

Harmonizing protection and rights: A review of age of consent policies in Eastern and Southern Africa

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Abstract

Introduction: Adolescents in Eastern and Southern Africa (ESA) remain disproportionately affected by HIV, early pregnancy, and gender-based violence. Age-of-consent laws critically shape access to sexual and reproductive health and rights (SRHR) services, yet regional legal frameworks are often inconsistent, restrictive, and discriminatory. Understanding these frameworks is essential for guiding rights-based policy reform.

Methods: A narrative desk review was conducted between March and July 2025, synthesizing peer-reviewed studies, policy documents, and regional reports. The review examined age-of-consent laws governing sexual activity, HIV services, contraception, and abortion, identifying legal gaps, enforcement challenges, and areas of reform.

Results: Significant heterogeneity was found across ESA. Many countries retain restrictive laws or parental consent requirements that deter adolescents from accessing SRHR services. South Africa has among the most progressive abortion laws, while Zimbabwe's adoption of WHO-aligned guidelines signals emerging reform. However, barriers such as stigma, misinformation, and provider bias persist, limiting service utilization even in supportive contexts. Few countries include close-in-age exemptions, and weak enforcement further undermines adolescent rights.

Conclusion: ESA's fragmented legal frameworks continue to constrain adolescent SRHR. Reforms must balance protection with recognition of adolescents' evolving autonomy.

Policy implications: Policymakers should harmonize age-of-consent laws, lower thresholds for HIV services, introduce close-in-age exemptions, and ensure confidential access to contraception and abortion. Strengthening comprehensive sexuality education, combating stigma, and aligning laws with human rights standards are crucial to reducing HIV infections, early pregnancies, and maternal mortality across the region.

Introduction

Africa has the youngest and most rapidly growing population in the world (Rocca & Schultes, 2020; United Nations, 2020). The same demographic trend is evident in the Eastern and Southern African (ESA) region, which has the fastest-growing population of children and young people in the world (UNICEF, 2024). In 2022, youth aged 10 to 24 years accounted for 32 percent of the population—approximately 208 million people (United Nations, 2018), representing a significant rise from the 16 percent recorded in 2017 (UNFPA, 2024). The resulting youth bulge poses a significant challenge, as the number of young people increases, many become vulnerable in countries lacking adequate protective policies and legal frameworks. Adolescents and young people in the ESA region navigate their sexual and reproductive health and rights (SRHR) within a complex legal landscape. In the region, legal frameworks defining the 'age of consent' which regulate sexual activity, access to HIV testing and treatment, SRH services (including contraception and abortion where permitted), medical treatment, and participation in research

are frequently fragmented, inconsistently applied, and vary widely across jurisdictions (Tallarico, Ozah & Orievulu, 2021; UNFPA, 2020). These frameworks matter profoundly in ESA, a region that continues to shoulder a disproportionate burden of adolescent HIV and SRH challenges despite substantial programmatic investments over the past decade (Lynch et al., 2024; Watson et al., 2021).

The 2013 ESA Ministerial Commitment on Education, Health and Well-being, renewed in December 2021 and extended to 2030, recognizes that youth-friendly laws and policies are essential to scale comprehensive sexuality education (CSE) and SRH services and reduce new infections and early or unintended pregnancies (UNESCO, 2025). Yet, in many countries across the region, age of consent laws remain absent, inconsistent, or poorly enforced, leaving millions of adolescents vulnerable to sexual exploitation, early marriage, and unprotected sexual activity (Lynch et al., 2024; Santhya & Jejeebhoy, 2015). Across ESA region, these frameworks remain heterogeneous and often contradictory. Combined with a rapidly growing youth population, these legal gaps contribute to high rates of adolescent pregnancy, HIV infection, and gender-based violence (Choonara et al., 2024; Tallarico et al., 2021). The intersection of demographic pressures and policy shortcomings threatens public health, human rights, and sustainable development. Strengthening age of consent frameworks is therefore essential to protect young people's SRHR and unlock the region's demographic potential.

International and regional human-rights instruments provide the normative backbone for adolescent consent policies. The African Charter on the Rights and Welfare of the Child (ACRWC) affirms every child's right to the highest attainable standard of health and obliges states to ensure access to necessary medical assistance (ACRWC, 1999). The Protocol to the African Charter on Human and Peoples' on the Rights of Women in Africa (the Maputo Protocol) reinforces SRHR, including access to HIV-related information and services, and requires states to create supportive legal and social environments that empower women and girls (Banda, 2008). Additional instruments, including the Convention on the Rights of the Child (CRC) and its Optional Protocol on the Sale of Children, Child Prostitution, and Child Pornography (UN, 1989; UN, 2000), as well as WHO standards on adolescent-friendly health services, further define consent as both a legal threshold and an operational duty to respect adolescents' evolving capacities (WHO, 2015).

Watson et al. (2021) underscores the growing recognition of the importance of young people's SRHR in Eastern and Southern Africa (ESA), given their central role in promoting health and well-being, preventing HIV and unintended pregnancies and advancing gender equality. Advocacy efforts have emphasized the need for evidence-informed, rights-based harmonization of age-of-consent policies (UNFPA, 2020). Policy briefs and reviews call for establishing lower, clearly defined ages of access for HIV testing, prevention (including PrEP), and clarifying linkage from testing to treatment and broader SRH services without additional parental barriers (Eba & Lim, 2017; Lynch et al., 2024; Tallarico & Orievulu, 2021; UNFPA, 2020). Against this backdrop, this manuscript examines age-of-consent policies across ESA region with three aims: (1) to map the current legal and policy landscape for adolescent consent to sexual activity, HIV testing and treatment, and SRH/medical services in the region; (2) to analyze coherence and gaps relative to regional and global human-rights standards and adolescent-friendly care

norms; and (3) to generate evidence-based recommendations for harmonized legal reforms that protect and promote the rights, health, and well-being of adolescents across the region.

Methods

Study design

An in-depth desktop review was conducted to systematically examine legislative and policy provisions related to adolescent sexual and reproductive health and rights (ASRHR) across ESA member states. The review focused on national laws, policies, and continental legal frameworks, as well as relevant scientific literature and reports documenting the implementation of age of consent regulations for ASRHR.

Data sources and search strategy

A comprehensive search was performed using public databases and websites, including PubMed, Google Scholar, the African Committee of Experts on the Rights and Welfare of Children (ACERWC) (<https://www.acerwc.africa/en>), and the African Legal Information Institute (AfricanLII) (<https://africanlii.org>). The search targeted peer-reviewed articles, policy briefs, reports, and legal documents published between 2018 and May 2024, when the final systematic search was conducted. An additional 13 references were subsequently identified through citation tracking and recommendations from members of the RIATT-ESA network and incorporated into the review by December 2024. The date restriction applied to the search for contemporary evidence but not to foundational sources required to establish the legal, policy, conceptual, or theoretical context of the review. Older authoritative sources, including key legal instruments such as the Maputo Protocol, as well as seminal theoretical works and relevant policy documents, were therefore purposively included where directly relevant to the review. Thus, references published before 2018 reflect foundational or contextual sources rather than studies identified through the date-limited search.

