AGE OF CONSENT: GLOBAL LEGAL REVIEW
There is one barrier to health access and a major impediment to national and regional development across the globe that could be removed within a few days if only the policy decisions would be made. The removal of this barrier would promote gender equality, help end child marriage, reduce teenage pregnancy and girl dropout rates from secondary school, lower HIV incidence rates, and achieve the prerequisite for the demographic dividend. Let me explain.

As the Sustainable Development Goals (SDGs) become the world’s compass towards development and a better life for all people on the planet, sub-Saharan Africa faces a potential demographic disaster that could undermine many of the SDGs. Many sub-Saharan countries have some of the highest fertility rates in the world which, if unaltered, will see those countries’ population, rising from 17 million to 43 million by 2050. Another country’s population that is currently at 27 million will more than double to 65 million by 2050, with yet another going from 53 million to 137 million. Not one of these countries will have reached the population turnaround required as an inescapable prerequisite for achieving a demographic dividend by 2050.

With increases like these on the same available land area, with the same or less access to drinking water, potentially less arable land available due to global warming, and services and GDP increasing at a far slower rate than population, it will be impossible to achieve the SDGs and improbable to even maintain the human development index achieved thus far by 2017. These are not scenarios or ‘maybes’. This is the inevitable future of the region unless something significant, such as the fertility rates, changes. Slowing and reversing population acceleration is essential to development in sub-Saharan Africa.
And yet, the world has a dark and shameful history of ‘population control’, legislating women’s rights to decide on having children away and forcing and coercing sterilisation. These restrictions on agency and autonomy have no place in a democratic, sustainable development world in the 21st century and the vast majority of nations achieving the demographic dividend have not resorted to such dark methods.

Increasing gender equality, keeping girls in safe schools for longer, reducing sexual and gender-based violence, and increasing the sexual and reproductive health knowledge of young people are also factors. And of course, it is the increased access to modern contraceptives and women making choices about their own reproductive health that have turned the tide.

So this research report turns its attention to this access to modern contraceptive methods, as well as all other sexual and reproductive health (SRH) services. There are many barriers for adolescents around the globe - the majority of citizens in many countries – to access SRH services. Distance from services, lack of transport, lack of available commodities, poverty, inherited beliefs, harmful practices, and hostile staff attitudes can all be barriers to access. But only one barrier is self-inflicted by countries.

And this barrier could disappear tomorrow, creating massive access for adolescents. It is the barrier of legal restrictions on adolescents’ access to SRH. The majority of countries in the region have placed arbitrary legal barriers to adolescent access by creating policies or laws with a number of parental consent and other restrictions, preventing adolescents from initiating their own healthcare.

In some cases, these have been gradually added to laws or policies with well-intentioned reasons to protect adolescents. In many cases, however, they reflect an idealised view of what older people think younger people should or should not be doing. Primarily, these idealised views revolve around sex. Older people, sometimes forgetting their own youth, think that the best protection for younger people is to abstain from sex until they are, perhaps 16, or even 18. Reality is, in many cases different, and by ignoring reality and locking adolescents out of the health system when it comes to sexual and reproductive health and rights (SRHR), adults are doing irreparable damage to their children and other children, as well as directly contributing to a looming demographic disaster for their nation.

Because this seems so obvious, recent global guidelines have called on countries to examine their current policies and consider revising them to reduce age-related barriers to access and uptake of all SRH services. To assist in this process, the SRHR Africa Trust (SAT) in collaboration with the Thomson Reuters Foundation, 20 global law firms, and UNICEF, has reviewed Age of Consent laws in 22 countries: Botswana, Kenya, Ivory Coast, Malawi, Morocco, Nigeria, South Africa, Swaziland, Tanzania, Zambia, Zimbabwe, Brazil, Jamaica, India, Indonesia, Thailand, Vietnam, Canada, United Kingdom, France, Sweden, and Ukraine. The range of countries was chosen to highlight a spread of geography, cultures, development status, nonachievement, in-transition and achievement of the demographic dividend, and adolescent health outcomes. In addition, SAT and UNICEF also undertook an Ethical, Cultural and Social review in nine countries (seven being from the 22 countries above, plus two others - Uganda and Philippines) to look at ethical cultural and social barriers impacting adolescent access to health and services including SRH services.

The data revealed some game-changing recommendations apparent to SAT:

1. Desexualise SRHR services and treat them as you would any other health system access;
2. Base both access and restriction decisions on child and adolescent development, competence and maturity to make decisions about their own health;
3. Do not make the age of sexual consent older than 16 years, and do not distinguish between young men and young women;
4. Have statutory rape provisions in place to protect adolescents from predatory adults;
5. Put ‘close in age’ exceptions to the age of sexual consent in place so that young adolescents having consensual sex with one another do not have to go to jail – a travesty affecting young men aged 13-16 years.

We offer this report and its insights to policymakers, legislators, development agencies, international cooperating partners, and activists wherever they may be. A thinking and action tool is currently being designed to accompany this report. If you wish to receive it or an electronic copy of this report, please send an e-mail to ageofconsent@satregional.org. Please also feel free to share ways in which you may have used this report or the action tool to create positive change with us and with one another.

Our hope is that these resources will create dialogue and action that will remove all legal barriers to adolescent access to SRH services and allow attention and resources to focus on the remaining and more intractable barriers.

Jonathan Gunthorp

Executive Director - SAT
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SAT is grateful to UNICEF for co-funding the review of the Age of Consent laws, policy frameworks, ethical, cultural and social impacts on sexual reproductive health and rights and HIV. Last but not least, SAT thanks Thomson Reuters Foundation for their continued collaboration with SAT on health and rights and for brokering the partnerships between SAT and the in-country law firms.

Countries in the study

Canada — United Kingdom — France —
Morocco —
Jamaica — Nigeria — Kenya —
Brazil —
Zambia — Botswana —
South Africa —
DISCLAIMER

This legal review report and the information it contains is provided for general informational purposes only.

It has been prepared as a work of comparative legal review only and does not represent legal advice in respect of the laws of any country in this study. It does not purport to be complete or apply to any particular factual or legal circumstances. It does not constitute, and must not be relied or acted upon as legal advice or create an attorney-client relationship with any person or entity.

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ACRONYMS

AIDS..............................Acquired Immune Deficiency Syndrome
ANC..................................Antenatal Care
ART..................................Antiretroviral therapy
HIV.................................Human Immunodeficiency Virus
HPV..................................Human Papillomavirus
HTC.................................HIV Counselling and Testing
PEP..................................Post-exposure Prophylaxis
PrEP.................................Pre-exposure Prophylaxis
SAT.................................SRHR Africa Trust
SRHS...............................Sexual and Reproductive Health Services
SRHR...............................Sexual and Reproductive Health and Rights
STI..................................Sexually Transmitted Infection
UNDP...............................United Nations Development Programme
UNFPA.............................United Nations Population Fund
UNICEF............................United Nations International Children’s Fund
WHO...............................World Health Organization
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EXECUTIVE SUMMARY

Laws and policies regulating Age of Consent to sex and to sexual and reproductive healthcare services create barriers for adolescents, blocking their access to vital services to protect and promote their sexual and reproductive health and rights.

In 25 All In! priority countries (Botswana, Brazil, Canada, Cote d’Ivoire, United Kingdom, France, India, Indonesia, Jamaica, Kenya, Malawi, Morocco, Nigeria, South Africa, Swaziland, Sweden, Tanzania, Thailand, Ukraine, Vietnam, Zambia and Zimbabwe), the Age of Consent to sexual intercourse is generally not clearly set out in law. It has to be inferred from criminal laws that criminalise sex with individuals below a specific age. This age ranges, but for most countries it is 16 to 18 years of age. A number of countries provide for exceptions to the Age of Consent to sex, such as when two young people are married.

In some countries these laws are also discriminatory – they discriminate against same-sex sexual relationships in a number of countries, providing for higher ages of consent for same-sex sex, or prohibiting same-sex sex altogether. In some countries these laws discriminate between young girls and boys, potentially increasing their vulnerability - they may create lower ages of consent for girls, fail to criminalise sex with a boy below a specific age or allow for a lowered Age of Consent in the case of a young person being married.

