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

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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 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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It has been prepared as a work of comparative legal review only and does not represent legal advice in respect of the laws of Kenya. 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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KENYA

AGE OF CONSENT
LEGAL REVIEW
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EXECUTIVE SUMMARY

The Age of Consent for sexual intercourse in Kenya is 18 years, therefore, sexual intercourse with a person under the age of 18 years is illegal. A defence is available if the minor deceived the accused as to his/her age and the accused reasonably believed he/she was of age. Gay sex is prohibited and criminalised.

In the absence of any age restrictions young persons of any age may access contraceptives without parental consent. There is no age restriction on access to emergency contraceptives.

The Age of Consent for HIV testing is 18 years, while certain exceptions apply in which case the patient can consent him/herself. Test results for a person under 18 years are released to the parents unless the child directly consented to the testing.

There is no statutory age limit and the law in Kenya is silent on whether consent by a parent is required for access to Anti – Retroviral therapy to a child however the law of Kenya states it is the responsibility of a parent of the child and Government to ensure provision of access to medical care(including ART).

There is no statutory age limit on access to Post-exposure Prophylaxis (PEP). The general policy of requiring parental consent for medical treatment of persons under 18 years may be applied. In Kenya the law requires the Ministry of Health to issue guidelines on PEP, however the law does not deal with Age of Consent.

Access to Pre-exposure Prophylaxis (PrEP) is determined by the general policy that parental consent is required for patients under 18 years of age. The country does not have legislation or policy specifically to enable PrEP use.

Abortion is illegal in Kenya and only permitted in limited circumstances, such situations where the life of the mother is at risk.

Kenya does not have a policy framework or legislation that specifically speaks to access to Antenatal Care (ANC).

The existing policy framework gives young girls aged between 9-13 years access the Human Papillomavirus screening and vaccine but it is unclear as to whether parental consent is required.
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 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% 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 at 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 Kenyan legal review was prepared by SAT and is based on research conducted by Hamilton, Harrison and Matthews lawyers in Kenya. 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 exist 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 for sexual intercourse

In Kenya the legal Age of Consent to sexual intercourse is 18 years. The Marriage Act provides the age for marriage to be 18 years and above for both male and female.

The Sexual Offences Act, No. 3 of 2006 provides that a person who commits an act which causes penetration with a child is guilty of the offence of defilement. A child is defined under the Children Act, No 8 of 2001 as any human being under the age of eighteen years. The Legislation on sexual offences has set out different categories of punishment to be rendered on an accused found guilty of defilement depending on the age of the victim. The Act sets out that the younger the victim the severe and the harsher the punishment. It is a defence to a charge of defilement if the child deceived the perpetrator into believing that he or she was over 18, and the perpetrator reasonably believed that the child was over 18 years. However, there is no defence where the perpetrator is themselves a child, and reviewers believe that law reform in this area is required.

Legislation and policy framework

The Marriage Act provides the legislative framework governing the Age of Consent for sexual intercourse. Section 4 of the Act states as follows: A person shall not marry unless that person has attained the age of eighteen years.

The Children Act, No 8 of 2001, Interpretations section states that a Child means any human being under the age of eighteen years.

The Sexual Offences Act, Section 8 defines Defilement as follows: (1) A person who commits an act which causes penetration with a child is guilty of an offence termed defilement. (2) A person who commits an offence of defilement with a child aged eleven years or less shall upon conviction be sentenced to imprisonment for life (3) A person who commits an offence of defilement with a child between the age of twelve and fifteen years is liable upon conviction to imprisonment for a term of not less than twenty years (4) A person who commits an offence of defilement with a child between the age of sixteen and eighteen years is liable upon conviction to imprisonment for a term of not less than fifteen years (5) it is a defence to a charge under this section if- (a) it is proved that such child, deceived the accused person into believing that he or she was over the age of eighteen years at the time of the alleged commission of the offence; and (b) the accused reasonably believed that the child was over the age of eighteen years (6) The belief referred to in subsection (5) (b) is to be determined having regard to all the circumstances, including any steps the accused person took to ascertain the age of the complainant. (7) where the person charged with an offence under this Act is under the age of eighteen years, the court may upon conviction, sentence the accused person in accordance with the Borstal Institutions Act and the Children's Act.

