AGE OF CONSENT: LEGAL REVIEW
CANADA COUNTRY REPORT
FOREWORD

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
ACKNOWLEDGEMENT

The SRHR Africa Trust (SAT) wishes to acknowledge, individuals, organisations, and law firms that contributed to this report through their expertise, co-operation, and hard work.

Special thanks go to Blake, Cassels and Graydon Law Firm in Canada that provided pro bono legal services to assist SAT with the underlying research for the review on the Age of Consent Legal Review in Canada, working with Arnold & Porter Kaye Scholer LLP, and in particular to Catherine Young for coordinating the legal review in all the participating countries.

SAT also wishes to thank civil society organisations and partners who attended the Age of Consent Validation Meeting that met to discuss and validate the draft Advocacy Toolkit. The meeting critically reviewed the draft reports, analysing the data collected for its accuracy and merits.

SAT is grateful to UNICEF for co-funding the review of the Age of Consent laws, policy frameworks, Ethical, Social, and Cultural (ESC) impacts on sexual reproductive health and rights (SRHR) and HIV.

Last but not least, SAT thanks TrustLaw at the Thomson Reuters Foundation for their continued collaboration with SAT on health and rights and for brokering the partnerships between SAT and the law firms. TrustLaw is the Thomson Reuters Foundation’s global pro bono legal programme, connecting law firms and corporate legal teams around the world with high impact NGOs and social enterprises working to create social and environmental change.
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AGE OF CONSENT
LEGAL REVIEW
ACRONYMS

AIDS    Acquired Immune Deficiency Syndrome
ANC    Antenatal Care
ART    Antiretroviral Therapy
EHP    Essential Health Package
GDP    Gross Domestic Product
HCT    HIV Counselling and Testing
HIV    Human Immunodeficiency Virus
HPV    Human Papillomavirus
MMC    Medical Male Circumcision
MPR    Multiple-perpetrator Rape
MSP    Multiple Sexual Partners
PLWHA  People Living with HIV/AIDS
PLWHIV People Living with HIV
PEP    Post-exposure Prophylaxis
PrEP    Pre-exposure Prophylaxis
SRHS   Sexual and Reproductive Health Services
UNAIDS Joint United Nations Programme on HIV/AIDS
UNICEF United Nations International Children’s Fund
UNFPA United Nations Population Fund
WHO    World Health Organization
YFS    Youth-friendly Services
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EXECUTIVE SUMMARY

Sexual intercourse with persons under the age of 16 years is illegal. Mistake of age is not a defence unless the accused took all reasonable steps to ascertain the age of the complainant.

The Age of Consent to access contraceptives varies from province to province. In most provinces in Canada (except in Quebec), the emergency contraceptive pill (ECP/ Plan B/ Morning-after pill) is available without age restrictions.

The Age of Consent to access HIV testing varies from province to province. If a young person can consent to medical decisions, he or she will be able to obtain the test results without the parents being made aware of the results.

The policy framework and legislation enabling or disenabling access to Antiretroviral Therapy (ART) varies from province to province. There is no legal prohibition on Pre-exposure Prophylaxis (PrEP) and Post-exposure Prophylaxis (PEP). Young people can legally access PrEP and PEP but the position concerning access and parental consent varies from province to province.

The ingredients used to make truvada are on the federal Prescription Drug List, which means this form of PrEP can be legally prescribed. The drugs underlying PEP are on the federal Prescription Drug List which means that PEP can be legally prescribed.

Abortion in Canada is legal. The rules on access to abortions with or without parental consent vary from province to province.

Healthcare is generally free in Canada, which enables access to Antenatal Care (ANC).

Federal funding was provided to provinces and territories in 2007 to support an HPV vaccination programme. The rules on access and parental consent are determined by each province.
Chapter One: Introduction

The world’s attention has moved beyond HIV and AIDS, yet it remains the leading killer of adolescents in Southern Africa, presenting a major impediment to healthy communities and a significant factor in the health and status of women and girls in the region.

According to a report by the Joint United Nations Programme on HIV/AIDS (UNAIDS) on prevention of HIV (2013), Eastern and Southern Africa is home to half the world’s population living with HIV, even if the region is only 5% of the world’s population. Today the region continues to be the most infected and affected by the HIV/AIDS epidemic, with 48% of the world’s new HIV infections among adults, 55% among children, and 48% of AIDS-related deaths.

