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Children and adolescents as subjects of sexual health care

1 Introduction

Two major global conferences, the International Conference on Population and Development (ICPD) and the Fourth World Conference on Women (FWCW), affirmed sexual and reproductive health as a fundamental human right. The ICPD Programme of Action (PoA) and the FWCW Platform for Action (PfA) recognised gender equality and the empowerment of women and girls as central to human development at individual, community and societal levels.[1] In this context, the ICPD Programme of Action articulated an expectation that states promote the health, well-being and potential of children, adolescents and the youth, including involving them in shaping services relevant to their lives, particularly sexual and reproductive health services.[2] It further emphasised that access to such services, including confidentiality and privacy, must be framed in relation to parental guidance and the Convention on the Rights of the Child (CRC).[3]

Because Malawi's Gender Equality Act (GEA) draws substantively on these international frameworks and legal norms, it provides an important context for examining how globally articulated sexual and reproductive health and rights (SRHR) standards are interpreted, implemented and contested within the national legal and policy domains, particularly concerning children and adolescents.[4] However, despite the apparent

1 United Nations Beijing Declaration and Platform of Action, adopted at the Fourth World Conference on Women, 27 October 1995 (1995); United Nations Population Fund Programme of Action of the International Conference on Population and Development Cairo, 5-13 September 1994 (20th Anniversary Edition) (2014).
2 United Nations Population Fund (n 1) para 6.7.
3 United Nations Population Fund (n 1) para 6.15.
4 The Gender Equality Act 3 of 2013 (Malawi) has already been introduced in the chapters above.

normative consensus reflected in instruments such as the ICPD and FWCW, significant contestation persists. This is especially evident in areas where sexuality intersects with deeply embedded cultural, religious and moral norms.

One of the most contested areas of SRHR concerns whether, and under what conditions, unmarried young people, particularly girls, are recognised as legitimate subjects of sexual health care. This resistance is sustained by dominant discourses that deny the sexual subjectivity of children and adolescents. A related site of contestation lies in the recognition of sexual conduct as a normative dimension of child and adolescent development.[5] Prevailing constructions of childhood as asexual, together with the framing of sexuality as appropriate only after puberty or within marriage, work to foreclose the intelligibility of children and adolescents as sexual agents. As a result, the promise of the ICPD and FWCW remains unevenly realised: Young people continue to be discursively excluded from recognition as sexual beings with sexual rights.[6]

In formulating the GEA, the Malawi Law Commission (MLC) recognised the need for a holistic approach to sexuality, one that attends to the complex, discursively constituted nature of sexual behaviour. In its analysis, the MLC observed that these complex factors 'address the question whether the expression of sexuality leads to sexual health and well-being or to sexual behaviour that puts people at risk or makes them vulnerable to sexual and reproductive ill-health'.[7] In doing so, the MLC arguably extended the scope of rights discourse to include children and adolescents by grounding sections 19 and 20 of the GEA within a rights-based and non-discriminatory framework. At the same time, the realisation of sexual health for children and adolescents entails negotiating, and at times unsettling, social and cultural norms that render child sexuality a taboo topic.

This chapter explores how the GEA may operate as a site for renegotiating norms that shape whether, and how, children and

5 C Barroso 'Beyond Cairo: Sexual and reproductive rights of young people in the new development agenda' (2014) 9 *Global Public Health* 641.

6 SJ Jejeebhoy and others 'Meeting the commitments of the ICPD Programme of Action to young people' (2013) 21 *Reproductive Health Matters* 21-22.

7 Malawi Law Commission Report of the Law Commission on the development of the Gender Equality Act (2011) 57.

adolescents are recognised as subjects of sexual health care. In particular, the chapter explores how legal frameworks structure the conditions under which children's sexual agency becomes intelligible within healthcare settings, including access to services, confidentiality and decision making. It asks how law might constitute more enabling subject positions for children as users of sexual healthcare services, and how adult-child relations, especially those involving parents, healthcare providers and the state, are configured in ways that either enable or constrain the realisation of sexual health and rights.

A central antecedent to the realisation of sexual health and rights during childhood and adolescence is the development of sexual autonomy through everyday social interaction. Yet, children's emerging sexual autonomy frequently encounters parental authority and state regulation. As Allen and Ingram observe, 'adults seek to block their access to crucial aspects of sexual scripts, thus making the acquisition of sexual knowledge and coming to terms with their own sexuality far more problematic than it might otherwise be'.[8]

Parental authority and state regulation thus shape the conditions under which children's sexual health and rights become intelligible and actionable. Advancing children's sexual health entails navigating a persistent tension between, on the one hand, recognition of sexual agency as a condition for well-being and, on the other, parental control and state intervention that often constrain such recognition. As Levesque explains, law structures this tension in multiple ways: through parental presumptions that limit state intervention in family life; through the doctrine of *parens patriae*, which authorises state supervision of children; and through criminal and regulatory powers, such as age of consent laws, that may restrict adolescents' consensual sexual activity and, in turn, their access to sexual health services.[9] Levesque further notes that 'although adolescents' rights have been recognised, they have not been fashioned in ways that substantially alter the distribution of power between

8 L Allen & T Ingram '"Bieber fever": Girls, desire and the negotiation of childhood sexualities' in E Renold and others (eds) *Children, sexuality and sexualisation* (2015) 42-43.

9 RJR Levesque *Adolescents, sex, and the law: Preparing adolescents for responsible citizenship* (2000) 35.

adolescents, parents, and state: Parents and the state largely control the content and expression of adolescents' rights.'[10]

This insight is critical for analysing the GEA's potential to transform sexual health for children and adolescents. Autonomy is not a zero-sum condition premised on independence from others. Rather, as Nedelsky argues, autonomy is constituted through relationships of interdependence; it emerges within social and institutional arrangements that enable individuals to develop the capacity for self-direction.[11] The child's autonomy, just as the adult's, is therefore realised through the relational networks in which the child is situated. Agency is thus best understood not as an intrinsic property of the individual, but as emerging within networks of dependence.[12]

Against this backdrop, the enactment of the GEA can be read as signalling a willingness by the state to recognise children as subjects of sexual health care. This recognition is reflected in the GEA's language, which implicitly acknowledges children's entitlement to services without discrimination. Section 20(1)(a), for example, requires healthcare providers to provide services without discrimination, while section 20(1)(c) mandates the provision of family planning services irrespective of marital status or spousal accompaniment. These provisions open interpretive space for understanding children and adolescents as legitimate users of sexual healthcare services. Whether such recognition is realised in practice depends on the ways in which duty bearers interpret and enact the GEA, and on how these practices shape the conditions for children's sexual agency.

This chapter, therefore, examines how children and adolescents are constituted as subjects of sexual health care within Malawi's legal and policy framework. Focusing on the Youth-Friendly Health Services (YFHS) programme as a key site of implementation, it analyses how adult-child power relations are negotiated within healthcare encounters, and how these relations shape possibilities for ethical, relational and inclusive practices of sexual health care.

10 Levesque (n 9) 35-36.
11 J Nedelsky 'Reconceiving autonomy: Sources, thoughts and possibilities' (1989) 1 *Yale Journal of Law and Feminism* 20.
12 N Lee 'Towards an immature sociology' (1998) 46 *The Sociological Review* 459.

2 Youth-Friendly Health Services (YFHS)

The concept of adolescent-friendly health services was articulated in a programming document by WHO in 2002 and has since gained wide acceptance.[13] However, the idea of facilitating the inclusion of young people in healthcare services was already evident at the ICPD. Drawing on the ICPD Programme of Action, subsequent United Nations (UN) commitments, including the 2001 UN General Assembly Special Session on HIV and AIDS, and the World Health Organisation (WHO)'s programmatic guidance, countries such as Malawi developed National Standards on Youth-Friendly Health Services (YFHS Standards). Malawi has implemented the YFHS programme since 2007, with the stated aim of increasing the accessibility and acceptability of health services for young people.[14]

The YFHS Standards articulate five core benchmarks intended to guide service provision. These benchmarks require that services be delivered in accordance with existing policy frameworks; that young people access services responsive to their needs; that health information be tailored to age, context and stage of development; that healthcare providers possess appropriate knowledge, skills and attitudes; and that data on young people's health be systematically collected and analysed.[15] These benchmarks do more than describe service delivery goals: They construct young people as particular kinds of subjects – users of services, recipients of information and objects of data – within a regulatory framework that seeks to balance protection, access and control.

The YFHS Standards form part of the architecture of the broader policy on adolescent sexual and reproductive health, alongside policy documents such as the National Policy on Sexual and Reproductive Health and Rights[16] and the National Youth-Friendly Health Services

13 World Health Organisation *Adolescent friendly health services. An agenda for change* (2002); World Health Organisation *Global standards for quality health-care services for adolescents* (2015).

14 Ministry of Health *National standards on youth friendly health services 2015-2020* (2018) 14.

15 Ministry of Health (n 14) 21-22.

16 Ministry of Health *National sexual and reproductive health and rights (SRHR) policy 2017-2022* (2017).

Strategy.[17] For the purposes of this chapter, however, the YFHS Standards are treated not primarily as policy instruments, but as a site through which legal, social and cultural norms concerning children's sexuality are enacted within healthcare settings, particularly in relation to sexual health.

An evaluation of the YFHS programme in Malawi was completed in 2014, and the results were reported in the Evaluation of Youth-Friendly Services in Malawi (YFHS Evaluation).[18] This chapter draws on that evaluation, especially its findings on personal, social and structural barriers affecting young people's access to services. Rather than approaching these barriers as implementation failures, the analysis treats them as entry points for examining the discursive and normative conditions through which children's sexual agency is enabled or constrained, and through which the GEA is interpreted and enacted in practice. While financial, political and governance factors are acknowledged as relevant, they fall outside the scope of this book, which instead focuses on the interaction between social norms and the legal framework established by the GEA.