In addition, there are inconsistencies in the laws relating to the Age of Consent to sex and the Age of Consent to access sexual and reproductive health services, particularly contraceptives. In some countries, such as Brazil, India, Swaziland and Tanzania, laws and policies have lowered the Age of Consent to access to contraceptives despite a higher Age of Consent to sex, creating potential uncertainty in the healthcare sector about the lawfulness of providing contraceptives to young people below the Age of Consent to sexual intercourse. In Morocco the Age of Consent to access sexual and reproductive health services exists alongside the prohibition on sex outside of wedlock, creating difficulties for young people who are lawfully old enough to access services but are unmarried.

It is vital that countries set a clear Age of Consent to sex separate from the criminal law, which reflects the evolving capacity, age and maturity of young people, and which does not discriminate based on sex, sexual orientation, gender identity or intersex status or marital status.

The Age of Consent to medical treatment in the 25 All In! countries is generally 16 years of age, in countries that provide for an age in law. However, the laws of a number of countries fail to provide an age of independent consent to access medical treatment generally, or for specific sexual and reproductive healthcare services (such as contraception, emergency contraception, HIV testing, Antiretroviral treatment, antenatal healthcare services and the HPV vaccine). In these cases, the Age of Consent is inferred from laws regulating the age of majority – ranging from 16 to 21 years of age.

There tends to be more certainty in law and policy regarding access to HIV testing and access to abortion. Most countries provide for a specific (and lowered) Age of Consent in law or policy for HIV testing. Additionally, the Age of Consent for access to abortion is often set out in law. Access to abortion is prohibited or limited in many cases. Similarly access to pre- and post-exposure prophylaxis is limited or not yet regulated in the laws of some countries.

A few countries empower medical personnel to take into account the evolving capacity and maturity of the child when determining the Age of Consent and the child’s right to express his or her preferences.

There are countries that provide in law and policy for a lowered Age of Consent to access certain services, such as contraceptives and HIV testing. However, this lowered Age of Consent is at times inconsistent with the Age of Consent to sex, creating potential uncertainty amongst both young people and healthcare providers regarding the lawfulness of access to services. In some countries a lowered Age of Consent to HIV testing is inconsistent with the Age of Consent to HIV-related healthcare services, such as antiretroviral treatment, placing young people in a position where they are, for example, unable to be linked with independent access to a continuum of care following an HIV diagnosis.

It is critical that countries set out a clear legal Age of Consent to medical treatment (including sexual and reproductive healthcare services) in law that reflects the evolving age, capacity and maturity of a young person and that is not higher than the Age of Consent to sex. The law should also clearly provide for access to sexual and reproductive healthcare services, irrespective of the Age of Consent to sex.

The evidence gathered in this and other recent research reports highlights the various inconsistencies, gaps and challenges in Age of Consent laws that create barriers to access to sexual and reproductive healthcare, in countries where young people are at high risk of HIV exposure. With the increasing urgency of reaching young people with sexual and reproductive healthcare, policy makers and civil society stakeholders are encouraged to use this information and the suggested recommendations, to work towards the review and reform of Age of Consent laws, regulations and policies in their countries and to collaborate to advocate for change at regional and supranational level.
Chapter One: Background

As children come into adolescence and begin to explore their sexuality, their need for sexual and reproductive health information and services, to protect and promote their sexual and reproductive health and rights, becomes particularly critical.

In addition to lawful and consensual sexual activity amongst young people, young people and especially young girls, are also more vulnerable to sexual and physical violence. This may result in adverse sexual and reproductive health outcomes. A World Health Organisation (WHO) study found that globally among girls aged 15-19 years who were ever partnered, over 29% had experienced physical or sexual violence perpetrated by an intimate partner. As the WHO study noted, intimate partner violence renders young people more vulnerable to HIV and other sexually transmitted infections (STIs) and results in increased adverse sexual and reproductive health outcomes, including leaving them at risk of unintended pregnancies and induced abortions.

In 2015, 670,000 young people aged 15 to 24 years were newly infected with HIV. Of this number, 250,000 were young people aged 15 to 19 years. The majority of these are young girls. In 2013 almost 60% of new HIV infections amongst young people aged 15 to 24 years occurred among adolescent girls and young women. Globally, 15% of women living with HIV are aged 15 to 24 years, of whom 80% live in sub-Saharan Africa.

In Eastern and Southern Africa, young people aged 15-24 years accounted for more than 50% of all young people living with HIV globally. Almost 1 in 4 new HIV infections in 2015 were in young people aged 15 to 24 years. Young women are disproportionately affected by the HIV epidemic in almost all countries in Eastern and Southern Africa. Recent research shows that adolescent girls and young women aged 15 to 24 years account for 25% of new infections versus 12% in boys and young men – almost two thirds of new HIV infections amongst young people occur amongst young girls aged 15 to 24 years.

One of the critical ways to better the sexual and reproductive health outcomes of young people is to ensure that they have unfettered access to sexual and reproductive health services to protect their sexual and reproductive health. However, in many countries, young people report obstacles and barriers to accessing sexual and reproductive health (SRH) services.

2 Id.
Research conducted in many parts of the world shows that several legal and human rights barriers hinder access to, and uptake of, HIV services for adolescents. Key among these barriers are Age of Consent legislation and policies. Research in Africa shows that barriers created by laws and policies include: the lack of clarity in laws and policies regarding the age at which young people can access specific sexual and reproductive health services; inconsistent laws/policies that provide conflicting ages of consent for access to various services; discriminatory laws that differentiate between young people’s access, based on sex, gender, sexual orientation and marital status; the stigmatising attitude of service providers towards young people’s sexuality; the lack of knowledge about the existing laws and policies, and poor enforcement of laws and policies. These gaps, challenges and inconsistencies in the legal and regulatory framework make it difficult for young people to access the necessary sexual and reproductive health services.\(^7\)

Recent global guidelines have therefore explicitly called on countries to examine their current policies and consider revising them to reduce age-related barriers to access and uptake of the overall SRH services, HIV testing and counselling (HTC) and to linkages to prevention, treatment and care. International bodies such as the United Nations Children’s Fund (UNICEF), the United Nations Population Fund (UNFPA), United Nations Development Programme (UNDP) and WHO, are currently undertaking a number of initiatives to strengthen global guidance for young people’s access to a range of HIV-related health services, including guidance on the Age of Consent to services; informed consent; confidentiality and the availability, accessibility, acceptability and quality of services.

This guidance aims to support countries to examine their Age of Consent laws and policies, with a view to reviewing and removing inconsistent and conflicting laws that act as barriers to access to SRH services and strengthening the sexual and reproductive health and rights of young people.

ALL IN To #EndAdolescentAIDS was launched as a global platform for action and collaboration for social change in February 2015 by global leaders and civil society partners. This global agenda provides an opportunity for ensuring that existing and new strategies and programmes on HIV prevention, treatment and care are effectively implemented to benefit young people. ALL IN To #EndAdolescentAIDS works through four work streams. As part of work stream 1, global partners have prioritised joint action to take stock of the current situation in countries with respect to Age of Consent for services including HIV by carrying out a systematic desk review of age-of-consent laws, and a mapping of the processes led and outcome of reforms undertaken by countries to address this barrier.

Through the ALL IN Platform, many agencies and global partners including UNDP, UNAIDS, PACT and the AIDS Alliance have already initiated actions on data collection to inform their policy advocacy efforts at global level and specifically within the 25 All IN! focus countries.

“One of the critical ways to better the sexual and reproductive health outcomes of young people is to ensure that they have unfettered access to sexual and reproductive health services to protect their sexual and reproductive health. However, in many countries, young people report obstacles and barriers to accessing sexual and reproductive health (SRH) services.”

\(^7\) See, for example, UNFPA (2016) Harmonization of Legal Environment on Adolescent Sexual and Reproductive Health in Eastern and Southern Africa.
Chapter Two:
Aims, Objectives and Methodology of this Review

2.1 Aims and Objectives

The Global Legal Review Report aims to provide an overview of the age at which young people may access and consent to a range of sexual and reproductive healthcare services in 22 countries. It furthermore aims to analyse these findings, in terms of a proposed ‘ideal’ Age of Consent, to identify inconsistencies, gaps and challenges and to identify the potential for solutions, with broad recommendations for law and policy review and reform to address legal and policy barriers to young people’s access to SRHR across countries.

