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**POLICY REVIEW ON AGE CONSENT POLICIES IN THE ESA
REGION: FINAL REPORT**
COMMISSIONED BY RIATT-ESA

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ACRONYMS

ART: Antiretroviral therapy

ASRHR: adolescent sexual and reproductive health and rights

CSE: comprehensive sexuality education

CSO: civil society organisation

ESA: Eastern and Southern African

ESARO: ESA Regional Office

HIV: human immunodeficiency virus

HPV: human papillomavirus

ICPD: International Conference on Population and Development

IPPF: International Planned Parenthood Federation

LMICs: low- and middle-income countries

SADC: Southern African Development Community

SAT: SRHR Africa Trust

SDGs: sustainable development goals

SRH: sexual and reproductive health

UNFPA: United Nations Population Fund

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EXECUTIVE SUMMARY

Adolescents and young people form the largest portion of Africa's population. However, they remain disproportionately affected in terms of their access to sexual and reproductive health services (SRH) and exercising their rights. Partly this spirals from the absence of clear laws on the legal age and provisions in accessing SRH information and services. The RIATT-ESA commissioned review aimed to provide an update on the status of legal age of consent for adolescents SRH in the Eastern and Southern African region.

The review period was between 2019 and August 2024. The review included 32 sources, among these were a continental protocol, a sub-regional SRHR framework, 15 reports including legal reviews, technical/briefing reports, milestone scorecards, and 15 research articles. This review unveiled the state of evidence regarding the minimum age of adolescent SRHR in the ESA region, with glaring variations across countries and gender differences in legislations, that have wider ramifications. Amid these, there have been notable achievements during the review period. This review identifies the following high-level recommendations for possible considerations.

1. There is a need for desexualizing SRHR and treated as any other health system access.
2. Recommend that access and restriction decisions should be based on child and adolescent development, competence and recognition of adolescence evolving capacity to make informed decisions about their own health.
3. The age of consent should not be older than 16 years with no distinction between young men and young women.
4. 'Close in age' exceptions to age of sexual consent should apply where young adolescents have consensual sex with one another.
5. Setting minimum age of consent to marriage to 18 years, without exception and without differentiating between boys and girls, and ensure the minimum age of consent to marriage takes precedence over any cultural, traditional or religious customs and practices.
6. There is need to ensure adolescents access to comprehensive sexual education (CSE) is aligned to international guidelines and inclusive of young out-of-school population.

The review recommends for an accelerated multi-sectoral coordination among ESA member states and stakeholders to achieve the commitments specifically targeting adolescents and young people in this continent.

ACKNOWLEDGEMENTS

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BACKGROUND

Africa's largest population is constituted by adolescents, estimated at 40% in 2023, and is anticipated to rise steadily [1]. Adolescence is a stage of rapid growth crucial for development; however, it is characterised by a myriad of challenges. Specifically, adolescents' sexual and reproductive health is a key public health concern, despite its recognition and emphasis as a priority area in Goal 3.7 of the United Nations Sustainable Development Goals [2, 3]. This is compounded by inequalities surrounding access and availability of age-appropriate health services for this population [4]. In Africa and in most low- and middle-income countries (LMICs), adolescents and young people between 10 to 24 years continue to face a high HIV burden, with new HIV infections higher among girls, and growing mental health concerns among adolescents living with HIV [4, 5]. To reverse these trends and achieve global commitments such as 'eliminate new HIV infections and increase access to HIV prevention efforts for young people by 2030', it calls for concerted efforts by governments, non-governmental organizations, and other regional and multinational agencies to address this plight.

The lack of clarity on adolescent age to access SRH services and legal provisions stipulating the minimum age of consent remains an eminent challenge. In 2019, the United Nations Population Fund (UNFPA) conducted an updated legal review on age harmonisation across 23 countries in the Eastern and Southern African (ESA) [6]. This technical report highlighted country differences in the minimal age to consent for sex, marriage, and access to health services, varying by age ranging from 15-24 years, and gender-specific exceptions to these laws. The recommendations put forward were the strong need to align the age of consent across member states. Since the publication of this report, there have been significant events that may change the course to which these laws and evidence is situated in the current period. For instance, the dawn of the COVID-19 pandemic in December 2019 has had devastating global effects. Specific to health, there have been rising reports surrounding gender-based violence, challenges with access to health and health commodities including the interruption of access to essential commodities such as anti-retroviral treatment, which may have put HIV patients especially adolescents at greater risk.

The RIATT-ESA commissioned assignment to conduct a desk review on the legal age of consent for ASRH in the ESA region is timely and much needed. The purpose of this review was to provide an update of the state of legislation across the ESA region from 2019 to present day, take stock of

progress of enforcement of these legal provisions, and provide recommendations to inform policy and programming work on ASRH interventions and services within the ESA region. The assignment was guided by the following objectives:

1. To conduct a comprehensive desk review on age of consent policies regarding adolescent sexual and reproductive health and rights (ASRHR). Specifically, the review investigated; age for sexual consent; age for marriage; age for consent to access family planning services; age for consent to access HIV testing, counselling services, pre-and post-exposure prophylaxis; and age of consent for abortion care.
2. Synthesize the evidence to provide policy recommendations that will enable stakeholders to design and implement targeted interventions that effectively meet the needs of young people across the Eastern and Southern Africa (ESA) region.
3. To provide evidence that can help advocate for policy reforms aimed at establishing consistent age consent standards, ultimately promoting the rights and well-being of young people in the ESA region.

Methods

A systematic search was conducted on public databases and websites on policies and laws for ESA member states on the legislative and policy provisions for ASRHR. This includes PUBMED, Google Scholar, and websites such as the Africa committee of experts on the rights and welfare of children (<https://www.acerwc.africa/en>), and the Africa Union Legal Information (<https://africanlii.org/>).

The scope of the review was restricted to the 23 members states of the Eastern and Southern Africa (ESA) Region between 2019 and May 2024, when the last search was performed. By December 2024, an additional 13 references were included in this review that were identified through citation referencing and recommendations from RIATT network members. The ESA countries reviewed include Angola, Botswana, Burundi, Comoros, Democratic Republic of Congo, Ethiopia, Eritrea, Eswatini, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Seychelles, South Africa, South Sudan, Tanzania, Uganda, Zambia, and Zimbabwe. While some sources of evidence were outside the ESA region, the report prioritizes findings from the ESA region.

