Barriers to the Promotion and Fulfilment of the Sexual Health Rights and Needs of Adolescents in Seychelles

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Paper accepted on 27 July 2016

Abstract

The post 2015 Millennium Development Goals era is an opportune time to revisit and strengthen commitment to fulfil the sexual and reproductive health (SRH) rights of adolescents. Adolescents in the Seychelles face a number of barriers to accessing specific rights to sexual and reproductive health (SRH) information, education, privacy and confidential services. In 2007-2008, the Seychelles

Ministry of Health and Social Development undertook the Project Child Wellbeing Survey to investigate the health of adolescents aged 12-19 years. Survey data suggests that the adolescents faced a number of barriers to accessing sexual and reproductive rights. Using a subset of the survey data, this paper considers human rights approaches to address these barriers and concludes that effective sexual and reproductive health programmes must be centred around adolescents, independently monitored and involve a multi-stakeholder approach given the resource-scarce SRH services in rural context.

Keywords: Seychelles, adolescents, human rights, sexual health, barriers, regulations, strategies

**For correspondences and reprints*

Introduction

The post 2015 Millennium Development Goals era presents an opportunity to revisit and strengthen global commitment to fulfil the sexual and reproductive health rights of adolescents. The global adolescent population is now 1.2 billion (UNICEF, 2015). Its rapid growth, current shifts in societal structure, behavioural patterns, and earlier onset of puberty, place adolescents at higher risk than other age groups for adverse reproductive health outcomes, such as early pregnancies, unsafe sex, and sexually transmitted infections (STIs) and HIV/AIDS. To address these risks, policies and programmes need to be underpinned by a human right approach which aims to protect adolescent rights, recognises their vulnerable status and involves them in service planning and delivery.

A number of international human rights instruments and conferences offer a clear pathway of actions to address the sexual and reproductive health (SRH) and rights of the adolescent population (Farzaneh and Shereen, 2011). These include the UN Convention on the Rights of the Child (CRC), the UN Convention on the Elimination of Discrimination against Women (CEDAW), the UN Covenant on Economic, Social and Cultural Rights and the 1994 International Conference,

Population and Development Programme of Action (ICPD 1994) (United Nations Population Fund [UNFPA], 1994).

Seychelles: country description

Seychelles is a middle income, small island developing state, located in the Western Indian Ocean. It has a population of approximately 88,000 which includes a high proportion of adolescents at17% of the total population. This adolescent group is at high risk of unwanted pregnancies, abortion, STIs, HIV/AIDS (UNFPA, 2012, Ministry of Social Affairs, 2012). Although the national prevalence of HIV (1%) is one of the lowest in southern Africa (UNDP, 2013a, UNFPA, 2012), young people (aged 15-24) have similar HIV prevalence to adults at approximately 0.8% (United Nations Development Programme [UNDP], 2013. In recent years, premarital sex among those aged 15 years or older has becoming increasingly accepted by the society {Calvès, 2009 #2141, Victor, 2010, Calvès and Copaul, 2009). Contraceptive use among adolescents remains low at 4.6% of all contraceptive users and adolescent fertility contributes to 24% of all births (UNFPA and the Government of Seychelles, 2012). The adolescent birth rate (78 per 1000 girls aged 15-19 years) is high in comparison to neighbouring countries. For example, Mauritius (23/1000) which shares similar development issues and historical connections with Seychelles ,has a significantly lower rate (UNICEF, 2013, Ministry of Social Affairs, 2012).

There is little research about SRH in Seychelles. In the last three decades, only two articles have been published about sexual health interventions and sexual perceptions amongst adolescents (Pardiwala, 1985, Victor, 2010). Pardiwala (1985) considers the necessity of prevention of early pregnancies and the introduction of sex education curriculum in school in the 1980s. (Calvès and Copaul, 2009), using a larger population, compare adolescent first sexual experiences in five South-West Indian Ocean countries, including Comoros, Madagascar, Mauritius, Reunions and Seychelles. They found that premarital sex for those aged 15 years and older was seen as acceptable and normal in Seychelles and Reunions, but not in other three countries. Of note, adolescents in Seychelles indicated concern about early pregnancies, STIs and the lack of access to SRH information and services. There are however, no subsequent published studies at that evaluate the effectiveness of current policies, law or regulation or the extent to which these comply with the human right law and principles.

