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 restrictions on 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 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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AGE OF CONSENT
LEGAL REVIEW
### ACRONYMS

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<tr>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>ANC</td>
<td>Antenatal Care</td>
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<td>ART</td>
<td>Antiretroviral Therapy</td>
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<td>EHP</td>
<td>Essential Healthcare Package</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>HCT</td>
<td>HIV Counselling and Testing</td>
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<td>HIV</td>
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<td>Medical Male Circumcision</td>
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EXECUTIVE SUMMARY

In Malawi the Age of Consent for sexual intercourse is 16 years for females and there is no specific age indication for males. In the country’s statutes sexual intercourse with a female under the age of 16 years is illegal. Gay sex is prohibited by law and it remains criminalised.

Adolescents do not require parental consent to access contraception commodities and services although it is not very specific at what age it applies.

Malawi published its first national Antiretroviral Therapy guidelines in 2003 and has since updated these regularly. They do not specify the Age of Consent, however the legal age of majority is 16 years. The country has no prohibition on Post-exposure Prophylaxis (PEP) and its existing guidelines do not specify the Age of Consent.

Abortion is legal in Malawi if it is performed in order to save the mother’s life. Ante-natal Care is part of the Essential Healthcare Package.

The Age of Consent for access to Antenatal Care is unclear but the legal age of majority is 16 years. The HPV vaccination programme was introduced in 2013 for 9-13 year olds. The Age of Consent for access to the Human Papillomavirus (HPV) vaccine is not clear.

On HIV testing, parental consent is not required for persons aged 13 years or older and for those younger than 13 years who have sufficient maturity.
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 Malawian legal review was prepared by SAT and is based on research conducted by Shearman and Sterling LLP Law Firm. 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.

It also summarises applicable laws, regulations and policies, and includes references referring back to the full text.

The review specifically looks at the following areas:

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

Malawi does not have an explicit Age of Consent law, however Section 138(1) of the Penal Code establishes the offence of defilement (cut off point: 16 years - (Note that the Penal Code refers to ‘girls’ only).

Case law has established that it is not necessary to ask whether the girl consented or not in defilement cases to determine the guilt of an accused person. Whether the girl consented to the sexual assault or not is irrelevant, the accused person would still be guilty. There is not information on the Age of Consent to sexual intercourse for males.

Legislation and policy framework

Penal Code, Section 138(1): Any person who unlawfully and carnally knows any girl under the age of sixteen years shall be guilty of a felony and shall be liable to imprisonment for life, with or without corporal punishment.

Definition of statutory rape

Malawi legislation defines two circumstances in which sexual intercourse will be said to be “without consent”. The first instance is where the woman did not agree to the sexual intercourse but the man forced himself upon her. The second instance is where the woman agrees to the sexual intercourse but that agreement is obtained by force, intimidation, threats, fear of bodily harm or was misrepresented as to the nature of the act, or in the case of a married woman, by personating her husband.

The definition of rape in the Penal Code is limited. It addresses women and girls only, and it does not address forced anal sex, or forced non-penile penetration of the vagina or anus as constituting rape.

Legislation and policy framework

Penal Code, Section 132: Any person who has unlawful carnal knowledge of a woman or girl, without her consent, or with her consent if the consent is obtained by force or means of threats or intimidation of any kind, or by fear of bodily harm, or by means of false representations as to the nature of the act, or in the case of a married woman, by personating her husband, shall be guilty of the felony termed rape. The term “carnal knowledge” is not defined in the Penal Code.

Exceptions for gay sex

In Malawi there is no explicit exception on gay sex. Information on the Age of Consent to sexual intercourse for males is not very clear.

Legislation and policy framework on exceptions on gay sex

A conflict of legislations could create a de facto category of exceptions for certain young girls: The Penal Code (Section 138 (1) establishes the offence of defilement (cut off point: 16 years). The Marriage, Divorce and Family Relations Act provides that the minimum age of marriage is 18 years. However Section 22 of the Constitution stipulates that girls and boys aged 15 to 18 years may marry with parental consent. Moreover, the Constitution does not specifically prohibit the marriage of children under 15 years, but merely directs the Government to “discourage” them. Certain experts referred to in an Nyasa Times article say that the Marriage, Divorce and Relations Act and the defilement provision in the Penal Code are both inconsistent with the Constitution: the Constitution can allow a child of 15 years of age to get married whereas the Penal Code establishes sexual intercourse with a girl under 16 years as an offence of defilement. It is unclear whether law enforcers will be able to prosecute a married man for defilement when the Constitution, i.e. the supreme law of Malawi, allows child marriage. The Penal Code criminalizes homosexuality. However in November 2012 the Government called for a moratorium on arrests under Penal Code provisions, pending a review of the constitutionality of the anti-homosexual laws.
Chapter Three: Access to contraception services and commodities

Malawi has a policy to guide and inform access to contraception services and products. The policy is titled *Preservice Education Family Planning Reference Guide* (September 2010). Clause Section 21.5: of the policy states that Adolescents need to know: That these methods are available to them and that they are not required to have parental or spousal consent to receive a contraceptive method.

