FOREWORD

There is one barrier to health access and a major impediment to national and regional development across the globe that could be removed within a few days if only the policy decisions would be made. The removal of this barrier would promote gender equality, help end child marriage, reduce teenage pregnancy and girl dropout rates from secondary school, lower HIV incidence rates, and achieve the prerequisite for the demographic dividend. Let me explain.

As the Sustainable Development Goals (SDGs) become the world’s compass towards development and a better life for all people on the planet, sub-Saharan Africa faces a potential demographic disaster that could undermine many of the SDGs.

Many sub-Saharan countries have some of the highest fertility rates in the world which, if unaltered, will see those countries’ population, rising from 17 million to 43 million by 2050. Another country’s population that is currently at 27 million will more than double to 65 million by 2050, with yet another going from 53 million to 137 million. Not one of these countries will have reached the population turnaround required as an inescapable prerequisite for achieving a demographic dividend by 2050.

With increases like these on the same available land area, with the same or less access to drinking water, potentially less arable land available due to global warming, and services and GDP increasing at a far slower rate than population, it will be impossible to achieve the SDGs and improbable to even maintain the human development index achieved thus far by 2017. These are not scenarios or ‘maybes’. This is the inevitable future of the region unless something significant, such as the fertility rates, changes. Slowing and reversing population acceleration is essential to development in sub-Saharan Africa.

And yet, the world has a dark and shameful history of ‘population control’, legislating women’s rights to decide on having children away and forcing and coercing sterilisation. These restrictions on agency and autonomy have no place in a democratic, sustainable development world in the 21st century and the vast majority of nations achieving the demographic dividend have not resorted to such dark methods.

Increasing gender equality, keeping girls in safe schools for longer, reducing sexual and gender based violence, and increasing the sexual and reproductive health knowledge of young people are also factors. And of course, it is the increased access to modern contraceptives and women making choices about their own reproductive health that have turned the tide.

So this research report turns its attention to this access to modern contraceptive methods, as well as all other sexual and reproductive health (SRH) services. There are many barriers for adolescents around the globe - the majority of citizens in many countries – to access SRH services. Distance from services, lack of transport, lack of available commodities, poverty, inherited beliefs, harmful practices, and hostile staff attitudes can all be barriers to access. But only one barrier is self-inflicted by countries. And this barrier could disappear tomorrow, creating massive access for adolescents. It is the barrier of legal restrictions on adolescents’ access to SRH. The majority of countries in the region have placed arbitrary legal barriers to adolescent access by creating policies or laws with a number of parental consent and other restrictions, preventing adolescents from initiating their own healthcare.

In some cases, these have been gradually added to laws or policies with well-intentioned reasons to protect adolescents. In many cases, however, they reflect an idealised view of what older people think younger people should or should not be doing. Primarily, these idealised views revolve around sex. Older people, sometimes forgetting their own youth, think that the best protection for younger people is to abstain from sex until they are, perhaps 16, or even 18. Reality is, in many cases different, and by ignoring reality and locking adolescents out of the health system when it comes to sexual and reproductive health and rights (SRHR), adults are doing irreparable damage to their children and other children, as well as directly contributing to a looming demographic disaster for their nation.
Because this seems so obvious, recent global guidelines have called on countries to examine their current policies and consider revising them to reduce age-related barriers to access and uptake of all SRH services. To assist in this process, the SRHR Africa Trust (SAT) in collaboration with the Thomson Reuters Foundation, 20 global law firms, and UNICEF, has reviewed Age of Consent laws in 22 countries: Botswana, Kenya, Ivory Coast, Malawi, Morocco, Nigeria, South Africa, Swaziland, Tanzania, Zambia, Zimbabwe, Brazil, Jamaica, India, Indonesia, Thailand, Vietnam, Canada, United Kingdom, France, Sweden, and Ukraine. The range of countries was chosen to highlight a spread of geography, cultures, development status, nonachievement, in-transition and achievement of the demographic dividend, and adolescent health outcomes. In addition, SAT and UNICEF also undertook an Ethical, Cultural and Social review in nine countries (seven being from the 22 countries above, plus two others - Uganda and Philippines) to look at ethical cultural and social barriers impacting adolescent access to health and services including SRH services.

