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
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UNITED KINGDOM

AGE OF CONSENT
LEGAL, ETHICAL, CULTURAL AND SOCIAL REVIEW
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EXECUTIVE SUMMARY

The Age of Consent to sexual intercourse is 16 years, although if one of the participants is under 16 years of age the impact of the criminal law differs depending on the precise age of the minor. Distinct provisions exist for those affected and are under 13 years and those 13-15 years of age. Sexual intercourse with a person who is under 13 years of age amounts to statutory rape. Sex with a minor aged 13-15 years is illegal if the defendant knew or should have known the minor was underage. However, in practice, consensual sex between minors of the same or similar age are unlikely to be prosecuted.

There are no age restrictions to access contraceptives that are a form of barrier method. The general rule on Age of Consent to medical treatment applies to doctors. Pharmacists have similar rules and are discouraged from supplying persons under 13 years.

Clinical use of Ante-retroviral Therapy (ART) for young persons is set out in Guidelines which are referred to by a Government body. The general rule on Age of Consent to medical treatment applies.

There is no prohibition on Post-exposure Prophylaxis (PEP). The Age of Consent to medical treatment is 16 years. Parental consent is required to medically treat persons under 16 years of age unless the patient has the capacity to consent on his/her own behalf. In addition United Kingdom has various policy guidelines enabling access to PEP.

There is no prohibition on Pre-exposure Prophylaxis (PrEP), young people can access PrEP subject to the rules Age of Consent for medical treatment. PrEP will be administered to a minor without parental consent if the patient has capacity to consent. However, PrEP is currently only available through a private prescription.

Abortion is permitted by law and there is no statutory age limit for abortion. The principles for assessing minors’ ability to seek advice and give valid consent to medical treatment applies.

Guidelines enable access to Antenatal Care (ANC) encompass any medical and/or social interventions that are designed to improve women’s experience of pregnancy and birth, or prepare women for motherhood.

The Human Papilloma Virus (HPV) vaccine and cervical screening both constitute medical treatments and a minor’s ability to access these treatments will be subject to the general rules on capacity to consent to medical treatment. The HPV vaccine is routinely offered to girls aged 12 to 13 years in school year 8.

A minor’s ability to access HIV testing services is subject to the individual’s capacity to consent. The general rule on Age of Consent to medical treatment applies. Test results are reported to the parents of patients under 16 years of age if the parents consented to the testing on the patient’s behalf.
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 United Kingdom legal, ethical, cultural and social review was prepared by SAT and is based on legal research conducted by Arnold & Porter Kaye Scholer LLP and the ethical, cultural and social review by Jerome Amir Singh, Centre for the AIDS Programme of Research in South Africa (CAPRISA), Durban, South Africa, and Dalla Lana School of Public Health, University of Toronto, Toronto, Canada.

The ethical, cultural and social review focuses on the norms and practices around the Age of Consent in relation to the various aspects relating to SRHR. The legal 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.

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 16 years, although if one of the participants is under 16 years of age (hereinafter treated as a ‘minor’) the impact of the criminal law differs depending on the precise age of the minor. Distinct provisions exist for ‘victims’ under 13 years and those 13-15 years of age.

“Victims” under 13 years - Statutory position
Sexual intercourse, and any form of sexual touching, with a minor under 13 years by a person of any age is illegal in any circumstances (i.e. amounts to ‘statutory rape’).

“Victims” under 13 years - penalties and prosecution guidance
The age and understanding of both parties will be taken into account in determining whether prosecution for an offence is in the public interest, and in determining the appropriate penalty. Where the victim is under 13 years, a prosecution normally results.

“Victims” aged between 13 and 15 years - statutory position
Sexual intercourse, and any form of sexual touching, with a minor aged between 13 and 15 years is illegal unless the defendant reasonably believes the victim is 16 years or over and the victim consented. Accordingly sex with a consenting individual who the defendant knows to be aged between 13 and 15 years could also be considered ‘statutory rape.’

“Victims” aged between 13 and 15 years - penalties
The penalties for sexual activity with a minor aged between 13 years and 15 years differ depending on whether the defendant is under or over 18 years. Where the defendant is over 18 years the maximum penalty is 14 years imprisonment; if the defendant is under 18 years, the penalty is a maximum of 5 years’ imprisonment.

“Victims” aged between 13 and 15 years - prosecution guidance
The UK’s prosecuting guidelines state that it is unlikely to be in the public interest to prosecute minors who are of the same or similar age and who engage in consensual sexual activity between the ages of 13 and 15 years.

Legislation and policy framework

Sexual Offences Act 2003
Section 5 Rape of a child under 13 years
1. A person commits an offence if—
   a. he intentionally penetrates the vagina, anus or mouth of another person with his penis, and
   b. the other person is under 13 years.

Section 6 Assault of a child under 13 years by penetration
1. A person commits an offence if—
   a. he intentionally penetrates the vagina or anus of another person with a part of his body or anything else,
   b. the penetration is sexual, and
   c. the other person is under 13 years.