According to the United Nations, adolescents are individuals from ages 10 to 19 years of age. (Source: *Preservice Education Family Planning Reference Guide* (September 2010), p. 545). It is not very clear if these guidelines are still applicable.

2.3.1 Access to Emergency contraceptives

Emergency contraceptives (e.g. the ‘day after pill’) are available in public sector clinics, pharmacies, and NGO-led clinics. There is no clear age limit for young people to access emergency contraception, although the *Preservice Education Family Planning Reference Guide* indicates that there are no contraindications for emergency contraceptive pills for adolescent women, referring to a research study on the use of these pills among girls 13 to 16 years old.
Chapter Four: Age of Consent and HIV testing

Children aged 12 years and under need consent for HIV testing from parents or guardians/care givers. However, mature minors under the age of 13 years should be allowed to consent to HIV testing services. Thus, any young person 12 years and under who is married, pregnant or engaged in risky behaviour should be considered a mature minor and be eligible to give consent for HIV testing.

In cases where a minor does not have parental or guardian consent, the counsellor can provide HIV testing services based on the best interests of the child, particularly if the child has been exposed to sexual and/or maternal transmission of HIV, is ill and diagnosis will facilitate appropriate care and treatment, or the child expresses concern that he or she will be denied access to care, treatment and social services if accompanied by a parent/caregiver.

Legislation and policy framework on HIV testing

HIV testing in Malawi is guided by the 2015 HIV testing Services Guidelines: Chapter 3.

Age of Consent to report HIV status directly to adolescents

Malawi Guidelines for paediatric HIV testing and counselling (2007) provide that the results of the test will be revealed to children older than 12 years in the same manner as they would for an adult. Health providers must ask children older than 12 years if there is anyone they can share the results with.

Healthcare workers receive disclosure training. They have a number of responsibilities in disclosure. They shall always advise children aged 13 years or over to share results with a parent/guardian or trusted adult. This is a recommendation they make to children aged 13 years or over, who are not legally required to report their status to their parents.

Children aged 13 years or over shall be entitled to access HIV testing without the consent of a parent or guardian.

Legislation and policy framework on HIV testing

The HIV testing Services Guidelines (2015) Section 4.1.3 provide that disclosure of HIV status to children should be regarded as a process that is guided by the developmental age of the child.
Chapter Five: Age of Consent and access to Anti-retroviral Therapy (ART)

In Malawi eligibility for ART is stipulated in the ART Guidelines that specify the enrolment criteria for Antiretroviral Therapy for various groups as follows;

**Children (5 years +) and Adults:**
- Confirmed HIV infection (through the HIV rapid antibody test)
- Pregnant or breastfeeding women (regardless of the age of the child) regardless of WHO stage and CD4 count; or
- WHO Stage 1 or 2 and CD4 ≤500 cells/mm³
- WHO Stage 3 or 4 regardless of CD4 count

**Children (12-59 months):**
- Universal ART eligibility where confirmed HIV infection (HIV rapid antibody test or DNA-PCR) irrespective of WHO stage and CD4 count

**Infants under 12 months:**

Universal ART eligibility where confirmed HIV infection (DNA-PCR needed) irrespective of WHO stage and CD4 count or CD4 %.

Special note has to made that Malawi expects that from mid-2016, all HIV infected Malawians will be universally eligible for ART.

In the absence of specific legal provisions or guidance on the Age of Consent to access ART local counsel assumes that the legal age of majority (16 years) applies for access without parental consent. In practice, however, children aged 13 years or over access ART without the consent of a parent or guardian. While it is not well outlined in policy, children as young as 10 years do come to access ART on their own. The assumption is that prior arrangements with their caretakers have been made. The 2015 HIV testing Services Guidelines are clear about acting in the ‘best interests of the child,’ which in practice includes placing a child on treatment (Source: Enquiries with Judith Sherman, UNICEF Malawi, Chief, HIV and AIDS).

