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 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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SWAZILAND

AGE OF CONSENT
LEGAL REVIEW
## ACRONYMS

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<tr>
<th>Acronym</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>ANC</td>
<td>Antenatal Care</td>
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<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
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<tr>
<td>EHP</td>
<td>Essential Health Package</td>
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<tr>
<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>
<td>Human Immunodeficiency Virus</td>
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<td>Human Papillomavirus</td>
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<td>Medical Male Circumcision</td>
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<td>Multiple-perpetrator Rape</td>
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<td>Multiple Sexual Partners</td>
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<td>PLWHA</td>
<td>People Living with HIV/AIDS</td>
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<td>PLWHIV</td>
<td>People Living with HIV</td>
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<td>Post-exposure Prophylaxis</td>
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<td>Sexual and Reproductive Health services</td>
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<td>World Health Organization</td>
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EXECUTIVE SUMMARY

The Age of Consent to sexual intercourse in Swaziland is 16 years for females and there is no specific age stipulated for males. Sexual intercourse with a female under the age of 16 is illegal and punishable. The law recognises as illegal indecent assault against someone (of any gender) under 18 years.

In Swaziland, homosexuality is illegal. Where a male person has sex with another male person this amounts to sodomy and they both can be charged. Although there is such an offence, prosecutions are extremely rare and, although homosexuality is discouraged, homosexuals are not charged.

Contraceptive services and devices including emergency contraception may be provided to persons under the age 18 years without parental consent.

The Age of Consent is for HIV testing without parental consent is 12 years, and unless the minor does not have sufficient maturity in which case it is 18 years.

Age of Consent at which the HIV status can be reported directly to an adolescent is 12 years, unless the minor does not have sufficient maturity in which case it is 18 years. A minor who has capacity to consent has the same right to confidentiality as any adult patient.

There are no laws or policies enabling access to Antiretroviral Therapy (ART). The Children’s Protection and Welfare Act provides for HIV testing when it is in the best interest of the child and the requisite consent is given. Consent may be given by the child if the child is 12 years or older. Parental consent must be given if the child is under 12 years or does not have sufficient maturity or does not have the mental capacity to understand the benefits, risks, and social implications of such a test. ART is a consequence of testing and, as such, the Age of Consent will be the same. We are not aware of any policy or any legislative framework, however, there is a national guideline for ART and Post-exposure Prophylaxis for adults and adolescents.

Swaziland does not have any prohibition and specified age limit on access to Post-exposure Prophylaxis even though the country has established guidelines to enable access to PEP. They do not deal with the Age of Consent. The country does not provide Pre-exposure Prophylaxis.

Section 15 (5) of the Swaziland Constitution outlaws abortion altogether, except in limited circumstances where continued pregnancy will endanger the life or mental health of the woman or the child, or where the pregnancy has resulted from rape or incest, or unlawful sexual intercourse with a mentally retarded female.
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 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 has the highest HIV prevalence in the world (26.0%), followed by Botswana (23.4%).

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

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

The advocacy campaign ‘All in To #EndAdolescentAIDS’ was launched as a global platform for action and collaboration for social change in February 2015 by global leaders and civil society partners. This global agenda provides opportunities for ensuring that existing and new strategies and programmes on HIV prevention, treatment and care are effectively implemented to benefit young people. These include the 2012 guidance on Pre-exposure Oral Prophylaxis (PrEP) for serodiscordant couples, men, and transgender women who have sex with men at high risk of HIV transmission, as well as the 2013 guidance for HCT and care for adolescents living with HIV and young key population policy briefs.

All in To #EndAdolescentAIDS works through four workstreams. As part of workstream 1, global partners have prioritised joint action to take stock of the current situation in countries with respect to Age of Consent for services including HIV by carrying out a systematic desk review of Age of Consent laws and a mapping of the processes led and outcome of reforms undertaken by countries to address this barrier. Through the All in To #EndAdolescentAIDS, many agencies, and global partners including the United Nations Development Programmes (UNDP), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the PACT and AIDS Alliance have already initiated actions on data collection to inform their policy advocacy efforts globally and specifically within the 25 focus countries. This review will inform the development of a source or toolkit for learning on this theme and capacity building of experts and policymakers worldwide.

Why Age of Consent review?

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

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

Therefore, the main goal of the project was to conduct research on “Age of Consent” laws, regulations, and policies, as well as ESC factors, in relation to adolescents. This entailed collecting country experiences to address Age of Consent laws / polices 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 HCT in adolescents aged 10–19 years.