The review primarily focused on 23 ESA member states: Angola, Botswana, Burundi, Comoros, Democratic Republic of Congo, Ethiopia, Eritrea, Eswatini, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Seychelles, South Africa, South Sudan, Tanzania, Uganda, Zambia, and Zimbabwe. While some evidence was sourced from outside the ESA region, priority was given to findings relevant to the ESA context.

Inclusion criteria

Sources were included in the review if they provided relevant information on national laws, policies, or legal frameworks governing ASRHR within the ESA region. Specifically, the review considered documents that addressed the age of consent for sexual activity, marriage, family planning services, HIV testing and

treatment, and abortion care where legally permitted. Eligible sources included peer-reviewed articles, policy reports, government documents, continental legal frameworks, and reputable institutional publications that were publicly accessible or identified through trusted networks. Overall, the inclusion criteria were designed to ensure that the review captured comprehensive, up-to-date, and regionally relevant evidence to support a robust analysis of age of consent legislation and its implications for adolescent health and rights

Data synthesis

The extracted data were synthesized using a comparative narrative approach, allowing for both cross-country and thematic analysis of age of consent laws and related ASRHR provisions in the ESA region. This approach enabled the review to highlight differences and similarities in legal and policy frameworks across the 23 member states, including the age thresholds for sexual consent, marriage, access to family planning, HIV testing and treatment, and abortion care. The narrative synthesis also focused on tracking recent legislative developments and trends in enforcement, providing insight into whether legal frameworks were being implemented effectively or remained largely aspirational. In addition, the review identified gaps and inconsistencies within and between countries, particularly where national laws diverged from regional or continental human-rights standards. Special attention was given to how these gaps could influence adolescents' access to essential services and their overall protection, emphasizing the potential public health and social implications of weak or fragmented legal provisions. The findings from this synthesis were then used to inform evidence-based recommendations, highlighting areas where harmonization of age of consent policies could strengthen adolescent rights, improve access to SRHR services, and support child protection objectives across the region. By integrating both legal analysis and policy context, the synthesis provides a comprehensive picture of the state of ASRHR legislation in ESA countries and identifies actionable pathways for reform.

Results and discussion

This section presents the study's findings pertaining to the ages of consent for sexual activity, marriage, and access to SRHR services in the ESA region, including HIV testing and counselling. The objective is to demonstrate that, in several ESA countries, existing legislative and policy frameworks are not fully harmonized with the international and regional legal instruments that most states have signed and/or ratified. The discussion further offers evidence-based insights to inform harmonized reforms that can better safeguard and promote adolescents' rights, health, and well-being across the region.

The summary of sources of evidence reviewed between 2019 and 2024 is presented in Table 1. These sources, which include policy briefs, legal reviews, and regional reports, provide the foundation for the analysis and highlight the breadth of documentation informing this study

Table 1
Summary of sources of evidence reviewed (2019–2024)

No	Document author: brief title	Year	Document type	Countries represented and scope
1	SADC: Strategy on Sexual and Reproductive Health and Rights (2019–2030)	2019	A Sub-regional Framework	SADC 16 member states: Angola, Botswana, Comoros, Democratic Republic of Congo, Eswatini, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Tanzania, Zambia & Zimbabwe
2	Ten-Year Review of the Addis Ababa Declaration on Population and Development in Africa beyond 2014	2023	Technical Report	All African Countries
3	UNFPA: Harmonization of the legal environment on ASRH in East and Southern Africa.	2020	Technical Report	Malawi, Uganda, Zimbabwe, South Africa, Namibia, Botswana, Seychelles, Lesotho, Mauritius, Comoros, Angola, Swaziland
4	APHRC: Why lowering the age of consent to SRHS is beneficial for adolescents' health and wellbeing.	2022	Briefing Report	Zimbabwe (primary focus compared with ESA countries)
5	SAT: Age of consent global review summary	2020	Legal Review Report	ESA countries Kenya, Zambia, Botswana, South Africa, Tanzania, Malawi, Zimbabwe, Swaziland Other African countries Nigeria, Morocco, Ivory Coast (Cote d'Ivoire) Other non-African countries Canada, United Kingdom, France, Jamaica, Brazil, Sweden, Ukraine, India, Thailand, Vietnam, Indonesia
6	SAT: Age of consent: Legal Review Zimbabwe Country Report	2021	Legal Review Report	Zimbabwe
7	SAT: Age of consent: Legal Review Zambia Country Report	2021	Legal Review Report	Zambia

No	Document author: brief title	Year	Document type	Countries represented and scope
8	SAT: Age of consent: Legal Review Botswana Country Report	2021	Legal Review Report	Botswana
9	IPPF: ICPD + 25 Nairobi Summit commitment analysis. A roadmap for fulfilling the promise.	2020	Technical Report	137 countries across the globe. African countries with quality and strong (SMART) commitments analysis with alignment to priority themes ESA countries Botswana, DRC (Congo), Eswatini, Malawi, Mozambique, Rwanda, South Africa Non-ESA countries Burkina Faso, Eritrea, Gambia, Ghana, Guinea Bissau, Mali, Nigeria, Sao Tome and Principe
10	ESARO UNFPA: Regional report on the Evaluation of the ESA ministerial commitment on CSE and SRHS for adolescents and young people	2024	Technical report	ESA Countries: Angola, Botswana, Burundi, DRC, Eswatini, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Rwanda, South Africa, South Sudan, Uganda, Tanzania Zambia, Zimbabwe
11	Score Card for Sexual and Reproductive Health and Rights in the SADC Region Fast tracking the Strategy for SRHR in the SADC Region 2019–2030	2019	Technical report	16 SADC countries: Angola, Botswana, Comoros, Democratic Republic of Congo, Eswatini (formerly Swaziland), Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, United Republic of Tanzania, Zambia, and Zimbabwe
12	SADC SRHR Score card 2023	2023	Technical report	16 SADC countries
13	SADC SRHR Score card 2021	2021	Technical report	16 SADC countries
14	UNFPA ESARO: Ending Child Marriage in Southern Africa:	2023	Technical report	SADC member states