Section 7 Sexual assault of a child under 13 years
1. A person commits an offence if—
   a. he intentionally touches another person,
   b. the touching is sexual, and
   c. the other person is under 13 years.
s.8 Causing or inciting a child under 13 years to engage in sexual activity
1. A person commits an offence if—
   a. he intentionally causes or incites another person (B) to engage in an activity,
   b. the activity is sexual, and
   c. B is under 13 years.


Code for Crown Prosecutors - Adult defendant
A prosecution will usually take place unless there are public interest factors tending against prosecution which outweigh those tending in favour. Given the seriousness of these offences, where the defendant is an adult, notwithstanding the wide nature of the activity in sections 5-8, a prosecution will normally be required.

Code for Crown Prosecutors - Child defendant (under 18 year)
The overriding public concern is to protect children. It was not Parliament’s intention to punish children unnecessarily or for the criminal law to intervene where it is wholly inappropriate. During the passage of the bill, Lord Falconer said: “Our overriding concern is to protect children, not to punish them unnecessarily. Where sexual relationships between minors are not abusive, prosecuting either or both children is highly unlikely to be in the public interest. Nor would it be in the best interests of the child …”

Section 9 Sexual activity with a child
1. A person aged 18 years or over (A) commits an offence if—
   a. he intentionally touches another person (B),
   b. the touching is sexual, and
   c. either—
      i. B is under 16 years and A does not reasonably believe that B is 16 years or over, or
      ii. B is under 13 years.

2. A person guilty of an offence under this section, if the touching involved—
   a. penetration of B’s anus or vagina with a part of A’s body or anything else,
   b. penetration of B’s mouth with A’s penis,
   c. penetration of A’s anus or vagina with a part of B’s body, or
   d. penetration of A’s mouth with B’s penis, is liable, on conviction on indictment, to imprisonment for a term not exceeding 14 years.

3. Unless subsection (2) applies, a person guilty of an offence under this section is liable—
   a. on summary conviction, to imprisonment for a term not exceeding 6 months or to a fine not exceeding the statutory maximum or both;
   b. on conviction on indictment, to imprisonment for a term not exceeding 14 years.

Section 13 Child sex offences committed by children or young persons
1. A person under 18 commits an offence if he does anything which would be an offence under any of sections 9 to 12 years if he were aged 18 years.

2. A person guilty of an offence under this section is liable—
   a. on summary conviction, to imprisonment for a term not exceeding 6 months or a fine not exceeding the statutory maximum or both;
   b. on conviction on indictment, to imprisonment for a term not exceeding 5 years.

It is not in the public interest to prosecute children who are of the same or similar age and understanding that engage in sexual activity, where the activity is truly consensual for both parties and there are no aggravating features, such as coercion or corruption. In such cases, protection will normally be best achieved by providing education for the children and young people and providing them and their families with access to advisory and counselling services. This is the intention of Parliament.

See above section on Age of Consent to sexual intercourse.
Chapter Three: Access to contraception services and commodities

There are no age restrictions on access to contraceptive commodities that are a form of barrier method e.g., condoms. These are available over-the-counter. Contraceptive services which are a form of medical treatment and available either on prescription or, in some cases, from pharmacists direct without the intervention of a doctor such as the Pill, are subject to the same rules on Age of Consent as general medical treatment.

All medical treatment requires appropriate consent. From the age of 16 years, individuals are presumed to have capacity to give consent unless proven otherwise.

Access to medical treatment without parental consent

A person aged 16 or 17 years can access contraceptive services that are a form of medical treatment without parental consent unless there is significant evidence to indicate that they lack capacity to decide on their own medical treatment.

A minor will have capacity to consent to medical treatment on his/her own behalf if he or she has a sufficient understanding and intelligence to enable him or her to understand fully what is proposed and the risks and benefits of treatment. If a minor lacks the capacity to consent, a doctor will usually rely on his or her parent to give consent on his or her behalf as described below.

A person aged under 16 years can be provided with contraceptive services without parental consent provided:

a. they understand all aspects of the advice provided by the doctor and its implications
b. they cannot be persuaded to tell their parents or to allow them to be told
c. the minor is very likely to have sex with or without such treatment
d. their physical or mental health is likely to suffer unless they receive such advice or treatment, and
e. it is in the best interests of the young person to receive the advice and treatment without parental knowledge or consent.

Access to medical treatment with parental consent

A minor may access contraceptive services that are a form of medical treatment with parental consent at any age, provided the treatment is medically appropriate. Decisions involving persons aged 16 or 17 years who lack the capacity to consent can be taken by their parents or, where their parents do not consent, made by doctors in accordance with the patient’s best interests, taking into account the views of the parents.

The best interests of patients who lack capacity to consent

Decisions involving persons aged 18 years or over who lack the capacity to consent are taken by doctors in accordance with the patient’s best interests. If there is any disagreement or uncertainty as to what action should be taken in a patient’s best interests, doctors or other concerned individuals may apply to the courts for an independent ruling. The same approach is taken when parents and doctors disagree about what is in the best interests of a minor who does not have capacity to consent. An example of such a case considered by the courts is described in the section on Access to ART.
Legislation and policy framework

**Family Law Reform Act 1969**, Section 8(1):
The consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, shall be as effective as it would be if he were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian.

