

**ACCESS TO EMERGENCY CONTRACEPTION AMONG ADOLESCENT GIRLS IN  
LESOTHO**

**BY**

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## **List of abbreviations**

ACHPR	African Charter on Human and People's Rights
ACRWC	African Charter on the Rights and Welfare of the Child
CRC	Charter on the Rights of the Child
CEDAW	Convention on Elimination of All forms of Discrimination Against Women
CSE	Comprehensive Sexuality Education
CESCR	International Covenant on Economic, Social and Cultural Rights
CPWA	Children's Protection and Welfare Act
CRDP	Convention on the Rights of Persons with Disabilities
FBOs	Faith- Based Organisations
ICPD	International Conference on Population and Development
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
LPPA	Lesotho Planned Parenthood Association
NAFCI	National Adolescent-Friendly Clinic Initiative
NGOs	Non-Governmental Organisations
STIs	Sexually Transmitted Infections
WHO	World Health Organisation

## Summary

The study was motivated by studies which have revealed that teenage pregnancy, maternal mortality and unsafe abortion are high in Lesotho. The purpose of the study was to examine whether or not lack of access to emergency contraception as one of the essential forms of contraception could be the reason for the aforementioned health challenges facing adolescent girls in Lesotho.

The study was a desktop review with content analysis of documents applicable to the health of adolescents and those relating to access to family planning services for adolescent girls. The woman question was used as a tool for ascertaining whether the health rights of adolescent girls are fulfilled by Lesotho. The legal framework relevant to access to emergency contraception was also scrutinised to ascertain whether they are compliant with human rights treaties ratified by Lesotho. The study is also a comparative analysis of Lesotho's policy frame with South Africa.

From the analysis of the literature review, the study uncovered how religious, cultural practices and some areas of the laws relevant to access to emergency contraception for adolescents were not responsive to the female adolescent question, thereby perpetuating infringement of various human rights belonging to adolescent girls. The study also revealed that lack of political will and poor coordination and monitoring of policies, budgetary deficiencies and shortages in human resources are some of the factors inhibiting adolescent's realisation of their full access to family planning services.

The study made recommendations which the Government of Lesotho could use to change the current state of access of adolescent girls to emergency contraception.

**Keywords:** Adolescents, emergency Contraception, sexual and reproductive health, sexual and reproductive health rights, unsafe abortion, unintended pregnancies, non-discrimination, maternal mortality, sexuality education, International human rights treaties

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# CHAPTER 1

## AN OVERVIEW OF THE STUDY

### 1.0 Background:

According to the World Health Organisation,<sup>1</sup> emergency contraception refers to methods of contraception that can be used to prevent pregnancy in the first five days after sexual intercourse. It is effective only in the first few days following intercourse before the ovum is released from the ovary and before the sperm fertilizes the ovum. Emergency contraception cannot however interrupt an established pregnancy or harm a developing embryo.<sup>2</sup> It can be used by any woman or girl of reproductive age who may need to avoid an unwanted pregnancy.

Emergency contraception is not meant to be a regular method of birth control. It can be used as a one-time emergency treatment in a number of situations following sexual intercourse. These include; when no contraceptive has been used, in cases of rape or coerced sex, when the woman was not protected by an effective contraceptive method or when there is a contraceptive failure or incorrect use, including: condom breakage, slippage, three or more consecutively missed combined oral contraceptive pills.<sup>3</sup>

There are 3 methods of emergency contraception: emergency contraceptive pills, combined oral contraceptive pills or the Yuzpe method, and copper-bearing intrauterine devices (IUDs).

The emergency contraception regimen recommended by WHO is either one dose of levonorgestrel (1.5 mg), or one dose of ulipristal (30 mg) which should be taken within 5 days (120 hours) of unprotected intercourse.<sup>4</sup> In order to ascertain the effectiveness of levonorgestrel, WHO conducted nine studies involving 10 500 women, and the findings suggest that levonorgestrel regimen is 52–94 percent effective in preventing pregnancy.<sup>5</sup> Levonorgestrel is more effective if it is taken soon after sexual intercourse. With regard to ulipristal, evidence shows that it prevents pregnancy in at least 98 percent of situations, especially if taken within 72 hours of sexual intercourse.<sup>6</sup>

The Yuzpe method uses combined oral contraceptive pills which are taken in two doses. Each dose must contain estrogen (100–120 mcg ethinyl estradiol) and progestin (0.50–0.60 mg levonorgestrel (LNG) or 1.0–1.2 mg norgestrel).<sup>7</sup> WHO recommends that the first dose should be should be should be taken as soon as possible after unprotected

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<sup>1</sup> World Health Organisation (WHO) *fact sheet on emergency contraception Geneva* (2016).

<sup>2</sup> WHO (n 1 above).

<sup>3</sup> WHO (n 1 above).

<sup>4</sup> WHO (n 1 above).

<sup>5</sup> WHO (n 1 above).

<sup>6</sup> WHO (n 1 above).

<sup>7</sup> WHO (n 1 above).

intercourse, preferably within 72 hours but as late as 120 hours, or five days and the second dose should be taken 12 hours later.<sup>8</sup>

A copper-bearing IUD is over 99 percent effective in preventing pregnancy when inserted within 5 days of unprotected intercourse.<sup>9</sup> It is the most effective form of emergency contraception available as it prevents fertilization by causing a chemical change in sperm and egg before they can meet.<sup>10</sup>

There is no law regulating licensing of medicine in Lesotho. This is a serious shortcoming on the part of Government, as there is no institution safeguarding public health through the effective regulation of medicines and medical devices in the country, thereby putting the lives of citizens in grave danger. There is in place however, a Medicine and Medical Device Control Bill which has been in existence for more than 20 years and as a result Licensing of medicine in Lesotho is regulated by WHO guidelines on Prequalification of medicines<sup>11</sup> whose objective is to assess the quality, safety and efficacy of medicinal products including products for reproductive health.

Currently in Lesotho, the product sold as an emergency contraception, commonly known as a 'morning after pill,' is Levonorgestrel. The Family planning guidelines 2012 highlight that emergency contraception in Lesotho can be provided at all levels of services delivery, from community level, mobile units, clinics, health centers, district hospitals to referral hospitals.<sup>12</sup> (Lesotho Family Planning Guidelines 2012 13) Family Planning Guidelines have in cooperated the 2009 WHO Medical eligibility criteria for contraceptive use which groups medical conditions into four categories, namely; conditions for which there is no restriction on the use of the contraceptive method; conditions for which the advantages of using the method generally outweigh the theoretical or proven risks; conditions for which the theoretical or proven risks usually outweigh the advantages of using the method and; conditions that present an unacceptable health risk if the contraceptive method is used.

## **2.0 Statement of the problem**

Globally, there are 1.8 billion adolescents and youth, composing 25% of the world's population.<sup>13</sup> While many adolescents and youth choose to delay sexual initiation, a significant number are sexually active and want to prevent or delay a pregnancy for multiple years—until finishing school, gaining employment, getting married, or to space their children. At the same time, one third of girls in developing countries are married or in union before the age of 18 and approximately 12% are married or in union before

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<sup>8</sup> WHO (n 1 above).

<sup>9</sup> WHO (n 1 above).

<sup>10</sup> WHO (n 1 above).

<sup>11</sup> WHO *fact sheet Prequalification of medicines Geneva* (2013).

<sup>12</sup> Ministry of Health Family planning guidelines (2012) 14.

<sup>13</sup> United Nations Population Fund. *The Power of 1.8 Billion: Adolescents, Youth and the Transformation of the Future*. United Nations Population Fund, 2014. Accessed 15 June 2016 on [http://www.unfpa.org/sites/default/files/pub-pdf/EN-SWOP14-Report\\_FINAL-web.pdf](http://www.unfpa.org/sites/default/files/pub-pdf/EN-SWOP14-Report_FINAL-web.pdf) .

reaching age 15,<sup>14</sup> with the expectation that most will become pregnant soon after their weddings.<sup>15</sup> Approximately 16 million adolescents, ages 15-19, give birth annually; for some, these births are planned, but for many others, they are not.<sup>16</sup> An estimated 33 million young women aged 15-24 across 61 low and middle income countries have an unmet need for contraception.<sup>17</sup> In addition to the well-documented risks of early childbearing for both adolescent women and their children, the phenomenon of rapid repeat pregnancy (that is, a pregnancy within two years of a previous pregnancy) is increasingly recognized and is associated with increased maternal and newborn morbidity, as well as abortions, including unsafe abortions.<sup>18</sup> Additionally, unsafe abortion among adolescents remains high in some parts of the world; in sub-Saharan Africa, women under 25 years of age account for 51 percent of unsafe abortions.<sup>19</sup>

The situation in Lesotho is that teenage pregnancy is a major health concern.<sup>20</sup> The Lesotho Demographic Health Survey shows that, 41 percent of women who have had a baby or are pregnant with their first child by the age of 19, and 20 percent of teenagers (15-19 years) have had at least one birth or are pregnant with their first child.<sup>21</sup>

The extent of this social problem is that 1 out of 32 women in Lesotho die of pregnancy and childbirth-related conditions and as such, Lesotho's maternal mortality ratio is among the highest in the Southern African Development Cooperation region, with an estimate of 1,155 deaths per 100,000 live births in 2009.<sup>22</sup> This is a drastic increase from 419 deaths per 100,000 live births in 2000, to 762 per 100,000 in 2004.<sup>23</sup>

Over and above the high risk of maternal mortality in adolescents who fall pregnant in Lesotho, is the issue of unsafe abortion. Abortion is restricted in Lesotho, section 45 (2) of the 2010 Penal Code authorises medical abortion only in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus. As a result, adolescent girls who fall

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<sup>14</sup> United Nations Population Fund. *Marrying Too Young End Child Marriage*. New York, NY: United Nations Population Fund, 2012. <http://www.unfpa.org/sites/default/files/pub-pdf/MarryingTooYoung.pdf>.

<sup>15</sup> United Nations Population Fund. *Motherhood in Childhood: Facing the Challenge of Adolescent Pregnancy*. United Nations Population Fund, 2013. <http://www.unfpa.org/sites/default/files/pub-pdf/EN-SWOP2013-final.pdf>.

<sup>16</sup> World Health Organization. *Preventing Early Pregnancy and Poor Reproductive Outcomes Among Adolescents in Developing Countries*. Geneva: World Health Organization, 2012. [http://www.who.int/maternal\\_child\\_adolescent/documents/preventing\\_early\\_pregnancy/en/](http://www.who.int/maternal_child_adolescent/documents/preventing_early_pregnancy/en/).

<sup>17</sup> MacQuarrie, Kerry L.D. *Unmet Need for Family Planning among Young Women: Levels and Trends DHS Comparative Reports No. 34*. Rockville, Maryland, USA: ICF International, 2014. <http://www.dhsprogram.com/pubs/pdf/CR34/CR34.pdf>.

<sup>18</sup> World Health Organization. *Global Consensus Statement: Expanding Contraceptive Choice for Adolescents and Youth to Include Long-Acting Reversible Contraception*. World Health Organisation 2015 <http://www.familyplanning2020.org/resources/10815>.

<sup>19</sup> World Health Organization. *Global Consensus Statement* (n 18 above).

<sup>20</sup> The Government of Lesotho and the UN System in Lesotho 'MDG Acceleration Frame Work: Improving Maternal Health' (2013) 28.

<sup>21</sup> Lesotho Ministry of Health 'Lesotho Demographic Health Survey' (2014) 11.

<sup>22</sup> The Government of Lesotho and the UN System in Lesotho (2013) 13.

<sup>23</sup> The Government of Lesotho and the UN System (n 22 above at 13).

pregnant in most cases resort to procuring abortions which are not performed by qualified medical personnel and thereby using extremely dangerous methods to terminate unwanted pregnancies.<sup>24</sup>

Further, failure to access emergency contraception debars adolescent girls from exercising their right to enjoy sex without fear of falling pregnant. Declarations and statements made at the 1994 International Conference on Population and Development (ICPD)<sup>25</sup> and the 1995 Beijing World Conference on Women<sup>26</sup>, have since paved way for discourse around adolescent sexuality rights. The 1994 International Conference on Population and Development has underscored the importance of information and services that should be made available to adolescents to help them understand their sexuality and protect them from unwanted pregnancies.<sup>27</sup> The discourse around adolescents reproductive and sexuality rights brought about various regional and global treaties safeguarding contraceptive rights of women and girls. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol)<sup>28</sup> also reaffirms women's rights to control their fertility; that is, their right of choice on the number and timing of their pregnancies as well as the right to choose their method of contraception. WHO recognises that adolescents have the right to have sexual pleasure, in a safe and responsible manner.<sup>29</sup> Cooks & Baur<sup>30</sup> contend that the fear of an unwanted pregnancy can interfere with coital enjoyment in a heterosexual relationship especially when couples do not have an effective method of contraception. This reaffirms that emergency contraceptives are imperative to enhance sexual pleasure for adolescents who are not ready or do not want to have children at the time.

### **3.0 Main objective:**

The main objective of this study was to evaluate whether the laws and policies in Lesotho provide for physical and economical accessibility by adolescent girls, without discrimination and whether adolescents are furnished with enough information about emergency contraception in order to enable proper use of such information.

### **3.1 Specific objectives were:**

- To evaluate whether there is any implication of using the woman question as a tool of realising access to contraception for adolescent girls in Lesotho

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<sup>24</sup> United Nations Population Fund Lesotho National Reproductive Health Survey Analytical Report' 2003 (1) 71.

<sup>25</sup> Programme of Action of the International Conference on Population and Development UN Doc.A/CONF 171/13 (1994).

<sup>26</sup> Beijing Declaration and the Platform for Action, Fourth World Conference on Women, China, September 4-15 1995, UN. Doc. A/CONF.177/20 1995

<sup>27</sup> ICPD (n 25 above at para 7.41).

<sup>28</sup> Protocol to the African Charter on the Rights of Women in Africa Adopted by the 2nd Ordinary Session of the African Union General Assembly in 2003 in Maputo CAB/LEG/66.6 (2003) entered into force 25 November, 2005 in art 14(1) (a), (b) and (c).

<sup>29</sup> WHO *Sexual and reproductive health* (2016).

<sup>30</sup> R Cooks, K Baur *Our Sexuality* (2013) 418.

- To ascertain whether the legal framework relevant to access to emergency contraception is compliant with human rights treaties ratified by Lesotho.
- To find out whether Lesotho could employ good practices from other jurisdictions in the realisation of access to contraception for adolescents.

#### **4.0 Justification/Rationale:**

The issue of adolescent fertility is important on both health and social grounds. Adolescent girls who fall pregnant are at an increased risk of sickness and death caused by maternal mortality and unsafe abortions. The issue of unintended pregnancy also prohibits adolescents from exercising their sexuality rights and consequently not being able to freely express themselves erotically.

The study illuminated the extent to which adolescent girls are able to access easy and confidential contraceptive services, in sufficient quantity, within health care centers in Lesotho, thereby curbing critical reproductive health challenges faced by adolescent girls.

