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 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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AGE OF CONSENT
LEGAL, ETHICAL, CULTURAL
AND SOCIAL REVIEW
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<td>Acquired Immune Deficiency Syndrome</td>
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<td>Essential Healthcare Package</td>
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EXECUTIVE SUMMARY

The Age of Consent to Sexual intercourse in India is 18 years for both males and females. Any sexual intercourse with a person under the age of 18 years is illegal. Sexual intercourse or sexual acts by a man with his own wife, the wife not being under 15 years of age can be the only exception. The law does not use the term ‘statutory rape’. However, when the woman is under 18 years of age, her consent is considered immaterial and the sexual intercourse amounts to rape.

Gay sex is illegal in the country by virtue of Section 377 of the IPC. Section 377 was enacted by the British colonial regime to criminalise ‘carnal intercourse against the order of nature. It was rooted in the Judeo-Christian religious morality that abhorred non-procreative sex.

There are no age restrictions on access to contraceptives so parental consent is not a legal requirement. There are no age restrictions on access to emergency contraceptives so parental consent requirement.

India does not have legislation which restricts access to antiretroviral therapy (ART) for children. There is no legal requirement to obtain parental consent in order to administer ART to a minor.

There is no prohibition on Post-exposure Prophylaxis and in the absence of an express prohibition, minors and adolescents can access PEP facilities even in the absence of parental consent.

There is no specific prohibition on Pre-exposure Prophylaxis (PrEP), however the country is still awaiting the approval of PrEP by the Drug Controller General. At the moment it is illegal to provide PrEP to anyone of any age.

Abortion is permitted by law under certain prescribed circumstances. Women under the age of 18 years require parental consent.

In India minors and adolescents are not expressly prohibited by law or policy from accessing Human Papillomavirus (HPV) vaccine and cervical cancer screening or treatment even in the absence of parental consent. The Advisory Committee on Immunization Practices currently recommends routine vaccination of females aged 11–12 years with three doses of the HPV vaccine.

There is no law governing Antenatal Care (ANC) in India and the provision of access to ANC is discretionary. However, there are certain guidelines introduced in April, 2010 governing the provision of maternity care by health workers like midwives and nurses during pregnancy, childbirth and thereafter.

There is currently no legislation in India dealing with HIV testing without parental consent. The National AIDS Control Organisation has issued guidelines on Voluntary Counselling and Testing, which is the process by which an individual undergoes confidential counselling to learn about his/her HIV status and to exercise informed choices in testing for HIV followed by further appropriate action.

The operational guidelines for Integrated Counselling and Testing Centres issued by the National AIDS Control Organisation, issued in July 2007, states that access to counselling and testing centres should be available to children and young people under the age of 18 years without parental consent based on an assessment of their evolving capacities and their ability to comprehend the nature and implications of HIV/AIDS and an HIV test result.

Information relating to a child’s HIV status is personal information and is protected under the India Constitution from disclosure. Though the law does not distinguish between the privacy rights of minors and those of adults so a minor would be entitled to the same protections as an adult and his/her HIV status could not be reported to another person without his/her consent, in practice, as consent is required at the stage of HIV testing, the privacy of the minor may not be protected with respect to the parent.
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 India legal, ethical, cultural and social review was prepared by SAT and is based on legal review research conducted by J Sagar Associates Law firm 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.

The Ethical, Cultural and Social review seeks to highlight social and cultural factors, and the ethical dimensions thereof, that impact on adolescent health in the following contexts:

1. Age of Consent for sex and age of sexual debut.
2. Homosexuality and transgender expression.
3. Access to Sexual and Reproductive Healthcare Services, including autonomous HIV counselling and testing [HCT] and contraception access.

India’s analysis was conducted through a desk review of publically accessible sources, including works published by international agencies such as UNICEF, WHO, UNAIDS, and the World Bank, Indian Government reports, and non-Governmental research outputs.
Country overview

