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

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

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

In Morocco sex outside of marriage is illegal at any age and the legal age of marriage is 18 years. Rape is the act by which a man has sex with a woman against the will of the woman or with a minor under the age of eighteen years, an incapable person, a disabled person, a person known to be mentally weak (such individuals are considered as incapable of giving consent). Gay sex is prohibited and criminalised.

A judge may authorise the marriage of a person under 18 years. Parental consent is legally required for persons aged under 18 years to access medical treatment, including contraceptives. Condoms are freely available in practice without parental consent.

Morocco does not have age restrictions, therefore, parental consent is not a legal requirement, but in practice unmarried women may not be able to obtain emergency contraceptives without parental consent. Parental consent is legally required for persons aged under 18 years to access medical treatment, including ART, but this requirement is unlikely to be strictly applied in practice.

Legally, parental consent is required for unmarried persons aged under 18 year. However, HIV testing is available without proof of age. Test results of persons known to be under 18 years are reported to their legal representative.

There is no prohibition on PEP in Morocco. Parental consent is legally required for persons aged under 18 years to access medical treatment, including PEP, but this requirement is unlikely to be strictly applied in practice.

The Ministry of Health authorised PEP in 2012, but the authorisation does not deal with Age of Consent. PrEP treatment is not currently authorised for sale in Morocco (but PrEP is undergoing clinical trials).

Parental consent is legally required for persons aged under 18 years to access medical treatment, and this is likely to apply to PrEP, but this requirement is unlikely to be strictly applied in practice.

Abortion is illegal except in limited circumstances and where a patient is under 18 years, the physician must attempt to obtain spousal or parental consent.

Policy enables access to ANC. The general rule on Age of Consent to medical treatment applies. Policy enables access to HPV vaccination and cervical cancer screening. The HPV vaccine is available to girls aged 9 years and over. The general rule on Age of Consent to medical treatment applies.
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 Morocco legal review was prepared by SAT and is based on research conducted by Nero Law Firm in Morocco. 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 include references referring back to the full text.

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 HPV vaccine and cervical cancer screening and treatment, including Age of Consent, with and without parental consent
9. Age of Consent to access HIV testing without parental consent.
Chapter Two: Age of Consent to sexual intercourse

In Morocco the age of legal majority and of legal matrimonial capacity is 18 years. Sex between consenting individuals cannot legally take place outside a wedlock.

The law in Morocco has been heavily influenced by Islam, which is recognised as the official state religion in the Moroccan constitution. Provisions of Moroccan legislation (for example, the Criminal Code) apply to people of any religion within Morocco.

In practice, the way in which the law is applied differs in urban and rural areas, and for foreigners compared to Moroccan citizens. The law is applied less strictly in urban compared to rural areas, and is applied even less strictly to foreigners.

Islam does not permit sexual relations outside of wedlock and the Moroccan Criminal Code, which applies to individuals of all religions within Morocco, strictly prohibits premarital sex and extramarital sex.

The legal age of marriage in Morocco is 18 years old but the marriage of a minor can be authorized by a family court judge, thereby lowering the age at which sex between “consenting” and married individuals may legally take place.

The age at which a judge will authorise marriage varies in different parts of the country; for example, in rural areas there is precedent for a judge authorising the marriage of a girl as young as 12 (Ytto Foundation report).

Legislation and policy framework

Religious law is not applicable in Morocco. However, it is relevant to keep it in mind to understand the Moroccan society’s standpoint on such issues.

Art. 490 of Dahir n° 1-59-413 approving the text of the Criminal Code (the Criminal Code): It is illegal for a man and a woman to have sexual relations outside of wedlock, under penalty of imprisonment of one month to one year.

Art. 19 of law 70-03 (the Family Code): The matrimonial capacity is acquired for the boy and the girl enjoying their mental faculties at eighteen years of Gregorian age.

Art. 20 of the Family Code: A family court judge may authorize the marriage of the boy and the girl before the age of the matrimonial capacity provided for in Article 19 above, by reasoned decision, specifying the interest and the reasons justifying such marriage (…).

For information only:

Qur’an 17:32: Nor come nigh to fornication/adultery: for it is a shameful (deed) and an evil, opening the road (to other evils).

Qur’an 24:2: The woman and the man guilty of fornication, - flog each of them with a hundred stripes: Let not compassion move you in their case, in a matter prescribed by Allah, if ye believe in Allah and the Last Day: and let a party of the Believers witness their punishment.