The study also discovered the barriers associated with administering emergency contraception by looking at the extent to which emergency contraception is acceptable in terms of medical ethics and the extent to which emergency contraception procedures are culturally appropriate.

The study extrapolated on how access to information on emergency contraception can capacitate adolescent girls about their sexuality, thereby allowing them to possess self-determination in order to make informed choices about their fertility.

The study also extrapolated on how best practices could be employed from other jurisdictions, with a view to ensuring effective access to emergency contraceptives through comparative analysis.

#### **5.0 Methodology:**

The study was a desktop review with content analysis of documents that are relevant to the general health of adolescents and those relating to access to family planning services for adolescent girls in Lesotho. The hard copies of laws, policies, programs and studies conducted in the area of adolescents' health were collected from various institutions in the country. Further, relevant documents regarding access to contraception in a form of journals, books, international human rights treaties and internet sources were obtained. Thereafter, the documents were analysed and summarised in order to ascertain whether the legal framework relevant to family planning services in Lesotho were in line with Lesotho's international obligations. The study also discovered the implications of using the female adolescent question as a method of fulfilling access to contraception for adolescent girls in Lesotho.

It was also a comparative study between Lesotho and South Africa as both are neighbours and Southern African countries which may be affected by the same problems in the area of sexual and reproductive health. They are both Commonwealth countries,

their legal systems are similar and their societies are both influenced by patriarchal norms, values and culture. The study revealed whether Lesotho could employ best practices from the laws, policies and guidelines from the Republic of South in order to improve its health programmes and provide an insight into how the Government could create a more adolescent-friendly service-delivery environment that would enable a holistic approach to access to emergency contraception.

## **6.0 Hypothesis:**

The more educated adolescent girls are about available options of emergency contraception, the more likely they are to access them, and thereby making informed decisions about their sexual and reproductive choices.

## **7.0 Study area:**

This dissertation scrutinized whether the laws and policies in Lesotho guarantee effective access to emergency contraception in adolescent girls, taking into consideration the obligations emanating from various regional and global human rights treaties ratified by Lesotho, safeguarding the right to health. The study further examined factors hindering access to emergency contraception in adolescent girls, and the human rights implications emanating from such hindrances on adolescent girls thereof. The study also invoked 'asking the woman question' under feminist theory in order to discover whether the laws and policies enable adolescent girls to fully realise their right of access to emergency contraception.

Lesotho has not only been represented in the 1994 ICPD and the 1995 Beijing Conferences, which paved way for discussion around sexual and reproductive rights of women and girls, which include access to contraceptives, it is also a state part to the following Conventions: The Convention on Elimination of All forms of Discrimination Against Women (CEDAW)<sup>31</sup>, the 1990 UN Charter on the Rights of the Child (CRC),<sup>32</sup> the African Charter on the Rights and Welfare of the Child (ACRWC),<sup>33</sup> The International Covenant on Economic, Social and Cultural Rights (ICESCR),<sup>34</sup> Convention on the Rights of Persons with Disabilities,<sup>35</sup> The African Charter on Human and People's Rights (ACHPR)<sup>36</sup> and the Protocol to the African Charter on Human and Peoples' Rights on

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<sup>31</sup> Convention on the Elimination of All Forms of Discrimination against Women GA Res 54/180 UN GAOR 34th Session Supp No 46 UN Doc A/34/46 1980.

<sup>32</sup> Convention on the Rights of the Child Adopted in 1989 U.N. Doc. A/44/49 entered into force Sept. 2, 1990.

<sup>33</sup> African Charter on the Rights and Welfare of the Child, OAU Doc. CAB/LEG/24.0/49 (1990) (entered into force Nov. 29, 1999).

<sup>34</sup> International Covenant on Economic, Social and Cultural Rights, adopted 16/12/1966; G.A. Res 2200 (XXI), UN. Doc A/6316 (1966) 993 UNTS 3 (entered into force 3/01/1976).

<sup>35</sup> Convention on the Rights of Persons with Disabilities A/Res/61/06, adopted 13 December 2006, entered into force 3 May 2008.

<sup>36</sup> African Charter on Human and Peoples' Rights O.A.U. Doc.CAB/LEG/67/3/Rev.5 Adopted by the Organization of African Unity, 27 June 1981, entered into force 21 October 1986.

the Rights of Women in Africa.<sup>37</sup> The Government has also adopted the 2015 Millennium Development Goals.

Lesotho has also developed Laws and policies aimed at facilitating access to emergency contraception in adolescent girls. The Constitution, the 2011 Children's Protection Act, Lesotho National Health and welfare policy 2003, National Family Planning Guidelines 2012, the National Health Strategy for Adolescents and Young People 2015-2020, and 2005 School Health Policy.

The study also discussed the concept of 'asking the female adolescent question' as one of the approaches used by feminist scholars, to address difficulties faced by female adolescents with regard to access to emergency contraception. The female adolescent question was used to expose how the features of the law, rules and practices adversely affect access to emergency contraception among adolescent girls in Lesotho and how might that be corrected. One of the feminist scholars, Bartlett<sup>38</sup> explains that, asking a woman question in law means examining how the law fails to take into account the experiences and values that seem more typical of women than men or how the existing legal standards and concepts might disadvantage women. The study therefore interrogated whether promulgated laws, policies and programmes take into consideration unique life circumstances surrounding adolescent girls. The study found out whether there are implications in the laws, rules and practices which otherwise might appear to be neutral and objective, yet are generally non neutral, but are 'male' specific in a sense.<sup>39</sup> Asking the female adolescent question therefore challenged the gender-neutral nature of laws, policies, programmes relating to access to contraception for adolescent girls in Lesotho. It was believed that this approach would help in eliminating discriminatory practices and barriers against adolescent girls, as legislators and policy makers will have the opportunity to put adolescent girls at the centre of all decisions taken in relation to access to contraception.

## **8.0 Literature review**

### **Introduction**

In trying to unpack a series of rights associated with the right of access to healthcare, Ngwena & Cook<sup>40</sup> emphasise that the right of access to health care services can not only be linked to the notion of self-determination or autonomy, but also to the rights to equality and human dignity. The rights to equality and human dignity can also be used as a platform for adolescent girls to seek access to contraceptives on the same footing with older women. The General Comment No. 14 of the International Covenant on Economic Social and Cultural Rights (ESCR) places the responsibility on the state to ensure, on a basis of equality of men and women, that adolescent girl's right of access to emergency

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<sup>37</sup> Maputo Protocol (n 28 above).

<sup>38</sup> K Bartlett 'Feminist Legal Methods' (1990) 10 *Harvard Law Review* 837.

<sup>39</sup> Bartlett (n 38 above at 837).

<sup>40</sup> C Ngwena & RJ Cook "Rights Concerning Health" in D Brand & C Haynes (eds) 'Socio-Economic Rights in Southern Africa' (2005) 131.

contraception, information and education about emergency contraception is respected, protected and fulfilled.<sup>41</sup>

The constitution of Lesotho makes provision for the protection of health and various policies relating to access to healthcare services, including access to emergency contraception have been developed. The study therefore, scrutinized how far the Lesotho legal frame work recognises and safeguards adolescents' right to equality and human dignity as far as access to emergency contraception is concerned.

The ESCR General Comment No. 14 recognises that, for adolescents to fully enjoy the use of emergency contraception, the government must ensure its availability, accessibility, acceptability and ensure that they are of good quality. It provides that in order for a state to ensure accessibility of emergency contraception, it has to respect, protect and fulfill four overlapping dimensions upon which accessibility is premised.<sup>42</sup> These include non-discrimination, physical accessibility, economic accessibility and information accessibility.

### **8.1 Non-discrimination**

In the quest to ensure access to health-care services, the Committee on the Convention on Elimination of All Forms of Discrimination Against Women (CEDAW) obligates states to eliminate discrimination against women in their access to family planning services, in particular, in facilitating emergency contraception to adolescent girls.<sup>43</sup> This suffices to say that similar treatment must be accorded to adolescent girls when they choose to access emergency contraception in the same manner as adolescent boys would be treated when they request other methods of contraceptives like condoms. There should not be any age restriction placed on the selling of emergency contraceptives as this perpetuates discrimination on the basis of sex and age. The College of Obstetricians and Gynecologists Committee on Health Care for Underserved Women<sup>44</sup> emphasises that it is incumbent on states to ensure that access to comprehensive contraceptive care and contraceptive methods forms an integral component of women's health care and that policies must ensure the availability of affordable and accessible contraceptive care and contraceptive methods. In order to accomplish this goal, the College notes that states must undertake efforts to increase access to emergency contraception, including removal of the age restriction for all levonorgestrel emergency contraception products, to create true over-the-counter access. Similarly, General comment 2 of the African commission in paragraph 29 discourages age discrimination. It encourages states to ensure availability, financial and geographical accessibility of women and girl's sexual and

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<sup>41</sup>The Right to the Highest Attainable Standard of Health; UN Committee on ESCR General Comment No 14, UN Doc E/C/12/2000/ General Recommendation No. 24 under article 12 of the Convention on Elimination of All Forms of Discrimination Against Women.

<sup>42</sup> ESCR General Comment No. 14 'the right to the highest attainable standard of health (n 41 above).

<sup>43</sup> General Recommendation No. 24 under article 12 of the Convention on Elimination of All Forms of Discrimination Against Women at para 2.

<sup>44</sup> The College of Obstetricians and Gynecologists 'Committee on Health Care for Underserved Women: Access to Contraception' 2015(615) 1.



reproductive health-care services, without any discrimination relating to age, health condition, disability, marital status or place of residence.

General comment No. 15 (2013) under article 24 of the Convention on the Rights of the Child (CRC)<sup>45</sup> encourages States to make short-term contraceptive methods such as condoms, hormonal methods and emergency contraception to be easily and readily available to sexually active adolescents. This in turn will enable adolescent girls to make sexual and reproductive decisions freely and responsibly, including deciding on the number, spacing and timing of their children as underscored by the Protocol to the African Charter on the Rights of Women in Africa (Maputo Protocol)<sup>46</sup> and the Committee of CRC.<sup>47</sup> Emergency contraception services must be accessible to all, including adolescent girls, without discrimination on any of the prohibited grounds. On that note, states are obliged to ensure sexuality rights of adolescents, which encompass access to emergency contraception, irrespective of their age or disability status.<sup>48</sup> The Committees on the CRC<sup>49</sup> and on Economic Social and Cultural Rights (CESCR)<sup>50</sup> make emphasis to the importance of the respect to confidentiality and privacy of adolescents when given sexual and reproductive health services, on the same footing with older women or adolescent boys.

Despite the existence of policies, most adolescent girls still face discrimination when trying to access health care center in Lesotho. The discrimination is often portrayed in negative attitudes of health care practitioners which may be perpetuated by cultural stereotypes and religious beliefs. Regrettably, health practitioners are state agents, who have the responsibility to implement international obligations emanating from various soft laws and international treaties which the Government has acceded to. These include Paragraph 25 of the General Comment 2 of the African Commission on Human and People's Rights (African Commission) under article 14 of the Maputo Protocol which provides that the right to health care without discrimination requires State parties to remove impediments to the health services reserved for women, including ideology or belief-based barriers. Likewise, Iyioha & Nwabueze<sup>51</sup> contend that whilst healthcare centres or place where they can seek information and services on contraception, they are often deterred from approaching them due to health practitioners with judgmental attitudes.

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<sup>45</sup> General comment No. 15 (2013) under article 24 of the Convention on the Rights of the Child (CRC) para 70.

<sup>46</sup> Maputo Protocol (n 28 above at art. 14 (1) (a), (b) and (c)).

<sup>47</sup> General comment No. 15 (2013) (n 45 above at para 69).

<sup>48</sup> Committee on the Rights of the Child, Adolescents health and Development in the context of the Convention on the Rights of the Child , General Comment N0 4 CRC/GC/2003/4 Thirty-Second Session May 2003 at para 28.

<sup>49</sup> CRC General Comment No. 4 (2003) (n 48 above at para 28).

<sup>50</sup> ECSR General Comment No. 14 (n 41 above).

<sup>51</sup> Iyioha, R Nwabueze (2015) Comparative Health Law and Policy: Critical Perspectives on Nigerian and Global Health Law: Ashgate Publishing 155.

The African Commission on Human and People's Rights developed General Comment No 2 of the Protocol to the African Charter on the Rights of Women,<sup>52</sup> which further underscores that the right to freedom from being subjected to discrimination prohibits any deprivation concerning access to family planning or contraception services by health care providers for any reason including conscientious objection. In Lesotho, whilst Section 13 of the 1993 Constitution permits health care providers to exercise their freedom of conscience, which includes the freedom of thought and of religion, subsection 5 of the same section puts a limit to the freedom to exercise conscience when it relates to providing public health services, which include offering emergency contraception services to adolescents.

The Committee of Experts of the rights and Welfare of the Child in Africa has developed general comments to guide states in their activities to ensure they are in full respect of the African Charter on the Rights and Welfare of the Child. However the Committee has not developed any General Comment relating to the sexual and reproductive rights of adolescent girls. Nonetheless, the Committee has the potential of ensuring that the provisions of the African Charter on the Rights and Welfare of the Child are fully implemented through its protective and promotional mandate. The Committee can do this by holding promotional missions in member states to popularize the Charter and sensitising governments to take heed of sexual and reproductive rights of adolescents and their opinions in decisions that affect their bodies. The Committee can also organise meetings and seminars to educate states and non-state actors about issues relating to adolescents sexuality and their reproductive rights in general. It can also encourage states to prepare state party reports under the Charter, to give an account of policy, legislative and institutional measures the state has undertaken to implement articles of the Charter safeguarding the right to health of adolescents, which include access to health care services including access to emergency contraception. Lesotho was reviewed by the Committee under the Charter in November 2015 and is yet to receive concluding observations from the Committee for further implementation of the Charter.

With regard to the protective mandate, the Committee can act as a quasi-judicial body and commission inter disciplinary assessment of situations on African problems in the fields of the rights and welfare of the child. The Committee can also hold fact finding missions in member states to ascertain whether human rights violations against children exist in that particular state.

## **8.2 Physical accessibility**

Emergency contraception services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as women, children, adolescents and persons with disabilities.<sup>53</sup> Physical accessibility also includes adequate access to buildings. Even though the study focus is on all adolescent girls, it is imperative

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<sup>52</sup> General comment No 2 on Art 14.1 (a), (b), (c) and (f) of the Protocol to the African Charter on the Rights of Women at para 26.

