

# Over-protected and under-served

A multi-country study on legal barriers to young people's access to sexual and reproductive health services

Senegal case study

# Who we are

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

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

# Contents

<b>1 Introduction</b>	<b>3</b>
<hr/>	
1.1 Rationale for the research	
1.2 Methodology	
1.3 The relationship between law and access	
<b>2 Young sexualities</b>	<b>6</b>
<hr/>	
2.1 Cultural context: 'youth', gender and sexuality	
2.2 The law: youth, gender and sexuality	
2.3 Intersection of law and culture	
<b>3 Access to services</b>	<b>10</b>
<hr/>	
3.1 Access to contraception, STI testing and other basic services	
3.2 Access to confidentiality	
3.3 Access to information and education	
3.4 Early pregnancy and access to services	
3.5 Access to abortion	
<b>4 Law, heteronormativity and discrimination</b>	<b>20</b>
<hr/>	
4.1 Law and perceptions of law	
4.2 Homophobic violence and access to SRH services	
<b>5 Sexual violence and law</b>	<b>21</b>
<hr/>	
5.1 Law and perceptions of law	
5.2 Law, sexual violence and access to services	
<b>6 Conclusions and recommendations for legal reform</b>	<b>22</b>
<hr/>	
6.1 Overarching conclusions	
6.2 Implications for law and policy	
<b>Endnotes</b>	<b>26</b>
<hr/>	

### **Acknowledgements**

This report was written by Elizabeth Yarrow, Coram Children's Legal Centre. The research was designed and carried out by the authors and by Kirsten Anderson, Kara Apland, Jorun Arndt, Hazel Kent, Jennifer Roest and Elizabeth Yarrow, and supported by the Association Sénégalaise pour le Bien-Etre Familial (ASBEF). Research assistance and assistance in data transcription was provided by Sara Beech and Julie Latrielle. Interpretation into Wolof was provided by Cheikh Fall. The authors are very grateful for all of the young people and service providers, who generously gave up their time to participate in the study, and to all of the professionals who assisted us in making contact with youth groups.

The author would also like to thank Doortje Braeken, Chelsea Ricker and Katherine Watson at IPPF for their support for the project, and for all of their helpful assistance and guidance throughout the course of the study.

# 1 Introduction

In 2012 the International Planned Parenthood Federation (IPPF) commissioned a pilot multi-country research project exploring legal barriers to young people's access to sexual and reproductive health (SRH) services.

The study was designed and implemented by the Coram Children's Legal Centre. It comprised two stages: a global mapping of laws related to young people's access to SRH services from around the world; and qualitative field research which took place in three jurisdictions, El Salvador, Senegal and the UK.

The case study countries were selected to represent different legal systems, and contrasting social, cultural, religious and political traditions. The case studies examined the operation of legal barriers to SRH services from the perspectives of young people and service providers; seeking to understand how both law, and knowledge and perceptions of law, intersect with other factors in different contexts to influence young people's experiences accessing a range of services.

This report contains an analysis of the research carried out in Senegal. Analyses of the research carried out in El Salvador and in the UK are available as separate publications.

## 1.1 Rationale for the research

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

In recent years there has been a growing interest among SRH advocates and activists in exploring the interplay between legal frameworks and access to SRH services.<sup>1</sup> This exploratory research project contributes to efforts to build evidence and knowledge in this area, to guide future advocacy and programming work, with the ultimate aim of fulfilling young people's right to sexual and reproductive health.

## 1.2 Methodology

The overall aim of the research was to assess the extent to which the law, as well as young people's and service providers' knowledge and perceptions of law, impact upon young people's access to sexual and reproductive health services.

The methodology and tools were designed to answer the following questions:

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

### 1.2.1 Country selection

Countries were selected to generate evidence relevant to a broad range of IPPF member associations, and to include a range of different socio-legal contexts. Senegal was selected as a case study for several reasons. Firstly, Senegal provided an example of a context where the law contains a mixture of restrictive and 'facilitative' laws regulating young people's access to SRH services (the meaning of these terms will be explored in the sections below). Furthermore, Senegal is a country in the sub-Saharan Africa region (a region not represented by any other country case study) with a majority Muslim population; and a context where cultural practices such as traditional forms of medicine have a strong role and influence in society.<sup>2</sup>

### 1.2.2 Sampling

Researchers accessed a range of different groups during the field research with a focus on reaching out to young people and service providers from both urban and rural communities, and from diverse economic and geographical contexts.

The research took place in urban, semi-urban and rural locations in **Dakar**, **Fatick** and **Kaolack** regions in Senegal. 12 focus group

discussions and 15 individual interviews were carried out with young people between the ages of 13–24 years; and 12 interviews were carried out with service providers. A total of 135 young people participated in the research.

Selection of communities and research participants was conducted by the Association Sénégalaise pour le Bien-Etre Familial (ASBEF), a member association of IPPF.

### 1.2.3 Research methods

#### Individual interviews

Given the sensitive nature of the research, and the fact that it involved speaking to young people about their behaviour, choices, perceptions and experiences related to accessing sexual health services, it was important to conduct a number of individual interviews in private settings to allow for the fullest possible responses to the research questions. Interviews were qualitative and semi-structured in nature. Data collection tools were developed to facilitate a level of standardisation in the data collected. The tools were used as guides to allow the interview to be steered by the respondent within the broader frame of the research questions.

Interviews included a mix of life history questions and questions that focused on perceptions of law and access to SRH services, in order to explore how participants' social environments and lived experiences have shaped both their understandings of law, and experiences relating to accessing services. This facilitated understanding of whether the legal environment affects young people's seeking of, and access to, SRH services differently depending on other social and environmental factors, and to determine how other factors, that influence access and service seeking behaviour, interact with the legal environment. Following a 'life history' structure through interviews, also allowed researchers to access information about how (and why) perceptions of law and access to SRH services might change over time.

#### Focus groups

Focus group discussions (FGDs) were conducted with both service providers and young people. FGDs consisted of groups of 8–12 individuals. Groups were separated according to gender, due to the sensitive nature of the issues under discussion. Data collection tools for focus group discussions were designed to encourage respondents to discuss issues in a general, hypothetical, or scenario-based format, so that they did not feel the need to reveal information about personal experiences.

FGDs provided a useful opportunity to investigate the contexts and situations that might impact on young people's access to SRH services. Respondents were presented with a series of 'scenarios' and asked to discuss/debate how they viewed the situation, as well as their perceptions of how the law applied to the situation.

Exploring these issues through an FGD enabled participants to respond to each other's ideas and opinions, stimulating discussion and debate. FGDs are generally more interesting for participants than individual interviews, and provided for a fun and relaxed environment for exploring the research questions. It was necessary for researchers to consider the implications of social pressure and other group dynamics when analysing group responses.

### 1.2.4 Ethical guidelines

Due to the sensitivity of the research topic, which dealt with core issues of identity and violence, and the young age of participants, special care was taken to ensure that the research did not cause harm to the participants and that ethical guidelines were set out and strictly followed. All researchers involved in the project were experienced in carrying out research with children and young people, including with particularly vulnerable children.

## 1.3 The relationship between law and access

This study explores the impact of law on young people's access to sexual and reproductive health services in practice. The findings indicate that the law in Senegal creates both **direct** and **indirect** barriers to access. There are also examples of laws that are intended to **facilitate** access to services.

**Direct legal barriers** are laws which explicitly and purposefully restrict delivery of, and access to, certain types of services, either universally, or for certain groups of people in certain circumstances. For example, in Senegal, provision of and access to abortion services constitutes a criminal offence, except in the circumstance that it is performed as a last resort to save the life of the mother.<sup>3</sup>

**Indirect legal barriers** are laws that do not directly impose restrictions on access to SRH services, but nonetheless may function in this way in a particular context. For example, legal rules which establish minimum ages for consent to sexual activity, marriage, and legal majority may create indirect legal barriers to young people's access to services. Young people and service providers may interpret these rules as forbidding persons under these legal ages from accessing SRH services. Furthermore, these laws may have a normalising influence on existing social taboos associated with childhood and youth sexuality, particularly among unmarried girls.

Limited legal definitions of sexual violence and rape, which fail to recognize sexual abuse in all the contexts within which it occurs, such as the failure to explicitly prohibit rape within marriage,<sup>4</sup> may also create indirect legal barriers to access to services. Individuals may be unable to access support services, in contexts where their

experiences are not recognized, or are seen as lacking validity or importance.

The criminalization of homosexuality and lack of recognition of transgender identity within Senegalese law can be understood as creating both **direct** and **indirect** barriers to young people's access to sexual and reproductive health services. On the one hand, these legal restrictions may actively prohibit the provision of certain services (including access to education and information, hormonal therapies, and others) required by young people for them to be able to have a healthy and satisfying sexual life (direct barrier). On the other hand, even where services do exist or are made available, some young people may be unable to access them due to fear of being criminalized or suffering discrimination and abuse on account of their sexual or gender identity (indirect barrier).

Laws do not only function as barriers to accessing SRH services. Laws can also **facilitate** access, where they empower young people to make informed decisions about their own sexual health, and create a framework where young people's rights to sexual and reproductive health are protected and promoted without discrimination. Confidentiality duties imposed on services providers, laws that prohibit exclusion of pregnant girls from school, and laws that actively protect the rights of children to access contraceptives at any age are examples of 'facilitative' laws in Senegal. In the sections below, facilitative laws in Senegal are examined in relation to the social and cultural realities within which they operate, in order to understand how they interact with other factors to impact on young people's access to services in practice.

## 2 Young sexualities

### 2.1 Cultural context: 'youth', gender and sexuality

Recent anthropological research carried out in Senegal has argued that: "[chronological] age is less important in defining adulthood and childhood than marital status. A 15 year old who is married can be considered more adult than a 30 year old who is single".<sup>5</sup> This perspective was supported by our field study. Local research counterparts interpreted our request to speak with 'young people' as referring to unmarried individuals, even if they did not fall within our specified age range of 13–24 years.<sup>6</sup> Furthermore, in focus groups and interviews, participants consistently linked being *young*, to being *unmarried*: "People...think that young people are not supposed to be having sex. [Because] In Senegal you are not supposed to have sex until you are married".<sup>7</sup>

Young, unmarried individuals in Senegal must navigate ambivalent sexual identities.<sup>8</sup> Their status is defined both by the fact that they are no longer (pre-pubescent) children, and by the fact that they are not yet fully adult. On the one hand, young people are (recognized as) developing into physically mature sexual beings;<sup>9</sup> on the other hand, their position as 'youths' implies that they are not meant to be sexually active.

The prohibition on pre-marital sex ostensibly applies to *all* young people. As research respondents typically explained: "It is an Islamic thing. According to religion you are not supposed to have sex before marriage".<sup>10</sup> It is girls' sexuality, however, that is subject to the most judgement, scrutiny and social control: "Young girls cannot have sex before marriage; it's just a cultural belief. Parents are always controlling their daughters but not their sons. Girls are supposed to be virgins the day they are married. That is simply something good and nice".<sup>11</sup> Girls who are able to 'prove' their virgin status upon marriage are said to bring honour to their families. During traditional wedding ceremonies this is associated with the payment of money and gifts by the groom (and the groom's family) to the bride, her relatives and her friends.<sup>12</sup> In this sense, according to respondents, a girl's virginity is of material interest to her and those connected to her: "If I were the one having [pre-marital] sex I could die. A woman is precious. Her price is so expensive. I would advise my friends to leave any boyfriend who is trying to pressure her for sex".<sup>13</sup>

In the same way that the (normative) requisite of virginity to enter marriage applies more strictly to girls compared to boys, so does the role of marriage in defining adulthood.<sup>14</sup> Recent research on young sexualities in Senegal has argued that these differences are reflected in language itself.<sup>15</sup> In *Wolof* (the dominant language spoken by participants) both gender and marital status are defining aspects of 'adulthood' and 'youth'. The word *njegemaar* describes a pre-pubescent girl. A different term, *janq*, is used to refer to a girl or young woman who is understood to be physically

mature enough to bear a child, but who remains unmarried. A third term, *jeek*, is used to refer to a married woman. The words *janq* and *jeek* also communicate information about a girl's (presumed) virgin status: *janq* are virgins; *jeek* are not. In language, therefore, the image of an adolescent girl, is a young woman who is both sexually mature (in a physical sense), and at the same time, abstinent.<sup>16</sup>

The situation for males is not symmetric. There are only two terms: *wazambaane* (boy) and *mag* (man). *Mag*, does not necessarily communicate specific information about marital status or virginity, rather, it is understood to imply that a male "is able to take care of himself in the broadest possible sense".<sup>17</sup> The social signifiers of adulthood are therefore different for males and females: while girls are understood to be adults once married; boys may establish adulthood through a variety of different means: including entering marriage, completing education, acquiring a job, and establishing success, wealth and status in their communities.<sup>18</sup>

The presentation of this analysis is crucial to this research, as it demonstrates the ways in which sexuality in Senegal is both gendered and 'aged'.<sup>19</sup> Understanding what it means to be an 'adult' and how this affects young sexualities is particularly important in light of recent trends which suggest that the average age of marriage in Senegal is rising for both boys and girls;<sup>20</sup> meanwhile, young people are tending to stay longer within education, and taking increasing time to find work, housing and accumulate wealth and resources required for independent, adult life.<sup>21</sup> This means that while 'traditional' society was characterised by a swift progression from childhood to adulthood,<sup>22</sup> in contemporary societies the period between the onset of physical maturity and the realisation of social adulthood is extending.<sup>23</sup> In other words the category of 'youth' is an increasingly emergent and significant one in the context of urbanisation and development in Senegal.<sup>24</sup>

This means that being attentive to the needs of youth should be an increasing concern for those working to promote and protect sexual and reproductive health in Senegal. As the period of 'youth' extends, so does the period during which people must navigate contradictory and conflicting sexual identities. During this time, many young people are liable to experience a disconnect between their beliefs and their realities: "according to religion you have sex when you get married, but actually it depends on whether you love your boyfriend";<sup>25</sup> in ways that can be understood to have a significant impact on young people's access to sexual and reproductive health services.

