hand, it will be necessary for researchers to consider the implications of social pressure and other group dynamics, which have the potential to skew opinions and information.

Other methods and tools

We will consider engaging the use of Participatory Learning and Action, which involves the use of visual techniques in order to ensure that certain groups are adequately involved in the research. For instance, when we pilot tools we will ask research participants to develop drawings or maps which present first, services they access (or cannot access), second, safe spaces where they can get advice or support on SRH matters, and, third, barriers to accessing SRH information and services. Maps can give insightful information about both the local environment and the young person's place in the community. This can generate further conversation about behaviour of individuals in the community, and the young person's views on and interpretations of this behaviour. We will use the mapping techniques discussed above depending on outcomes of the pilot.

We will also engage in role-play with practitioners. Researchers will approach practitioners as a young person who wishes to access SRH services (contraceptives or abortion) to get a strong sense of how practitioners responses, and treatment of young people in such a scenario.

Involving young people in the research

Young people are important agents for change. Participation of young people in the research has potential to challenge cultures of taboo surrounding discussion of and access to SRH services, and stigma that can be attached to those who have access such services. As such, at all stages of the research we will ensure that we work in partnership with young people.

For instance, we will pilot data collection tools with a group of young person volunteers (who we will access through our institutional affiliation with Coram) before beginning to implement research to determine the accessibility, effectiveness and 'young-person friendliness' of tools. Young people may be able to comment on ways of making them feel confident to speak about sensitive subjects.

We also intend to include young people in the initial findings presentation/data validation workshop as they are likely to raise important questions and provide useful inputs into the interpretation of data.

We would like to include young people in the development a young-person-friendly version of the report, if funding allows.

Cultural considerations

We will ensure that the diversity of young people is recognised in all stages of the research. We will work to ensure that patterns of inequality are not reinforced, allowing young people from traditionally dominant groups to get a greater say (e.g. based on gender, race etc.). We will do this by engaging interpreters, conducting meetings and research at a time and place most convenient for people (i.e. near the schools or homes of particular young people), and setting ground rules about what language it is and is not appropriate to use. We will also ensure that young people with disabilities are considered and will make arrangements to enable their participation as necessary.

We will consult with member associations and (where feasible) with young people, carers and support institutions on particular cultural considerations that might need to be taken into account, and use this information to guide the project.

We will be sure to plan for sharing the outcomes of the research with participants.

Gender sensitive approach

The team employs a gender sensitive approach in all our research. This is particularly important when conducting research related to sexual health. From a research perspective: it will be important to consider how gender identities and power dynamics within relationships are linked to young people's understandings of legal contexts and barriers in access to SRH services.

From an ethics perspective: when designing the methodology and data collection tools, and whilst conducting interviews and focus groups, it will be crucial to be sensitive to how gender identities affect individual experiences related to seeking of and access to SRH services.

Ethical guidelines

Due to the sensitivity of the research topic, which deals with core issues of identity and violence, and the young age of participants, special care will be taken to ensure that the research does not cause harm to the participants and that ethical guidelines are set out and strictly followed. The CCLC researchers involved in the project have expertise in carrying out research with young people, including with particularly vulnerable young people. In addition, interpreters will undergo a day and a half of training on skills and ethical issues involved in carrying out research with young people, and on the purpose, methodology and tools for the study.

Do no harm and best interests of the child
It is of the upmost importance to ensure that research carried out with children and young people does not cause them harm. The welfare and best interests of the participants will be the primary consideration in data collection. The research will be guided by the UN Convention on the Rights of the Child, in particular Article 3.1 which states: "In all actions concerning children, whether undertaken by public or private social welfare institutions, courts or legislative bodies, the best interests of the child shall be a primary consideration." Due to the sensitivity of the research topics, particular care will be taken to ensure that questions are asked sensitively and in a child-friendly manner that is appropriate to the age of the participants. Clear language will be used which avoids victimisation, blame and judgement. Where it is clear that the interview is having a negative effect on a participant, the interview will be stopped. Any child protection concerns will be identified and dealt with appropriately (see below).

Children involved in individual interviews will be provided with the opportunity to be interviewed with a trusted adult or friend if this would make them feel more at ease. Researchers should identify staff at institutions (schools, community groups) that are available to accompany participants, if requested.