No	Document author: brief title	Year	Document type	Countries represented and scope
	Domesticating the SADC Model Law on Child Marriage			
15	Watson et al. The ESA ministerial commitment: a review of progress toward fulfilling young people's SRHR 2013–2018	2021	Research article (review)	ESA countries and 13 high-level key informant interviews from organisation and country officials
16	Barr- DiChiara et al: Adolescent and age of consent to HIV testing: An updated review of national policies	2021	Research paper (policy review)	38 countries within sub-Saharan Africa (review of policies between 2005 and 2019)
17	McKinnon and Vandermorris: National age-of consent laws and adolescents HIV testing in sub-Saharan Africa	2018	Research paper (secondary analysis)	A focus on selected sub-Saharan Africa countries: ESA: DRC, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, Uganda, Tanzania, Zambia, Zimbabwe Non-ESA: Cameroon, Cote d'Ivoire, Nigeria
18	Manguro and Temerman: A critical review of ASRHR in Kenya	2022	Research article (commentary)	Kenya
19	Perehudoff et al. A Comprehensive human rights analysis of laws and policies for adolescent contraception in Uganda and Kenya	2022	Research article (Legal analysis)	Kenya and Uganda
20	Mollet and authors 2022: Legal age for consent for HIV testing in SSA	2022	Research article (Systematic review) - a policy and legal review framework:	33 sub-Saharan African countries (with available 2013, 2019 HIV reports): ESA countries Angola, Burundi, Comoros, Congo, Democratic Republic of Congo, Kenya, Madagascar, Mauritius, Mozambique, Rwanda, Senegal, Sierra Leone, Tanzania, Togo and Uganda, South Africa Non-ESA countries Benin, Burkina Fasso, Central African Republic, Chad, Cape Verde, Cote d'Ivoire, Equatorial

No	Document author: brief title	Year	Document type	Countries represented and scope
				Guinea, Gambia, Guinea, Guinea Bissau, Liberia,
21	Melesse et al: Adolescent sexual and reproductive health in sub-Saharan Africa: who is left behind?	2019	Research article (Analysis):	A. Country data reports i.e. • ESA: Ethiopia, Kenya, Malawi, Mozambique, Tanzania, Uganda, Zambia and Zimbabwe • Non-ESA: Ghana, Nigeria, Mali, Mauritania, Niger B: Desk review of HIV related laws in 28 SSA countries C: Review of health policy gaps that affect adolescents access to HIV services in Rwanda D: Review of South African legislative reform for improvement of adolescents' access to sexual and reproductive health services
22	Tallarico et al. Age of consent: A case for harmonizing laws and policies to advance, promote, protect ASRH	2021	Research article (Legal analysis)	ESA countries with in-depth analysis of data from 6 countries: Malawi, South Africa, Eswatini, Tanzania, Uganda and Zambia
23	Ninsiima et al: Factors influencing access to and utilisation of youth-friendly sexual and reproductive health services in sub-Saharan Africa: a systematic review	2021	Research article (Systematic Review)	7 African countries (data available from 2009 and 2019) ESA countries: Ethiopia, Kenya, South Africa, Tanzania Non- ESA countries: Ghana, Nigeria
24	HiVOS: Making access a reality. Addressing age of consent barriers in East and Southern Africa	2022	Policy brief	ESA country contextual analysis on the Consent2Access campaign Kenya, Malawi, Zambia, and Zimbabwe
25	HiVOS: Contextual analysis on the age of consent for adolescents' access to SRHR in Malawi	2022	Policy brief	Malawi
26	Black et al: Prevention of cervical cancer in sub-Saharan Africa: the	2018	Research article	SSA African Countries ESA countries featured: Botswana, Lesotho, Mauritius,

No	Document author: brief title	Year	Document type	Countries represented and scope
	advantages and challenges of HPV vaccination			Mozambique, Rwanda, Seychelles, South Africa, Tanzania, Uganda
27	Lane et al: Policy considerations for scaling up access to HIV pre-exposure prophylaxis for adolescent girls and young women: Examples from Kenya, South Africa, and Uganda	2021	Research article	ESA countries: Kenya, South Africa, Uganda
28	Strode et al: Adolescent self-consent to medical interventions in South Africa	2023	Research article	ESA country: South Africa
29	Amponsah-Dacosta et al: Human papillomavirus vaccination in South Africa: programmatic challenges and opportunities for integration with other adolescent health services?	2022	Research article	ESA country: South Africa
30	Mwambene: Recent legal responses to child marriage in Southern Africa: The case of Zimbabwe, South Africa and Malawi	2018	Research article	ESA country: Malawi, Zimbabwe, and South Africa
31	Kangaude et al: (De)Criminalizing adolescent sex: a rights-based assessment of age of consent laws in Eastern and Southern Africa	2018	Research article	ESA countries reviewed: Angola, Botswana, Burundi, Comoros, DRC, Eswatini, Ethiopia, Kenya, Madagascar, Malawi, Mozambique, Namibia, Rwanda, South Africa, Uganda, Zambia, Zimbabwe

{Table 1: Summary of sources of evidence reviewed (2019–2024)}

Age of legal consent for sexual activity

The SADC SRHR strategy 2019–2030 recommends ‘*reducing the age of consent to 16 years, irrespective of gender, taking into consideration the rights of adolescents and youth to healthy consensual sexual relations based on their evolving capacity, and include close-in-age provisions (known as Romeo and Juliet provisions)*’ (SADC, 2019). However, there is notable variation among many ESA countries on the age of consent to sexual activity, with age and gender disparity as defined in existing legal instruments and influenced by customary laws – see Table 2. According to the 2020 UNFPA report, the age of consent

varies from as low as 13 years in Comoros, 14 years (Namibia and Seychelles), 16 years (Swaziland, Lesotho, Mauritius, Malawi, South Africa and Zimbabwe), and 18 years (Botswana, Burundi, Eritrea, Ethiopia, Kenya, Mozambique, Rwanda, South Sudan, Tanzania, Uganda, Angola and DRC). Countries like Seychelles and Comoros, with very low thresholds of 13–14 years, risk exposing adolescents to coercion and abuse, contravening international conventions such as the Convention on the Rights of the Child (CRC). Several countries including Angola and DRC set different ages of consent for adolescent boys and girls, embedding gender disparity into statutory frameworks that undermine equal protection (Tallarico et al., 2021). Such inconsistencies not only contravene international human rights standards but also perpetuate systemic inequalities in access to protection and justice. In South Africa, while the age of consent for sexual activity is 16 years, the law decriminalizes consensual sexual activity between adolescents aged 12–16, and between adolescents, where one is under 18 but less than 2 years older than the other (Kangaude & Skelton, 2018). This close-in-age exemptions often referred to as a two-tier system is meant to avoid criminalizing consensual sexual activity between consenting peers. In contrast, Uganda laws explicitly criminalize sex between adolescents, with different provisions based on age. For instance, if both are under 12 years, it is not a criminal offense, whereas if one is under 12 years, the older child may be placed under supervision. If both are 12–18 years, they may be prosecuted as child offenders (Kangaude & Skelton, 2018). There has been changes in raising the age of consent to sexual activity in a few ESA countries, alluding to country efforts towards enforcing protective laws for adolescents. In January 2023, the Government of Zimbabwe raised the legal age of consent for sexual relations from 16 to 18 years through a statutory instrument issued by President Emmerson Mnangagwa (UNICEF, 2023). This change aims to enhance the protection of children and adolescents, particularly in response to concerns about early child marriage and exploitation, with perpetrators facing penalties of up to 10 years' imprisonment (VOA, 2024).