India is the second most populous country in the world, with a population of approximately 1.325 billion people. An estimated 51.6% of the country’s population is male and 48.4% is female; the literacy rates for the youth (15-24 years of age) is approximately 91.83% for males and 87.24% for females. Fifty percent of India’s population is under 25 years of age. Approximately 30% of the Indian population is under 15 years of age. India is the most populous democracy in the world and the seventh-largest country, with a total land area of approximately 3,287,240 km². Approximately 72.2% of the population resides in about 638,000 villages and 27.8% in roughly 5,480 towns and cities. Ethnically, an estimated 72% of the population is Indo-Aryan, 25% are Dravidian, and 3% comprise of Mongoloids and various other ethnic minorities. The Indian Constitution designates Hindi as the official language of India in Devnagari script, although English can also be used in Parliament and for official Government purposes. There are several languages spoken in India, the most prevalent being Hindi (41%), followed by Bengali (8.1%), Telegu (7.2%), Marathi (7%), Tamil (5.9%), Urdu (5%), Gurjarati (4.5%), and Kannada (3.7%), with other languages comprising the balance. Hinduism is the most prevalent religion in India with 80% of Indians identifying as Hindu, 14.2% identifying as Muslim, 2.3% as Christian, 1.7% as Sikh, 1.7% as belonging to other religious minorities, and 2% not specifying their religion. There are approximately 462 million Internet users in India, which translates to roughly 35% of the country’s population and 13.5% of worldwide Internet users. Internet penetration is approximately 18% and active mobile social media usage is estimated to be 9%. There are about 303 million active mobile Internet users in the country, while 70 million actively use WhatsApp on a monthly basis. With 243 million adolescents, India currently boasts the world’s largest adolescent population.

Country context

- India is classified as a lower middle income country with a GDP of $2.049 trillion.¹
- India’s population as of May 2016 is estimated to be approximately 1.325 billion persons.² India is home to approximately 684 million males and 640 million females.³ The sex ratio is estimated to be 943 females per 1,000 males.⁴
- Adolescents (10-19 years of age) comprise approximately 21% of India’s total population.⁵
- 6% of the global population of people living with HIV (PLWHIV) are Indian, and 43% of PLWHIV in Asia and the Pacific are Indian.⁶
- India has the third largest population of PLWHIV in the world: an estimated 2.1 million.⁷
- Approximately 80% of Indians do not have access to HIV antiretroviral therapy.⁸
- India contributes 8% of AIDS-related deaths globally and 51% of AIDS-related deaths in Asia.⁹
- India accounts for an estimated 38% of the total number of new infections in Asia and the Pacific.¹⁰
Chapter Two: Age of Consent to sexual intercourse

In India the Age of Consent to sexual intercourse is 18 years of age for both males and females, subject to the exceptions described in this report. This is not directly specified in any Indian legislation and is understood from the way ‘rape’ is defined under the Indian Penal Code (as amended by the Criminal Law Amendment Act, 2013) and the way ‘penetrative sexual assault’ is defined under the Protection of Children from Sexual Offences Act, 2012 (POCSO). Under the Indian law, only men can be accused of rape and penetrative sexual assault; though under the POCSO, the victim can be of either gender. However, under the Indian Penal Code, Section 377, even consensual sexual activity between adult men is penalised.

Legislation on Age of Consent to sexual intercourse


Section 2 (d) - A ‘child’ is defined as any person under 18 years of age.

Section 3- ‘penetrative sexual assault’ - A person is said to commit ‘penetrative sexual assault’ if:

- He penetrates his penis, to any extent, into the vagina, mouth, urethra or anus of a child or makes the child to do so with him or any other person;
- He inserts, to any extent, any object or a part of the body, not being the penis, into the vagina or urethra or anus of the child or makes the child to do so with him or any other person; or
- He manipulates any part of the body of the child so as to cause penetration into the vagina, urethra, anus or any part of the body of the child or makes the child to do so with him or any other person;
- He applies his mouth to the penis, vagina, anus, urethra of the child or makes the child to do so to such person or any other person.

Indian Penal Code (IPC) - Section 375. ‘A man is said to commit “rape” if he—penetrates his penis, to any extent, into the vagina, mouth, urethra or anus of a woman or makes her to do so with him or any other person; or inserts, to any extent, any object or a part of the body, not being the penis, into the vagina, the urethra or anus of a woman or makes her to do so with him or any other person; or manipulates any part of the body of a woman so as to cause penetration into the vagina, urethra, anus or any part of body of such woman or makes her to do so with him or any other person; or applies his mouth to the vagina, anus, urethra of a woman or makes her to do so with him or any other person, under the circumstances falling under any of the following seven descriptions:

First.—against her will. Secondly.—Without her consent. Thirdly.—With her consent, when her consent has been obtained by putting her or any person in whom she is interested, in fear of death or of hurt. Fourthly.—With her consent, when the man knows that he is not her husband and that her consent is given because she believes that he is another man to whom she is or believes herself to be lawfully married. Fifthly.—With her consent when, at the time of giving such consent, by reason of unsoundness of mind or intoxication or the administration by him personally or through another of any stupefying or unwholesome Substance, she is unable to understand the nature and consequences of that to which she gives consent. Sixthly.—With or without her consent, when she is under eighteen years of age. Seventhly.—When she is unable to communicate consent. Explanation I.—For the purposes of this section, “vagina” shall also include labia majora. Explanation 2.—Consent means an unequivocal voluntary agreement when the woman by words, gestures or any form of verbal or non-verbal communication, communicates willingness to participate in the specific sexual act.