**Mental Capacity Act 2005**, Section 1(2), 1(5) and 2(5):
A person must be assumed to have capacity unless it is established that he lacks capacity. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.

No power which a person ('D') may exercise under this Act—

a. in relation to a person who lacks capacity, or
b. where D reasonably thinks that a person lacks capacity,
is exercisable in relation to a person under 16 years.

Case Law

**Decision of the UK House of Lords in Gillick v West Norfolk and Wisbech AHA and anr [1986] AC 112:**
Lord Scarman made the following comments about consent to medical treatment in general:

"[...] as a matter of law the parental right to determine whether or not their minor child under the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed. It will be a question of fact whether a child seeking advice has sufficient understanding of what is involved to give a consent valid in law."

A child under the age of 16 years who demonstrates “sufficient understanding” is said to be “Gillick competent”.

Lord Fraser addressed the specific question of consent to receive contraceptive medications: "The doctor will, in my opinion, be justified in proceeding without the parents’ consent or even knowledge provided he is satisfied on the following matters: (1) that the girl (although under 16 years of age) will understand his advice; (2) that he cannot persuade her to inform her parents or to allow him to inform the parents that she is seeking contraceptive advice; (3) that she is very likely to begin or to continue having sexual intercourse with or without contraceptive treatment; (4) that unless she receives contraceptive advice or treatment her physical or mental health or both are likely to suffer; (5) that her best interests require him to give her contraceptive advice, treatment or both without the parental consent."

**GMC 0-18 years guidance: Children and young people who lack capacity to consent**

27. If a child lacks the capacity to consent, you should ask for their parent’s consent. It is usually sufficient to have consent from one parent. If parents cannot agree and disputes cannot be resolved informally, you should seek legal advice about whether you should apply to the court.

28. The legal framework for the treatment of 16 and 17-year-olds who lack capacity to consent differs across the UK:
   a. In England, Wales and Northern Ireland, parents can consent to investigations and treatment that are in the young person’s best interests.
   b. In United Kingdom, treatment can also be provided in the young person’s best interests without parental consent, although the views of parents may be important in assessing the young person’s best interests.
GMC Consent guidance: Resolving disagreements

77. You should aim to reach consensus about a patient’s treatment and care, allowing enough time for discussions with those who have an interest in the patient’s welfare. Sometimes disagreements arise between members of the healthcare team and those close to the patient. It is usually possible to resolve them, for example by involving an independent advocate, consulting a more experienced colleague, holding a case conference, or using local mediation services. You should take into account the different decision-making roles and authority of those you consult.

78. If, having taken these steps, there is still significant disagreement, you should seek legal advice on applying to the appropriate court or statutory body for review or for an independent ruling. Patients, those authorised to act for them, and those close to them, should be informed as early as possible of any decision to start such proceedings so that they have the opportunity to participate or be represented.

Re S (A Minor) (Medical Treatment) [1993] 1 FLR 377
The parents of the child were Jehovah’s Witnesses who refused to consent to a transfusion of blood for their son. Their son was likely to die without the transfusion. The court overruled the parent’s objections and endorsed the child’s interest in survival.

Re S (Adult Patient: Sterilisation) [2000] 3 WLR 1288
The judgement refers to situations where it is unclear what should be done to protect the patient’s welfare and states that “... if a particular case lies anywhere near to boundary line it should be referred to the court”.

Access to Emergency contraceptives

A minor can access emergency contraceptives via three routes. These are described in more detail below, but the general rule is that a minor under 16 can be provided with emergency contraception subject to the general rules on capacity to consent to medical treatment without a parent’s consent.

a. Prescribed by a doctor or a specialist contraception or sexual health clinic.
   Access to emergency contraceptives via a doctor or specialist clinic will be subject to the general rules on capacity to consent to medical treatment. Doctors may prescribe any relevant medicinal product, even if it is not regulated as a “prescription-only” medicine.

b. Prescription-only medicine supplied by a pharmacist under a “patient group direction” (PGD)
   A PGD is an agreement that allows pharmacists in a specific area of the UK to supply prescription-only medicines, which would otherwise have to be prescribed by a doctor, to specific groups of patients. Emergency contraceptives are available under PGDs in some areas of England and throughout Wales. The terms of regional PGDs will vary, but typically will provide that emergency contraception should be provided to minors aged between 13 and 16 years provided they meet the general rules on capacity to consent, but not to minors aged under 13 years.

c. Over-the-counter medicine purchased from a pharmacist
   Emergency contraception is available to buy over-the-counter. The Royal Pharmaceutical Society’s guidance on over-the-counter emergency contraceptives states that contraception can be provided to a minor under 16 years and notes that children under the age of 13 years are legally unable to consent to sexual activity, although it does not state that children under 13 years must not be provided with contraception. The guidance refers to further guidance on consent, for example the General Pharmaceutical Council’s guidance, which outlines the general principles relating to consent set out above.
Legislation and policy framework