Sexuality in Senegal is both 'gendered' and 'aged'. Young people, especially young girls, are normatively prohibited from having sex until they are 'adult'; which also means they must be married (for girls).

### 2.1.1 Young and married

Despite this analysis, it is important to recognize that there are of course many people in Senegal who are both of a young age, and who are also married.<sup>26</sup> Socially, these individuals are likely to be considered more adult than their unmarried peers of the same age, and are therefore unlikely to experience difficulties accessing sexual and reproductive health services on particular account of their ‘youth’ status. Young married women and girls, however, may face difficulties accessing services for other reasons, related to their marital status. Young brides are often under pressure to ‘prove’ their fertility by getting pregnant at the earliest opportunity.<sup>27</sup> Furthermore, it may be difficult for young women to access contraceptives services without the knowledge and approval of their husbands. These issues are explored in more detail in **Section 4** below.

## 2.2 The law: youth, gender and sexuality

Significantly, the gendered and ‘aged’ construction of sexuality in Senegal is not just a matter of culture; *it is also a matter of law*.

### 2.2.1 Legal age of consent

Article 320 of the Senegalese Penal Code defines the crime of ‘paedophilia’ as any gesture, touch, caress, pornographic handling or use of images or sounds, for the sexual abuse of a child under 16 years, and establishes a penalty of 5 to 10 years imprisonment for a breach of this provision.<sup>29</sup> This (somewhat vague) provision does not explicitly refer to sexual intercourse, although it can be reasonably understood as falling within the scope of this definition. As such, this article has been widely understood as establishing the legal age of consent to sexual activity at 16 years.<sup>30</sup> The law effectively criminalizes all sexual activity, involving a child under the age of 16 years including kissing and touching, whether factually consensual or not. While this provision may ostensibly be intended to prevent adults from engaging in sexually abusive and exploitative relationships with children, it (at least formally) applies to a much broader purview of relationships. The law also criminalizes young people under the age of 16 years, who have physically romantic or sexual relationships with their peers. This law is not only significant in the sense of how it is applied; it is also significant in terms of the ethico-legal norms that it communicates, and how these are perceived and interpreted by young people, SRH practitioners and broader society.

### “The law is fighting for young people not to have sex”.<sup>28</sup>

Article 320 of the Senegalese Penal Code criminalizes all sexual activity involving a child under the age of 16 years including kissing or touching, regardless of the context of the relationship, or factual consent.

Our field study indicates that the legal age of consent does not reflect the realities of young people’s sexual relationships. The vast majority of participants reported that many young people start having sex below the age of 16 years, with most participants estimating the average age of first sex at somewhere between 13–15 years. Some participants, including service providers, felt that it is not unusual for children as young as 10, 11 or 12 years old to be having sex. One group of boys boasted: “as soon as your mother stops breastfeeding you, you can start having sex”.<sup>31</sup>

Few participants correctly identified the legal age of sexual consent as 16 years (for both boys and girls). Interestingly, most participants believed that the age of sexual consent is 18 years; the age at which a person is *legally* considered to be an adult (the legal age of ‘simple majority’).<sup>32</sup> Participants, especially young boys, consistently explained to researchers that: “the law says if you have sex with a girl who is under the age of 18 years, you will go to jail for 10 years”;<sup>33</sup> “if the girl is under 18 years it looks like a rape. Then you have to go to prison for 10 years. This is only true for the boys – it is our responsibility”.<sup>34</sup> As reflected by this quote, these views were usually presented as if the hypothetical ‘victim’ of the ‘crime’ were female, and the ‘perpetrator’ male, reflecting dominant constructions of male and female sexuality: while boys and men are perceived as powerful sexual agents, girls are women are typically represented as passive and naive victims of an overzealous masculine sexuality.<sup>35</sup>

An alternative view among participants was to presume the legal age of consent to be the same as the legal age for marriage (which is 18 for boys, and 16 for girls, although participants were not often clear about these ages).<sup>36</sup> This was a view that was more likely to be expressed by girls. Some respondents thought this to be explicitly written into law; whereas others attributed this to a sort of customary or informal blending of law and social and religious norms: “In Senegal there is no such thing as the age of consent exactly, but in Senegal you are not supposed to have sex until you are married”; “according to religious law you don’t have sex until you’re married”; “you take a little bit of Islam and mix it with the law. That is why it is like that”.<sup>37</sup>

It is interesting that participants on the one hand believed the law on sexual consent to be more restrictive than it actually is, and on the other hand, did not feel that this (supposed) law reflects the realities of young people's sexual relationships. The (mis-)perceptions of the law support the analysis that being sexually active is presumed the preserve of persons who are socially and legally adult and married, and conversely that being legally permitted to have sex is understood at least partially as demarcating the distinction between children and adults, as well as the distinction between unmarried and married individuals.

### 2.2.2 Law and sex discrimination

Significantly, the law in Senegal treats boys and girls differently, reflecting gendered norms governing sexuality and pre-marital abstinence. While the age of consent for both boys and girls is 16 years, the age of legal marriage is 16 for girls and 18 years for boys. As such, the legal age at which a girl can consent to sexual activity is precisely the same as the legal age at which she can get married, while boys may legally have sex for two years before they are eligible for marriage. Interestingly, participants' perceptions of marriage law tended to presume an even wider gender-gap: most people identified the minimum age for legal marriage as 16 years for girls, but believed the minimum age for legal marriage for boys to be around 20 or 21 years.

The ideal that "girls get married younger than boys",<sup>38</sup> reflects inequalities between men and women, and reinforces the hierarchical structure of the relationships between them, as men are expected to be dominant in the marriage: "The mentality here is that girls have to get married early; it can even happen at the age of 9 years! Once you get married you will be under the control of your husband. Everything is so hard for women in Senegal".<sup>39</sup> The practice of marrying girls younger than boys has also been linked to the institution of polygamy (widely practiced in Senegal), as it creates the perception that "the number of potential brides is always larger than the number of grooms".<sup>40</sup> The ideal (that a wife should be younger than her husband) is justified through claims about gender and sexuality, which presume that girls have a different rate of (sexual) development from boys, and are naturally suited to different social roles: "girls grow up faster than boys. Anyway, most of the girls want boys to help them with money. So the boys need to be older. So they have money".<sup>41</sup> It is significant that these norms and identities are so salient that they have been formalised and entrenched through legal rules; rules which in turn legitimise and reinforce the notion that girls are 'marriageable' earlier than boys.<sup>42</sup>

This analysis is revealing; especially because laws that govern the minimum ages for consent to sexual activity and minimum ages for marriage are commonly presumed to have a protective purpose; derived from an attempt to balance the (presumed) 'protection'/ 'autonomy' tension at the heart of all negotiations

concerning children and young people's rights. This explanation, however, cannot justify a minimum age for marriage which is lower for girls than boys, since the (potential) harm of early marriage disproportionately affects women and girls.<sup>43</sup>

The gendered asymmetry both in the law itself, as well as perceptions of the law, are reflection of (discriminatory) ideas about gender, and norms relating to (pre-marital) sexuality. These laws, therefore, must be understood (at least partially) in terms of the role that they play in institutionalising inequalities between men and women, and criminalizing sexual activity among children and young people, especially that expressed by unmarried girls.

## 2.3 Intersection of law and culture

The law is both a reflection of culture, and a regulatory force which normalises ideas about forms of acceptable and unacceptable (sexual) behaviour. The normative influence of law, and its role in shaping ideas about SRH and access to services, was evident in the ways that respondents conflated restrictive and judgemental narratives concerning young people's sexuality with legal definitions and rules: "Young people start having sex at 15 years. But that is wrong. The legal age [of sexual consent] is 18 years. If a girl is less than 18 years and she starts having sex that can push her into prostitution".<sup>44</sup> Here the participant, a SRH service provider, clearly associates her ideas about sexual decency with her perception of what is (il)legal; and implies that it is through breaking the law that a girl places herself at risk of descending into (what is widely considered to be) one of the most catastrophic forms of sexual degradation: 'prostitution'. As other participants explained: "a girl is not supposed to be a prostitute";<sup>45</sup> "in Senegal, 'prostitute' is such a rude word".<sup>46</sup>

While, on the one hand, laws prohibiting early sex and marriage have the potential to protect children from exposure to rights violations (such as rape, forced marriage and a range of risks to their physical and mental health, including complications during pregnancy and heightened risk of HIV and other STI infection); on the other hand, they may function to deny children and young people basic human rights, including their rights to privacy and family life, and to sexual and reproductive health, as well as inhibiting their access to vital services. These issues are explored further in **Section 3** below.

Law both reflects culture, and reinforces ideas about what is 'acceptable' and 'unacceptable' (sexual) behaviour. The normative influence of law in Senegal is evident in the ways that participants associated judgemental attitudes about sex, with legal definitions and rules. For example, one girl commented that having sex under the age of "18 years" could "push" a girl into "prostitution". Laws prohibiting early sex and marriage have the potential to protect children from rights violations such as rape, forced marriage, and risks to their physical and mental health. On the other hand these laws may also function to deny children and young people basic human rights, including access to SRH services.

## 3 Access to services

This section explores participants' perceptions and (reported) experiences related to young people's access to a range of sexual and reproductive health (SRH) services, including information and education, contraception, sexual health testing and treatment, abortion and pre- and post-natal pregnancy care. It demonstrates how law in Senegal creates both direct and indirect barriers to access to SRH services for young people. It also explores the ways in which law can sometimes be understood as an enabling or facilitating factor, aimed promoting and protecting children and young people's rights to access services; although improved access may not always be realized in practice do to the intersection of other (cultural, social, economic) barriers.

### 3.1 Access to contraception, STI testing and other basic services

#### 3.1.1 Legal principles: access to services

There are no legal restrictions on young people's access to contraceptives and other basic services such as pregnancy and STI testing in Senegal, except for article 12 of the HIV/AIDS law which provides that a child must have reached the age of 15 years in order to independently consent to HIV testing.<sup>49</sup>

The law provides young people with a very general positive right to reproductive health, and access to a variety of services.<sup>50</sup> The 2005 Law in Relation to Reproductive Health, recognizes reproductive health as a "fundamental and universal right guaranteed to all individuals without discrimination based on age, sex, wealth, religion, race, ethnicity, matrimonial situation or any other situation".<sup>51</sup> Article 1 defines sexual health broadly as the general physical, psychological and social well-being of the person, for everything that concerns the reproductive system, its functions and its functioning, and that everyone has the right to access methods of family planning (*that are not against the law*).<sup>52</sup> The law covers access to a range of services, including: contraceptive services, treatment for STIs, the right to information and education; contraceptive HIV and AIDS treatment and care; and pre- and post-natal care. Significantly the law specifically protects the reproductive health of adolescents,<sup>53</sup> and article 10 provides that everyone is entitled to receive every treatment for reproductive health without discrimination on the basis of age.<sup>54</sup>

It has been argued, however, that the failure to positively establish a specific minimum age at which a child or young person *may* consent to SRH services (other than HIV treatment which, as mentioned, requires a young person to have reached 15 years) may be tantamount to a lack of recognition in law of young people's ability to consent to treatment, contraceptives or other services.<sup>55</sup>

"I don't need sexual health services because I'm not married yet".<sup>47</sup> (Young mother)

"We are not going to the [SRH] clinic because we are ashamed, we are scared. We don't know exactly if we can go there because we are under 18 years old".<sup>48</sup>

On the one hand establishing a minimum age for access to SRH services prohibits children under a certain age from accessing services, on the other hand it safeguards the right of young people over this age to access services (even if they are under the legal age of majority, consent or marriage).