Sources of evidence included country laws and policies, continental legal frameworks, published reports, and scientific articles documenting the legislation and progress in implementation of laws on age of consent for ASRH in the ESA region. Additionally, reference tracking and hand searching were used to identify any relevant sources for this review. Overall, the included sources of information largely depended on availability of documents in the public domain and may have restricted the countries reported in this review.

A structured extraction template was used to retrieve information from sources of evidence under the following sub-headings: age for sexual consent; age for marriage; age for consent to access family planning services; age for consent to access HIV testing and counselling services, HIV pre- and post-exposure prophylaxis; and age of consent for abortion care. A comparative narrative approach was used to synthesise the evidence identified, with special focus on differences across ESA member states, tracking recent progress on legislation and enforcement of laws, and provision of recommendations.

FINDINGS

Thirty two sources were included in this review, among these were: a continental protocol and (sub)regional frameworks and declarations [7-9]; 14 reports including legal reviews, technical/briefing reports, and SRHR score cards [7, 10-22], and 15 research articles [4, 23-36], whose details are summarized in **Table 1** and **Supplementary File 1**. Across the sources of evidence there was good representation of most of the ESA countries. The findings section is structured around seven overarching themes in presenting the evidence by investigating the minimum age of consent, identifying current progress, policy gaps, and recommendations.

Table 1: Summary of sources of evidence reviewed (2019-2024)

No	Document author: brief title	Year	Document type	Countries represented and scope
1	The Maputo Protocol	2003	Continental Framework	Though covering all 55 Africa Union member states, the focus here was on the 16 SADC Countries. All ESA countries have ratified except for Botswana, South Sudan and Somalia.
2	SADC: Strategy on Sexual and Reproductive Health and Rights (2019-2030)	2019	A Sub-regional Framework	SADC 16 member states: Angola, Botswana, Comoros, Democratic Republic of Congo, Eswatini, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Tanzania, Zambia & Zimbabwe
3	Ten-Year Review of the Addis Ababa Declaration on Population and Development in Africa beyond 2014	2023	Technical Report	All African Countries
4	UNFPA/ESARO: Harmonization of the legal environment on ASRH in East and Southern Africa.	2020	Technical Report	Malawi, Uganda, Zimbabwe, South Africa, Namibia, Botswana, Seychelles, Lesotho, Mauritius, Comoros, Angola, Swaziland
5	APHRC: Why lowering the age of consent to SRHS is beneficial for adolescents' health and wellbeing.	2022	Briefing Report	Zimbabwe (primary focus compared with ESA countries)
6	SAT: Age of consent global review summary	2020	Legal Review Report	ESA countries Kenya, Zambia, Botswana, South Africa, Tanzania, Malawi, Zimbabwe, Swaziland Other African countries Nigeria, Morocco, Ivory Coast (Cote d'Ivoire) Other non-African countries Canada, United Kingdom, France, Jamaica, Brazil, Sweden, Ukraine, India, Thailand, Vietnam, Indonesia
7	SAT: Age of consent: Legal Review Zimbabwe Country Report	2021	Legal Review Report	Zimbabwe
8	SAT: Age of consent: Legal Review Zambia Country Report	2021	Legal Review Report	Zambia
9	SAT: Age of consent: Legal Review Botswana Country Report	2021	Legal Review Report	Botswana
10	IPPF: ICPD+25 Nairobi Summit commitment analysis. A roadmap for fulfilling the promise.	2020	Technical Report	137 countries across the globe. African countries with quality and strong (SMART) commitments analysis with alignment to priority themes ESA countries Botswana, DRC (Congo), Eswatini, Malawi, Mozambique, Rwanda, South Africa Non-ESA countries

No	Document author: brief title	Year	Document type	Countries represented and scope
				Burkina Faso, Eritrea, Gambia, Ghana, Guinea Bissau, Mali, Nigeria, Sao Tome and Principe
11	ESARO UNFPA: Regional report on the Evaluation of the ESA ministerial commitment on CSE and SRHS for adolescents and young people	2024	Technical report	ESA Countries: Angola, Botswana, Burundi, DRC, Eswatini, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Rwanda, South Africa, South Sudan, Uganda, Tanzania Zambia, Zimbabwe
12	Score Card for Sexual and Reproductive Health and Rights in the SADC Region Fast tracking the Strategy for SRHR in the SADC Region 2019 – 2030	2019	Technical report	16 SADC countries: Angola, Botswana, Comoros, Democratic Republic of Congo, Eswatini (formerly Swaziland), Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, United Republic of Tanzania, Zambia, and Zimbabwe
13	SADC SRHR Score card 2023	2023	Technical report	16 SADC countries
14	SADC SRHR Score card 2021	2021	Technical report	16 SADC countries
15	UNFPA ESARO: Ending Child Marriage in Southern Africa: Domesticating the SADC Model Law on Child Marriage	2023	Technical report	SADC member states
16	Watson et al. The ESA ministerial commitment: a review of progress toward fulfilling young people's SRHR 2013-2018	2021	Research article (review)	ESA countries and 13 high-level key informant interviews from organisation and country officials
17	Barr- DiChiara et al: Adolescent and age of consent to HIV testing: An updated review of national policies	2021	Research paper (policy review)	38 countries within sub-Saharan Africa (review of policies between 2005 and 2019)
18.	McKinnon and Vandermorris: National age-of consent laws and adolescents HIV testing in sub-Saharan Africa	2018	Research paper (secondary analysis)	A focus on selected sub-Saharan Africa countries: ESA: DRC, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, Uganda, Tanzania, Zambia, Zimbabwe Non-ESA: Cameroon, Cote d'Ivoire, Nigeria
19	Manguro and Temerman: A critical review of ASRHR in Kenya	2022	Research article (commentary)	Kenya
20	Perehudoff et al. A Comprehensive human rights analysis of laws and policies for adolescent contraception in Uganda and Kenya	2022	Research article (Legal analysis)	Kenya and Uganda
21	Mollé and authors 2022: Legal age for consent for HIV testing in SSA	2022	Research article (Systematic review) - a policy and legal review framework:	33 sub-Saharan African countries (with available 2013, 2019 HIV reports): ESA countries Angola, Burundi, Comoros, Congo, Democratic Republic of Congo, Kenya, Madagascar, Mauritius, Mozambique, Rwanda, Senegal, Sierra Leone, Tanzania, Togo and Uganda, South Africa Non-ESA countries