Qur’an 24:4-5: And those who accuse free women then do not bring four witnesses, flog them, (giving) eighty stripes, and do not admit any evidence from them ever; and these it is that are the transgressors. Except those who repent after this and act aright, for surely Allah is Forgiving, Merciful.

Book 17, Hadith 4191: ‘Ubada b. as-Samit reported: Allah’s Messenger as saying: Receive (teaching) from me, receive (teaching) from me. Allah has ordained a way for those (women). When an unmarried male commits adultery with an unmarried female, (they should receive) one hundred lashes and banishment for one year. And in case of married male committing adultery with a married female, they shall receive one hundred lashes and be stoned to death.
Definition of statutory rape

According to Moroccan legislation rape is the act by which a man has sex with a woman against the will of the woman or with a minor under the age of eighteen years, an incapable person, a disabled person, a person known to be mentally weak (such individuals are considered as incapable of giving consent).

Sex between two individuals who are married is legal, regardless of their age and whether both parties consent (Moroccan law does not recognise spousal rape).

Legislation and policy framework

Article 486 of the Criminal Code: Rape is the act by which a man has sex with a woman against the will of the woman. Such rape is punished with imprisonment of five to ten years.

However, if the rape was committed against a minor under the age of eighteen years, an incapable person, a disabled person, a person known to be mentally weak, or a pregnant woman, the penalty is ten to twenty years’ imprisonment.

Age of Consent on sexual intercourse exception for example gay sex

Sex between individuals of the same sex (male or female) is illegal irrespective of age or consent.

Morocco does not allow same-sex marriages nor does it recognize same-sex marriages entered into abroad.

Legislation and policy framework on exceptions for example on gay sex

Article 489 of the Criminal Code: prohibits “acts of a lewd nature or against nature with a person of the same sex”, which is a misdemeanour punishable by a jail sentence of six months to three years and a fine of 200 to 1,000 dirhams (unless the act constitutes a more serious infraction).
Chapter Three: Access to contraception services and commodities

Morocco does not have specific legal provision regarding age of access to contraceptives, and the general legal provisions regarding Age of Consent to medical treatment apply, quoted in Column E.

With the exception of emergency contraceptives see access to emergency contraception below, access to contraceptives (not including barrier contraceptives, such as condoms) requires a prescription issued by a gynaecologist, physician, surgeon, mid-wife or trained nurse.

The Moroccan Family Code provides that decisions regarding the medical treatment of a minor under the age of 18 years must be made by their legal representative (usually, their parent or other legal guardian - the necessary consent is referred to as “parental consent”).

In theory it is possible for a person aged 16 years to request formal legal emancipation, in which case they will no longer require parental consent for medical treatment, but emancipation is not common and is not typically invoked in order to obtain access to medical treatment.

In addition, pharmacists are subject to the Code of Deontology, which provides that pharmacists must not condone practices that go against good morality. This would include premarital or extramarital sex.

However, the position in practice is different. Contraceptive services and commodities are freely accessible under governmental programs to women who are married. Married women of all ages, provided that they are of age to procreate (normally considered to be between 15 and 49 years old but this can vary on an individual basis) readily have access to contraceptive services, including contraceptive commodities, in all public hospitals and through private clinics.

Pharmacists frequently dispense medications without a prescription and without checking the patient's age and marital status.

Where there are policy reasons for encouraging access to medical treatment - in particular, in the case of contraceptives, HIV testing and treatment, HPV vaccination, cervical cancer screening and antenatal care - physicians will frequently not strictly apply the requirement to check the patient's age or to obtain parental consent. In addition, doctors can be found criminally liable for failing to provide treatment in case of an emergency, so if treatment is required urgently the doctor will not wait to obtain parental consent.

Barrier contraceptives (condoms) are, in practice, routinely distributed for free to men and women by physicians and NGOs and can be purchased over the counter in pharmacies, even by minors aged under 18 years, with or without parental or spousal consent.

In practice, therefore, it is frequently possible for minors aged under 18 years to access contraceptives. However, because of the contradiction between legislation and practice, it is possible that an unmarried woman, particularly a minor under the age of 18 years, may have difficulty in obtaining contraceptives in some instances.

There are no restrictions on the access to condoms. In practice, however, pharmacists will not sell condoms to individuals who clearly appear to be minors.

Legislation and policy framework

Art. 166 of the Family Code: Guardianship of a minor lasts until he/she reaches the age of legal majority.