#### 3.1.2 Accessing services in practice

Despite generally permissive legal provisions, the field research indicates that very few young people are accessing formal SRH services in practice. Some boys reported buying condoms in local shops,<sup>56</sup> a smaller number of boys had accessed an HIV test, and a few girls had accessed a service due to problems relating to menstruation. One girl reported that she had attempted to access the contraceptive pill, but was denied on account of her age. The vast majority of participants, however, claimed not to have accessed *any* SRH service, either to obtain contraceptives, or STI testing, or for any other reason related to sexual and reproductive health. This is despite the fact that many young people did report being sexually active; articulated knowledge of available services; and expressed the view that practicing 'safe' sex is important.

#### Young people's perceptions of age related restrictions on access to services

The fact that the *only* girl (interviewed during the study) who reported attempting to access a modern form of contraceptive was denied because of her age is telling. Many young people explained that one of the reasons they are unwilling to visit clinics in order to access services is that they are uncertain whether they are 'allowed' to before the age of 18 years; this was found to be particularly the case in relation to contraceptive services.

Young participants explained that staff at hospitals, clinics and even pharmacies are liable to ask young people for age verification "to see if they are 18 years old"<sup>57</sup> before providing contraceptives: "most of the pharmacy's ask you for ID when you get contraception to see if you are 18";<sup>58</sup> "sometimes if you are under 18 years and you go buy condoms they are not going to sell them to you";<sup>59</sup> "if a person is under 18 years they can go to the clinic to get advice, but they are not allowed contraceptives".<sup>60</sup>

Some participants attributed this to a formal legal rule:

**When young people start having sex are they able to access contraception?**

Eventually...yes.

**Is there a law about that?**

The law is not ok with that.

**At what age does the law say a young person can access contraception?**

At 18 years.

Most participants, however, expressed confusion about what the law actually says: “if a young girl tries to get contraception, people will say ‘how old are you, why are you asking for this?’ Sometimes we want to ask about the law, but people don’t give us any straight reasons”.<sup>61</sup> Participants usually settled the question of law, either by responding that they have no knowledge of formal legal rules, or by declaring that the law says nothing about the subject of young people’s access to contraceptives. Other participants explained that there is no legal barrier to accessing services, but that social norms and attitudes, that censure being sexually active at a young age, prevent adolescents accessing services in practice: “there is no problem with the law to access contraceptives, but there is something about the Senegalese mentality. People will ask – how do you need it. Why? – People are not going to respect you”.<sup>62</sup>

As discussed in **Section 2** above, legal and social barriers may be very much interrelated. Respondents’ consistent references to the specific age of ‘18 years’ as the (age) threshold for determining access to services, indicates that’s young people’s ideas about when it is appropriate for them to access services are influenced by standardised legal rules that define childhood/ adulthood and distribute rights and obligations accordingly. As mentioned, 18 years is commonly considered to be the age of ‘simple majority’ in Senegal: the age at which a person is considered legally adult;<sup>63</sup> 18 years is also recommended within international instruments and by rights advocates as the age below which a person should be considered *in law* to be a child.<sup>64</sup> Interestingly, as discussed in **Section 2** above, 18 years is also the age at which (most) participants believed a young person is permitted in law to be sexually active. It appears, therefore, that the legal age of majority is being interpreted in a context where an individual’s status as ‘a child’ normatively prohibits them from being sexually active, creating barriers to young people’s access to sexual and reproductive health services.

Young people explained that one of the reasons they are unwilling to visit clinics in order to access contraception is that they are uncertain whether they are ‘allowed’ contraception before the age of 18 years, although they were often unclear about whether this is due to a formal legal rule.

### Young people’s perceptions of restrictions on access to services related to marital status

Some participants, especially girls, felt that marital status<sup>65</sup> is more important than age in determining eligibility for access to services: “There is no [minimum] age. Only if you are married and have kids – that’s the only time you are allowed the [contraceptive] pill. You have to go see your doctor first”.<sup>66</sup> Another group of girls explained: “If you are not married you don’t need to get tested. Islam doesn’t allow you to do that”.<sup>67</sup> The majority of participants did not necessarily attribute this to State (government) law, but to religious ‘law’ and Islam: “It depends what type of law you are talking about. We are just following religious law. According to Islam if you are not married, you are not allowed to get pregnant. You don’t need to go to the clinic”.<sup>68</sup>

While some participants emphasised that being unmarried can create a significant barrier to accessing SRH services, particularly for girls, others explained that being married itself can be a barrier. Previous research in Senegal has demonstrated that: “According to dominant norms, adolescents do not need contraception, since they are either not married and therefore presumably not in need of protection as they are not supposed to be sexually active, or they are newlyweds who need to respond to the desire to have an offspring”.<sup>69</sup> Although participants did not believe it is illegal for married girls and women to independently access services without the consent of their husbands, they explained that it could often become difficult in practice: “It is easier for boys to access [SRH] services. If you are a woman and married you will be hiding your contraception. If you have an appointment you will never take an [appointment] card. If your husband reads the card, you might be in trouble”.<sup>70</sup> Furthermore, respondents reported there can be shame associated with accessing SRH services as a married woman: “Some of the girls are married, so they don’t want male doctors to see their body parts”.<sup>71</sup>

### Perceptions of service providers

In general, service providers demonstrated a greater understanding of the law relating to sexual and reproductive health than young people: “the law is opening the door for young people to access services, except for abortion”;<sup>72</sup> “the law says we can do anything for young people – except for abortion”.<sup>73</sup> While service providers were clear that they would not deny young people services on account of their *marital status* (“in the past we used to ask the husband before giving a married woman contraception. Now we don’t do that anymore;”)<sup>74</sup>, interviews with services providers appeared to confirm young people’s concerns that they may be

refused services on account of their age. While service providers generally expressed knowledge that young people are entitled under law to access services at any age, they also reported that they would try to informally discourage or limit young people's access, by placing pressure on them to justify or reconsider why they needed services, especially in the case that young people ask for contraception: "A young girl of about 15 years came to me and said she wanted contraception. I asked her why. She laughed. I said you have to tell me why you need it or I won't give it to you. Then she was just silent. She left and she didn't come back".<sup>75</sup>

Service providers reported that they would explain to young people that they are 'still young' and therefore shouldn't be in need of services: "If any young person comes here [to the SRH clinic], I will give advice. I will say 'it's too early for you. Why do you want this? It's so early for you.' But if they insist, then I will give it to them".<sup>76</sup> Another service provider appeared to contradict herself: "*whether we provide [young people] contraception depends on their story.* If they are so young, definitely you are going to talk to them. But *you will give them contraception*".<sup>77</sup> [emphasis added] reflecting a general ambivalence at service providers (and amongst young people) as to whether young people are entitled to, and/or in need of, SRH services.

### Perceptions that young people "don't need" SRH services

For young people, being told that they "don't" or "shouldn't" need services at the time of attempting to access them, reinforces the contradictions they experience trying to reconcile restrictive norms with their own realities; as one group of girls pointed out: "Sometimes if you are under 18 years old, and you go to buy condoms, they are not going to sell them to you... It's not fair, because even if you are under 18 years old you can still get pregnant!"<sup>78</sup>

The idea that young people aren't in 'need' of services pervaded both young people's and service providers' responses in interview and focus groups: "[the doctor] will say 'you are so young, you don't need a test!'"<sup>79</sup> One young mother extraordinarily claimed: "I don't need sexual and reproductive health services yet, because I am not married",<sup>80</sup> despite the fact that she had already been through pregnancy and child birth.

These findings reveal a surprising contradiction: on the one hand, respondents emphasised the importance of contraceptive use and STI testing for 'preserving oneself' and staying sexually healthy; on the other hand, sexually active young people are not accessing these services in practice on the basis that they do 'not need' them. This contradiction can be explained by understanding that respondents' conversations about sexual health appeared to be predominantly focused on communicating *normative* ideas concerning gender and sexual behaviour and identities, rather than discussing practical safe sex methods and strategies, and their actual value and use. For example, when respondents mentioned

the need to protect themselves against infectious diseases, these ideas appeared to be more strongly connected to participants' concerns about the moral pitfalls of sexual activity, rather than fears about the factual prevalence of STIs: "If someone is married they are not going to have any sexual health problems";<sup>81</sup> "if you are faithful it is easy to preserve yourself";<sup>82</sup> "you have to be careful and see what kind of girl you are having sex with";<sup>83</sup> "you have to preserve yourself. Some girls are like prostitutes".<sup>84</sup>

When asked what 'problems' related to sexual health concerned them most, participants revealed that boys' biggest fear is impotence: "Boys will worry if they can't get hard"; "sometimes boys need help with sexual prowess. If their penis can't get hard, or if they have a little penis, they might go see the *Marabout* [traditional, religious healers]".<sup>85</sup> (Erectile dysfunction is associated with witchcraft which requires intervention by *Marabout*, rather than a medical practitioner.) Girls on the other hand reported to be most worried about the shame and stigma associated with pregnancy outside of marriage, and of being seen to be an 'easy' or promiscuous: "If a guy has sex with a girl, he is definitely not going to marry her. He'll find a good girl who is a virgin".<sup>86</sup> These responses are revealing, especially since, while sexual virility and power is a dominant (valued) image of masculinity, girls are expected to remain virgins until they are married.

These responses shed light on how young people understand sexual health and the need for services. Young people appear predominantly concerned with their ability to successfully perform or express the valuable aspects of gendered sexual identities; which affects the value they place on staying sexually healthy, as well as their service-seeking behaviour. While young people speak of the need to 'preserve' themselves (protect themselves against STIs and unwanted pregnancy) the expression of these ideas is best understood as constituting a normalising exploration of gender identity and sexual behaviour, rather than a discussion about specific practices or precautions that are generally understood to promote 'safe' sex.

This analysis is significant, because, as discussed the sexual identities and norms that young people strive to express, often directly contradict their ability to access SRH services in practice; and this is especially the case for young girls. These identities both reinforce perceptions that laws, such as the legal ages of majority, consent and marriage, restrict young people's ability to access services based on age and marital status; and are themselves reinforced by the normative influence of legal rules.

### 3.1.3 Conclusion: access to contraception, STI testing and other basic services

The law in Senegal creates no *direct* barriers to accessing contraceptives, STI tests, and other basic sexual and reproductive health services. In fact the law contains a positive right for the provision of, and access to, SRH services for young people.

Nevertheless, the evidence suggests that legal rules and norms do play an *indirect* role in creating barriers to access to these services. Legal rules that define adulthood, and that establish a minimum age for consent to sexual activity, are functioning to establish a formal framework through which normative prohibitions on youth and childhood sexuality (and sexual activity) can be understood and applied: “People start having sex between 13–16 years, but I think that people should wait until they are 18 years. *The law is fighting for young people not to have sex.* The legal age [of sexual consent] is not young. If my friend was having sex at 15 I would advise her to plan for her family ... [but] when I was 15 I tried to get the pill and they asked me – how old are you, and why do you ask for this?”<sup>87</sup>

Furthermore, and linked to this, social and cultural norms that emphasise pre-marital abstinence and virginity, especially for girls, are creating barriers to the implementation of permissive legal rules that emphasise the importance of affording young people access to SRH services: “The law says that every person is allowed access to health. But it is not easy for the law to help the young people to get in [access services]. It doesn’t matter what the law says”.<sup>88</sup> Restrictive social norms have an influence on the decision-making of both young people and service providers, and affect their interpretation and application of legal rules; leading many young people to believe that they are not ‘supposed’ to access services under the age of 18, and influencing many service providers’ attempts to informally limit or discourage young people’s access to services, especially contraception:

While the majority of young people were uncertain as to whether there is a particular law that limits young people’s access to services, their fixation on the specific age of “18 years” as potentially demarcating the point at which it might be acceptable for a young person to access SRH services, indicates that legal rules are having an influence on young people’s (and service providers’) reasoning about if and when it is appropriate for young people to be accessing services.

Legal rules, especially the legal age of majority (18 years), appears to be indirectly reinforcing barriers to young people’s access to SRH services, because this legal rule is being interpreted in a context where childhood sexuality is taboo.