No	Document author: brief title	Year	Document type	Countries represented and scope
				Benin, Burkina Fasso, Central African Republic, Chad, Cape Verde, Cote d'Ivoire, Equatorial Guinea, Gambia, Guinea, Guinea Bissau, Liberia,
22	Melesse et al: Adolescent sexual and reproductive health in sub-Saharan Africa: who is left behind?	2019	Research article (Analysis):	A. Country data reports i.e. • ESA: Ethiopia, Kenya, Malawi, Mozambique, Tanzania, Uganda, Zambia and Zimbabwe • Non-ESA: Ghana, Nigeria, Mali, Mauritania, Niger B: Desk review of HIV related laws in 28 SSA countries C: Review of health policy gaps that affect adolescents access to HIV services in Rwanda D: Review of South African legislative reform for improvement of adolescents' access to sexual and reproductive health services
23	Tallarico et al. Age of consent: A case for harmonizing laws and policies to advance, promote, protect ASRH	2021	Research article (Legal analysis)	ESA countries with in-depth analysis of data from 6 countries: Malawi, South Africa, Eswatini, Tanzania, Uganda and Zambia
24	Ninsiima et al: Factors influencing access to and utilisation of youth-friendly sexual and reproductive health services in sub-Saharan Africa: a systematic review	2021	Research article (Systematic Review)	7 African countries (data available from 2009 and 2019) ESA countries: Ethiopia, Kenya, South Africa, Tanzania Non- ESA countries: Ghana, Nigeria
25	HiVOS: Making access a reality. Addressing age of consent barriers in East and Southern Africa	2022	Policy brief	ESA country contextual analysis on the Consent2Access campaign Kenya, Malawi, Zambia, and Zimbabwe
26	HiVOS: Contextual analysis on the age of consent for adolescents' access to SRHR in Malawi	2022	Policy brief	Malawi
27	Black et al: Prevention of cervical cancer in sub-Saharan Africa: the advantages and challenges of HPV vaccination	2018	Research article	SSA African Countries ESA countries featured: Botswana, Lesotho, Mauritius, Mozambique, Rwanda, Seychelles, South Africa, Tanzania, Uganda
28	Lane et al: Policy considerations for scaling up access to HIV pre-exposure prophylaxis for adolescent girls and young women: Examples from Kenya, South Africa, and Uganda	2021	Research article	ESA countries: Kenya, South Africa, Uganda
29	Strode et al: Adolescent self-consent to medical interventions in South Africa	2023	Research article	ESA country: South Africa
30	Amponsah-Dacosta et al: Human papillomavirus vaccination in South Africa: programmatic challenges and opportunities for integration with other adolescent health services?	2022	Research article	ESA country: South Africa
31	Mwambene: Recent legal responses to child marriage in Southern Africa: The case of Zimbabwe, South Africa and Malawi	2018	Research article	ESA country: Malawi, Zimbabwe, and South Africa

No	Document author: brief title	Year	Document type	Countries represented and scope
32	Kangaude et al: (De)Criminalizing adolescent sex: a rights-based assessment of age of consent laws in Eastern and Southern Africa	2018	Research article	ESA countries reviewed: Angola, Botswana, Burundi, Comoros, DRC, Eswatini, Ethiopia, Kenya, Madagascar, Malawi, Mozambique, Namibia, Rwanda, South Africa, Uganda, Zambia, Zimbabwe

Age of legal consent for sexual activity

The SADC SRHR strategy 2019-2030 recommends ‘*reducing the age of consent to 16 years, irrespective of gender, taking into consideration the rights of adolescents and youth to healthy consensual sexual relations based on their evolving capacity, and include close-in-age provisions (known as Romeo and Juliet provisions)*’ [7]. However, there is notable variation among many ESA countries on the age of consent to sexual activity, with age and gender disparity as defined in existing legal instruments and influenced by customary laws – see **Table 2**. According to the 2019 UNFPA/ESARO report, the age of consent varies from as low as 13 years in Comoros, 14 years (Namibia and Seychelles), 16 years (Swaziland, Lesotho, Mauritius, Malawi, South Africa and Zimbabwe), and 18 years (Botswana, Burundi, Eritrea, Ethiopia, Kenya, Mozambique, Rwanda, South Sudan, Tanzania, Uganda, Angola and DRC) [7, 10, 15, 16]. There has been changes in raising the age of consent to sexual activity in a few ESA countries, alluding to country efforts towards enforcing protective laws for adolescents. For instance, Burundi’s penal code 2018 amendment raised the age of consent for sex for both boys and girls from 16 to 18 years [16]. Zimbabwe in January 2023, the government raised the legal age of consent for sexual relations from 16 to 18 years through a statutory instrument issued by President Emmerson Mnangagwa [37]. This change aims to enhance the protection of children and adolescents, particularly considering concerns about early child marriage and exploitation [38]. Perpetrators of this law may face a 10-year jail sentence [38].

Table 2: Legal age of consent to sexual intercourse and laws on sexual intercourse

Country	Gender variation	Boys age	Girls age	Comments on exceptions and laws on (de)criminalizing sexual activity
Angola	Varies	18	16	Angola Penal Code. Adolescent under 18 with a sexual partner below 16 cannot be prosecuted under law
Botswana	Same	18	18	2018 Amendment raised age for boys and girls from 16 to 18 years. Law can prosecute adolescent under 18 having consensual sex with under 16.
Burundi	Same	18	18	Criminalizes sexual activity of under 18 with an adult, even if adolescent provides consent (Rape)
Comoros	Same	13	13	Law can prosecute adolescent under 18 having consensual sex with under 16.
DRC	Varies	18	14	Consensual sex among adolescents below the prescribed ages is prosecuted by law.
Eritrea	Same	18	18	No exceptions specified
Eswatini	Same	16	16	Consensual sex with adolescent girl below 16 is prosecuted by law.
Ethiopia	Same	18	18	Consensual sex among adolescents below 18 is prosecuted by law.
Kenya	Same	18	18	Consensual sex among adolescents below 18 is prosecuted by law. Sex with under 18 considered defilement.