Guidance produced by the Faculty of Sexual & Reproductive Healthcare, which produces accredited clinical guidance on sexual health issues, confirming the coverage of PGDs in the UK, is available at http://www.fsrh.org/pdfs/FSRH_ECDecisionGuide.pdf


The Royal Pharmaceutical Society’s Guidance on Oral Emergency Contraception, not available online, states:

“You can provide contraception or sexual health advice to a child under 16 years however you may wish to consider the following additional factors:

Children under the age of 13 years are legally too young to consent to any sexual activity. Instances should be treated seriously with a presumption that the case should be reported to social services, unless there are exceptional circumstances backed by documented reasons for not sharing information.”

Chapter Four: Age of Consent and HIV testing

A minor’s ability to access HIV testing services is subject to the individual’s capacity to consent (see Page 7).

Legislation and policy framework

Gillick v West Norfolk and Wisbech AHA and anr [1986] AC 112.

Age of consent to report HIV status directly to adolescents

A minor who has capacity to consent has the same right to confidentiality as any adult patient. A minor who does not have capacity to consent would only be tested for HIV with his/her parents’ consent and they would, therefore, be informed of the test result.

A minor who does not have capacity to consent

We are not aware of any case law that directly addresses the extent to which a minor who lacks capacity to consent is entitled to patient confidentiality. The assumption is that patient/doctor confidentiality applies, subject to disclosure to guardians/parents and others where this is in the patient’s best interests. Current guidelines state that, in the event that the patient does not have capacity to consent, the doctor should disclose information to an appropriate person (usually the parents) if it is in the patient’s best interests.

We note that decisions involving persons 16 years or over who lack the capacity to consent are made in accordance with their best interests. Doctors also have a duty, where practicable, to consult appropriate persons about the patient’s treatment. If such exceptions exist for adult patients who lack competence to consent, then we expect that the law would also recognise exceptions for minors who lack capacity to consent.

A minor who has capacity to consent

A doctor can only disclose information about a competent minor on the same basis as permitted for disclosure of medical information about adult patients. A breach of patient confidentiality can be justified if it is in the public interest. The nature of the information revealed is relevant when judging the balance between private and public interests and it is likely that disclosure of information as sensitive as someone’s HIV status would require very strong justification in order for it to be in the public interest.

Duty to notify

Please note that if a doctor is concerned that sexual activity is occurring as part of or because of situations involving abuse or neglect at home, GMC guidelines place them under a duty to inform responsible authorities (and, in particular, [the doctor does] not need to be certain that the child or young person is at risk of significant harm to take this step).

Based on the above we have speculated as to whether a physician who suspects that a minor has or is about to expose him/herself to a risk of infection (e.g., where the patient seeks Pre-exposure Prophylaxis (PrEP) medication), due to ongoing reckless behaviour (e.g., intravenous drug use), would be under a duty to notify the minor’s parents or a responsible authority.

The GMC guidelines do not state whether the duty to notify arises in relation to competent and/or non-competent minors; nonetheless, we are of the opinion that a breach of patient confidentiality in such circumstances (be they suspected abuse/neglect or reckless behaviour) would only be lawful when it falls into the exceptions described above for competent and non-competent minors.
Legislation and policy framework

*Human Rights Act 1998 Sch. 1 Part I Article 8*

1. Everyone has the right to respect for his private and family life, his home and his correspondence.

*R (Axon) v Secretary of State for Health [2006] EWCA 37:*

Confirmed that:

1. Gillick (see Page 7 above) applies to all decisions about young persons’ treatment and care, including abortion; and
2. Parents have no general right to be informed if their child seeks medical advice and treatment.

*The GMC’s 0-18 years guidance: Disclosures when a child lacks the capacity to consent*

The General Medical Council offers the following guidance:

“Occasionally, children who lack the capacity to consent will share information with you on the understanding that their parents are not informed. You should usually try to persuade the child to involve a parent in such circumstances. If they refuse and you consider it is necessary in the child’s best interests for the information to be shared (for example, to enable a parent to make an important decision, or to provide proper care for the child), you can disclose information to parents or appropriate authorities. You should record your discussions and reasons for sharing the information.”

**GMC, ‘Protecting children and young people: The responsibilities of all doctors’ (2012):**

“You must tell an appropriate agency, such as your local authority children’s services, the NSPCC or the police, promptly if you are concerned that a child or young person is at risk of, or is suffering, abuse or neglect unless it is not in their best interests to do so […] You do not need to be certain that the child or young person is at risk of significant harm to take this step. If a child or young person is at risk of, or is suffering, abuse or neglect, the possible consequences of not sharing relevant information will, in the overwhelming majority of cases, outweigh any harm that sharing your concerns with an appropriate agency might cause.” (para.32)
Chapter Five: Age of Consent and access to Anti-retroviral Therapy (ART)

Availability of ART under the National Health Service: Medicines must have valid marketing authorisations in order to be sold in the UK but the decision to fund a particular medicine under the National Health Service (NHS) in England is usually taken by the National Institute for Clinical Excellence (NICE). NICE’s decisions on cost effectiveness of medicines are legally binding and can be enforced in court.