## 3.2 Access to confidentiality

### 3.2.1 Feeling shame: the importance of confidentiality

As discussed, despite being legally able to access SRH services, only a small minority of participants in our study had done so

“If [people see you at the clinic], they will think ‘she is having sex with a lot of people’ – they will talk, talk, talk”.<sup>89</sup>

in practice. Feeling *ruus* (shame) was the most preeminent and consistently reiterated explanation of why young people are not accessing services in practice. A direct English language translation of *ruus* is hard to capture, but concepts of modesty, decency, propriety, demureness and shame all convey comparable notions. *Ruus* is a trait that forms part of an individual’s general character and behaviour. According to respondents, it is a quality that is culturally valued and endorsed among children and young people, and most especially among young girls:

**Have you ever accessed a sexual health service?**

No.

**Why not?**

I don’t know why it is that I don’t have the mind to go there. I think it’s because I don’t want to look the doctor in the face. I am so young; if I looked the doctor in the face I would feel ashamed (*ruus*).<sup>90</sup>

Feelings of shame prevent young people from talking openly about sex, and create barriers to access to advice, treatment and services: “We have never been to the clinic because we are ashamed. All the people are going to talk about you. It’s a taboo subject”.<sup>91</sup> As this quote demonstrates, feelings of shame are strongly related to lack of confidentiality. Where young people are not able to access services privately, feelings of shame and embarrassment are intensified. Young people are afraid of becoming the subject of gossip, because being known to be sexually active (if unmarried), or to be accessing contraception (if married), may have serious consequences for a young person’s reputation: “If you leave that place [the SRH clinic] people are not going to respect you, they are not going to have a good vision of you”.<sup>92</sup> “if somebody sees you there [at the SRH clinic], the first thing that will be one their mind is that you have a sexual problem. If you are a girl they will think you are pregnant. They will think ‘she is having sex with a lot of people’. They will talk, talk, talk”.<sup>93</sup>

These statements reveal how lack of confidentiality induces feelings of shame associated with judgemental attitudes towards young, female sexuality. Accessing a service as a young, unmarried, person is automatically associated with having a ‘sexual problem’, as well as with being pregnant, both of which are perceived negatively, and subject to social condemnation. Another participant explained: “Young people are afraid someone will see them in the hospital. If they see you they will

think you are pregnant. They will think that you have AIDS".<sup>94</sup> These findings support the analysis (in **Section 3.1**) above, which explores the ways in which ideas about sexual health are generally subsumed within a judgemental and restrictive moral framework, which associates sexual health 'problems' with indecent and inappropriate behaviour, creating barriers to young people's access to services.

In this context it is unsurprising that young people consistently raised and emphasised the importance of being able to access SRH services in confidence and privacy; these views were also expressed by SRH providers who seek to cater for young people: "Young people are ashamed; they don't want to bump into anyone they know. That is why we have opened a separate room specifically for young people. We take them behind a door to give them advice".<sup>95</sup>

### 3.2.2 Law on confidentiality: principles, perceptions and practices

The law in Senegal protects young people's confidentiality upon accessing SRH services. Data protection laws make it illegal for a doctor in Senegal to disclose personal information about a patient to a third party.<sup>96</sup> Almost all service providers interviewed for this research reported that they are both aware of the law, and careful to apply it in practice. Young people, however, were less certain of the law. Most young people appeared to have a general sense that their medical information *ought* to be private, but weren't sure if this was a protection formally guaranteed to them under the law.

I think it should be a secret when you talk to your doctor. We need confidentiality.

#### Is that the law?

I don't have any idea.<sup>97</sup>

What you tell your doctor is a secret he can't tell anyone anyway.

#### Is that the law?

The law doesn't say anything about confidentiality.<sup>98</sup>

There is evidence that the law protecting confidentiality is not always applied in practice. The National Network of Associations of People Living with HIV (PLHUV) has expressed concern over health facilities' ability to keep medical test results confidential, a concern that derived from a survey carried out in December 2012.<sup>99</sup> In our study, service providers' failure to safeguard young people's confidentiality in practice, was one reported reason why young people experience barriers to accessing SRH services:

#### Is it easy for young people to access the services here?

No. Young people never want to come here. But now I am pushing for that. I had a meeting with some young people from the area to encourage them.

#### Why do they not want to come?

Because their perception of our services wasn't very good. They said the staff here were not respecting young people's confidentiality. They were talking to people outside.

#### Is it against the law for staff to do that?

The law says these things have to be confidential. But most of the staff aren't educated [about this].<sup>100</sup>

Sometimes participants reported that young people's marital status or age might affect their ability to access SRH services confidentially. One nurse reported: "If a young person comes here to the clinic people will say – this girl is single, she's not married – they might tell your parents".<sup>101</sup> Young people's confidentiality may be especially at risk in closely-knit communities, where family and community ties are such that young people, service providers and patients are likely to share social and family connections: "Young people are afraid that the doctor might know their Dad";<sup>102</sup> "if you come here, the doctor might tell your parents [you are having sex], and your parents are not going to be happy about that".<sup>103</sup> Even where the law is carefully applied, other social realities may affect young people's ability to access service privately in practice: "Definitely the law says that medical records have to be confidential. It doesn't matter about your age – they will just call you a patient. But if young people go to the doctor they could see their aunty or uncle. Then that will not be confidential. Someone there will know them".<sup>104</sup>

Data protection laws make it illegal for a doctor in Senegal to disclose personal information about a patient to a third party. There is evidence, however, that young people's confidentiality is not always protected in practice.

### 3.2.3 Conclusions: access to confidentiality

The 2008 Protection of Personal Data Act protects young people's right to access SRH services in confidence. Nevertheless, evidence suggests that the law is not always applied in practice, particularly in close knit communities. Furthermore, other social realities (such as a lack of youth specific services) mean that privacy rights, while available formally and legally, are not always realized in practice.

Young people and services providers often emphasised the importance of making youth-specific services available exclusively for young people, to prevent young people having to come into

contact with and interact with older generations, especially in waiting areas. The shame that young people experience accessing SRH services derives from their status as youth, and is particularly felt when they are confronted by an older person: “Those old people will be looking at you. They will think you are so young and wonder why you are here”;<sup>105</sup> “if it’s the boys they don’t care. But if it’s the girls they will care because they mix with older women. They mix them with their mum and aunty. They feel ashamed. They will say look at this girl look at what she’s doing”.<sup>106</sup>

## 3.3 Access to information and education

### 4.3.1 SRE education: policy and practice

As far as this review was able to determine, there is no law that mandates compulsory sexual and reproductive health education in Senegal. Nevertheless, all participants reported to have received some education in their Biology, and ‘Family Economics’ (*économie familiale*) classes at school.

Young people explained that SRH education in school is generally perceived as being a lesson primarily for girls: “those lessons are just for the girls. Boys will think it’s a taboo”.<sup>108</sup> It was reported that boys typically cause disruptions in class, laugh, refuse to listen, or leave the room altogether: “Only the girls do family economics. The boys leave the class”.<sup>109</sup> A minority of boys, however, did say that they were interested in learning about SRH: “Some of the boys leave, but some of us wanted to know”.<sup>110</sup>

Education at school appears to predominantly focus on the physical, biological and reproductive aspects of sexual health: describing body parts, explaining periods, providing information about how to get pregnant, pregnancy health and care, child birth, and prevention of sexually transmitted diseases. Broader learning and discussion about the social and relationship contexts of sexual and reproductive health is (reportedly) absent. There also appears to be a disproportionate focus on female reproductive identities and roles (which could at least partially explain boys’ lack of interest and engagement in the subject):

#### Where do you learn about sex?

At school – in Family Economics and Biology classes.

#### What do they teach you in those classes?

They teach you about your periods.

They teach you about what you have to do when you give birth.

They teach you how to take care of the baby, how to bring it up.

## “They teach us not to have sex”.<sup>107</sup>

### Do they also teach the boys about that?

No! Of course not! Men don’t look after babies in Senegal.<sup>111</sup>

These findings are significant because reducing sexual and reproductive health to female identities and roles is both ineffective as a SRH strategy and harmful. It reinforces gender stereotypes that objectify girls and women and hold them responsible for controlling male sexually and reproduction, and ignores the essential role that boys and men play in guaranteeing safe sexual and family planning practices.

Participants reported that education in school places a strong emphasis on abstinence: “They teach you not to have sex”;<sup>112</sup> “they teach you that if you have a baby too young it will be hard for you”.<sup>113</sup> Sexual health education may also include teaching young people how to use condoms correctly, and the importance of wearing a condom for protection against STI infection and unwanted pregnancy. In general, sensitising young people about the risks of unprotected sex, in terms of sexually transmitted infections (STIs), and most particularly HIV transmission, appears to be a core component of these lessons, with abstinence peddled as the preferred ‘preventative strategy’. Some participants reported being taught about different types of contraception in schools, such as the contraceptive pill and injections; others, however, reported to have only been taught about condoms. No participants reported having received any education or information about **law** related to sexual and reproductive health during their schooling. This fits with the finding that most young people interviewed in the research demonstrated a lack of knowledge and misperception of law related to SRH.

### Do you teach young people about the law related to sexual and reproductive health?

No. We don’t go inside those issues.<sup>114</sup>

No participants reported having received any education or information **about law** related to sexual and reproductive health, at school or elsewhere.

In general, participants seemed to feel that their education in school was limited, and that there is an unmet need for information and education about SRH, which means that young people turn to other avenues and sources for learning about SRH: “At school we have family economics but the teachers don’t go into the real thing. At the ASBEF centre<sup>115</sup> you can get better information. For example, they don’t teach you about the morning after pill at

school. But at ASBEF they do. At school they just teach you about your period and your body".<sup>116</sup>

Participants felt that other sources of information were more reliable and informative than SRE at school: "At the ASBEF centre, you can get better information. For example, they don't teach you about the morning after pill at school. But at ASBEF they do".

Few young people felt it to be appropriate to discuss sex or sexual health at home, and with their parents: "We are ashamed to talk to our parents [about sexual health]".<sup>117</sup> Internet, films and television were reported to be alternative sources of information for young people about sexual and reproductive health, although these sources were usually characterised as being negative influences on young people's (sexual) behaviour: "The problem is that parents don't teach you. School is never going to teach you. Most people learn those things from the TV and internet. Those things they see are not good for them".<sup>118</sup> The construction of media sources as negative influences on young people's behaviour, and the unwillingness to discuss sexual health within the family and at home, can be linked to the contradictions that young people experience attempting to reconcile powerful 'traditional' discourses that emphasise pre-marital abstinence and virginity, with the realities of young people's contemporary sexual lives: "Everyone's families are talking about the tradition. Senegal is a traditional society. But these days young people can have sex at any age. Watching films gives them those ideas".<sup>119</sup>

### 3.3.2 Education as a normative force

The education and information that young people access about sexual and reproductive health, as well as the way that young people receive and interpret these messages and influences, clearly reflects a series of hierarchical ideas concerning acceptable and unacceptable forms of sexual behaviour. Acceptable sex takes place within marriage, has a reproductive purpose, and is primarily the domain of women and girls, who take responsibility for pregnancy, child birth, and caring for the family. Unacceptable sex takes place at a young age, prior to, or outside of marriage, and is associated with STIs and unwanted pregnancy. This is why abstaining from sexual activity is presented as the endorsed or preferred method of preventing STI transmission and pregnancy: to avoid the moral pitfalls of unacceptable sex.

#### Do they teach you about contraception and prevention of STIs?

At our age, because we are young, the first thing they have to teach us is about abstinence.<sup>120</sup>

### "If you are pregnant you are going to hate your life".<sup>121</sup>

Leaving aside critiques of the effectiveness of abstinence-focused SRH education, the mere construction of 'abstinence' as a 'prevention strategy' is problematic, as it conflates young people's decisions about whether to have sex at all, with their decisions about how to stay sexually safe and healthy; in the contexts of young people's real lives and relationships, it is reductive to presume that the former can be understood exclusively or primarily in terms of the latter.

Framing sexual and reproductive health education (SRE) in this way can be understood to have a detrimental influence on young people's access to SRH services. It reinforces gendered and aged constructions of sexuality: reducing sexual health to a discussion about female reproductive roles, and reinforces taboos and stigma associated with being sexually active while young and unmarried. The research findings, therefore, indicate that the lack of legal guidance in Senegal mandating comprehensive, objective and value-neutral SRE in schools in Senegal is creating a barrier to access to education for young people in practice.

## 3.4 Early pregnancy and access to services

Teenage pregnancy outside of marriage attracts heavy social stigma in Senegal. This is despite the fact that unmarried pregnancy is not uncommon. As most surveys on early pregnancy focus on the age of the girl rather than marital status, statistics on early unmarried pregnancy are hard to come by. A study in 1995, however, estimated that as many as one third of all pregnancies occur prior to marriage.<sup>122</sup>

While there are no direct legal restrictions on young pregnant girls' access to pregnancy care; the failure (in law and practice) to provide free and universal pre- and post-natal services, together with restrictive social norms and stigma, appears to be creating barriers to young people's access to services in practice.