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

Country	Gender variation	Boys age	Girls age	Comments on exceptions and laws on (de)criminalizing sexual activity
Angola	Varies	18	16	Angola Penal Code. Adolescents under 18 with a sexual partner below 16 cannot be prosecuted under law
Botswana	Same	18	18	2018 Amendment raised age for boys and girls from 16 to 18 years. Law can prosecute adolescent under 18 having consensual sex with under 16.
Burundi	Same	18	18	Criminalizes sexual activity of under 18 with an adult, even if adolescent provides consent (Rape)
Comoros	Same	13	13	Law can prosecute adolescent under 18 having consensual sex with under 16.
DRC	Varies	18	14	Consensual sex among adolescents below the prescribed ages is prosecuted by law.
Eritrea	Same	18	18	No exceptions specified
Eswatini	Same	16	16	Consensual sex with adolescent girl below 16 is prosecuted by law.
Ethiopia	Same	18	18	Consensual sex among adolescents below 18 is prosecuted by law.
Kenya	Same	18	18	Consensual sex among adolescents below 18 is prosecuted by law. Sex with under 18 considered defilement.
Lesotho	Same	16	16	No exceptions specified
Madagascar	Same	14	14	Consensual sex with adolescent girl below 14 is prosecuted by law. Indecent assault of below 14-year-old girls is criminalised.
Malawi	Same	16	16	In terms of the Penal Code, sexual activity with a person under the age of 16 is criminalized.
Mauritius	Same	16	16	No exceptions specified
Mozambique	Same	18	18	Differences in age of consent reported in sources of evidence (16 vs 18 years). Consensual sex among adolescents below 16 is prosecuted by law.

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

Country	Gender variation	Boys age	Girls age	Comments on exceptions and laws on (de)criminalizing sexual activity
Namibia	Same	14	14	Consensual sex with a person below 14 years is not criminalized if the older party is not more than 3 years older
Rwanda	Same	18	18	Consensual sex among adolescents below 18 is prosecuted by law.
Seychelles	Varies	14	14	No exceptions specified
South Africa	Varies	16	16	Consensual sex between adolescents within 12 to 16 years is not criminalized. Where the older party is between 16 and 18 years, consensual sex is not criminalized if the older partner is not more than 2 years older.
South Sudan	Same	18	18	No exceptions specified
Tanzania	Varies	18	18 (12)	Differences in age of consent for girls reported in sources of evidence (12 vs 18 years). No exceptions specified
Uganda	Same	18	18	Consensual sex among adolescents below 18 is prosecuted by law.
Zambia	Same	16	16	Consensual sex with adolescent girl below 16 is prosecuted by law. Sex with under 16-year-olds is considered defilement and criminalized.
Zimbabwe	Same	18	18	Previously was 16 years until 2023 amendment of the law raising the age to 18 years.
<i>Sources: APHRC 2022; Kangaude 2018; Melesse et al 2020; SADC Strategy (2019–2030); SAT 2021 Ambia, Botswana and Malawi; Tallarico et al 2021; UNFPA 2020 and 2024.</i>				

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

Age of consent to marriage and child marriage prevention

Across all sources of evidence there was recognition of the marked variation in the age of consent for marriage by country, gender, and in some instances contradictions in the legal and customary laws regarding age/gender exceptions as summarized in Table 3. In all 23 ESA countries, 11 countries have the age of consent to marriage set at 18 years, and only seven countries do not permit exceptions (Tallarico, Ozah & Orievulu, 2021). These findings corroborate with the SADC SRHR scorecard reports of 2021 and 2023, where 13 countries had set the minimum legal age to consent to marriage at 18 years, and at 21 years in Botswana, Namibia and Zambia (SADC, 2021; 2023). In South Africa, the minimum age for boys (14 years) and girls (12 years) is below most of ESA country lowest age of consent, and marriage for this age group is permitted by a minister and parental consent required as stipulated in the

Customary Marriages Act 120 of 1998 (UNFPA, 2020). Further, there are contradictory provisions and disharmony between statutory and customary law provisions in South Africa, where there are approximately three age provisions: 12, 14 and 18 years (Tallarico, Ozah & Orievulu, 2021). To put this in context, customary practices that allow for child marriage with parental consent are prevalent in Southern African countries (Mwambene, 2018). In South Africa, the recognition of the Customary Marriages Act sets the minimum age for customary marriage at 18 years for both parties. However, the Act, read together with the Marriage Act, allows for marriage below 18 with parental consent (Mwambene, 2018). Some other Sub-Saharan countries, such as Angola and the Democratic Republic of Congo (DRC), have gender-differentiated ages of consent, with the legal age set lower for girls than for boys. (See Table 3)

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

Country	Gender variation	Boys age	Girls age	Comments on exceptions
Angola	Varies	16	15	With permission from persons with authority and in special circumstances review taking minor's best interest (Angola Family Code)
Botswana	Same	18	18	With parental consent (Marriage Act 2021)
Burundi	Varies	21	18	Exceptions may be granted if serious reasons by provisional governor (Code of Persons and Family 1993)
Comoros	Same	18	18	Exceptions may be granted if serious reasons by competent judge (<i>Code de la Famille</i> 2005)
DRC	Same	18	18	Stipulated in the Family Code and Child Protections Code No exceptions permitted
Eritrea	Same	18	18	Stipulated in the Transitional Civil Code as amended by the Proclamation 1/1991 No exceptions permitted
Eswatini	Varies	18	16	Ministerial exceptions though child marriages are outlawed (Children's Protection and Welfare Act).
Ethiopia	Same	18	18	Stipulated in the Revised Family Code of 2000. Minister of Justice can grant dispensation not more than 2 years for applications with serious cause.
Kenya	Same	18	18	Stipulated in the Constitution of 2010 and child marriage prohibited and criminalized under Child Act 2001 and 2022. No exceptions permitted
Lesotho	Varies	18	16	Minister must provide written permission for marriages of children below these stated (Marriage Act)
Madagascar	Same	18	18	Stipulated in the Family Code Law 2007. Permits court application of parents and children (with parental consent) for consideration to authorize marriage for children
Malawi	Same	18	18	Stipulated in the Constitution of 1994. The 2017 Constitutional Amendment has raised age of minority to 18 as child protection measures.
Sources: UNFPA 2020 and 2024; SADC Strategy (2019–2030); Melesse et al 2020; Mwambene 2018; Tallarico et al 2021; SADC SRHR Scorecards 2021 and 2023				