The severity of the sentence imposed will depend on the age of the ‘victim’ - where the victim is:

a. 11 years or under, the sentence is life imprisonment
b. between 12 years and 15 years, the sentence is up to 20 years’ imprisonment
c. between 16 years and 18 years, the sentence is up to 15 years’ imprisonment.

The High Court Case of CWK v Attorney General of Kenya and another Petition Number 6 of 2013 gives some indication of the approach likely to be taken where two minors engage in consensual sex. In this case a minor engaged in sex with another minor. Both minors were guilty of an offence of defilement. In this case the male minor was the only one charged with the offence. A different view was taken in the High Court case of Martin Charo v Republic, Criminal Appeal No. 32 of 2015 which dealt with the case where a minor engaged in consensual sex with an adult. In this case the court took into consideration the behaviour of the child and acknowledged that young children engage in sex at a very young age. At the trial court stage the adult was charged with the offence of defilement but after a successful appeal he was released within the defence under section 8(5) of the Sexual Offences Act.

Current practice is indicated, as per the above case of CWK v Attorney General of Kenya and another Petition Number 6 of 2013 and Martin Charo v Republic, Criminal Appeal No.32 of 2015.
Definition of statutory rape

Kenya does not have an expressed definition of statutory rape, however there is a definition of defilement in the Sexual Offences Act, No. 3 of 2006 as noted previously in this report. The law needs to be reformed to include an express definition of statutory rape, and to change the position in relation to a minor who engages in consensual sexual intercourse with another minor.

Exceptions on gay sex

In Kenya, gay sex is prohibited and criminalized. Gay sex between two men is expressly prohibited by Section 165 of the Penal Code, which prohibits acts of ‘gross indecency’ between two men.

There is no express prohibition on sex between two women. However, Section 162(a) of the Penal Code refers to ‘any person’ who ‘has carnal knowledge of any person against the order of nature’ shall be guilty of unnatural offense. Although there is no precedent for this provision being applied to sex between two women, it could be interpreted to cover such acts.

Law Reform would be required to legalise gay sex in Kenya, however there is need to evaluate whether Kenya will move forward with legalizing gay sex and marriage.

Legislation and policy framework exceptions on gay sex in Kenya

The Constitution of Kenya Article 45(2) provides that every adult has the right to marry a person of the opposite sex, based on the free consent of the parties.

The Penal Code:
Section 162: Any person who:

a. has carnal knowledge of any person against the order of nature; or
b. has carnal knowledge of an animal; or
c. permits a male person to have carnal knowledge of him or her against the order of nature, is guilty of a felony and is liable to imprisonment for fourteen years:

Section 165 provides that any male person who, whether in public or private, commits any act of gross indecency with another male person, or procures another male person to commit any act of gross indecency with him, or attempts to procure the commission of any such act by any male person with himself or with another male person, whether in public or private, is guilty of a felony and is liable to imprisonment for five years.
Chapter Three: Access contraceptive services including contraceptive commodities

There is currently no Act that expressly covers modern contraceptives. In the absence of any age restrictions young persons of any age may access contraceptives without parental consent.

However, at the time of the legal review, a bill was being discussed in Parliament which defines contraception and the provision of contraceptives i.e. Reproductive Healthcare Bill 2014 (Reached the 2nd Reading). The bill proposes that the Cabinet Secretary for Health shall consult with the still to be constituted Reproductive and Child healthcare Board, to provide adolescent-friendly reproductive health services. The bill defines an adolescent as any person between the ages of 10 and 17 years. Parental consent is not required for an adolescent to access reproductive health services.