In 2007-2008, the Seychelles Ministry of Health and Social Development undertook the Project Child Wellbeing Survey to investigate the health of adolescents aged 12-19 years. Using a subset of the published secondary data, this paper employs a human rights based approach to examine the fulfilment of adolescent rights to information and education about SRH, STI's and HIV/AIDs and rights to privacy and confidential youth centred services in Seychelles. Examples of international human rights containing the following rights, include the UN Convention on the Rights of the Child (1989), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW 1979); the International Covenant on Civil and Political Rights (ICCPR 1966) and relevant international conferences on sexual and reproductive health, like the International Conference on Population and Development (ICPD 1994) (See details in Table 1) (UNICEF, 1989, United Nations, 1979, United National Human Rights, 1966).

Methodology

To assess the fulfilment of the SRH rights, a generic human rights guideline has been developed to examine the barriers to adolescent access to SRH health services, information and education. The guideline is informed by human rights studies conducted in countries like Brazil, Mozambique, Sri Lanka, Republic of Moldova, Tajikistan Malawi and Indonesia (Cottingham et al., 2010, World Health Organisation [WHO] and Ministry of Health of the Republic of Indonesia, 2006, The Republic of Indonesia Ministry of Health, 2008). It is also informed by key international human rights instruments such as the Convention on the Rights of the Child (CRC); the Convention on the Elimination of Decimation against Women (CEDAW); the UN International Covenant on Civil and Political Rights (ICCPR) and the UN International Covenant on Economic, Social and Cultural Rights (ESCR). Relevant country reports published by international agencies and researchers are also considered, for example, (UNFPA and the Government of Seychelles, 2012, UNFPA, 2012, UNDP, 2013a, Rue, 2015, Pradervand, 1981,

Ministry of Health and Social Development (MHSD) [Seychelles], 2008, Committee on the Elimination of Discrimination against Women, 2013, Bodwell, 2012, African Development Bank, 2009)

As children transition from childhood to adulthood, receipt of the right information, education and access to appropriate SRH services are key to building positive attitudes and SRH outcomes (Igras et al., 2014, Bankole et al., 2007, Svanemyr et al., 2015, Haberland and Rogow, 2015, Chandra-Mouli et al., 2015). Accordingly, this paper will focus on 1) the rights to information and education on SRH, STI, HIV/AIDS and 2) the rights to privacy and confidential youth-friendly services.

Developing a generic human rights guideline for analysis

A human-right based approach is useful for evaluating programme and policy developments, identifying vulnerable groups in societies and advocating for finding the common ground between public health objectives and human rights goals (FXB Center for Health and Human Rights Harvard School of Public Health, 2013). According to the United Nations, any rights based guideline must contain the following:

1. acknowledge that it is important for programmes and policies to contribute directly to the realization of one or more human rights;
2. include the key human rights principles of universality, non-discrimination, equality, participation and inclusion in all stages of planning, design, implementation, monitoring and evaluation of health programmes and policies
3. embody those human rights principles in the process to strengthen rights-related health outcomes and accountability of stakeholders (FXB Center for Health and Human Rights Harvard School of Public Health, 2013).