The YFHS Evaluation gathered data from young people aged 10 to 24 years, with findings presented according to three age categories: 10 to 14, 15 to 19 and 20 to 24 years. In line with Malawi's legal definition, this chapter limits its scope to the experience of the child – defined as any person below the age of 18. Although overlaps between age categories make it difficult to isolate findings exclusively relating to those under 18, this does not detract from the chapter's central concern: to analyse how socio-cultural norms shape children's positioning as subjects of sexual health care, and how these norms interact with the rights-based framework of the GEA.

2.1 The meaning of 'friendliness' for the child as a sexual subject and adolescent

In international human rights and public health discourse, 'friendliness' in youth healthcare services is understood as a rights-based standard

17 Ministry of Health *National youth-friendly health services strategy 2015-2020* (2015).

18 Evidence to Action Project 'Evaluation of youth-friendly health services in Malawi' (2014).

that requires services to be accessible, acceptable, confidential and non-discriminatory, and to recognise children's evolving capacities, rather than being shaped by moral or ideological constructions of childhood sexuality.[19] Building on the understanding that YFHS is a key site through which children are constituted as subjects of sexual health care, this part of the book examines how the notion of 'friendliness' is given meaning in practice, particularly in relation to children's sexual knowledge, experiences, and emerging needs.

Evidence from the YFHS Evaluation illustrates these dynamics: 72 per cent of adolescents aged 10 to 14 years had heard of or talked about sex, and about 13 per cent had already engaged in sexual activity.[20] Not surprisingly, the percentage of those who report sexual activity increases with age. Almost 52 per cent of adolescents aged 15 to 19 had had sex. The median age of having had sex for both males and females was 16.[21] Of the sexually active youth aged 10 to 24, almost 50 per cent used contraceptives, most commonly the male condom. The most popular facilities at which male condoms were obtained were government facilities, hospitals, health centres, outreach posts, and from health surveillance assistants or community-based distribution assistants. About 25 per cent of the adolescents obtained contraceptives from the market or shops.

Another finding of the YFHS Evaluation, reported with some degree of surprise by the authors of the evaluation report, was that '[a]wareness about sex is high, *even among the youngest age group* – those 10-14 years old'.[22] Yet, this is not unexpected: Long before sexual intercourse begins, children encounter questions, meanings and norms related to sexuality that shape their emerging understandings of sexual conduct and impact their sexual well-being. These encounters and experiences generate sexual health-related needs that are not reducible to sexual activity alone.

19 Committee on the Rights of the Child General Comment 4: Adolescent health and development in the context of the Convention on the Rights of the Child, CRC/GC/2003/4 (1 July 2003); Committee on the Rights of the Child General Comment 20: The implementation of the rights of the child during adolescence UN Doc CRC/C/GC/20 (6 December 2016); World Health Organisation 'Global consultation on adolescent friendly health services – A consensus statement' Geneva: World Health Organisation (2002) 29.

20 Evidence to Action Project (n 18) 51.

21 As above.

22 Evidence to Action Project (n 18) 12 (my emphasis).

Indeed, there is a growing recognition, globally, of the need to address the sexual health concerns of younger adolescents.[23]

In their work, Suleiman and others describe how biophysiological changes associated with puberty, including hormonal and neurological developments, shape early and nascent sexual behaviours and experiences.[24] By around the age of 10 years, children often begin to develop interests in romantic relationships, affection and intimacy. The surprise expressed by the authors of the YFHS Evaluation at children's engagement in sexual talk thus reflects adult assumptions about childhood sexuality rather than that there is a problem with children talking about sex. As Suleiman and others explain, early crushes and sexual curiosity among pubescent children are normative features of human development. From this point, sexual interests and experiences tend to intensify rather than recede. Consistent with this, as described above, the YFHS Evaluation found that by the age of 16, approximately half of the young people surveyed reported to have had initiated sexual intercourse.

When read through the lens of 'friendliness' as a rights-based standard, age thresholds within YFHS standards are not objective truths but socially constructed norms that govern the recognition of children as legitimate subjects of sexual health care. The YFHS programme focuses on the child or adolescent of 10 years or older.[25] While this age-based boundary reflects a developmental logic, it risks reinforcing artificial discontinuities. Social policies often frame sexuality development through fixed chronological stages, obscuring its continuous and evolving character.[26] Framing sexuality development through fixed chronological thresholds can inadvertently reinscribe a binary between the sexual and the pre-sexual child. Yet, even where younger children do not grasp sexuality in the same way as older adolescents, they nevertheless participate

23 V Woog & A Kågesten *The sexual and reproductive health needs of very young adolescents aged 10-14 in developing countries: What does the evidence show?* (2017) 4.

24 AB Suleiman and others 'Becoming a sexual being: The "elephant in the room" of adolescent brain development' (2017) 25 *Developmental Cognitive Neuroscience* 209.

25 V Chandra-Mouli and others 'Twenty years after international conference on population and development: Where are we with adolescent sexual and reproductive health and rights?' (2015) 56 *Journal of Adolescent Health* S5.

26 W Simon & J Gagnon *Sexual conduct: The social sources of human sexuality* (2017) 6.

in processes of meaning-making as their linguistic, communicative and cognitive capacities evolve.[27] The view that children below the age of 10 are non-sexual reflects dominant discourses of childhood innocence that obscure young children's capacity to engage with meanings of sexuality.[28]

In light of findings that very young adolescents talk about sex and, in some cases, engage in sexual activity, the authors of the YFHS Evaluation proposed a review of the content of sexuality education, 'particularly those related to misconceptions about sex, contraception, and pregnancy'.[29] From a discursive perspective, such recommendations draw attention to how definitions of friendliness are shaped by assumptions about readiness, risk and legitimacy.

While attention to risk and harm remains an important dimension of sexual health care, an exclusive focus on danger may undermine the recognition of children and adolescents as developing sexual subjects. When dominant discourses construct children as non-sexual, or render their sexual development problematic, adults may become less willing or less able to engage with young people's sexuality in ways that support ethical navigation, autonomy and well-being. In this sense, 'friendliness' is compromised not only by denial of services, but by discursive frameworks that fail to acknowledge children's evolving capacities as sexual subjects.

2.2 The challenges for children and adolescents amidst adult anxieties about sexualisation

Sexual agency is a key concept running throughout this book. In this part, it is taken up to analyse findings from the YFHS Evaluation concerning the socio-cultural factors that constrain children's and adolescents' sexual agency, particularly through the influence of parents, community gatekeepers and healthcare providers. These constraints are mediated through anxieties related to sexualisation, that is, discursive processes through which children are perceived to move from a pre-sexual state to sexual maturity, as interpreted through prevailing social norms and cultural scripts. Sexualisation operates as a gendered lens through which

27 S Jackson & S Sue 'A sociological history of researching childhood and sexuality: Continuities and discontinuities' in Renold and others (n 8) 43.

28 J Kitzinger 'Defending innocence: Ideologies of childhood' (1988) 28 *Feminist Review* 77-78.

29 Evidence to Action Project (n 18) 14.

children's sexuality is rendered risky, inappropriate or dangerous, shaping adult responses to both sexual knowledge and access to sexual health care.

The perspectives of parents and other adults, as documented in the YFHS Evaluation, provide insight into how adolescent sexual behaviour is viewed. In one focus group discussion, parents stated: '[Sexual] problems arise from girls who put on miniskirts with the aim of seducing boys to have sex with them with this resulting in transmission of HIV/STIs. Government should introduce punishments for these girls and they should be jailed for one week.'[30]

Elsewhere in the YFHS Evaluation, adults expressed similar sentiments in the following manner:[31] 'Today, girls go on their own to their boyfriends' houses. There are some old men who have sexual relationships with them and when they become pregnant the men abandon them. This is seen as a big problem because children's rights are being abused.'

As these quotes illustrate, parents and adult gatekeepers often express anxiety about the sexuality of girls. Girls who display sexual agency are either cast as dangerous temptresses leading boys astray or as vulnerable victims of adult male sexuality. These anxieties reflect dominant discourses of childhood innocence, where good girls are imagined as sexually passive and non-agentic, while girls who express desire or autonomy are positioned as deviant, precocious, or morally suspect.[32]

Sexuality, as Hawkes and Egan argue, 'has come to symbolically represent and to operate as the key dynamic in the naturalization of fears about risks posed to children by the prevailing social environment. Sexualization is thus emblematic of instability and danger, both for the individual and the social order.'[33]

Discourses of sexualisation frame children's emerging sexuality as a threat both to individual well-being and to the moral order, rendering sexual agency a site of fear rather than development. These anxieties are deeply gendered: Sexualisation is overwhelmingly constructed as a danger associated with girls rather than boys.

30 Evidence to Action Project (n 18) 162.
31 Evidence to Action Project (n 18) 163.
32 Jackson & Sue (n 27) 143.
33 G Hawkes & RD Egan 'Landscapes of erotophobia: The sexual(ized) child in the postmodern Anglophone West' (2008) 12 *Sexuality & Culture* 194.

Findings from the YFHS Evaluation illustrate how such discourses circulate in Malawian contexts. Parents and other adult gatekeepers frequently attributed social problems, such as HIV transmission, early pregnancy and moral decline, to girls' clothing, mobility and perceived sexual assertiveness.[34] Girls were described as seductive, disrespectful or insufficiently restrained, while boys' sexual behaviour was comparatively naturalised or left unexamined. Access to youth-friendly sexual health services was also framed as encouraging defiance of cultural values, with parents expressing concern that the YFHS programme enabled young people to access services of which they did not approve, and thereby facilitated moral transgression.[35]

These narratives reveal how adult anxieties about sexualisation function to constrain children's sexual agency. Hawkes and Egan define agency as 'a level of self-consciousness and independence from and even resistance to restricting social structures within which the agentic individual is positioned'.[36] Understood in this way, agency entails choice, including the possibility of conforming to, negotiating or resisting prevailing norms. Sexual agency refers to the capacity to position oneself as a sexual subject in relation to dominant discourses that structure meanings of sexuality by invoking norms of respectability, risk and morality.

