but the Sexual Offences Act continued to criminalise consensual underage sex. This hindered access as children who sought these services could be reported to the police. The fact that this Act also requires that a person with knowledge of a sexual offence against a child had to report it, compounded the challenge.

Age of consent

The Sexual Offences Act provides that the age of consent to sex is 16 years old, but it has been amended to provide that those between 12-15 years old may engage in consensual sex with peers in the same age category. The Sexual Offences Act also decriminalised underage consensual sex between 12-15-year-olds and 16-17-year-olds, if there is less than a two-year gap between them. This approach follows from the Constitutional Court's finding that sexual activity and exploration is part of normal adolescent development into adulthood.

Adolescents at various ages also have the right to services such as HIV testing, male circumcision, contraceptives and virginity testing without the involvement of their parents, provided that certain capacity and public policy requirements are satisfied. Sterilisation is the only sexual and reproductive health service that they may not consent to below the age of 18.

South Africa's liberal approach

Strode and Essack write that South Africa can be commended for expressly identifying an age of consent that applies equally to boys and girls and that does not discriminate based on sexual orientation. By absolving service providers such as doctors and nurses from reporting consensual sex among the younger children to authorities, it is hoped that the uptake of sexual and reproductive health services will improve.

International guidelines recommend that legislators ensure that adolescents can consent independently to medical treatment before the age of 18. South Africa addressed this issue by creating both an age and capacity requirement for consent to medical treatment. The assumption is that more complex forms of treatment may require greater maturity. South Africa also chose to deal with consent to accessing prescribed drugs, contraceptives, HIV testing and male circumcision separately from medical treatment.

Concerns remain.

Strode and Essack write that there remains some disjuncture between the approach in criminal and children's law pertaining to adolescents when there is more than a 2-year age gap between older and younger adolescents who engage in consensual sex because both parties can still be prosecuted.

'This has a disparate impact on girls, who are more likely to have older partners. Where such cases are reported, young girls may be required to testify against their older partners, which may result in social harm to them. Furthermore, the legislature retained the strict mandatory requirements, and as a result, if adolescents declare that they have older partners whilst seeking sexual and reproductive health services, this information may have to be reported to the police,' they write.

The legal framework only recognises sexual and reproductive health services rights for adolescents over the age of 12 years, except for termination of pregnancy, which can be accessed by girls of any age granted that they meet certain maturity requirements. This ensures that there is consistency between criminal and children's law. The Sexual Offences Act provides that adolescents below 12 years do not have the capacity to consent to sex. However, it also means that the Act is not in sync with the World Health Organisation's approach or with recent empirical research showing that children aged 10-11 have the capacity to consent to medical research. According to Strode and Essack, it can be argued that many research-related decisions would be similar to sexual and reproductive health services choices. They recommend that pragmatic guidance for service providers on how to assess children's capacity to consent, should be drafted.

According to Strode and Essack, the Children's Act does not define medical treatment leaving uncertainty if adolescents would have access to new forms of HIV prevention such as vaccines and microbicides, should they be proven effective and registered for that purpose in future.

Virginity testing?

There is also concern that the Children's Act has legitimised the contentious cultural practice of virginity testing. The Act allows girls who are over the age of 16 years to consent to be physically examined to establish whether they are virgins. The authors cite Prof. John Mubangizi from the University of KwaZulu-Natal who argued that making this customary practice lawful in certain circumstances, violates children's rights to privacy, bodily integrity and dignity.

While Essack and Strode encourage other countries to follow South Africa's nuanced approach around specifying that access to contraceptives, HIV testing and male circumcision fall outside the area of medical treatment; they caution legislators about consent regarding practices like virginity testing.

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Review Article

Enhancing **healthcare services** for sexual and gender minorities in Africa: MORE INCLUSIVE POLICIES NEEDED

Natasha Gillespie and *Dr Finn Reygan* reflect on the reduced health and wellbeing that sexual and gender minorities continue to experience and the need for more inclusive policies

The idea that homosexuality is unAfrican is widespread in Africa. Resistance to decriminalisation of same-sex sex acts in many African countries is often underpinned by a reluctance to yield to Western pressure calling for the acceptance of sexual and gender minorities. Yet an increasing body of research by African scholars suggests that homophobic attitudes are largely driven by colonial era legislation and religious morality that continues to marginalise people who are seen as different.

Emerging research on pre-colonial attitudes towards sexual orientation and gender identity (SOGI) shows a greater openness to social inclusion. Thus, African advocacy that strategically positions lesbian, gay, bisexual, trans and intersex people as historical and contemporary members of the societies in which they live, holds the potential to create more enabling and inclusive environments for the provision of healthcare services to sexual and gender minorities that are currently severely limited across the continent.