As the interviews may cover particularly sensitive or traumatic material, including personal experiences of violence, it is important to ensure that participants feel empowered and not solely like victims. Towards the end of the interview, therefore, questions will be asked about what would make life better for young people in their country context. This will help to ensure that young people do not leave the interview focusing on past experiences of abuse. Also, where young people reveal past experiences of violence, researchers will convey empathy, but will not show shock or anger, as this can be harmful to young people who have experienced violence.

Voluntary participation
Participation in the study will be on a voluntary basis. No incentives will be provided. Researchers will explain to participants in clear, age-appropriate language that they are not required to participate in the study, that they may refuse to answer any questions and may stop the interview or stop participating in the focus group at any time. Researchers will carefully explain that refusal to participate will not result in any negative consequences.

Informed consent
At the start of all interviews and focus group discussions, participants will be informed of the purpose and nature of the study through the information and consent form, where possible. Where it is not possible for the participant to sign a consent form (e.g. due to illiteracy), interviewers will explain the nature and purpose of the study and request the verbal consent of the participants to conduct the interview / focus group and then record that permission has been granted. Special effort must be made to explain the nature and purpose of the study in clear, age-appropriate language. Where researchers are not certain that a participant has understood the nature and purpose of the study and the involvement of the participant, they will request the participant to relay the key information back to them. Participants will also be advised that the information they provide will be held in strict confidence (see below).

Anonymity
Due to the sensitive nature of the information likely to be provided to participants, ensuring confidentiality and anonymity is of the upmost importance. The participants will be told that their identities will be kept confidential throughout the process of data collection as well as in the analysis and writing up the study findings. The following measures will be used to ensure anonymity:

- Researchers will not record the name of participants and will ensure that names are not recorded on any documents containing data collected for the study, including on transcripts of interviews and focus group discussions;
- Interviews will take place in a separate room which ensures that the participant's answers are not overheard;
- Researchers will be advised, once the CCLC has confirmed receipt of transcripts from interviews and focus group discussions from researchers, that they must delete the transcript from their computers;
- CCLC will store all data on a secure, locked server, to which persons who are not employed by the Centre cannot gain access. All employees of the CCLC, including volunteers and interns, receive a criminal record check before employment commences; and
- Research findings will be presented in such a way so as to ensure that individuals are not able to be identified.

Addressing child protection concerns
During the interviews and also possibly the focus group discussions, participants may disclose information that raises child protections concerns (i.e. information indicating that they are currently at risk of or are experiencing violence, exploitation or abuse). Prior to the data collection taking place, researchers should be provided

with copies of the child protection policies and procedures of each institution from which participants are recruited (i.e. schools, community groups) and should familiarise themselves with child protection referral mechanisms and child protection focal points. Participants should be advised before the interview or focus group commences that, should any information they provide indicate that they are at risk of abuse or exploitation, then researchers will need to follow the relevant child protection procedures, and should explain these procedures and why they will be used to participants.

Participants will always be interviewed with at least two persons present (two researchers or one researcher and one translator).

Ensuring the physical safety and well-being of researchers and participants

Interviews and focus group discussions will all take place on the premises of the institutions through which participants are recruited into the study (i.e. schools, community group buildings). As noted above, participants will always be interviewed with at least two persons present (two researchers or one researcher and one translator).

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Qualitative research on legal barriers to young people's access to sexual and reproductive health services

Inception report

The International Planned Parenthood Federation (IPPF) is a global service provider and a leading advocate of sexual and reproductive health and rights for all. We are a worldwide movement of national organizations working with and for communities and individuals.

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Across the world, laws create barriers to young people accessing the sexual and reproductive health services that they need. Often, the rationale for such laws is cited as 'protection' but, in reality, they have the opposite effect.

While there is an extensive body of literature that explores social, cultural and economic barriers to young people's access to SRH services in a range of contexts around the world, much less is known about the role of law in influencing and shaping their access. This is despite the fact that every state around the world, without exception, has developed legislation that is in some manner designed to purposefully regulate and restrict access to SRH services.

This inception report is the first stage in an exploratory research project which will attempt to fill this gap. It includes a summary global mapping of the basic ways in which different legal systems impose restrictions on young people's access to sexual and reproductive health services both directly and indirectly. Based on this analysis, the report sets out a methodology for the primary research, which will contribute to the existing evidence base on the barriers that prevent young people from accessing SRH services. The research will inform advocacy and programmatic work aimed at fulfilling young people's sexual rights.

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