**Methodology**

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

The review specifically looked at the following:

1. Age of Consent to sexual intercourse including the age for statutory rape
2. Age of Consent to access modern contraceptives, with and without parental consent
3. Age of access to emergency contraceptives, with and without parental consent
4. Policy framework and legislation enabling or disenabling access to Pre-exposure Prophylaxis (PrEP) including Age of Consent, with and without parental consent
5. Policy framework and legislation enabling or disenabling access to Post-exposure Prophylaxis (PEP) including Age of Consent, with and without parental consent
6. Policy framework and legislation enabling or disenabling access to safe abortions and postabortion care including Age of Consent, with and without parental consent
7. Policy framework and legislation enabling or disenabling access to Antenatal Care (ANC) including Age of Consent, with and without parental consent
8. Policy framework and legislation enabling or disenabling access to HPV vaccines and cervical cancer screening and treatment, including Age of Consent, with and without parental consent
9. Age of Consent to access HIV testing without parental consent.

Chapter Two: Age of Consent to sexual intercourse
In Swaziland, the recognised Age of Consent for sexual intercourse with a woman is 16 years of age. There is no prescribed age for sexual intercourse with a boy. However, it must be noted that rape is not recognised as being an offence against a male. The only relevant offence in terms of the Age of Consent for a male is the common law offence of indecent assault against a minor (i.e., a person under the age of 18 years). However, this offence requires the perpetrator to use force for the purpose of committing an 'indecent act' with the victim. It does not, therefore, include consensual sexual activity.

It must be noted that a person who is mentally unstable or suffers for a mental defect cannot give their consent to sexual intercourse because they cannot understand the nature of the sexual act - sex with a mentally unstable person, therefore, would amount to rape as that person cannot legally give consent.

**Legislation and policy framework**

*Section 3 (1) of The Girls’ and Women’s Protection Act 1920* provides that:

Every male person who has unlawful carnal connection with a girl under the age of sixteen years or who commits with a girl under that age immoral or indecent acts or who solicits or entices a girl under such age to the commission of such acts shall be guilty of an offence and liable on conviction to imprisonment not exceeding six years with or without whipping not exceeding twenty-four lashes and with or without a fine not exceeding one thousand emalangeni in addition to such imprisonment and lashes.

*Section 41 of the Crimes Act* provides that:

Any person who is the parent or guardian of any girl or woman and who:

a. procures such girl or woman to have unlawful connection with any man other than the procurer; or
b. orders, is party to, or permits or receives any consideration for the defilement, seduction or prostitution of such girl or woman

shall be guilty of an offence and, on conviction, shall be liable to imprisonment for five years and, if such girl is under the age of 12 years, shall be liable to imprisonment for life and to be whipped.

*Section 42 of the Crimes Act* provides that:

Any person who procures or attempts to procure any girl or woman who is not a common prostitute or of known immoral character to have unlawful carnal connection either within or outside of Swaziland with any other person shall, when such offence does not amount to rape or attempted rape, be guilty of an offence and on conviction liable to a fine of E1,000.00 or imprisonment for five years.

**Definition of statutory rape**

Currently, rape is a Statutory and a Common Law offence and it is defined as a male having intentional sexual intercourse with a female without her consent. This definition is archaic in that it only recognises rape against a woman by a man, although a woman cannot commit the crime of rape, she can be guilty as an accomplice to its perpetration as is stipulated by the statutory offence contained in Section 3 (1) of The Girls’ and Women’s Protection Act 1920.

**Legislation and policy framework**

The Common Law definition of rape is a crime consisting of a male having intentional sexual intercourse with a female without her consent.

There is currently no statutory definition of rape. However, there is a Sexual Offences and Domestic Violence Bill which, although not law, is currently being debated in parliament and will become law at some point and will codify the Common Law definition.

*Section 3 (1) provides, a person who rapes another commits an offence of Rape and for the purposes of this Act the offence of Rape is committed either by a male or female person against the person of another.*
Section 2 provides that Rape is defined as an unlawful sexual act with a person.

Section 3 defines an unlawful sexual act as constituting a sexual act committed under any of the following circumstances a) in any coercive circumstance; b) under false pretences or by fraudulent means; c) in respect of a person who is incapable in law of appreciating the nature of the Sexual Act; d) duress; e) psychological oppression or fear of violence.

The penalty for rape is contained in S3 (1) of The Girls and Women’s Protection Act 1920, which provides that:

Every male person who has unlawful carnal connection with a girl under the age of sixteen years or who commits with a girl under that age immoral or indecent acts or who solicits or entices a girl under such age to the commission of such acts shall be guilty of an offence and liable on conviction to imprisonment not exceeding six years with or without whipping not exceeding twenty-four lashes and with or without a fine not exceeding one thousand emalangeni in addition to such imprisonment and lashes.