Provided that a woman who does not physically resist to the act of penetration shall not by the reason only of that fact, be regarded as consenting to the sexual activity. Exception I.—A medical procedure or intervention shall not constitute rape. Exception 2.—Sexual intercourse or sexual acts by a man with his own wife, the wife not being under fifteen years of age, is not rape.'
Definition of statutory rape

In India the law does not use the term 'statutory rape'. However, when the woman is under 18 years of age, her consent is considered immaterial and the sexual intercourse amounts to rape under the Indian Penal Code. Under the POCSO, the child victim can be either a male or female who is under 18 years of age.

Legislation and policy framework on statutory rape

See section above with regards to the Protection of Children from Sexual Offences Act, 2012. (POCSO) and the Indian Penal Code (IPC) - Section 375.

Age of Consent for sex and sexual debut

In India, the legal Age of Consent of sex is 18 years of age.\[11,12\] India’s National Family Health Survey (NFHS-3) conducted a study on Indian youth between 15-24 years of age. It revealed that 50.7% of women and 26.9% of men in that age bracket, have had sexual intercourse, of which 10.1% and 2.3%, respectively, had sexual intercourse prior to reaching 15 years of age.\[13\] Only 8% of women and 15% of men used a condom at first sexual intercourse.\[14\] Three percent of young men and 12.7% of young women residing in rural areas had early sexual debuts (prior to 15 years of age), in comparison to 4.5% and 1% of urban dwelling women and men, respectively.\[15\] Additionally, the Youth Study, a subnational survey across six states, found that 42.3% of all men and 25.6% of women between 15-24 years of age from both urban and rural areas of India, have had premarital sexual intercourse.\[16\] 29.8% and 14.6% of urban men and women, respectively, and 47.1% and 31.7% of rural men and women, respectively, had engaged in premarital sexual intercourse.\[17\] Only 28% of men and 12% of women utilized contraception at first sexual intercourse, with unmarried and urban youths more likely to use contraception at first sexual intercourse.\[18,19\] 0.6% of men and 0.4% of women sexually debuted before 15 years of age, 4.4% and 2.8%, respectively, had debuted before 18 years of age, and 11% and 4.9%, respectively, debuted before 20 years of age.\[20\]

A community-based study conducted in the rural settings and urban slums of Pune, Maharashtra, found that 17-24% of Indian youth (15-24 years of age) were in romantic relationships, of which 16-18% were sexually active.\[21\] Another school-based study conducted in Patna, Bihar, showed that of learners in classes 9-11, 10% of adolescent males had sexual experience as opposed to 1% of their female peers.\[22\] Another revealed that of students living in Ahmedabad, Anand, and Vadodara, Gujarat, 16% of male and 10% of female students reported having heterosexual sexual intercourse.\[23\] Hinduism does not consider premarital sex to be a religious taboo.\[24\] However, such interactions are discouraged for cultural and caste reasons.\[25\] Both Christianity and Islam place a high premium on preserving virginity until marriage and premarital sex is deemed unacceptable.\[26\]

Early marriage

The legal age for marriage in India is 18 years of age for women and 21 years of age for men.\[27\] Currently, the national average of men and women married before the legally prescribed age stands at 26.6% and 45.6%, respectively.\[28\] Yet, in traditional Hinduism, fathers are encouraged to arrange their daughter’s marriage soon after she reaches puberty\[29\] and marriage is permissible if both parties have reached puberty.\[30\] Likewise, Islam and Christianity permits marriage upon the attainment of puberty.\[31,32\] Child marriage is pervasive in India. According to the NFHS, 27% of Indian women aged between 20-49 years of age married before 15 years of age, while 58% married before reaching 18 years of age, the legal age of marriage.\[33,34\] 49.4% of women aged between 15-24 years of age are currently married compared to only 16.8% of men in the same age group, the majority identifying as Hindu and Muslim.\[35\] 27.1% of adolescent girls 15-19 years of age are currently married in comparison to 2.8% of adolescent male peers.\[36\] 8% of married adolescent girls 15 years of age are currently living with their husbands, while a further 4% are married, but have yet to start living with their husbands.\[37\]