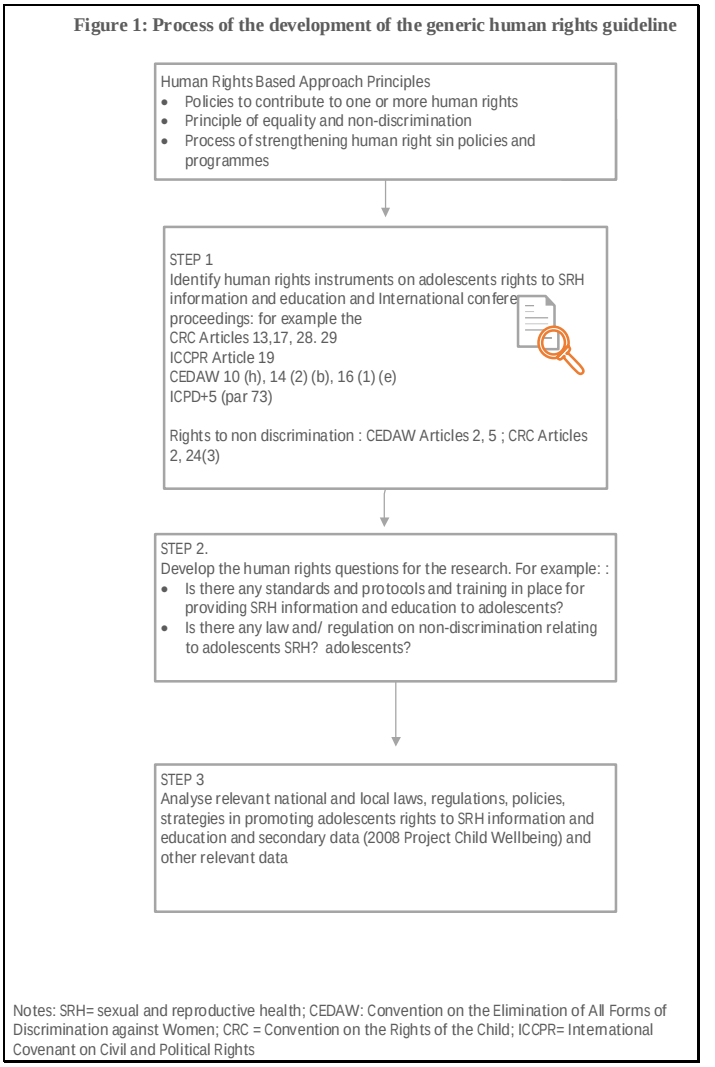
In addition, a guideline can support the development a country's regulatory environment and its relationships to adolescent sexual and reproductive health outcomes (Cottingham et al., 2010) and as a useful point of reference for relevant stakeholders and policy makers to reflect on their policies and plan for further actions.

The development of a guideline usually involves three steps (Figure 1). The first step requires identification of the key international human rights instruments that

are relevant to the study's objectives. The second step includes a process of selecting and evaluating relevant national documents, regulations, policies and programmes. In the third step, a set of questions is then developed based on the identified key international human rights articles, to be discussed later.

Figure 1 insert about here

Figure 1: Process of the development of the generic human rights guideline



Notes: SRH= sexual and reproductive health; CEDAW: Convention on the Elimination of All Forms of Discrimination against Women; CRC = Convention on the Rights of the Child; ICCPR= International Covenant on Civil and Political Rights

To complement the 2008 PCW data and to examine the extent to which Seychelles, as a State Party to relevant human right instruments has fulfilled its SRH obligations to adolescents, the first author [SAS] prepared a draft of the generic human rights-based guideline. Development of the guideline involved the following steps (see also Figure 1). One of the co-author (PD), a senior human rights advocate, checked the guideline for accuracy. Details of the three steps to develop the generic guideline are:

Step 1: Identify key international instrument relevant to the study's objectives, which aim to examine barriers and implementation of adolescent rights to information and education and privacy and confidential youth friendly services.

Table1: examples of identified international human rights instruments used in this study

Instrument	**Status**	**Articles**
Convention on the Rights of the Child 1990 (CRC)	State Party Ratification/ Accession: 1990	2.1. States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.
Convention on the Rights of the Child 1990 (CRC)	State Party Ratification/ Accession: 1990	16.1. No child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, or correspondence, nor to unlawful attacks on his or her honour and reputation.
Convention on the Rights of the Child 1990 (CRC)	State Party Ratification/ Accession: 1990	24.1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities …
Convention on the Rights of the Child 1990 (CRC)	State Party Ratification/ Accession: 1990	28.1 States Parties recognize the right of the child to education, and with a view to achieving this right progressively and on the basis of equal opportunity…
Convention on Elimination of all Forms of Discrimination against Women 1979 (CEDAW)	State Party Ratification/ Accession: 1992	10 (h) States Parties shall take all …measures to eliminate discrimination against women… to ensure access to …educational information and advice on family planning

Convention on Elimination of all Forms of Discrimination against Women 1979 (CEDAW)	State Party Ratification/ Accession: 1992	16.1. States Parties shall ensure that men and women to have the same rights to information and education and all means to enable them to exercise those rights.
Conferences		
International Conference of Population and Development (ICPD) 1994		Para 7.3 … full attention should be given to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality Para 7.8 … adolescents, with the support and guidance of their parents, and in line with the Convention on the Rights of the Child, should also be reached through schools, youth organizations and wherever they congregate. Para 7.11 Services must be particularly sensitive to the needs of … adolescents and responsive to their often powerless situation, with particular attention to those who are victims of sexual violence. Para 11.8 Countries should take affirmative steps to keep girls adolescents in schools … Pregnant adolescents should be enabled to continue their schooling.