<sup>53</sup> ESCR General Comment No. 14 (n 41 above at para12).

to mention adolescent girls living with disabilities as they are a group that faces compounded discrimination not only because they are girls, but also that they are disabled. Indeed General Comment No. 4 (2003) on Adolescent health and development in the context of the Convention on the Rights of the Child,<sup>54</sup> urges states to ensure that adolescents with mental and/or physical disabilities have an equal right to the highest attainable standard of physical and mental health by ensuring that health facilities, goods and services are available and accessible to all adolescents with disability and that these facilities and services promote their self-reliance and their active participation in the community. The Committee on CEDAW have also underlined the fact that women with disabilities, of all ages, often have difficulty with physical access to health services, and as such, governments must ensure that health services, including access to emergency contraceptives are sensitive to the needs of these, with a view to respecting their human rights and dignity.<sup>55</sup>

Physical accessibility also means that emergency contraception must be accessible in hard to reach places. General Comment No. 22 (2016) on the Right to sexual and reproductive health under article 12 of the International Covenant on Economic, Social and Cultural Rights (ESCR)<sup>56</sup> emphasises that physical accessibility should be ensured for all, especially persons belonging to disadvantaged and marginalized groups, including, but not limited to, persons living in rural and remote areas. In the context of Lesotho, emergency contraception should not only be available to adolescents living in urban areas, but to those living in the rural areas as well. Taking into account the mountainous terrain of the rural areas in Lesotho, this dimension requires the government to ensure that transport and road infrastructure allow adolescents to reach clinics and health centers in order to obtain emergency contraception services. At the present moment, most roads are so tarnished that it becomes a challenge to reach some clinics using road transport. The issue of poor infrastructure is compounded by the fact that, several health centers and hospitals which offer services mainly to rural and hard to reach communities around the country are Faith- Based Organisations (FBOs). The Roman Catholic Church owns more of such facilities than other FBOs and their doctrine is against the use of contraceptives and in these facilities have not been able to provide services or a comprehensive package of family planning package or services mentioned to adolescent girls and women.<sup>57</sup>

The African Commission under General Comment 2 article 14(2) (a) of the Maputo Protocol underscores the importance of availability, and geographical accessibility of sexual and reproductive services.<sup>58</sup> It also notes that states must guarantee the right to adequate, affordable health services at reasonable distances, including information,

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<sup>54</sup> CRC General Comment No. 4 (2003) (n 48 at para 28).

<sup>55</sup> CEDAW General Recommendation No. 24 (n 43 above at para 25).

<sup>56</sup> The Right to sexual and reproductive health; UN Committee on ESCR General Comment No. 22 UN Doc E/C.12/GC/22 at para 16.

<sup>57</sup> I Kimane 'An Updated Situation Analysis for Adolescents and Young People's Health: Ministry of Health Lesotho' (2015)10.

<sup>58</sup> General Comment 2 article 14(2) (a) of the Maputo Protocol (n 52 above).

education and communication programs for women, especially those living in rural areas.<sup>59</sup>

### 8.3 Economic accessibility

Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups.<sup>60</sup> Bryn & others<sup>61</sup> explain that the problem of cost with regard to sexual and reproductive for adolescents can be particularly challenging in a world where it is estimated that about 22.5 percent of young people were living below 1 US\$ per day. Research shows that nearly 90 percent of young people live in developing countries, including countries in Africa.<sup>62</sup> Lesotho equally experiences poverty among its young people. It is classified as one of the least developed countries and its national poverty figures indicate that 57.1% of the population lives below the national poverty line.<sup>63</sup> Notwithstanding, the cost of emergency contraceptives in pharmacies and private hospitals range from M170 to M200, the equivalent of 12 US\$ to 14 US\$. This high cost can contribute to limiting adolescent girl's access to the emergency contraception, especially those girls who are from disadvantaged families. Iyioha & Nwabueze have also observed that poverty can limit female adolescent's capabilities to seek contraceptive services as they may be unable to afford the cost of contraception.<sup>64</sup>

The Committee on ESCR has noted that equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households and that emergency contraception must therefore be affordable for all adolescent girls, irrespective of their social circumstances. Poverty and lack of financial resources adversely affect access to health care services, including access to sexual and reproductive services for adolescent girls.<sup>65</sup> While commenting on challenges in the health care sector, hindering access to emergency contraception in developing countries, Shiappacasse and Diaz<sup>66</sup> have observed that lack of privacy, unfriendly attitudes towards adolescents and high cost of the product often act as a stumbling block to adolescents' access to the product. General comment No 2 of the African Commission under the Maputo Protocol<sup>67</sup> underlines the importance of financial accessibility and quality of women's sexual and reproductive health-care services.

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<sup>59</sup> General Comment 2 article 14(2) (a) of the Maputo Protocol (n 52 above at para 29).

<sup>60</sup> ESCR General Comment No. 14 (n 41 above at para12).

<sup>61</sup> M de Bruyn, S Parker (2004) *Adolescents, Unwanted Pregnancies and Abortion: Policies, Counselling and Clinical care*: Chapel Hill, NC Ipas 7.

<sup>62</sup> I Iyioha, R Nwabueze (2015) (n 51 above at 154).

<sup>63</sup> United Nations Development Fund 'About Lesotho' 2012  
<http://www.ls.undp.org/content/lesotho/en/home/countryinfo.html>

<sup>64</sup> I Iyioha, R Nwabueze (2015) (n 51 above at 154).

<sup>65</sup> I Iyioha, R Nwabueze (2015) (n 51 above at 154).

<sup>66</sup> Shiappacasse V & Diaz S 'Access to emergency contraception' 2006 *International Journal of Gynecology and Obstetrics* 94.

<sup>67</sup> General Comment 2 article 14(2) (a) of the Maputo Protocol (n 52 above at para 29).

Isuigo- Abanihe & Oyediran<sup>68</sup> conducted a research in Nigeria and found that adolescent girls from less affluent household are more likely to have sex without using contraception than their peers from wealthy households. This reality is also true for adolescent girls in Lesotho as well. This suffices to show that poverty aggravated gender inequality and suppress girl's sexual autonomy. ESCR General Comment No. 22<sup>69</sup> also emphasise that sexual and reproductive health services must be affordable for all. It goes on to show that essential goods and services, including those related to the underlying determinants of sexual and reproductive health, must be provided at no cost or based on the principle of equality to ensure that individuals and families are not disproportionately burdened with health expenses. Similarly, General Recommendation No. 24<sup>70</sup> imposes an obligation on states to ensure that women, including adolescent girls have timely and affordable access to health services, including emergency contraceptives. Most adolescent girls in Lesotho are school going, so it is imperative for the costs of emergency contraception to be inexpensive in order for them to be able to access them.

People without sufficient means should be provided with the necessary support to cover the costs of health insurance and accessing health facilities providing sexual and reproductive health information, goods and services.<sup>71</sup>

#### **8.4 Information accessibility**

Accessibility includes the right to seek, receive and impart information and ideas concerning health issues.<sup>72</sup> The information about emergency contraception must be in a language that adolescent girls understand. The African Commission in General Comment No. 2 in paragraph 28 urges states to ensure that information on family planning or contraception is provided to communities in accessible languages and in a form that is accessible to all women and girls, including those with disabilities. The Committee on the Rights of the Child<sup>73</sup> denotes that states should provide a safe and supportive environment for adolescents by according them an opportunity to participate in decisions affecting their health, to acquire appropriate information, counselling and to negotiate the health behaviour choices they make, such as choosing to use emergency contraceptives. In Lesotho, one of the impeding factors to effective access to information about emergency contraception is the religious principles that most Basotho associate with. Most religious doctrines require a girl to preserve her virginity until she gets married. This in turn deters adolescent girls from seeking knowledge about emergency contraception because this would mean they want to engage in sexual activities, which is contrary to their religious principles. This in turn subjects them to labels such as promiscuity and

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<sup>68</sup> UC Isuigo- Abanihe & KA Oyediran, 'in Household Socio-economic Status and Sexual Behaviour among Nigerian Youth' in I Iyioha, R Nwabueze (2015) *Comparative Health Law and Policy: Critical Perspectives on Nigerian and Global Health Law*: Ashgate Publishing 154.

<sup>69</sup> ESCR General Comment No 22 (n 56 above at para 17).

<sup>70</sup> CEDAW General Recommendation No. 24(n 43 above).

<sup>71</sup> ESCR, General Comment No. 14 (n 41 above at para. 19).

<sup>72</sup> ESCR General Comment No. 14 (n 41 at para 12).

<sup>73</sup> CRC General Comment No. 4 (2003) (n 48 above at para 33).

unworthy of marriage due to their deviance from their religious norms and principles. Religious principles of this nature debar otherwise, noble initiatives meant to protect children against religious beliefs that may be detrimental to their health. Section 11(2) of the Children's Protection and Welfare Act provide that a child should not be denied or hindered from medical treatment by reason of religious or other beliefs. General Comment 2 of the African Commission also warns against administrative laws, policies and procedures of health systems and structures which restrict access to family planning or contraception on the basis of religious beliefs.

General recommendation 21 of CEDAW notes that in order to make an informed decision about safe and reliable contraceptive measures, women must have information about contraceptive measures and their use and guaranteed access to sex education and family planning services as provided for in article 10 (h) of the Convention on Elimination of All Forms of Discrimination Against Women.<sup>74</sup> At the national level, Section 11(6) of the Children's Protection and welfare Act 2011 emphasises that a child has a right to sexual and reproductive health information and education appropriate to his age. The CRC Committee<sup>75</sup> also stresses that family planning services should be situated within comprehensive sexual and reproductive health services and should encompass sexuality education, including counselling and that states should ensure that adolescents are not deprived of any sexual and reproductive health information or services due to providers' conscientious objections.<sup>76</sup> The 1994 International Conference on Population and Development<sup>77</sup> also puts an obligation on states to ensure that women and men have access to the information, education and services needed to achieve good sexual health and exercise their reproductive rights and responsibilities.

An obligation to pass sexuality education to adolescents is not only the responsibility of the state. Parents also have the role to play in educating their children about sexuality issues. In a patriarchal society like Lesotho, it becomes a challenge for adolescents to learn about their sexuality or even find out how they can access emergency contraception, as subjects of that nature are outside the purview of discussions between a parent and a child. In an attempt to illuminate on challenges regarding access to emergency contraceptives that are brought about by socio-cultural factors, Iyioha & Nwabueze,<sup>78</sup> write that parents and guardians are fairly in their responsibility to equip their children with the essential information they require for their healthy growth, and most parents do not realise that they are primary educators with regard to the sexuality of their children.

This outcry for communication was captured in a plaintive plea by a 14 year old girl from Botswana who contended that in Botswana, there is a serious challenge of

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<sup>74</sup> Committee of CEDAW General recommendation 21 on Equality in Marriage and family relations, 13th Session, General Assembly Report Supplement No. 38 (A)/49/38) at para 10.

<sup>75</sup> CRC General comment No. 4 (2003) (n 48 above at para 69).

<sup>76</sup> General Recommendation No. 24 (n 43 above at para 13).

<sup>77</sup> The 1994 ICPD (n 25 above at para 7.36).

<sup>78</sup> I Iyioha, R Nwabueze (n 51 at 153).

communication between parents and their children.<sup>79</sup>The girl goes on to show that without their parent's communication, guidance and dialogue, young people are a lost generation.<sup>80</sup> In as much as the plea was made by an adolescent from Botswana, unfortunately, the same plight is reality for most adolescent girls in Lesotho. This contravenes Section 20(2) of the Children's Protection and Welfare Act 2011 which compels parents to provide good guidance and assistance to their children in order to ensure their survival and development. Article 5 of the Convention on the Rights of the Child and article 19(2) of the African Charter on the Rights and Welfare of the Child also impose an obligation on parents to provide appropriate direction and guidance to the child, in a manner consistent with the evolving capacities of the child also taking cognisance of the best interest of the child.

Further, General Comment 2 of the African Commission in paragraph 28 urges state to provide complete and accurate information that is provided in printed form or by other means, such as the Internet, radio and television, mobile phone applications, and other telephone assistance service. This information should be necessary for the respect, protection, promotion and enjoyment of health, including the choice of contraceptive methods. Similarly, Paragraph 18 of the ESCR Committee in General Comment No. 22 has noted that adolescents have the right to evidence-based information on all aspects of sexual and reproductive health, including maternal health, contraceptives and family planning.

When the state has fulfilled all the four aspects of accessibility as discussed above, then the right of access to emergency contraception in adolescent girls in Lesotho will have been fully realised. Failure for states like Lesotho to provide access as articulated above, results in unintended pregnancies, which may lead to unsafe abortion, maternal mortality and restrictions on adolescents to enjoy sex. A congruent example of the state's failure to provide access to emergency contraception is shown in *Mildred Mapingure v Minister of Home Affairs & others*<sup>81</sup>whereupon, on 4 April 2006, Mapingure was attacked and raped by robbers. She immediately lodged a report with the police and requested that she be taken to a doctor in order to access medication to prevent pregnancy and any sexual infections. However, the doctor stated that he could only provide the medicine to prevent pregnancy and any sexual infections in the presence a police officer. Mapingure repeatedly went to the police in the days that followed but was advised that the police officer mandated to deal with her case was not available. On 7 April, Mapingure was eventually accompanied to the hospital by another police officer but was informed that she could not receive the medication she had requested as the prescribed 72 hours within which the emergency contraception should be administered had elapsed. Consequently, on 5 May 2006, Mapingure's pregnancy was formally confirmed and she was subjected to carrying the baby to full term.

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<sup>79</sup> UNAIDS (1998) Force for Change: World AIDS Campaign 5.

<sup>80</sup> UNAIDS (1998) (n 79 above).

<sup>81</sup> *Mildred Mapingure v Minister of Home Affairs & others* HH 452/12 1-2.

## **9.0 Study Structure**

Chapter 1 of this study (the current chapter) is an introduction and gives an overview of the study.

Chapter 2 scrutinised domestic laws relevant to access to emergency contraception by examining their compliance with international treaties safeguarding contraceptive rights of adolescent girls. It further applied the 'woman question' to critically evaluate and analyse, from the point of view of the rights of women and laws adopted by the Government of Lesotho, with a view to changing the perspective of policy makers when legislating on laws applicable to access to emergency contraception for adolescent girls. The chapter further discussed certain barriers to access to contraceptive services and the human rights implications for adolescent girls, consequent to such hindrances.

Chapter 3 is a comparative analysis of policies between Lesotho and South Africa.

Chapter 4 is recommendations and conclusions.



## CHAPTER 2

# LESOTHO'S LEGAL FRAMEWORK RELEVANT TO ACCESS TO CONTRACEPTION FOR ADOLESCENTS AND ITS COMPLIANCE WITH INTERNATIONAL HUMAN RIGHTS LAW

### 2.1 Introduction

The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health maintains that women are entitled to reproductive health care services, goods and facilities that are available in adequate numbers, accessible physically and economically, accessible without discrimination and of good quality.<sup>82</sup> The current chapter will scrutinise domestic laws relevant to access to emergency contraception and then examine compliance by Lesotho, of international treaties safeguarding contraceptive rights of adolescent girls. It will also determine whether the laws have considered the female adolescent question when addressing adolescents' sexual and reproductive rights. The chapter will further discuss barriers to accessing contraceptive services and the human rights implications for adolescent girls thereof.

Adolescents' health and their access to contraception, is a recognised public health component, and is a major concern regionally and globally. This concern has been expressed in various regional and international conferences which Lesotho participated in and in conventions which Lesotho is a party to. In the same vein, the Government of Lesotho has developed legislative framework with a view to addressing provision of emergency contraceptives.