However, it is not clear from the bill what the adolescent-friendly reproductive health services will be. The Reproductive Healthcare Bill needs to pass its third reading and thereafter be assented to law. At the time of the legal review there was no clear indication as to when the next reading will be scheduled or whether the bill will pass.

It is incumbent on the Kenyan Government to make clear the process and restrictions (if any) on an adolescent purchasing contraceptive commodities at shops or over the counter at chemists. The bill should be amended to provide clarity on what adolescent-friendly reproductive health services mean and if any parental consent is required to purchase the same.

Legislation currently under discussion

Reproductive Healthcare Bill 2014 (Reached the 2nd Reading). Contraception under this bill is defined as the deliberate prevention of pregnancy by measures that prevent the normal process of ovulation, fertilization and implantation. Under this bill, Section 4 provides that “The National and County Governments shall make available contraception and family planning services, including contraceptive options, counselling, information and education.

Clause 5 of this bill provides that:

Every healthcare service provider prescribing a contraceptive method shall provide information to the person to whom the prescription is being given as to its advantages and disadvantages and ensure informed consent.

Clause 33 and 34 of the bill provides that:

33(1) The Cabinet Secretary for health shall consult with the Board and facilitate the provision of adolescent friendly reproductive health services.

33(2) In the provision of reproductive health services to adolescents, parental consent is not mandatory.

33(3) Despite sub-section (2) above, nothing prevents a healthcare provider from whom reproductive health services are sought by an adolescent, from referring the adolescent to a qualified person for provision of the necessary services.

Section 34(1) The Board in consultation with Government institutions and other bodies shall- (a) facilitate the provision to of adolescent - friendly reproductive health and sexual health information and education; (b) facilitate the provision to adolescents, non-judgmental and affordable reproductive health services; (c) develop policies to protect adolescents from physical and sexual violence and discrimination including cultural practices that violate the reproductive health rights of the adolescents; and (d) facilitate adolescents access to information, comprehensive sexuality education and confidential services. (2) The Board shall make such recommendations to Cabinet Secretary on a continuous basis as to changes inclusions to make such regulations as may be necessary to ensure that the object of section 33(1) is achieved.
Access to emergency contraceptives

There is no prescribed legal age at which a young person can access emergency contraceptives. However in practice the reviewers noted that one is able to purchase emergency contraceptives over the counter with or without a prescription. The common practice is that any adult or adolescent is able to access emergency contraceptives over the counter. There is no guideline on age restriction and in practice the dispensation of the contraceptive is at the discretion of the person dispensing the contraceptive.

There is a need for an Act that regulates the policy and rules on emergency contraceptives, and/or for the Cabinet Secretary of Health to sign off on the common practice of purchasing of the emergency contraceptives (day after pill) over the counter.

Legislation and policy framework

In Kenya the Pharmacy and Poisons Act aims to regulate the dispensation of all medicine. Section 29(2) of the Act provides that an authorized seller of poisons may sell Part I poisons to any person who is in possession of a prescription by a duly qualified medical practitioner. We are not able to establish if emergency contraceptives are listed as Part 1 medications as the Act has used chemical terms and not reference to specific medicines.
Chapter Four: Age of Consent and HIV testing

In Kenya, a written consent of a parent or legal guardian must be obtained for a child (definition stated earlier in the report) for purposes of HIV testing. However there are certain exceptions where any child who is pregnant, married, a parent or is engaged in behaviour which puts him or her at risk of contracting HIV may, in writing, directly consent to an HIV test.

Legislation and policy framework

The HIV and AIDS prevention and control Act Section 14 states that: (1) Subject to subsection 2, no person shall undertake an HIV test in respect of another person except-

a. With the informed consent of that other person;
b. If that person is a child, with the written consent of a parent or legal guardian of the child; Provided that any child who is pregnant, married, a parent or is engaged in behaviour which puts him or her at risk of contracting HIV may, in writing, directly consent to an HIV test;
c. If, in the opinion of the medical practitioner who wishes to undertake the HIV test, the other person has a disability by reason of which he appears incapable of giving consent with the consent of-
   (i) a guardian of that person; (ii) a partner of that person; (iii) a parent of that person; or (iv) an adult offspring of that person: Provided that a medical practitioner may undertake the HIV test if the persons referred to in paragraphs (i), (ii), (iii) and (iv) are either absent or are unwilling to give consent;
d. where the person is required to undergo an HIV test under the provisions of this Act or any other written law.