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. 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 Counselling and Testing (HCT) and to linkages to prevention, treatment and care.

HIV is the most severe in the Southern Africa sub-region which includes Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe, with each having an adult HIV prevalence of over 10%. UNAIDS reports that Swaziland have the highest HIV prevalence in the world (26.0%), followed by Botswana (23.4%).

In 2011, there was an estimated 1.2 million adolescents aged 10-19 years old living with HIV, more than half of all HIV positive adolescents globally. Eastern and Southern Africa now have 10.5 million children who have lost one or both parents to AIDS.

The risk of becoming infected with HIV is higher for girls and young women and currently, HIV prevalence among young women aged 15-24 years stands at 4.8%, which is two and a half times higher than among men of the same age. In Swaziland, 15.6% of young women are HIV positive, compared to 6.5% of young men.

The advocacy campaign ‘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 opportunities for ensuring that existing and new strategies and programmes on HIV prevention, treatment and care are effectively implemented to benefit young people. These include the 2012 guidance on Pre-exposure Oral Prophylaxis (PrEP) for serodiscordant couples, men, and transgender women who have sex with men at high risk of HIV transmission, as well as the 2013 guidance for HCT and care for adolescents living with HIV and young key population policy briefs.

All In To #EndAdolescentAIDS works through four workstreams. As part of workstream 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 prevention 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 To #EndAdolescentAIDS, many agencies, and global partners including the United Nations Development Programmes (UNDP), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the PACT and AIDS Alliance have already initiated actions on data collection to inform their policy advocacy efforts globally and specifically within the 25 focus countries. This review will inform the development of a source or toolkit for learning on this theme and capacity building of experts and policymakers worldwide.

Why Age of Consent review?

Several global bodies, including UNICEF and WHO, are currently undertaking a number of initiatives to change the global guidelines with regard to adolescent access to a range of HIV prevention services, including Age of Consent and informed consent, confidentiality, availability, accessibility, and acceptability. Adherence and quality must inform these services.
The SRHR Africa Trust (SAT) in collaboration with UNICEF worked with participating local law firms, and a consultant to conduct the Age of Consent research. The three areas of the research included the following:

1. Age of Consent legal review
2. Ethical, Social, Cultural (ESC) desktop review
3. Youth attitudes survey

Therefore, the main goal of the project was to conduct research on “Age of Consent” laws, regulations, and policies, as well as ESC factors, in relation to adolescents. This entailed collecting country experiences to address Age of Consent laws / policies and ESC factors that serve as potential barriers to adolescents accessing SRH services, including HIV prevention, care and treatment. The research explored implications for expanding SRHR services and HTC in adolescents aged 10–19 years.

**Methodology**

The Canada legal review was prepared by SAT and is based on research conducted by the Blake, Cassels and Graydon Law Firm in Canada. The legal review focuses on the laws and policy support around the Age of Consent in relation to the various aspects relating to SRHR. The review looks at all the relevant national laws (including nationally recognised customary or religious laws), regulations, and policies exploring the ages for girls and boys separately, where relevant, including where contradictions in laws, policies, and regulations on these issues exist.

The review specifically looked at the following:

1. Age of Consent to sexual intercourse including the age for statutory rape
2. Age of Consent to access modern contraceptives, with and without parental consent
3. Age of access to emergency contraceptives, 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 postabortion care including Age of Consent, with and without parental consent
7. Policy framework and legislation enabling or disenabling access to Antenatal Care (ANC) including Age of Consent, with and without parental consent
8. Policy framework and legislation enabling or disenabling access to HPV vaccines 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.
Chapter Two: Age of Consent to sexual intercourse

The Age of Consent to sexual intercourse in Canada is 16 years even though there are a number of exceptions. Notably, mistake of age is not a defence to sexual assault, unless the accused took all reasonable steps to ascertain the age of the complainant.

Legislation and policy framework


Consent no defence

150.1 (1) Subject to Subsections (2) to (2.2), when an accused is charged with an offence under Section 151 or 152 or Subsection 153(1), 160(3) or 173(2) or is charged with an offence under Section 271, 272 or 273 in respect of a complainant under the age of 16 years, it is not a defence that the complainant consented to the activity that forms the subject-matter of the charge.