Participants reported that unmarried, pregnant girls are liable to be 'thrown out' of their father's house in disgrace, and sent to live with extended family, usually an aunt or an uncle. Furthermore, it was reported that boyfriends will usually attempt, at least initially, to deny paternity: "If you get a girl pregnant, you are just going to run";<sup>123</sup> "most of the boys are going to run if your girlfriend gets pregnant, because girls have more than one boyfriend, and you don't want the responsibility";<sup>124</sup> "if your girlfriend gets pregnant the first thing you're going to say it's not me, even if you know it's

you”.<sup>125</sup> This means that pregnant girls may find themselves with no help or support to cover the expense of medical care: “If your family is supportive, then it’s ok, you can access help. But if they are not supportive, then where can you get the money to go to the doctor?”<sup>126</sup> “Most of the girls who give birth, it is going to be so hard for them. You can only go to the hospital if your parents have enough money”.<sup>127</sup>

Almost all young people interviewed in the research appeared to view early pregnancy extremely negatively, associating it with other types of socially objectionable and immoral behaviour, and with heavy punitive consequences: “Your parents and friends will leave you. They will say you are not good. You will have stress. People will say you are a prostitute, even if it is not true. You might start using drugs, or kills yourself from too much sex”.<sup>128</sup> The shame associated with pregnancy outside of marriage both reinforces social norms prohibiting sexual activity outside of marriage, and is itself a product of them; as pre-marital pregnancy is, of course, evidence of a young girls’ violation of the norm requiring them to preserve their virginity until marriage. This was also reported to create barriers to access to sexual and reproductive health services: “Some girls feel so shy, because the doctor is not nice to them. He will say – why did you get pregnant?”<sup>129</sup>

While there are no formal (legal) restrictions on young girls’ access to pregnancy care; social stigma together with high costs of medical services may play a considerable role in creating barriers to access to SRH services.

Pregnant girls are also liable to exclusion from other services; participants reported that girls are likely to be expelled from school, “the teachers will tell you to leave”,<sup>130</sup> as soon as their pregnancy is discovered, leading many young girls to conceal their condition for as long as possible. Some participants believed this to be a (direct) legal requirement: “the law says if you are in college you have to leave”.<sup>131</sup> Other participants associated this with the legal age of majority and with (their understanding of) the age of consent: “If you are under 18 years you are not allowed to get pregnant; the headmaster will ask you to leave the school”.<sup>132</sup>

The majority of participants, however, were aware of a recent policy which prohibits schools from expelling pregnant girls. The research findings indicate that the policy is influencing a positive change in the ways that young people reason about teenage pregnancy. Mitigating some of the negative consequences associated with early pregnancy, such as expulsion from school, appears to have lessened the judgement associated with it: “If you are pregnant, for the first few months everyone will be talking about you. But then it won’t last long. They will still have a celebration for you. You can keep studying. Girls can stay in school. Before the law said that girls have to leave, but now they are able to stay”.<sup>133</sup> This provides an example of how legal and

“Most of the girls can’t cope with having a baby on their own, that’s why they are having abortions”.<sup>134</sup>

policy factors can influence social and cultural norms that impact on young people’s access to SRH services, demonstrating how it may be difficult to isolate the influence of legal barriers from other factors in practice.

## 3.5 Access to abortion

### 3.5.1 Law on abortion

Access to abortion is heavily restricted in Senegal: criminalized in the overwhelming majority of circumstances. Article 305 of the Penal code provides that anyone who ‘provokes’ the performance of abortion of a girl or woman, regardless of her consent, will be liable to 1–5 years imprisonment and a fine of between 20,000–100,000 CFA; as well as 5 years to permanent suspension from the medical profession.<sup>135</sup> If a person regularly performs abortion the penalty is increased to 5–10 years imprisonment, and 50,000–500,000 CFA. A woman that performs her own abortion, or consents to an abortion will be subject to a relatively lesser penalty of imprisonment of 6 months to 2 years, and a fine of the same degree.<sup>136</sup>

Although not recognized under the penal or civil code, the Medical Code of Ethics permits the performance of therapeutic abortion, but only as a last resort to save the life of the mother. In such a case, two doctors will need to take the decision that abortion is necessary, and submit a written declaration attesting that the mother’s life could only be save through such intervention.<sup>137</sup>

Senegal ratified in Maputo Protocol in December 2004, which includes an article (14, 2, c) extending the conditions under which therapeutic abortion may be performed: “[authorizing] medical abortion 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 fetus”.<sup>138</sup> Senegal, however, has made reservations to article 14 regarding the right to abortion.<sup>139</sup>

Abortion is prohibited in Senegal accept as a last resort, in order to save the life of the mother.

Interestingly, article 4 of the 2005 reproductive health law recognizes abortion as a ‘treatment’ or ‘service’ related to

reproductive health. Article V, however, provides that abortion is prohibited unless authorised by the law (i.e. therapeutic abortion to save the life of the mother), and in a statement of ambiguous meaning, adds that abortion shall in no circumstances be “considered as a method of contraception”.<sup>140</sup>

### 3.5.2 Abortion in practice

Despite the fact that abortion is illegal in almost all circumstances, the vast majority of participants in the study reported that abortion is common: “It is not legal in any circumstances. You can go to prison. But it’s easy [to get one]”.<sup>141</sup> “lots of young people are having clandestine abortions”.<sup>142</sup> Staff at hospitals reported that young women and girls often come to them seeking assistance with obtaining an abortion, or requiring treatment after suffering injury caused by having accessed an unsafe abortion elsewhere. This resonates with previous research conducted in Senegal which has concluded that “the complications of induced and illegal abortions are one of the major causes for which women in their reproductive ages are hospitalized”.<sup>143</sup>

The quality of abortion services varies dramatically between different service providers. Safe services do exist, but are expensive, and likely to only be available to the wealthy and well connected. More common and highly risky methods of abortion include drinking dissolved soap or bleach to induce miscarriage, or inserting sharp objects into the vulva: “You get blue soap and mix it with water. They drink it to have a miscarriage. My best friend did that when his girlfriend got pregnant. He got her soap and water”.<sup>144</sup>

Researchers interviewed a young man who had helped his unmarried 15 year old sister access an abortion after fearing their father would “throw her out of the house”.<sup>145</sup> She was driven to a secret location several hours away by arrangement of her boyfriend. What exactly happened there is uncertain, but she came home in considerable pain. Three days later the pain worsened, so her brother took her to hospital. It turned out that she was still pregnant, and the ‘procedure’ she had undergone had given her an infection.

It is not only expense that excludes most women and girls from accessing safe services. Researchers were told of a story of a young girl whose expat friend took her to a trusted service that she (the expat) had accessed before. This time the doctor refused to help, explaining that she didn’t mind assisting ‘*toubab*’ [foreign women] because she could ‘trust them not to talk’; but that she wasn’t willing to help a Senegalese woman in case her husband or boyfriend found out, and reported her to the police.<sup>146</sup>

The law that criminalizes abortion has a disproportionate impact on young women and girls. Young women and girls are less likely to have the money and connections to access safe, clandestine

abortion; meanwhile they are particularly likely to need abortion services due to their circumstances, and the stigma associated with early pregnancy: “Girls have abortions, because they are afraid to tell their parents that they are pregnant”,<sup>147</sup> “most of the girls can’t cope with having a baby on their own, that’s why they are having abortions”.<sup>148</sup> Many young participants reported that abortion would be the first or preferred option that a young couple would turn to when confronted by an unplanned pregnancy: “Boys don’t want the responsibility, [if your girlfriend gets pregnant] you will tell her to have an abortion”,<sup>149</sup> “even though it’s forbidden, a lot of young people have an abortion anyway. Most of the time it’s the girls who want to have the abortion”,<sup>150</sup> “if a girl gets pregnant, all her friends and her family are going to help her to get an abortion”.<sup>151</sup> Statistical evidence on rates of abortion is hard to come by, however, a survey in 1995 estimated that as many as 52% of all women accessing abortions were between the ages of 15 and 19 years of age.<sup>152</sup>

Law prohibiting abortion is likely to disproportionately affect young, unmarried women and girls, because they are most likely to be in need of abortion services, and are less likely to have the money and connections required to access safe, clandestine services.

### 4.5.3 Perceptions about abortion and law

All participants were aware that abortion is illegal, and may attract a prison sentence. Most participants started off by expressing the view that abortion is illegal in every circumstance, although when prompted expressed knowledge that abortion is legally available to save the life of the mother. A minority of participants were unsure whether abortion might be legally available in other circumstances, such as if a woman or girl becomes pregnant as a result of rape.

Participants’ views about abortion varied, and appeared to reflect a degree of ambivalence towards both law and practice relating to abortion. While most participants declared that they are “not okay with” abortion, they seemed comfortable talking about the subject, and were willing to discuss both real life and hypothetical situations where they appeared to find abortion ordinary and understandable, if not wholly acceptable.

A few participants directly challenged the law criminalizing abortion, expressing the view that it is wrong and needs to change: “We would like abortion to be legal, that’s what we are fighting for. Everyone does it anyway so many young people can die or get an infection”,<sup>153</sup> “if a girl would like to have an abortion, she can do it – that’s her life”.<sup>154</sup> Others spoke in a more neutral or descriptive way about the law, or spoke of how ‘others’ may view the law, in an apparent attempt to avoid sharing their own views on the matter; this was particularly the case during interviews with

service providers: “the only thing young people don’t like about the law is the law on abortion. That’s why we are fighting to help people use contraception;” “the law doesn’t create any barriers accept for abortion. We can do anything for young people except for abortion”.<sup>155</sup>

When asked if and why they thought abortion should be illegal, a few participants expressed the view that it is contrary to religious principles: “regardless of the law we are Muslims, so we can’t have any abortion”,<sup>156</sup> “if you get pregnant you should have your baby. You should never abort, because our religion says that’s bad”.<sup>157</sup> However, the overwhelming majority of participants primarily referred to the health risks associated with accessing abortion, which are, of course, (in most instances) a direct result of criminalization of the practice:

#### **What do you think about having an abortion?**

It’s not good.

#### **Why do you think that?**

Abortion can make you infertile it can give you an infection.<sup>158</sup>

These responses illustrate how restrictive laws may simultaneously serve to undermine and compromise young people’s access to sexual and reproductive health; while being *justified* on the grounds of needing to preserve and protect it, because advocates for criminalization draw upon the risks associated with abortion in order to portray it as a dangerous procedure which ought to be prohibited. This provides another example of how legal rules both reinforce and are reinforced by social narratives, further entrenching barriers to access to SRH services.

While only a few participants openly declared that abortion should be legalised, many more young people (and especially) girls stated that they found the law to be ‘very hard’ on young women and girls: “abortion is not legal in any condition. It is so hard that the law is like that”.<sup>159</sup> Furthermore, most participants appeared to find abortion acceptable in a wider number of circumstances than those provided for in law, and believed that abortion should be made legally available in these conditions. For example, most participants reported to find abortion ‘okay’ if a woman or girl has become pregnant through rape, with some believing this to be currently legal: “if a girl has been raped then it’s ok for her to have an abortion, even though it’s still not legal”.<sup>160</sup>

#### **Are there any circumstances in which you think abortion should be made legal?**

Yes. Like if a girl is raped. The law is supposed to do more for those young girls – to help them.<sup>161</sup>

Other participants thought that abortion should be allowed in the case that a girl is especially young, is single, or is not in a position to support the baby: “if a girl gets pregnant, and the man runs away. In that case the law should accept the girl to have an abortion”.<sup>162</sup> Some thought that abortion is okay if it happens within a particular (usually very short) time frame: “Within 8 days you can have an abortion”.<sup>163</sup>

# 4 Law, heteronormativity and discrimination

## 4.1 Law and perceptions of law

Homosexuality is criminalized, for both men and women. Article 319 (law 66-16 on 1st February 1966) provides that anyone who commits an 'indecent' or 'unnatural' act with an individual of the same sex will be punished by imprisonment of 1 to 5 years, and fined 100,000 to 1,500,000 CFA. Critically, the law specifies that, regardless of factual consent, homosexual sex with a person under the age of 21 years will automatically attract the maximum penalty. This provision has an especially discriminatory impact on young homosexual people; they are liable subject to even higher penalties than adults if they have relationships with their peers.

As far as this review was able to determine, there is no recognition of transgender or non-binary gender identity in Senegalese law; and there is no protection in law of homosexual or transgender people from discrimination.