Age of Consent to report HIV status directly to adolescent

HIV status is normally reported to a parent or legal guardian of a child. HIV test results will only be reported directly to a child under the age of 18 years if the child consented to a HIV test directly by reason of being pregnant, married, a parent or engaged in a behaviour which puts him or her at risk of contracting HIV.

Legislation and policy framework

HIV and AIDS Prevention and Control Act Section 18 states as follows:
That the results of an HIV test shall be confidential and shall only be released:

a. to the tested person;
b. in the case of a child, to a parent or legal guardian of such child; Provided that where any such child consents to an HIV test directly under section 14(1)(b), the results thereof shall be released to the child; or
c. in the case of a person with a disability which, in the opinion of the medical practitioner undertaking the test, renders him incapable of comprehending such result to
   i. the legal guardian of that person;
   ii. a partner of that person;
   iii. a parent of that person; or
   iv. an adult offspring of that person.
Chapter Five: Age of Consent and access to Antiretroviral Therapy (ART)

There is no statutory age limit and the law in Kenya is silent on whether consent by a parent is required for access to Anti – Retroviral therapy to a child however it is the responsibility of a parent of the child and Government to ensure provision of access to medical care (including ART). At the time of the review, a bill was being discussed in parliament that seeks to establish a unified health system, including the requirement for consent i.e. the Health Bill, 2015.

The Ministry of health has provided National Guidelines on Antiretroviral therapy that outlines eligibility for ARV use, regimen selection and monitoring for Treatment. These guidelines were developed and reviewed in line with available local and international evidence and in line with guidelines for public health provision of ART by the World Health Organisation through a process of stakeholder consultations and consensus. The ART guidelines were first published 2001 and subsequently revised and updated in 2002, 2006, 2011 and 2014. The National AIDS and STI’s Control Programme (NASCOP) was established as a unit within the Ministry of Health and is involved in technical co-ordination of HIV and AIDS programmes in Kenya. The guidelines provide the criteria for when ART should be started in children however it does not clearly state whether parental consent is required or not.

There is no specific policy on age of access to ART with or without parental consent.

Legislation and policy framework

Section 9: Every child shall have a right to health and medical care the provision of which shall be the responsibility of the parents and the Government.

- ART should be initiated in all HIV infected children above 10 years of age with CD4 cell count ≤500 cells/mm3, regardless of WHO stage
- All HIV-infected children above 10 years with WHO stage 3 and 4 disease, Hepatitis B Virus/HIV, TB/HIV co-infection should be initiated on ART irrespective of CD4 count
- In circumstances where DNA PCR testing is not readily available ART should be initiated in any child younger than 18 months of age who meets criteria for presumptive diagnosis of severe HIV disease, confirmatory DNA PCR testing should be done as soon as possible


NASCOP’s website provides that Antiretroviral therapy (ART) may be initiated in HIV positive adults and adolescents with the following:

- CD4 count ≤ 350 cells/mm3 regardless of WHO clinical stage; or
- WHO clinical stage 3 or 4 regardless of CD4 count; or
- HIV and TB co-infection regardless of the CD4 count (remember these patients are in WHO clinical stage 3 or 4, depending on the type of TB); or
- Hepatitis B virus (HBV) co-infection with evidence of active liver disease (elevated ALT), cirrhosis or other evidence of chronic liver disease (including HBsAg remaining positive when repeated at least 6 months after initial positive HBsAg test), regardless of CD4 count.
Chapter Six: Age of Consent and access to Pre-exposure Prophylaxis (PrEP) and Post-exposure Prophylaxis (PEP)

HIV Pre-exposure Prophylaxis (PrEP)

There are no legislations, regulations or policies governing PrEPs in Kenya. Accordingly there is no express prohibition on the use of HIV PrEP in Kenya. However the Ministry of Health; National AIDS and STI Control Programme (NASCOP), Guidelines on use of Antiretroviral drugs for treating and preventing HIV infection; A rapid advice, June 2014 in its recommendations seeks to limit the use of PrEP to research purposes.