The data revealed some game-changing recommendations apparent to SAT:

1. Desexualise SRHR services and treat them as you would any other health system access;
2. Base both access and restriction decisions on child and adolescent development, competence and maturity to make decisions about their own health;
3. Do not make the age of sexual consent older than 16 years, and do not distinguish between young men and young women;
4. Have statutory rape provisions in place to protect adolescents from predatory adults;
5. Put ‘close in age’ exceptions to the age of sexual consent in place so that young adolescents having consensual sex with one another do not have to go to jail – a travesty affecting young men aged 13-16 years.

We offer this report and its insights to policymakers, legislators, development agencies, international cooperating partners, and activists wherever they may be. A thinking and action tool is currently being designed to accompany this report. If you wish to receive it or an electronic copy of this report, please send an e-mail to ageofconsent@satregional.org. Please also feel free to share ways in which you may have used this report or the action tool to create positive change with us and with one another.

Our hope is that these resources will create dialogue and action that will remove all legal barriers to adolescent access to SRH services and allow attention and resources to focus on the remaining and more intractable barriers.

Jonathan Gunthorp

Executive Director - SAT
ACKNOWLEDGEMENT

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

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

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

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

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

This legal review report and the information it contains is provided for general informational purposes only.

It has been prepared as a work of comparative legal review only and does not represent legal advice in respect of the laws of Sweden. It does not purport to be complete or apply to any particular factual or legal circumstances. It does not constitute, and must not be relied or acted upon as legal advice or create an attorney-client relationship with any person or entity.

Neither White and Case Law Firm, the SRHR Africa Trust, nor the Thomson Reuters Foundation accept responsibility for losses that may arise from reliance upon the information contained in this review note or any inaccuracies therein, including changes in the law since the review commenced in February 2016. Legal advice should be obtained from legal counsel qualified in the relevant jurisdiction(s) when dealing with specific circumstances.

Neither White and Case Law Firm, nor any of the lawyers at White and Case, the SRHR Africa Trust, nor the Thomson Reuters Foundation is holding itself, himself or herself out as being qualified to provide legal advice in respect of any jurisdiction as a result of his or her participation in or contributions to this legal review report.
SWEDEN

AGE OF CONSENT
LEGAL REVIEW
## ACRONYMS

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

FOREWORD i
ACKNOWLEDGEMENT iii
DISCLAIMER iv
ACRONYMS vi
EXECUTIVE SUMMARY viii

Chapter One: Introduction 1
Chapter Two: Age of Consent to sexual intercourse 3
Chapter Three: Age of Consent and access to contraception services and commodities 5
Chapter Four: Age of Consent and HIV testing 6
Chapter Five: Age of Consent and access to Antiretroviral Therapy (ART) 7
Chapter Six: Age of Consent and access to Pre-exposure Prophylaxis (PrEP) and Post-exposure Prophylaxis (PEP) 8
Chapter Seven: Age of Consent and access to safe abortions and/or postabortion care 9
Chapter Eight: Age of Consent on access to Antenatal Care 10
Chapter Nine: Recommended intervention on legal and policy framework 11
Annex 12
EXECUTIVE SUMMARY

The age of Consent to sexual intercourse is 15 years in general but if the victim is the perpetrator’s offspring or has a comparable relationship with the perpetrator, the age of Consent is 18 years. Sexual intercourse with a person under the age of 15 years is illegal. An exception, however, exists if the circumstances in which the sexual act took place indicate that the minor was not abused e.g., only a slight age difference.

There is no express prohibition for young people to access contraceptives and there are no age restrictions that require young persons to obtain parental consent. There is guidance, however, that indicates that a young person’s parents may be informed of the fact that their child has received a prescription for contraceptives.

Sweden recognises views of children 12 years and older and these are taken into account as to whether the parents are informed. The more mature the child, the more influence it should have over the decision.

Access to Antiretroviral for HIV is by the Swedish Medical Products Agency. The recommendation lists specific ages and disease severity as factors on when to prescribe which kind of ART treatment. Age is not a relevant factor when deciding on child or adolescent access to treatment. The decision to treat a young person without parental consent is a judgement call of the attending physician.

The Swedish Abortion Act enables the right to safe abortions. There is no age limit and the decision to perform an abortion without the parental consent of a young person is primarily a judgement call of the doctor as per the general rule on public health guidelines.