A number of ART drugs can be marketed in the UK but NICE has not assessed HIV treatments to determine their cost effectiveness. In the absence of any directive from NICE the decision to fund ART is taken by NHS England Commissioning or local NHS trusts. NHS England Commissioning issues policy guidelines about certain treatments that the NHS in England must follow and in practice ART is made available to HIV patients under the NHS. Another factor to bear in mind when considering accessibility is the role that prices play. These are negotiated between the NHS and the companies marketing the medicines and the agreed prices will affect what treatments are offered to patients under the NHS. Treatments that are not available to patients under the NHS can still be prescribed to patients on a private prescription.

Guidelines: The UK Children’s HIV Association (CHIVA) Standards of Care for Infants, Children and Young People with HIV state that management of children with HIV in the UK should be in accordance with the current PENTA Guidelines. Although the CHIVA guidelines are not formally endorsed by the Government, CHIVA is referred to by NICE, a Governmental body responsible for public health guidance, as a source of information for healthcare professionals on treatment of children with HIV.

The PENTA Guidelines recommend ART in children of any age if therapeutically appropriate (e.g. subject to disease severity). Treatment of young people with ARTs will be subject to the general requirements discussed above relating to competence to consent.

The PENTA guidelines recommend the use of some ARTs which are not currently authorised for use in children in the UK. For example, the preferred first line treatment regime for children aged over 12 years is Truvada (tenofovir + emtricitabine) in combination with either atazanavir, darunavir or efavirenz. However, in the EU, Truvada is not licensed for use in patients under 18 years of age. The Guidance for doctors published by the General Medical Council (GMC), the body responsible for maintaining the register of doctors in the UK, permits the use of a medicine outside the terms of its authorisation if necessary to meet the needs of the patient (so called “off-label” supply). The GMC guidance specifically permits the treatment of a child with a medicine authorised only for adults, if necessary to meet the child’s needs. Doctors in the UK are therefore free to follow recommendations to treat children with products only currently authorised for adults, if therapeutically appropriate.

The courts have, in at least one case, found that it was in the best interests of a minor to take ART. The courts were asked to determine whether a 14-year-old boy who was HIV positive was competent to make decisions about his medical treatment and ART specifically. The court decided that because the minor did not accept his HIV diagnosis he lacked an understanding of the consequences of not taking ART medication. He, therefore, also lacked the understanding necessary to consider the pros and cons of the information presented to him. On this basis, the court found that he was not competent to make a decision as to whether he should or should not take ART. The court then considered the medical evidence presented to it as well as the minor’s personal circumstances and declared that it was in the minor’s best interests to start taking ART as soon as possible.
Legislation and policy framework

In order to determine whether a particular HIV treatment is available under the NHS a patient would need to check the policy of the local NHS Trust.


Case Law

An NHS Trust, A Local Authority v Mr A, Mrs A, JA, His Children’s Guardian [2014] EWHC 1135 (Fam)
This case arose because the patient refused to consent to ART due to his fear of side effects from the medication. His parents, who were also HIV positive, supported their son’s decision not to take ART so the responsible healthcare provider applied to the courts for an order allowing them to treat the minor without his or his parent’s consent.
Chapter Six: Age of Consent and access to Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP)

Pre-exposure Prophylaxis (PrEP)

There is no prohibition on Pre-exposure Prophylaxis (PrEP) and it will be administered to a minor without parental consent if the patient has capacity to consent.

Young people’s access to PrEP

PrEP is not currently funded by the National Health Service in England (the ‘NHS’), so it is only available via private prescription. There are no specific restrictions on age of access to PrEP, and treatment of minors will be subject to the general requirements discussed above relating to capacity to consent. However, the cost of private treatment (£400 per 30 day course at one UK clinic) is likely to be prohibitive for many minors. NHS funding for PrEP is being evaluated, in a large scale clinical trial, due to run in 2017 - 2018.

Legislation and policy framework on PrEP

No current policy in place.

Post-Exposure Prophylaxis

There is no prohibition on Post-Exposure Prophylaxis (PEP). Consent considerations are the same—see below. PEP may be administered to a minor without parental consent if the patient has capacity to consent.