For example, Table 1 shows that with adolescent rights to SRH information and education, the main human rights instruments include the UN Convention on the Rights of the Child (CRC) articles 13, 17, 28, and 29 and the UN Convention on the Elimination of the Discrimination against Women (CEDAW) article 16 (1) which protects equal rights of men and women to access information, education and means to enable them to exercise these rights. (Figure 1 for details). Specific international conferences relevant to adolescents SRH rights can also be considered and in this case, the International Conference on Population and Development (ICPD+5), was relevant as it states that SRH services for young

people shall be user friendly and protect the rights of adolescents to privacy, confidentiality, informed consent. It also states that SRH services shall ensure information and education to reduce vulnerability to HIV/AIDs for young people.

Step 2, develop relevant questions based on the relevant Articles and Conferences. Both the human rights instruments and the Conference proceedings led to the following questions:

a. What standards, protocols, regulations, or programmes and training to provide education and information on adolescents SRH (ie. SRH services, prevention and services for HIV/AIDs, family planning, privacy and confidentiality)
b. Have these been implemented?
c. Is there legislation to prohibit discrimination?
d. Are there policies/regulations prohibiting discrimination against adolescents?
e. Is there legislation/regulation to support the continuing education of adolescents mothers?

Step 3, analyse relevant national policies, regulations and secondary data to examine barriers of policies and regulation in promoting the identified rights in this study. The second co-author (JL) who is based in Seychelles, provided access to the 2008 PCW secondary data and relevant national policy and programme documents. Only with all authors agreement, the following national laws, regulations, strategies and policies to be included in the analysis:

- Seychelles MDGs Status Report 2013 (United Nations Development Programme [UNDP], 2013)
- Seychelles Sexual and Reproductive Health Policy (Southern Africa Gender Protocol Alliance, 2012)
- ICPD Country Report for Seychelles and ICPD implementation (Ministry of Social Affairs, 2012, International Conference on Population and Development, 2012)
- Seychelles Reproductive Health Policy (Ministry of Health [Seychelles], 2012)

- Seychelles Progress Report on Commitment on HIV and AIDS (UNGASS, 2010)
- National Action Plan on gender based violence (Ministry of Health and Social Development (MHSD) [Seychelles], 2012)
- Relevant statistics from the National Bureau of Statistics
- As well as the latest national data on the sexual health of secondary school students aged 12-19 years old, which was collected by in 2008 by the Seychelles Ministry of Health and Social Development (known as the 2008 Project Child Wellbeing Survey or PCW) (Victor, 2010, Ministry of Health and Social Development (MHSD) [Seychelles], 2008) and other relevant statistics published by the National Bureau of Statistics.

Seychelles: application of the generic guideline

We employed content analysis to examine which national policies, regulations an programmes were the most relevant documents to record government commitments to promote and fulfil the SRH rights of adolescents to education and information and non-discriminatory SRH services. We also used the 2008 Project Child Wellbeing and recent millennium development goals (MDGs) report to examine discrepancies and potential barriers between government commitment to SRH of adolescent and the reality in the field (Curry et al., 2009). We grouped secondary data to adolescent first sex experience, sexual behaviour after the first sex, condoms used, and knowledge of HIV transmission. Other secondary data used included the rates of teenage pregnancy, condoms used and the HIV/AIDs prevalence in adolescent (UNDP, 2013a).

Findings

Adolescents in Seychelles continue to show high rates of early pregnancies and sexually transmitted infection (STI) ((UNDP, 2013b, Rue, 2015, National Bureau of Statistics, 2013, UNFPA, 2012, Ministry of Social Affairs, 2012, Victor, 2010). Sexual reproductive health services for adolescents continue to be limited, and policy does not sufficiently reflect what is needed (Victor, 2010).

Government's commitment to adolescent sexual and reproductive rights

In 1990 and 1992 respectively, the Seychelles Government ratified the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of Discrimination against Women (CEDAW). These bind the government to prevent the disregard or breach of SRH rights of adolescents. (NGO group for the CRC, 2011, The Gender Commission Liaison Unit of NGOs in Seychelles [LUNGOS], 2013). The Government is also committed to the 1994 International Conference on Population and Development (ICPD Cairo. The following examines the situation of sexual reproductive health (SRH) of adolescents in Seychelles using the generic human rights questions.