There is no policy or legislation dealing with Antenatal Care (ANC). The decision to treat a minor without parental consent is the decision of the attending physician.

Treatment policies enable access to PEP. They do not deal with the Age of Consent. Although there is no legal instrument prohibiting Pre-exposure Prophylaxis access (PrEP) PrEP is effectively limited.

The Human Papillomavirus (HPV) vaccine is offered to girls aged 11-12 years through the school health system. Parental consent is required. Swedish Law for Communicable Disease Control, governs access to the HPV vaccine is part of the Swedish National Immunisation Programme. Girls aged 11-12 years will be offered the vaccine through the school health system. The parents need to give their consent to the vaccination.
Chapter One: Introduction

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

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

Research conducted in many parts of the world shows that several legal and human rights barriers hinder access to, and uptake of, HIV services for adolescents. Key among these barriers are Age of Consent legislation and policies. Recent global guidelines have, therefore, explicitly called on countries to examine their current policies and consider revising them to reduce age-related barriers to access and uptake of the overall SRH services, HIV Counselling and Testing (HCT) and 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 Sweden legal review was prepared by SAT and is based on research conducted by White and Case Law Firm in Sweden. The legal review focuses on the laws and policy support around the Age of Consent in relation to the various aspects relating to SRHR. The review looks at all the relevant national laws (including nationally recognised customary or religious laws), regulations, and policies exploring the ages for girls and boys separately, where relevant, including where contradictions in laws, policies, and regulations on these issues exist.

The review specifically looked at the following:

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

The Age of Consent to sexual intercourse is 15 years in general but if the victim is the perpetrator’s offspring or has a comparable relationship with the perpetrator the Age of Consent is 18 years.

However, there is an exception if it is obvious that the act did not involve any abuse of the child in view of the slight difference in age and development between the person who committed the act and the child and the circumstances in general.

Legislation and policy framework on Age on Consent to sexual intercourse

The Swedish Penal Code (1962:700) Chapter 6, Sections 4, 5 and 14:

Section 4: A person who has sexual intercourse with a child under fifteen years of age or who with such a child carries out another sexual act that, in view of the seriousness of the violation, is comparable to sexual intercourse, shall be sentenced for rape of a child to imprisonment for at least two and at most six years.

This also applies to a person who commits an act referred to in the first paragraph against a child who has attained the age of fifteen but not eighteen and who is the perpetrator’s offspring or is being brought up by or has a comparable relationship with the perpetrator, or for whose care or supervision the perpetrator is responsible by decision of a public authority.

If a crime referred to in the first or second paragraph is considered gross, a sentence to imprisonment for at least four and at most ten years shall be imposed for gross rape of a child. In assessing whether the crime is gross, special consideration shall be given to whether the perpetrator used violence or the threat of a criminal act or whether more than one person assaulted the child or in any other way took part in the assault or whether the perpetrator, in view of the method used or the child’s young age or otherwise, exhibited particular ruthlessness or brutality.

Section 5: If, in view of the circumstances associated with the crime, a crime provided for in Section 4 first or second paragraph is considered less serious, a sentence to imprisonment for at most four years shall be imposed for sexual exploitation of a child.

Definition of statutory rape

Sexual intercourse or another sexual act that, in view of the seriousness of the violation is comparable with intercourse, with a child under 15 years, is illegal (i.e. amounts to statutory rape).

Legislation and policy framework on statutory rape

See part on Section 4 of the The Swedish Penal Code (1962:700) Chapter 6 described above.

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

A person who has committed an act shall not be held criminally responsible if it is obvious that the act did not involve any abuse of the child in view of the slight difference in age and development between the person who committed the act and the child and the circumstances in general.
Legislation and policy framework

The Swedish Penal Code (1962:700) Chapter 6, Section 14:

A person who has committed an act under Section 5 or Section 6 first paragraph against a child under fifteen years of age or under Section 8 first paragraph or Section 10 first paragraph shall not be held criminally responsible if it is obvious that the act did not involve any abuse of the child in view of the slight difference in age and development between the person who committed the act and the child and the circumstances in general.