The Government of Lesotho was represented at the 1994 ICPD<sup>83</sup> Conference and at the 1995 Beijing World Conference on Women.<sup>84</sup> It is also a state party to the following Conventions: CEDAW,<sup>85</sup> CRC,<sup>86</sup> ACRWC,<sup>87</sup> International Covenant on Civil and Political Rights (ICCPR),<sup>88</sup> ICESCR,<sup>89</sup> CRPD,<sup>90</sup> ACHPR<sup>91</sup> and the Maputo Protocol.<sup>92</sup>

The above conventions and consensus statements recognise adolescents' right to contraceptive information, and that access and services are to be grounded on human rights such as the rights to life, privacy, information, equality, non-discrimination, the right

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<sup>82</sup>Hunt P *Report of the Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health Sexual and Reproductive Rights A/61/338* (2006) at para 17-18.

<sup>83</sup> ICPD (n 25 above).

<sup>84</sup> Beijing Declaration (n 26 above).

<sup>85</sup> CEDAW (n 31 above).

<sup>86</sup> CRC (n 32 above).

<sup>87</sup> ACRWRC (n 33 above).

<sup>88</sup> International Covenant on Civil and Political Rights, G.A. Res. 2200, U.N GAOR, Supp. NO. 16 at 52, U.N DOC. A/6316 (1966), 999 U.N.T.S. 171, 174 (entered into force on March 23, 1976).

<sup>89</sup> ICESCR (n 34 above).

<sup>90</sup> CRPD (n 35 above).

<sup>91</sup> ACHPR (n 36 above).

<sup>92</sup> Maputo Protocol (n 28 above).

to the highest attainable standard of health and the right to decide the number and spacing of one's children.<sup>93</sup> Article 5 of the Vienna Programme of Action<sup>94</sup> states that all rights are interdependent and indivisible, meaning that the improvement of one right facilitates advancement of the others, as much as the deprivation of one right adversely affects the others. This therefore means that the right to the highest attainable standard of health, for instance, which includes access to emergency contraception, cannot be fulfilled without promotion and protection of the rights to education and information, because people must know about health services to be able to use them.<sup>95</sup>

## 2.2 Legislation relevant to Adolescents in Lesotho

### 2.2.1 The Constitution

Women's sexual and reproductive health is related to multiple human rights, including freedom from torture, the right to life, health, privacy, education, and the prohibition of discrimination.<sup>96</sup> The Constitution of Lesotho does not have explicit provisions dealing with sexual and reproductive health needs of adolescents. Nonetheless, some of the provisions in Chapter II of the Bill of Rights could be used to invoke the right of access to emergency contraception in adolescents. The provisions include the right to life in section 5, right to personal liberty in section 6, right to dignity and freedom from inhuman treatment in section 8, right to privacy in section 11, freedom from discrimination in section 18 and right to equality before the law in section 19. In support of this, the Centre for Reproductive studies and UNFPA<sup>97</sup> report that, women's and adolescents' right to contraceptive information and services is grounded in internationally recognized human rights, including the rights to life, health, privacy, information, equality, non-discrimination and the right to decide the number and spacing of one's children.

The issue of health in the Constitution is covered in Chapter III of the Constitution as a principle of state policy. The principles of state policy are deemed unenforceable by any court, achieved progressively and are subject to the limits of the economic capacity and development of the Government.<sup>98</sup> Notwithstanding that, Courts in Lesotho can adopt a more progressive approach from other jurisdictions whose provision on the right to health in their constitutions are similar to that of Lesotho, and still hold Government responsible for infringing on the rights related to the right to health, as discussed above. A congruent example could be employed from the Indian case of *Pachim Banga Khet Majoor Samity*

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<sup>93</sup> Office of the High Commissioner for Human Rights *What are human rights? In: Office of the High Commissioner for Human Rights* United Nations( 2013)

<sup>94</sup> Vienna Programme of Action accessed on 02 June 2016 at <http://www.ohchr.org/EN/ProfessionalInterest/Pages/Vienna.aspx> .

<sup>95</sup>Cottingham J, Germain A & Hunt P (2012) Use of human rights to meet the unmet need for family planning: *Lancet* 2012(380) 175.

<sup>96</sup> Hunt (n 82 above).

<sup>97</sup> Center for Reproductive Rights and UNFPA. *Briefing paper: The right to contraceptive information and services for women and adolescent* New York (2010) 6.

<sup>98</sup> Constitution of Lesotho 1993, section 25.

*v State of West Bengal*,<sup>99</sup> whereupon the Indian Supreme Court has held that failure on the part of a government hospital to provide emergency treatment to a citizen amounted to a violation of the right to life guaranteed under article 21 of the Indian Constitution. The Court underscored that the Indian government could not rely on the excuse of a lack of resources to justify its failure to preserve the loss of lives. Apart from that, Courts can also recommend enactment of a legislation giving life to the right to health, which in turn will make health rights enforceable.

### **2.2.1.1 The right to equality and freedom from discrimination**

Equality connotes that people should be given rights in equal measure irrespective of their social circumstances. In the context of access to reproductive health services, the equality being referred to here is formal equality, which means the right of women to be equal to men, as far as the provision of contraceptives is concerned. This means that emergency contraceptives must be available in the same measure as male condoms are in public health centers. Section 19 of the 1993 Constitution guarantees the right to equality before the law and to equal protection of the law. The limitation of this section is that it does not make provision for equality to include the full and equal enjoyment of all rights and freedoms, which would mean that women and girls have the right to enjoy equal treatment with men when exercising their right to access health care services. The 1993 Constitution ought to have adopted article 3 of CEDAW which gives positive affirmation to the principle of equality by requiring states like Lesotho to take all appropriate measures, including legislation, to ensure the full development and advancement of women, for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality with men.<sup>100</sup>

The drafters of the Constitution failed to take into consideration the female question in developing this specific section of the law, by failing to ask how the Government can best promote access to health care service by women who have been suffering inequalities and unfair treatment as a result of culture and religion which remain discriminatory against women in general and women's sexual health needs in particular.

Further, the supreme law of the land is in defiance to the Maputo Protocol which encourages states in article 3 to establish legislative, administrative and institutional measures to ensure the full development and advancement of women, for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality with men. ICCPR<sup>101</sup> also guarantees the rights of every citizen to have the opportunity, without any of the distinctions and without unreasonable restrictions to have access, on general terms of equality, to public service in his country, including health services.

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<sup>99</sup>*Pachim Banga Khet Majoor Samity v State of West Bengal* (1996) 4 SCC 37.

<sup>100</sup> CEDAW (n 31 above at article 3).

<sup>101</sup> ICCPR (n 88 above at article 26).

The principles of equality of rights and respect for human dignity are often violated by discrimination against women, and as such, discrimination is an obstacle to the participation of women, on equal terms with men, in the political, social, economic and cultural life of their countries, and hampers the growth of the prosperity of society and the family and makes more difficult the full development of the potentialities of women in the service of their countries and of humanity.<sup>102</sup> As such, discrimination is defined as affording different treatment to different persons attributed wholly or mainly to their respective descriptions by race, sex, birth or other status.<sup>103</sup> Lesotho is a state party to the Convention on Elimination of All Forms of Discrimination Against Women (CEDAW).<sup>104</sup> Article 1 of CEDAW describes "discrimination against women" as any distinction, exclusion or restriction made on the basis of sex which has the effect of impairing the enjoyment of women, on a basis of equality of men and women, of their human rights and fundamental freedoms. Section 18(2) and (3) of the 1993 Constitution is similar to articles 2(2) and 26 of the International Covenant on Civil and Political Rights,<sup>105</sup> article 2 of CRC<sup>106</sup> and article 2 of ACHPR.<sup>107</sup> All these provisions prohibit discrimination on any ground such as race color sex and gender, or other status.

Article 12 of CEDAW also obligates states to take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning. In the same vein, article 25 of Convention on the Rights of Persons with Disabilities<sup>108</sup> (CRPD) also mandates states to provide women and girls with disabilities, on the same footing with others, the same range of health care services including family planning services and to prevent discriminatory denial of health care or health services on the basis of disability.

The 1993 Constitution does not seem to be gender-inclusive in its wording. Section 18(4) (c) explicitly permits discrimination against women and girls on issues relating to inheritance, marriage and customary law. It seems to perpetuate discrimination against women and does not seem to address challenges that young women face in Lesotho, more especially as a result of patriarchal norms, which continue to render women as subordinate to men and perpetuates inequality. This is direct discrimination and it has the effect of disadvantaging women and adolescent girls from accessing emergency contraception in comparable terms with men and adolescent boys who need male condoms in health centers. This specific provision of the law has totally disregarded asking the female adolescent question because as it stands, it is 'male' specific and also fails to take into consideration unique life circumstances surrounding adolescent girls and women in general. The legislator failed to question the rationale for differential treatment

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<sup>102</sup> CEDAW (n 31 above at preamble).

<sup>103</sup> Constitution (n 98 above at section18 (3)).

<sup>104</sup> CEDAW (n 31 above).

<sup>105</sup> ICCPR (n 88 above).

<sup>106</sup> CRC (n 32 above).

<sup>107</sup> ACHPR (n 36 above).

<sup>108</sup> CRPD (n 35 above).

of men and women in customary matters. In essence, the provision adversely affect access to emergency contraception of adolescent girls as it has the implication of denying women and adolescent girls the right to access family planning services when married under customary law or even in cases where they are not married, but their way of living is predominantly governed by custom. The Government therefore denied itself of the opportunity to challenge the gender-neutral nature of this provision by failing to ask the female adolescent question and perhaps review it.

Further, during the country's review under CEDAW in 2011, the CEDAW Committee also made remarks on section 18(4) (c) and its prejudicial impact on women and girls in Lesotho. It stated that, while noting that section 18 of the Constitution of the Lesotho prohibits discrimination of any kind and unfair treatment, the Committee was concerned at the absence of a specific prohibition of discrimination against women as defined in article 1 of the Convention.<sup>109</sup> The Committee expressed its concern that the Lesotho's Constitution contains exceptions to the principle of non-discrimination, in matters where customary law is applicable, in contravention of articles 2 and 16 of CEDAW.<sup>110</sup> This provision of the Constitution is also not in line with most human right instruments such as article 18 (3) of ACHPR which puts an obligation on Lesotho to ensure elimination of every discrimination against women and also to ensure the protection of the rights of a woman and the child as stipulated in international declarations and conventions. Another pertinent instrument for adolescent girls, safeguarding their freedom from discrimination is CRPD.<sup>111</sup> Article 6(1) of the CRPD obligates states like Lesotho to ensure that adolescent girls with disabilities are not discriminated against, either on the basis of their sex, disability or other status.

It is the responsibility of the state to develop a legal framework protecting women against any form of discrimination. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol)<sup>112</sup> encourages states to combat all forms of discrimination against women by appropriate legislative, institutional and other measures. As such, section 18(4) (c) of the Constitution does not reflect a suitable provision for fighting discrimination against women and girls.

In essence, the 1993 Constitution can be criticised as being <sup>113</sup>gender-neutral and failing to adequately reflect the specific human rights challenges women and girls experience. Since the Government ratified the Optional Protocol on CEDAW in 2004, pursuant to article 8, the non-governmental organisations (NGOs) or citizens can challenge the arbitrary provisions of the Constitution before the CEDAW Committee as perpetuating subjugation and discrimination of women's rights. Likewise, in 2008, the CEDAW

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<sup>109</sup> CEDAW Committee 2011 concluding observations to Lesotho para 12 CEDAW/C/LSO/CO/1-4.

<sup>110</sup>Concluding observations to Lesotho (n 108 above) see also Constitution (n 97 above at section 18(4) (c)).

<sup>111</sup> CRPD (n 35 above).

<sup>112</sup> Maputo protocol (n 28 above at article 2(1))

<sup>113</sup>Unpublished: E Durojaye 'Realising access to contraception for adolescents in Nigeria: A human rights analysis' unpublished LLD thesis, University of the Free State, 2010 chap 5 155.

Committee<sup>114</sup> received a joint submission from three non-governmental organisations requesting an inquiry into the Philippines under article 8 of the Optional Protocol. The request alleged that the implementation of Executive Order No. 003 (2000) and Executive Order No. 030 (2011) which regulated access to contraceptives in Manila, violated the provisions of CEDAW. The Committee confirmed that indeed the Executive Orders are in violation of articles 2(d), 2(f), 10(h) and 12 of CEDAW. According to the Committee, the orders severely affected women's lives and health over a number of years and resulted in unplanned pregnancies and unsafe abortions.

### 2.2.1.2 The right to human dignity

The right to dignity denotes that the value and worth of all individuals in the society must be acknowledged.<sup>115</sup> Section 8 of the Constitution provides that no person should be subjected to torture or to inhuman or degrading treatment. Article 37 of CRC,<sup>116</sup> article 7 of the International Covenant on Civil and Political Rights (ICCPR)<sup>117</sup> and article 5 of the Universal Declaration of Human Rights (UDHR)<sup>118</sup> protect children from torture or other cruel, inhuman or degrading treatment. Failure to provide adolescent girls with family planning services is a form of torture. This is supported by the Report of the Special Rapporteur on Torture, Cruel, Inhuman and Degrading Treatment,<sup>119</sup> which reveals that International and regional human rights bodies have begun to recognize that abuse and mistreatment of women seeking reproductive health services can cause tremendous and lasting physical and emotional suffering, inflicted on the basis of gender. Examples of such violations include abusive treatment and humiliation in institutional settings.<sup>120</sup> Notwithstanding the provision on torture in the Constitution, adolescent girls still face degrading treatment from health care practitioners, which eventually makes them reluctant to access health centers in order to attain emergency contraceptives. Durojaye<sup>121</sup> asserts that, lack of skilled or trained health care providers to provide sexual and reproductive health services to women is one of the greatest challenges for most African states. This sometimes leads to a situation where women and girls seeking sexual and reproductive health services experience abuse and mistreatment at the hand of health care personnel. Slattery<sup>122</sup> also points out that reproductive violations in health

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<sup>114</sup> Committee on the Elimination of Discrimination against Women (CEDAW) Inquiry concerning the Philippines (CEDAW/C/OP.8/PHL/1).

<sup>115</sup> Ackermann J in *the National Coalition for Gay and Lesbian Equality and Others v Minister of Justice and Others 1999(1) SA* at para 29.

<sup>116</sup> CRC (n 32 above).

<sup>117</sup> ICCPR (n 88 above).

<sup>118</sup> Universal Declaration of Human Rights, G.A. Res. 217 A (III), U.N. Doc. A/810 (10 December 1948).

<sup>119</sup> Méndez JE Report of the Special Rapporteur on Torture, Cruel, Inhuman and Degrading Treatment (2013) A/HRC/22/53 at para 46, see also CAT/C/CR/32/5 at para 7.