Sexuality, as Hawkes and Egan argue, has come to represent and operate as a focal point for broader anxieties about social instability and risk. In their analysis of Anglophone Europe, they observe that sexualisation is constructed as a danger to young people, and that this construction is directed primarily at girls.[37] Discourses of sexualisation thus frame children's emerging sexuality as a threat both to individual well-being and to the moral order. It is precisely this possibility of resistance that generates adult anxiety, a dynamic evident not only in the Anglophone contexts examined by Hawkes and Egan, but also in Malawi, as reflected in the findings of the YFHS Evaluation.

Grant's study, introduced in chapter 4, conducted in rural Malawi, reveals how anxieties about girls' sexuality translate into material

34 Evidence to Action Project (n 18) 162.
35 Evidence to Action Project (n 18) 166.
36 Hawkes & Egan (n 33) 195.
37 As above.

constraints on their educational trajectories.[38] Grant found that parents often overestimated pregnancy as the primary reason for girls' school drop-out, while underappreciating how their own fears and restrictive practices limited their daughters' choices.[39] Parents attempted to control girls' sexuality by forbidding relationships with boys, driven by the assumption that their daughters' sexual agency would inevitably result in pregnancy and school failure. Girls who resisted such control were labelled stubborn or rebellious. Grant further shows that poverty shaped these dynamics: Economic hardship not only limited material support but also influenced how parents perceived sexually mature daughters, as future wives or burdens rather than as individuals in whom to invest. This attitude led parents to invest instead in sons' education.[40]

However, Hawkes and Egan caution against reducing the pathologisation of female sexuality to economic explanations alone. They emphasise that female sexuality has historically been constructed as dangerous regardless of class position.[41] In their analysis of Anglophone Europe, sexualisation is framed as a threat to social order, especially for girls. This pattern resonates with the Malawian context documented in both the YFHS Evaluation and Grant's study. Colonial histories, globalised norms of adolescence and schooling systems developed to regulate young people for capitalist and patriarchal social orders have shaped contemporary understandings of female adolescence. The subjugation of Black female sexuality during colonialism further contributes to the persistence of these meanings.[42] Therefore, the pathologisation of female sexuality described by Hawkes and Egan demonstrates that anxieties about sexualisation are neither local nor incidental, but structurally and historically produced.

As Robinson and Davies observe, 'through the repressive regulations around children's access to sexual knowledge, society contributes to

38 MJ Grant 'Girls' schooling and the perceived threat of adolescent sexual activity in rural Malawi' (2012) 14 *Culture, Health & Sexuality* (2012) 73.
39 Grant (n 38) 76.
40 Grant (n 38) 84.
41 Hawkes & Egan (n 33) 195.
42 C Macleod 'Danger and disease in sex education: The saturation of "adolescence" with colonialist assumptions' (2009) 11 *Journal of Health Management* 381; N Lesko *Act your age! A cultural construction of adolescence* (2012) 10-11; A Coetzee & L du Toit 'Facing the sexual demon of colonial power: Decolonising sexual violence in South Africa' (2018) 25 *European Journal of Women's Studies* 216-217.

children's misinformation around sexuality, their increased vulnerability to sexual exploitation and abuse, and to their potential lack of sexual health and well-being'.[43]

Read together, Grant's findings and the YFHS Evaluation demonstrate how parental and community anxieties about sexualisation operate as key barriers to girls' educational continuation and access to sexuality-related knowledge and services. Adolescents who persist in asserting sexual agency, whether through maintaining intimate relationships or seeking healthcare services, are frequently cast as rebellious, dangerous or deviant. In this way, sexualisation-related anxieties function not only as moral discourses, but as mechanisms that actively constrain girls' agency and life chances.

The rights recognised in the GEA have horizontal application, meaning that their binding force is not confined to the state, but extends to relationships between private actors. In this sense, third parties, including parents, fall within the scope of duties generated by the GEA in their interactions with children. However, enforcing these rights in the face of parental resistance is challenging due to the private nature of the family sphere and the state's traditionally deferential stance toward parental authority. Comparative jurisprudence offers insight into how courts have approached the limits of such authority where children's health rights and evolving capacities are at stake.

For instance, in the UK case of *Gillick v West Norfolk & Others*,[44] a parent challenged the treatment protocol that allowed a doctor to provide contraceptive advice and services to minors under 16 without parental consent. The House of Lords held that where a health provider could establish that an adolescent had sufficient maturity and competence to understand the nature and implications of the treatment, parental consent was not required. The case articulated what later became known as Gillick competence, recognising children as rights holders capable of making autonomous health decisions in certain circumstances.

The CRC Committee's General Comment 15 has similarly affirmed that the right of children to health entails freedoms and entitlements that

43 K Robinson & C Davies 'Docile bodies and heteronormative moral subjects: Constructing the child and sexual knowledge in schooling' (2008) 12 *Sexuality & Culture* 223.

44 1986 (1) AC 112.

expand in importance with children's evolving capacity and maturity. These include the right to control one's health and body and to make sexual and reproductive decisions.[45] While not stated explicitly, such freedoms necessarily encompass decisions about whether to engage in sexual activity, the nature of such activity, and access to sexual and reproductive health information, goods and services, including contraception. The Committee has further recognised that children may access healthcare services without third party consent where this is consistent with their evolving capacities and best interests.[46]

Still, in practical terms, the enforcement of such rights remains challenging. Parents may exert control through informal means, such as withholding resources or denying permission to visit clinics, or indeed simply by the silence around sexuality matters. These subtle barriers fall largely outside the reach of formal legal enforcement, yet they fundamentally restrict children's access to care. The mere existence or availability of services is, therefore, insufficient to ensure access. For the YFHS programme to be effective, it must engage with and disrupt the normative structures that prevent children and adolescents from exercising sexual agency. In this respect, the GEA provides a legal and normative framework that can be mobilised to support such engagement.

The existence of a rights-entrenching law, such as the GEA, does not in itself guarantee realisation of rights in practice. As Morison demonstrates in her discursive study of contraceptive providers, power asymmetries between patients and providers may be obscured by the language of rights-based care.[47] Providers may endorse reproductive choice in principle while engaging in directive or coercive practices, often justified through benevolent intentions and normative assumptions about responsible sexuality. Such practices, though framed as empowering, may in fact constrain agency, particularly for those deemed vulnerable or 'at risk'.

45 Committee on the Rights of the Child General Comment 15: The right of the child to the enjoyment of the highest attainable standard of health (art 24) UN Doc CRC/C/GC/15 (17 April 2013) para 24.

46 General Comment 15 (n 45) para 31.

47 T Morison 'Patient-provider power relations in counselling on long-acting reversible contraception: A discursive study of provider perspectives' (2023) 25 *Culture, Health & Sexuality* 548.

If adult women, situated in more visible and legally protected frameworks, can experience paternalistic coercion under the guise of empowerment, how much more vulnerable are adolescents, whose agency is already delegitimised by dominant constructions of childhood innocence and dependency? Indeed, practices presented as youth-friendly or rights-based risk reproducing the very hierarchies they claim to dismantle, where adolescent sexuality remains unrecognised or denied, thereby sustaining the barriers that keep young people from approaching health facilities at all.

Read through a post-structural lens, the transformative potential of YFHS programmes lies not only in addressing structural and familial barriers, but also in interrogating the implicit power relations that shape provider-child interactions. Practices framed as education or protection may, in practice, reproduce paternalism and moral control if these relations remain unexamined. As Morison argues, this draws attention to the importance of provider reflexivity, structural competency and justice-oriented approaches that take seriously young people's evolving capacities and voices, including those of children themselves.[48]

3 The concept of sexual health and rights in the GEA

The GEA could play a significant role in advancing children's sexual agency, particularly through its articulation of sexual rights. The MLC proposed sections 19 and 20 of the GEA based on the following definition of sexual and reproductive health and rights, adopted from a WHO document:[49]

> [a] subset of human rights that are already recognized in national laws, international human rights law and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to –
>
> (a) the highest attainable standard of sexual health, including access to sexual and reproductive health care services;
> (b) seek, receive and impart information related to sexuality;
> (c) sexuality education;
> (d) respect for bodily integrity;
> (e) choose their sexual partner;
> (f) decide to be sexually active or not;

48 Morison (n 47) 549.
49 Malawi Law Commission (n 7) 58.

(g) have consensual sexual relations;
(h) enter into consensual marriage;
(i) decide whether or not and when, to have children; and
(j) pursue a satisfying, safe and pleasurable sexual life.

Sections 19 and 20 of the GEA are progressive insofar as they recognise the sexual agency of all persons. The challenge lies in how these sections are rendered meaningful in practice, particularly in relation to adolescent sexual health and rights. This book contributes to addressing this challenge by offering a conceptual exploration of the meanings of sections 19 and 20 of the GEA in relation to childhood and adolescence, gender and sexuality.

Just as the above definition recognises sexual rights as already anchored in national and international law, section 20 of the GEA restates the principles of non-discrimination and dignity as core human rights values applicable to all persons, including children. The critical question, taken up in this chapter, is what these principles mean for children in practice, particularly within programmes such as YFHS and related community and school-based interventions. This framework of equality and non-discrimination provides the normative basis for analysing how children's sexual health and rights are recognised, or constrained, within legal and policy frameworks such as the GEA.

3.1 Equality and non-discrimination

Section 20(1)(a) mandates health officers to respect the sexual and reproductive health and rights of every person without discrimination. Discrimination is prohibited in Section 20 of the Constitution which states:[50]

> Discrimination of persons in any form is prohibited and all persons are, under any law, guaranteed equal and effective protection against discrimination on grounds of race, colour, sex, language, religion, political or other opinion, nationality, ethnic or social origin, disability, property, birth or other status.