This also applies to a person who has committed an act under Section 10a if it has aimed at an act referred to in the first paragraph which, if it had been completed, in line with what is stated there obviously would not have involved any abuse of the child.
Chapter Three: Age of Consent and access to contraception services and commodities

There is no expressed prohibition for young people to access contraceptives and there are no age restrictions that require young people to obtain parental consent. There is guidance, however, that indicates that a young person’s parents may be informed of the fact that their child has received a prescription for contraceptives.

The Swedish Parliamentary Ombudsman has in one case stated that it does not seem reasonable to demand that the parents are informed if a 17-year-old girl is asking for a prescription for contraceptives. Further, the Ombudsman stated that in the case of a 13-year-old girl, it may be appropriate to inform the parents that their daughter has received a prescription for contraceptives. But the Ombudsman concluded that it should ultimately be an individual test and there may be valid reasons for not informing the parents even when the girl is as young as 13 years.

Legislation and policy framework on accessing contraceptives

The Swedish Parliamentary Ombudsman (sw. Justitieombudsmannen, JO), JO:s ämbetsberättelse 1992/93 s. 439 f. [Not available online and only available in Swedish]

A decision by the Parliamentary Ombudsman is not legally binding but in practice their decisions are in most cases adhered to.

Young people’s access to emergency contraceptives

Emergency contraceptives are available to buy over the counter at pharmacies, at sexual health clinics or prescribed by a doctor. There is no prohibition for young people to access emergency contraceptives at pharmacies and there are no age restrictions that require them to obtain parental consent. When emergency contraceptives are provided by a doctor, the general rule as described below applies.

General rule: There is in no age prohibition to access prescriptions or medical treatments, it is primarily a judgement call of the doctor as to whether he/she will treat a young person without parental consent. Current policy regarding patient confidentiality prescribes that the child’s view shall be taken into account from 12 years of age (and the more mature and developed the child is, the more influence it should have over the decision as to whether the parents should be informed).

Legislation and policy framework on access to emergency contraceptives

Chapter Four: Age of Consent and HIV testing

Sweden does not have a specific regulation for Age of Consent for young people to access HIV testing without parental consent and for reporting the HIV status directly to an adolescent. However, the general rule as described below applies.

General rule: There is in no age prohibition to access prescriptions or medical treatments, it is primarily a judgement call of the doctor as to whether he/she will treat a young person without parental consent. Current policy regarding patient confidentiality prescribes that the child’s view shall be taken into account from 12 years of age (and the more mature and developed the child is, the more influence it should have over the decision as to whether the parents should be informed).

Government is working on passing new regulations to address the policy and legislation gaps on access to HIV testing.
Chapter Five: Age of Consent and access to Antiretroviral Therapy (ART)

Recommendation regarding use of ART to treat HIV has been issued by the Swedish Medical Products Agency. The recommendation lists specific ages and disease severity as factors on when to prescribe which kind of ART treatment. Age is not a relevant factor when deciding on child or adolescent access to treatment per se.

There is no express prohibition on medical treatment of young people without parental consent, please see the general rule described in Chapter Four.

Legislation and policy framework

The Swedish Medical Products Agency recommendation 3:2011 on antiretroviral treatment on HIV-infections available at:

https://lakemedelsverket.se/upload/halso-och-sjukvard/behandlingsrekommendationer/110518_Antiretroviral%20behandling%20av%20HIV-infektion%20uppdaterad%20rekommendation_bokm%C3%A4rken.pdf [Only in Swedish]

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

Pre-exposure Prophylaxis (PrEP)

Sweden has a prohibition to Pre-exposure Prophylaxis (PrEP), although not supported by a legal instrument, the prohibition limits access to PrEP. The medication available in the EU, truvada, is currently only approved for treatment after HIV infection. The Public Health Agency of Sweden (sw. Folkhälsomyndigheten), issued a statement regarding PrEP in relation to truvada noting that use of the medication for preventive treatment is not approved within the EU. Therefore, the agency does not recommend that truvada be prescribed as a preventive HIV treatment. It can also be noted that preventive treatments are in general not covered by the medical insurance in Sweden.

Legislation and policy framework


If truvada were to be authorised for PreP, the Swedish council’s preliminary assessment is that it would be available for young people in accordance with the general rule described in Chapter Three on access to contraception. However, we cannot know for certain until it becomes authorised.