Right to information and education on SRH, family planning, STI and HIV/AIDS, and accessing free condoms

To examine the government's commitment and potential barriers to promote the following rights, we conduced three review stages. First, the relevant international human rights instruments and conferences include for example the CRC, CEDAW, and the ICPD. [see also Table 1]. Examples of relevant articles include article 16, para 1 of the Women's Convention (CEDAW) that States Parties shall ensure that men and women to have the same rights to information and education and all means to enable them to exercise those rights. The ICPD Cairo supports the rights to make decision regarding reproduction free of discrimination and coercion (Para 7.3). Generally, identified key SRH rights include the rights to information and education on family planning, prevention of sexually transmitted infection (STI) and HIV, and access to free condoms.

Second, secondary data on adolescents SRH behaviours; including age of first sex and knowledge of HIV using the 2008 Project Child Wellbeing (PCW), data from the National Bureau of Statistics, and the MDGs report. From the 2008 PCW survey we know that 40% of surveyed adolescents or 717 secondary students aged 12-18 years old had already had their 1st sex (Table 2). Of those 717 students, 444 students (62%) had their 1st sex when they were about 16 years; 215 had it when they were about 14-15 years; and 100 students had it when they were as young as 12-13 years old. Although there no report on significant gender differences, the data showed that more boys (42%) than girls (33%) had 1st sex at younger age of 12-14 years.

Table 2: Age of first sexual intercourse amongst 717 students aged 12-19 years.

Age of first sexual intercourse	717 total students		336 female students		381male students	
	Number	%	Number	%	Number	%
12-13 years old	100	14%	38	11%	62	16%
14-15	209	29%	74	22%	135	35%
16-17	273	38%	131	39%	142	38%
18-19	135	19%	93	28%	42	11%
Total	717	37%	336	33%	381	42%

The data trends in Table 2, suggests a mark change of sexual behaviour at the age of 14. There was a very big leap in the proportion of 14 years who had 1st sex from the younger 12-13. This is a particular concern given that 15 the age of consent to sex in Seychelles (AU Solemn Declaration on Gender Equality in Africa [SDGEA], 2007) and that most sexual health education in school is provided to 15 years and older. This regulation on the age of consented sex potentially ignores the significant proportion of sexually active younger adolescents who might miss out the opportunities to needed sex education and services.

Table 3 shows the number of students who continued to be sexually active after 1st sex. Of 717 students who had 1st sex, the majority or 505 students (70%) were sexually active. Boys whose 1st sex at 12-15 years, were twice more likely to continue to be sexually active than girls at 47% and 27% respectively. No statistically significant differences between boys and girls were reported.

Table 3: Sexually active 505 secondary students aged 12-19 years

Became sexually active after first intercourse by age	505 sexually active students		237 sexually active female students		268 sexually active male students	
	Number	%	Number	%	Number	%
12-13 years	54	11%	22	9%	32	12%
14-15 years	136	27%	43	18%	93	35%
16-17 years	204	40%	94	40%	110	41%
18-19 years	111	22%	78	33%	33	12%
Total	505	100%	237	47%	268	53%

According to the National Bureau of Statistics (National Bureau of Statistics, 2013), in 2012, as many as 229 babies were born to girls aged 15-19. One in every 10 adolescents had already had more than one pregnancy.

The 2013 MDGs country report (United Nations Development Programme [UNDP], 2013) further highlighted the failure of the government of Seychelles to reduce teenage pregnancy. Little has changed in the last 12 years, adolescents birth rate continues to be at 1.9 [births per 1 000 women aged 15-19] (United Nations Development Programme [UNDP], 2013). 16% of first time visitors for antenatal clinics were young women aged 15-19; and 15% of them had already expected 2nd child. Teenage sexuality, unwanted pregnancies and abortions then remain a huge challenge post 2015MDG (UNDP, 2013a)

For condoms used, 416 of 717 (58%) students in the 2008 PCW survey reported using a condom during 1st sex. The other 300 students would then be at a higher risk for having sexually transmitted infections (STI/HIV), unwanted pregnancies, unsafe abortion and associated social, psychological and financial problems (Ministry of Social Affairs, 2012, UNFPA and the Government of Seychelles, 2012, Victor, 2010, Ministry of Health [Seychelles], 2012). The 2013 MDG report notes a very low contraceptive rate. Yet, condoms are easily available for free in all health centres, workplaces, social venues, like hotels, bars,

discotheques. This suggests that adolescents are not fully accessing existing SRH services and reasons for this likely to include lack of knowledge on contraceptive use, STIs, HIV, AIDs, the health harm of adolescent pregnancies; and stigma associated with accessing condoms. Low use of condoms is consistent with high adolescent pregnancy rate at 15% to 29% (2000-2012) and the health risk might be worsen with 30% of adolescent pregnancies ends with abortions (UNDP, 2013a).