Mistake of age

(4) It is not a defence to a charge under Section 151 or 152, Subsection 160(3) or 173(2), or Section 271, 272 or 273 that the accused believed that the complainant was 16 years of age or more at the time the offence is alleged to have been committed unless the accused took all reasonable steps to ascertain the age of the complainant.

(5) It is not a defence to a charge under Section 153, 159, 170, 171 or 172 or Subsection 286.1(2), 286.2(2) or 286.3(2) that the accused believed that the complainant was eighteen years of age or more at the time the offence is alleged to have been committed unless the accused took all reasonable steps to ascertain the age of the complainant.

(6) An accused cannot raise a mistaken belief in the age of the complainant in order to invoke a defence under subsection (2) or (2.1) unless the accused took all reasonable steps to ascertain the age of the complainant.

Definition of statutory rape

There is no definition of statutory rape in the Criminal Code.

The Criminal Code defines assault and makes clear that the assault provision applies to sexual assault. It also contains provisions for ‘sexual interference’, ‘invitation to sexual touching’, and ‘sexual exploitation’ which specifically relate to sexual assault of someone under the Age of Consent.

Legislation and policy framework

See Subsection 151-153 & 265 of the Criminal Code:

Sexual interference

151 Every person who, for a sexual purpose, touches, directly or indirectly, with a part of the body or with an object, any part of the body of a person under the age of 16 years

a. is guilty of an indictable offence and is liable to imprisonment for a term of not more than 14 years and to a minimum punishment of imprisonment for a term of one year; or

b. is guilty of an offence punishable on summary conviction and is liable to imprisonment for a term of not more than two years less a day and to a minimum punishment of imprisonment for a term of 90 days.
Invitation to sexual touching

152 Every person who, for a sexual purpose, invites, counsels or incites a person under the age of 16 years to touch, directly or indirectly, with a part of the body or with an object, the body of any person, including the body of the person who so invites, counsels or incites and the body of the person under the age of 16 years,

a. is guilty of an indictable offence and is liable to imprisonment for a term of not more than 14 years and to a minimum punishment of imprisonment for a term of one year; or
b. is guilty of an offence punishable on summary conviction and is liable to imprisonment for a term of not more than two years less a day and to a minimum punishment of imprisonment for a term of 90 days.

Sexual exploitation

153 (1) Every person commits an offence who is in a position of trust or authority towards a young person, who is a person with whom the young person is in a relationship of dependency or who is in a relationship with a young person that is exploitative of the young person, and who (a) for a sexual purpose, touches, directly or indirectly, with a part of the body or with an object, any part of the body of the young person; or (b) for a sexual purpose, invites, counsels or incites a young person to touch, directly or indirectly, with a part of the body or with an object, the body of any person, including the body of the person who so invites, counsels or incites and the body of the young person.

Exceptions on Age of Consent - For example ‘gay sex’

While there is an exception for anal intercourse in the Criminal Code (which states that the age for anal intercourse is 18), this provision has been found to be unconstitutional and, therefore, of no force and effect by many appellate courts.

Legislation and policy framework

Peer Group Exceptions

See s. 150.1 of the Criminal Code:

Consent no defence

150.1 (1) Subject to subsections (2) to (2.2), when an accused is charged with an offence under section 151 or 152 or subsection 153(1), 160(3) or 173(2) or is charged with an offence under section 271, 272 or 273 in respect of a complainant under the age of 16 years, it is not a defence that the complainant consented to the activity that forms the subject-matter of the charge.

Exception - Complainant aged 12 or 13 years

2. When an accused is charged with an offence under section 151 or 152, subsection 173(2) or section 271 in respect of a complainant who is 12 years of age or more but under the age of 14 years, it is a defence that the complainant consented to the activity that forms the subject-matter of the charge if the accused

a. is less than two years older than the complainant; and
b. is not in a position of trust or authority towards the complainant, is not a person with whom the complainant is in a relationship of dependency and is not in a relationship with the complainant that is exploitative of the complainant.
Exception - Complainant aged 14 or 15 years

2.1. If an accused is charged with an offence under Section 151 or 152, Subsection 173(2) or Section 271 in respect of a complainant who is 14 years of age or more but under the age of 16 years, it is a defence that the complainant consented to the activity that forms the subject-matter of the charge if the accused
   a. is less than five years older than the complainant; and
   b. is not in a position of trust or authority towards the complainant, is not a person with whom the complainant is in a relationship of dependency and is not in a relationship with the complainant that is exploitative of the complainant.