Country	Gender variation	Boys age	Girls age	Comments on exceptions and laws on (de)criminalizing sexual activity
Lesotho	Same	16	16	No exceptions specified
Madagascar	Same	14	14	Consensual sex with adolescent girl below 14 is prosecuted by law. Indecent assault of below 14-year-old girls is criminalised.
Malawi	Same	16	16	Consensual sex among adolescents below 18 is prosecuted by law. Sexual activity or intercourse with below 18-year-olds is criminalised.
Mauritius	Same	16	16	No exceptions specified
Mozambique	Same	18	18	Differences in age of consent reported in sources of evidence (16 vs 18 years). Consensual sex among adolescents below 16 is prosecuted by law.
Namibia	Same	14	14	Consensual sex with a person below 14 years is not criminalized if the older party is not more than 3 years older
Rwanda	Same	18	18	Consensual sex among adolescents below 18 is prosecuted by law.
Seychelles	Varies	14	14	No exceptions specified
South Africa	Varies	16	16	Consensual sex between adolescents within 12 to 16 years is not criminalized. Where the older party is between 16 and 18 years, consensual sex is not criminalized if the older partner is not more than 2 years older.
South Sudan	Same	18	18	No exceptions specified
Tanzania	Varies	18	18 (12)	Differences in age of consent for girls reported in sources of evidence (12 vs 18 years). No exceptions specified
Uganda	Same	18	18	Consensual sex among adolescents below 18 is prosecuted by law.
Zambia	Same	16	16	Consensual sex with adolescent girl below 16 is prosecuted by law. Sex with under 16-year-olds is considered defilement and criminalised.
Zimbabwe	Same	18	18	Previously was 16 years until 2023 amendment of the law raising the age to 18 years.

Sources: APHRC 2022; Kangaude 2018; Melesse et al 2020; SADC Strategy (2019-2030); SAT 2021 Ambia, Botswana and Malawi; Tallarico et al 2021; UNFPA/ESARO 2020 and 2024.

This review identified variations in the legal age of sexual consent by gender across ESA countries as highlighted in **Table 2**. For example, Angola (16 years females, 18 years males), DRC (14 females, 18 males), Tanzania (12 years females), Mozambique (16 years), and Rwanda (21.5 years females) [7, 26, 29]. Across most of ESA countries, ‘young men who have sex with men’ is criminalised and there is no express exception that exists [16].

Consensual sexual activity among adolescents is divided for different ESA country laws – see details in **Table 2** [35]. For instance, while in Zimbabwe the age of sexual consent is set at 16 years, those aged 12-14 years can consent to sex if capable of doing so [14]. In South Africa, while the age of consent for sexual activity is 16 years, the law decriminalizes consensual sexual activity between adolescents aged 12-16, and between adolescents, where one is under 18 but less than 2 years older than the other [35]. In contrast, Uganda laws explicitly criminalize sex between

adolescents, with different provisions based on age. For instance, if both are under 12 years, it is not a criminal offense, whereas if one is under 12 years, the older child may be placed under supervision. If both are 12-18 years, they may be prosecuted as child offenders [35].

Taken together, these variations perpetuate gender inequality, reinforce unhealthy gender norms that disempower girls, and the absence of clear legislations poses a threat to adolescents evolving capacity and autonomy with their right to protection [29]. These circumstances put adolescents especially girls vulnerable to sexual offences/violence. In Kenya, the 2019 survey on violence against children reported that 15.6% of girls had ever experienced sexual violence, compared to 6.4% of boys [24]. Among girls, the risk of sexual violence increases with age; 18.4% experienced violence before the age of 13, 27% between the ages of 14 and 15, and approximately 55% between the ages of 17 and 18 [24]. In subsequent sections, the report highlights how this age of consent variations and exceptions affects adolescents access to sexual and reproductive health services.

Age of consent for marriage

Across all sources of evidence there was recognition of the marked variation in the age of consent for marriage by country, gender, and in some instances contradictions in the legal and customary laws regarding age/gender exceptions as summarized in **Table 3**. In all 23 ESA countries, 11 countries have the age of consent to marriage set at 18 years, and only seven countries do not permit exceptions. i.e. Botswana, Comoros, DRC, Eritrea, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Rwanda, South Sudan, Uganda and Zimbabwe [29]. These findings corroborate with the SADC SRHR scorecard reports of 2021 and 2023, where 13 countries had set the minimum legal age to consent to marriage at 18 years, and at 21 years in Botswana, Namibia and Zambia [20, 21]. In South Africa, the minimum age for boys (14 years) and girls (12 years) is below most of ESA country lowest age of consent, and marriage for this age group is permitted by a minister and parental consent required as stipulated in the Customary Marriages Act 120 of 1998 [16]. Further, there are contradictory provisions and disharmony between statutory and customary law provisions in South Africa, where there are approximately three age provisions: 12, 14 and 18 years [29]. To put this in context, customary practices that allow for child marriage with parental consent are prevalent in Southern African countries [36]. In South Africa, the recognition of the Customary Marriages Act sets the minimum age for customary

marriage at 18 years for both parties. However, the Act, read together with the Marriage Act, allows for marriage below 18 with parental consent [36].

Table 3: Legal age of consent for marriage in ESA countries summary

Country	Gender variation	Boys age	Girls age	Comments on exceptions
Angola	Varies	16	15	With permission from persons with authority and in special circumstances review taking minor's best interest (Angola Family Code)
Botswana	Same	18	18	With parental consent (Marriage Act 2021)
Burundi	Varies	21	18	Exceptions may be granted if serious reasons by provisional governor (Code of Persons and Family 1993)
Comoros	Same	18	18	Exceptions may be granted if serious reasons by competent judge (<i>Code de la Famille</i> 2005)
DRC	Same	18	18	Stipulated in the Family Code and Child Protections Code No exceptions permitted
Eritrea	Same	18	18	Stipulated in the Transitional Civil Code as amended by the Proclamation 1/1991 No exceptions permitted
Eswatini	Varies	18	16	Ministerial exceptions though child marriages are outlawed (Children's Protection and Welfare Act).
Ethiopia	Same	18	18	Stipulated in the Revised Family Code of 2000. Minister of Justice can grant dispensation not more than 2 years for applications with serious cause.
Kenya	Same	18	18	Stipulated in the Constitution of 2010 and child marriage prohibited and criminalised under Child Act 2001 and 2022. No exceptions permitted
Lesotho	Varies	18	16	Minister must provide written permission for marriages of children below these stated (Marriage Act)
Madagascar	Same	18	18	Stipulated in the Family Code Law 2007. Permits court application of parents and children (with parental consent) for consideration to authorize marriage for children
Malawi	Same	18	18	Stipulated in the Constitution of 1994. The 2017 Constitutional Amendment has raised age of minority to 18 as child protection measures.
Mauritius	Same	18	18	Stipulated in the Civil Code. Exceptions apply for 16-18 with permission from persons with authority or under court.
Mozambique	Same	18	18	Stipulated in the Family Law Act 2004. No exceptions permitted
Namibia	Same	18	18	Stipulated in the amended Married Persons Equality Act. Waiver for age below 18, with written permission of a Minister if marriage is considered desirable.
Rwanda	Same (>18yrs)	21	21	Stipulated in the Civil Code. Only in serious ground and person is over 18 years, can a Minister of Justice give a waiver of age No exceptions permitted
Seychelles	Varies	18	15	Marriages below this age can be prescribed by a Minister under serious reasons (Civil Status Act)
South Africa	Varies	14	12	Stipulated in the Marriage Act of 1961. Exceptions under the Customary Marriages Act 120 of 1998, where a minister and parental consent allows for marriage for children of this age
South Sudan	Same	18	18	Stipulated in the Transitional Constitution of 2011. Child marriage is prohibited and criminalised under Child Act 2009.