This Global Legal Review is based on a desk review of the findings of 22 national legal reviews of Age of Consent laws, commissioned by the SRHR Africa Trust (SAT).

The findings of the Global Legal Review Report will support the development of a learning toolkit for SRHR policy influencers and civil society role players. The learning toolkit will enable these stakeholders to examine their legal frameworks and to address legal and policy gaps and barriers in their Age of Consent laws within their countries and regions.

2.2 Methodology

During the course of 2016, SAT, UNICEF and Thomson Reuters Foundation collaborated to conduct various studies into different aspects of young people’s ability to consent to and access SRH services in order to identify barriers to access to SRH services, including HIV prevention, treatment and care and to consider opportunities for expanding SRH services and HTC for young people. The studies included an Age of Consent legal review; an ethical, social and cultural review and a youth attitudes mobile based survey.

The primary research was carried out by, in most cases, in-country law firms in the following countries: Botswana, Brazil, Canada, Cote d’Ivoire, United Kingdom, France, India, Indonesia, Jamaica, Kenya, Malawi, Morocco, Nigeria, South Africa, Swaziland, Sweden, Tanzania, Thailand, Ukraine, Vietnam, Zambia and Zimbabwe. The choice of countries was determined according to a set of criteria, detailed in Appendix A. The research resulted in 22, country-specific legal review reports prepared by SAT. The underlying research looked at the Age of Consent to nine issues:

1. Age of Consent to sexual intercourse (including the age for statutory rape)
2. Age of Consent to access contraceptives (including with and without parental consent)
3. Age of access to emergency contraceptives (including with and without parental consent)
4. Policy framework and legislation enabling or disenabling access to Pre-exposure Prophylaxis (PrEP), including Age of Consent with and without parental consent
5. Policy framework and legislation enabling or disenabling access to Post-exposure Prophylaxis (PEP); including Age of Consent with and without parental consent
6. Policy framework and legislation enabling or disenabling access to safe abortions and post abortion care, including Age of Consent with and without parental consent
7. Policy framework and legislation enabling or disenabling access to Ante-Natal Care (ANC), including Age of Consent with and without parental consent
8. Policy framework and legislation enabling or disenabling access to Human Papillomavirus (HPV) vaccine, and cervical cancer screening and treatment, including Age of Consent with and without parental consent
9. Age of Consent to access HIV testing without parental consent;
10. Age at which HIV status will be reported directly to an adolescent and legal/policy requirements to report status to her/his parents

The 22 country reviews assessed all relevant national laws (including nationally recognised customary or religious laws, where relevant), regulations as well as health and related policies, programmes and plans to determine the age at which young people could access and consent to various sexual and reproductive healthcare services relevant in the context of HIV and AIDS within the country. The legal reviews were asked to indicate ages for girls and boys separately, where relevant and to indicate where contradictions existed between the various Age of Consent laws, regulations and policies.

Based on existing international and regional guidance on the Age of Consent to sex and to sexual and reproductive health services.

The law firms covering Malawi and Indonesia were not based in country.
2.3 Limitations of the Global Review

The Summary Review is limited to the information in and the findings of the initial 22 country review. This review does not take into account information beyond that which is in the 22 legal country reviews. As a result, the following limitations are noted:

Insufficient information available in-country: The country reports indicate that laws and policies in countries do not provide clear answers to a number of the specific questions asked. The findings show that in most countries, there is a lack of clarity and/or a lack of specific provision for the Age of Consent to sexual intercourse and the Age of Consent to access each sexual and reproductive healthcare service that formed part of the initial review. Where country reports failed to answer each aspect of the questions posed, the Summary Review was confined to analysing the available information. In other cases, where country reports drew broader conclusions from the lack of information, the

Direct Questions included in Country Legal Review

Questions relating to the Age of Consent to sexual intercourse

1. At what age may sex between consenting individuals legally take place?
2. Are there exceptions to this? e.g. gay sex?
3. Is there a definition of statutory rape?

Questions relating to access to and the Age of Consent to SRHR

1. At what age may a young person access contraceptive services including contraceptive commodities?
2. May a young person access emergency contraceptives? At what age?
3. Do laws and policies enable or disenabling access to ART? What is the Age of Consent (with / without parental consent)?
4. Is there any prohibition on HIV PEP? What is the Age of Consent (with / without parental consent)?
5. If there is no prohibition, would young people be legally able to access PEP, were it offered? At what ages (with / without parental consent)?
6. Is there any legislation or policy specifically enabling PEP use in country? Does it deal with Age of Consent and if so, what does it provide?
7. Is there any prohibition on HIV PrEP? What is the Age of Consent (with / without parental consent)?
8. If there is no prohibition, would young people be legally able to access PrEP, were it offered? At what ages (with / without parental consent)?
9. Is there any legislation or policy specifically enabling PrEP use in country? Does it deal with Age of Consent and if so, what does it provide?
10. Are there laws / policies enabling or disenabling access to safe abortions and/or post abortion care? What is the Age of Consent (with / without parental consent)?
11. Are there laws / policies enabling or disenabling access to ANC? What is the Age of Consent (with / without parental consent)?
12. Are there laws / policies enabling or disenabling access to the HPV vaccine and cervical cancer screening and treatment? What is the Age of Consent (with / without parental consent)?
13. What is the Age of Consent to access HIV testing without parental consent?
14. What is the age at which HIV status will be reported directly to any young person? What are the legal/policy requirements for any young person to report HIV status to her/his parents?
15. Are there any inconsistencies to the answers?
Summary Review was not able to confirm the conclusions drawn from the information provided. E.g. where laws and policies did not specifically provide for an Age of Consent to a particular sexual and reproductive healthcare service, country reports may indicate that there was no age restriction on access to services. Other country reports indicated that the general Age of Consent to medical treatment, or the age of majority, would apply.

Limited to written laws / policies: The country legal reviews analyse the legal and policy framework to determine young people’s access to sexual and reproductive healthcare services. In some cases, countries reported on what takes place in practice but for the most part, the reviews do not deal with the level of practical implementation of laws and policies (or the lack of clarity in laws and policies) at healthcare service level. As a result the Summary Review confined itself to an analysis of available laws and policies and made recommendations for law and policy review and reform.

Other areas of interest and impact: The country legal review reports had a narrow scope and did not examine other possible legal and policy issues that impact on access to services. For instance, it did not examine whether law / policy provided for access to healthcare for all persons within the country or only to citizens of the country.

As a result of the various limitations set out above, the Global Legal Review focuses on those areas where the country reports were able to provide sufficient information and highlights where there were gaps in information. It analyses the major responses seen across countries in terms of information available, identifying common gaps, challenges and inconsistencies. On this basis, it provides broad and generalised recommendations for law and policy review and reform rather than individual country-based recommendations. It encourages countries to use this information to do further in-depth research at country level, where necessary, and to advocate for law and policy review and reform based on their findings.

2.4 How can you use the Global Review?

The Global Legal Review will be used to support the development of a learning toolkit on Age of Consent laws, regulations and policies and opportunities for increased access to SRH services for young people. However, in its stand-alone form it may also be used by policy makers and civil society stakeholders to:

- Provide information on the access to and Age of Consent laws, regulations and policies in the 22 participating countries, including potential gaps, challenges and inconsistencies within laws, regulations and policies and applicable recommendations for law and policy review and reform.
- Provide impetus to non-participating countries to conduct similar analyses of access to and Age of Consent laws, regulations and policies in terms of the generalised ‘ideal standard’, to identify gaps, challenges and inconsistencies and agree on recommendations for law and policy review and reform.
- To provide an evidence base for advocacy for law and policy review and reform at national level.
- To encourage collaborative efforts for supranational and regional advocacy for law and policy review and reform.