Legislation and policy framework on access to PEP

The discussion on the availability of ART on the NHS is also relevant for PEP. There are various policy guidelines enabling access to PEP in the UK:

a. Guidelines published by the Children’s HIV Association (CHIVA) on PEP for children;

b. Guidelines published by the British Association of Sexual Health and HIV (BASHH) on PEP following sexual exposure (PEPSE), and


PEP for children

The CHIVA Guidelines recommend that children are given PEP if there is a high or, in some situations, moderate risk that they have been exposed to HIV. The decision whether to administer PEP is based on an assessment of the risk of exposure and transmission, weighed against the severity of the side effects of treatment.
The CHIVA guidelines envisage the administration of PEP to children of any age (the lowest age bracket specifically considered is ‘under 2’). Although the Guidelines refer to discussing treatment with parents or family, they do not make any recommendation as to when children can be treated without parental consent, and any decision to do so would be subject to the general requirements discussed in above relating to capacity to consent. Where a child presents for PEP following sexual exposure, the BASHH Guidelines on PEPSE (discussed below) should be followed. The CHIVA Guidelines recommend that HIV testing be carried out on presentation and as follow-up - in relation to the disclosure of HIV test results. Although the CHIVA guidelines are not formally endorsed by the Government, they are referred to in the Department of Health guidance on PEP following occupational exposure.

**PEP following sexual exposure (PEPSE)**

The BASHH Guidelines recommend the use of PEPSE where there is a significant risk of HIV transmission, and provide detailed guidance as to the situations in which PEPSE is recommended. The Guidelines state that they are aimed “primarily” at individuals aged 16 years or over, but do not contain any restrictions regarding access to treatment, either with or without parental consent. Given the cross-reference to these guidelines contained in the CHIVA guidelines for children, the information in the PEPSE guidelines is likely to be used to inform the risk assessment and treatment decisions for children under 16 years presenting for PEP following sexual exposure. The BASHH Guidelines are endorsed by NICE, a non-departmental Government body responsible for developing public health guidance.

**PEP for occupational exposure**

The EAGA guidance relates primarily to occupational exposure, which is unlikely to be relevant to treatment of minors. However, the guidance does state that the same considerations apply in relation to non-occupational exposure, for example through sharing drug injecting equipment (see Chapter 5.4).

The guidance provides that healthcare workers should be given PEP if they have had a significant occupational exposure (injury e.g. from needlestick or a bite, exposure of broken skin or exposure of mucous membranes) to blood or another high-risk body fluid (see Chapter 3.1 of the guidance), and the same risk assessment may be applied in the case of non-occupational exposure. The EAGA guidance refers to the CHIVA guidelines in relation to PEP for children. The EAGA is a Departmental Expert Committee of the UK Government’s Department of Health.
Legislation and policy framework

Post-Exposure Prophylaxis (PEP) Guidelines for children and adolescents potentially exposed to blood-borne viruses, Childrens HIV Association, June 2015

Fig.1, page 2 sets out the treatment algorithm for treating children with PEP

P.2: “Up to 40% of 15 year olds in the UK are sexually active. Following the widespread use of HAART (Highly Active Antiretroviral Therapy) children with perinatally acquired HIV-1 infection are surviving into adolescence and entering sexual relationships with their HIV negative peers who may present for PEPSE (Post-exposure Prophylaxis following Sexual Exposure). Please refer to BASHH Guidelines”

P.5: “Ascertainment that the child / adolescent is not already HIV infected is important, as treatment with PEP in that circumstance would be inappropriate (although awaiting this result should not delay PEP as it can be started and subsequently stopped or switched if necessary). The baseline HIV test result on the child/adolescent should be available at the first follow up visit (within 24-72 hours of PEP initiation).”

P.10 “A minimum of 4 weeks AFTER PEP completion (8 weeks from high risk exposure):
Follow-up HIV testing should be undertaken”
Table 3, p.6 refers to use of PEP in children under 2.

UK Guideline for the use of HIV Post-Exposure Prophylaxis Following Sexual Exposure (PEPSE) 2015, British Association of Sexual Health and HIV

Available at http://www.bashh.org/documents/PEPSE%202015%20guideline%20final_NICE.pdf
Table 3, p.18 lists detailed guidance as to when PEPSE is appropriate.
P.7: “The recommendations are aimed primarily at individuals aged 16 or older “

Guidance from the UK Chief Medical Officers’ Expert Advisory Group on AIDS: HIV Post-Exposure Prophylaxis

P.37, Section 5.3 (Children): “If a child has been exposed, specialist advice from a paediatrician experienced in the field of HIV should be sought. PEP guidelines for children exposed to blood-borne viruses can be found on the website of the Children’s HIV Association of UK and Ireland”
Chapter Seven: Age of Consent and access to safe abortions and/or post-abortion care

If an individual has capacity to consent to treatment, the availability of abortion services is determined by the Abortion Act 1967 (as amended). Abortion is lawful in England, Wales and Scotland provided the criteria set out in the Abortion Act 1967 (as amended) are fulfilled.

The majority of abortion cases rely on ground (a) (extracted in the column to the right), which requires that the pregnancy has not exceeded 24 weeks. However, if there is a substantial risk to the woman's life or foetal abnormalities, there is no time limit (grounds (b)-(d)). These is no statutory age limit for abortion. The principles for assessing minors' ability to seek advice and give valid consent to medical treatment apply (see Page 7).