Country	Gender variation	Boys age	Girls age	Comments on exceptions
				No exceptions permitted
Tanzania	Varies	18	15	Court may allow marriage below specified age (Law of Marriage Tanzania). The Education Act of Zanzibar bans marriage for any enrolled learner until completion of basic education.
Uganda	Same	18	18	Stipulated in the Constitution of 1995. No exceptions permitted
Zambia	Same (<18 yrs)	16	16	Exceptions can be granted by a Judge of the High Court for marriage below 16 years, where parental consent is obtained and marriage is not against public interest (Marriage Act).
Zimbabwe	Varies	18	15	Constitution 2013 sets marriage above 18 years. Exceptions for persons <16 years under parental consent/court (Marriage Act)

Sources: UNFPA/ESARO 2020 and 2024; SADC Strategy (2019-2030); Melesse et al 2020; Mwambene 2018; Tallarico et al 2021; SADC SRHR Scorecards 2021 and 2023

Given the wide variation by country on legal age of consent for marriage, there have been calls towards advocacy for harmonizing the minimum age. The SADC SRHR 2019-2030 strategy [7], recommends the alignment of national laws with continental and international legal frameworks, which recommends age of marriage to 18 years, irrespective of gender to minimise child marriages. An important indicator to examine this progress has been to track how countries are progressing with the elimination of child marriages. For instance, by examining ESA's ministerial commitment 2020 target 4.8 of eliminating child marriage, there are 20 countries that have instituted programmes to prevent and mitigate against child marriage although this has not been regularly reported towards. [30] In four countries namely, Kenya, Malawi, Uganda, and Zambia, the available data indicates a decline in the proportion of girls married or in union before age 15 and 18 years [30]. The 2023 report on ending child marriages using the SADC model showcases country progress in instituting national action plans/strategies on ending child marriage as witnessed in Mozambique, Zimbabwe, Malawi and Zambia [21]. In other sources, while there has been reported decline in child marriages, this has not been uniform across ESA and the rest of African countries, and more so disparities observed by income quintiles, rural-urban divide, and education levels [26].

Adolescents comprehensive sexual and reproductive health education (CSE)

The momentum to prioritise comprehensive sexual and reproductive health education (CSE) for adolescents was signified after the endorsement of the ESA countries ministerial commitment on CSE in 2013 [17]. This was re-affirmed in 2021, although with less than the original 21 member states. The SADC SRH strategy backs this through its recommendation of the need to ensure *adolescents and young people both in and out of school have access to good quality, comprehensive, age-appropriate, scientifically accurate life skills-based comprehensive sexuality education (CSE), with linkages to SRH services that are youth friendly* [7].

Some recorded progress since the ministerial commitment implementation include 17 countries had a costed national CSE strategy or framework for out-of-school youth by 2018, with a target to increase to all 21 countries by 2020 – see **Table 4** [30]. In 2018, 14 out of 15 countries reported to have schools that provided life skills-based HIV and sexuality education in the previous academic year, though at varying levels of coverage (5% to 100%), with an aim to increase to 95% by 2020 [30]. Based on the 2021 and 2023 SADC SRHR scorecards, most member states reported to be on track in achieving the 95% target to offer life skills-based HIV and sexuality education in primary schools [20, 21]. South Africa’s successful CSE approach involved working with the education ministry to develop lesson plans, posters and tailored media campaigns to increase awareness [9]. In Namibia, this is credited to raising awareness to parliamentarians and staff, which led to the successfully passing of motions such as menstrual hygiene brought to parliament [9].

Table 4: Progress with CSE implementation in ESA countries

CSE strategy domain	Progress by country since ESA ministerial commitment implementation
CSE strategies for out-of-school youth	Angola, Botswana, Burundi, DRC, Eswatini, Kenya, Lesotho, Madagascar, Malawi, Mozambique, Namibia, Seychelles, South Africa, Tanzania, Uganda, Zambia and Zimbabwe
Countries with national policy on pregnant learners	Angola, Botswana, Burundi, DRC, Eswatini, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Seychelles, South Africa, Tanzania, Uganda, Zambia and Zimbabwe
Integration of CSE in school curriculum (primary or secondary)	DRC, Ethiopia, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Uganda and Zambia.
CSE as an examinable subject	Malawi, Namibia, South Africa, Swaziland and Uganda
Schools providing life-skills based HIV and sexuality curriculum in 2018	100% coverage: Botswana, Kenya, Mauritius, Mozambique, Namibia, Seychelles, South Africa Others: Malawi (80%), Zimbabwe (78%), Lesotho (75%), Zambia (62%), Tanzania (53%), Rwanda (30%), Swaziland (30%), Madagascar (5%)

CSE strategy domain	Progress by country since ESA ministerial commitment implementation
Countries providing pre- and in-service training on adolescent and youth friendly services	Angola, Botswana, Burundi, DRC, Eswatini, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Seychelles, South Africa, South Sudan, Tanzania, Uganda, Zambia and Zimbabwe

Sources: ESARO/UNFPA 2024; IPPF: ICPD+25; UNFPA/ESARO 2020; Watson et al 2021.