The Government should introduce policies and regulations on the use of HIV Pre-exposure Prophylaxis (PrEP).

Legislation and policy framework

The Ministry of Health; National AIDS and STI Control Programme (NASCOP), Guidelines on use of Antiretroviral drugs for treating and preventing HIV infection, rapid advice, June 2014.

Section 9 states that Pre-exposure Prophylaxis (PrEP) for HIV is the daily use of ARV drugs by HIV uninfected people to prevent the acquisition of HIV. PrEP is not currently recommended for routine use in Kenya except in research settings.

Young people’s access to PrEP

It is the responsibility of a parent of the child and Government to ensure provision of access to medical care (including access to PrEP). PrEP is currently used for research purposes and not for treating and preventing HIV infection.

Kenya does not have a statutory prohibition on HIV Post-exposure Prophylaxis (PEP) however there are national recommendations by the Ministry of Health on the use of PEP. However the recommendations do not cover the Age of Consent and requirement for parental consent.

The Government needs to formalise its various policies on PEP into one place preferably in the form of regulations to the HIV and AIDS Prevention and Control Act (No. 14 of 2006 Laws of Kenya).

Legislation and policy framework

HIV and AIDS Prevention and Control Act (No. 14 of 2006 Laws of Kenya) covers, Post-exposure Prophylaxis. It defines it as the administration of one or a combination of Anti-retroviral drugs after probable exposure to HIV, for purposes of preventing transmission.

Section 6(4) of the Act provides that the Minister for the time being responsible for matters relating to health shall, in collaboration with relevant stakeholders, provide guidelines for Post-exposure Prophylaxis.

The Frequently asked questions (FAQs) manual on national AIDS/STIs control programme (NASCOP) does not prohibit HIV PEP however it recommends that first a test for HIV be conducted and if the exposed person is actually HIV positive then enrol into care and if the exposed person is HIV negative then to give TDF/AZT + 3TC + LPV/r or TDF/AZT + 3TC (only if 3 drugs are not tolerated) for 4 weeks. The manual goes further to state the PEP should not be initiated after 72 hours as it works best within 72 hours of exposure to HIV.
Young people’s access to PEP

There is no statutory age limit on access to PEP in Kenya. The national recommendations by the Ministry of Health on the use of PEP do not cover the Age of Consent and requirement for parental consent.

The Government needs to formalise its various policies on PEP into one place preferably in the form of regulations to the HIV and AIDS Prevention and Control Act (No. 14 of 2006 Laws of Kenya).

The recommendations by the Ministry of Health appear to be silent on the age at which young people can access PEP. In the absence of such a requirement the general recommendations as explained above in the response will apply.

Legislation and policy framework on access to PEP

The HIV and AIDS prevention Act together with the Ministry of Health guidelines provide the legislative and policy framework for access to PEP in Kenya. However both the Act and the guidelines do not deal with the age of consent for using the PEP.

The Government needs to formalise its various policies on PEP into one place preferably in the form of regulations to the HIV and AIDS Prevention and Control Act (No. 14 of 2006 Laws of Kenya).

The HIV and AIDS Prevention and Control Act defines Post-exposure Prophylaxis as – ‘the administration of one or a combination of Anti-retroviral drugs after probable exposure to HIV, for purposes of preventing transmission.’