Legislation and policy framework

**Abortion Act 1967** (as amended by the Human Fertilisation and Embryology Act 1990), s1:

> [A pregnancy can be lawfully terminated by a registered medical practitioner, in an NHS hospital or premises approved for this purpose, if two medical practitioners are of the opinion, formed in good faith:]

a. that the pregnancy has not exceeded its twenty-fourth week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family; or
b. that the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman; or
c. that the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated; or
d. that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

Age of Consent to abortion is governed by statute and common law (as set out above - see in particular the Mental Capacity Act 2005, Family Law Reform Act 1969 and Gillick)

**R (Axon) v Secretary of State for Health [2006] EWCA 37:**

Confirmed that:

1. Gillick (see Page 7) applies to all decisions about young persons' treatment and care, including abortion; and
2. Parents have no general right to be informed if their daughters under 16 are seeking advice about abortions.
**Re P [1986] 1 FLR 272:**

A parent’s refusal to give consent to abortion cannot override the consent of a competent young person. However, if a person under the age of 16 years is found to lack competence, those with parental responsibility for the young person can consent on their behalf so long as the abortion is in the young person’s best interests.

**General Medical Council (GMC) Guidance:**

Provides that young people under 16 may be provided with abortion treatment, without parental knowledge or consent, provided that:

- they understand all aspects of the advice and its implications
- you cannot persuade the young person to tell their parents or to allow you to tell them
- in relation to contraception and STIs, the young person is very likely to have sex with or without such treatment
- their physical or mental health is likely to suffer unless they receive such advice or treatment, and
- it is in the best interests of the young person to receive the advice and treatment without parental knowledge or consent. (http://www.gmc-uk.org/guidance/ethical_guidance/children_guidance_70_71_contraception.asp)
Chapter Eight: Age of Consent on access to Antenatal Care (ANC)

The understanding on ANC to encompass any medical and/or social interventions that are designed to (i) improve women's experience of pregnancy and birth, or (ii) prepare women for motherhood.

Health-related ANC is provided for in accordance with general principles of English health law. Policy, rather than law, dictates the specific nature of ANC that women in United Kingdom can reasonably expect. The National Institute for Health and Care Excellence (NICE) has published extensive guidance on the quality standards of ANC that women are entitled to receive. (https://www.nice.org.uk/guidance/qs22)

NICE's ANC policy makes no distinction with respect to the age of the pregnant woman, and nor is parental consent addressed. Rather, the receipt of ANC by minors and the confidentiality attaching thereto will be guided by criteria established under case law.

Legislation and policy framework

Age of Consent to ANC is governed by statute and common law (as set out above - see in particular the Mental Capacity Act 2005, Family Law Reform Act 1969 and Gillick)

1. Law
   As mentioned, ANC is governed in accordance with general English law. However, please note in particular the following:

   i. The Human Rights Act 1998 incorporated the European Convention of Human Rights (ECHR) into national law. Article 8 of the ECHR guarantees a right to private life, which the courts have interpreted to include the right to physical autonomy, integrity and - in particular - the right for women to make choices about the circumstances in which they give birth, including whether to give birth at home (Terovskzy v Hungary, ECHR 2011/6).

   ii. The UK is signatory to the Convention on the Elimination of Discrimination against Women, which prohibits pregnancy-related discrimination and requires the provision of healthcare for pregnant and lactating women.
2. **Policy**

According to NICE, the following aspects should form part of ANC in the UK (http://www.nice.org.uk/guidance/cg62):

1. Pregnant women are supported to access Antenatal Care, ideally by 10 weeks 0 days.
2. Pregnant women are cared for by a named midwife throughout their pregnancy.
3. Pregnant women have a complete record of the minimum set of antenatal test results in their hand-held maternity notes.
4. Pregnant women with a body mass index of 30 kg/m² or more at the booking appointment are offered personalised advice from an appropriately trained person on healthy eating and physical activity.
5. Pregnant women who smoke are referred to an evidence-based stop smoking service at the booking appointment.
6. Pregnant women are offered testing for gestational diabetes if they are identified as at risk of gestational diabetes at the booking appointment.
7. Antenatal assessment of pre-eclampsia risk in hypertension in pregnancy
8. Pregnant women at intermediate risk of venous thromboembolism at the booking appointment have specialist advice provided about their care.
9. Pregnant women at high risk of venous thromboembolism at the booking appointment are referred to a specialist service.
10. Pregnant women are offered fetal anomaly screening in accordance with current UK National Screening Committee programmes.
11. Pregnant women with an uncomplicated singleton breech presentation at 36 weeks or later (until labour begins) are offered external cephalic version.
12. Nulliparous pregnant women are offered a vaginal examination for membrane sweeping at their 40- and 41-week antenatal appointments, and parous pregnant women are offered this at their 41-week appointment.
Chapter Nine: Access to HPV vaccine and cervical cancer screening and treatment

The Human Papillomavirus (HPV) vaccine and cervical screening both constitute medical treatments and a minor’s ability to access these treatments will be subject to the general rules on capacity to consent to medical treatment.