Country	Gender variation	Boys age	Girls age	Comments on exceptions
Mauritius	Same	18	18	Stipulated in the Civil Code. Exceptions apply for 16–18 with permission from persons with authority or under court.
Mozambique	Same	18	18	Stipulated in the Family Law Act 2004. No exceptions permitted
Namibia	Same	18	18	Stipulated in the amended Married Persons Equality Act. Waiver for age below 18, with written permission of a Minister if marriage is considered desirable.
Rwanda	Same (> 18yrs)	21	21	Stipulated in the Civil Code. Only in serious ground and person is over 18 years, can a Minister of Justice give a waiver of age No exceptions permitted
Seychelles	Varies	18	15	Marriages below this age can be prescribed by a Minister under serious reasons (Civil Status Act)
South Africa	Varies	14	12	Stipulated in the Marriage Act of 1961. Exceptions under the Customary Marriages Act 120 of 1998, where a minister and parental consent allows for marriage for children of this age
South Sudan	Same	18	18	Stipulated in the Transitional Constitution of 2011. Child marriage is prohibited and criminalized under Child Act 2009. No exceptions permitted
Tanzania	Varies	18	15	Court may allow marriage below specified age (Law of Marriage Tanzania). The Education Act of Zanzibar bans marriage for any enrolled learner until completion of basic education.
Uganda	Same	18	18	Stipulated in the Constitution of 1995. No exceptions permitted
Zambia	Same (< 18 yrs)	18	18	The landmark amendment, passed in December 2023, defines a child as a “person who has attained, or is below, the age of eighteen years”. Any marriage between persons where either is a child is void. No exceptions permitted.
Zimbabwe	Varies	18	18	The Marriage Act of 2020 provides that “No person under the age of eighteen years may contract a
Sources: UNFPA 2020 and 2024; SADC Strategy (2019–2030); Melesse et al 2020; Mwambene 2018; Tallarico et al 2021; SADC SRHR Scorecards 2021 and 2023				

Country	Gender variation	Boys age	Girls age	Comments on exceptions
				marriage or enter into an unregistered customary law marriage or a civil partnership”.
Sources: UNFPA 2020 and 2024; SADC Strategy (2019–2030); Melesse et al 2020; Mwambene 2018; Tallarico et al 2021; SADC SRHR Scorecards 2021 and 2023				

Evidence suggests that in Kenya, Malawi, Uganda, and Zambia, there has been a decline in the proportion of girls married or in union before 15 and 18 years, reflecting partial policy effectiveness (Melesse et al., 2020). Nevertheless, disparities persist across income quintiles, rural versus urban populations, and educational attainment, demonstrating that legal reforms alone are insufficient without complementary socio-economic interventions (Ayalew et al., 2022). It is evident that legislative reform alone does not guarantee the protection of adolescents from early marriage. Socio-cultural norms, economic vulnerabilities, and gendered power dynamics continue to drive child marriage, particularly in rural and low-income settings, undermining the impact of formal legal frameworks (Melesse et al., 2020; Ayalew et al., 2022). In addition, gaps in enforcement and limited public awareness of national laws contribute to persistent violations, as families may prioritize customary practices or economic considerations over statutory requirements (UNFPA, 2020; Watson et al., 2021). Educational attainment emerges as a critical protective factor, with evidence showing that girls who remain in school are less likely to enter early unions, reinforcing the interconnection between legal reform, education, and social empowerment (Starrs et al., 2024). Regional strategies, such as the SADC model law, emphasize multi-sectoral approaches that combine legal reform with community engagement, health interventions, and educational support to create an enabling environment for adolescents (UNFPA ESARO & Equality Now, 2023). Despite these initiatives, monitoring mechanisms remain fragmented, and reliable data on child marriage prevalence are limited, hindering targeted interventions and evaluation of policy effectiveness (Watson et al., 2021).

Variation in the legal age of marriage across ESA directly affects adolescents’ access to SRHR services and their sexual autonomy. Where laws set the marriage age below 18 years or allow exceptions, young girls face higher risks of early sexual debut, unintended pregnancies, and sexually transmitted infections, including HIV (Ayalew et al., 2022; Ninsiima et al., 2021). These risks intersect with inconsistently applied sexual consent laws, creating uncertainty around adolescents’ rights to contraceptives, HIV testing, and other SRH services (Barr-DiChiara et al., 2021; McKinnon & Vandermorris, 2019). For instance, while South Africa permits adolescents as young as 12 to consent to sexual activity and medical interventions, Kenya, Uganda, and Zimbabwe maintain higher age thresholds, often requiring parental or judicial approval (Starrs et al., 2024). Such discrepancies highlight the urgent need for harmonized legal frameworks across ESA that align marriage and consent laws with international standards, ensuring equitable access to SRHR services.

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

Adolescents comprehensive sexual and reproductive health education (CSE)

The momentum to prioritize comprehensive sexual and reproductive health education (CSE) for adolescents was signified after the endorsement of the ESA countries ministerial commitment on CSE in 2013 (UNFPA ESARO, 2024). This was re-affirmed in 2021 showing a continued dedication to its goals (CEHURD, 2022). Some recorded progress since the ministerial commitment implementation include 17 countries had a costed national CSE strategy or framework for out-of-school youth by 2018, with a target to increase to all 21 countries by 2020 – see Table 4 (Watson et al., 2021). In 2018, 14 out of 15 countries reported to have schools that provided life skills-based HIV and sexuality education in the previous academic year, though at varying levels of coverage (5% to 100%), with an aim to increase to 95% by 2020 (Watson et al., 2021). Based on the 2021 and 2023 SADC SRHR scorecards, most member states reported to be on track in achieving the 95% target to offer life skills-based HIV and sexuality education in primary schools (SADC, 2021; 2023). South Africa’s successful CSE approach involved working with the education ministry to develop lesson plans, posters and tailored media campaigns to increase awareness (AU, 2023).