There was steady progress and demand to provide pre-service and in-service CSE and SRH training for health and social workers on delivering CSE and delivering adolescent and youth friendly health services. In 2015, only 10 countries reported offering pre-service training and 17 countries had in-service training established [30], and by 2018 all 21 countries had met this target [17]. Additionally, 16 countries had and were implementing a comprehensive policy to manage adolescent pregnancy whilst in school, except for Ethiopia, DRC, Botswana, Angola and Lesotho [17].

Regarding provision of adolescent and youth-friendly SRH (YFSRH) services, 65% of countries offer a standard minimum package of youth-friendly SRH services in 2015 [30]. In 2018, some countries had improved the proportion of health service delivery point offering adolescent and youth-friendly SRH services i.e. Eswatini (74%), Kenya (23%), South Africa (100%), Tanzania (30%), Uganda (17%), and Zimbabwe (20%) [30].

There are still eminent challenges for instance, it is estimated below 50% of young people demonstrate accurate knowledge about HIV prevention and transmission [17]. The 2020 targets aims to increase the number of adolescents and young people, aged 10–24, who demonstrate comprehensive HIV prevention knowledge levels to 95% [30]. Other prevailing challenges affecting CSE implementation reported in the sources of evidence [17, 30], include opposition to CSE and SRHR from some stakeholders, which has affected the efficiency of implementation in several countries. Coordination issues between ministries and siloed ways of working has also contributed to inefficiencies. Lastly, dissemination, implementation and enforcement of policy and legal changes at subnational levels has been limited among service providers and local decision-makers.

Age of consent for HIV testing, pre- and post-exposure prophylaxis

Based on the sources of evidence [10, 12-15, 23, 25, 27], there were variations in the minimum age of consent for HIV testing and treatment as stipulated in country legislations and informed by existing medical guidelines. In **Table 5**, a summary of the age of consent is provided, circumstances where parental consent or other authority permission is required, where evidence was available.

Table 5: ESA countries age of consent for select HIV services and consent

Country	HIV testing & counselling	ART access	PREP	PEP	Comments on age and consent
Angola	15	NS	NS	NS	
Botswana	16 (PC)	18 (NPC)	18 (TA)	PC	HIV testing with parent consent
Burundi	NE	NE	NE	NE	
Comoros	NE	NE	NE	NE	
DRC	NE	NE	NE	NE	
Eritrea	18	NS	NS	NS	
Eswatini	16	12	12	12	
Ethiopia	15	NS	NS	NS	
Kenya	18 (NPC)	PC	PC	PC	
Lesotho	12	NS	NS	NS	
Madagascar	NE	NE	NE	NE	
Malawi	12 (PC)	16 (NS)	16 (NS)	16 (NS)	HIV testing with parent consent
Mauritius	NE	NE	NE	NE	
Mozambique	16*	NS	NS	NS	*Variation by source i.e. age 12, 16
Namibia	16	NS	NS	NS	
Rwanda	12	NS	NS	NS	*Variation by source i.e. age 12, 15
Seychelles	NE	NE	NE	NE	
South Africa	12	12-17	12-17	12-17	
South Sudan	18	NS	NS	NS	
Tanzania	18	NPC	NR	NPC	HIV testing with parent consent
Uganda	12	NS	NS	NS	
Zambia	16 (PC)	16 (NS)	NS	16 (PC)	HIV testing with parent consent
Zimbabwe	16	16 (NS)	15 (NS)	16 (PC)	

ABBREVIATIONS: NE: Not evaluated in cited evidence; NPC: No parental consent required or according to the policy or law; PC: Parental consent needed in the absence of clear policy guideline; NR: No age or other restrictions; NS: Age not specified, unclear; TPA: Third party authority

In five of the 23 ESA countries, there was no reported information on the minimum age adolescents can access various HIV services. With regards to adolescent autonomy to access HIV services, some reports provided explicit reasons circumstance under which consent was required, which has an implication on reporting results status to adolescents. For instance, in Zimbabwe the legal age for consent is 16 years, however, emancipated minors below this age can provide consent [14]. There was ambiguity over the provision of HIV treatment and adolescent autonomy. Most

countries abide to the universal provision of Antiretroviral treatment. However, there are restrictions in the provision of PEP, in most cases under medical directive and allowable where adolescents are victims of sexual abuse. In Botswana PEP is available, however, there are prohibitions in its provision this relating to the decision as to whether it should be administered [13]. For instance, where sexual intercourse is consensual, there is absolute prohibition. The prohibition does not apply to victims of sexual violence [13].

In Kenya there is no specific statutory age of consent for medical care and this could potentially create ambiguity regarding adolescents' access to PrEP [33]. The absence of a defined age may allow for more flexible interpretations in practice [33]. Crossing over to Uganda, the age of consent for medical treatment, including PrEP, is estimated to be 18 years. However, the HIV/AIDS Prevention and Control Act allows children aged 12 years and older to self-consent to an HIV test, which may imply some access to PrEP services, although it is not explicitly stated in the law [33]. Finally in South Africa, the Children's Act allows adolescents aged 12 years and older to self-consent to medical treatment, including PrEP, provided they demonstrate sufficient maturity to understand the implications of their decision [34]. This may imply that adolescents can access PrEP without needing parental consent if deemed mature enough by a healthcare provider [33, 34].

Adolescents access to contraceptives, HPV vaccine and cervical cancer screening

Six reports/articles [10, 12-15, 28], explicitly provide ages of consent for adolescents accessing different contraceptive methods, and outline permissions required for access, with mixed views on the presence of legislations and restrictions of contraceptive access – see **Table 6**. In Kenya, Tanzania, and Zambia there are no laws permitting or restricting access to hormonal or barrier method contraceptives such as condoms [10, 15]. Some ESA countries have specified age restrictions to access various contraceptive services. For instance, in Botswana and South Africa adolescents 10-12 years can access barrier method contraceptives, while access to hormonal contraception requires parental consent in Zimbabwe, and with restrictions to adolescents aged 10 years (in the event of rape) in Botswana, and 13 years in South Africa [10]. In Zambia, there is no legal restriction on the age of access to emergency contraceptives, however, if a young person reaches the age of reproduction and is under the age of 16 years, parental consent may be required

to access emergency contraceptives in practice [12]. In exceptional circumstances such as sexual abuse of children of any age, emergency contraceptives are readily available [12]. Similar to Botswana, this is made available in the event of rape, defilement, and incest [13].