<sup>120</sup> Méndez (n 119 above at para 46), See also Center for Reproductive Rights, *Reproductive Rights Violations as Torture and Cruel, Inhuman, or Degrading Treatment or Punishment: A Critical Human Rights Analysis* (2011).

<sup>121</sup> E Durojaye 2016 *Litigating the Right to Health in Africa: Challenges and Prospects* Routledge 61.

<sup>122</sup> E Slattery 2011 *Out of Silo: Using Reproductive Rights Jurisprudence to Litigate Abuses in Health Care Settings* 16 INTERRIGHTS Bulletin 185.

care settings include verbal and physical abuse and denial of services. This reality is also true for health services in Lesotho. The refusal to let adolescents and young people access to sexual and reproductive services and family planning commodities in Lesotho is linked to individuals' attitudes and religious inclinations.<sup>123</sup> In terms of culture and Christianity, girls are expected to preserve their virginity until they are married. There are practices emanating from ancient times that were aimed at screening virginity among girls who were not married at the time and also who had just got married so that they would be shamed should they be found to have lost their virginity; in other words they are negatively labeled as less of virtuous daughters as they are deemed to have deviated from the norm.<sup>124</sup> These factors fail to consider the woman question raised by these discriminatory cultural and religious practices in the country. These practices infringe on adolescent girl's enjoyment of their fundamental rights, which includes access to emergency contraception, as they perpetuate subjugation of women, as boys of the same age as adolescent girls do not suffer condemnation and labelling if they engage in sexual intercourse before marriage.

Consequent to this, adolescent girls in Lesotho are more likely not to use emergency contraception, in order to avoid the negative labeling and that becomes a barrier for their use of emergency contraception. Further, this treatment impacts negatively on the health of adolescent girls as their reluctance to approach health care services perpetuates sexual ill-health or unintended pregnancies. Further, this is a serious violation of their dignity and self-worth. In support of this, Durojaye<sup>125</sup> reaffirms that cultural practices are not only products of patriarchy but also discriminatory to women and are potentially harmful to their sexual and reproductive rights. This also violates adolescent girl's reproductive and sexual rights as safeguarded by declarations and convention which Lesotho is party to. Sexual and reproductive rights are defined by International Conference on Population and Development (ICPD) Programme<sup>126</sup> as the recognition of the basic right of all couples and individuals to have the information and means to decide freely about their bodies. The Human Rights Law Network<sup>127</sup> also shows that reproductive health implies that people are able to have a satisfying and safe sex life, and that they have the capacity to reproduce and the freedom to decide if, when and how to do so. As mentioned by the Special Rapporteur on Torture,<sup>128</sup> denying adolescent girls their right to have a healthy sexual relations by denying them emergency contraceptives is a form of torture and it adversely affects their dignity. Similarly, the CEDAW Committee<sup>129</sup> and the

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<sup>123</sup> Ministry of Health 'National Health Strategy for Adolescents and Young People' 2015-2020 19.

<sup>124</sup> The practice of screening virginity in girls is still practiced in conservative societies, even though it is not as rampant as it was in the 18<sup>th</sup> and 19<sup>th</sup> century.

<sup>125</sup> Unpublished: E Durojaye (n 113 above at 121).

<sup>126</sup> ICPD (n 25 above).

<sup>127</sup> Human Rights Law Network 2009 *Claiming Dignity: Reproductive Rights & the Law* Socio Legal Information Center 6.

<sup>128</sup> Méndez (n 119 above at para 45).

<sup>129</sup> CEDAW Committee 2005 Concluding observations to Ireland para38-39 CEDAW/C/IRL/CO/4-5

Committee on the Rights of the Child<sup>130</sup> highlighted that restrictive abortion laws in Ireland has dire consequences on women and girls.

#### **2.2.1.4 The right to privacy**

Section 11(1) of the 1993 Constitution guarantees the right to respect for private and family life. Section 11 is similar to article 17(1) of the ICCPR. This right is intended to protect the inner spectrum of a person. The right to privacy includes ‘freedom from unwarranted and unreasonable intrusions into activities that society recognizes as belonging to the realm of individual.’<sup>131</sup> The right to privacy, protected by other key international and regional treaties, protects the right of individuals and couples to make fundamental decisions about their private lives without government interference,<sup>132</sup> and decisions about whether and when to found a family falls within the protected zone of privacy.<sup>133</sup> Such treaties include article 16(1) of CRC<sup>134</sup> and article 22(1) of CRPD<sup>135</sup> which proscribe arbitrary or unlawful interference with adolescent girls’ privacy. In the context of adolescent girls in Lesotho, dictating virginity rules on girls interferes with their private space and infringes on their right to enjoy sex. Before executing customary practices such as virginity testing, it would have been appropriate to ask the female adolescent question to ascertain whether it is in the interest of adolescent girls to be subjected to virginity testing as opposed to adolescent boys and why Government continues to cling to customary practices that are discriminatory to women.

The Government of Lesotho is the key provider of health services, including reproductive health and family planning in the country. Its efforts are supplemented by the private sector such as the Christian Health Association of Lesotho (CHAL) and NGOs who also provide hospital and clinic-based Health services in Lesotho.<sup>136</sup> Several Faith- Based Organisations (FBOs) who are members of CHAL hold proprietorship over a number of health centers (clinics) and hospitals which offer service mainly to rural and hard to reach communities around the country. The Roman Catholic Church owns more of such facilities than other FBOs<sup>137</sup> and their doctrine is against the use of contraceptives. Where the religious beliefs, of the respective denominations come in conflict with those promoted in the public health sector, the former have tended to dominate, consequently leading to such facilities not providing family planning services to women and girls.<sup>138</sup> The responsibility of providing health services rests on the Government as the duty bearer,

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<sup>130</sup> Committee on the Rights of the Child 2016 Concluding Observations to Ireland para57-58 CRC/C/IRL/CO/3-4 2

<sup>131</sup> Durojaye (n 121 above at 61).

<sup>132</sup> ICCPR (n 88 above)

<sup>133</sup> CEDAW Committee, General Recommendation 21: Equality in marriage and family relations, (13th Sess., 1994), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies* (Vol. II), at 337, para. 22, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (1994).

<sup>134</sup> CRC (n 32 above).

<sup>135</sup> CRPD (n 35 above).

<sup>136</sup> Lesotho Planned Parenthood Association Strategic Plan 2010-2014 14.

<sup>137</sup> Health Strategy for Adolescents (n 123 above at 18).

<sup>138</sup> Kimane (n 57 above at 10).



not necessarily the FBOs. In order to safeguard the right to privacy of adolescent girls, the Government has the duty to build more health centers to accommodate girls who need emergency contraceptive services. This duty is corroborated in article 14(2)(b) of CEDAW,<sup>139</sup> which places the responsibility on Government to take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, they have access to adequate health care facilities, including information, counselling and services in family planning.

However, in defiance to its international obligations, the Government has not established enough health care centers in the rural areas, and the status quo is that, the health facilities for FBOs still dominate in the rural areas, and adolescent girls are not able to get contraceptive services they need. This is evidenced by the study carried out by Akintade and others,<sup>140</sup> which reveal that the prevalence of girls who fall pregnant in the rural areas in Lesotho is high, when compared to that of girls living in the lowlands. The Center for Reproductive Rights and United Nations Population Fund (UNFPA)<sup>141</sup> states that women's enjoyment of the right to privacy is incumbent on access to contraceptive information and services without undue interference in their ability to select a contraceptive method that works for them. Choosing when young people can engage in sexual intercourse is a form of restriction and interference, which must be avoided by Government and the leaders of the society, such as religious and traditional leaders. The Center for Reproductive Rights and United Nations Population Fund (UNFPA)<sup>142</sup> also notes that restrictions on access to certain contraceptive methods, such as the emergency contraception, impair the ability of women and girls to make informed, autonomous decisions about their personal lives and health and violate the rights to privacy.

#### **2.2.1.5 Right to health**

The Committee on Economic, Social and Cultural Rights (ESCR Committee) and the Committee on the Elimination of Discrimination against Women (CEDAW) have both clearly indicated that women's right to health includes their sexual and reproductive health.<sup>143</sup> This means that States have obligations to respect, protect and fulfill rights related to women's sexual and reproductive health. The Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment notes that mistreatment in health-care settings is the denial of health-care and it has been understood as essentially interfering with the "right to health."<sup>144</sup> The 1993 Constitution of Lesotho

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<sup>139</sup> CEDAW (n 31 above).

<sup>140</sup> Akintade O, Pengpid S, Peltzer K 'Awareness and Use of and Barriers to Family Planning Services Among Female University Students in Lesotho' *Southern African Journal of Gynecologist* 2011(17).

<sup>141</sup> Center for Reproductive Rights and UNFPA. 'Briefing paper: The right to contraceptive information and services for women and adolescents' Center for Reproductive Rights and United Nations Population Fund, New York; 2010.

<sup>142</sup> Center for Reproductive Rights (n 141 above at 3).

<sup>143</sup> CEDAW Committee, General Recommendation 24 (n 43 above at para. 1); ESCR Committee, General Comment No. 14 (Art. 12, Right to the highest attainable standard of health), para. 8 (n 41 above).

<sup>144</sup> Méndez (n 119 above at para 46).

recognises the right to health as a directive principle of state policy under Chapter III of the Constitution and not as a justiciable right as discussed above. Section 27(1) (e) of the Constitution provides that the Government shall adopt policies aimed at ensuring the highest attainable standard of physical and mental health for its citizens, including policies designed to improve public health. The section does not really place the kind of responsibility required by article 12 of CEDAW which puts an obligation on Lesotho to take all appropriate measures, including legislative measures to ensure elimination of discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

Further, the provision can be criticised as being too general. The expectation would be that in this particular section, the Constitution could highlight the need for family planning services to be provided to women and girls, on the same footing with men and boys. Article 24(1) of CRC mandates states to recognise the right of the child to the enjoyment of the highest attainable standard of health. CRC also mandates states parties like Lesotho to develop preventive health care, guidance for parents and family planning education and services.<sup>145</sup> Perhaps before adopting this provision, the Parliament should have ascertained whether the provision is in line with international human rights principles and the obligations it has acceded to under human rights conventions. That methodology would have enabled the Government to ask the female adolescent question, especially in respect to the part dealing with sexual and reproductive health care. This in turn would place the responsibility on Government to ensure that the right to health of women is justiciable and enforceable in the courts of law. It would seem that little regard to human rights consequences of failure to guarantee the right to health of women was not taken into consideration before placing health under the Principles of State Policy.

Legal and practical barriers to contraceptive information and methods lead to higher rates of unwanted pregnancies, with the attendant risks of unsafe abortion or maternal mortality and morbidity, thus violating women's and adolescents' rights to life and health.<sup>146</sup> Adolescent girls in Lesotho are beset with numerous obstacles such as maternal mortality and severe morbidity which could otherwise be avoided, by Government ensuring their right of access to emergency contraceptives.<sup>147</sup> Statistics suggest that in 2009 teenage pregnancy increased from 25 to 41 percent.<sup>148</sup> It has also been documented that, teenage pregnancy has been a major health concern, as it is associated with higher maternal and child mortality and morbidity and carries high risks such as pregnancy-induced hypertension, obstructed labour, prolonged labour and unsafe abortion.<sup>149</sup> All these defy the international obligations of the Government as they appear in article 12(1) International Covenant on Economic, Social and Cultural Rights (ICESCR) and article

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<sup>145</sup> CRC (n 32 above at Article 2(f)).

<sup>146</sup>Center for Reproductive Rights (n 141 above at 13).

<sup>147</sup> MDG Acceleration Frame Work (n 20 above at 18).

<sup>148</sup> Ministry of Health 'Lesotho National HIV and AIDS Strategic Plan' 2011/12-2015/16.

<sup>149</sup>Demographic Health Survey (n 21 above at 11).

16(1) of ACHPR, which mandates states like Lesotho to recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Further, the CEDAW Committee's General Recommendation 24<sup>150</sup> recommends that states prioritise the prevention of unwanted pregnancy through family planning and sex education.

Therefore, access to and use of contraception, especially emergency contraception, reduces maternal and infant morbidity and mortality, and also contributes to individuals being able to take control over their sexuality, health and reproduction.<sup>151</sup> The issue of control is imperative. It reinforces adolescent girls' right to self-determination and independence to make informed decisions about their bodies, especially when their right to access emergency contraceptives, which are affordable and are of good quality has been fulfilled by Government. The right to have control is safeguarded by a number of consensus statements and human rights treaties binding Lesotho. A congruent example is the 1995 Beijing Platform for Action,<sup>152</sup> which states that the human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. There is also the 1994 International Conference on Population and Development (ICPD)<sup>153</sup> which advises that family planning options should be able to assist couples and individuals in order to fulfill their reproductive goals and to give them an opportunity to exercise their right to have children by choice. Further, the Committee on CRC, in its General Comment No. 15, provides that, in accordance with evolving capacities of children, they should have access to confidential counselling and advice without parental or legal guardian consent, such as HIV testing and sexual and reproductive health services, including education and guidance on sexual health, contraception and safe abortion.<sup>154</sup>

### **2.2.1.6 The right to life**

The rights to life and health are central to the enjoyment of all other human rights, and access to contraceptive information and services bears directly on the enjoyment of these rights.<sup>155</sup> Section 5 (1) of the 1993 Constitution provides that every human being has the inherent right to life, and that no one shall be arbitrarily deprived of their life. Article 6(1) of ICCPR,<sup>156</sup> Article 4 of ACHPR<sup>157</sup> and Article 6(1) CRC,<sup>158</sup> and article 10 of CRDP<sup>159</sup> guarantee the right to life. The Human Rights Committee has indicated that the right to

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<sup>150</sup>CEDAW Committee's General Recommendation 24 (n 43 above).

<sup>151</sup>World Health Organization *Developing sexual health programmes: a framework for action* Geneva(2010)

<sup>152</sup> Beijing Platform of Action (n 2 above).

<sup>153</sup> ICPD (n 26 above at para 7.2 (b)).

<sup>154</sup>General comment No. 15 (2013) (n 45 above at para 31).

<sup>155</sup>Center for Reproductive Rights (n 141 above at 13).

<sup>156</sup> ICCPR (n 88 above)

<sup>157</sup> ACHPR (n 36 above).

<sup>158</sup> CRC (n 32 above).

<sup>159</sup> CRPD (n 34 above).

life should not be narrowly interpreted<sup>160</sup> and that the fulfillment of this right requires governments to take steps to reduce maternal mortality and increase life expectancy.<sup>161</sup>

Even though the Constitution guarantees the inherent right to life, failure on the part of the Government to avail emergency contraceptives to adolescent girls can lead to their death. The same concern was raised by Durojaye,<sup>162</sup> when he asserted that, notwithstanding the guarantee of the right to life under the Nigerian Constitution, a narrow construction of the provision does not seem to accommodate the reality of women, especially young women who continue to die of pregnancy-related complications or unsafe abortion. As earlier mentioned, human rights are interrelated and interdependent, so failure on the part of Government to provide the right to health of adolescent girls can eventually cause their right to life to be negatively affected. There are a number of health deficits in the access to emergency contraceptives in most Government health services, which eventually cause adolescent girls to unwillingly become pregnant and eventually die of child birth.