**Legislation and policy framework on access to ART**

*2014 Malawi Integrated Guidelines for Clinical Management of HIV in Children and Adults, Section 6.4.5. Definition of ART Eligibility. The next edition of these guidelines is scheduled for release in 2016.*

*The Constitution’s Section 23: states that “Children shall be persons under sixteen of age. 2015 HIV testing Services Guidelines: Chapter 3; The issue of consent in relation to ART is not directly addressed in the 2015 HIV testing Services Guidelines. However the legal Age of Consent for accessing ART is in practice deemed identical to the legal Age of Consent for HIV testing (see answer to question 16) (Source: Enquiries with Judith Sherman, UNICEF Malawi, Chief, HIV and AIDS).*
Chapter Six: Age of Consent and access to Pre-exposure Prophylaxis (PrEP) and Post-exposure Prophylaxis (PEP)

Pre-exposure Prophylaxis (PrEP)

The review did not find any specific prohibition on HIV Pre-exposure Prophylaxis (PrEP). However, the drug used for PrEP is registered for treatment, but not for prevention, and there were some failed PrEP trials undertaken around 2004-2005 and in 2009.

Young people’s access to PrEP

The review did not find any information on the conditions for young people to access PrEP. Assumption drawn from the review is that the legal age of majority of 16 applies to any consideration for Age of Consent.

Legislation and policy framework on PrEP

Malawi Constitution, Section 23: Children shall be persons under sixteen years of age, is the binding legislation that is used. The legal review did not find any legislation specifically enabling PrEP use in Malawi.

Annexed to the National HIV Prevention Strategy 2015-2020 is a series of prevention packages that capture the biomedical, behavioral and structural change interventions necessary to achieve the 90-90-90 goals with specific target populations. PrEP is listed as a biomedical intervention necessary to achieve the 90-90-90 goal with (i) men who have sex with men (MSM) and (ii) sero-discordant couples. In February 2016, however, the Ministry of Health of Malawi stated that the universal ART strategy would be prioritized over PrEP.

The 90-90-90 concept describes the treatment target set up by UNAIDS to help end the AIDS epidemic: by 2020, 90% of all people living with HIV will know their HIV status. By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy. By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression.

Post-exposure Prophylaxis

There is no prohibition on the provision of PEP, young people have the legal right to access PEP if they fulfil the criteria for eligibility described earlier.

The Age of Consent is not specified in relation to eligibility to start PEP. Local counsel assumes that the legal age of majority of 16 applies. However in some instances, children and adolescents under the age of 16 could be eligible to start PEP without parental consent. In the case of child abuse, for instance, a child, who would have gone through an official process (e.g., reporting the abuse), could access PEP without parental consent. In such cases, the ‘best interests of the child’ rules applicable to HIV testing may be extended in practice to cover HIV treatment (Source: Enquiries with Judith Sherman, UNICEF Malawi, Chief, HIV and AIDS).

Legislation and policy framework on access to PEP

The national Constitution Section 23: states that ‘Children shall be persons under sixteen years of age.’ Child Care, Protection and Justice Act 2010, Article 2: ‘Child’ means a person under the age of sixteen years. The ‘best interests of the child’ underlying rule is, for instance, provided for in the 2015 HIV testing Services
Guidelines: In cases where a minor does not have parental or guardian consent, the counsellor can provide HTS based on the best interests of the child (2015 HIV testing Services Guidelines, Chapter 3, p. 6). Eligibility to start PEP in Malawi is premised on the following:

- Any exposure classified as risk in the last 72 hours
- Survivor of violence tests HIV negative on initial testing
- Survivor of violence consents to treatment

PEP shall never be refused on moral judgment about the kind of exposure (accident, negligence, rape, 'burst condom'). PEP is safe in pregnancy and breastfeeding. Severe anaemia (<8g/dl) is contraindication for AZT/3TC (used as standard PEP regimen for patients weighing under 35kg). Severe renal failure is contraindication for TDF/3TC (used as standard PEP regimen for patients weighing 35kg and above). New HIV test from the source person is mandatory to confirm negative HIV status but this shall not delay starting PEP if HIV testing and counselling is not immediately available (no test kits, night, etc.). The ‘2014 Malawi Integrated Guidelines for Clinical Management of HIV in Children and Adults’: Section 6.13 Post-exposure Prophylaxis. The next edition of these guidelines is scheduled for release in 2016.
Chapter Seven: Age of Consent and access to safe abortions and/or post abortion care

In Malawi abortion is currently legal only to save the life of a pregnant woman. The Law Commission of Malawi has drafted a bill of law (known as the “Termination of Pregnancy Bill”) to be presented in parliament to legalise safe abortion and eliminate unsafe abortion. The bill would permit abortion not only where it is necessary to save the life of the mother but also to preserve the physical and mental health of the pregnant woman, in the case of severe foetal problems, or pregnancy resulting from incest and rape.

Legislation and policy framework

Penal Code, Section 149-151 and 243: Section 149. Any person who, with intent to procure a miscarriage of a woman, whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, shall be guilty of a felony and shall be liable to imprisonment for fourteen years.