In relation to the provision of education and information on STI and HIV/AIDS, Seychelles' 2010 Declaration on Commitment on HIV/AIDS (UNGASS, 2010) recognizes the right for adolescents to correct information on HIV and AIDs. The ICPD+5 affirms for the states to ensure access to information, education and services necessary to reduce vulnerability to HIV/AIDS for 15-24 years old by 95% by 2010.

The 2008 PCW survey showed that of the 1932 adolescents, the majority (86%) knew that HIV/AIDS can be transmitted by unprotected sex. Still 77 of them (less than 5%) believed that HIV/AIDS can be transmitted by sharing drinks from the same glass (Table 4).

Table 4: Knowledge of HIV and AIDS transmission of 1932 students aged 12-19

Identified modes of HIV/ AIDS transmission	1932 total students		1015 female students		917 male students	
	Number	%	Number	%	Number	%
Unprotected sex	1655	86%	908	90%	747	82%
Kissing	68	3%	27	3%	41	4%
Drinking in same glass	73	4%	35	3%	38	4%
Not stated	136	7%	45	4%	91	10%

According to the 2013 MDGs report, 7%-17% of people still believe that HIV can be carried through mosquito bites, sharing a bus seat or sharing a meal. Other

regulatory analysis of HIV/AIDS in Seychelles can be found elsewhere (UNDP, 2013b).

Third, we examined potential barriers in existing laws, policies and regulation to the fulfilment of adolescents SRH rights to 1) information and education on family planning and prevention of sexually transmitted infection (STI) and HIV/AIDs and access to free condoms.

Barriers to SRH information, family planning, STI and HIV/AIDS and free condoms.

Seychelles is committed to provide accessible SRH education and information for adolescents (see (Southern Africa Gender Protocol Alliance, 2012). Unfortunately specific SRH programmes have mainly targeted migrant workers, sailors, sex workers, men have sex with men, and travellers, and little mention has been made about adolescents (Southern Africa Gender Protocol Alliance, 2012). The absence of appropriate sexual education which promotes safe sex and health relationships, may result in adolescents soliciting information from other sources such as peers and popular media which often expose them to a range of sexual information which may have negative impacts on their sexual behaviours and decisions (West, 1999; Fortenberry, 2003; Stone & Ingham, 2006; Powell, 2008).

Barriers to promoting SRH education and information also include reluctance of parents and teacher to talk about youth sexuality. We asked how effective is sex education in schools? Sexual health curriculum has been in place since the early 1980s (Pardiwala, 1985). Yet our earlier review of secondary data and reports, shows little change in relation to adolescent SRH outcomes. A report by the WHO regional office (WHO Regional Office for Africa, 2009) noted that concistently in the past 5 years, 30% of pregnancies occur in 15-19 years old group. Others suggest that the rejections of some secondary schools to the distribution of free condoms in educational institutions may well reflect those school attitudes toward adolescents SRH education, despite the evidence that 12 years old adolescents are sexually active (Bodwell, 2012).

Regarding parents as the source of SRH information, 70% of the students in the 2008 PCW identified parents as the primary source of information. Yet, parents are often ill-prepared to discuss topics on sexuality and sexual health (Igras et al., 2014). The 2013 MDG reported that parents tended to think that sexuality is shameful and may choose to avoid discussing sexual health with adolescents. Parents most likely will rely on the schools and teachers to talk about SRH with teenagers (UNDP, 2013a).