Homosexuality is criminalized under the penal code. Critically, the law specifies that, regardless of factual consent, homosexual sex with a person under the age of 21 years automatically attracts the maximum penalty. This provision has an especially discriminatory impact on young people.

All participants were aware of the law criminalizing homosexuality. The overwhelming majority of participants expressed their support of the law, declaring that they were 'not ok' with homosexuality and that it is contrary to religious principles. Some participants also defended their views in terms of the law.

In the few cases where participants did express more tolerant views towards homosexuality, they expressed discomfort speaking on the subject: "I don't have any problems if people are homosexual. But I don't want to talk too much about this. I will just say some quick things but I don't want to go 'inside the circle' of the issues too much, because we are not ok with that here";<sup>165</sup> "I'm ok with gay and lesbian people, but I don't want to go into these issues too much. Senegal is a Muslim country".<sup>166</sup> The fact that homosexuality is criminalized may contribute to young people's fears about speaking openly about the subject.

"The law tries to hide homosexuality – it doesn't want to help those people".<sup>164</sup>

## 4.2 Homophobic violence and access to SRH services

Many participants were of the view that as a result of widespread discrimination, and the law criminalizing homosexuality, gay men and lesbian women are at risk of pervasive violence: "people will hurt you on the street".<sup>167</sup> Many participants also felt that the law may prevent victims of violence for seeking support: "there are gay and lesbian people in this country, but it is not legal under Islam. If you are gay in this country people are going to beat you. The police won't arrest you for beating a gay person. The police are in with those who are beating them";<sup>168</sup> "there are lots of [homosexual] people who get beaten up, the law doesn't offer them any protection".<sup>169</sup> Other participants, however, expressed a different view: "of course the police will help [a gay person subject to violence and rape]. All violence is bad, and the law doesn't accept that".<sup>170</sup>

Participants pointed out that in such conditions many gay and lesbian people may be unwilling or unable to access support services due to fear of being criminalized on account of their identity or sexual orientation: "when the police arrive they will not hurt you, but they may put you in prison".<sup>171</sup> Some participants also mentioned that boys and men may be unwilling to report experiences of sexual violence for fear of being labelled as 'gay': "boys and men can get raped, and they should have access to services. But boys will be ashamed. If that was you, you wouldn't tell anyone. People would say – what is it about you that meant you were raped by a man/boy".<sup>172</sup>

The law, therefore, both fails to acknowledge and actively discriminates against homosexual and transgendered people in ways that creates barriers to access to SRH services, both *directly* through the criminalization and prosecution of these identities, and *indirectly* through reinforcing an oppressive social context in which homosexual and transgender identities are not recognized or seen as legitimate.

# 5 Sexual violence and law

## 5.1 Law and perceptions of law

In 1999, the penal law in Senegal was amended to include provisions addressing domestic violence (including incest), rape, sexual harassment and female genital mutilation. Evidence suggests, however, that in practice these types of offenses are rarely prosecuted.<sup>173</sup> Both service providers and young people perceived gender based sexual violence, including domestic violence, to be widespread, and seemed doubtful that victims of violence are able to seek support in most cases. This was particularly true for cases of rape. Researchers spoke to one girl who had herself been a victim of rape, and three others who told stories of close friends who had been raped. In each case the participants reported that the situation was resolved between the families, due to a reluctance to involve the police: “My best friend was raped when she was 12 years old. The parents of the two [the victim and perpetrator] said – we know it’s rape, but please don’t go to the police. Let’s sort it out in the family – the families of those two are so close. So they sorted it out”.<sup>174</sup> Significantly, the law in Senegal does not contemplate marital rape. Most participants looked confused when researchers asked them questions about marital rape, the consensus was that rape within marriage “isn’t possible”, with some boys finding the idea laughable.<sup>175</sup>

Penal law in Senegal criminalizes domestic violence, rape, sexual harassment and female genital mutilation. The law does not contemplate marital rape. Participants reported that GBV is pervasive, and appeared doubtful that victims of violence are able to access support in most cases.

While young people expressed some knowledge of sexual and gender-based violence laws, they also expressed views that appeared to justify and endorse male (sexual) dominance, control and violence, particularly in the context of intimate partner relationships and marriage: “girls have to take a lot of force from boys – that is why they need to preserve themselves”,<sup>176</sup> “most of the young girls who get pregnant have been raped. Most of the time, a guy gives a girl money to go buy food. The thing is you are going to give a girl money, and then take her back to your house. You are going to talk a lot about ‘sex’, ‘sex’, ‘sex’. Then the girls can’t control herself. You might even give her drugs.”<sup>177</sup> This second quote reveals the ways in which young people often conflated issues of underage sex, early pregnancy, rape, coercion and consent, in ways that demonstrated a lack of understanding of ‘rape’ as both a social and legal concept.

## 5.2 Law, sexual violence and access to services

Limited legal definitions of sexual violence, such as the lack of recognition of marital rape within law, and the failure to prosecute sexual and gender-based violence laws has significant consequences for young people’s access to sexual and reproductive health services. Victims of violence may be unwilling to access help due to shame, and fear that their experiences will not be recognized or seen as legitimate: “there is no such thing as marital rape. If you go to the court people will just laugh at you. If you are raped by your husband, you just have to wait in your room crying. You will not seek any help”.<sup>178</sup> An unwillingness to report cases of rape to the police also discourages access to other services: “if a girl is raped, she doesn’t want to go to the doctor. She just wants to keep what happened in the family”.<sup>179</sup> One young mother recounted her experiences:

I was raped when I was 15 years old. His [the perpetrator’s mother] told him “never accept that you raped her and never accept the baby.”

### Did you report to the police?

No. The thing is we are neighbours. My brother said he was going to take him to the court. But his mother said “no – please don’t. We are neighbours. Let’s sort it out.”

### Did you go to the hospital?

No. I was scared. I was hiding. I was scared to tell anyone what had happened to me.<sup>180</sup>

Furthermore, impunity for sexual violence normalises male dominance and control over sexuality, reproduction and access to services. Previous research conducted in Senegal has found that 65.2% of women feel that it is acceptable for a man to beat his wife for a range of reasons;<sup>181</sup> the same study also found that a strikingly similar percentage of men, 66.8%, were making decisions about their wives’ health without consulting them.<sup>182</sup> Participants in our study emphasised that it is usually more difficult and less likely for young women to be accessing SRH services compared to young men, because of the greater constraints placed on female sexuality, and the fact that young women are likely to be subject to the control of either their father or their husband.

Limited legal definitions of sexual violence, and a failure to implement law, creates indirect barriers to access to sexual and reproductive health services. Victims of violence may be unwilling or unable to seek support; furthermore, sexual violence reinforces male dominance and control over sexual and reproductive health.

# 6 Conclusions and recommendations for legal reform

## 6.1 Overarching conclusions

Law in Senegal impacts on young people's access to sexual and reproductive health services in both direct and indirect ways. The law does not only act as a barrier, however, it also serves to facilitate and enable access to services in some circumstances.

Direct legal barriers in Senegal include the criminalization of abortion, except as a last resort to save the life of the mother, as well as the criminalization of homosexuality which directly denies young people access to essential services and care. Both the law on abortion and the criminalization of homosexuality have a disproportionate and discriminatory impact on *young* people. The law prohibiting homosexuality directly discriminates against young people by establishing higher penalties for homosexual sex with a person under the age of 21 years, regardless of factual consent. The law on abortion, on the other hand, has a substantive discriminatory effect, because young women and girls are especially likely to require abortion services, for a range of reasons arising from their age and circumstances.

The research indicates that **direct** legal barriers to access to services are having a devastating impact on young people's sexual and reproductive health in Senegal. Despite the fact that abortion is illegal in most circumstances, participants reported that it is common. As a result of criminalization, safe services are only available to the wealthy, privileged and well connected. Unsafe, clandestine abortion services place women at significant risk of injury, infertility and even death; evidence suggests that abortion is one of the most common major causes of hospitalisation of women and girls of reproductive age in Senegal.<sup>183</sup> Furthermore, the research indicates that young homosexuals or transgendered persons are liable to be subject to widespread, State-sponsored violence because of their orientation or identity. Young people of homosexual or transgendered orientation or identity are unlikely to seek support and services either for general SRH needs, or needs that arise from experiences of violence, because of fear of being subject to discrimination and prosecution.

There are other laws in Senegal which appear to be having an **indirect** impact on young people's access to SRH services. Indirect legal barriers include the criminalization of any sexual activity involving a person under the age of 16 years, the legally prescribed and sex-discriminatory minimum ages for marriage (18 for boys and 16 for girls) and the establishment of the legal age of majority at 18 years. These laws do not directly restrict young people's access to SRH services; they are, however, being interpreted and applied in a context where young people are normatively prohibited from being sexually active until they are adult and married, which creates barriers to young people's access to services in practice.

The research indicates that these laws are interpreted as intending to prohibit young people under a certain age from engaging in any sexual activity: "the law is fighting for young people not to have sex",<sup>184</sup> as opposed to (only) serving a more limited purpose of protecting children and young people from sexual exploitation and violence. The consequence of this idea is that young people and service providers are uncertain whether children under the ages of majority, marriage and sexual consent are permitted to access sexual and reproductive health services. The reason for this is palpable: if young people are conforming to the expectation of 'pre-adult', pre-marital abstinence, then they should not be in need of those SRH services that are linked to being sexually active, such as contraceptives and STI testing. Critically, while the expectation of pre-marital abstinence is prescribed through social and religious norms, the expectation of 'pre-adult' abstinence is, at least partially, a matter of law, because of the establishment of an absolute minimum age for sexual consent at 16 years. This analysis explains why service providers reported that they will attempt to limit and restrict young people's access to services, through forcing young people to justify precisely *why* they *need* them. It also explains why young people are not willing to access services in the first place, and why they are often unsure if they are legally permitted to do so.

Laws in Senegal that **facilitate** access to SRH services include data protection laws which safeguard young people's right to access services confidentially, and a newly introduced policy requirement that prohibits the expulsion of girls from education institutions. The research indicates that these laws have the potential to improve young people's access to SRH services, through enabling young people to make positive choices about their own sexual health; and reducing some of the shame and stigma associated with accessing services, and pre-marital pregnancy. These laws and policies were valued positively by research participants; and young people were especially likely to underscore their importance and relevance. Nevertheless, the evidence indicates that introducing or reforming 'facilitative' law and policy is not enough to realize access to services in practice. The value of formal, legal rights must always be considered in the light of other social realities. For example, the research suggests that despite the law on confidentiality, young people are unlikely to be able to access SRH services privately in practice; because service providers do not always comply with laws, and because young people are likely to encounter acquaintances and relatives at SRH clinics.

In general, it is difficult to isolate the impact of law from the impact of other barriers on young people's access to sexual and reproductive health services. The development, interpretation and application of law, is shaped by other social and cultural factors; factors which are themselves influenced by law. In particular, in Senegalese contexts, law which influences young people's access to SRH services, is primarily interpreted

through two interrelated social narratives. The first of these is that sexual activity is primarily the preserve of individuals who are both married and adult, especially for girls. The second is that young people are in need of ‘protection’ from the harmful consequences of sexual activity, unwanted pregnancy, STI infections, sexual violence and so forth. Understanding these narratives and how they intersect with legal rules is crucial for understanding the operation of both direct and indirect legal barriers to access to SRH services in Senegal. It also resolves an apparent paradox in the research findings: on the one hand young people, and service providers, generally dismissed the idea that law is a primary factor shaping access to SRH services; on the other hand, the law does appear to be having a significant impact, both direct and indirect, on access to services.

## 6.2 Implications for law and policy

### 6.2.1 Age of sexual consent

The research reveals that age of consent laws may create indirect barriers to young people’s access to SRH services. Furthermore, the provision in Senegalese law that has been interpreted as establishing the minimum age of sexual consent at 16 years is vague.

Advocacy efforts should focus on reforming and clarifying the law in the area according to the following principles:

- The law should make a distinction between (1) factually consensual sexual activity taking place in the context of a child’s sexual development; and (2) sexual activity that by its very nature is exploitative.<sup>185</sup>
- A ‘sliding scale’ approach which considers the age difference between parties is more effective than a legal rule that criminalizes all sexual activity below the age of 16 years.
- The law should consider whether one of the parties to the relationship is in a position of power, trust, authority or dependency in relation to the other (e.g. the relationship between a teacher and student; and doctor and patient etc). In such cases the age of sexual consent should be higher than in cases where this is not the case.
- Finally the law should clearly establish the difference between the age of consent to (medical) treatment, including access to SRH services, and the age of sexual consent.