It has been documented that, 1 out of 32 women in Lesotho die of pregnancy and childbirth-related conditions and as such, Lesotho's maternal mortality ratio is among the highest in the SADC region, with an estimate of 1,155 deaths per 100,000 live births in 2009.<sup>163</sup> This is a drastic increase from 419 deaths per 100,000 live births in 2000, to 762 per 100,000 in 2004.<sup>164</sup> Taking into consideration the health situation of adolescent girls in Lesotho, the interpretation of the provision of the right to life in the Constitution was supposed to prompt the asking of the female adolescent question. The Government would have to account as to why adolescent girls do not have access to emergency contraceptives in government health care centers on the same footing with their male counterparts who seek male condoms. It should be noted that the right to life is a fundamental right of which no derogation is permitted.<sup>165</sup> As a result, the justification of the violation of adolescent girl's right to life by claiming lack of resources by Government cannot hold water.

The Ministry of Health and Social Welfare<sup>166</sup> reported that, due to the low use and inaccessibility of contraceptives among the adolescents, there are high pregnancy rates which lead to adolescents committing unsafe abortions. These adolescents use extremely dangerous methods to terminate unwanted pregnancies. The Ministry of Health and Social Welfare<sup>167</sup> noted that some drink methylated spirit, medicinal herbs and others corrosive preparations, whilst others use sharp instruments which may result in perforation of the uterus, severe bleeding, infections and psychological trauma that may

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<sup>160</sup>Center for Reproductive Rights (n 141 above at 13).

<sup>161</sup>Center for Reproductive Rights (n 141 above at 13).

<sup>162</sup>Unpublished: E Durojaye (n 113 above at 155).

<sup>163</sup>MDG Acceleration Frame Work (n 20 above at 13).

<sup>164</sup>MDG Acceleration Frame Work (n 20 above at 13).

<sup>165</sup>Unpublished: E Durojaye (n 113 above at 160).

<sup>166</sup> National Reproductive Health Survey Analytical Report (n 24 above at 71).

<sup>167</sup>National Reproductive Health Survey (n 24 above).

lead to sterility and severe bleeding which result in death. This suffices to show that the right to life of adolescent girls is mostly disregarded by the Government itself by failing to provide emergency contraceptives among other health services.

### **2.2.1.7 Right to education**

Section 28(a) of the 1993 Constitution provides that the Government shall endeavor to make education available to all and shall adopt policies with a view to ensuring that education is directed to the full development of human personality and sense of dignity and strengthening the respect for human rights and fundamental freedoms. This section recognises that women and adolescents' right to contraceptive information and education is grounded in basic human rights, and thus should be fulfilled by Government by adopting policies in that regard. However, just like the right to health, the 1993 Constitution recognizes education as a principle of state policy and not as a justiciable right. Both the Committee on Economic, Social and Cultural Rights (ESCR Committee) and the CEDAW Committee recognize that contraceptive information and services are necessary to fulfill the right to health.<sup>168</sup> The Programme of Action of the International Conference on Population and Development recognized "the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice."<sup>169</sup> Additionally, the Committee on the Rights of the Child has indicated that "States parties should provide adolescents with access to sexual and reproductive information, including on family planning and contraceptives, the dangers of early pregnancy, the prevention of HIV and the prevention and treatment of sexually transmitted diseases (STDs).

The requirement to provide information and education about contraceptive methods, is enshrined in various human rights treaties ratified by Lesotho. Article 23 (b) of CRPD provides that, adolescent girls with disabilities, just like any other person, have the right to have access to age-appropriate information, reproductive and family planning education in order to also decide freely, on the same footing with others. However, women with disabilities are often subject to double discrimination based on their disabilities and their gender.<sup>170</sup> Reproductive health services, particularly contraceptive information and services, are largely unavailable to individuals with disabilities due to barriers to physical access, lack of disability-related technical and human support, stigma, and discrimination.<sup>171</sup> Despite the fact that individuals with disabilities are equally as likely to be sexually active as persons without disabilities, misconceptions that they are asexual are widespread.<sup>172</sup> These discriminatory views contribute to barriers to accessing contraceptive information and services because of the inaccurate perception that

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<sup>168</sup>ESCR Committee, General Comment 14, para. 34; CEDAW Committee, General Recommendation 24, para. 17.

<sup>169</sup> ICPD (n 25 above at para 7.2).

<sup>170</sup> Center for Reproductive Rights (n 141 above at 11).

<sup>171</sup>World Health Organisation and UNFPA *Promoting Sexual and Reproductive Health for Persons with Disabilities* Geneva (2009).

<sup>172</sup> World Health Organisation and UNFPA (n 171 above).

individuals with disabilities do not require such information and services. Further, article 10(h) of CEDAW mandates states to provide access to specific educational information to help ensure the health and well-being of families, including information and advice on family planning. Article 9(1) of ACHPR provides that every individual shall have the right to receive information. Article 14(1) (f) of the Maputo Protocol safeguards the right to have family planning education. Article 17 of CRC mandate states to ensure that the child has access aimed at the promotion of his or her social, spiritual and moral well-being and physical and mental health. These provisions place an obligation on Government to offer education and information about family planning services to everybody including adolescents. However, the 2011 Education Act does not make mention of education and information about contraceptives to school going children.

Lack of evidence-based sexuality education and information hampers adolescents' ability to make informed decisions around contraceptive use, which in turn leads to high rates of teenage pregnancy and high abortion rates among adolescents and young women.<sup>173</sup> When adolescent girls have received information about emergency contraceptives, they are able to make informed decisions about their bodies. Counselling is one way to offer information. Health care practitioners could enhance the quality of adolescent girl's contraceptive decision-making if they took a more active role in contraceptive counselling, for example, by relating information on specific methods to adolescent girl's personal circumstances and helping them weigh the advantages of correctly using other methods of contraceptives, whilst leaving an option that should such fail, emergency contraceptive is available as a last resort to preventing unwanted pregnancies. After engaging with health care practitioners, adolescents may voluntarily decide whether to delay sexual intercourse without the fear of falling pregnant. Adolescent girls also have the right to receive accurate information and make their own decisions about reproductive health care. This is their right of informed choice, which will motivate them to give informed consent.

The center for reproductive rights and UNFPA<sup>174</sup> define Informed consent as a process of communication between a healthcare provider and patient that requires the patient's consent to be given freely and voluntarily, without threats or inducements, after the patient has been counseled on available contraceptive methods and the benefits, risks, and potential side effects of different methods, in a manner that is understandable to the patient. This therefore means that the information about the timeframes upon which emergency contraception is supposed to be administered should be clearly communicated to adolescent girls. CEDAW<sup>175</sup> corroborates this by outlining that, women must be given the same rights as men, to have access to the information, education and means to enable them to exercise their reproductive rights.

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<sup>173</sup> CRC Committee, General Comment No. 4(n 48 above at para 28).

<sup>174</sup> Center for Reproductive Rights (n141 above at 17).

<sup>175</sup> CEDAW (n 31 above at article 16(1) (e)).

The challenge that has been faced by adolescent girls in Lesotho is lack of education and information about contraceptive services. This is proven by the statistics of women and girls who die at child birth, and the high rates of teenage pregnancy as discussed above. Several factors account for Lesotho's poor realisation of this right. One of the reasons is what was earlier mentioned by Durojaye<sup>176</sup> as lack of skilled or trained health care providers to offer sexual and reproductive health services to adolescent girls. Besides the health care providers not giving accurate information because they themselves are not knowledgeable about various contraceptive methods and how they should be administered. Even for those who have the knowledge, some are not willing to give it out to adolescent girls due to religious and cultural stereotypes.

### **2.2.3 2011 Children's Protection and Welfare Act**

In 2011, Lesotho enacted the Children's Protection and Welfare Act (CPWA) as the main piece of legislation protecting the interests of children in Lesotho. The Act domesticates CRC and African Children's Charter.

CPWA<sup>177</sup> protects adolescent girls from discrimination, either on the grounds of gender, disability, socio-economic status or other status. It also upholds the child's right to access education, including sexual and reproductive health information and education appropriate to their age.<sup>178</sup> The Act safeguards the right to health of children. It proscribes the denial or hindrance of medical treatment to children by reason of religious or other beliefs.<sup>179</sup> The rights of adolescent girls with disabilities are also taken into consideration in sections 11(3) and 13 which guarantee the right to education and medical treatment of children with disabilities respectively. Degrading cultural practices such as subjecting adolescent girls to virginity testing as mentioned above are prohibited by section 16(1) of CPWA which provides that, a child has a right to be protected from torture or other cruel, inhuman or degrading treatment, including any cultural practice which degrades or is injurious to the physical, psychological, emotional and mental well-being of the child. This is corroborated by section 17, which vehemently discourages subjecting a child to harmful cultural rites, custom and traditional practices that are likely to negatively affect the child's life and health, among other things. Virginity testing and culturally stereotyped attitudes of health care givers discourage adolescent girls who are sexually active, from approaching health centers to seek advice about contraceptives, especially emergency contraception. This negatively affect a series of rights belonging to adolescent girls, which are interrelated to the right to health. Parents also have a duty to ensure that their children are not subjected to cultural rites, or traditional practices.<sup>180</sup> Unfortunately conservative parents play a major role in defying this provision of the Act, as they are they are the ones who perpetuate virginity testing.

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<sup>176</sup> Durojaye (n 121 above at 61).

<sup>177</sup> Lesotho Children's Protection and Welfare Act section 6.

<sup>178</sup> CPWA (n 177 above at section 11(1) & (6)).

<sup>179</sup> CPWA (n 177 above at section 11(2)).

<sup>180</sup> CPWA (n 177 above at section 20(2) (e)).

The ICPD together with CRC<sup>181</sup> obliges parents and other persons legally responsible for adolescents to provide information and guidance in sexual and reproductive matters, in a manner consistent with the evolving capacities of the adolescent. They further underscore that countries must ensure that the programmes and attitudes of health-care providers do not restrict the access of adolescents to appropriate services and the information they need. In support of this, Haynes<sup>182</sup> writes that the changing circumstances regarding access to emergency contraception warrant nurses' review of its current status. In essence, this means that health service providers must discard stereotypes against adolescents when it comes to their use of contraception.

It is also the responsibility of the state to protect and promote all rights belonging to children. The Act requires Government to formulate policies which will ensure that children are protected from any form of discrimination and ensure that primary and preventive health care and public health education are offered, there is reduction of infant mortality and that no child is deprived of access to effective health services.<sup>183</sup> In the light of what has been discussed above, in relation to high pregnancy rates, maternal mortality and morbidity rates, the Government does not seem to have complied with its international obligations, least of all, its domestic law. The age of medical consent according to the Act is twelve years of age.<sup>184</sup> However, the Government has adopted the definition of adolescents as defined by the World Health Organisation (WHO) which stipulates that adolescents are persons who are in the 10-19 years age group.<sup>185</sup> The limitation of this provision is that, adolescent girls between 10 and 11 years are not eligible to approach the health centers on their own to seek emergency contraceptive services. This is a serious setback on their right to health. Therefore, section 232 of the CPWA has also not considered the female adolescent question before imposing the age of medical eligibility to twelve years. It has not considered the peculiar circumstances faced by adolescent girls, which include the fact that in recent times, adolescents have become sexually active at a young age. This is echoed in the National Health Strategy,<sup>186</sup> which shows that one of the challenges facing young people is that their sexual debut is very

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<sup>181</sup> ICPD (n 25 above at para. 7.45) see also CRC article 5.

<sup>182</sup> Haynes K 'An Update on Emergency Contraceptive Use' *Journal of Pediatric Nursing* 2007 22(3) 187.

<sup>183</sup> CPWA (n 177 above at section 22).

<sup>184</sup> CPWA (n 177 above at section 232).

<sup>185</sup> Lesotho National Family Planning Guidelines (n 12 above at 12).

<sup>186</sup> Ministry of Health 'Lesotho National Health Strategy for Adolescents and Young People 2015-2020' 18.



low and as such, they need to be protected from reproductive challenges that may arise as a result of failure to access contraceptives.

#### **2.2.4 1970 Public Health Order**

Lesotho does not have a domestic law guaranteeing sexual and reproductive health rights and care of women and girls, except for the 1970 Public Health Order which aims at promoting the personal health and environmental health of citizens and controlling communicable diseases, among others. The Ministry of Health is in the process of drafting a Health Bill, and hopefully sexual and reproductive health issues of adolescents will be included as the Order is outdated and does not address adolescent's health rights.

#### **Conclusion**

The legal implication of the laws on sexual and reproductive rights of women and girls is that the Government has obligations under international and domestic law to ensure that adolescent girls effectively access emergency contraceptives as one of their rights to health care services. The legal framework in Lesotho is to a certain extent conducive for effective access to emergency contraceptives in adolescent girls, however, this has not been translated into measurable targets aimed at providing contraception to every woman, including adolescent girls, as adolescent girls still do not adequately access emergency contraceptives. There is indeed a huge gap between the legal framework and the practical implementation of access to emergency contraception in adolescent girls in Lesotho. Further, the legislator has not taken into consideration the female adolescent question when developing most of the provisions of the laws, especially the Constitution in addressing health rights of adolescents. In a patriarchal society like Lesotho, stigma around adolescent sexuality may be a contributing factor deterring adolescents from seeking such services or may result in denials of reproductive health services. Lesotho is yet to realise that the full implication of effective access of emergency contraception includes good quality, availability, accessibility and acceptability of emergency contraceptives, which are to be administered on the basis of non-discrimination, physical accessibility, economic accessibility and information accessibility.

## CHAPTER 3

### COMPARATIVE ANALYSIS OF LESOTHO'S POLICIES AND THEIR REALISATION WITH SOUTH AFRICA

#### 3.1 Introduction

The World Health Organisation (WHO) has reported that many unwanted pregnancies occur during adolescence, when young women and their partners become sexually active before they are fully aware of the need for contraceptives.<sup>187</sup> The current chapter is a comparative analysis of policies between Lesotho and South Africa. This chapter will look into the jurisdiction of South Africa to ascertain how its approach into the international law and domestic obligations emanating from its policies has enhanced the sexual and reproductive health rights of adolescent girls, in particular their access to contraceptives. The reasons for choosing to compare Lesotho with South Africa is that South Africa's policies granting the right to reproductive health care to women and adolescent girls is clearly defined,<sup>188</sup> so Lesotho could employ good practices thereof.