Barriers to accessing family planning including free condoms have been observed in law and the legal age to access family planning without parental consent is those aged 18 years (Ministry of Employment and Social Affairs (MESA) [Seychelles] 2007; MHSD, 2007; MHSD, 2008b). Noting that the age of consented sex is 15 years old, current legislation makes it difficult for sexually active younger adolescents to access family planning including free condoms without parental consent. This law is thus contributing to an increasing rate of teenage pregnancy and the heightened risk of STIs amongst adolescents in Seychelles (Ministry of Foreign Affairs [Seychelles], 2013).

Right for pregnant adolescents to continue their schooling

Within the right of adolescents to SRH information and education, the 1994 ICPD (para 11.8) affirms that "Countries should take affirmative steps to keep girls adolescents in schools … Pregnant adolescents should be enabled to continue their schooling". Seychelles' Teenage Pregnancy Support Policy (2005) allows for pregnant students to return to school after the delivery of the child. However, a study conducted by the Seychelles Association of Women Professionals between 2004 and 2008, showed that only 5 out of 37 pregnant adolescents returned to school. Key barriers faced by pregnant adolescents to return to schools include lack of adequate information on the policy, lack of motivation, finance, shame and embarrassment, and expectation of motherhood.

The right to youth-friendly and confidential SRH services and facilities

Paragraph 7.3 of the ICPD Programme of Action recognizes that reproductive health care services for youth should be provided in a 'youth friendly environment' to meet the educational and service needs to adolescents and to enable them to make responsible and positive choices with regard to their SRH

needs. SRH services should safeguard the rights of adolescents to privacy, confidentiality, informed consent, respecting their cultural values and religious beliefs and in conformity with relevant existing international agreements and conventions including the Conventions on the Rights of the Child and the Women's Convention (Woods, 2005).

Seychelles is also legally committed to "create the conditions where privacy and confidentiality can be enjoyed" (CRC, Article 16). Health care workers are obliged to keep medical information and health status of all individual confidential and private, in light of the principles of non-discrimination. Adolescents are "deemed mature enough to receive counselling without the presence of a parent or other person are entitled to privacy and may request confidential services, including treatment" (Committee on the Rights of the child 33rd session, 2003).

In terms of the provision of the youth-friendly SRH services, the youth health clinic (YCH) was purposefully designed to provide youth-friendly and

confidential SRH services, including 'drop-in' care, family planning, STI/HIV testing and counselling (Raoul Fransen-dos Santos, 2009). The data from the 2008 PCW survey noted that only 28% of secondary school adolescents had ever utilized the youth health centre (YHC), mostly for free condoms. A report from the Ministry of Health and Social Development noted low use of the YHC by males. 85% the clients vising the YHC clinic have been young girls and women (MHSD, 2007). 40% of the clients were below the age of 18. Until 2008, there was only one YHC located in Mahe, the main island. This Mahe clinic provided information and counselling to 23% youth; 10% of their clients were diagnosed and treated for STIs and 3% screened for HIV/AIDS (MHSD, 2007).

To date, one more new YHC has been built on the main island of Victoria (the capital city of Seychelles). Thus adolescents from other islands and those living in rural find it difficult or are unable to fully access services. Discrepancies in data and lack of monitoring system may contribute to the failure to address the SRH needs of adolescents. This highlights the need for increased allocation of resources and infrastructure to effective monitoring and surveillance systems.

Barriers to the protection of adolescents' privacy and confidentiality may include discrepancies in existing regulation between the age 15 years of consent to sex and the legal age of 18 years to accessing contraceptives without parental consent (Ministry of Employment and Social Affairs (MESA) [Seychelles] 2007; MHSD, 2007; MHSD, 2008b).

This regulation places a significant barrier to sexually active younger adolescents to confidentially access contraceptives.

Discussion

This article reviews a number of international human rights conventions, regulation, conferences; implementation of local and regional laws, regulation, strategies on SRH of adolescents and relevant nation-wide secondary data included the 2008 Project Child Wellbeing, the National Bureau of Statistics, and the 2013 MDG report. In our analyse the research team first, identified key

human rights elements; second, examined data on SRH behaviours of adolescents; and third, examined barriers regulations, strategies, policies to fulfilled the abovementioned SRH rights. Barriers to the promotion of SRH rights exist within current Seychelles' regulation, policies or strategies as well as disharmony of two or more regulations, strategies or implementation of SRH education, information and services. Below we discuss four key priority actions needing to reduce barriers to current laws, regulation or implementation of adolescent SRH: harmonization of laws, policies programmes on adolescents SRH education and services; the need for targeted adolescent-centred programmes policies; improvement of monitoring and surveillance systems in existing SRH programmes for adolescents; and the need for multi-stakeholder integrated SRH services to cater the needs and rights of adolescents within a resource-scarce context.