Art. 209 of the Family Code: The age of legal majority is eighteen.

Art. 218 of the Family Code: (...) When the minor reaches the age of sixteen years, he may apply to the court for an emancipation (...)
Article 54 of the Family Code: parents have a legal duty to protect the right of their children to life and health “from the time of pregnancy” (Art. 54§1(1°)) as well as to take “all possible measures to ensure the normal growth of children by protecting their physical and psychological integrity and by protecting their health through prevention and treatments” (Art. 54§1(5°)).

Art. 54§4 of the Family Code: the State is responsible for taking the measures necessary for the protection of children, to guarantee and protect their rights under the law.

Article 1 of Law n° 34-09 on the Health System and the Offer of Care: the right to healthcare is a duty of the State and of society.

Decree n° 2-63-486 of 9 chaabane 1383 (26 December 1963) approving and making applicable the Code of Deontology of Pharmacists.

Chap. II, Art. 5 of the Code of Deontology of Pharmacists: the pharmacist must not condone, by his/her advice or actions, practices that go against good morality.

Morocco no prescription is required for condoms access. The researcher consulted pharmacists who informed them that condoms are available OTC in practice (except when the individual in question appears to the pharmacist to be a minor, in which case the pharmacist will not supply that individual with condoms).

The researcher consulted two doctors working in local clinics who informed them that some oral contraceptives are available OTC in practice.

Access to Emergency Contraception

Emergency contraceptives (NORLEVO® and POSTINOR®) are authorized for distribution and sale and are available at all authorized points of sale without a prescription since 2008. Legally, a person under the age of 18 years would not require parental consent to access an emergency contraceptive.

Nonetheless, as a contraceptive, its sale falls under the provisions of Chap. II, Art. 5 of the Code of Deontology of Pharmacists, which provides that “the pharmacist must not condone, by his/her advice or actions, practices that go against good morality,” which would include prohibited practices such as any sexual activity outside of wedlock. A married woman, irrespective or her age, may access the “day after pill” with or without spousal consent. Although pharmacists frequently do not check a person’s age and marital status before dispensing medications, it is possible that an unmarried woman, particularly a minor aged under 18 years, may have difficulty in finding a pharmacist willing to sell it to her without parental consent.

Legislation and policy framework

Decree n° 2-63-486 of 9 chaabane 1383 (26 December 1963) approving and making applicable the Code of Deontology of Pharmacists.

Chap. II, Art. 5 of the Code of Deontology of Pharmacists: the pharmacist must not condone, by his/her advice or actions, practices that go against good morality.

Pharmacists consulted by local counsel confirm that it is common practice not to request to see proof of age of individuals seeking to access to emergency contraceptives. However, if the relevant individual clearly appears to be aged under 18 years (in the view of the pharmacist), the pharmacist will normally refuse to supply that individual with emergency contraceptives.
Chapter Four: Age of Consent and to access HIV testing

The position regarding parental consent is as set out in the chapter parental consent is legally required to provide medical treatment to minors aged under 18 years, but in practice this requirement is unlikely to be strictly applied in relation to HIV testing.

In addition, free and anonymous HIV testing is available in information centres opened by the ALCS in 26 cities across Morocco and, since no proof of age is required from patients, a number of test subjects may in fact be minors in their mid-teens (15-17 years) acting without parental consent and passing themselves up as adults.

Legislation and policy framework on HIV testing

See the legislation and policy framework governing access to contraception in Chapter 3 above.

Health professionals consulted by local counsel confirm that it is common practice not to request to see proof of age of individuals seeking to access HIV testing. An ALCS centre has informally confirmed to local counsel that ALCS’s screening centres commonly provide free and anonymous HIV testing to individuals who may be minors in their mid-teens.

Age of Consent to report HIV status directly to adolescents

Although parental consent is legally required for HIV testing, in practice this requirement is unlikely to be strictly applied.

Therefore, while results of HIV testing conducted in ALCS Information Centres will only be reported to the patient when the test subject is an adult, or believed to be one, the physician will normally inform the legal representative present of the result when the person seeking the test is known to be a minor aged under 18 years.

Legislation and policy framework reporting HIV status to adolescents

Article 2§2 of Law n° 131-13 on the Practice of Medicine: Any medical doctor, irrespective of the sector (public or private) in which he works and the method of exercise, must abide by Human rights universally recognized and to observe the following principles: (...) - The right of the patient or, as the case may be, his/her guardian or legal representative, to information about the diagnostic of his/her illness, possible therapeutic options and their expected results and the consequences of a refusal of care, subject to said information being recorded in the medical record of the patient, of which the patient, or his/her legal representative or his/her heirs if he/she dies, may obtain a copy.