Enabling environments

The baseline results of an HSRC study, *Situational analysis and critical review of sexual and reproductive health and HIV services for men who have sex with men in eastern and southern Africa*, indicate that simply increasing healthcare services is not enough to improve the health and wellbeing of sexual and gender minorities. The study, led by Prof. Heidi van Rooyen, Dr Zaynab Essack, and Dr Finn Reygan, indicates an enabling environment that promotes positive attitudes toward sexual and gender minorities is key to improving the uptake of healthcare services.

Currently, multiple barriers hinder sexual and gender minorities from accessing healthcare. These include negative attitudes of healthcare providers, the lack of SOGI training for healthcare providers and limited access to tailored sexual and gender minority healthcare information. There are also safety concerns related to disclosing SOGI, ongoing stigmatisation or criminalisation of same-sex sex acts and gender nonconformity, as well as sexual and gender minority human rights violations, including widespread abuses by states and police forces. Other barriers include cultural and religious arguments against sexual and gender diversity, the perpetuation of discourses of hate

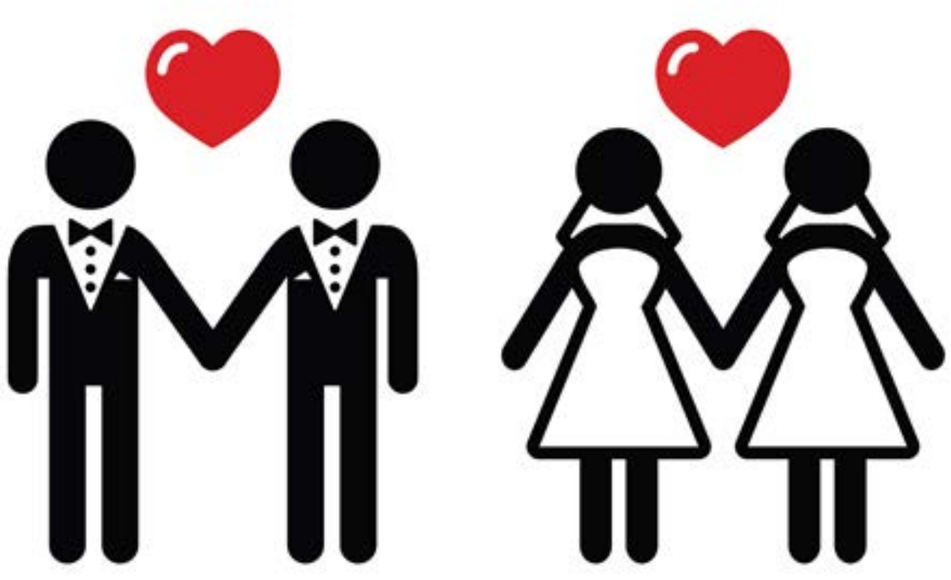
by governmental and community leaders in particular, and the scapegoating of sexual and gender minorities for political gain across the region, especially in the run up to elections.

Countering barriers

Increasing the number of sensitised healthcare providers who are competent to provide healthcare for sexual and gender minorities should be a priority. Despite the efforts of queer civil society organisations to introduce modules and awareness training, higher education institutions generally do not provide pre-service SOGI education for students in healthcare and allied professions. For sexual and gender minority advocacy, a consortium approach to the challenges faced by sexual and gender minorities is increasingly perceived as the most effective method although funding challenges and different approaches can function as barriers to collective mobilisation. For instance, in contexts where sexual and gender minorities are criminalised, stakeholders often opt for a public health approach to advocate for sexual health services. However, many stakeholders perceive a human rights approach as superior because the public health approach serves to further pathologise this already marginalised population.

Potential value for policymakers

The baseline results across the seven study countries (South Africa, Kenya, Malawi, Namibia, Tanzania, Uganda and Zambia) suggest that new approaches are needed to bring about improvements in the life experiences of sexual and gender minorities. A holistic view of sexual and gender minorities should be promoted when designing interventions or engaging with governments, religious leaders, and communities, among others. It is hoped that these new approaches will lead to change in relation to the decriminalisation of homosexuality; the development of inclusive policies across the region;



Currently, multiple barriers hinder sexual and gender minorities from accessing healthcare.

and the roll-out of interventions to promote the health and wellbeing of sexual and gender minorities. In the absence of such work, sexual and gender minorities will continue to experience reduced health and wellbeing across Africa.

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