While this Review focuses and makes recommendations relating to legal barriers, it should be read alongside the Ethical Social and Cultural desk review, conducted by Jerome Amir Singh (lead author), Faadiela Jogee and Samanatha Chareka (co-authors) of Centre for the AIDS Programme of Research in South Africa (CAPRISA), Durban, South Africa, and Dalla Lana School of Public Health, University of Toronto, which provides information on ethical, social and cultural factors impacting on young people’s sexuality.

Multi-country Ethical Social and Cultural Review

The Ethical, Social, and Cultural (ESC) desk review looked at ESC factors influencing and impacting adolescents’ access to SRHS in 11 countries (Africa: Nigeria, South Africa, Uganda; Asia: India, Indonesia, Philippines, Thailand; Latin America and the Caribbean: Brazil, Jamaica; Europe: Ukraine, United Kingdom).

The review explored how ESC factors impact adolescents’ access to SRHS, regardless of the enactment of relevant national laws and regulations, including nationally recognized customary or religious laws, policies, and human rights protections. The review specifically considered how ESC factors impact on sex and sexual debut; adolescent homosexuality and transgender expression; and access to sexual and reproductive health services, including autonomous HCT, and access to contraceptive.

The review defines ‘ethics’ as what ought to be done in a particular context, regardless of prevailing laws, social norms, and prevailing morals, whereas ‘morals’ is described as reflecting an individual’s inner value system, which is often shaped by, amongst other factors, social and cultural influences. With SRHR service provision, service providers and decision-makers are repeatedly confronted with the question of this distinction as they serve or deliberate on the interests of adolescents. For example, while abortion may be unlawful, and a healthcare provider may believe abortion is immoral, that provider has an ethical obligation to do everything they can, including setting aside their moral perspective on the issue, in order to save the life of an adolescent presenting to a facility with life-threatening complications due to an abortion.

The enquiry also determined the permissible Age of Consent for sexual intercourse, activities, and the permissible circumstances for adolescents to engage in sexual intercourse or activities from an ethical, social and cultural perspective.

Sex and sexual debut has historical, religious and cultural acceptance for children having sex in the context of marriage as evidenced in all countries were the reviews were done. Early sexual debut amongst adolescents is usually indicative of engagement in risky sexual practices. Religious beliefs and morals often dictate early sexual behaviour amongst adolescents. There are historical religious and cultural objections in reference to premarital sex in most countries.

Common global themes reviewed included child marriage commonly recognized as a traditional cultural practice in most countries except in South Africa, Brazil and United Kingdom. The ESC review noted gender roles and gender-based violence – particularly in Nigeria, South Africa, Uganda, Brazil, Jamaica, Philippines and Thailand – as one
the major social and cultural impact on access to services. Intergenerational sex and multiple concurrent sexual partnering in Nigeria, South Africa, Uganda, and Jamaica, among others factors, served as a major driver for risky behaviours among adolescents.

The research further enquired how adolescent homosexuality and transgender expressions is viewed in the local context from a social and cultural perspective regarding both males and females. The reports also highlighted the ethical dimensions of homosexuality and transgender expression. The review reported that no country openly accepts homosexuality, with some countries more homophobic than others. Generally, no reviewed country accepted homosexuality, bisexuality, and transgenderism - socially, culturally, or religiously. Although some countries were tolerant of non-heterosexual behaviour, none openly embraced homosexuality, bi-sexual, and transgender expression.

The ESC reviews also looked at other harmful traditional practices that impacted upon adolescent sexual and reproductive health, such as virgin kidnapping and bride kidnapping, which is practiced amongst some communities in Ukraine and South Africa. ESC reviews also noted injection drug use amongst orphans in the Ukraine, and migrant child labour and child abuse in Thailand as impacting on adolescent SRH.

Social and cultural norms that reinforce male dominance, and female subordination and powerlessness, serve as a major barrier to female adolescents accessing SRHS. The report noted other common global themes influencing adolescent SRH, such as child labour in Uganda, India, Indonesia, Philippines, Ukraine, and the United Kingdom.

Orphanhood or homelessness among adolescents, for instance, in Nigeria, Uganda, India, and Ukraine, alongside poverty in Brazil, Indonesia, and Philippines, further prohibited access to SRHR services through ethical, social and cultural tenets. The lack of youth and adolescent friendly services in most countries, such as South Africa, India, Indonesia, Philippines, and United Kingdom also served as barriers to adolescent SRH. The ESC reviewed stigma and discrimination in Nigeria, South Africa, Indonesia, and United Kingdom as an ethical, social and cultural barrier to access SRHR services.

Other factors that influenced and impacted upon adolescents’ access to SRHS included parental absence in Jamaica, lack of sexual education and legislative barriers in Philippines, geographical location of services in Brazil, and social class, migration, incarceration, FSW, and IDU (Ukraine).
Chapter Three: Key Issues

3.1 Age of Consent to sexual intercourse

What is the Age of Consent to sexual intercourse? The Age of Consent to sex refers to the age at which the national law of a country determines it is lawful for a person to consent to sexual intercourse. Often, the Age of Consent to sexual intercourse is expressed in the negative – that is, a country’s criminal laws provide that it is unlawful to have sex with a person below a specific age.

Why is the Age of Consent to sexual intercourse relevant in the context of HIV and AIDS? The age at which a young person may lawfully consent to sex requires balancing the need to protect young people (e.g. from sexual abuse and exploitation) as well as the need to recognise the evolving age, capacity and maturity of a young person. The age at which a country determines that a young person is capable of lawfully consenting to sexual intercourse should recognise this balance between a young person’s right to be protected from harm (including exposure to HIV, STIs and unintended pregnancy amongst other things) and recognising their sexual rights, particularly as they mature.

Being sexually active impacts on the sexual and reproductive health of a young person and requires access to an increased range of sexual and reproductive health services. In the context of HIV and AIDS, once individuals are sexually active, they are at risk of acquiring HIV and other STIs. The Age of Consent to sexual intercourse interrelates with the Age of Consent to sexual and reproductive health services, since it is critical to ensure that individuals who can consent to sex can also consent to HIV prevention and treatment services and treatment, including HIV testing, access to pre and post-exposure prophylaxis and ART. In addition, having sex also exposes young people to pregnancy and thus, it is critical that the ages of consent to access contraceptives or antenatal healthcare services are the same as the Age of Consent to sexual intercourse.

In addition, research shows that it is critical that young people are able to independently consent to access confidential SRH services. The requirement for parental consent to access SRH services has been shown to create barriers for young people, discouraging them from accessing necessary healthcare.

What are some of the difficulties and barriers created by laws regulating Age of Consent to sex? Often, the Age of Consent to sexual intercourse is not explicitly provided for in law. Rather, it is inferred through provisions criminalising sex with an individual below a specific age, regardless of consent. This creates confusion regarding the Age of Consent to sex between and with young people and creates potential barriers to access to appropriate services.

The laws on the Age of Consent to sexual intercourse are discriminatory in many countries, reflecting prejudicial attitudes, exacerbating discrimination and inequality and potentially creating inequality in access to sexual and reproductive healthcare services. The age of independent consent may differ for young boys and girls – for example, Age of Consent laws may provide for a lower age at which girls may lawfully consent to sex, potentially exposing
young girls to sexual exploitation. The Age of Consent to sexual intercourse sometimes differs and discriminates in relation to heterosexual and homosexual sex, with higher ages of consent provided for same-sex sexual relationships (and in many cases, outright prohibition of same-sex sex). This poses additional barriers to access to services for young people involved in same-sex sexual relationships which are prohibited by law. In some countries, marriage is required for consent to sex, and / or marriage creates an exception to the Age of Consent to sexual intercourse – a young person may consent to sex at a younger age, where he or she is married – increasing the vulnerability of young girls to HIV exposure in countries where early marriage is permitted in law.

In some countries, the Age of Consent to sex is set at a higher age (e.g. 18 to 21 years of age) than the actual age at which young people engage in consensual sexual intercourse within countries. This exposes young people to possible prosecution for engaging in consensual sex and discourages access to healthcare services where young people fear being reported to the criminal justice system. In other countries, religious or customary laws allow for young people, and particularly young girls to consent to sex at low ages, exposing these young girls to possible sexual exploitation and placing them at risk of HIV exposure, STIs and pregnancy.