Section 150. Any woman who, being with child, with intent to procure her own miscarriage, unlawfully administers to herself any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, or permits any such thing or means to be administered or used to her, shall be guilty of a felony, and shall be liable to imprisonment for seven years.

Section 151. Any person who unlawfully supplies to or procures for any person anything whatever, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman, whether she is or is not with child, shall be guilty of a felony and shall be liable to imprisonment for three years.

Section 243. A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for his benefit, or upon an unborn child for the preservation of the mother’s life, if the performance of the operation is reasonable, having regard to the patient’s state at the time, and to all the circumstances of the case.
Chapter Eight: Age of Consent on access to Antenatal Care (ANC)

The Malawi Health Sector Strategic Plan (2011-2016) includes the Essential Healthcare Package (EHP). The objective of the EHP is to ensure universal access to quality EHP services consisting of promotive, preventive, curative and rehabilitative services to all people in Malawi.

ANC is part of the Essential Healthcare Package. The research could not identify details on policy framework enabling ANC and Age of Consent for access. The general assumption is that the legal age of majority of 16 applies in order to access ANC without parental consent.

Legislation and policy framework

The Malawi Health Sector Strategic Plan (2011-2016) is used to define access to ANC. It is however unclear if there are any other policies that directly address ANC access.
Chapter Nine: Access to Human Papillomavirus (HPV) vaccine, and cervical cancer screening and treatment

Malawi introduced a Human Papillomavirus (HPV) vaccination routine immunization programme in 2013. The target vaccination age for routine immunization is 9-13 years. Currently, almost all 29 health districts in the country provide cervical cancer screening services using visual inspection with acetic acid as recommended by the WHO. However, despite the availability of the screening services, statistics show very few women have been screened for cervical cancer (Source: Fresier C. Maseko et al., Client satisfaction with cervical cancer screening in Malawi, BMC Health Serv Res., 2014, 14:420). Data collected did not give much detail on the policy framework enabling access to HPV vaccine and cervical cancer screening and treatment, including the Age of Consent.
Chapter Ten: Contradictions and inconsistencies

The Age of Consent to access HIV testing is clearly stated to be 13 years in the HIV testing Services Guidelines. However, the position with respect to HIV treatments of ART, PEP and PrEP are unclear and in the absence of specific guidelines or legal provisions local counsel takes the position that the constitutional age of majority of 16 years applies. This would mean that persons aged 13-15 years could access HIV testing on their own but would require parental consent in order receive treatment with ART, PEP or PrEP. Local counsel has been informed that, in practice, clinics will extend the rules in the HIV testing guidelines to treatments.

Legislation and policy framework

Constitution, Section 23: Children shall be persons under sixteen years of age. Child Care, Protection and Justice Act 2010, Article 2: 'Child' means a person the age of sixteen years.

2015 HIV testing Services Guidelines: Chapter 3: Verbal informed consent must be obtained by the HTS Provider. Clients should be informed of the process for HTS and their right to decline testing. Any person aged 13 years and above should be considered mature enough to give informed consent.
Chapter Eleven: Recommended intervention on legal and policy framework

<table>
<thead>
<tr>
<th>Area</th>
<th>Category of regulation</th>
<th>Required intervention</th>
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<tr>
<td>Age of sexual intercourse</td>
<td>L</td>
<td>LR</td>
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<tr>
<td>Definition of statutory rape</td>
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<td>LR</td>
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<tr>
<td>Exceptions on Age of Consent - For example ‘gay sex’</td>
<td>L</td>
<td>Constitution LR</td>
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<tr>
<td>Young people’s access to contraceptive services</td>
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<td>PR</td>
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<tr>
<td>Young people’s access to emergency contraceptives</td>
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<td>N/A</td>
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<tr>
<td>Policy framework and legislation on access to Antiretroviral Therapy (ART)</td>
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<td>PR</td>
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<td>Policy and legislation on young people’s access to PEP</td>
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<td>Policy and legislation on young people’s access to PrEP</td>
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<tr>
<td>Policy framework and access to Antenatal Care (ANC)</td>
<td>P</td>
<td>PR</td>
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<tr>
<td>Policy framework and legislation on access to HPV vaccines and cervical cancer screening and treatment</td>
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<td>N/A</td>
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<td>Policy framework and/or legislation on access to safe abortions and/or postabortion care</td>
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<td>Age of Consent to access HIV testing without parental consent</td>
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<tr>
<td>Legal and policy framework on the Age of Consent HIV status will be reported directly to an adolescent</td>
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<td>PR</td>
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<tr>
<td>Addressing various policy and legislation inconsistencies</td>
<td>L G</td>
<td>LR Minister sign off new guidelines</td>
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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 was it 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.