Table 6: Minimum age of consent for contraceptives, HPV vaccination, and cervical cancer screening

Country	Barrier method contraceptives	Hormonal method contraceptive	HPV vaccination and cervical cancer screening	Comments on age and consent
Botswana	10-12	10*	9-13 (PC)	*In the event of rape
Eswatini	NS	NS	16 (NS)	
Kenya	NR	NR	9-13 (NPC)	
Malawi	NS	NS*	9-13 (NPC)	No clear directives on parental consent for emergency contraceptives
South Africa	10-12	13	9-10	
Tanzania	NS	NS	NS	
Zambia	NR	NR/PC ⁺	9, 10, 16 (PC)*	+ Parent consent for emergency contraceptives for under 16 except for rape circumstances *Age and consent vary by source
Zimbabwe	NR	PC	10 & 16	

ABBREVIATIONS: NPC: No parental consent required or according to the policy or law; PC: Parental consent needed in the absence of clear policy guideline; NR: No age or other restrictions; NS: Age not specified, unclear; TPA: Third party authority

Most of the ESA countries have introduced HPV vaccination for adolescents, with the majority using the school-based programme [32]. In Zambia, the HPV vaccination programme targets both in-school girls (Grade 4 aged 9-10 years) and out-of-school girls (10 years) in facility or community settings [12]. In Zimbabwe, there is a policy framework in place allowing for access to HPV and cervical cancer screening for adolescents aged 10 years, although it is not yet codified [14]. In Botswana, girls in-school (standard 5,6, and 7) and those out-of-school (aged 9-13 years) can access HPV vaccination and cervical cancer screening [13]. Parental consent may be required for persons under 16 to access HPV vaccines and cervical cancer screening or treatment, which are deemed by law as medical interventions in Zambia [12]. Similarly, in Botswana, parental consent is a requirement, but not the case for Kenya and Zambia [10]. In some ESA countries, there are clear age specification in laws regarding adolescents access to HPV and cervical cancer screening, that is; from 9-13 years (Botswana, Kenya, Malawi, South Africa), 16 years (Swaziland,

and Zimbabwe) [10, 15]. In the SADC region, the proportion of girls receiving recommended dose of HPV vaccine before age 15 is estimated at 72% in 2023, which is below target [21]. The implementation of HPV vaccination programmes across ESA countries has been suboptimal and challenges exist to integrate HPV vaccination in national immunization programmes [31, 32]. For instance, while some countries like South Africa and Rwanda continue to record high coverage rates (i.e. nearly 90% for the first dose) among in-school adolescent girls, many of the out-of-school adolescents are left behind [31]. The suboptimal coverage has also been attributed to disruptions emanating from the recent COVID-19 pandemic [31].

There are factors that potentially facilitate or hinder the operationalisation of legislations on age of consent for contraceptives, and their variation across different ESA countries. In Zambia for instance, the Government backing through policies to ensure access to family planning for young people to improve their health status has enabled both young and older adolescents ease of access to contraceptive services and commodities [12]. In Uganda and Kenya, adolescents aged below 18 years are considered children, which brings moral questions for age of consent to contraceptive services and therefore policies remain silent over the issue [28]. Besides South Africa, no ESA country appears to be regulating the age of access to contraceptives, and this is a significant concern considering the drive to stem the rise of new HIV infections among young people [29]. Despite regional and international commitments and treaties supporting SRHR, young women and girls continue to face significant discrimination accessing these services resulting to a high number of deaths and complications related to pregnancy, child birth, and unsafe abortions [16].

Age of consent for legal abortion and post-abortion care

The Maputo Protocol, also known as the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, is a women's human rights agreement that was adopted in 2003 [8]. It's considered one of the most progressive human rights instruments in the world. As of June 2023, 44 out of 55 African Union Member States have ratified the Maputo Protocol. However, in the ESA region, Botswana, Malawi, South Sudan and Somalia have not ratified due to concerns about specific provisions such as abortion rights and cultural or religious sensitivities.

Article 14(2)(c) explicitly calls for the provision of access to safe abortion for women and girls under certain conditions. It stipulates that states should legalize abortion in cases of rape; incest; threat to the physical or mental health of the mother and when the pregnancy threatens the woman's life. This provision is particularly relevant to adolescents, who may be particularly vulnerable to unintended pregnancies, sexual violence, and unsafe abortions

The protocol emphasizes the need for post-abortion care, which includes providing appropriate medical attention and psychological support to women and girls who undergo an abortion, whether safe or unsafe. Post-abortion care is critical for preventing complications, ensuring recovery, and supporting mental health, especially for adolescents who may face unique emotional and psychological challenges in such situations.

According to the SADC strategy for SRHR, while not specific on age of consent, it recommends ‘...the need for provision of safe abortion services as a human right for women and exploring ways in which the policy and legal environment can protect the health, lives, and rights of women and girls, while ensuring that policies facilitate the provision of comprehensive post-abortion care in all contexts’ [7]. However, most ESA countries criminalise abortion with few countries providing room for exceptions at the discretion of health professionals or require parental consent – see **Table 7** based on available data from sources included. Where abortion is permitted (e.g. Botswana), in countries like Tanzania and Malawi abortion may be permitted to preserve a woman's/mother's life [15, 18]. There is ambiguity and contradicting evidence over the age for consent and legal exceptions where abortion is permitted. Based on a recent report, parental consent is a requirement in Kenya, while in South Africa parental consent is not required by law or policy [10]. Furthermore, in countries where legal age is not prescribed in law, it assumes the age of sexual consent; for instance, 16 years in Malawi, Zambia, Zimbabwe, and 18 years in Botswana, Swaziland and Tanzania [15]. According to country-based legal reviews of circumstances where abortion is permitted, in Zimbabwe’s Termination of Pregnancy Act and with reference to the Children’s Act Section 76, an application to the Magistrate can be made to determine whether to grant the order for an abortion or not for persons under 18 years [14]. In Botswana, the law allows medical practitioners (i.e. doctors) to carry out an abortion within the first 16 weeks of pregnancy under the following circumstances: if the pregnancy arises from rape, defilement or incest; if the mother's life is at risk or may cause serious physical or mental

disabilities to the unborn child [13]. Similar provisions are made in Zambian laws, where the Penal code chapter 87 criminalizes abortion unless under medical directive covered in the termination of pregnancy act chapter 304 [12]. According to the 2023 SADC SRHR scorecard, except for South Africa where abortion is legal, 14 countries provide legal restrictions to provision of abortion, while in Madagascar the laws consider abortion as illegal [21].