Table 4
Progress with CSE implementation in ESA countries

CSE strategy domain	Progress by country since ESA ministerial commitment implementation
CSE strategies for out-of-school youth	Angola, Botswana, Burundi, DRC, Eswatini, Kenya, Lesotho, Madagascar, Malawi, Mozambique, Namibia, Seychelles, South Africa, Tanzania, Uganda, Zambia and Zimbabwe
Countries with national policy on pregnant learners	Angola, Botswana, Burundi, DRC, Eswatini, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Seychelles, South Africa, Tanzania, Uganda, Zambia and Zimbabwe
Integration of CSE in school curriculum (primary or secondary)	DRC, Ethiopia, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Uganda and Zambia.
CSE as an examinable subject	Malawi, Namibia, South Africa, Swaziland and Uganda
Schools providing life-skills based HIV and sexuality curriculum in 2018	100% coverage: Botswana, Kenya, Mauritius, Mozambique, Namibia, Seychelles, South Africa Others: Malawi (80%), Zimbabwe (78%), Lesotho (75%), Zambia (62%), Tanzania (53%), Rwanda (30%), Swaziland (30%), Madagascar (5%)
Countries providing pre- and in-service training on adolescent and youth friendly services	Angola, Botswana, Burundi, DRC, Eswatini, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Seychelles, South Africa, South Sudan, Tanzania, Uganda, Zambia and Zimbabwe
Sources: ESARO/UNFPA 2024; IPPF: ICPD + 25; UNFPA 2020; Watson et al 2021.	

Table 4: Progress with CSE implementation in ESA countries

There was steady progress and demand to provide pre-service and in-service CSE and SRHR training for health and social workers on delivering CSE and delivering adolescent and youth friendly health services. In 2015, only 10 countries reported offering pre-service training and 17 countries had in-service training established (Watson et al., 2021), and by 2018 all 21 countries had met this target (UNFPA ESARO, 2024). Additionally, 16 countries had and were implementing a comprehensive policy to manage adolescent pregnancy whilst in school, except for Ethiopia, DRC, Botswana, Angola and Lesotho (UNFPA ESARO, 2024). Regarding provision of adolescent and youth-friendly SRH (YFSRH) services, 65% of countries offer a standard minimum package of youth-friendly SRH services in 2015 (Watson et al., 2021). In 2018, some countries had improved the proportion of health service delivery point offering adolescent and youth-friendly SRH services i.e. Eswatini (74%), Kenya (23%), South Africa (100%), Tanzania (30%), Uganda (17%), and Zimbabwe (20%) (Watson et al., 2021).

However, significant challenges persist, for example it is estimated that below 50% of young people demonstrate accurate knowledge about HIV prevention and transmission (UNFPA ESARO, 2024). This falls short of the 2020 targets, which aimed to increase the proportion of adolescents and young people aged 10–24 demonstrating comprehensive HIV prevention knowledge 95% (Watson et al., 2021). Other prevailing challenges affecting CSE implementation include coverage gaps for out-of-school youth, opposition to CSE from some stakeholders, limited data disaggregation and weak monitoring for targeted interventions which has affected the efficiency of implementation in several countries (Achen et al., 2024; Watson et al., 2021). Coordination issues between ministries and siloed ways of working have also contributed to inefficiencies. Lastly, dissemination, implementation and enforcement of policy and legal changes at subnational levels have been limited among service providers and local decision-makers (UNFPA ESARO, 2024; Watson et al., 2021).

Age of consent for HIV testing and treatment

Adolescents' ability to self-consent to HIV testing and treatment varies widely in ESA countries, reflecting a lack of regional coherence. Table 5 provides a summary of the age of consent is provided, circumstances where parental consent or other authority permission is required, where evidence was available. In five of the 23 ESA countries, there was no reported information on the minimum age adolescents can access various HIV services. In South Africa, the Children's Act allows adolescents aged 12 and older to self-consent to HIV testing, ART, PrEP, and PEP if deemed sufficiently mature by a healthcare provider (Strode et al., 2023; Lane et al., 2021). By contrast, Uganda permits self-consent for HIV testing from age 12 under the HIV and AIDS Prevention and Control Act, but PrEP access remains ambiguous due to unclear statutory provisions (Barr-DiChiara et al., 2021). In Kenya there is no specific statutory age of consent for medical care and this could potentially create ambiguity regarding adolescents' access to PrEP (Lane et al., 2021). Countries like Botswana and Tanzania require parental consent for most HIV services, although exceptions exist for victims of sexual violence (SAT, 2019b; HiVOS, 2022a). Such legal barriers are associated with delayed diagnosis and treatment, increasing

adolescent vulnerability to HIV acquisition and poor clinical outcomes (Orth & Van Wyk, 2022; McKinnon & Vandermorris, 2019). Evidence indicates that lowering the age of consent for HIV testing and ensuring adolescent-friendly service provision improves uptake and adherence to care (Tallarico et al., 2021; APHRC, 2022).

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

Country	HIV testing & counselling	ART access	PREP	PEP	Comments on age and consent
Angola	15	NS	NS	NS	
Botswana	16 (PC)	18 (NPC)	18 (TA)	PC	HIV testing with parent consent
Burundi	NE	NE	NE	NE	
Comoros	NE	NE	NE	NE	
DRC	NE	NE	NE	NE	
Eritrea	18	NS	NS	NS	
Eswatini	16	12	12	12	
Ethiopia	15	NS	NS	NS	
Kenya	18 (NPC)	PC	PC	PC	
Lesotho	12	NS	NS	NS	
Madagascar	NE	NE	NE	NE	
Malawi	12 (PC)	16 (NS)	16 (NS)	16 (NS)	HIV testing with parent consent
Mauritius	NE	NE	NE	NE	
Mozambique	16*	NS	NS	NS	*Variation by source i.e. age 12, 16
Namibia	16	NS	NS	NS	
Rwanda	12	NS	NS	NS	*Variation by source i.e. age 12, 15
Seychelles	NE	NE	NE	NE	
South Africa	12	12–17	12–17	12–17	
South Sudan	18	NS	NS	NS	
Tanzania	18	NPC	NR	NPC	HIV testing with parent consent
Uganda	12	NS	NS	NS	
Abbreviations: NE: Not evaluated in cited evidence; NPC: No parental consent required or according to the policy or law; PC: Parental consent needed in the absence of clear policy guideline; NR: No age or other restrictions; NS: Age not specified, unclear; TPA: Third party authority					

Country	HIV testing & counselling	ART access	PREP	PEP	Comments on age and consent
Zambia	16 (PC)	16 (NS)	NS	16 (PC)	HIV testing with parent consent
Zimbabwe	16	16 (NS)	15 (NS)	16 (PC)	
Abbreviations: NE: Not evaluated in cited evidence; NPC: No parental consent required or according to the policy or law; PC: Parental consent needed in the absence of clear policy guideline; NR: No age or other restrictions; NS: Age not specified, unclear; TPA: Third party authority					

However, even where supportive legal frameworks exist, persistent barriers including stigma, negative parental attitudes, and variable healthcare provider practices continue to limit adolescents' actual access to services (Chandra-Mouli et al., 2019). In response, advocacy efforts increasingly emphasize the need to separate the age of consent for HIV services from the age of sexual consent, aiming to reduce misinformation and reduce structural barriers (Barr-DiChiara et al., 2021; McKinnon & Vandermorris, 2018). The overarching goal is to ensure that adolescents can access HIV testing and treatment based on informed and confidential consent, thereby supporting early diagnosis, timely treatment initiation, and effective prevention. This underscores the need for harmonized regional policies that balance protection with autonomy while addressing both legal and social determinants of access.