The constitutional provision further states that '[l]egislation may be passed addressing inequalities in society and prohibiting discriminatory

50 Constitution of the Republic of Malawi (1994) sec 20(1).

practices and the propagation of such practices and may render such practices criminally punishable by the courts'.[51]

The Human Rights Committee has defined discrimination as[52]

> [a]ny distinction, exclusion, restriction or preference which is based on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, and which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise by all persons, on an equal footing, of all rights and freedoms.

Additional grounds for discrimination have since been recognised, including age, disability, ethnicity and sexual orientation. Various human rights treaties have been developed to address specific grounds or, indeed, intersecting grounds of discrimination. These treaties include CRC, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the Convention on the Rights of Persons with Disabilities (CRPD). Discrimination on the grounds of sex and gender is defined by the African Commission on Human and Peoples' Rights (African Commission) and the African Committee of Experts on the Rights and Welfare of the Child (African Children's Committee) as follows: 'Sex and gender-based discrimination include any distinction, exclusion or restriction or any differential treatment which is based on sex or gender and which has the objective or effect of compromising or destroying the recognition, enjoyment or exercise of a human right or a fundamental freedom.'[53]

Malawi, among other African countries, is party to these treaties and, therefore, is obligated to realise the right to non-discrimination on any of the grounds established by these treaties, including the discrimination that children experience because of their age, and the intersection of this discrimination with other grounds such as sex and gender. The next part further explores the notion of equality.

51 Constitution of the Republic of Malawi (n 50) sec 20(2).

52 Human Rights Committee CCPR General Comment 18: Non-discrimination (10 November 1989) para 7.

53 African Commission on Human and Peoples' Rights & African Committee of Experts on the Rights and Welfare of the Child Joint General Comment of the African Commission on Human and Peoples' Rights and the African Committee of Experts on the Rights and Welfare of the Child on ending child marriage (2017) para 11.

3.1.1 The dimensions of substantive equality

Non-discrimination law is described as having two elements. The first is the prohibition on direct discrimination, that is, two individuals should be treated similarly. One should not be treated less favourably than the other because of the characteristic they possess.[54] States are obligated to ensure that laws and policies do not discriminate on prohibited grounds. For instance, a girl seeking contraceptives should not be refused contraceptives because she is not yet married or because of her age, because it would imply that she is being treated less favourably because of her marital status or age. A healthcare provider satisfies the obligation not to discriminate when they do not take any positive action to treat a person differently from anyone else. In this instance, girls come to seek contraceptives, and the healthcare provider provides the contraceptives to any girl without questioning marital status or age. Healthcare providers discriminate directly when they intentionally deny adolescents access to contraceptives on grounds such as marital status or age.

The second element of non-discrimination is the prohibition on indirect discrimination; that is, two dissimilarly situated individuals should be treated differently to achieve equality that would otherwise not be attained if they are treated similarly.[55] Treating persons equally, regardless of background differences, may entrench inequality. For instance, even if contraceptives are made available at healthcare facilities, children may not have the same confidence levels as adults to approach the healthcare facilities for contraceptives, because of prejudicial attitudes about the sexuality of children, especially girls. Thus, making contraceptives available does not necessarily address the discrimination in accessing them.

The 2014 YFHS Evaluation revealed such indirect discrimination: Despite sexual health services and commodities being available in public facilities, young people, especially girls, faced barriers such as community and provider attitudes about unmarried children accessing condoms, that such practices go against cultural norms.[56] From a substantive equality

54 M Liebel and others 'Introduction' in D Kutsar & H Warming (eds) *Children and non-discrimination: Interdisciplinary textbook* (2014) 16.

55 As above.

56 'Parents cannot be happy with youth accessing RH services and the whole community cannot accept the idea that youth should access such services'

perspective, these prejudices constitute structural barriers that impair adolescents' equal enjoyment of sexual health services, even in the absence of formally discriminatory rules.

Fredman has argued that the notion of equality should be understood as encompassing four interrelated dimensions.[57] The first dimension is the *redistributive dimension* of equality, whereby equality aims to break the cycle of disadvantage associated with status.[58] Disadvantage has predominantly been understood in terms of the distribution of resources, such as a failure to allocate material resources to the YFHS programme, including training personnel adequately. Fredman, however, maintains that this ignores other aspects of disadvantage, such as the dominations or the structures of power that exclude people or undermine their self-determinative capacities. An example from the YFHS programme is the dominant discourse that the child is non-sexual, which undermines children's sexual self-determination. Without addressing these power relations, the YFHS programme risks reproducing inequalities by excluding children, especially girls.

The second dimension is the *recognition dimension*, which concerns the necessity for respecting dignity and redressing the stigma, stereotyping and humiliation that is based on identity.[59] This dimension is particularly relevant to the symbolic violence produced through the denial of, and silence surrounding, child and adolescent sexuality, a theme that is taken up further in the discussion of dignity below.

The third dimension is the *transformative dimension*, which requires the accommodation of difference, and challenges structural barriers rather than promoting conformity. Children and adolescents often lack the confidence, access to resources or social permission that adults have when seeking sexual healthcare services, a pattern consistently documented in evaluations of youth-friendly health services and systematic reviews from sub-Saharan Africa.[60] From a transformative equality perspective, these

(participant, FGD with male parents, Phalombe); Evidence to Action Project (n 18) 170.

57 S Fredman *Discrimination Law* (2011).

58 Fredman (n 57) 26.

59 Fredman (n 57) 28.

60 Evidence of Action Project (n 18); see also LR Ninsiima, IK Chiumia & R Ndejjo 'Factors influencing access to and utilisation of youth-friendly sexual and reproductive health services in sub-Saharan Africa: A systematic review' (2021) 18 *Reproductive Health* 135; OD Akinwale and others 'Evaluation of adolescent/

barriers are not incidental but reflect deeper cultural and institutional logics that frame adolescent sexuality as problematic or deviant.

An example of how social norms create a difficult environment for supporting adolescents is Mkhwanazi's ethnographic study of teenage pregnancy in Nyanga East, Cape Town. Her research shows how local ideals of good parenting and female respectability create a no-win situation for sexually active girls.[61] They were expected to avoid pregnancy, yet parents and healthcare providers provided little or vague information about menstruation, contraception or sexual relationships. When girls attempted to access contraception, nurses – often from the same community – shamed and ridiculed them, reinforcing the view that sexually active girls were morally deviant. Thus, whether seeking contraception or becoming pregnant, girls risked losing respectability. Mothers were similarly positioned within a contradiction: expected to guide their daughters while culturally prohibited from discussing sex. Teenage pregnancy, therefore, became a site through which local moral codes were reasserted and intergenerational control maintained. Even after becoming mothers, many young women remained silent about sexuality, thereby reproducing the norms that had disempowered them.[62]

The fourth dimension is the *participative dimension*, which requires that those historically excluded, such as children, be enabled to take part in shaping the decisions and programmes that affect their lives.[63] The YFHS Evaluation found that adult gatekeeping, especially of children's sexuality, is a major barrier to equality. Within this framework, the effectiveness of youth-friendly healthcare services is closely tied to the extent to which adolescents can participate meaningfully in shaping programme design and delivery. Linking YFHS with sexuality education in schools or community programmes could provide an avenue for fostering participation. These spaces would allow young people not only to access accurate information but also to express their perspectives, negotiate meanings and claim agency. As the CRC Committee has affirmed, states

youth-friendly sexual and reproductive health services: A seven-year systematic review from January 2016 to April 2022' (2022) 4 *Journal of Integrative Nursing* 177.

61 N Mkhwanazi 'Understanding teenage pregnancy in a post-apartheid South African township' (2010) 12 *Culture, Health & Sexuality* 347.

62 Mkhwanazi (n 61) 357.

63 Fredman (n 57) 31.

play a critical role in promoting the participation of adolescents as rights holders capable of contributing to the transformation of their own lives.[64]

3.1.2 Discrimination as processual

The discrimination that young people face in accessing sexual healthcare services, within families, communities and healthcare facilities, as documented in the YFHS Evaluation, is more usefully understood as a process rather than as a discrete event. This processual framing draws attention not only to structural conditions, but to the ways in which discrimination accumulates over time through dispersed acts, actors and institutional interactions. According to Makkonen, dominant legal understandings of discrimination tend to focus on isolated incidents traceable to individual intent. However, discrimination often consists of a complex mix of direct and indirect, institutional and interpersonal practices, such that intent is diffuse and cannot be neatly located in a single actor or moment.[65]

As the YFHS Evaluation illustrates, children's access to sexual healthcare services is shaped not only by the conduct of healthcare providers, but also by prejudicial views about sexuality circulating among parents and within the broader community. In this context, although section 20(2) of the GEA imposes criminal liability on healthcare providers who discriminate in the provision of sexual healthcare services, the limitation of children's sexual agency emerges through a genealogy of both direct and indirect discrimination, produced across multiple institutional sites and everyday practices.

Makkonen's observation is that 'acts and situations of victimisation often form a continuum in which one act follows another, and in which the totality becomes worse than the sum of its constituent parts'.[66] The challenges facing the YFHS programme cannot be reduced to isolated instances of provider bias or parental control. Rather, they are sustained through dominant social and legal discourses that frame childhood and

64 Committee on the Rights of the Child General Comment 20: The implementation of the rights of the child during adolescence UN Doc CRC/C/GC/20 (6 December 2016) para 4.

65 T Makkonen *Multiple, compound and intersectional discrimination: Bringing the experience of the most marginalised to the fore* (2002) 5.

66 As above.

adolescent sexuality as problematic, for example, through age of consent laws that criminalise consensual sexual activity between adolescents.

Read in this way, discrimination in access to sexual and reproductive healthcare services appears not as a singular breach at the point of care, but as a process embedded within legal, policy and institutional arrangements and reproduced through their everyday operation over time, that collectively constrain young people's sexual and reproductive autonomy. Understanding discrimination as processual exposes the limits of approaches that focus exclusively on individual liability, while leaving intact the broader structures through which inequality is reproduced.