The common law provides that any person who assists in the rape of another person is an accomplice to the crime. An accomplice is defined as being a person who is, in any way, involved with another in the commission of a crime, whether as a principal or an accessory.

**Section 218 of the Children’s Welfare & Protection Act:**

A maintenance order issued by the Children’s Act shall expire when the child attains the age of eighteen years.

The common law offence of “indecent assault” is defined as being the unlawful and intentional, direct or indirect application of force to the person of another with the objective of committing an indecent act.

With regard to the common law offence of indecent assault against a minor, a ‘minor’ is a person under the age of 18 years (Section 2 of the Children’s Act of 2012).

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

In Swaziland, homosexuality is illegal. Where a male person has sex with another male person, this amounts to sodomy and they both can be charged. Although there is such an offence, prosecutions are extremely rare and, although homosexuality is discouraged, homosexuals are not charged. Note, however, that the crime is sodomy, and not necessarily homosexuality. Sodomy is the act of penetration in the anus of one man by another.

**Legislation and policy framework**

Section 3 (1) of The Girls and Women Protection Act 1920 provides the legal framework to address suspected gay sex.
Chapter Three: Age of Consent and access to contraceptive services commodities

In Swaziland, there is no age limitation in respect of access to contraceptive services, emergency contraceptives services such as the morning-after pill, including contraceptive commodities. Reproductive health devices and technologies may be provided without parental consent where proper medical advice is given to the child and a medical examination is carried out on the child to determine whether there are any medical reasons why a specific reproductive health protective device or technology should not be provided to the child. ‘Child’ means a person under the age of 18 years.

Legislation and policy framework

Section 244 of Children’s Protection and Welfare Act of 2012 provides that:

Reproductive health devices, information and technologies may be provided even to a child without parental consent where proper medical advice is given to the child and a medical examination is carried out on the child to determine whether there are any medical reasons why a specific reproductive health protective device or technology should not be provided to the child. According to the Act a child is a person under the age of eighteen years (Section 2 of the Children’s Act of 2012).
Chapter Four: Age of Consent and HIV testing

The Age of Consent to access HIV testing without parental consent is 12 years of age, provided the child can demonstrate competence.

Legislation and policy framework

Section 240 of Children’s Protection and Welfare Act 2012, states that; No child may be tested unless testing is in the best interests of the child and consent has been given under subsection (2).

Subsection 240 (2) provides that consent for an HIV test on a child may be given by (a) the child if the child is twelve years or older; (b) the parent, guardian or care giver, if the child is under the age of twelve years or is not of sufficient maturity or does not have the mental capacity to understand the benefits, risks and social implications of such a test; (c) a social worker arranging the placement of the child if the child is under the age of twelve or is of insufficient maturity to understand the implications of such a test; (d) the head of a hospital if the child is under the age of twelve years of age or is not of sufficient maturity to understand the nature of such a test or the child has no parent or guardian and there is no designated child protection organisation arranging the placement of the child or (e) the Children’s Court if consent under paragraphs a), b), c) or d) is unreasonably withheld or the child, parent or guardian is incapable of giving consent.

Age of Consent to report HIV status directly to adolescents

In Swaziland, a minor who has capacity to consent has the same right to confidentiality as any adult patient. Medical practitioners are required to keep the confidence of their patients. If there was no protection of their confidence, patients would be unwilling to make certain disclosures to their physicians and this could inhibit their treatment. Ethically medical practitioners may not divulge in writing any information regarding a patient which ought to be divulged except with the express consent of the patient.
Chapter Five: Age of Consent on Antiretroviral Therapy (ART)

The research did not identify specific policy or legislative frameworks designed to enable access to ART. The Children’s Protection and Welfare Act provides for HIV testing when it is in the best interest of the child and the requisite consent is given. Consent may be given by the child if the child is 12 years or older. Parental consent must be given if the child is under 12 years or does not have sufficient maturity or does not have the mental capacity to understand the benefits, risks and social implications of such a test. ART is a consequence of testing and, as such, the Age of Consent will be the same. We are not aware of any policy or any legislative framework, however, there is a national guideline for ART and Post-exposure Prophylaxis (PrEP) for adults and adolescents.