#### 3.2 Comparing the policies of South Africa and Lesotho safeguarding adolescent girls' access to contraceptive information and services

Both countries have established policies aimed at protecting adolescent's right to access reproductive health care services and to receive information about such services. While South Africa has the Integrated School Health Policy and the National Contraception and Fertility Planning and Service Delivery Guideline 2012,<sup>189</sup> among others, Lesotho has developed the National Health Strategy for adolescents and Young People 2015-2020, the National Health Policy of 2010<sup>190</sup>, the 2006 National Adolescent policy,<sup>191</sup> the 2012 Family Planning guidelines,<sup>192</sup> National Minimal Standards for the Provision of Adolescents-friendly Health Services and Health Sector Strategic Plan 2013-2017,<sup>193</sup> the 2005 School Health Policy,<sup>194</sup> the 2009 Curriculum and Assessment Policy,<sup>195</sup> and the 2003 Lesotho National Health and Welfare Policy.<sup>196</sup>

They have both ratified regional and international human rights treaties safeguarding the right to health and reproductive rights of women and girls. Nonetheless, these two

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<sup>187</sup>World Health Organization *Emergency Contraception: A Guide for Service Delivery* WHO 1998 8.

<sup>188</sup>OA Savage-Oyekunle & A Nienaber 'Adolescent girls' access to contraceptive information and services: An analysis of legislation and policies, and their realisation, in Nigeria and South Africa' *African Human Rights Law Journal* (2015) 15437.

<sup>189</sup>Savage-Oyekunle & A Nienaber (n 188 above).

<sup>190</sup>National Health Strategy for Adolescents (n 186 above).

<sup>191</sup>Ministry of Health 'National Adolescent policy 2006'.

<sup>192</sup>Family Planning guidelines (n 12 above).

<sup>193</sup>Ministry of Health 'National Minimal Standards for the Provision of Adolescents-friendly Health Services and Health Sector Strategic Plan 2013-2017'.

<sup>194</sup>Ministry of Health 'School Health Policy 2005'.

<sup>195</sup>Ministry of Health 'Curriculum and Assessment Policy 2009'.

<sup>196</sup>Ministry of Health 'Lesotho National Health and Welfare policy of 2003'.

countries differ in their methods of interpretation, protection, enforcement and in the limitations placed upon the enjoyment of these rights.

### **3.3 Comparing access to services and information in Lesotho and South Africa**

Both countries have recently adopted Sexual and Reproductive Health Policies. In 2012, Lesotho adopted the Family Planning Guidelines,<sup>197</sup> whose aim is to ensure that clients receive proper family planning knowledge and skills from service providers such that clients are not denied provision of various methods of family planning services and that service providers do not transmit improper information to clients. According to the National Family Planning Guidelines 2012,<sup>198</sup> Lesotho recognises the central role played by family planning in attaining both national and international goals. Consequent to studies conducted by the Ministry of Health and Social Welfare in collaboration with UNFPA in 2007, the Ministry identified a weakness in family planning knowledge and skills from service providers resulting in transmission of improper information to the clients and clients being denied provision of other methods hence the Ministry acknowledged the need to redouble its efforts to ensure access to family planning services.<sup>199</sup> The Guidelines highlight that there shall be no discrimination in providing services to adolescents. The document stresses on the provision of services with care and thorough understanding of the clients and their needs.<sup>200</sup> It emphasises on the importance of confidentiality, use of appropriate language and misinformation about sex, sexually transmitted infections and contraceptives. The Guidelines explicitly stipulates that, irrespective of whether or not adolescents are married, they possess the right to information about all methods of contraceptives and general good health.<sup>201</sup>

In 2013, South Africa adopted the National Contraception and Fertility Planning Policy and Service Delivery Guidelines with a view to establishing a system that is constantly monitoring the implementation of its policies in order to correct shortcomings that were reflected in the National Contraception Policy Guidelines within a reproductive health framework 2001 and the National Contraception Service Delivery Guidelines 2003.<sup>202</sup> In the same vein, the Lesotho National Adolescent Health Policy<sup>203</sup> states that the Government, through the Ministry of Health, shall monitor and evaluate the concerted efforts from all partners and other line ministries with a view to realising the general wellbeing and health of adolescents. The Lesotho National Health Strategy for Adolescents and Young People 2015-2020,<sup>204</sup> corroborates this by highlighting that the

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<sup>197</sup> Family Planning Guidelines (n 12 above at 1).

<sup>198</sup> Family Planning Guidelines (n 12 above at 1).

<sup>199</sup> Family Planning Guidelines (n 12 above at 1).

<sup>200</sup> Family Planning Guidelines (n 12 above at 2).

<sup>201</sup> Family Planning Guidelines (n 12 above at 3).

<sup>202</sup> Department of Health 'National Contraception and Fertility Planning Policy and Service Delivery Guidelines' Para 1.3, 14 see also OA Savage-Oyekunle & A Nienaber 'Adolescent girls' access to contraceptive information and services: An analysis of legislation and policies, and their realisation, in Nigeria and South Africa' *African Human Rights Law Journal* (2015) 15 437.

<sup>203</sup> Adolescent Health Policy (n 191 above).

<sup>204</sup> Health Strategy for Adolescents (4 above at 13).

Ministry of Health of Lesotho shall be a coordinating body on sexual and reproductive health rights of adolescents and the Ministry intends to do this by collaborating with various stakeholders who have interest on adolescent issues, such as the Ministries of Justice, Social Development and Education, UNICEF and UNFPA. One of the concerns identified by the Strategy is that the current curriculum does not comprehensively address sexual and reproductive health issues of primary school going children. Notwithstanding this commitment by the Ministry, there seems to be no coordination taking place on adolescent health issues, as the same curriculum has been piloted to Grade seven students in the current school year, 2016 and there has not been any steps taken by Government to review the curriculum. Lesotho must exercise a considerable amount of political will when it comes to sexuality education in schools, as children suffer exclusion from parents, religious leaders and other members of the community when it comes to sexuality issues.

Moreover, the Lesotho National Health and welfare Policy 2003<sup>205</sup> provides that the Government will respect people's choice to reproduce and facilitate safe, effective, affordable and acceptable methods of family planning, and also protect the rights to family planning decisions, information, services, sexual security, freedom from sexual violence, and sexual privacy. According to the National Health Strategy for Adolescents and Young People Adolescents and young people 2015-2020,<sup>206</sup> adolescents have the right to access information, skills and services regarding their health, they have the right to participate in health and development programmes that affect their lives, and the right to grow up in a safe and supportive environment. The Strategy substantiates the Committee on the Rights of the Child, which urged Lesotho to increase the availability of sexuality education and contraceptive services to adolescents in its concluding observations when Lesotho was undergoing review under the Convention on the Rights of the Child.<sup>207</sup>

The Strategy further provides that access to contraceptives would benefit adolescent girls, who are at an increased risk for medical complications associated with pregnancy and who are often forced to make compromises in education and employment that may lead to poverty and lower educational attainment. It further connotes that public health workers in collaboration with schools and members of the community should be involved in activities targeting to increase access to information among adolescents and members of the community and as such adolescents will be equipped with information on family planning services among other things.<sup>208</sup>

The National Adolescent Policy 2006<sup>209</sup> acknowledges that adolescents are beset with numerous health challenges including teenage pregnancy, contraceptive prevalence, abortion rates, sexual abuse and violence, gender issues and disability. Through this policy, the Government pledges its political will to reverse aforementioned adolescents'

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<sup>205</sup>Health and welfare policy (n 196 above).

<sup>206</sup>Health Strategy for Adolescents (123 above at 12).

<sup>207</sup>Concluding observations: Lesotho, para. 46, U.N. Doc. CRC/C/15/Add.147 (2001).

<sup>208</sup>Health Strategy for Adolescents and Young People (123 above at 24).

<sup>209</sup>National Adolescent Policy (n 191 above).

health problems. The policy set specific targets and strategies for reversing the adolescent health situation. However, since 2006 there seems to be little effect on what the Government has done in adolescent's health issues. The National Health Strategy for Adolescents and Young People<sup>210</sup> also reports that maternal mortality rate has increased from 762/100,000 in 2004 to 1,155/100,000 live births in 2009 and young people contribute significantly to maternal and newborn morbidity and mortality. The Ministry of Health writes that "...a lot more needs to be done in the health sector, particularly by way of implementation in order to respond fully to the health needs of adolescents and young people".<sup>211</sup> The Ministry goes further to show that this population group still faces significant challenges including limited knowledge regarding their health that will empower them to make healthy choices, inadequate sexual and reproductive health education and life skills, negative influence from harmful social and cultural practices, risky behaviors and inadequate resources for equitable delivery of friendly health services.<sup>212</sup> The Strategy underscores the challenges that inhibit full realisation of adolescents' sexual and reproductive rights, to include budgetary deficiencies, lack of commitment from political and policy-making levels, development of legislations and policies that are not costed to facilitate their implementation, shortages in human resources, weak coordination, dominance of certain cultural and religious beliefs are some of the factors that inhibit progress in adolescent's realisation of their full access to family planning services.

Cherry & Dillon<sup>213</sup> write that knowledge without the tools needed to use the information, has the same effect and eventual outcome as not having the knowledge in the first place. Both sexual education and the availability of all forms of contraception, are essential if unintended adolescent pregnancy is to be decreased and eventually become a rarity. South Africa has adopted an Integrated School Health Policy, which aims at enabling access to sexual, reproductive and health care services and information for adolescents in the school context.<sup>214</sup> In the same vein, Lesotho has adopted the School Health Policy,<sup>215</sup> which aims at creating an enabling environment for the implementation of a wide range of health services within the school going population. The policy views the school environment as the right place to undertake advocacy and social awareness activities for the protection of children's rights through education and information.<sup>216</sup> The school is further seen as a centre where various key health players including the family, civil society and development partners could join hands in promoting and supporting the general health of young people, including adolescents. With regard to access to adolescent's sexual and reproductive health protective devices, the School Health Policy makes reference to dispensing and distributing condoms. It explains that condoms shall

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<sup>210</sup>Health Strategy for Adolescents (123 above at 15).

<sup>211</sup>Health Strategy for Adolescents (123 above at 13).

<sup>212</sup>Health Strategy for Adolescents (123 above at 13).

<sup>213</sup>Cherry A, Dillon M 'An International Perspective on Adolescent Pregnancy' International Handbook of Adolescent Pregnancy: Medical, Psychosocial, and Public Health Responses 2014.

<sup>214</sup>OA Savage-Oyekunle & A Nienaber (n 188 above at 438).

<sup>215</sup>School Health Policy (n 194 above).

<sup>216</sup>School Health Policy (n 194 above at 14).

be distributed only upon the invitation of the School Committee or School Board and shall be restricted to consenting adults to promote safer sex.<sup>217</sup> The policy however, does not mention any other protective device like emergency contraceptives, other than condoms. This is a serious shortcoming, as condoms cannot be held out to be the only method of contraception, as other methods are equally important, more especially emergency contraception, which can be effectively used to prevent unwanted pregnancy when condoms fail. Conversely, the South African 2012 Integrated School Health Policy makes mention of contraceptives, which includes emergency contraception.<sup>218</sup>

The 2005 School Health Policy's main objectives include formulating curriculum that shall promote, protect and support the health and welfare of students. The Policy states that no person will be denied access to reproductive health information and that sexual and reproductive health content and skills provided through the school health activities are age, gender and culture responsive in order to prevent early sex and unwanted pregnancies.<sup>219</sup> Whereas prevention of unwanted pregnancy could be applauded, as it contributes to giving adolescents their right to engage in sex without the fear of falling pregnant, preventing early sex on the contrary, could be viewed to be somehow denying adolescents their sexual rights. As long as they have information about various methods of contraceptives, including emergency contraception, they should be allowed to choose when to start their sexual debut.

Both the South Africa's National Youth Policy 2009-2014 and Lesotho's National Youth Policy define youth as someone between the ages of 14 to 35 years and 15 to 35 years respectively. The Lesotho National Youth Policy categorises people from ages 12 to 15 as developing youth. Both policies have adhered to age stipulations provided for in the African Youth Charter,<sup>220</sup> which also makes it easier and realistic when it comes to sexuality issues affecting adolescents.

Notwithstanding the similarities in the establishment of policies between the two countries, it is evident that the level of commitment invested by South Africa, in safeguarding female adolescents' protection and access to contraceptive information and services far outweighs that of Lesotho.

### **3.4 Comparing approaches to sexuality education in Lesotho and South Africa**

Both Lesotho and South Africa have developed sexuality education programmes which address sexual and reproductive health information to adolescents. Lesotho has adopted the Curriculum and Assessment Policy 2009,<sup>221</sup> introducing the Primary Schools' Curriculum, which includes content specific to sexual and reproductive health. However, in 2012, the Ministry of Education and Training developed a new curriculum as the

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<sup>217</sup> School Health Policy (n 194 above).

<sup>218</sup>Department of Health 'Integrated School Health Policy' 2012 14.

<sup>219</sup>School Health Policy (n 194 above at 14).

<sup>220</sup>African Youth Charter entered into force 8 August 2009 [www.au.int/en/treaties/african-youth-charter](http://www.au.int/en/treaties/african-youth-charter) (accessed 20 July 2016).

<sup>221</sup>Curriculum and Assessment Policy (n 195 above).

Ministry felt that the previous one seemed to have a number of gaps and needed to be revised. The curriculum was changed from Comprehensive Sexuality Education to 'life skills- based sexuality education'. The International Conference on Population and Development programme of Action (ICPD)<sup>222</sup>, connotes that sexuality education programmes in states should include topics such as gender relations and equality, violence against adolescents, responsible sexual behaviour, contraception, family life and sexually transmitted infections (STIs), HIV and AIDS prevention. The content of the curriculum includes topics such as HIV/AIDS prevention, gender equality, human rights, life skills, alcohol and substance abuse and sexual and reproductive health. However, the content on education and various methods of contraceptives, especially emergency contraception is lacking. The content does not encompass sexuality education that includes a full range of information, skills and values to enable young people to exercise their sexual and reproductive rights and to make decisions about their health and sexuality, as provided for in 'Youth and comprehensive sexuality education' by United Nations Educational, Scientific and Cultural Organisation (UNESCO).<sup>223</sup>

Another challenge relates to the fact that in Faith Based Schools (FBS), integrating sexual and reproductive health curriculum into subjects has been proved to be difficult as such schools have reservations in teaching on issues relating to sex before marriage.<sup>224</sup> There are no monitoring mechanisms to ascertain effective implementation of the curriculum. This may be the case because the curriculum is not compulsory. Further, the curriculum is offered from upper primary from grade four to grade ten. It has been piloted in grades four, five and six and is yet to be introduced to grade seven students in the current year, 2016. The curriculum is also offered in secondary schools. The curriculum leaves out students at pre-primary entry level up until grade three. This is a serious limitation, as consensus statements such as the ICPD encourages sexuality education to take place both in schools and at the community level, and that it should be age appropriate and begin as early as possible.<sup>225</sup> This is also in line with the Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Young people in Eastern and Southern Africa <sup>226</sup> which also encourages sexuality education to be integrated not only in schools but in communities and families. In the same vein with Nigeria, Lesotho needs to adopt a realistic approach and accept the inevitability that allowing early in-depth teaching of sexuality and family life education in its schools is a positive way of disseminating and ensuring that important information

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<sup>222</sup>ICPD (n 25 above).