3.1.3 Gendered discrimination

Children face discrimination not only based on age but also through gendered norms that shape how their sexuality is perceived and policed in health settings. The YFHS Evaluation found that adolescent girls encountered greater barriers than boys when seeking contraceptives, despite both groups having similar service needs. This disparity reflects deeply entrenched gender norms: Girls are often burdened with the moral responsibility of regulating sexuality, while boys are granted greater freedom, a pattern confirmed in multiple studies across sub-Saharan Africa.[67]

Prejudicial attitudes toward girls' sexuality contribute to a gendered disparity in access to services. The YFHS Evaluation identified gender as significant grounds for differential access to services, and found that parents were more likely to tolerate boys accessing contraceptives than girls.[68] Compared to boys, girls are often less confident and receive less support in seeking sexual health care, not because of any inherent shyness, but due to the discourses that construct girls as sexually passive and in need of protection.[69] These male-drive or heteronormative scripts position boys as naturally desiring sex, while girls are expected to avoid or resist it. As a result, girls who assert sexual agency face moral judgment and social sanctions. Indeed, the sentiments of the judge and

67 C Moreau and others 'Measuring gender norms about relationships in early adolescence: Results from the global early adolescent study' (2019) 7 *SSM – Population Health* 100314.
68 Evidence to Action Project (n 18) 170.
69 As above.

the magistrate in the *Charo* and *Gondwe* cases, introduced in chapter 1, reflect the views of many parents and gatekeepers, namely, that sexually active girls are immoral and deviant, except when they are married.

These dynamics demonstrate that unequal access to sexual and reproductive healthcare services is sustained not only through service provision gaps but through power relations that render girls' sexuality suspect. Where healthcare and educational practices fail to interrogate these norms, they risk reinforcing a broader culture of gender inequality that undermines the objectives of both the GEA and the YFHS programme.

3.2 Dignity

Section 20(1)(b) of the GEA stipulates that healthcare providers shall 'respect the dignity and integrity of every person accessing sexual and reproductive health services'.[70] The right to dignity is also recognised in the Constitution under section 19.[71] However, the concept 'dignity' is not easy to define in law. Drawing from jurisprudential development and case law, Steinmann identifies three conceptual elements of dignity: first, the ontological claim that every human being is priceless, unique and irreplaceable; second, that each person deserves respect and recognition as such; and third, that the state bears responsibility for creating conditions that enable each person to flourish.[72] Understood this way, the right to dignity includes the right to develop one's personality and autonomy, to have control over one's body and life, and to make meaningful choices, always within the context of human interdependence and the state's enabling role.

In considering how the right to dignity operates in relation to children, McGuirk and Mills argue that two factors are particularly significant.[73] First, the right to dignity applies to children of any age in the same fundamental sense that it applies to adults. Second, because children are wholly or partially dependent on adults, infringements of

70 Gender Equality Act (Malawi) (n 4) sec 20(1)(b).
71 The Constitution of the Republic of Malawi sec 19(1).
72 R Steinmann 'The core meaning of human dignity' (2016) 19 *Potchefstroomse Elektroniese Regsblad* 2.
73 M McGuirk & B Mills 'Climate change and the dignity rights of the child', https://www.ohchr.org/Documents/Issues/ClimateChange/RightsChild/Dignity_Rights_Project.pdf (accessed 5 July 2025).

adults' rights that deprive children of an environment in which they can flourish, or that interfere with their development of autonomy, have a profound impact on children's dignity. Children's vulnerability should not justify paternalistic control; rather, it heightens the state's responsibility to ensure that children's rights to self-determination and personal development are actively protected.

Fredman links dignity with equality, by suggesting that the pursuit of equality is fundamentally about protecting individuals from stigma, humiliation, and stereotyping on grounds such as age, disability, race or socio-economic status.[74] This resonates with the reasoning of the South African Constitutional Court in *Teddy Bear Clinic*, which affirmed that children are entitled to dignity and sexual autonomy just as adults are. The Court recognised that criminalising consensual sexual conduct between adolescents interferes with the development of their autonomy and imposes stigma that undermines their personhood. The judgment exemplifies Steinmann's and McGuirk and Mills's theoretical accounts: that dignity is both about recognition and the conditions necessary for children to flourish.[75] Recognising dignity, therefore, means that the development of the child's sexual autonomy, sexual choices and sexual preferences must be respected. Respecting a child's autonomy does not imply abandoning the child to self-direction. It means that, even as the child is dependent on the guidance of adults in the community, their sexual autonomy should be respected in accordance with their evolving capacities.

In contrast to the reasoning in *Teddy Bear Clinic*, the *CKW* case illustrates an infringement of a child's dignity. A 16 year-old challenged the law that criminalised consensual sexual activity between adolescents, by arguing that this conduct is not criminalised for adults, and that treating adolescents differently in this regard is discriminatory and degrading. Yet, the High Court of Kenya upheld the law, thereby reinforcing discourses that construct children as sexually incompetent. Such legal framings not only misrecognise children's capacity for sexual agency, but also entrench moral hierarchies that support paternalism. These discourses are not without material effects. They shape the very

74 Fredman (n 57) 29.

75 *Teddy Bear Clinic v Minister of Justice and Constitutional Development & Another* 2014 (2) SA 168 (CC) para 55 (*Teddy Bear Clinic*).

barriers that adolescents encounter when trying to access YFHS, despite the government's commitment to making such services available.

Respecting children's dignity in sexual and reproductive health contexts, therefore, requires more than the formal availability of services. It entails recognising children as evolving sexual subjects whose autonomy, capacity for desire and decision making must be acknowledged rather than silenced or stigmatised. Legal, institutional and cultural practices that infantilise or morally discredit children's sexuality undermine not only access to care, but also the conditions necessary for children to flourish as rights-bearing persons.

Dignity, in this sense, is not exhausted by non-interference. It requires the creation of social and institutional environments in which children can develop their identities, exercise autonomy in age-appropriate ways, and receive guidance that supports rather than negates their personhood. Autonomy here does not imply leaving it to them; it implies relational support that treats the child as a subject whose choices are exercised within a framework of care, responsibility and interdependence.

3.3 Access to sexual healthcare services

Sections 19(1)(a) and (b) of the GEA affirm every person's right to adequate sexual and reproductive health, including access to sexual and reproductive health services and family planning. In public health and policy discourse, access to sexual health services for sexually active adolescents is frequently through a problem-oriented framing that emphasises the prevention of sexually transmitted infections and unintended pregnancies.[76] These concerns have been central to the design of youth-friendly healthcare services and sexuality education programmes.[77]

However, as the 2014 YFHS Evaluation makes clear, when this prevention-focused framing is taken up through adult moral anxieties about adolescent sexuality, it often becomes operationalised in punitive or restrictive ways. Rather than supporting adolescents' sexual development and well-being, such interpretations hinder access to contraceptives

76 KL Dehne & G Riedner 'Sexually transmitted infections among adolescents: The need for adequate health services' (2001) 9 *Reproductive Health Matters* 170.

77 F Mantula and others 'Sexual health interventions for adolescents' in R Sterling (ed) *Sexual education around the world: Past, present and future issues* (2023).

and reinforce control. A common view among parents and community members was that children should not engage in sexual activity until they are older or married, and that permitting access to condoms would encourage sexual activity.[78]

Interventions grounded primarily in problem prevention risk crowding out approaches that recognise sexual health care as a space for supporting, nurturing and guiding children's and adolescents' sexual development. This problem-oriented logic is frequently reinforced through legal and regulatory frameworks that seek to prevent harm by controlling sexual behaviour. In Malawi, for example, the Penal Code sets the age of consent at 18, reflecting a normative assumption that sexual activity below this age is problematic. Yet, the YFHS Evaluation revealed that 20,3 per cent of boys and 5,3 per cent of girls aged 10 to 14 had already engaged in sexual activity.[79] Although delaying sexual debut may be a valid public health goal, pursuing this aim through punitive or moralising strategies risks violating children's rights. Such strategies can cause direct harms, such as the prosecution of consensual and non-exploitative sexual conduct, as well as indirect harms such as shame, fear and the stigmatisation of normative adolescent sexual behaviour. As a result, adolescents may be deterred from seeking guidance and care, including from healthcare providers.

Moreover, efforts that focus primarily on preventing adolescents from having sex risk misrecognising the central issue: the need to support adolescents' evolving capacity for sexual decision making and bodily autonomy. When access to contraception and related sexual health care is restricted on moral grounds, this not only undermines the GEA's mandate but also reinforces discourses that cast children as incapable of ethical and responsible agency.

Not all children encounter these barriers in the same way. Some live in contexts where restrictions are fewer, whether due to supportive parents or reduced adult surveillance. Younger adolescents, however, are especially vulnerable to sexual and reproductive health stigma, as they are more likely to be constructed as 'innocent' or non-sexual. Girls experience this stigma more acutely than boys because of entrenched gendered expectations of sexual restraint. A study conducted in two urban centres

78 See the discussion under part 2.2 in this chapter.
79 Evidence to Action Project (n 18) 52.

in Ghana found that the youngest adolescent girls reported the highest levels of environmental sexual and reproductive health (SRH) stigma, particularly in relation to sexual activity, pregnancy and abortion.[80] These findings illustrate how social norms and community attitudes disproportionately affect girls and underscore the need to address stigma as a structural barrier to access to adolescent sexual and reproductive healthcare services.

Realising the GEA's vision, therefore, requires the YFHS programme to move beyond service availability and to confront the discourses and institutional practices that reproduce unequal access. A justice-based approach must address age- and gender-based discrimination as interlocking forms of inequality impacting dignity. In this way, the GEA can function not only as a legal mandate but also as a normative resource for challenging deeply embedded hierarchies of power, morality and control.