Article 31 of the Medical Code of Deontology: a serious prognostic can be legitimately hidden from a patient and that a fatal prognostic should only be revealed to the patient with great circumspection, although, in this last case it must generally be revealed to the family, provided that the patient has not forbidden such revelation or designated other third parties to whom it must be made.
Chapter Five: Age of Consent and access to Antiretroviral Therapy (ART)

In Morocco access to ART forms part of the general policy regarding access to care and treatment (guaranteed by the new Constitution) as well as the General Health Plan and the specific Plan to fight HIV/AIDS.

As explained in the answer to question 4 above, parental consent is legally required to provide medical treatment to minors aged under 18, but in practice this requirement is unlikely to be strictly applied in relation to ART.

ART, which must be prescribed, is provided free-of-charge in Association de lutte contre le SIDA (ALCS) facilities, which also provide additional psychological support to HIV/AIDS-infected individuals.

Legislation and policy framework on access to ART


Health professionals consulted by local counsel confirm that it is common practice not to request to see proof of age of individuals seeking to access ART.
Chapter Six: Age of Consent and access to Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP)

Pre-exposure Prophylaxis (PrEP)

PrEP treatment is not currently available in Morocco. As with any medicine, PrEP drugs would need to be authorised by the Ministry of Health in order to be offered in Morocco. There are currently no PrEP drugs which have a marketing authorisation that is valid in Morocco. However, certain PrEP drug(s) are undergoing clinical trials in the public health system.

Hospital-employed physician (consulted by local counsel) confirmed that PrEP drugs are undergoing clinical trials.

If PrEP were to become available, local counsel expect that the position will be the same as for PEP and ART. If so, parental consent will be legally required to treat minors aged under 18 years with PrEP, but this requirement is unlikely to be strictly enforced in practice.

However, after much lobbying by the Association de lutte contre le SIDA (ALCS) and considering the positive results of this treatment, the Ministry of Health will consider authorising the widespread distribution of PrEP treatment in 2017, after a 13-month study, set to start in 2016 and to be conducted jointly by the Ministry of Health and the ALCS, to show the acceptability and adherence to the PrEP treatment by homosexual men and sex workers and to provide weekly follow-ups to study the effects of taking the medication on daily life.

Legislation and policy framework

See the legislation and policy framework governing access to contraception in Chapter 3 above.

Post-exposure Prophylaxis (PEP)

There is no prohibition on HIV Post-exposure Prophylaxis (PEP) in Morocco. Parental consent is required if the patient is a minor aged under 18 years as set out in Chapter Three on access to conception.

The presence (and therefore consent) of the legal representative is also legally required for minors aged under 18 years to answer the preliminary questions of the physician, who, alone, may decide to prescribe PEP treatment based on the answers collected and the results of the HIV test, irrespective of the age of the minor - again, Chapter Three on access to conception. In the event of a conflict between the physician’s decision to provide PEP treatment and parental refusal to consent to such treatment on behalf of a minor, the physician’s decision will prevail.

The Ministry of Health authorized the distribution of PEP medication in 2012. To local counsel’s knowledge, the authorization (regulation) does not specifically deal with ages of consent. In the absence of specific provisions, the position will be as set out in the provision of PEP above. PEP treatment is available for free in all university medical centres and Association de lutte contre le SIDA (ALCS) Information Centres across Morocco.
Legislation and policy framework

Refer to Chapter Three on access to contraception.


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

In Morocco abortion is currently illegal, unless the health of the pregnant woman is threatened and the abortion is practiced openly by a physician or surgeon with the authorisation (consent) of the spouse.

If the practitioner deems that the life of the woman concerned is in jeopardy, he may proceed without the authorisation (consent) of the spouse, provided that he notifies the head medical doctor of the prefecture (county) or province.

If there is no spouse, or if the spouse refuses to or cannot give his consent, the physician or surgeon cannot practice the abortion or use a therapy that may result in an interruption of the pregnancy until and unless he notifies the head medical doctor of the prefecture (county) or province in writing, stating that the health of the woman concerned can only be preserved by this intervention.

In practice, the legal requirements are applied relatively strictly; to the knowledge of local counsel it is rare for illegal abortions to be performed.