At a national level, 1 in 5 adolescent girls (19%) between 15-17 years of age are married compared to 1 in 17 adolescent boys (7%) between 15-20 years of age.\[38\] More than a fifth of adolescent girls 15-17 years of age are married in Bihar, Jharkhand, Rajasthan, West Bengal, and Uttar Pradesh, with Bihar and Jharkhand having the highest rates: 38% and 36% respectively.\[39,40\] According to the Youth Survey, 19% or 1 in 5 young women 15-24 years of age marry before 15 years of age, 49% are married before reaching 18 years of age, and 67% before 20 years of age.\[41\] On the other hand, only 7% of young men married before 18 years and 16%
before 20 years. Early marriage rates amongst rural women 15-24 years of age were found to be between 59% and 77%, compared to urban women at 26% and 44%, respectively. The study also found that 27% of women’s first marital sexual intercourse was forced. Rates were higher amongst rural women (29%) than urban women (19%). Only 10% of men reported perpetrating marital rape, with such reports being more common in rural areas (11%) than urban areas (7%). Early childbearing is a natural consequence of early marriage. According to the NFHS-3, 12% of adolescents aged between 15-19 years of age had already given birth to their first child and an additional 4% were pregnant at the time of the survey. Therefore, one in six adolescent girls within the 15-19-year age group have experienced childbearing. Early childbearing rates are much higher in rural areas (19%) than urban areas (9%) amongst girls 15-19-years of age. Further, more than a quarter of adolescents who become mothers have no education. State wise, Jharkhand carries the highest rates of early childbearing (28%), followed by West Bengal and Bihar, with 25% and less than 5% of early child bearing is reported in Himachal Pradesh, Goa, and Jammu and Kashmir. Furthermore, compared to other religions, Hindu and Muslim women have the lowest median age for marriage in India (16.7 years), as well as the highest rates for early childbearing and teenage pregnancy (16%). The reason for the high rate of early and child marriage is usually because girl children are commonly viewed as burdens; thus, society and tradition deems it acceptable for marriage take place as soon as possible. Further, in spite of the Dowry Prohibition Act, No 28 of 1961, which criminalizes the giving or receiving of dowry, parents and communities continue to use a lower dowry as an excuse to marry off their young children. This practice avoids a higher dowry, which would be required if the bride was older. Early marriage is also viewed a means of securing the chastity and virginity of the girl child, as it is believed that she will be protected from sexual violence, unwanted male attention, and promiscuity. Child marriage is considered to be a way to secure a child’s financial and social future in India. Moreover, lower levels of education, lack of awareness of the harmful implications of early and child marriage, “poor implementation of law” and the administrations poor form only exacerbate India’s child marriage issue.

Ethical implications and recommendations

The Indian Government must do more to encourage adolescents to delay sexual debut. Furthermore, the Government must intensify its efforts to eradicate gender inequality and child marriage, particularly in the country’s rural areas. Authorities must do more to prevent sexual violence, particularly against young females. Authorities and other role-players should engage with communities (including adolescents) on the social and cultural factors that facilitate early sexual debut, child marriages, and gender-based sexual violence, and the health risks implicit in such practices. Such engagement should include focused campaigns in communities where early sexual debut and child marriages are deemed socially acceptable.

Country experiences in addressing the barriers

India has enacted the Prohibition of Child Marriage Act No 6 of 2006 in order to eradicate the harmful practice of child marriage plaguing Indian society. This statute replaced the Child Marriage Restraint Act, 1929. According to the Prohibition of Child Marriage Act, the term ‘child’ refers to any male under 21 years of age and any female under 18 years of age. According to Act, anyone who conducts, directs, abets or performs a child marriage will be punished with imprisonment for up to two years or subject to a fine up to one lakh rupees or both, unless proven that they had reason to believe that it was not, in fact, a child marriage. The law criminalizes marriages between adult males and children, which is punishable by imprisonment for up to two years or a fine up to one lakh rupees, or both.

Private schools in India are at liberty to choose whether or not to include sexual education in their school curricula; however, the number of private schools that have incorporated an extensive curriculum remains unknown. Still, all private schools that are associated with the Central Board of Secondary Education (CBSE) are obligated to incorporate sexual education in their school curricula; however, these schools remain in the minority. The majority of schools (public and private), associated with the state boards of secondary education do not have a sexual education programme in their school curricula. In order to address this gap, the Central Government, along with the National AIDS Control Organisation (NACO) and UNICEF, created the Adolescent Education Program (AEP) which is to be implemented in all secondary and higher secondary schools throughout India. The aim of the AEP is to provide students with valuable and authentic knowledge on Adolescent Reproductive and Sexual Health (ARS) including HIV/AIDS, and to assist students in developing “healthy attitudes and responsible behaviours towards ARSH issues and HIV/AIDS”.
the All Indian Educational and Vocation Guidance Institute revealed that between 42% and 52% of young students report that they lack adequate knowledge about sex.65