<sup>223</sup>WHO, UNFPA, UNAIDS & UNICEF 2009 International Technical Guidance on Sexuality Education in UNESCO (2015) Emerging evidence, lessons and practice in comprehensive sexuality education: a global review UNESCO Publishing 44.

<sup>224</sup>Kimane (n 57 above at 10).

<sup>225</sup> ICPD (n 33 above at paras 4.29, 7.37 and 7.47).

<sup>226</sup>Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Young people in Eastern and Southern Africa 2013 at para 3.6.

on the protection of sexual and reproductive health generally becomes ingrained in the consciousness of adolescents.<sup>227</sup>

In the case of South Africa, the Government has developed a Life Skills and HIV/AIDS Programme. Health education is incorporated into the school curriculum and provided through the Life Orientation learning areas. The content covered through Life Orientation includes, chronic illnesses (including HIV and TB), abuse (sexual, physical and emotional abuse, including bullying and violence), sexual and reproductive health, menstruation, contraception, Sexually Transmitted Infections (STIs) including HIV/AIDS, Male circumcision, teenage pregnancy, Choice of Termination of Pregnancy.<sup>228</sup> One of the positive aspects of the programme include the fact that, the Programme is compulsory in all schools, from Grade R, for students ranging from six to seven years old.<sup>229</sup> Lesotho also need to adopt this aspect of early teaching of sexuality education as it is lacking in its policies. Early sexuality education is supported by international organisations such as WHO, United Nations Population Fund (UNFPA), UNAIDS AND UNICEF<sup>230</sup> which encourage states to teach sexuality education at a very young age. They define Comprehensive Sexuality Education (CSE) as an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, non-judgmental information.<sup>231</sup> This is also supported by the Maputo Plan of Action<sup>232</sup> which encourages states to provide sexuality education to young people in and out of school.

Further, Lesotho can also adopt good practices in relation to introducing early age teaching of sexuality education in schools from some counties in the West, such as Denmark and Germany which have enforced compulsory education in schools, including lower primary schools. A congruent example could be deduced from the case of *Kjeldsen, Busk Madsen and Pedersen v Denmark*,<sup>233</sup> whereupon some parents who withdrew their wards from school due to the introduction of sexuality education in public schools brought an action against the state claiming a violation of the right to education in article 2 of Protocol 1 of the European Convention. It was held by the European Court that no violation of article 2 had occurred by the introduction of sexuality education and that parents had the option to train their wards about consequences of sexuality education. Further, in *Dojan and others v Germany*,<sup>234</sup> European Court declared inadmissible complaints by five parents of Baptist background that the mandatory introduction of sexuality education in schools was in violation of their rights to religious beliefs and to educate their children.

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<sup>227</sup>OA Savage-Oyekunle & A Nienaber (n 188 above at 440).

<sup>228</sup>Integrated School Health Policy (n 32 above at 13).

<sup>229</sup>OA Savage-Oyekunle & A Nienaber (n 188 above at 439).

<sup>230</sup>WHO, UNFPA, UNAIDS & (n 223 above at 44).

<sup>231</sup>WHO, UNFPA, UNAIDS & UNICEF (n 223 above at 44)

<sup>232</sup> Maputo Plan of Action 2007-2010 at para 4.3.4

<sup>233</sup>*Kjeldsen, Busk Madsen and Pedersen v Denmark* (1 EHRR 711)1976.

<sup>234</sup>*Dojan and others v Germany* (application nos. 319/08, 2455/08, 7908/10, 8152/10 and 8155/10).



Even though both countries have adopted policies and programmes in which sex education is taught, the curriculum and content of the information differs. There are similarities in as far as full realisation of the right of adolescents to be provided with comprehensive sexuality education in the two countries is concerned. The negative attitudes of educators and health care providers in facilitating sex education is an identical challenge in both countries. Whether or not students receive proper and comprehensive sexuality education in schools depends on an open attitude on the part of the instructors teaching the subject. The same case is true for health care providers in both countries. The problem with administering sex education is a result of religious and cultural beliefs that promote chastity and purity and thereby motivating teachers to exercise their reservations about teaching adolescents about sexuality. Consequently, the teachers' attitudes towards sexuality fundamentally affect the content and delivery of school-based sexuality education.<sup>235</sup>

Further, religious leaders, parents and other conservative members of the societies in Lesotho play a major role in inhibiting sexuality education as topics surrounding sex with adolescent girls are regarded as a taboo. Unless these group of people change their perspective towards adolescent' sexuality issues, and embrace the developments that have been undertaken to safeguard sexuality rights of adolescents at the international level, full realisation of their reproductive and sexuality rights shall remain an illusion and adolescents shall continue to live under the scourge of incurable diseases, unwanted pregnancies and unsafe abortions. There is still a lot that Governments of both countries have to do in order to capacitate parents and religious leaders on sexuality issues affecting adolescents. The ICPD together with the CRC<sup>236</sup> oblige parents and other persons legally responsible for adolescents to provide information and guidance in sexual and reproductive matters, in a manner consistent with the evolving capacities of the adolescent. They further underscore that countries must ensure that the programmes and attitudes of health-care providers do not restrict the access of adolescents to appropriate services and the information they need.<sup>237</sup>

### **3.5 Comparing access to sexual and reproductive health care services in Lesotho and South Africa**

The 2009 National Reproductive Health Policy<sup>238</sup> recognises the fundamental human rights to health including provision of sexual and reproductive health care services to all without any form of discrimination. The Ministry of Health has aligned the present policy with other relevant policies and legal instruments in order to ensure a comprehensive and inclusive approach to universal access to sexual reproductive health care services that are acceptable and affordable to every citizen.

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<sup>235</sup>KA Smith & K Harrison 'Teachers' attitudes towards adolescent sexuality and life skills education in rural South Africa' Sex Education (2013) 13 69.

<sup>236</sup> ICPD (n 25 above at para. 7.45), see also CRC (n 32 above at art 5).

<sup>237</sup> ICPD (n 25 above at para. 7.45).

<sup>238</sup> Ministry of Health 'National Reproductive Health Policy 2009'.

The policy sought to increase the use of sexual and reproductive health care services by 80 percent in all communities. It intends to achieve this by removing financial barriers, developing user friendly health services and devising a more welcoming approach to clients by health care practitioners. However, financial barriers have to date not been removed. Cost is a significant obstacle for adolescents in Lesotho, as they frequently lack their own source of income or control over their finances to be able to afford emergency contraceptives. The policy also intends to take on board religious and traditional sectors to ensure that all individuals have access to sexual and reproductive health goals.

The policy proposed to increase the 2009 Government budget for sexual and reproductive health services by 15 percent. It intended to make available a comprehensive sexual and reproductive health services package in all health care centers in Lesotho. The package was intended to include family planning services, post-abortion care, sexually transmitted infections and gender based violence. Similarly, the National Health and Welfare Policy 2003<sup>239</sup> recognises the positive impact of family planning on saving the lives of mothers and children, as well as improving the quality of health of individuals and couples. The same policy provides for improved access to and utilization of quality family planning services.

Both countries have developed policies with a view to ensuring that adolescent girls have access to emergency contraceptives and other reproductive health care services. In the case of Lesotho, irrespective of the existence of the policy framework enabling access to sexual and reproductive health care, studies reveal that such access is far from being a reality as there are a number of concerns around the actual access to sexual and reproductive health care services for adolescent girls, which include getting permission to go and receive contraceptives, especially emergency contraceptives, getting money for the contraceptives, distance to health facility or lack of skilled personnel to give education about the use of emergency contraception.<sup>240</sup> This ordeal is compounded by the fact that in the rural areas, there are fewer government owned health facilities, which leave health centers owned by Faith Based Organisations (FBOs) which oppose the use of contraceptives operating at a large scale. Kimane<sup>241</sup> shows that, due to conflict in beliefs, most FBOs' facilities have not been able to provide services or a comprehensive package of family planning package or services mentioned to adolescent girls and women.

This suffices to show that there is a still a lot the Government of Lesotho has to do in order to ensure full realisation of adolescents' sexual and reproductive rights. From the discussion, it would seem that the Government has failed in its obligation to ensure effective access to emergency contraception, which incorporates physical, economic and information accessibility, accorded on the basis on non-discrimination between adolescent girls and boys as well as older women with adolescent girls. Worthy of note is

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<sup>239</sup>National Health and Welfare Policy (n 196 above).

<sup>240</sup>Demographic Health Survey (n 21 above at 141).

<sup>241</sup>Kimane (n 57 above at 10).

that, regardless of subsidised fees in Government health care centers, adolescents still do not afford the charge levied against them as a great number of them are not working.

Conversely in South Africa, Savage-Oyekunle & Nienaber<sup>242</sup> assert that adolescent girls have access to contraception because there are policies that ensure the availability and accessibility of free family-planning services at public health centres. They further state that, the Government of South Africa has worked together with Non-Governmental Organisations to develop a National Adolescent-Friendly Clinic Initiative (NAFCI) programme which sets standards that are used in regulating the provision of adolescent friendly services within the country, which include an Essential Service Package containing among others, information and education on sexual and reproductive health, contraceptive information and counselling, and provision of methods including oral contraceptive pills, emergency contraception, injectables and condoms.<sup>243</sup> As a result of these standards, various adolescent clinics are being operated in different parts of the country.<sup>244</sup> The initiative was so successful that it was conceptualised and implemented between 1999 and 2005, reaching all nine provinces by January 2001.<sup>245</sup> One of the positive aspect about this initiative is the use of peer instructors, a measure which has been supported by adolescents. Lesotho could also employ this practice of peer instructors. In Lesotho, Youth-friendly services are being provided by the Ministry of Health, through the adolescent Health Corners, and LPPA and other agencies such as UNICEF, and it appears that communities and families are supportive of these services.<sup>246</sup> According to the National Adolescent Health Policy,<sup>247</sup> the Government of Lesotho, assisted by WHO, established a Special Adolescent Reproductive Health Services within hospitals in order to ensure that research findings relating to health challenges faced by adolescents are translated into practical interventions that are integrated within the health care delivery system. Despite these measures, it is evident that there is still need to scale up the provision of youth services, ensure more private settings for provision, and to conduct additional research in order to implement more innovative strategies to attract and maintain youth clients.<sup>248</sup>

## Conclusion

The policies in Lesotho are reflective of the Government's good intentions and endeavors. However, they don't have the binding effect on Government, as such the implementation rate may be lower than desired. However, from the above discussion, it is clear that there is need for Lesotho to invest in a greater political and financial commitment towards assuring female adolescents access to contraceptive information and services, as is the case in South Africa. The Lesotho National Health Strategy for

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<sup>242</sup>OA Savage-Oyekunle&ANienaber (n 188 above at 441).

<sup>243</sup>MIET Africa Literature review: Youth-friendly health services (2011) 15.

<sup>244</sup>OA Savage-Oyekunle&ANienaber (n 188 above at 441).

<sup>245</sup>MIET Africa (n 243 above at 14).

<sup>246</sup>LPPA Strategic Plan (n 136 above at 14).

<sup>247</sup>Adolescent Health Policy (n 191 above at 2).

<sup>248</sup>LPPA Strategic Plan (n 136 above at 14).

Adolescents and Young People 2015-2020 is reflective of this, it provides that lack of commitment from political and policy-making levels is one of the factors preventing adolescent girl's access to quality health care which includes access to emergency contraception.

## CHAPTER 4

### CONCLUSION AND RECOMMENDATIONS

#### 4.1 Conclusion

With the analysis obtained from content analysis of the laws, policies and strategic frameworks, together with international human rights treaties and existing literature, the hypothesis has proved to be true. Indeed, when the laws are permissible for adolescent girls to receive education and information about emergency contraception, and the infrastructure allowing them access, they are likely to make informed decisions about their sexual and reproductive choices. In Chapter one, various issues relating to the right of adolescent girls' access to emergency contraceptive services and information were discussed, and it was concluded that, in order for a state to ensure accessibility of emergency contraception, it has to respect, protect and fulfill four overlapping dimensions upon which accessibility is premised, which include non-discrimination, physical accessibility, economic accessibility and information accessibility.<sup>249</sup>

Even though the study has revealed a number of shortcomings in the legal framework as displayed in Chapter two, to some extent, Lesotho is trying to adhere to its international obligations as they appear in various human rights treaties. Another discovery made is that practical implementation of laws and policies is lacking. The National Health Strategy for Adolescents and Young People<sup>250</sup> attested to this when it revealed that, "despite existence of legislation, policies and strategic frameworks, a lot more needs to be done in the health sector, particularly by way of implementation in order to respond fully to the health needs of adolescents and young people."

Further, the study unraveled various factors inhibiting effective access to emergency contraception, and these included lack of political will and poor coordination and monitoring of adopted policies, cultural and religious beliefs. In addition, budgetary deficiencies, policies that are not quoted to enable their implementation and shortages in human resources, are some of the factors that undermine progress in adolescent's realisation of their full access to family planning services.<sup>251</sup>

Lastly, the study uncovered how religious, cultural practices and some areas of the laws relevant to access to emergency contraception for adolescents were not responsive to the female adolescent question, thereby perpetuating discrimination, stigmatisation and ill-treatment of adolescent girls, which makes it difficult or impossible for adolescent girls to access sexual and reproductive health care.

Furthermore, the discussion in Chapter 3 shows that there are several lessons that could be drawn from South Africa as its legal framework is more consistent with international

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<sup>249</sup>ESCR Committee, General Comment No 14 (n 41 above) see also CEDAW Committee General Recommendation No. 24(n 43 above).

<sup>250</sup>National Health Strategy for Adolescents (n 186 above at 13).

<sup>251</sup>National Health Strategy (n 186 above at 27).

provisions on the right to reproductive health than that of Lesotho. Moreover, the study has discovered that the content of Lesotho's curriculum does not encompass sexuality education that includes a full range of information, skills and values to enable young people to exercise their sexual and reproductive rights and to make decisions about their health and sexuality, when compared to policies in South Africa. Of particular importance in this regard, is the oversight of the content regarding emergency contraception. This is supported by the National Health Strategy which emphasises that, "despite the existence of the curriculum, there is still concern that the content is still not sufficiently addressing health issues in depth."<sup>252</sup>

## **4.2 Recommendations**

- Lesotho should establish a Medical Licensing Agency to regulate licensing of medicines.
- The Medicine and Medical Device Control Bill should be enacted into law so as to provide the legal framework for the control of medicines entering the country.
- Government should consider adopting a Health Act that shall address adolescents' sexual and reproductive health issues and thereby making the right to health enforceable in courts.
- Government should completely remove costs of health services for adolescents.
- Government should also employ good practices from South Africa as far as monitoring and implementation of policies on sexual and reproductive health is concerned. Also, review its 2009 Curriculum and Assessment Policy such that sexual and reproductive health education is part of the mandatory school curriculum.
- Government should also consider asking the 'female adolescent question' in order to appraise the current state of access of adolescent girls to contraceptive information and services in Lesotho as this will help overcome the shortcomings manifested in the legislation and policies.

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<sup>252</sup>National Health Strategy (n 186 above at 17).

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