Post-exposure Prophylaxis (PEP)

Sweden does not have any prohibition, legislation or specific policy framework on Post-exposure Prophylaxis (PEP). Under the Swedish Law for Communicable Disease Control Chapter 1, Section 4, all measures concerning children shall pay particular attention to what is in the best interest of the child.

There is no express prohibition on medical treatment of young people without parental consent, so young people can access PEP without parental consent, subject to the general rule described above.

Legislation and policy framework

The Swedish Law for Communicable Disease Control (2004:168) Chapter 1, Section 4:

Measures to prevent communicable diseases shall be based on science and proven results and shall not be more far-reaching than what can be justified with respect to the threat to peoples’ health. The measures shall be taken with respect to all humans equal value and the individuals personal integrity. Measures that involves children shall pay particular attention to what is in the best interest of the child. Measures that an individual is opposing shall only be carried out if no other means are at hand.

PEP treatment is handled under treatment policies issued by various County councils, it is standard procedure to offer PEP to a person within 4-36 hours after being exposed to HIV via needles or intercourse. The policies do not deal with ages of consent (please see the answer to question 8 for the discussion on the age of consent to access PEP).

Treatment policy issued by the county council of Västerbotten regarding HIV-Postexpositionsprofylaxm (PEP) 2014-03-20 available at:

https://www.vll.se/Sve/Centralt/Standardsidor/V%c3%a5rdOchH%c3%a4lsa/Smittskydd/Nedladdningsboxar/Filer/PEP%20HIV%20basmall%20platina.pdf [only in Swedish].
Chapter Seven: Age of Consent and access to safe abortions and/or postabortion care

The Swedish Abortion Act enables the right to safe abortions. There is no age limit and the decision whether to perform an abortion without the parental consent for a young person is primarily a judgement call of the doctor as per the general rule described above.

Current policy regarding patient confidentiality prescribes that the child’s view shall be taken into account from 12 years of age (and the more mature and developed the child is, the more influence it should have over the decision whether the parents should be informed) as per the general rule described in Chapter Four.

Under regulations issued by the National board of Health and Welfare, every care centre shall have internal guidelines on informing the parents and/or the Board of Social Welfare in abortion cases where the patient is under 18 years. These guidelines supersede the general rule, however, the guidelines Swedish counsel have reviewed state that it is a judgement call where age, maturity, as well as other factors should be taken into account (i.e. similar to the general position for medical treatment) indicating that it is unlikely that there would be any conflict between the two.

Legislation and policy framework

*The Swedish Abortion Act (1975:595) Section 1:*

If a woman demands that her pregnancy shall be terminated, an abortion may performed, if the measures will be carried out before the end of the eighteenth week of the pregnancy and if such measures do not pose a serious threat to the life or health of the woman.

*The National Board of Health and Welfare administrative provisions and general guidelines on abortion (SOSFS 2009:15) Chapter 3, Section 3-4.*

**Women under 18 years**

The healthcare provider is responsible for establishing guidelines on how to evaluate if information shall be provided to the guardians when the women demanding the abortion is under 18 years.

The healthcare provider is responsible for establishing guidelines on how to evaluate if the board of Social Welfare should be notified when the woman demanding the abortion is under 18 years.
Chapter Eight: Age of Consent on access to Antenatal Care (ANC)

Under the Swedish Health and Medical Services Act and government policy, all women have the right to access free Antenatal Care (ANC). There are no age restrictions and young people of any age can access ANC without parental consent subject to the general rule described in Chapter Four. ANC for asylum seekers and illegal immigrants is covered under the Health and Medical Services Act for asylum seekers and the Health and Medical Services Care Act for aliens residing in Sweden without necessary permits. There are no specific provisions for young people.

Health and Medical Services Act (1982:763), Section 3, states that:

Every County council shall offer health and medical services to the persons residing within the area of the County council.

Kunskapsstöd för mödrahälsovården
(available in Swedish at: http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/19328/2014-2-2.pdf)

This is a policy issued by the Swedish National Board of Health and Welfare wherein it is stated that free healthcare pursuant to the Swedish Health and Medical Services Act includes Antenatal Care.
Chapter Nine: Recommended intervention on legal and policy framework

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