Finally, the Age of Consent to sexual intercourse is often inconsistent with the Age of Consent to access sexual and reproductive healthcare services in a country, allowing young people to lawfully consent to sex but rendering them unable to legally obtain sexual and reproductive health services such as contraception without parental consent.

### 3.2 Age of Consent and access to SRHR

What is the Age of Consent to sexual and reproductive health services? The Age of Consent to medical treatment refers to the age under national law at which an individual can independently consent to medical treatment. In this Summary Review, legal provision for consent to medical treatment has been interpreted to also include consent to preventive technologies and services such as PEP and PrEP. 10

Why is the Age of Consent to medical treatment, especially sexual and reproductive health services, relevant in the context of HIV and AIDS? Young people are particularly vulnerable to HIV exposure and there is increasing recognition of the fact that, unless concerted efforts are made to prioritise young people’s access to SRH services, they are in danger of being “left behind” in the global HIV response. Accessing HIV-related information, prevention and treatment services as well as related sexual and reproductive healthcare services can empower young people to protect their health, prevent HIV and other STIs and to secure life-saving treatment if they are living with HIV. 11 Young members of key populations, such as gay, lesbian and transgender young people and young people who use drugs, have even more specific and complex healthcare and support needs and their access to targeted services is critical to protect their health.

Research shows that in order to best promote access to healthcare, young people need to be able to independently access SRH services at an appropriate age, consistent with the age at which they become sexually active. Requiring parental consent for access to SRH services may dissuade many young people from accessing prevention, care and support – particularly young people who are members of key populations (e.g. young men who have sex with men and young people who use drugs) who not only fear parental disapproval but also stigma and discrimination from healthcare workers and punitive legal environments that criminalise their activities. The legal requirement for parental consent may also create barriers for those without parents or legal guardians. Young people who head up households, are abandoned and those living or working on the streets may be particularly vulnerable to the risk of HIV exposure and in need of an enabling legal and regulatory framework that facilitates their access to appropriate healthcare services.

Thus, promoting the health of young people requires promoting independent access to medical treatment, where appropriate. In the context of Age of Consent laws, this requires ensuring that laws provide for an appropriate age where young people can independently consent to access medical treatment (including prevention technologies and services) and that such laws are appropriate, reflective of the evolving capacities of young people as they enter adolescence and are not higher than those providing for the age at which young people can lawfully consent to sex.

What are some of the difficulties and barriers created by laws regulating access to and Age of Consent to medical treatment, particularly sexual and reproductive health services? The majority of countries do not specifically provide for access to a range of sexual and reproductive healthcare services in law. For example, this study shows that health laws may refer more broadly to a person’s right to primary healthcare, or to a women’s right to antenatal health care. In the case of more specific SRH services, in some cases health policies, protocols and guidelines may refer to the availability of and access to specific interventions such as ART or HPV vaccines. Of more concern, there are instances where law specifically prohibits or limits access to specific services (such as abortion, PEP and PrEP). In order to protect young people’s sexual and reproductive health and rights, it is important that laws, regulations, policies and guidelines do not prohibit their access to key SRH services that may prevent HIV, STIs and unintended pregnancies and promote their sexual and reproductive health.

In many countries, young people require the consent of a parent or guardian in order to access healthcare services, at times even where national laws simultaneously provide that they may lawfully consent to sex. 12 In other instances, laws and policies provide young people with the right to independently consent to healthcare services, but this age is inappropriately high in the context of the evolving capacity of the young person. This raises a number of concerns. Laws which limit proxy consent to parents or legal guardians act as barriers to services for orphaned or abandoned children who live with caregivers who are neither parents nor legal guardians. In addition, research

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10 In some legal jurisdictions, the definition of “medical treatment” is narrow and is confined to interventions to manage diseases, arguably excluding prevention technologies and services such as emergency contraception, PEP and PrEP. This may create uncertainty regarding the application of laws on the Age of Consent to medical treatment to these SRH services.

11 Here, we specifically cover Age of Consent to HIV-related healthcare services, such as access to HIV prevention, treatment and care. Age of Consent to HIV testing is covered separately, below.

shows that where young people require parental consent to get youth health services, fear of disapproval makes them avoid accessing these services. By contrast, where they can access services independently at an appropriate age, higher numbers of young people do so. Parental consent is a particular concern for young key populations. For example, young people in same-sex sexual relationships may fear disclosing their sexual behaviour or orientation to their parents. In addition, these young people may live in contexts where their sexual behaviour is criminalized, potentially driving them “underground”, making it difficult for them to obtain condoms, lubricants and counselling and creating obstacles for service-providers to provide services and commodities.

Conflicting laws also create confusion, uncertainty and stigma amongst healthcare providers and uncertainty and fear amongst young people. This may frustrate efforts to provide accessible and appropriate sexual and reproductive healthcare for young people. Laws regarding the Age of Consent to medical treatment may conflict with laws regarding the Age of Consent to sexual intercourse – for example, young people may lawfully be able to consent to sex at a younger age but be too young to consent to the necessary SRH services to protect their sexual health. They may be legally able to consent to sexual intercourse but subsequently unable to access safe abortion services or post-exposure prophylaxis resulting from unprotected sex.

Alternatively, laws regarding the Age of Consent to sexual intercourse may be too high (or may be higher or completely prohibit sex in the case of same-sex partners or sex outside of marriage), dissuading young people from accessing SRH services which they are entitled to in law and policy, for fear of sanctions. Finally, laws and policies regarding the Age of Consent to different SRH interventions may differ, creating anomalies such as allowing a person of a lowered age to consent independently to an HIV test but not to access ART or allowing a young person to access contraception, including emergency contraception to prevent pregnancy but not to access an abortion in the event of an unintended pregnancy.

Some laws provide for independent access to SRH services for young people who demonstrate a particular level of maturity, capacity and understanding alongside, or irrespective of, a particular Age of Consent. While this nuanced approach is laudable, discretionary laws and policies fail to provide legal certainty of the right to access healthcare services. In the absence of specific guidance regarding their application, they also potentially expose young people to the subjective and perhaps prejudiced attitudes of individual healthcare workers, rather than providing objective assurance of access to healthcare.

Finally, in many countries the Age of Consent to medical treatment (as well as the age at which the right to confidentiality with regard to such treatment and other health information, accrues to a person) is not clearly specified in law. In the event that it is, it is unclear whether that Age of Consent to medical treatment also applies to the Age of Consent to specific sexual and reproductive health services. In countries where there is no Age of Consent to medical treatment provided by law, the implication is that the age of majority would be the Age of Consent to medical treatment in the absence of further guidance. However, there is no certainty. This lack of clarity in law as to the Age of Consent to sexual and reproductive health services and the age at which confidentiality rights apply, can result in young people being unaware of when they can access confidential services without parental consent and in service providers being unaware of when they can provide such services.

Conflicting laws also create confusion, uncertainty and stigma amongst healthcare providers and uncertainty and fear amongst young people.
Chapter Four: Findings

4.1 Age of Consent to sexual intercourse

4.1.1 What is the ideal Age of Consent to sexual intercourse?

Though there is no clear consensus on the specific Age of Consent to sex worldwide; according to UNICEF, most countries have chosen to set the Age of Consent at 16 years.16

Under international law, countries are required to provide a specific Age of Consent to sexual activities. The CRC Committee has noted that countries who have ratified the CRC are required to ensure that specific legal provisions are provided for under domestic law that clearly set a minimum age for sexual consent. Further, the CRC Committee notes that the minimum age for sexual consent should be the same for males and females and that the minimum age should reflect the evolving capacity, age and maturity of the child.17 General Comment No 22 (2016) on the Right to Sexual and Reproductive Health18 stresses the need for non-discrimination in the context of the right to sexual and reproductive health;19 on this basis laws on Age of Consent to sex should also ensure they apply uniformly to all persons, irrespective of sexual orientation, gender identity or intersex status.