Anal intercourse

See Section 159 of the Criminal Code:

159 (1) Every person who engages in an act of anal intercourse is guilty of an indictable offence and liable to imprisonment for a term not exceeding ten years or is guilty of an offence punishable on summary conviction.

Exception

2. Subsection (1) does not apply to any act engaged in, in private, between
   a. husband and wife, or
   b. any two persons, each of whom is eighteen years of age or more, both of whom consent to the act.

But see, for example, R v M.(C.) (1995), 98 CCC (3d) 481 (Ontario Court of Appeal) (http://canlii.ca/t/231v2) which holds that the section discriminates on the basis of age and, therefore, is of no force and effect.
Chapter Three: Access to contraception services and commodities

A young person’s ability to consent to healthcare varies by province/territory. In British Columbia, for example, a young person can consent to healthcare (including accessing contraceptives) where the healthcare provider is satisfied that the person understands the nature and consequences and the reasonably foreseeable benefits and risks of the healthcare and has made reasonable efforts to determine and has concluded that the healthcare is in the person’s best interests. (See Annex 2 ‘Schedule A’ ) for the relevant consent legislation in British Columbia, Ontario, and Quebec.

Legislation and policy framework

The Infants Act, RSBC 1996, c 223, s. 17 (‘infant’ includes those under the age of 19) which is applicable in the province of British Columbia only:

Consent of infant to medical treatment

Section 17 (1) states that:

Healthcare means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health related purpose, and includes a course of healthcare;

‘healthcare provider’ includes a person licensed, certified or registered in British Columbia to provide healthcare.

2. Subject to subsection (3), an infant may consent to healthcare whether or not that healthcare would, in the absence of consent, constitute a trespass to the infant's person, and if an infant provides that consent, the consent is effective and it is not necessary to obtain a consent to the healthcare from the infant's parent or guardian.

3. A request for or consent, agreement or acquiescence to healthcare by an infant does not constitute consent to the healthcare for the purposes of subsection (2) unless the healthcare provider providing the healthcare
   a. has explained to the infant and has been satisfied that the infant understands the nature and consequences and the reasonably foreseeable benefits and risks of the healthcare, and
   b. has made reasonable efforts to determine and has concluded that the healthcare is in the infant’s best interests.

Access to emergency contraceptives

In most provinces in Canada (except in Quebec), the emergency contraceptive pill (ECP/ Plan B/ Morning-after pill) is available in pharmacies without a prescription. There is no age restriction for an individual seeking emergency contraceptive. In all provinces, except for Saskatchewan and Quebec, the Plan B contraceptive is available on the shelf and without requiring a prescription. In Saskatchewan, the drug is kept behind the counter, meaning a pharmacist can ask screening questions. In Quebec, a prescription is required to acquire the Plan B drug.

Legislation and policy framework

See, for example, the Drug Schedules Regulation, BC Reg 9/98, ss. 1-2 & schedule III, which is applicable in British Columbia.


Also see: Website for the “Plan B” emergency contraceptive: http://www.planb.ca/where-to-get-it.html
Chapter Four: Age of Consent and HIV testing

In Canada, a young person’s ability to consent to healthcare varies by province/territory. In British Columbia, for example, a young person can consent to healthcare (including accessing contraceptive), where the healthcare provider is satisfied that the person understands the nature and consequences and the reasonably foreseeable benefits and risks of the healthcare and has made reasonable efforts to determine and has concluded that the healthcare is in the person’s best interests. Access may also be granted through a sexual health clinic. (See Annex 2 - Schedule A)

Age of Consent to report HIV status directly to adolescents

A young person in Canada may consent to make medical decisions and he or she will be able to obtain their test results without their parents being made aware of the results. Healthcare information is also protected by privacy legislation.