Legislation and policy framework

Section 240 of Children’s Protection and Welfare Act 2012

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Section 240 (as opposed to Section 239) applies to determine the age of consent to ART because ART is a consequence of HIV testing, which is the subject of Section 240.)
Chapter Six: Age of consent and access to Pre-exposure Prophylaxis (PrEP) and Post-exposure Prophylaxis (PEP)

Pre-exposure Prophylaxis (PrEP)

Swaziland currently does not offer Pre-exposure Prophylaxis (PrEP) for HIV. However, the study noted that young people, particularly 12 years and above, would be able to access PreP if it was offered. If PrEP were available, there would be no prohibition on this and the same rules would apply (i.e. a child 12 years or older capable of understanding the benefits, risks, and implications of such would be entitled without the consent of its parents; or a child under the age of twelve years or a child over 12 who cannot appreciate the benefits, risks, and implications of such would require the consent of his/her parent, guardian or caregiver as provided in section 240 of the Children’s Protection and Welfare Act of 2012).

Legislation and policy framework

Section 240 of the Children's Protection and Welfare Act 2012 provides the basis for PrEP access.

Post-exposure Prophylaxis (PEP)

Swaziland does not have any prohibition on Post-exposure Prophylaxis (PEP). In particular, the relevant provision on access to medical treatment (Section 239 of the Children’s Protection and Welfare Act 2012) contains no prohibition.

Legislation and policy framework

Section 239 of Children’s Protection and Welfare Act 2012:

1. A child may be subject to medical treatment or a surgical operation only if the child’s consent for such treatment has been given in terms of either subsection (2) or (3) or alternatively (4) or (5).

2. A child may consent to medical treatment provided the child is --
   a. at least 12 years of age; and
   b. of sufficient maturity and has the mental capacity to understand the benefits, risks, social, and other implications of the treatment or operation.

3. A child may not consent to a surgical operation without the assistance of --
   a. the parent or guardian of the child; or
   b. the caregiver of the child.

4. The parent, guardian or caregiver of the child may consent to the medical treatment or surgical operation of the child if the child is -
   a. under the age of 12 years; or
   b. over that age but is of insufficient maturity or does not have the mental capacity to understand the benefits, risks, and social implications of the treatment or operation.

5. The superintendent of a hospital or the person in charge of a hospital in the absence of the superintendent, shall consent to the medical treatment or surgical operation on a child if-
   a. the treatment is necessary to preserve the life of the child or to save the child from serious or lasting physical injury or disability; and
   b. the need of the treatment or operation is so urgent that it cannot be deferred for the purposes of obtaining consent that would otherwise have been required.
6. A Children’s Court may consent to the medical treatment or surgical operation on a child if-
   a. the child has been abandoned; or
   b. the parent, guardian or caregiver of the child -
      i. unreasonably refuses to give consent or to assist the child in giving consent;
      ii. is physically or mentally incapable of giving consent or assisting the child in giving consent;
      iii. is deceased; or
      iv. cannot readily be traced.

7. No parent, guardian or caregiver of a child may refuse to assist a child under subsection (2)(b) or withhold consent under subsection (3) by reason only of religious, cultural or other beliefs, unless the parent, guardian or caregiver can show that there is a medically accepted alternative choice to the medical treatment or surgical operation concerned.

Young people’s access to PEP

In Swaziland, young people are legally able to access PEP without parental consent at the age of 12 years and above. The child’s consent is necessary for medical treatment if he/she is 12 years and above and is mature enough to understand the benefits, risks, social, and other implications of the treatment or operation. Such consent, however, must be with the assistance of the parent, guardian or caregiver of the child.

Legislation and policy framework

Section 240 Children’s Protection and Welfare Act 2012 in Swaziland provides the legislative and policy framework for young people to access PEP. There is a policy that specifically enables PEP use in Swaziland. However, it does not deal with the issue of Age of Consent as such the policy must be read in relation to the Children’s Protection and Welfare Act of 2012. The Ministry of Health, Kingdom of Swaziland published the PEP Guidelines 2010.
Chapter Seven: Age of Consent and access to safe abortions and/or postabortion care

There is no specific legislation applicable in Swaziland permitting abortions and there is no policy dealing with postabortion care. Section 15 (5) of the Constitution outlaws abortion all together, except in limited circumstances where continued pregnancy will endanger the life or mental health of the woman or the child, or where the pregnancy has resulted from rape or incest, or unlawful sexual intercourse with a mentally retarded female.

The Age of Consent for lawful abortions (i.e. abortions which fall within the limited exceptions) is 18 years. The consent of both the patient and her parents is required in order to perform a lawful abortion on a person who is under the age of 18 years. This conclusion is based on local counsel’s interpretation of the relevant provisions of the Constitution, the definition of a minor in the Children's Protection and Welfare Act, and General Common Law. It must be emphasised that in the ordinary course, abortion is unlawful according to the Constitution and is only permissible in the limited circumstances set out above.