The Moroccan King has recently indicated his consent to an amendment to the laws on abortion, which would facilitate access to some degree (in comparison to the current position). Such amendment to the laws would include an exception to the prohibition on abortion in circumstances involving rape. Please note, however, that even though the King has consented, any legal amendment must be approved by the House of Representatives before it comes into effect.

In the case of therapeutic abortions and with the exception of extreme urgency, if the physician knows that the consenting patient is a minor aged under 18, he must, before practicing the abortion, try to obtain the consent of the husband or the members of the family having authority over her.

Legislation and policy framework

Art. 54§1(1°) of the Family Code: Parents have a legal duty to protect the right of their children to life and health from the time of pregnancy.

Art. 453§1 of the Criminal Code: Abortion is illegal unless the health of the pregnant woman is threatened and the abortion is practiced openly by a physician or surgeon with the authorisation (consent) of the spouse.

Art. 453§2 of the Criminal Code 11/07/2016: if the practitioner deems that the life of the woman concerned is in jeopardy, he may proceed without the authorisation (consent) of the spouse, provided that he notifies the head medical doctor of the prefecture (county) or province.

Art. 453§3 of the Criminal Code: If there is no spouse, or if the spouse refuses to or cannot give his consent, the physician or surgeon cannot practice the abortion or use a therapy that may result in an interruption of the pregnancy until and unless he notifies the head medical doctor of the prefecture (county) or province in writing, stating that the health of the woman concerned can only be preserved by this intervention.

Art. 449§1 of the Criminal Code: Abortion, with or without consent of the woman concerned, is a criminal offense punishable by a jail sentence of one to five years and a fine of 200 to 500 dirhams unless:

1) the death of the woman ensues, in which case it is considered a crime punishable by a prison term of 10 to 20 years (Art. 449§2 of the Criminal Code);

or 2) the abortion was performed by someone who is deemed to have performed abortions on a habitual basis, in which case these penalties are doubled (Art. 450 of the Criminal Code).

http://telquel.ma/2015/05/16/mohammed-vi-legalise-lavortement-au-maroc-nouveaux-cas_1447111
Art. 454 of the Criminal Code: A woman that wilfully aborts or attempts to abort outside of this framework or that has accepted to use means or follow instructions given to her to this end, is punishable by a prison term of six (6) months to two (2) years and a fine of 200 to 500 dirhams.

Article 32 of the Medical Code of Deontology: in the case of therapeutic abortions and with the exception of extreme urgency, if the physician knows that the consenting patient is a minor, he must, before practicing the abortion, try to obtain the consent of the husband or the members of the family having authority over her.
Chapter Eight: Age of Consent on access to Antenatal Care (ANC)

Access to Ante Natal Care (ANC) an integral part of Morocco’s policy towards lowering the rate of maternal mortality, which remains high (at 42 per 1000 women).

A study shows that 77.1% of pregnant women received qualified ANC and 73.6% received assistance from qualified personnel at the time of birth in 2011, up from 67.8% and 63% respectively in 2004, but also notes that the difference between urban and rural populations remains significant (92.1% versus 55%).

The position regarding parental consent is as set out in the answer to question 4 above: parental consent is legally required to provide medical treatment to minors aged under 18, but in practice this requirement is unlikely to be strictly applied in relation to ANC.

Legislation and policy framework

Refer to guidelines governing access to contraceptive articulate in Chapter 3.

Programme National d’Immunisation: Aspects pratiques de la vaccination Manuel de formation, Ministere de Sante, 2013:

HPV vaccine (Gardasil®) is authorised for administration to women aged 9 to 45 years with a prescription since 1st November 2007 (for 1,500 dirhams per dose). It is recommended to be administered before the first sexual relations and as such, is often administered around the age of 11-12 years, with parental consent. It is reimbursable at 80% by insurance providers as a vaccine up to the age of 12 years.

Thanks to the lobbying of the Lalla Salma Association for the Fight Against Cancer (ALSC), cervical cancer screening is now generalised.

The position regarding parental consent is as set out in the answer to question 4 above: parental consent is legally required to provide medical treatment to minors aged under 18, but in practice this requirement is unlikely to be strictly applied in relation to HPV vaccination and cervical screening.

Legislation and policy framework


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

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**Legislation (religious law is not applicable in Morocco. However, it is relevant to keep it in mind to understand the Moroccan society’s standpoint on such issues)**
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 it 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 HPV vaccine 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.