Legislation and policy framework on HIV testing

As a note, anonymous HIV testing is provided in Ontario (see: http://hasslefreeclinic.org/home/about-hfc/clinic-history-philosophy), and as a pilot project in British Columbia (see: http://www.bccdc.ca/our-services/programs/anonymous-hiv-testing)

Also see: Personal Health Information Protection Act, 2004, S.O. 2004, s. 29

Requirement for consent

29. A health information custodian shall not collect, use or disclose personal health information about an individual unless,

a. it has the individual’s consent under this Act and the collection, use or disclosure, as the case may be, to the best of the custodian’s knowledge, is necessary for a lawful purpose; or
b. the collection, use or disclosure, as the case may be, is permitted or required by this Act.

In British Columbia, several statutes apply to the disclosure of health information (see: http://www.healthinfoprivacybc.ca/the-laws/overview). The Personal Information Protection Act, SBC 2003, c 63 applies to healthcare providers in private practice. See section 6:

6. (1) An organisation must not
   a. collect personal information about an individual,
   b. use personal information about an individual, or
   c. disclose personal information about an individual.

2. Subsection (1) does not apply if
   a. the individual gives consent to the collection, use or disclosure,
   b. this Act authorizes the collection, use or disclosure without the consent of the individual, or
   c. this Act deems the collection, use or disclosure to be consented to by the individual.
Chapter Five: Age of Consent and access to Antiretroviral Therapy (ART)

Young people can access Antiretroviral Therapy in Canada following the stated regulations that the young person’s ability to consent to healthcare varies by province/territory. In British Columbia, for example, a young person can consent to healthcare where the healthcare provider is satisfied that the person understands the nature and consequences and the reasonably foreseeable benefits and risks of the healthcare and has made reasonable efforts to determine and has concluded that the healthcare is in the person’s best interests. ART (i.e. tenofovir, lamivudine, and emtricitabine) requires a prescription in Canada.

Legislation and policy framework

Chapter Six: Age of Consent and access to Pre-exposure Prophylaxis (PrEP) and Post-exposure Prophylaxis (PEP)

There is no legal prohibition on Pre-exposure Prophylaxis and Post-exposure Prophylaxis in Canada, although there may be practical difficulties accessing it in cases involving non-occupational exposures (see the following article for a discussion of practical issues: http://www.catie.ca/fact-sheets/prevention/post-exposure-prophylaxis-pep Young people can legally access PEP and there is no legislation that prohibits the use of PEP.

Legislation and policy framework

The drugs underlying PEP are on the federal Prescription Drug List, which means PEP can be legally prescribed.

The Food and Drugs Act, R.S.C., 1985, c. F-27, s. 29.1 (http://laws-lois.justice.gc.ca/eng/acts/F-27/page-4.html);

Chapter Seven: Age of Consent and access to safe abortions and/or postabortion care

Abortion is legal in Canada and access to safe abortion and postabortion care, given that any young person has an ability to consent to healthcare varies by province/territory. In British Columbia, for example, a young person can consent to healthcare (including accessing contraceptives where the healthcare provider is satisfied that the person understands the nature and consequences and the reasonably foreseeable benefits and risks of the healthcare and has made reasonable efforts to determine and has concluded that the healthcare is in the person’s best interests.

Legislation and policy framework

Chapter Eight: Age of Consent on access to Antenatal Care (ANC)

There is no specific policy/legislation enabling access to Antenatal Care (although healthcare is generally free in Canada, which naturally enables access to ANC). Access and consent to Antenatal Care for young people varies by province/territory. As an example in British Columbia, a young person can consent to healthcare where the healthcare provider is satisfied that the person understands the nature and consequences and the reasonably foreseeable benefits and risks of the healthcare and has made reasonable efforts to determine and has concluded that the healthcare is in the person’s best interests.
Chapter Nine: Access to HPV vaccines and cervical cancer screening and treatment

Access and consent to Human Papillomavirus (HPV) and cervical cancer screening varies by province/territory. Specific details are defined in the Annex 2 ‘Schedule A’ legislation for the relevant consent legislation in British Columbia, Ontario, and Quebec.