### 6.2.2 Laws on access to services (contraceptives, testing, consultation)

The 2005 Law in Relation to Reproductive Health broadly establishes young people’s right to access SRH services; however, this provision is too vague and general. Advocacy efforts should

focus on the development and adoption of a legal rule that explicitly recognizes the capacity of children and young people to consent to access sexual and reproductive health services, without the need for parental or other consent. This can assist in avoiding ambiguity and the risk that informal restrictions will be applied at the discretion of service providers.

While children and young people should never be denied access to services when they need them, clear child protection mechanisms should be put in place to ensure that instances of abuse are identified and addressed. The risk is that child protection procedures will simultaneously fail in their attempt to address abuse, while creating barriers to access to services for children who need them. This is an area that needs further research and development.

### 6.2.3 Law and policy on confidentiality

The research revealed that many young people experience feelings of shame when accessing sexual and reproductive health services, which are linked to a lack of confidentiality in practice.

Although the law in Senegal protects young people’s right to confidentiality when accessing services, more work needs to be done to support the implementation of this law in practice.

There is a need to build capacity and knowledge of service providers so that they are able to implement the law on confidentiality in practice; including supporting the development of data protection case management systems, as well as industry guidelines on how to locate and configure SRH services.

Awareness raising activities should be undertaken among young people regarding their right to confidentiality. Young people should be reassured of this through education, public messaging and within clinics themselves.

Resources should be directed towards expanding and increasing the number of youth specific SRH services. These were frequently felt to be more confidential and more neutral spaces; facilitating improved access to SRH services for young people. Another option would be to consider locating SRH services within other types of youth services.

### 6.2.4 Access to information and education

Comprehensive and compulsory sexual and reproductive health education (SRE) should be a mandatory part of school curricula. SRE should avoid propagating dominant stereotypes about sex and gender. The research revealed that the curriculum primarily focuses on the biological and reproductive aspects of SRE, and is skewed to focus on (traditional) feminine identities

and roles. Priority should be given to including boys within these lessons; and adopting a broader focus on healthy relationships.

Information should be directed towards both boys and girls, with emphasis placed on shared responsibility for protecting sexual and reproductive health. This curriculum should also clearly explain the SRH services that are available for young people and the content and implications of relevant provisions in law.

Finally, the research revealed that education about safe sexual practices places a heavy emphasis on abstinence, and that there is an unmet need for broader information about SRE, including with regard to different types of contraceptives and how to access these. Abstinence should not be taught as a method for 'preventing' STIs and unwanted pregnancy, as this erroneously conflates young people's decisions about whether to engage in sexual activity with their decisions about how to stay sexually healthy.

### 6.2.5 Pregnancy and care

Support for pregnant women, and particularly vulnerable pregnant women, should be strengthened. This might include basic social benefits, and the provision of free or subsidised child-care support for women who are working or studying. Furthermore, providing SRH services specifically for *young* pregnant women and mothers could help address their reluctance to access general SRH services due to fear of experiencing stigma. Legal provisions prohibiting discrimination against pregnant women in school and the workplace should be developed, and increased effort made to raise awareness on the recent change in policy protecting young girls from school expulsion due to pregnancy. This policy was found to be having a positive impact on reducing some of the shame associated with early pregnancy.

All advocacy and policy interventions aimed at reducing rates of teenage pregnancy must be framed with respect for a young women's choice and autonomy, including her choice to become pregnant, her need for services, and her right to live in freedom of discrimination. This is essential to avoid reinforcing harmful cultural narratives that expose young pregnant girls to stigmatisation and discrimination, in ways that have a significant impact on SRH and access to services. Given the heavy stigma associated with teenage pregnancy in Senegal, it is especially important that information campaigns run by sexual health advocates do not unwittingly contribute to this culture of stigma.

### 6.2.6 Abortion

Abortion in Senegal is currently illegal except as a last resort to save the life of the mother. Any criminalization of abortion creates direct legal barriers to access to sexual and reproductive services.

Advocacy efforts should focus on realising the ultimate goal of unrestricted access to abortion services, and protection of this right under the law. Abortion services should be made free, safe, accessible and confidential for all women and girls.

Current advocacy campaigns are underway in Senegal, seeking to alter the specific grounds under which abortion is permitted. These initiatives should be supported as part of the broader fight against the criminalization of abortion; however, this should always be carried out with the understanding that anything other than full decriminalization will often lead to abortion remaining inaccessible to all but a very small number of women, who then bear the burden of proving why they are entitled to access the service.

Advocating for incremental changes to law are unlikely to have much impact on the availability of legal abortion in practice. Incorporating such efforts within a broader campaign towards full decriminalization of abortion, however, may have the potential to foster public engagement with the issue and help gain wider social and political support for decriminalization of abortion and (young) women's rights more broadly.

### 6.2.7 Gender, sexual orientation and discrimination

The law in Senegal criminalizes homosexuality creating both direct and indirect barriers to access to sexual and reproductive health services. Advocacy efforts should be directed towards providing protection and legal support to local activist groups engaged in the fight for LGBTI rights.

### 6.2.8 Gender based and sexual violence

The failure to recognize, in law, all forms of gender based and sexual violence (GBV), as well as the failure to implement laws, can have a serious impact on SRH and access to services. While survivors of violence may be unable to seek support, GBV reinforces harmful gender roles and norms which support heteronormative, male dominance and control over sex and reproduction, excluding access to services for women, girls and other individuals at risk of gender-based discrimination (such as homosexual and transgendered people).

In order to address these issues, the following principles should be considered:

- The law should recognize all forms of GBV regardless of the context (e.g. in the home, school community or within other institutions) or relationship (e.g. whether married or not) within which it occurs;
- Sexual abuse should be defined in terms of absence of **consent**, rather in terms of 'force' or violence. All forms of sexual abuse

should be recognized within law. The law should specifically acknowledge and criminalize rape within marriage;

- All acts of sexual violence, including both physical and non-physical acts of violence should be criminalized within law.

# Endnotes

- 1 For example, UNFPA, UNAIDS and UNDP in Asia and the Pacific recently joined forces to produce a review of laws and policies affecting young people's access to sexual and reproductive health and HIV services in Asia and the Pacific. Available at: <<http://unesdoc.unesco.org/images/0022/002247/224782e.pdf>>. Accessed February 2014.
- 2 Leonardo A. Villalón (1995), *Islamic Society and State Power in Senegal: Disciples and Citizens in Fatick* Cambridge University Press.
- 3 Article 305, Code Penal, Senegal, 1999.
- 4 The Penal Code in Senegal does not explicitly contemplate spousal rape. Article 300, Code Penal, Senegal, 1999. Also see the Social Institutions & Gender Equality Index, available at: <[http://genderindex.org/country/senegal#\\_ftn48](http://genderindex.org/country/senegal#_ftn48)>. Accessed January 2014.
- 5 Anouka Van Eerdewijk, *The ABC of Unsafe Sex: Gendered Sexualities of Young People in Dakar (Senegal)*, 2007.
- 6 We had expected that some of our 'young' participants would be married, especially as we had specified that we would like to interview a selection of young mothers. In each case, however, we were presented with unmarried, single women and men, reflecting a mutual misunderstanding brought about by our (somewhat) different conceptions of what it means to be a 'youth'. Although age does appear to play a role in definitions of 'youth' in Senegal (for example in no cases were we presented with a participant over the age of around 32 years); in Senegal it is also a necessary condition of 'youth' that a young person is unmarried.
- 7 Girls, 18-24, Focus Group Discussion XX, Dakar.
- 8 Anouka Van Eerdewijk, *The ABC of Unsafe Sex: Gendered Sexualities of Young People in Dakar (Senegal)*, 2007.
- 9 Adolescence is often characterised as a critical period in the development of sexuality, during which desires, behaviours and values are developed and explored.
- 10 94% of the total population of Senegal are Muslim. The remainder of the population is predominantly Christian and similarly express pre-marital abstinence as an important principle of their faith.
- 11 Individual interview, young woman, Fatick, Monday 8 July 2013.
- 12 Anouka Van Eerdewijk, *The ABC of Unsafe Sex: Gendered Sexualities of Young People in Dakar (Senegal)*, 2007.
- 13 Focus group discussion, young women, Dakar, 4 July 2013.
- 14 Anouka Van Eerdewijk, *The ABC of Unsafe Sex: Gendered Sexualities of Young People in Dakar (Senegal)*, 2007.
- 15 Anouka Van Eerdewijk, *The ABC of Unsafe Sex: Gendered Sexualities of Young People in Dakar (Senegal)*, 2007.
- 16 Ibid.
- 17 Ibid.
- 18 Ibid.
- 19 The use of the word 'aged' here does not necessarily infer chronological age, but rather 'age' as a social construction.
- 20 Michel Garenne, Age at Marriage and Modernisation in Sub Saharan Africa, *Southern African Journal of Demography*, 9(2), 57-79; Giles Pison, Kenneth H. Hill, Barney Cohen, Karen A. Foote, *Population Dynamics of Senegal*, Working Group on Senegal, Commission on Behavioural and Social Sciences and Education, National Research Council, National Academic Press, 1995.
- 21 Anouka Van Eerdewijk, *The ABC of Unsafe Sex: Gendered Sexualities of Young People in Dakar (Senegal)*, 2007.
- 22 Anouka Van Eerdewijk, *The ABC of Unsafe Sex: Gendered Sexualities of Young People in Dakar (Senegal)*, 2007.
- 23 Ibid.
- 24 Ibid.
- 25 Focus group discussion, young women, Dakar, 4 July 2013.
- 26 Olivier Dagneliev, *Too young to Marry: Evidence from Senegal on Child Mortality*, March 2010.
- 27 United Nations Population Fund (UNFPA), *Marrying too Young*, 2012. Available at: <<https://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/MarryingTooYoung.pdf>>. Accessed February 2012.
- 28 Individual interview, young woman, Dakar, 4 July 2013.
- 29 Code Penal Sénégal, Loi n° 99-05 du 29 Janvier 1999, Article 320.
- 30 Women's Network for a Better World, Senegal: sexual and reproductive rights Available at: <<http://www.map-srhr.org/chapters/ch-3-overview-of-sexual-and-reproductive-health-and-rights-in-africa/senegal>>. Accessed February 2014.
- 31 Focus group discussion, young men, Dakar, 3 July 2013.
- 32 Code de la Famille Sénégalaise, 17 Janvier 1989. Article 276 provides that a 'minor' is a person of either sex that has not yet turned 18 years old.
- 33 Focus group discussion, young men, Kaolack, 10 July 2013.
- 34 Focus group discussion, young men, Thiombly, 8 July 2013.
- 35 These ideas were reflected in conversations with participants and have also been widely discussed in existing literature on gender and sexuality in Senegal.