3.4 Protection and self-protection from sexually transmitted infections

Sections 19(1)(c) and (d) of the GEA recognises the right to protection and the right to self-protection from sexually transmitted infections (STIs). In proposing these provisions, the MLC drew upon article 14(1)(d) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol), which recognises the right to self-protection and to be protected against STIs, including HIV. Importantly, the MLC explicitly rejected an assumption of 'an idealised world in which everyone is equal and free to make empowered choices and can opt to abstain from sex, stay faithful to one's partner or use condoms consistently'.[81] Instead, the GEA was envisaged as part of a legal framework attentive to 'the critical role that gender relations plays in sexual and reproductive life and how it affects HIV prevention'.[82]

Guidance on the scope of state obligations in relation to protection and self-protection may be drawn from the African Commission's

80 KS Hall and others 'Factors associated with sexual and reproductive health stigma among adolescent girls in Ghana' (2018) 13 *PLOS ONE* e0195163.
81 Malawi Law Commission (n 7) 70.
82 As above.

interpretation of the right to self-protection and to be protected from STIs.[83] The African Commission recognised that

> [t]here are multiple forms of discrimination based on various grounds such as: race, sex, sexuality, sexual orientation, age, pregnancy, marital status, HIV status, social and economic status, disability, harmful customary practices and/or religion. In addition, the African Commission recognises that these forms of discrimination, individually or collectively, prevent women from realising their right to self-protection and to be protected.[84]

The African Commission affirms that this right entails an obligation on states to create an 'enabling, supportive, legal and social environment that empowers women to be in a position to fully and freely realise their right to self-protection and to be protected [from STIs and HIV]'.[85]

Read in the context of children and adolescents, this obligation underscores that protection cannot be achieved solely through behavioural regulation or moral injunctions. Rather, creating an enabling environment for children requires recognising and supporting their developing sexual agency, while addressing the structural, relational and gendered conditions that expose them to sexual health risks.

As discussed earlier in this book, even very young children are not blank slates in relation to sex, intimacy and love. Although they may not comprehend these in adult terms, children actively interpret and internalise sexual meanings from their social environments.[86] Research has shown that children may engage in exploratory sexual play, not out of deviance, but in pursuit of affection, curiosity or pleasure. This play is filtered by their cognitive and emotional development.[87] Such experiences are qualitatively distinct from adult sexuality.

However, dominant social norms often interpret children's bodily exploration or expressions of intimacy through adultist and moralistic lenses. This misrecognition collapses children's experiences into adult frameworks of sexual meaning, leading to shame, discipline or moral panic rather than care and guidance.

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83 African Commission on Human and Peoples' Rights General Comment 1 on arts 14(1)(d) and (e) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (6 November 2012).
84 African Commission General Comment 1 (n 83) para 4.
85 African Commission General Comment 1 (n 83) para 10.
86 Jackson & Sue (n 27) 51.
87 P Talavera 'The myth of the asexual child in Namibia' in S LaFont & D Hubbard (eds) *Unravelling taboos: Gender and sexuality in Namibia* (2007) 63.

Such moral panic is reflected in legal reasoning, as illustrated by the *Charo* case, where the court's language effectively shamed a 14 year-old girl for being sexually active, despite her legal status, which merited protection from sexual access by someone significantly older than her. This illustrates how institutions charged with protecting children's rights may themselves reproduce stigma and discursive harm, thereby undermining the very rights they purport to uphold.

Applying the African Commission's framework to Malawi's obligations under the GEA and the YFHS programme, the following responsibilities arise:

- the obligation to respect requires the state to refrain from interfering – directly or indirectly – with children's rights to protect themselves or to be protected from STIs;
- the obligation to protect entails preventing third parties, including parents, teachers, or healthcare workers, from violating these rights;
- the obligation to fulfil, or promote, requires the state to actively cultivate the legal, social, and economic conditions that allow children to realise these rights.[88]

The African Commission suggests that fulfilling these obligations would involve 'engaging in sensitisation activities, community mobilisation, training of healthcare workers, religious, traditional and political leaders on the importance of the right to protection'.[89]

However, sensitisation and training alone are inadequate to disrupt the deeply embedded discourses of childhood innocence that frame children as sexually passive. As argued throughout this book, these discourses are not neutral but operate as forms of power that shape what is sayable, knowable, and ultimately actionable within health systems. Read in this way, the realisation of the right to protection and self-protection from HIV depends not only on the dissemination of information, but on how healthcare providers' assumptions about childhood, sexuality and agency are rendered visible and interrogated. Without such reflexive engagement, practices framed as protective risk reproducing moral hierarchies and exclusions contrary to the GEA's explicit intention to protect SRHR for everyone, including children.

88 African Commission General Comment 1 (n 83) para 23.
89 As above.

4 Including children in sexual health programming

The preceding parts have examined how the GEA affirms children's and adolescents' rights to sexual health, dignity, access to services and protection from STIs. These rights are not realised automatically through legal recognition alone. Rather, they are shaped, mediated, and at times constrained by prevailing social norms, legal interpretations and programmatic arrangements such as the YFHS programme. As socially embedded rights, sexual and reproductive health entitlements remain politically and culturally contested and are enacted within discursive contexts that condition which forms of sexual subjectivity are rendered intelligible, legitimate or impermissible.

This part turns to the broader question of how sexual health programming, including the YFHS, might be understood, and potentially reconfigured, to include children and adolescents as subjects of sexual health rights. Drawing on feminist and poststructuralist perspectives, I interrogate the normative assumptions embedded in key concepts such as 'sexuality', 'health' and 'risk', and examine how these concepts are mobilised in ways that may either support or silence young people's sexual agency. Building on theoretical insights and comparative evidence, the analysis suggests that dominant risk-prevention models tend to pathologise adolescent sexuality, whereas alternative framings foreground autonomy, relationality and social support. From this perspective, questions of reform extend beyond service design to the deeper issue of how childhood and adolescent sexual subjectivity itself are constituted within sexual health governance.

4.1 The politics of sexuality and health

The preceding discussion raises a fundamental question about the extent to which the GEA envisages the inclusion of children and adolescents as subjects of sexual and reproductive health rights. In formulating the GEA, the MLC was cognisant of the role of sexuality in advancing sexual health and well-being and recognised the need to attend to the complex factors that shape human behaviour.[90] However, both 'sexuality' and 'health' are political concepts and must be recognised and treated as such.

90 Malawi Law Commission (n 7) 57.

Miller and Vance analyse the concept of 'sexuality' in the health and human rights discourse to describe the politics of these terms.[91] They observe that the expansion of sexual rights claims through global advocacy movements reveals sexuality to be a contested terrain structured by what Vance terms a 'sexual hierarchy' – a socio-cultural device through which sexual relationships, expressions and behaviours are evaluated, legitimising some forms while stigmatising others.[92] This framework is particularly relevant to child and adolescent sexuality. As the YFHS Evaluation indicates, sexual relationships outside marriage are generally not considered legitimate for adolescents, and sexual conduct between unmarried adolescents is therefore widely disapproved of by parents and community gatekeepers.[93] Healthcare providers frequently adopt similar attitudes toward adolescent sex and sexuality. These hierarchies of legitimacy function as barriers to children's and adolescents' access to sexual health services, with particularly exclusionary effects for girls.[94]

Beyond sexuality, the concept of 'health' is itself politically charged. While health has been strategically mobilised by policymakers and advocates to advance sexual rights claims, it can also operate as a gatekeeping mechanism that excludes non-normative practices, such as same-sex intimacy.[95] In the context of adolescent sexuality, health is frequently framed through a discourse of risk. Adolescent sexual activity is presumed to naturally give rise to problems such as pregnancy or STIs, with the result that consensual sex between adolescents is positioned as inherently unhealthy. This risk-based framing narrows the scope of what is recognised as legitimate sexual health care and legitimises restrictive or punitive responses rather than supportive engagement.

Similarly, sexualities such as homosexuality, or sexual expression perceived to be homosexual, may be pathologised not because of any inherent harm, but because of dominant cultural and moral judgments. As discussed above in this chapter, girls have been expelled from school on allegations of engaging in lesbian acts, not necessarily because this

91 AM Miller & C Vance 'Sexuality, human rights and health' (2004) 7 *Health and Human Rights Journal* 5.
92 CS Vance 'Pleasure and danger: Toward a politics of sexuality' in CS Vance (ed) *Pleasure and danger: Exploring female sexuality* (1984) 19.
93 Evidence to Action Project (n 18) 169 para 7.6.
94 N Holtman and others 'Adolescent girls' sexual and reproductive health information needs and barriers in Cape Town' (2024) 29 *Health SA Gesondheid* 2650.
95 Miller & Vance (n 91) 863.

is their sexual orientation, but because their conduct is read through a heteronormative lens.[96] Whether a particular sexuality is recognised as healthy or unhealthy thus depends less on questions of harm than on prevailing moral norms. Where adolescent sexuality is morally condemned, it is likely to be constructed as unhealthy and, at best, merely tolerated. When it comes to pre-pubescent children, sexuality is rendered almost entirely unintelligible except in the context of abuse. The possibility of healthy childhood sexuality remains largely foreclosed within dominant discourses that systematically deny sexual agency to child subjects.

4.2 Accepting childhood sexual behaviour as normative

To reiterate, mainstream cultural and legal narratives tend to position children as non-sexual and construct adolescent sexuality as risky and justifying strict regulation. Narratives of childhood innocence and non-sexuality are historically and discursively constructed, rather than biologically inevitable. The idea that children become sexual only at puberty obscures the developmental continuity of sexuality across the life course. I briefly return to this argument here to frame comparative reflections on how different societies, through law, policy and everyday practice, construct childhood and adolescent sexuality.