Table 7: Minimum age of consent for legal abortion and post abortion care

Country	Legal abortion and post abortion care	Comments legal status and consent requirement
Botswana	NS (18)	Permitted
Eswatini	NS (18)	
Kenya	PC	Illegal by law
Malawi	NS (16)	Permitted. No clear directives on parental consent
South Africa	NPC	
Tanzania	NS (18)	Permissible to preserve woman's life
Uganda	NR	Permissible to preserve woman's life
Zambia	NS (16)	
Zimbabwe	NS (16)	Illegal by law but exceptions

ABBREVIATIONS: NPC: No parental consent required or according to the policy or law; PC: Parental consent needed in the absence of clear policy guideline; NR: No age or other restrictions; NS: Age not specified, unclear; TPA: Third party authority

A few country level guidelines such as Kenya's National Adolescent SRH Policy (2015) and Uganda's Adolescent Health Policy Guidelines and Service Standards (2012) advocate for high-quality post-abortion care services as part of the broader adolescents SRH services [28]. However, these policies/guidelines fail to document mechanisms of removal of existing financial and legal barriers or third-party authorization that may hinder provision of broader contraceptive services including abortion from happening [28].

With regards to gaps and policy directions, some countries have pledged commitments towards expanding safe abortion and post-abortion care as witnessed in country commitments to attain universal access to SRHR as envisioned in the International conference on population and development (ICPD) programme of action commissioned in 1994, and later reviewed in 2019 [11]. Eritrea an ESA member state commitment epitomizes this vision, as the only African country to have made full commitments to include access to safe abortion to the full extent of the law, and measures for preventing and avoiding unsafe abortion care into the national universal health care (UHC) policy [11]. Specifically, Eritrea committed to reduce preventable maternal deaths to zero through integrating access to safe abortion, to the full extent of the law, into UHC strategies,

policies and programmes, to protect and ensure all individuals' (including adolescents) right to bodily integrity, autonomy and reproductive rights [11]. Tracking and documenting progress towards achieving these commitments are important next steps.

Policy implications and recommendations

This review has unveiled the state of evidence regarding the minimum age of adolescent SRHR in the ESA region, with glaring variations across countries and gender differences in legislations, that have wider ramifications. Amid these, there have been notable achievements during the review period (post-2019) and as articulated in the sources reviewed. This section underscores some of the gains in championing ASRHR in the ESA region and continent at large, and points out some policy implementation gaps, priority areas, and recommendations emanating from this review. These are summarized in the section below.

Achievements witnessed

The 2020 ICPD summit in Nairobi showcased a renewed force and commitment to steering the SRHR agenda in the next decade, as witnessed in the country commitments for the period 2020-2030 [11]. There is alignment between the Nairobi Summit commitments from African governments and the strategic interventions as set in the Maputo Protocol Action Plan (MPoA). The commitments represent strong political buy-in for ending sexual and gender-based violence, sexually transmitted infections including HIV, ensuring access to contraception, preventing maternal and child mortality, ending early child and forced marriage, and female genital mutilation. In addition, there is significant commitment to providing youth-friendly programs including access to SRH. While there was commitment to increase domestic funding, this only made 13% of financial commitments from African countries [11].

A significant stride has been the implementation of the ESA ministerial commitment on the roll-out of the CSE, with a strong emphasis on integrating rights into the curriculum and offering the standard minimum package of ASRHR services [7]. Second, resource mobilisation and planning has been enhanced for boosting CSE projects and facilitating interventions by civil society organisations (CSOs) and governments [17]. Thirdly, galvanizing coordination and CSOs'

engagement mechanism has provided a platform for youth movements to directly engage and advocate their priorities with decision makers [17].

A direct effect of the legislation on minimum age for adolescents has been in different fronts. First, the provision for minimum age of consent to HIV testing and counselling without parental consent has ensured that all adolescents are aware of their HIV status, and enabled them to access treatment and care [10]. By revising the sexual consent law from 16 to 18 years, it has helped reduce the risk of criminalisation of young people engaging in consensual sexual activity, which is a factor that has limited their rights to accessing services and information on SRHR [16].

Policy gaps and recommendations

Collectively, the review identified cross-cutting issues that are on the way of implementing legal provisions on ASRH. These issues and recommendations are summarized below.

1. SRHR should be desexualized and treated as any other health system access [15].
2. Access and restriction decisions should be based on child and adolescent development, competence and recognition of adolescent's evolving capacity to make informed decisions about their own health [15]. Laws requiring parental consent before adolescents are provided sexual and reproductive health services may also prevent healthcare providers from fulfilling their oath of caring for everyone [10].
3. Age of consent should not be older than 16 years with no distinction between young men and young women [15].
4. Statutory rape provisions should be in place to protect adolescents from predatory adults [15].
5. 'Close in age' exceptions to age of sexual consent should apply where young adolescents have consensual sex with one another [15].
6. Setting minimum age of consent to marriage to 18 years, without exception and without differentiating between boys and girls, and ensure the minimum age of consent to marriage takes precedence over any cultural, traditional or religious customs and practices [16]. Zimbabwe's latest legislation on raising the age of sexual consent to 18 years mirrors efforts to ensuring protection of adolescents rights and ending early child marriages [38].
7. Access to Comprehensive Sexual Education (CSE) that is aligned to international guidelines and inclusive of young out-of-school population [16]. Accelerated efforts are urgently needed

to reduce early and unintended pregnancy, gender-based violence, and the impact of humanitarian emergencies like COVID-19. Few strategies for domestic resource mobilization have been reported, and the COVID-19 pandemic has highlighted sustainability gaps in youth programming due to budget reallocations [17, 30].

CONCLUSION

This review affirms the urgent need to harmonise the minimum age of consent for adolescents to respectfully make choices about their health and sexuality. Addressing this could help ensure the reversal of early marriages disproportionately affecting adolescent girls. The disconnect between legal and customary laws infringes on adolescent's autonomy in accessing SRH information and services. There has been notable progress in some areas of adolescent sexual and reproductive health and rights, for instance, in expanding comprehensive sexuality education, however, there have been variations in implementation and coverage of core SRH services for different adolescent groups. For ESA countries to realize the SDG goals as well as Africa's Agenda 2063, it calls for an accelerated multi-sectoral coordination to achieve the commitments specifically targeting adolescents and young people in this continent,

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