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

Access to contraceptives, HPV vaccination, and cervical cancer screening

Access to contraceptives for adolescents in ESA countries is constrained by inconsistent age-of-consent laws and parental consent requirements. South Africa and Botswana permit barrier methods for adolescents from ages 10–12 without parental consent, while hormonal contraceptives often require parental approval in Zimbabwe and Zambia (HiVOS, 2022a). In Kenya and Tanzania, no statutory age limits exist, yet cultural and provider biases can impede access (Perehudoff et al., 2022; Ninsiima et al., 2021). These barriers contribute to high rates of unintended pregnancies and related health complications among adolescents (Ayalew et al., 2022; Galal, 2024). Furthermore, emergency contraception is often provided only in exceptional circumstances, such as sexual violence, reflecting policy gaps between protective intentions and practical implementation (HiVOS, 2022a). Besides South Africa, few ESA countries have explicit statutory provisions regulating adolescents' access to contraceptives, creating significant barriers to uptake and undermining efforts to reduce new HIV infections among young people. Addressing this legal gap is critical, as evidence suggests that lowering age restrictions and eliminating unnecessary parental consent requirements can enhance contraceptive uptake among adolescents, thereby reducing maternal mortality and promoting SRHR (Starrs et al., 2024; Tallarico et al., 2021).

HPV vaccination programs have been rolled out in most ESA countries, predominantly via school-based initiatives targeting girls aged 9–13, though parental consent requirements vary (Black & Richmond, 2018; Amponsah-Dacosta et al., 2022). In Botswana and Zambia, consent requirements for adolescents under 16 exist, whereas in Kenya parental consent is generally not mandated (SAT, 2019c; UNFPA, 2020). Despite high policy coverage, vaccination uptake remains uneven, particularly among out-of-school adolescents, due to factors such as limited awareness and logistical challenges (Amponsah-Dacosta et al., 2022; UNFPA ESARO, 2024). Furthermore, as Naidoo et al. (2024) argue, effective HPV prevention requires addressing gender-specific barriers, such as masculine norms that discourage health-seeking behavior among boys and fostering a sense of shared responsibility. In the SADC region, the proportion of girls receiving recommended dose of HPV vaccine before age 15 is estimated at 72% in 2023, which is below target (SADC, 2023). Cervical cancer screening is similarly constrained, with adolescent-friendly services often lacking, limiting early detection and prevention efforts (Black & Richmond, 2018). Strengthening community awareness, integrating vaccination with broader adolescent health services, and harmonizing consent policies are critical to improving coverage and aligning with regional SRHR targets (SADC, 2023; Starrs et al., 2024). Ultimately, expanding HPV vaccination to include boys and engaging men through community education are essential strategies for breaking transmission cycles and achieving equitable cancer prevention (Naidoo et al., 2024).

Age of consent for legal abortion and post-abortion care

The Maputo Protocol, adopted in 2003, is a progressive African women's human rights treaty. The protocol emphasizes the need for post-abortion care (PAC), which includes providing appropriate medical attention and psychological support to women and girls who undergo an abortion, whether safe or unsafe (Banda, 2008). Post-abortion care, including treatment of complications from unsafe abortion, is recognized as a critical health service across ESA countries (Aantjes et al., 2018). By June 2023, 44 of 55 African Union member states had ratified it, though Botswana, Malawi, South Sudan, and Somalia in the ESA region have not, citing concerns over provisions such as abortion rights and cultural or religious sensitivities. Most ESA countries criminalize abortion with few countries providing room for exceptions at the discretion of health professionals or require parental consent – see Table 6 based on available data from sources included. South Africa, which has one of the most progressive abortion frameworks in ESA as per the Choice on Termination of Pregnancy Act (1996, amended 2008), allows abortion on request up to 12 weeks without parental consent and provides comprehensive post-abortion care services including counseling and medical care without age restrictions (Nabaneh, 2023). By contrast, most other countries in the region permit abortion only under restrictive circumstances, such as when parental consent is provided, to save the life of the mother, in cases of rape, or when the fetus has severe abnormalities (SAT, 2019; Starrs et al., 2024). For example, in Botswana, the law allows medical practitioners (i.e. doctors) to carry out an abortion within the first 16 weeks of pregnancy under the following circumstances: if the pregnancy arises from rape, defilement or incest; if the mother's life is at risk or may cause serious physical or mental disabilities to the unborn child (SAT, 2019).

Table 6
Minimum age of consent for legal abortion and post abortion care

Country	Legal abortion and post abortion care	Comments legal status and consent requirement
Botswana	NS (18)	Permitted
Eswatini	NS (18)	
Kenya	PC	Illegal by law
Malawi	NS (16)	Permitted. No clear directives on parental consent
South Africa	NPC	
Tanzania	NS (18)	Permissible to preserve woman's life
Uganda	NR	Permissible to preserve woman's life
Zambia	NS (16)	
Zimbabwe	NS (16)	Illegal by law but exceptions
<i>Abbreviations: NPC: No parental consent required or according to the policy or law; PC: Parental consent needed in the absence of clear policy guideline; NR: No age or other restrictions; NS: Age not specified, unclear; TPA: Third party authority</i>		

In contexts where abortion is criminalized or socially stigmatized, adolescents are often reluctant to seek care, leading to preventable complications (UNFPA, 2020; Starrs et al., 2024). These restrictive frameworks can drive adolescents to unsafe abortion practices, contributing to high rates of maternal morbidity and mortality (Ayalew et al., 2022; Ninsiima et al., 2021). Post-abortion care is legally mandated in most ESA countries, but implementation remains inconsistent, with service quality affected by provider biases, resource constraints, and inadequate adolescent-friendly approaches (Watson et al., 2021; Starrs et al., 2024). For example, research in Zimbabwe shows critical gaps in the availability of PAC services, where only 21% of facilities had basic PAC capability, 10% of referral facilities had comprehensive capability and only one-fourth (25%) of PAC patients were treated with the appropriate medical procedure (Riley et al., 2020). However, in 2024, Zimbabwe's Ministry of Health adopted new WHO-aligned abortion care guidelines to expand access within the parameters of existing law.