Based on the above, international guidance suggests that:

- Countries should clearly provide for the Age of Consent to sex in law
- The age of consent to sex should be appropriate, taking into account the evolving capacity, age and maturity of young people
- The Age of Consent to sex should be non-discriminatory on the basis of marital status, sex, sexual orientation, gender identity or intersex status

There is little international guidance on the age of criminal responsibility for individuals engaging in consensual sexual relations with persons under the Age of Consent. The CRC Committee has not recommended an age of criminal responsibility, but has made clear that the minimum age of criminal responsibility should be 12 years and that countries should then "continue to increase it to a higher age level".20 The CRC Committee has cautioned countries with an age of criminal responsibility higher than 12 years to not lower it. The CRC Committee has also recommended that countries clearly provide for the age of criminal responsibility. Finally, the CRC Committee recommends that countries ensure that all individuals 18 and younger when the crime was committed are "treated in accordance with the rules of juvenile justice".21

21 Id. at para 37.
4.1.2 What did the legal review find?

- The Age of Consent to sexual intercourse for most countries in the study was either 16 or 18 years of age.
- The Age of Consent to sexual intercourse ranged from 14-21 years and in the case of Aceh and Morocco, sex is only permitted within marriage regardless of the parties’ ages.
- A number of countries provided for exceptions to the Age of Consent to sex. These included being married to the underage person, if the two parties were close in age, and if the perpetrator reasonably believed the underage person was of age. For example, in South Africa children 16-17 years of age can engage in consensual sex acts with a child if the age difference between the children is two years or less.
- Very few countries in the study have differing ages of consent for men and women or boys and girls. However, a number of countries in the study did not explicitly provide an Age of Consent for men / boys. For instance, in Malawi there is no Age of Consent provided for men or boys as the criminal law only provides penalties for sex between a man and an underage girl, not between a woman and an underage boy.
- There was inconclusive information regarding the Age of Consent to same-sex sex. However, a number of countries in the study provided different ages of consent for heterosexual sex as opposed to homosexual sex. For instance, in Indonesia the Age of Consent for same-sex sex is 21 years while the Age of Consent for heterosexual sex is lower.
- A number of countries criminalised sex between men. Fewer countries explicitly criminalised sex between women though in most cases the law failed to specifically address sex between women. Thus, existing laws may be used to prosecute sex between women.
- All of the countries in the study provide criminal penalties for engaging in sex with an individual under the Age of Consent. However, in some countries criminal penalties are only provided for instances where an individual engages in sex with a woman who is under the Age of Consent. For instance, in Malawi the Penal Code criminalises anyone who “carnally knows” a girl under the age of sixteen. There is no similar penalty for engaging in sexual activities with boys who are under the Age of Consent.
- In all of the countries in this review, the Age of Consent to sex is not specifically provided for under the law. Instead, countries criminalize sex with individuals below a specific age or, in the case of Morocco, outside of marriage. Thus, the Age of Consent to sexual intercourse is inferred based on the criminal law. Having to infer the lawful Age of Consent to sexual intercourse from the criminal law, in the absence of a specific legal provision for Age of Consent to sex brings challenges. Foremost, the Age of Consent to sex is often unclear and difficult to determine as national laws may include numerous criminal provisions to address sex with persons, depending on the age of the victim and the type of sexual offence. Further, most criminal provisions do not explicitly provide that persons under a specific age are considered unable to consent. This has to be inferred from the criminal provisions often in conjunction with case law.
- The study is inconclusive on the minimum age of criminal responsibility. For example, the Age of Consent to sexual intercourse in Brazil is 14 years. Under Brazilian law, the law provides criminal penalties for anyone who has sexual intercourse or engages in lewd acts with an individual under 14 years. However, it is unclear whether if a 15 year old engages in sex with a 13 year old if he or she would be criminally prosecuted.

4.1.3 Gaps, Challenges and Inconsistencies

Major gaps and challenges identified from the findings above include the following:

- The Age of Consent to sex is generally not clearly set out in law but is inferred from criminal laws that criminalise sex with individuals below a specific age.
- Laws discriminate against same-sex sexual relationships in a number of countries, providing for higher ages of consent for same-sex sex, or prohibiting same-sex sex altogether.
- Laws in some countries discriminate between young girls and boys, potentially increasing their vulnerability - they may create lower ages of consent for girls, fail to criminalise sex with a boy below a specific age or allow for a lowered Age of Consent in the case of a young person being married.
- There are inconsistencies in the laws relating to the Age of Consent to sex and the Age of Consent to access sexual and reproductive health services, particularly contraceptives. In some countries (e.g. Brazil, India, Swaziland, Tanzania), laws and policies have lowered the Age of Consent to access to contraceptives despite a higher Age of Consent to sex, creating potential uncertainty in the healthcare sector.

4.1.4 Opportunities for further research

The initial study did not systematically research the minimum age of criminal responsibility in each country and any reporting obligations, which is relevant to understanding when and how young people may be held criminally liable for engaging in sexual activities. Additional research may also be useful to determine the legality and Age of Consent for same-sex consensual sexual activities.

4.1.5 Recommendations

This review recommends the following:

- Countries should set a clear Age of Consent to sex separate from the criminal law.
- The Age of Consent to sexual intercourse should reflect the evolving capacity, age and maturity of young people.
- Countries should ensure there is a clear Age of Consent to sexual intercourse for all persons with no distinction on the basis of sex, sexual orientation, gender identity or intersex status.
- Countries should set a clear minimum age of criminal responsibility which should be higher than 12 years of age.
- Countries should consider permitting close-in-age defences in the case of consensual sex between peers.

4.2 Age of Consent and access to HIV-related and sexual and reproductive healthcare services

4.2.1 What is the ideal Age of Consent to access sexual and reproductive healthcare services

At an international level, there is no guidance on a fixed age at which a young person should be entitled to consent independently to medical treatment in general, or to
In the case of access to abortion, however, laws in the

The Review found the following:

4.2.2 What did the legal review find?

The Review looked for the Age of Consent to specific
interventions in the national laws of 22 countries. It did
not consider the Age of Consent to specific medical
treatment in law.

The Review found the following:

General Findings:

- Most countries did not specifically provide for access
to a range of sexual and reproductive healthcare
services in law, even where those services are available
in-country. In many cases health policies, protocols and
guidelines referred to the availability of and access to
the sexual and reproductive healthcare services.

- The law on Age of Consent should consider providing
for young people below the specified Age of Consent
to provide consent, where they have sufficient capacity
to understand and appreciate the intervention.

- The Age of Consent may include consideration of the
special circumstances of the particular young person’s
need for independent access to health services.
Factors may include, for example, the young person’s
risk of HIV infection, lack of a parent, guardian or
alternative caregiver (e.g. a young person living on
the street), independence from a parent, guardian or
alternative caregiver (e.g. a “mature” or emancipated
minor who lives separately from a parent or guardian
or is married) or the young person being a parent him
or herself.

Access to Contraception:

- In a number of the countries surveyed, there is no
age restriction on access to contraception, including
emergency contraception. In over half of the countries
surveyed, young people may access barrier methods
of contraception at any age without parental consent.
However in some of these countries there is a specified
Age of Consent for access to contraception that
amounts to medical treatment, such as emergency
contraception.

Access to Antiretroviral Therapy (ART):

- Almost all countries specifically provide for access
to ART for affected populations in general, including
young people, in written documents – primarily in

27 The CRC Committee urges countries to consider allowing children (i.e. those under 18 years of age) to consent to “certain medical treatments and interventions without the permission of a parent, caregiver, or guardian, such as HIV testing and sexual and reproductive health services, including education and guidance on sexual health, contraception and safe abortion.” The Committee on Economic, Social and Cultural Rights General Comment No. 22 (2016) at para 49 provides that “states should refrain from enacting laws and policies that
create barriers in access to sexual and reproductive healthcare services, such as those that require parental consent for access to sexual and reproductive healthcare services.
28 Ibid.
30 In jurisdictions based on English common law, including England, Wales, Australia, Canada and New Zealand, young people may consent independently to medical treatment if they have “sufficient understanding and intelligence to understand fully what is proposed” as was the approach followed in Gillick v West Norfolk and Wisbech Area Health Authority [1985] 3 A; ER 402 (HL).
31 The World Health Organisation (2013) Adolescents: Guidance for HIV Testing and Counselling and Care for Adolescents Living with HIV note that “[a]uthorities should also consider especially how to facilitate access to HTC and linkage to care for orphans and vulnerable adolescents, including those living on the streets, adolescents in child-headed households, and particularly vulnerable adolescents from key populations, girls engaged in sex with older men and in multiple or concurrent sexual partnerships, and adolescent girls affected by sexual exploitation. http://apps.who.int/iris/bitstream/10665/94334/1/9789241506168_eng.pdf?ua=1 (Accessed 11 December 2016).
health policies, guidelines and protocols. In a few cases, access to ART is provided for in laws, regulations and/or decrees.