Simon and Gagnon observe that 'we do not become sexual all at once at puberty; there is a significant level of continuity with the past'.[97] Children learn about sexuality through communicative processes with adults, both explicitly through verbal instruction and implicitly through adults' reactions to perceived sexual behaviour. In this way, children absorb and internalise sexual scripts made available to them by social institutions, cultural norms and interpersonal relationships. Adolescent sexuality, therefore, does not erupt unpredictably; it is shaped, recognised and conferred by the adult social world. As Simon and Gagnon note,

96 Correspondent 'Schoolgirls exiled for bed camping' *Nation Online* (Blantyre) 4 June 2025, https://mwnation.com/schoolgirls-exiled-for-bed-camping/ (accessed 25 August 2025); S Winner 'Cameroon: Two school girls lose their right to education because of a lesbian love note' *Erasing 76 Crimes* 1 December, 2023, https://76crimes.com/2023/12/01/cameroon-two-school-girls-lose-their-right-to-education-because-of-a-lesbian-love-note/ (accessed 22 December 2025).

97 W Simon & J Gagnon *Sexual conduct: The social sources of human sexuality* (2017) 21.

it is 'the entry into the new social status that triggers an increase in the rates of overt sexual behaviour and the attribution and integration of new meanings for the behaviour'. [98] This process is not merely biological but discursive, structured by the meanings assigned to childhood, adolescence and sex.

From this perspective, adolescence is not a fixed stage of hormonal chaos but a socially produced category, one that varies in meaning and effect depending on the surrounding discursive and cultural context. Understanding sexual health in childhood and adolescence thus depends on how children and adolescents are imagined as sexual subjects, whether their evolving sexualities are framed as pathological, or as part of a normative and socially mediated developmental trajectory.

This point becomes clearer through comparative analysis. The Netherlands is often cited in the literature as an example of how adolescent sexual health outcomes have been shaped by an affirming, rights-based and relational understanding of adolescent sexuality. Berne and Huberman observe that adolescent sexual health outcomes in The Netherlands have been more positive than those in the United States, a difference they attribute in part to greater cultural openness toward adolescent sexuality.[99] There is broader societal and parental acceptance of the idea that adolescents may engage in intimate relationships before marriage, and that such relationships are not harmful but may contribute to the development of sexually healthy adults.

Schalet's comparative research between the Netherlands and the United States further illuminates how parental discourses shape adolescent sexuality. She observed that Dutch parents tend to normalise adolescent sexuality by integrating it into family life, whereas American parents are more likely to dramatise adolescent sexuality, treating it as a disruptive force that must be controlled or repressed.[100] Dutch parents are

98 Simon & Gagnon (n 97) 37. This could very well explain the effect of sexual initiation as described in AC Munthali & EM Zulu 'The timing and role of initiation rites in preparing young people for adolescence and responsible sexual and reproductive behaviour in Malawi' (2007) 11 *African Journal of Reproductive Health* 150. At initiation rites, it is the act of recognition of the new sexual status of the initiates by adults and peers that empowers the initiates to go out and pursue sex.

99 L Berne & B Huberman *European approaches to adolescent sexual behaviour and responsibility* (1999) v-vi.

100 A Schalet 'Sex, love, and autonomy in the teenage sleepover' (2010) 9 *Contexts* 17.

more inclined to recognise adolescents as capable of love, commitment and relational decision making, focusing less on preventing sex and more on supporting responsible and autonomous choices. By contrast, American parents perceive adolescent sexuality as inherently risky and morally suspect, thereby legitimising disciplinary and regulatory interventions.

This contrast is analytically useful for reflecting on how adolescence is constructed within African health policy frameworks, without suggesting direct equivalence between contexts. The Eswatini Ministry of Health's *National guidelines for adolescent sexual and reproductive health* provide an illustrative example. The Guidelines include a table describing developmental changes during adolescence, particularly for girls, and are preceded by the following characterisation of adolescence: 'Adolescence is a stressful period of life as the transition between childhood and adulthood occurs and it is characterised by discernible physical, mental, social, and behavioural changes.[101]

Figure 1: Table showing changes in girls following puberty

Physical changes	**Emotional changes**	**Social changes**
Breasts grow bigger	Mood swings occur	Peer pressure
Hips become round		Friends matter more than they used to
Hair begins to grow in the private parts	Attachments to friends	Partying
Menstruation begins	Issues of identity	Experimentation and curiosity
Develop pimples	Become sensitive	Social disorder
	Conflicting thoughts	Concern about body image
	Sexual feelings begin to occur	Sense of belonging
	Become aware of their bodies	Self-centred

101 Eswatini Ministry of Health *National guidelines for adolescent sexual and reproductive health* (2021) 14, https://infocenter.nercha.org.sz/sites/default/files/2022-02/Ministry%20of%20Health%20Adolescent%20Sexual%20and%20Reproductive%20Health%20Guidelines_Final%20Copy%202021_0.pdf (accessed 3 August 2025).

The Guidelines describe adolescence as 'a stressful period of life' characterised by emotional volatility and behavioural risk. Adolescent girls, in addition to being described as starting to experience sexual feelings, are portrayed as experiencing mood swings, partying, peer pressure, self-centredness, conflicting thoughts and social disorder. While some of these descriptors may reflect commonly observed experiences, their cumulative framing produces adolescence as a period of instability and risk, and positions the adolescent girl as an emotionally volatile and potentially problematic subject.

From a post-structural perspective, this policy document does more than describe developmental change. By drawing a sharp conceptual boundary between childhood and adolescence, it constructs childhood as a space of presumed sexual unintelligibility, while casting adolescence as a stage of emerging sexual danger requiring regulation. This framing legitimises adult authority over adolescent decision-making by representing young people as unreliable and their sexual desires as disruptive. Such characterisations have been criticised for reinforcing negative stereotypes about adolescents, with material consequences for how policy actors, such as healthcare providers and educators, engage with young people in practice.[102]

In contrast to the Dutch model, which foregrounds adolescent agency and relational responsibility, the Eswatini framing privileges adult control and marginalises adolescent subjectivity. Similar patterns are evident in Malawi. As the YFHS Evaluation and related studies indicate, many Malawian parents and healthcare providers do not openly accept adolescent sexual activity as a normative aspect of development. Even in cultural contexts that practise initiation rites, where adolescent boys, and sometimes girls, are expected to become sexually active, such conduct is shaped by adult expectations rather than by recognition of adolescent autonomy. Yet, Munthali and others observe that 'although premarital sexual intercourse is disapproved of in many Malawian communities, studies have shown that many adolescents initiate sex at an early age'.[103]

102 CM Buchanan and others 'Adolescent storm and stress: A 21st century evaluation' (2023) 14 *Frontiers in Psychology* 1257641.

103 AC Munthali and others *Adolescent sexual and reproductive health in Malawi: A synthesis of research evidence* (2004) 4.

This tension between moral disapproval and normative adolescent sexual behaviour reveals a central contradiction: adolescents are sexually active, yet without institutional or social recognition of their rights and agency, they remain unsupported and vulnerable. In this sense, adult withdrawal of guidance and care, rather than adolescent sexuality itself, becomes a source of risk.

Schalet found that Dutch parents and institutions 'expend less time and effort trying to prevent young people from having sex and more time and effort in educating and empowering young people to behave responsibly when they decide to have sex'.[104] Such support enables adolescents to develop autonomy, assume ethical responsibility for their decisions, and access sexual health services without shame or fear.

By contrast, evidence from YFHS evaluation suggests that adolescents often encounter social and institutional environments in which sexual agency is viewed with suspicion rather than recognised as a normative aspect of development. Prevailing moral discourses tend to frame adolescent sexuality as potentially dangerous, limiting the kinds of support available to young people as they navigate intimate relationships and sexual decision-making.

From this comparative perspective, a rights-based approach to sexual health in childhood and adolescence cannot be reduced to service provision alone. The contrast between Dutch and Malawian contexts illustrates how legal frameworks such as the GEA are mediated by broader social norms that shape whether adolescent sexuality is recognised as a legitimate site of care or treated primarily as a problem to be controlled. What is at stake, therefore, is not only access to services, but whether young people are recognised as sexual subjects capable of meaningful decision-making within supportive social relationships.

According to Miller, self-determination is 'the right to make choices to self-identify in a way that authenticates one's self-expression, and which has the potential for the embodiment of self-acceptance'.[105] However, self-determination does not arise in isolation. As Lee observes, '[t]he powers of the human agent, though apparently concentrated in individual persons, are derived from a distributed network of materials,

104 Berne & Huberman (n 99) v.

105 S Miller 'A queer literacy framework promoting (a)gender and (a)sexuality self-determination and justice' (2015) 104 *English Journal* 38.

texts, bodies and persons. *Agentic independence is an emergent property of patterns of dependency*'.[106] Sexual autonomy, therefore, is not opposed to dependence; it is constituted through it.

Dependency does not defeat independence. Rather, it is through supportive relationships with caregivers, healthcare providers and community actors that young people develop the capacity for ethical and autonomous sexual decision making. Read in this way, the GEA can be understood as gesturing toward a model of sexual health governance that values relational support and institutional responsibility as conditions for the realisation of adolescent sexual health and rights.

4.3 Positive approaches to childhood and adolescent sexuality

In the YFHS Standards, adolescent sexuality is cast predominantly in negative terms. References to sex or sexual conduct appear primarily in association with risk, danger and disease. An illustrative example is the following statement: 'Reasons for early sexual encounters include curiosity, peer influence, expectation of gifts/money (poverty) and coercion. Young people therefore need skills to deal with these pressures and expectations without putting themselves at risk.'[107]

This framing leaves little room for recognising that young people may also value intimacy, relationships, affection and love, or that sexual exploration can form part of normative development. Sex is constructed as a problem to be managed and, by extension, the sexually active adolescent is positioned as a problematic subject. In this way, the YFHS programme marginalises adolescents' sexual feelings, desires and relational aspirations at the level of policy design, even before adolescents encounter healthcare services.