A few country level guidelines such as Kenya's National Adolescent SRH Policy (2015) and Uganda's Adolescent Health Policy Guidelines and Service Standards (2012) advocate for high-quality post-abortion care services as part of the broader adolescents SRH services (Perehudoff et al., 2022). However, these policies/guidelines fail to document mechanisms of removal of existing financial and legal barriers or third-party authorization that may hinder provision of broader contraceptive services including abortion from happening. With regards to gaps and policy directions, some countries have pledged commitments towards expanding safe abortion and post-abortion care as witnessed in country commitments to attain universal access to SRHR as envisioned in the International Conference on

Population and Development (ICPD) programme of action commissioned in 1994, and later reviewed in 2019 (ICPD, 2020). Eritrea epitomizes this vision, as the only African country to have made full commitments to include access to safe abortion to the full extent of the law, and measures for preventing and avoiding unsafe abortion care into the national universal health care (UHC) policy (ICPD, 2020). Specifically, Eritrea committed to reduce preventable maternal deaths to zero through integrating access to safe abortion, to the full extent of the law, into UHC strategies, policies and programmes, to protect and ensure all individuals’ (including adolescents) right to bodily integrity, autonomy and reproductive rights.

Access to safe abortions for adolescents in ESA remains constrained by both structural and social barriers. Even where supportive legal frameworks exist, adolescents frequently encounter misinformation, stigma, provider bias, and systemic obstacles that delay or deny services (Koiwa et al., 2024). In South Africa, despite having one of the region’s most progressive abortion laws, evidence indicates persistent challenges in enforcing adolescents’ rights to abortion without parental consent or discrimination (Kangaude et al., 2022). Systematic tracking and documentation are therefore critical to assess progress and ensure accountability in advancing ASRHR.

Table 6: Minimum age of consent for legal abortion and post abortion care

Implications for policy, research, and practice

Significant policy gaps persist in the ESA region’s legal and policy frameworks governing adolescent SRHR. Age of consent laws for sexual activity remain inconsistent, with some countries setting thresholds as low as 13 years while others embed gender disparities that undermine equal protection, leaving adolescents vulnerable to coercion and criminalization. Similarly, contradictions between statutory and customary laws on marriage create loopholes that perpetuate child marriage, despite regional and international commitments. Access to SRHR services is further constrained by ambiguous or restrictive consent requirements for contraception, HIV testing, and abortion care, with most countries apart from South Africa lacking explicit statutory provisions that guarantee adolescents’ confidential access. Comprehensive sexuality education has expanded, yet coverage remains uneven, hindered by political resistance, poor coordination, and limited domestic resource mobilization (Watson et al., 2021). To address these gaps, ESA countries should harmonize legal frameworks to set the minimum age of marriage at 18 years without exceptions and without gender differentiation, in accordance with continental and global human rights instruments. These provisions must override customary, religious, or traditional laws that allow for child marriage. Zimbabwe’s recent reform to raise the age of sexual consent to 18 years is an important precedent that illustrates regional momentum toward stronger child protection. Framing SRHR as an integral part of health systems, akin to access to immunization or primary care aligns with SDG 3.7 which seeks to ensure universal access to sexual and reproductive health-care services and the integration of reproductive health into national strategies and programmes by 2030 (Sachs et al., 2021).

Access to SRHR services should be guided by assessments of child and adolescent development, competence, and the principle of evolving capacities, as enshrined in the Convention on the Rights of the Child (UN, 1989). Restrictive age-based laws that disregard maturity levels risk denying capable adolescents essential health services, thereby undermining both autonomy and health outcomes. The legal age of consent to sexual activity should not exceed 16 years and must apply equally to boys and girls, as higher age thresholds may criminalise consensual sexual activity between adolescents, discourage young people from seeking SRHRs, and create barriers to HIV prevention, contraception, and other essential healthcare. An age of consent of 16 years is more consistent with international human rights principles that recognise adolescents' evolving capacities while maintaining legal protections against sexual exploitation and abuse. Gender-differentiated laws, such as those found in Angola and the DRC, entrench discrimination, violate equality principles, and perpetuate systemic vulnerabilities for girls, particularly around protection and access to justice.

Legal frameworks should incorporate close-in-age provisions that exempt consensual sexual activity between peers from criminal prosecution (Strout, Vasudevan & Shah, 2020). Without such exemptions, adolescents may face unnecessary criminalization, which can have long-term social, psychological, and legal consequences. This approach balances protection from exploitation with recognition of adolescent agency. Governments should also lower barriers to HIV testing and contraceptive access by eliminating unnecessary parental consent, while scaling up adolescent-friendly HPV vaccination in line with WHO recommendations including extending coverage to men and boys along with cervical cancer screening, and confidential post-abortion care (WHO, 2018). Crucially, legal reform must be integrated with community engagement, socio-economic support, and education initiatives to shift harmful norms and ensure that reforms translate into real improvements in adolescent health, rights, and wellbeing across the region.

Conclusion

This review demonstrates that fragmented, inconsistent, and at times discriminatory age-of-consent frameworks in the ESA region continue to undermine adolescents' sexual and reproductive health and rights. While regional and international instruments provide a robust normative foundation, many national laws remain misaligned. A central challenge lies in balancing the protection of minors from exploitation with recognition of adolescents' evolving autonomy. Setting the age of consent too high risks criminalizing normative, consensual peer relationships and severely restricting access to essential SRH services. Evidence confirms that laws enabling adolescents, typically from age 12, to independently consent to HIV testing and treatment are critical for uptake and improved health outcomes, whereas mandatory parental consent often deters access due to stigma, fear, or fractured family structures. Harmonizing legal frameworks is therefore paramount, as ambiguities create confusion for adolescents, providers, and law enforcement, and risk excluding marginalized youth. Effective policies must incorporate close-in-age exemptions, adopt a gender lens, and reflect social realities, acknowledging that adolescents engage in sexual activity at varying ages. Criminalization without parallel access to comprehensive sexuality education and youth-friendly services is both ineffective and harmful. Although

progress has been made in expanding CSE and youth-friendly health services, gaps in enforcement, resource allocation, and community acceptance persist. Advancing coherent and rights-based consent policies is central not only to reducing adolescent HIV infections, early pregnancies, and maternal mortality, but also to unlocking the demographic dividend and promoting inclusive, sustainable development across the ESA region. Ultimately, effective age-of-consent policies must combine protection with respect for adolescent agency, ensuring legal frameworks are harmonized, practical, and responsive to the health and rights of all young people.

Declarations

Conflicts of interest/Competing interests

Not applicable

Ethical Approval

This article does not contain any studies with human participants performed by any of the authors.

Informed Consent

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Author Contribution

P.N., R.H. and K.G. led the conceptualization, literature review, data synthesis, and manuscript drafting. L.M., R.I., M.T. and C.M. contributed to data interpretation, regional contextualization, and critical review of the manuscript. All authors reviewed and approved the final version of the manuscript.

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Code availability

Not applicable

Data Availability

All data supporting the findings of this study are available within the paper and its Supplementary Information.

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