- In most cases, these documents do not specifically provide for the Age of Consent to access ART.
- In the absence of specific guidance, in most cases, the Age of Consent to ART can be said to be the same as the Age of Consent to medical treatment (ranging from 12 - 18 years, with 16 years being the most common age).
- In the absence of specific guidance regarding the Age of Consent to medical treatment in some countries, the Age of Consent to ART is assumed to be the age of majority (ranging from 16 - 21 years).
- In some countries, a healthcare provider uses his or her discretion whether or not to provide access to ART to a young person without parental consent. For example in Sweden the decision to treat a young person without parental consent is a judgement call for the attending physician. In Nigeria, there is no established Age of Consent but in practice a healthcare professional may ask to speak to the parent of a patient who has not reached adolescence.

Access to post-exposure prophylaxis (PEP):

- Almost all countries specifically provide for access to PEP for those requiring it - including young people - in written documents – primarily in health guidelines, policies and plans and in some countries in laws, regulations, ordinances and decrees.
- No countries prohibit the use of PEP. However, its use is limited in a few countries.
- In most cases, countries do not specifically provide for the Age of Consent for access to PEP in the aforementioned health guidance and law.
- In the absence of specific guidance, in most cases, the Age of Consent to PEP can be said to be the same as the Age of Consent to medical treatment (ranging from 12 to 18 years, with 16 - 18 years being the most common age).
- In the absence of specific guidance regarding the Age of Consent to medical treatment in some countries, the Age of Consent to PEP is assumed to be the age of majority (ranging from 16 to 21 years).
- In some countries, a healthcare provider may provide access to PEP to a young person without parental consent based on considerations such as the capacity of the young person or the risk to the young person’s health.

Access to pre-exposure prophylaxis (PrEP):

- Most countries do not specifically provide for nor prohibit access to PrEP. A small number of countries have registered and regulated (and in cases, limited) the use of PrEP in their regulations. But in a number of cases PrEP is not registered for use.
- Countries do not specifically provide for the Age of Consent for access to PrEP in their laws, regulations or policies.
- In the absence of specific guidance, in most cases where PrEP is available the Age of Consent to PrEP can be said to be the same as the Age of Consent to medical treatment (ranging from 12 - 18 years, with 16 - 18 years being the most common age).
- In the absence of specific guidance regarding the Age of Consent to medical treatment (e.g. in countries like Cote d’Ivoire and Malawi), the Age of Consent to PrEP is assumed to be the age of majority (ranging from 16 -21 years).
- In some countries, a healthcare provider may provide access to PrEP to a young person without parental consent based on considerations such as the capacity of the young person or the risk to the young person’s health.

Abortion:

- All countries have laws dealing with abortion.
- In a small number of countries, abortion is unlawful and is prohibited. In more than half of the countries surveyed, abortion is limited, sometimes severely limited – where it may only be performed to save the life of a woman.
- In a number of countries, young people may not consent to an abortion without parental consent until they have reached the age of majority.
- In some countries, the Age of Consent to an abortion is the same as the Age of Consent to medical treatment, ranging from around 10 to 18 years.
- There are countries (e.g. South Africa, Sweden) where there is no age restriction on a young person’s access to an abortion.

Antenatal care:

- Almost all countries specifically provide for access to antenatal care for those requiring it - including young people - in written documents – primarily in health guidelines, policies, health packages and plans. In some countries access to antenatal care is provided for in laws and regulations.
- In many of the countries surveyed, there is no age restriction on the Age of Consent to access to antenatal care.
- In the remaining countries, the Age of Consent tends to accord with the Age of Consent to medical treatment (ranging from 12 - 18 years) and/or the age of majority (ranging from 16 - 21 years).
- Some countries indicated that, despite provisions (or a lack of provision) in law or policy, in practice healthcare workers provide access to antenatal care at their discretion and without parental consent.

HPV Vaccine and Cervical Cancer Screening:

- Most countries provide for HPV vaccines to be available to girls from ages ranging from 9 - 26 years. Only one region in Canada appears to provide an HPV vaccine to boys.
- HPV vaccines are generally provided for in terms of policies, guidelines, plans and/or programmes and not in law. One country provided for it in regulations.
- There was inconclusive information in the study on whether countries provided for cervical cancer screenings as a number of countries failed to address the issue. Though from those who did specifically address the issue, most countries provided cervical cancer screenings for women at ages ranging from 18 - 64 years.
- In most countries, the Age of Consent to accessing cervical cancer services or the HPV vaccines was set at the general Age of Consent to medical treatment or the age of majority. In a few cases girls of any age can consent but in most cases it would seem that the Age of Consent accords with that of the Age of Consent to medical treatment - below that age, children require parental consent to access HPV vaccines.
- A number of countries offer the HPV vaccine in schools. In such instances, generally parental consent is required.
HIV testing:
- In countries where a specific Age of Consent is provided for HIV testing it is generally provided for in policy or regulations. For instance, in Indonesia the Age of Consent to HIV testing is provided for in the Health Ministerial Regulation (74/2014) on the guidelines for examinations, counselling and HIV testing.
- The Age of Consent to HIV testing varies among the countries covered in the study but most countries set the age at between 16 and 18 years. The study found that Age of Consent to HIV testing ranged from 12 -18 years. In Thailand, the study found an individual of any age could consent to an HIV test.
- A few countries provide for specific exceptions to the general Age of Consent to HIV testing. For example, in Kenya the Age of Consent to HIV testing is 18 years but exceptions are made where a child is pregnant, married, a parent or is engaged in behaviour which puts him or her at risk of contracting HIV. In such cases an individual under 18 years could independently consent to an HIV test.
- Some countries provided specifically for an Age of Consent to HIV testing while for other countries the Age of Consent was the Age of Consent to medical treatment. For the former countries, the Age of Consent to HIV testing was the same or lower than the Age of Consent to other medical treatment more generally.
- In most countries, the person consenting to the HIV test receives the test results. Thus, if a child can independently consent to an HIV test, then he or she receives the HIV test results; where a parent or guardian consents on behalf of the child, the parent receives the HIV test results.

4.2.3 Gaps, Challenges and Inconsistencies
- Most countries did not specifically provide for access to a range of sexual and reproductive healthcare services in law, even where those services are available in-country. In many cases health policies, protocols and guidelines referred to the availability of and access to the sexual and reproductive healthcare services.
- Access to some sexual and reproductive healthcare services, such as abortion, PEP and PrEP, is prohibited, limited or not yet regulated in some countries.
- Many countries also fail to specifically provide for the Age of Consent to medical treatment in general or for consent to specific sexual and reproductive healthcare services in law or policy.
- Some countries provided in law / policy for a lowered Age of Consent to access certain services, such as contraceptives and HIV testing. This lowered Age of Consent was at times inconsistent with the Age of Consent to sex, creating potential uncertainty amongst both young people and healthcare providers regarding the lawfulness of access to services. In other countries, a lowered Age of Consent to HIV testing was inconsistent with the Age of Consent to HIV-related healthcare services (e.g. ART, PEP and PrEP), placing young people in a position where they are, for example, unable to be linked with independent access to a continuum of care following an HIV diagnosis.

4.2.4 Opportunities for further research
This review identified a number of areas of additional research. These are as follows:
- There was little information from the study regarding at what age there is an obligation to disclose a minor’s HIV test results to the minor. The research focused instead on when the HIV test results were disclosed to the patient and when they were to be disclosed to the parent or guardian. Thus, additional research into whether countries have laws or policies outlining when a parent or guardian must disclose a minor’s HIV test results to the minor would be useful.
- Additional research into at what age cervical cancer services are available for girls and women is needed.