The 2007 Federal Government budget provided $300 million for HPV vaccines. The Budget Plan 2007 states: “The Government will provide funding to the provinces and territories to support the launch of a national programme “for the HPV vaccines that will focus on protecting women and girls from cancer of the cervix.”

Ontario has expanded its publicly funded immunisation programme to help protect youth from HPV infection and related cancers. Beginning in the 2016-2017 school year, Ontario will offer the cancer-fighting HPV vaccines to all boys and girls in Grade 7 as part of its routine school-based HPV immunisation programme.

In British Columbia, girls in Grade 6 and boys/men aged 9-26 who are “high risk” are able to get the vaccines for free.

Legislation and policy framework


## Chapter Ten: Recommended intervention on legal and policy framework

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<td>Young people’s access to emergency contraceptives</td>
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<td>GR  LR</td>
</tr>
<tr>
<td>Policy framework and legislation on access to Antiretroviral Therapy (ART)</td>
<td>L  GR</td>
<td>GR  LR</td>
</tr>
<tr>
<td>Policy and legislation on young people’s access to PEP</td>
<td>L  GR</td>
<td>GR  LR</td>
</tr>
<tr>
<td>Policy and legislation on young people’s access to PrEP</td>
<td>L  GR</td>
<td>GR  LR</td>
</tr>
<tr>
<td>Policy framework and access to Antenatal Care (ANC)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Policy framework and legislation on access to HPV vaccines and cervical cancer screening and treatment</td>
<td>P</td>
<td>P</td>
</tr>
<tr>
<td>Policy framework and/or legislation on access to safe abortions and/or postabortion care</td>
<td>L</td>
<td>LR</td>
</tr>
<tr>
<td>Age of Consent to access HIV testing without parental consent</td>
<td>L</td>
<td>LR</td>
</tr>
<tr>
<td>Legal and policy framework on the Age of Consent where HIV status will be reported directly to an adolescent</td>
<td>L</td>
<td>LR</td>
</tr>
<tr>
<td>Addressing various policy and legislation inconsistencies</td>
<td>N/A</td>
<td>N/A</td>
</tr>
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KEY QUESTIONS FOR THE LEGAL REVIEW

1. At what age may sex between consenting individuals legally take place? (Age of Consent to sexual intercourse) Indicate if there are different ages for males and females?

2. Is there a definition of statutory rape? Please define.

3. Are there exceptions to question (1)? For example gay sex?

4. At what age may a young person access contraceptive services including contraceptive commodities? Please specify with and without parental consent if the answers are different.

5. May a young person access emergency contraceptives (e.g. the ‘Morning-after pill’) At what age? Please specify if there are different ages with and without parental consent.

6. Policy framework and legislation enabling or disenabling access to Antiretroviral Therapy (ART), including Age of Consent, with and without parental consent.

7. Specify whether there is any prohibition on HIV Post-exposure Prophylaxis (PEP), including Age of Consent, with and without parental consent.

8. If there is no prohibition in question 7, would young people be legally able to access PEP if it was offered? At what ages? Please specify if there are different ages with and without parental consent.

9. Is there any legislation or policy specifically enabling PEP use in country? Please specify if it deals with Ages of Consent and give details.

10. Specify whether there is any prohibition on HIV Pre-exposure Prophylaxis (PrEP), including Age of Consent, with and without parental consent.

11. If there is no prohibition in question 10, would young people be legally able to access PrEP if it was offered? At what ages? Please specify if there are different ages with and without parental consent.

12. Is there any legislation or policy specifically enabling PrEP use in the country? Please specify if it deals with Ages of Consent and give details.

13. Please state whether there is policy framework and/or legislation enabling or disenabling access to safe abortions and/or postabortion care, including Age of Consent, with and without parental consent.

14. Policy framework and legislation enabling or disenabling access to Antenatal Care (ANC), including Age of Consent, with and without parental consent.

15. Policy framework and legislation enabling or disenabling access to HPV vaccines and cervical cancer screening and treatment, including Age of Consent, with and without parental consent.

16. What is the Age of Consent to access HIV testing without parental consent?

17. What is the Age of Consent at which the HIV status will be reported directly to an adolescent and legal/ policy requirements to report the status to her/his parents?

18. Please explain any inconsistencies between the answers above.