**HPV vaccine**

The HPV vaccine is routinely offered to girls aged 12 to 13 years in school year 8 on the basis that:

1. It is presumed that most girls will not be sexually active before the age of 16 years and, therefore, girls aged 12 to 13 years are unlikely to have been exposed to the HPV virus.
2. The vaccine is more effective in girls aged 12 to 13 years than in older girls. However, as a matter of policy, the vaccine is also available on the NHS to girls up to the age of 18 years. Women over the age of 18 years may request the vaccine, but it will be offered at the discretion of their responsible physician.

**Cervical screening**

The NHS cervical screening programme is available to women in the UK aged 25 to 64 years. Women aged between 25 and 49 years are invited to be screened every three years; women aged between 50 and 64 years, every five years. This reflects the risk profiles of the two groups. Cervical screening is not routinely offered to women under the age of 25 years because changes in the cervix are very common up until this age. Whilst there is a high chance of women under 25 years receiving abnormal test results, there is also a high chance that any abnormalities that were identified by the test would resolve without medical intervention. Therefore, the lower age bracket is set at 25 to avoid young women undergoing unnecessary medical treatment. As with the HPV vaccine, women under the age of 25 years may request a cervical examination, but it will be offered at the discretion of their responsible physician.

**Legislation and policy Framework**

*Gillick v West Norfolk and Wisbech AHA and anr [1986] AC 112* (see Page 7)

**HPV vaccine**

Recommendations of the Joint Committee on Vaccination and Immunisation (“JCVI”) and the National Institute for Clinical Excellence (“NICE”):


**Cervical screening**

Chapter Ten: Recommended intervention on legal and policy framework

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Annex 1

KEY QUESTIONS IN ESC REVIEW

I. Age of Consent for sexual intercourse: From an ESC perspective, what is considered to be the permissible Age of Consent for sexual intercourse / activities, and/or what are the permissible circumstances for adolescents to engage in sexual intercourse / activities? Indicate if different ages for heterosexual adolescents (males and females), and if applicable, homosexual adolescents (males and females).

II. Adolescent homosexuality and transgender expression: From an ESC perspective, how is (i) adolescent homosexuality, and (ii) transgender expression, viewed in the local context? Specify if different for males and females.

III. Contraception access and use: From an ESC perspective, how is contraception access / use amongst adolescents viewed in the local context? Specify if different for males and females.

IV. Access to sexual and reproductive health services: What are the potential ESC factors that hinder or facilitate adolescents accessing sexual and reproductive health services? Specify if different for heterosexual adolescents (males and females), and/or homosexual adolescents (male and female).

V. Autonomous HIV testing: What are the potential ESC factors that hinder or facilitate adolescents accessing HIV testing without parental consent? Specify if different for male and female. In each country-specific case study, research will focus on:

VI. How ESC factors impact on adolescent health in the above contexts, regardless of the enactment of relevant national laws (including nationally recognized customary or religious laws), regulations, and policies in relation to the respective contexts.
Annex 2

KEY QUESTIONS FOR THE LEGAL REVIEW

1. At what age may sex between consenting individuals legally take place? (Age of Consent to sexual intercourse) Indicate if there are different ages for males and females?
2. Is there a definition of statutory rape? Please define.
3. Are there exceptions to question (1)? For example gay sex?
4. At what age may a young person access contraceptive services including contraceptive commodities? Please specify with and without parental consent if the answers are different.
5. May a young person access emergency contraceptives (e.g. the 'Morning-after pill') At what age? Please specify if there are different ages with and without parental consent.
6. Policy framework and legislation enabling or disenabling access to Antiretroviral Therapy (ART), including Age of Consent with and without parental consent.
7. Specify whether there is any prohibition on HIV Post-exposure Prophylaxis (PEP), including Age of Consent with and without parental consent.
8. If there is no prohibition in question 7, would young people be legally able to access PEP if it was offered? At what ages? Please specify if there are different ages with and without parental consent.
9. Is there any legislation or policy specifically enabling PEP use in country? Please specify if it deals with Ages of Consent and give details.
10. Specify whether there is any prohibition on HIV Pre-exposure Prophylaxis (PrEP), including Age of Consent with and without parental consent.
11. If there is no prohibition in question 10, would young people be legally able to access PrEP if it was offered? At what ages? Please specify if there are different ages with and without parental consent.
12. Is there any legislation or policy specifically enabling PrEP use in the country? Please specify if it deals with Ages of Consent and give details.
13. Please state whether there is policy framework and/or legislation enabling or disenabling access to safe abortions and/or postabortion care, including Age of Consent with and without parental consent.
14. Policy framework and legislation enabling or disenabling access to Antenatal Care (ANC), including Age of Consent with and without parental consent.
15. Policy framework and legislation enabling or disenabling access to HPV vaccines and cervical cancer screening and treatment, including Age of Consent with and without parental consent.
16. What is the Age of Consent to access HIV testing without parental consent?
17. What is the Age of Consent at which the HIV status will be reported directly to an adolescent and legal/policy requirements to report this status to her/his parents?
18. Please explain any inconsistencies between the answers above.