- 36 Code de la Famille Sénégalaise, 17 Janvier 1989, Article 111.
- 37 Individual interview, two young women from the Association of Women's Law, Dakar, 4 July 2013.
- 38 Focus group discussion, young women, Fatick, 8 July 2013.
- 39 Individual interview, two young women from the Association of Women's Law, Dakar, 4 July 2013.
- 40 J Rank, Senegal – Entry into Union. Available at: <<http://family.jrank.org/pages/1480/Senegal-Entry-into-Union.html>>. Accessed April 2014.
- 41 Individual interview, young woman, Dakar, 6 July 2013.
- 42 The practice of marrying girls earlier than boys has also been linked to the institution of dowry.
- 43 United Nations Children's Fund, *The State of the World's Children*, 2009. Available at: <<http://www.unicef.org/protection/SOWC09-FullReport-EN.pdf>>. Accessed February 2009.
- 44 Individual interview, service provider (nurse), kaolack, 10 July 2013.
- 45 Focus group discussion, young men, Fatick, 9 July 2013.
- 46 Focus group discussion, young women, Kaolack, 11 July 2013.
- 47 Individual interview, young mother, Kaolack. 10 July 2013.
- 48 Focus group discussion, young women, Kaolack, 10 July 2013.
- 49 Article 12, Law on HIV and AIDs, Law n° 2009-06, 2009.
- 50 Law in Relation to Reproductive Health, Law n° 2005-18, 5 August 2005.
- 51 Law in Relation to Reproductive Health, Law n° 2005-18, 5 August 2005.
- 52 The significance of this caveat will be addressed in the sections below.
- 53 Article 4, Law in Relation to Reproductive Health, Law n°2005-18, 5 August 2005.
- 54 Article 10, Law in Relation to Reproductive Health, Law n°2005-18, 5 August 2005.
- 55 UNDP, *Regional Issues Brief: Children, HIV and the Law*, p.10.
- 56 Although boys reported purchasing condoms, no girls indicated doing so: in fact they seemed confused by the idea that they might. Young women in our study appeared to think that condoms are exclusively the concern of men, presumably because men wear them. These notions may be exacerbated by attempts to promote the 'female condom' despite its lack of use in practice. When researchers asked girls about condoms (in general) they would invariably assume that the question must be about the 'female condom', responding that they had heard of them but had never used one.
- 57 Focus group discussion, young women, Dakar, 5 July 2013.
- 58 Focus group discussion, young women, Dakar, 4 July 2013.
- 59 Individual interview, two young women from the Association of Women's Law, Dakar, 4 July 2013.
- 60 Individual interview, young man, Kaolack, 11 July 2013.
- 61 Focus group discussion, young women, Dakar, 6 July 2013.
- 62 Individual interview, two young women from Kaolack, 11 July 2013.
- 63 Code de la Famille Sénégalaise, 17 Janvier 1989, Article 111.
- 64 For example, The United Nations Convention on the Rights of the Child, opened for signature 20 November 1989, UNTS vol. 1577, (entered into force 2 September 1990).
- 65 Since many marriages in Senegal take place through customary processes, 'marital status' does not necessarily imply *legal* marriage.
- 66 Focus group discussion, young women, Dakar, 5 July 2013.
- 67 Focus group discussion, young women, Dakar, 5 July 2013.
- 68 Focus group discussion, young women, Dakar, 5 July 2013.
- 69 Anouka Van Eerdewijk, *The ABC of Unsafe Sex: Gendered Sexualities of Young People in Dakar (Senegal)*, 2007.
- 70 Individual interview, two young women from the Association of Women's Law, Dakar, 4 July 2013.
- 71 Focus group discussion, young women, Dakar, 5 July 2013.
- 72 Individual interview, service providers (nurse), Dakar, 4 July 2013.
- 73 Individual interview, two young women from the Association of Women's Law, Dakar, 4 July 2013.
- 74 Individual interview, service provider (nurse), Dakar, 4 July 2013.
- 75 Individual interview, service provider (nurse), Dakar 5 July 2013.
- 76 Individual Interview, service provider, Thiombly, 8 July 2013.
- 77 Individual interview, service provider (nurse), Dakar, 4 July 2013.
- 78 Focus group discussion, young women, Dakar, 3 July 2013.
- 79 Focus group discussion, mixed (a group of youth leaders speaking out about SRH), Kaolack, 11 July 2013.
- 80 Individual interview, young mother, Kaolack, 10 July 2013.

- 81** Focus group discussion, young men, Dakar, 4 July 2013.
- 82** Focus group discussion, young men, Dakar, 5 July 2013.
- 83** Boys. FDG 2. In her study *The ABC of Unsafe Sex: Gendered Sexualities of Young People in Dakar (Senegal)*, Anouka Van Eerdewijk argues that the creation of a 'typology' of girls, reflects the construction of the male sexual self and the contradictions young boys experience trying to reconcile hegemonic masculine identities, which required men to be sexually active and libidinous, with a general normative prohibition on sex before marriage.
- 84** Focus group discussion, young men, Dakar, 4 July 2013.
- 85** Focus group discussion, young men, Fatick, 9 July 2013.
- 86** Focus group discussion, young women, Fatick, 9 July 2013.
- 87** Individual interview, young woman, Dakar, 4 July 2013.
- 88** Individual interview, service provider, Kaolack, 10 July 2013.
- 89** Individual interview, young mother, Kaolack, 10 July 2013.
- 90** Individual interview, young man, Thiombly, 8 July 2013.
- 91** Focus group discussion, young men, Kaolack, 10 July 2013.
- 92** Focus group discussion, young men, Fatick, 9 July 2013.
- 93** Individual interview, young women, Dakar, 4 July 2013.
- 94** Focus group discussion, young women, Dakar, 4 July 2013.
- 95** Individual interview, service provider (nurse), Dakar, 4 July 2013.
- 96** Loi n° 2008-12 sur la Protection des données à caractère personnel, 2008.
- 97** Individual interview, young women, Dakar, 4 July 2013.
- 98** Individual interview, young man, Kaolack, 10 July 2013.
- 99** AIDS, Enhancing Care Initiative, <<http://www.eci.harvard.edu/teams/senegal/>> accessed February 2014.
- 100** Individual interview, service provider (nurse), Kaolack, 10 July 2013.
- 101** Individual interview, service provider (nurse), Kaolack, 10 July 2013.
- 102** Focus group discussion, young boys, Kaolack, 10 July 2013.
- 103** Individual interview, service provider (nurse), Kaolack, 10 July 2013.
- 104** Focus group discussion, young women, Dakar, 5 July 2013.
- 105** Individual interview, young woman, Dakar, 4 July 2013.
- 106** Individual interview, young man, Thiombly, 8 July 2013.
- 107** Focus group discussion, young women, Dakar, 3 July 2013.
- 108** Individual interview, young man, Dakar, 5 July 2013.
- 109** Focus group discussion, young women, Dakar, 3 July 2013.
- 110** Focus group discussion, young men, Dakar, 4 July 2013.
- 111** Focus group discussion, young women, Kaolack, 10 July 2013.
- 112** Focus group discussion, young women, Dakar, 3 July 2013.
- 113** Focus group discussion, young women, Dakar, 3 July 2013.
- 114** Individual interview, teacher of familie economics, Kaolack, 10 July 2013.
- 115** A centre run by The Association Sénégalaise pour le Bien-Etre Familial (ASBEF), a partner organisation of IPPF.
- 116** Individual interview, young woman, Dakar, 4 July 2013.
- 117** Focus group discussion, young men, Dakar, 4 July 2013.
- 118** Individual interview, young man, Dakar, 4 July 2013.
- 119** Focus group discussion, young women, Dakar, 3 July 2013.
- 120** Individual interview, young man, Kaolack, 10 July 2013.
- 121** Focus group discussion, young women, Dakar, 4 July 2013.
- 122** Anouka Van Eerdewijk, *The ABC of Unsafe Sex: Gendered Sexualities of Young People in Dakar (Senegal)*, 2007, p.96.
- 123** Focus group discussion, young men, Kaolack, 9 July 2013.
- 124** Focus group discussion, young men, Dakar, 5 July 2013.
- 125** Focus group discussion, young men, Fatick, 8 July 2013.
- 126** Individual interview, service provider, Dakar, 3 July 2013.
- 127** Individual interview, young man, Dakar, 2 July 2013.
- 128** Focus group discussion, young women, Dakar, 5 July 2013.
- 129** Focus group discussion, young men, Dakar, 3 July 2013.
- 130** Focus group discussion, young women, Dakar, 5 July 2013.
- 131** Focus group discussion, young women, Kaolack, 10 July 2013.
- 132** Focus group discussion, young women, Kaolack, 10 July 2013.
- 133** Focus group discussion, young women, Dakar, 4 July 2013.
- 134** Individual interview, young man, Kaolack, 10 July 2013.
- 135** Code Penal, 1999, Article 305.
- 136** Code Penal, 1999, Article 305.
- 137** Population Policy Data Bank, maintained by the Population Division of the Department of the Department of Economic and Social Affairs of the United Nations Secretariat. Available at: <[www.un.org/esa/population/publications/abortion/doc/senegal.doc](http://www.un.org/esa/population/publications/abortion/doc/senegal.doc)>. Accessed February 2014.

- 138** 'Maputo Protocol'; Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa. Available at: <<http://www.africa-union.org/root/au/Documents/Treaties/Text/Protocol%20on%20the%20Rights%20of%20Women.pdf>>. Accessed February 2014.
- 139** East Africa Centre for Law and Justice, The Maputo Protocol in line with the New Constitution. Available at: <<http://www.eaclj.org/constitution/20-constitution-featurearticles/39-the-maputo-protocol-in-line-with-the-newconstitution.html>>. Accessed February 2014.
- 140** Law in Relation to Reproductive Health, Law n°2005-18, 5 August 2005, Chapter V.
- 141** Focus group discussion, young women, Dakar, 5 July 2013.
- 142** Individual interview, service provider, Dakar, 4 July 2013.
- 143** Anouka Van Eerdewijk, *The ABC of Unsafe Sex: Gendered Sexualities of Young People in Dakar (Senegal)*, 2007, p.174.
- 144** Focus group discussion, young men, Dakar, 5 July 2013.
- 145** Individual interview, service provider, Dakar, 3 July 2013.
- 146** Individual interview, young man, Dakar, 6 July 2013.
- 147** Focus group discussion, young women, Kaolack, 10 July 2013.
- 148** Individual interview, young woman, Dakar, 6 July 2013.
- 149** Focus group discussion, young men, Dakar, 5 July 2013.
- 150** Individual interview, young man, Dakar, 4 July 2013.
- 151** Focus group discussion, young men, Fatick, 8 July 2013.
- 152** Focus group discussion, young men, Dakar 3 July 2013.
- 153** Individual interview, two young women from the Association of Women's Law, Dakar, 4 July 2013.
- 154** Individual interview, young women, Kaolack, 10 July 2013.
- 155** Individual interview, service provider, Dakar 4 July 2013.
- 156** Focus group discussions, young men, Fatick 9 July 2013.
- 157** Focus group discussion, young women, Dakar 5 July 2013.
- 158** Focus group discussions, young men, Fatick 9 July 2013.
- 159** Focus group discussion, young women, Dakar, 4 July 2013.
- 160** Individual interview, young man, Dakar, 4 July 2013.
- 161** Individual interview, young woman, Thiombly, 8 July 2013.
- 162** Individual interview, young woman, Kaolack, 10 July 2013.
- 163** Individual interview, young woman, Kaolack, 11 July 2013.
- 164** Individual interview, two young women from the Association of Women's Law, Dakar, 4 July 2013.
- 165** Individual interview, young woman, Dakar, 4 July 2013.
- 166** Individual interview, young woman, Dakar, 4 July 2013.
- 167** Focus group discussion, young women, Kaolack, 10 July 2013.
- 168** Individual interview, young woman, Dakar, 4 July 2013.
- 169** Focus group discussion, young men, Kaolack, 10 July 2013.
- 170** Focus group discussion, young women, Kaolack, 11 July 2013.
- 171** Focus group discussion, young women, Kaolack, 10 July 2013.
- 172** Individual interview, young woman, Dakar, 5 July 2013.
- 173** Social Institutions and Gender Index, "Senegal country profile". Available at: <<http://genderindex.org/country/senegal>>. Accessed February 2014.
- 174** Individual interview, young woman, Fatick, 9 July 2013.
- 175** Individual interview, young man, Thiombly, 8 July 2013.
- 176** Focus group discussion, young men, Dakar, 4 July 2013.
- 177** Focus group discussion, young boys, Fatick, 9 July 2013.
- 178** Individual interview, young woman, Dakar, 5 July 2013.
- 179** Individual interview, young woman, Thiombly, 8 July 2013.
- 180** Individual interview, young woman, Fatick, 9 July 2013.
- 181** Demographic and Health Surveys (DHS) 2005/2006, Senegal. Available at: <<http://www.measuredhs.com/what-we-do/survey/survey-display-233.cfm>>. Accessed February 2014.
- 182** Demographic and Health Surveys (DHS) 2005/2006, Senegal. Available at: <<http://www.measuredhs.com/what-we-do/survey/survey-display-233.cfm>>. Accessed February 2014.
- 183** Anouka Van Eerdewijk, *The ABC of Unsafe Sex: Gendered Sexualities of Young People in Dakar (Senegal)*, 2007, p.174.
- 184** Individual interview, young woman, Dakar, 4 July 2013.
- 185** ECPAT, 'Strengthening laws addressing child sexual exploitation', 2008, p.50.

# Over-protected and under-served

A multi-country study on legal barriers to young people's access to sexual and reproductive health services

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

Published in March 2014 by the International Planned Parenthood Federation

4 Newhams Row, London SE1 3UZ, UK

**tel** +44 (0)20 7939 8200  
**fax** +44 (0)20 7939 8300

**web** [www.ippf.org](http://www.ippf.org)  
**email** [info@ippf.org](mailto:info@ippf.org)

UK Registered Charity No. 229476

Typeset by worldaccent.com

Front cover photo by IPPF/Jennifer Woodside/Senegal

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

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

This exploratory research project contributes to the evidence base on the barriers that prevent young people from accessing SRH services, and the hope is that it will inform advocacy and programmatic work aimed at fulfilling young people's sexual rights. The research took place in three countries: El Salvador, Senegal and the UK (England, Wales and Northern Ireland). Young people themselves were the main respondents, with their views, opinions and perceptions on the role of the law remaining central to the findings and recommendations.



**IPPF**

**coram** **clc**  
Children's Legal Centre