From this perspective, the effectiveness of the YFHS programme depends in part on whether sexuality is recognised not only as a site of risk, but also as a dimension of human development with positive meanings. This position is not foreign to Malawi's legal framework. As the Malawi Law Commission (MLC) itself observed, '[s]exual and reproductive health requires a positive approach to human sexuality and an understanding of the complex factors that shape human sexual

106 Lee (n 12) 459 (my emphasis).
107 Ministry of Health (n 14) 6.

behaviour'.[108] Interpreted from this perspective, a positive approach entails shifting analytical attention away from sex as a problem, toward the conditions under which adolescents' evolving sexual autonomy can be supported.

Attending to the complex factors shaping sexual behaviour requires integrating physical, psychological, social, cultural, educational, economic and spiritual dimensions into sexual health programming. Feminist scholarship further cautions that without interrogating gender ideologies, sexual health programmes risk reproducing patriarchal norms that shape sexual behaviour and outcomes.[109] This insight is particularly relevant to YFHS programming under the GEA, whose explicit aim is to transform gendered power relations rather than merely manage sexual risk.

Schalet proposes what she describes as an ABCD conceptual model to suggest possible approaches to promoting adolescent sexual health. The framework is used here to illustrate how the YFHS programme might be reconceptualised to better integrate an approach that recognises adolescents as subjects of sexual health and rights.[110]

The *A* stands for *sexual autonomy*. For adolescents to make confident and informed decisions about sexuality, they require opportunities to develop a sense of autonomy, understood here as the capacity to recognise their sexual feelings and desires, and to distinguish between what they want and what others expect of them.[111] Research suggests that adolescents who experience greater sexual autonomy tend to exercise more control over sexual decision-making, including contraceptive use, and are better positioned to recognise and manage sexual risk.[112] In such contexts, sexual activity is more likely to be planned and negotiated, rather than experienced as a random occurrence. By contrast, studies of girls' first sexual experiences have found that some describe sex as

108 Malawi Law Commission (n 7) 57.
109 DL Tolman 'Femininity as a barrier to positive sexual health for adolescent girls' (1999) 54 *Journal of the American Medical Women's Association* 133; DL Tolman and others 'Gender matters: Constructing a model of adolescent sexual health' (2003) 40 *Journal of Sex Research* 4.
110 AT Schalet 'Beyond abstinence and risk: A new paradigm for adolescent sexual health' (2011) 21 *Women's Health Issues* s5.
111 Schalet (n 110) s6.
112 J Pearson 'Personal control, self-efficacy in sexual negotiation, and contraceptive risk among adolescents: The role of gender' (2006) 54 *Sex Roles* 615-625.

something that 'just happened', reflecting limited agency over the circumstances leading to the encounter.[113]

B refers to *building* relationships. As adolescents begin to form intimate relationships, their sexual well-being is shaped not only by individual knowledge but also by their capacity to navigate relational dynamics. This includes skills such as building trust, negotiating power, managing conflict and deriving pleasure and enjoyment without coercion or harm.[114] Relationship building cannot be separated from gender norms. Dominant constructions of masculinity and femininity often position boys as driven by uncontrollable sexual desire and girls as sexually passive, making it difficult for girls to negotiate consent and for boys to imagine non-aggressive forms of sexual expression.[115] Attending to gender, therefore, becomes central to supporting identities in which adolescents of all genders can develop sexual assertiveness without resorting to either timidity or domination.[116]

C in Schalet's framework refers to *connectedness* with parents, caregivers and other adults. The development of sexual autonomy emerges relationally, through adolescents' interactions with adults with whom they can engage openly and honestly about sexuality without fear of punishment, shame or withdrawal of support.[117] Such connectedness creates the conditions under which adolescents can develop confidence, ethical judgment and responsibility in relation to their sexual lives. As discussed earlier in this chapter, the criminalisation of adolescent sexual conduct constitutes a significant barrier to these forms of openness, undermining the relational environments through which autonomy is cultivated.

D stands for *diversity* and *disparity*. Adolescents are not a homogeneous group; they inhabit diverse social positions shaped by gender, disability, socio-economic status, sexual orientation and geographic location.[118] Programmes such as YFHS, therefore, need to be attentive to the specific needs of adolescents who have historically

113 E Impett and others 'To be seen and not heard: Femininity ideology and adolescent girls' sexual health' (2006) 35 *Archives of Sexual Behaviour* 141.
114 Schalet (n 110) s6.
115 Tolman and others (2003) (n 109) 6.
116 Tolman and others (2003) (n 109) 11.
117 Schalet (n 110) s6.
118 As above.

been marginalised or excluded from sexual and reproductive health and rights services, including adolescents with disabilities, adolescent mothers and those living with HIV. These differences profoundly shape how adolescents experience sexuality and access sexual and reproductive health information and services.

Attention to diversity, however, is incomplete without an analysis of disparity: the structural inequalities that produce differential access to care, information and support. Disability provides a clear illustration of such inequality in the context of sexual and reproductive health. As Braathen and others have found, despite widespread recognition of the importance of sexuality education for adolescents, those with disabilities consistently receive less sexual education than their non-disabled peers.[119] Evidence further indicates that girls with disabilities are among the most disadvantaged, reflecting the intersection of gendered and ableist forms of exclusion.[120]

Schalet similarly draws attention to socio-economic disparities. Poverty, conflict and material insecurity shape the conditions under which adolescents develop sexual autonomy and make decisions about their sexual health.[121] Drawing on the same body of evidence analysed by Braathen and others, in poorer contexts the higher material and institutional resources required to support children with disabilities may lead families to deprioritise their education in favour of non-disabled children.[122] As a result, children with disabilities are more likely to miss out on school-based sexuality education, reinforcing cycles of exclusion and vulnerability.

Read through the ABCD framework, the GEA emerges as a potential normative resource for rethinking adolescent sexual health programming. Rather than positioning adolescents as problems to be managed or risks to be contained, the GEA offers a legal vocabulary for recognising children and adolescents as dignified sexual subjects whose autonomy develops within networks of care, support and social responsibility. This orientation points towards the importance of just resource allocation,

119 SH Braathen and others 'Physical disability and sexuality: Some history and some findings' in X Hunt and others (eds) *Physical disability and sexuality: Stories from South Africa* (2021) 38.
120 Braathen and others (n 119) 39.
121 Schalet (n 110) s6.
122 Braathen and others (n 110) 39.

as well as sustained engagement with service providers, carers and communities, to facilitate the recognition of children's sexual agency in all its diversity, without discrimination based on disability, gender diversity, sexual orientation, socio-economic status or other intersecting factors.

5 Concluding thoughts

Cultural discourses about childhood and adolescent sexuality significantly shape how sexual healthcare services are delivered and accessed. As this chapter has shown, even where health structures such as the YFHS exist, adolescents, especially girls, often remain excluded from meaningful access. This exclusion is not incidental; it is sustained by entrenched norms that frame adolescent sexuality as potentially problematic and in need of control. Healthcare providers, themselves embedded within these discursive regimes, may become agents of marginalisation by denying or discrediting the legitimacy of adolescent sexual feelings and conduct, particularly when expressed outside marriage.

Simon and Gagnon describe how children acquire sexual agency through cultural scripts that shape how they understand themselves and others as sexual beings. This process reveals a persistent intergenerational tension: While children internalise adult sexual norms, adults frequently respond with anxiety or disapproval when young people assert their own sexual agency. This tension constrains the free development of the child's personality and is frequently expressed through strategies of resistance, concealment or defiance, particularly by girls, who are more harshly judged than boys. Girls who openly display sexual agency are often cast as deviant, rebellious, immoral or victimised. These anxieties are mirrored in the judgmental attitudes documented in the YFHS Evaluation, particularly when adolescents, especially girls, seek services such as contraception.

Egan and Hawkes's critique of sexualisation discourse helps to illuminate these adult responses. As their work suggests, anxieties about sexualisation produce discursive environments in which adolescent sexuality is not only feared but pathologised. The consequence is the withdrawal or withholding of support, whether educational, familial or health-related, based on perceived moral threat. Such constructions constrain rather than enable the realisation of adolescent sexual health and rights.

When children and adolescents are treated solely as problems to be managed or victims to be protected, their sexual well-being is undermined. These cultural and institutional practices resonate with what the GEA defines as harmful practices: practices that impair dignity, health or liberty because of sex or gender. Denying children recognition as sexual subjects, or responding to adolescent sexuality with moral disapproval, is not benign. These discursive acts have material consequences, including restricted access to health services, information and psychosocial support. The existence of YFHS structures alone, therefore, do not guarantee meaningful access. The GEA as an instrument capable of unsettling these cultural assumptions and enabling more open, rights-affirming engagement between adults and young people could be interpreted to facilitate the implementation of the YFHS standards.[123]

In this sense, the transformative potential of the GEA lies in its capacity to support interventions that unsettle dominant discourses of childhood innocence and adolescent sexuality. Sexual and reproductive health rights cannot be realised through silence or shame. They require social environments in which young people are recognised as sexual beings with the capacity to act, decide and take responsibility for themselves and others.

Ultimately, a central task of the GEA is to reshape the adult-child relational dynamics. It is within this relational space that adolescents may come to understand themselves as capable and ethical agents, able to care for their own sexual well-being and that of their peers and partners. It is also within such relationships that a more just future may be cultivated, one in which today's adolescents, having experienced support rather than suppression, are better positioned to guarantee and defend the sexual agency and rights of the next generation.

123 See IAD Lydia & G Marina Bernal 'Youth, sexuality, and human rights: Some reflections from Mexico' (2004) 7 *Health and Human Rights* 223: a strategy in working with young people in Mexico involved creating colourful bags that contained accurate information. Boys and girls also wore condoms around their necks not only to facilitate open discussions about sex and sexuality involving condom use, but also to show others that they are sexually active, and it is acceptable to be sexually active.