Section 6(4) of the Act provides that the Minister for the time being responsible for matters relating to health shall, in collaboration with relevant stakeholders, provide guidelines for Post-exposure Prophylaxis.
Chapter Seven: Age of Consent and access to safe abortions and/or post abortion care

The Constitution of Kenya does not permit abortion except if there is a need for emergency treatment or if the life or health of the mother is in danger. The Ministry of Health introduced the National Adolescent Sexual and Reproductive Health Policy in 2015. The aim of the NASRH policy is to enhance the Sexual reproductive health status of adolescents in Kenya. The implementation of the policy is managed by the Ministry of Health.

The constitution of Kenya does not include the Age of Consent with or without parental consent. In the absence of any specific policy, doctors will follow the general policy for medical treatment in an emergency treatment and the policy more particularly described in the section on ART, and require parental consent to perform an abortion for a woman under 18 years of age.

However the Reproductive Healthcare Bill, 2014 (yet to come into force) refers to the need to obtain consent from a person with parental responsibility before terminating a pregnancy in the case of a pregnant minor. The Bill refers to a minor as a person under the age of 18 years.

The Reproductive Healthcare Bill needs to pass its third reading and thereafter be assented to law. At the moment there is no clear indication as to when the next reading will be scheduled and if the bill will pass this reading.

Legislation and policy framework on abortion and post care

The Constitution of Kenya 2010, Article 26(4) provides that abortion is not permitted unless, in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger.

Reproductive Healthcare Bill 2014

Section 20 provides that subject to section 19(1); termination of pregnancy may take place: (a) only with the consent of the pregnant woman (b) in the case of pregnant minor, after consultation with the minor’s parents, guardian or such other persons with parental responsibility over the said minor, provided that the best interest of the minor shall prevail, in the case of a mentally unstable person, after consultation with the parents, guardian or such other persons with parental responsibility over the said person.

The National Adolescent Sexual and Reproductive Health Policy, 2015 policy 5.4.4.4 (8) seeks to enhance the provision of high quality post abortion care services to adolescents.

Section 9 of The Children Act (Laws of Kenya) (as highlighted under access to ART).
Chapter Eight: Age of Consent on access to Antenatal Care (ANC)

There is no legislation or policy in place relating to Antenatal Care (ANC). However there is a proposed Reproductive Healthcare Bill 2014 which will require public hospitals to provide free Antenatal Care. The proposed Bill does not include any provisions regarding Age of Consent to ANC.

At the time of the legal review, the Kenyan Government still needed to pass the new bill, and there was a need for clarity on how the proposed free Antenatal Care should be administered.

Legislation and policy framework

Kenya is currently discussion at parliament level a new legislation on Antenatal Care. The Reproductive Healthcare Bill 2014 defines Antenatal Care as including the correct diagnosis of pregnancy, followed by periodic examinations, screening and management of complications during pregnancy. Section 17 that: Every public hospital whether under the management of a County Government or National Government shall provide free ante-natal care and delivery services.
Chapter Nine: Age of Consent and access to HPV vaccines, and cervical cancer screening and treatment

The Ministry of Public Health and Sanitation and Ministry of Medical Services introduced the National Cervical Cancer Prevention Programme Strategic Plan 2012 - 2015 in January 2012. There are two types of Human Papillomavirus (HPV) vaccines licensed and available in Kenya known as Gardasil and Cervarix. The HPV vaccination is being introduced as a school based programme targeting girls aged 9 to 13 years.

The plan states that cervical cancer screening will be integrated into routine service provision in both public and private sector. It is not clear from the plan if parental consent is a prerequisite for access to the HPV vaccine and cervical cancer screening. There is a need for an Act that covers HPV vaccine, cervical cancer, screening and treatment.

Legislation and policy framework on access to HPV vaccine and cervical cancer screening and treatment

Existing policy framework governing HPV vaccine and cervical screening is the National Cervical Cancer Prevention Programme Strategic Plan 2012 - 2015: Section 3.2.1.