4.2.5 Recommendations
General recommendations
- Countries should stipulate a legal Age of Consent to medical treatment in law.
- The Age of Consent to medical treatment should reflect the evolving age, capacity and maturity of a young person.
- Countries should ensure that the legal Age of Consent to sexual and reproductive healthcare services is set below 18 years of age and should be the same as or lower than the Age of Consent to sexual intercourse. The law should clearly stipulate that access to SRH services is lawful, irrespective of the Age of Consent to sex.
- Where a lowered Age of Consent is provided for access to specific sexual and reproductive healthcare services (e.g. barrier methods of contraception) this should be set out clearly in law rather than in policy.
- The law should clearly provide that the legal Age of Consent to medical treatment applies equally to prevention technologies and services, unless otherwise specified.

Specific recommendations
- Countries should clearly provide in law or policy for any Age of Consent to contraception, (including emergency contraception), ART, PEP, abortion, ANC, HPV vaccines, cervical cancer screening and treatment and HIV testing. Policy on these issues should be either as part of the general Age of Consent to medical treatment or, where a lowered age is considered appropriate, as a specific provision, to ensure legal clarity and certainty.
- Countries should remove legal limits to access to PEP and PrEP.
- Countries should take steps to register ART for use as pre-exposure prophylaxis, in terms of their national drug regulatory systems.
- Countries should consider making HPV vaccines available to boys at the same ages as they are available to girls.
Restrictions on agency and autonomy have no place in a democratic, sustainable development world in the 21st century...
REFERENCES AND RESOURCES


### ANNEX

<table>
<thead>
<tr>
<th>Countries/Jurisdictions</th>
<th>Selection criteria</th>
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<tr>
<td>Eastern and southern African countries</td>
<td>These countries endure the worst of the global epidemic and have populations up to and above 50% young people. Every country has to find better ways to end HIV epidemic, prevent young people in particular from contracting HIV and facilitate access to testing, treatment and care. Cultural and traditional inheritances are often at variances with good public health and the barriers for adolescents accessing sexual and reproductive health and rights are significant. LGBTI people are criminalized in all but one country (South Africa), and sex workers in all countries. If ‘game changers’ are not put in place, the toll on health, health systems and on adolescents in particular will be enormous. At the collective level, research from these countries will allow SADC, the regional economic community agency, to work towards common guidelines for the region that will then influence individual countries.</td>
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<tr>
<td>Botswana, South Africa, Swaziland, Kenya, Zambia, Zimbabwe, Malawi, Tanzania, Mozambique, Uganda</td>
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<td>West African countries</td>
<td>As the most populous country in Africa, the leading economy and a de facto leader in influencing many issues in west Africa the Nigerian response and in particular, its response to young people has a large impact.</td>
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<tr>
<td>Nigeria</td>
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<tr>
<td>North African / Francophone countries</td>
<td>While the epidemics in Francophone west Africa and the MENA region are far smaller than on the rest of the continent, there remain significant SRHR issues for adolescents. Sex outside of wedlock is prohibited and sex, sexuality and SRHR are most frequently taboos with resultant barriers to access to health services and information. LGBTI illegality in the MENA region also prevents these citizens from accessing any SRHR services and lack of good data does not allow us to know the harmful impacts of HIV prevalence. Morocco has incidences of sex trade and homosexuality is illegal.</td>
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<td>Morocco</td>
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<td>Cote d’ivoire</td>
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<tr>
<td>OECD countries</td>
<td>Generally showcasing jurisdictions in which legal reform or ‘liberal’ legal systems with regard to adolescent access to sexual and reproductive health and rights.</td>
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<tr>
<td>United Kingdom</td>
<td>Currently towards the end of a process of consideration of law reform to allow PrEP. Significant advocacy by LGBTI groups and some controversy has made for a useful case study.</td>
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<tr>
<td>Sweden</td>
<td>Has significantly high indicators for adolescent health and an ethical, social context which might be classified as very liberal with regard to sexuality and sex.</td>
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<tr>
<td>France</td>
<td>Although France has not yet made final decisions as to the regulatory framework for PrEP, a large and impactful French PrEP study - ANRS Ipergay – has made significant positive findings that are likely to influence regulatory thinking. In addition, French scientific findings are likely to resonate in Francophone Africa, and a French law firm will provide a triangulation to two proposed Francophone legal reviews.</td>
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<td>Canada, British Columbia</td>
<td>In sharp contrast to Federal direction in Canada, BC has taken on PrEP as part of a package that is credited with an over 80% drop in the epidemic in the province. The changes that have occurred and the coalitions brought together to do this are worth examining.</td>
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<td>Continental exemplars</td>
<td>Selected to stimulate review and reflection wider than the chosen country about and from the selected continent. Intended that civil society, UN agencies and other bodies who operate at a continental level will use the case studies to stimulate advocacy and policy reform in a larger number of countries</td>
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<tr>
<td>Europe</td>
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<td>Ukraine</td>
<td>Overwhelming drug use driven concentrated HIV epidemic. Eastern Europe generally legislation is punitive rather than supportive. Evidence based harm reduction practices and legislation are not in place and are seen as somehow threatening to culture. For instance, Age of Consent for males is 18 years while that of girls is 17 years. And according to the Criminal Law of Ukraine, victims of sexual offences can only be female meaning men and transgender are left out.</td>
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<td>Latin America and Caribbean</td>
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<td><strong>Brazil</strong></td>
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<td>Is globally recognised as having taken early and strong measures in responding to HIV combined with poverty reduction and gender affirmative policies. This combination makes it a recognised leader in Latin America. Its population size as well makes is a significant player in the HIV response</td>
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<td><strong>Jamaica</strong></td>
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<td>The Caribbean in general is characterised by societies, cultures and legal systems that discriminate against and criminalise LGBTI people. Hate speech and hate crimes are common and so it is a climate in which LGBTI people face significant barriers to all health but in particular to sexual health and rights. More so, Age of Consent for sexual activities is 16 years and that of marriage is 18 years. Analysing how legal systems might still give better access to LGBTI adolescents by removing more general barriers to adolescent access to could be a significant human rights advocacy issue built on top of a country legal review</td>
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<th>Asia</th>
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<td><strong>India</strong></td>
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<td>India has significant key population concentrated epidemics of HIV. In particular, HIV is significantly high amongst sex workers. India also straddles being both a modern democracy as well as enormously traditionally and culturally bound. As a democracy with well-respected legal system and use of courts, it makes a valuable case study at a time when a socially conservative Government is leading the HIV response. Key populations and even the issue of women’s equality are in contest, all with implications for young girls’ and key populations’ health.</td>
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<td><strong>Thailand</strong></td>
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<td>Thailand has proven to have an intensely practical response to a concentrated epidemic. While many activities related to sex workers, LGBTI sex and sexuality and drug use are illegal, the response has found ways supported by Government of allowing public health to supersede legislation. The combination of policy without legislation is an important one for conservative countries elsewhere. Thailand is also on track to achieve SDGs related to HIV which makes it an important showcase for success</td>
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<td><strong>Indonesia</strong></td>
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<td>The largest Muslim country in the world presents an intersection of religion, culture, democracy and legislation. The legal review and a follow on meta-analysis will highlight issues of working with these intersections more broadly than the country.</td>
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<td><strong>Vietnam</strong></td>
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<td>As a small country emerging from decades of tightly controlled Communist rule and entering an era of far more openness including geographical travel internally and in the region, the epidemic has the potential to increase rapidly.</td>
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<td><strong>Philippines</strong></td>
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<td>While the prevalence of HIV and AIDS in the Philippines is still low, the country is one of only seven countries globally where the number of new HIV cases has increased by over 25 per cent from 2001 to 2009. New infections are largely concentrated among key populations with specific risk behaviours, such as unprotected male-to-male sex, transactional sex and intravenous drug use. Primary prevention of HIV infection for key populations has to start in adolescence mainly because infections now occur at a younger age: 20–29 years. On average, the initiation to sex and drug use is between 14 and 19 years old. Very few of those at-risk have taken an HIV test, with the number at zero for those under 18 years.</td>
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