Harmonization of laws, policies programmes on adolescents SRH education and services

Our analysis of existing regulations, policies, strategies and data on the SRH behaviours of adolescents highlights inconsistencies in laws and regulations that make it difficult for adolescents to get confidential SRH services. The Ministry of Health and Social Development guideline states that adolescents under 18 years need parental consent to access family planning (United Nations, 2009). Yet, those aged 15 years can consent to sex, yet not have the rights to access confidential services or contraceptive without parents' permission (Victor, 2010). The Committee on the Rights of the Child in its concluding observation in 2009 urges for the government of Seychelles to prioritize access to SRH information, education and access for contraceptives for especially adolescent girls also without parental consent. Reviews on existing regulation of adolescents' access to family therefore is overdue.

Targeted adolescent-centred programmes/interventions

Legal guardians and parents have the duties to provide in a manner consistent with the evolving capacities of the child appropriate direction and guidance in the exercise of the children's rights; hence the best interest if the child should be the primary consideration (Committee on the Rights of the child 33rd session, 2003).

The Department of Social Development in close collaboration with the Ministry of Education and the Ministry of Community Development, Youth, Sports and Culture aims to support initiatives in adolescents and parenting education at the community and national level (United Nations, 2009). This means that there needs to be more active engagement of non-government organisations (NGO) to raise awareness, knowledge, and upskill concerned and interested parents and legal guardians on adolescents SRH rights, knowledge of SRH services and referral services. For example, international and local NGOs and civil societies (ie. UNFPA, IPPF, AFSS and the Alliance of Solidarity for Family) have been at the forefront in addressing the need for SRH education not only for adolescents but also for parents. These organisations can play a key role in championing for quality and youth-friendly SRH education, and parents training to be taken forward by the Government of Seychelles (UNFPA and the Government of Seychelles, 2012, Bodwell, 2012).

At the same time, policies and programmes need to move away from narrow health promotion approaches focusing merely on donor-driven HIV/AIDs or child protection programmes, to more broadly addressing the upstream determinants of SRH and to implement the mainstreaming of human rights into advocacy and programme activities. As such, programmes will need to provide a space for adolescents to develop self-efficacy skills, explore their attitudes on sexuality, and learn about puberty, fertility, as well as their sexual and reproductive rights, and how to address gender inequity and discrimination. Support services are also important to link adolescents with supportive adults, health services and social networks (Girard, 2014, Igras et al., 2014). Policies and programmes need to use explicit SRH languages that are also youth-friendly (Bearinger et al., 2007, Kempers et al., 2014).

Independent monitoring and surveillance mechanism

Our analysis also confirms the observations of the 2009 CRC and its concluding remark for Seychelles. Lack of independent and systematic monitoring and surveillance mechanism have made it hard for programmes to address the needs of adolescents. Likewise, an independent mechanism or body would be able to

provide remedies for violation of children's rights under the CRC (Committee on the Rights of the child 33rd session, 2003) and advocate for public policies. For example, having only two YCH located in the main island will impede the rights of rural youths to youth friendly SRH services.

Integrated services

Current Country Programme Action Plan (CPAP 2012-2015) launched by Government of Seychelles and UNFPA is under its final implementation period. This Action plan acknowledges the need to improve targeted programmes aimed at HIV prevention, treatment and care especially for vulnerable populations. Within the context of adolescents SRH and HIV, it specified the need for a targeted integrated effort involving relevant stakeholders to tackle high rates of unwanted teenage pregnancies and reduce STI and HIV. Yet, under existing regulation, only those aged 18 can get confidential SRH services (Government of

Seychelles & UNFPA, 2012). Once again, this highlights the needs to review existing laws and regulation to effectively promote and fulfil the sexual and reproductive rights and needs of adolescents in Seychelles.

Regarding the availability and accessibility of the youth health clinics, the proportion of sexually active adolescents in Seychelles is too large to be adequately address by only two YHCs (Victor, 2010). Innovative strategies are urgently required to develop existing health services which could include mobile clinic, the inclusion of youth-friendly services within wider SRH facilities, and inclusive participation of youth-based organizations in sexual and reproductive health policies, programmes and education.

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