Recommendations for HPV vaccination in Kenya are as follows;

i. The target for vaccination will be Pre and young adolescent girls before first coitus. The recommended age group is 9-13 years. Antibody response is high in this age group and vaccine efficacy is highest in those who are naive to vaccine specific oncogenic HPV types. Hence the greatest impact of HPV vaccination on cervical cancer is through broad participation of young adolescent girls rather than older girls or women. In line with the country vision of universal free primary education, the best approach would be a school based programme targeting upper primary classes 4 to 8.

ii. Either bivalent or quadrivalent type of vaccine may be used

iii. Out of school population will be targeted through facility or outreach approach

iv. Catch up vaccination will be provided for non-sexually active older girls; however, modelling studies suggest diminishing protection when age of vaccination is increased

v. No boosters will be given

The focus of the programme is females. These is because there are presently no studies indicating that HPV vaccination of males will result in less sexual transmission of vaccine specific HPV infection from males to females thereby reducing cervical cancer.

The roll out of this programme will be led by the Division of Vaccine and immunization whose systems for the national vaccine programmes are already in place, through the school health programme. Other collaborating divisions include the Division of Reproductive Health and the Division of Child and Adolescent Health. With the main entry point being the schools, the Ministry of Education is a key stakeholder in ensuring smooth implementation in primary schools.

Clause 3.3.1.4 on Entry points states that cervical cancer screening will be integrated into routine service provision in both public and private sector.

These are the recommended initial service entry points:

- MCH/FP clinics - Comprehensive Care clinics (CCCs) - Obstetrics and gynaecology wards/ clinics - Outreach/In reach – (for mass screening campaigns). Information on cervical cancer screening will be provided at all service areas where women present. These include: The Outpatient Department; The Female wards; The TB clinics; The Maternity Unit.
Chapter Ten: Discussion of inconsistencies on Age of Consent

There is a discrepancy in respect of the Age of Consent on sexual intercourse, which is 18 years, and the age that a young person may access contraceptives. At the time of the review the law was silent on the age a young person may access contraceptives and so in effect access is not restricted by age. There is a need for law reform to ensure across the board certainty and in this situation we need laws that clearly state the age one can gain access to contraceptives. It was hoped that the Reproductive Healthcare Bill, 2014 would provide clarity on this issue however it appears to create further uncertainty as in its current form it makes provision for access to adolescent friendly reproductive health services. The bill defines an adolescent as any person between the age of ten and seventeen years which is younger than the Age of Consent. The bill is also not clear on what will be included in reproductive health services. The Marriage Act Section 4 states that ‘A person shall not marry unless that person has attained the age of eighteen years.

The Children Act, No 8 of 2001 defines a child to mean any human being under the age of eighteen years;

The Sexual Offences Act, Section 8 defines Defilement as follows: (1) A person who commits an act which causes penetration with a child is guilty of an offence termed defilement. (2) A person who commits an offence of defilement with a child aged eleven years or less shall upon conviction be sentenced to imprisonment for life (3) A person who commits an offence of defilement with a child between the age of twelve and fifteen years is liable upon conviction to imprisonment for a term of not less than twenty years (4) A person who commits an offence of defilement with a child between the age of sixteen and eighteen years is liable upon conviction to imprisonment for a term of not less than fifteen years (5) it is a defence to a charge under this section if- (a) it is proved that such child, deceived the accused person into believing that he or she was over the age of eighteen years at the time of the alleged commission of the offence; and (b) the accused reasonably believed that the child was over the age of eighteen years (6) The belief referred to in subsection (5) (b) is to be determined having regard to all the circumstances, including any steps the accused person took to ascertain the age of the complainant. (7) where the person charged with an offence under this Act is under the age of eighteen years, the court may upon conviction, sentence the accused person in accordance with the Borstal Institutions Act and the Children’s Act.
Chapter Eleven: Recommended intervention on legal and policy framework

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Annex

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 this status to her/his parents?
18. Please explain any inconsistencies between the answers above.