(The rules on consent to surgical operations and medical treatment are contained in section 239 of the Children’s Protection and Welfare Act. However, local counsel’s interpretation of section 239 is that these rules only apply to acts which are ordinarily lawful. These rules do not apply to abortion because abortion is, in the first instance, an illegal act.)

Legislation and policy framework

The Constitution of Swaziland Act of 2005 addresses issues on abortion:

Section 15 (5) of the Constitution of Swaziland provides as follows; Abortion is unlawful but may be allowed - (a) on medical or therapeutic grounds including where a doctor certifies that - (i) continued pregnancy will endanger the life or constitute a serious threat to the physical health of the woman; (ii) continued pregnancy will constitute a serious threat to the mental health of the woman; (iii) there is serious risk that the child will suffer from a physical or mental defect of such a nature that the child will be irreparably and seriously handicapped; (b) where the pregnancy resulted from rape or incest, or unlawful sexual intercourse with a mentally retarded female; or (c) on such other grounds as Parliament may prescribe.

Section 2 of the Children’s Protection and Welfare Act of 2012:

A ‘minor’ is a person under the age of 18 years.

General Common Law - A minor must obtain the consent of their parent or guardian in order to validly enter into a contract (including a medical contract).

Section 239 of the Children’s Protection and Welfare Act 2012 as stated in Chapter 6.
Chapter Eight: Age of Consent on access to Antenatal Care (ANC)

The research could not identify specific policy framework or legislation enabling or disenabling access to ANC, nonetheless, having regards to the provisions of the Girls and Women’s Protection Act of 1920, it is only a girl above the age of 16 years that can consent to sexual intercourse. Consequently, ANC with or without parental consent can be accessed by a minor aged 16 years or above. In the event that a child under the age of 16 may become pregnant, any ANC would have to be with the consent of her parents and or guardian. However, local counsel notes that contraceptives may be accessed by children without parental consent.

There is an inconsistency with the law as the Children’s Protection and Welfare Act provides that the Age of Consent is 12 years of age but the Girls and Women’s Protection Act provides for the Age of Consent to be 16 years of age as stated above. The rules in the Child Protection and Welfare Act differ between medical treatment and surgical treatment.

Legislation and policy framework

There is no specific legislation or policy framework on ANC in the country. The Age of Consent for females is contained in the Girls’ and Women’s Protection Act 1920, Section 3(1) (see Chapter One above). The Age of Consent to medical treatment is contained in the Children’s Protection Act 2012, Section 239.
Chapter Nine: Age of Consent and access to HPV vaccines and cervical cancer screening and treatment

The research did not identify any policies specifically to enable access to the Human Papillomavirus (HPV) vaccine or cervical screening. HPV vaccines and cervical cancer screening constitute medical treatment and, therefore, can only be dispensed with in accordance with the Children’s Protection and Welfare Act of 2012.

Legislation and policy framework

*Children’s Protection and Welfare Act 2012, s 239.* (See sections on PEP and safe abortions)
Chapter Ten: Legislature and policy inconsistencies

The study noted a number of discrepancies in the national legislation in relation to Age of Consent.

The study noted that the Girls’ and Women’s Protection Act 1920 provides that the Age of Consent to sexual intercourse is 16 years of age for females. The Children’s Protection Act of 2012 provides that a person will become a major at the age of 18 years. On the other hand, Section 240 of the Children’s Protection Act provides that an HIV test may done on a child aged 12 years or older without parental consent and further that a child of any age may give its consent to reproductive healthcare.

The discrepancies can be viewed in that and it may well be that Law Reform is needed to align all these pieces of legislation. Furthermore, specific healthcare policies that are readily accessible to all need to be put in place for the sake of certainty.
## Chapter Eleven: Recommended intervention on legal and policy framework

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<thead>
<tr>
<th>Area</th>
<th>Category of regulation</th>
<th>Required intervention</th>
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<tr>
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<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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<td>Exceptions on Age of Consent - For example ‘gay sex’</td>
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<td>LR</td>
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<td>Young people’s access to contraceptive services</td>
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<td>LR MP</td>
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<td>Government To Implement New Policy</td>
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<tr>
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<td>LR</td>
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<tr>
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<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>LR</td>
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<tr>
<td>Addressing various policy and legislation inconsistencies</td>
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<td>LR</td>
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</tbody>
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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 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 if it 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 the status to her/his parents?
18. Please explain any inconsistencies between the answers above.