Homosexuality and transgender expression

Homosexuality and homoerotic activity in India dates back to antiquity as evidenced in early Hindu and Buddhist scriptures. For instance, reference is made to same-sex sexual attraction and behaviours in the Arthasastra, Kamasutra, and Manusmriti.66 The Rigveda, Hinduism’s earliest, and one of its four canonical, sacred texts, recognizes both homosexuality and transsexuality.67 Hindu scripture mentions Baghirittha, who was the product of a sapphic union, and there is evidence of a dual-gendered God named Ayyapa (the female avatar of the God Vishnu) praised by India’s transgender Hijras, and homoerotic activity can be found in sculptors and carvings in Khajuraho and on temples.68 There is also evidence of cross-gender and cross-gender behaviours in texts such as the Mahabharata and Ramayana.69 Furthermore, India’s most pronounced example of gender diversity are the Hijras. Hiija is an Urdu term translating to ‘eunuch’70 or hermaphrodite, but the term is also used to describe men who are transgender, intersex, homosexual, and bisexual.71 Although the preferable term for transgender is ‘khawaajasira’, Hijras do not subscribe to specific sexual orientations.

In India, effeminate MSM that undertake receptive roles in sex are referred to by themselves and others as ‘kothi’.72 Hijras were known to perform blessings and rituals at weddings and births having been thought to possess fertility powers and bring luck; once revered, they are now ostracised despite their official recognition as the ‘third gender’.73 Nevertheless, contemporary Indian culture and society is relatively conservative and homophobia is often propagated by community leaders and spiritual gurus, hence sexual minorities are often met with discrimination.74

Section 377 of the Indian Penal Code of 1860 criminalizes homosexual activities conducted privately between consenting adults. However, this section was revoked by the Delhi High Court because it breached the constitutional rights to life, liberty and equality.75,76 This decision was overturned by the Supreme Court of India four years later.77 Further, homosexuality is condemned by Islam and Christianity.78 Both religions have had a major impact on the mores of Indian society following centuries of Islamic Moghul rule (1526-1757), and British rule (1858-1947), the latter of which introduced conservative Victorian-era (Anglican Church) values in India and other British colonies. With homosexuality considered sinful in Islam, and Victorian morality deeming homosexuality taboo, (which led to homosexuality being criminalised under Section 377 of the British-introduced 1860 Indian Penal Code), Indian society, in turn, became progressively more conservative.79,80

Today, homophobia is pervasive and homosexuality is still deemed taboo by India’s contemporary Government and society. However, the growth of the Internet, mainstream media, and social media in India has seen public discussions on homosexuality increase in news, media and film, resulting in a shift in attitude.81 Nonetheless, deep-rooted societal homophobia culminates in the social rejection, abandonment, and sexual and physical violence for Indian MSM.82 Evidence from 17 states found that the transgender community is subjected to stigma, prejudice, exploitation, physical violence perpetuated by law enforcement authorities, legal issues, abandonment and lack of job opportunities leading to sex work.83

Exceptions for Gay sex

There are legal exceptions involving gay sex. The statutory exceptions are the following:

a. medical procedure or intervention.
b. Sexual intercourse or sexual acts by a man with his own wife, the wife not being under 15 years of age.
Legislation and policy framework on gay sex

Gay sex is illegal in India by virtue of section 377 of the IPC. Section 377 was enacted by the British colonial regime to criminalise ‘carnal intercourse against the order of nature’. It was rooted in the Judeo-Christian religious morality that abhorred non-procreative sex. Lacking precise definition, Section 377 became subject to varied judicial interpretation over the years. Initially covering only anal sex, it later included oral sex and still later, read to cover penile penetration of other artificial orifices. The law made consent and age of the person irrelevant by imposing a blanket prohibition on all penile-non-vaginal sexual acts under the vague rubric of ‘unnatural offences’.

The section was read down to exclude from its scope sexual acts between consenting adults by the High Court of Delhi on July 2009 (Naz Foundation (India) Trust v. Government of NCT of Delhi and Ors). That judgement was overturned by the Supreme Court of India on 12 December 2013 (Suresh Kumar Koushal & Ors. v. Naz Foundation (India) Trust & Ors), with the Court holding that amending or repealing Section 377 should be a matter left to Parliament, not the judiciary. On 6 February 2016, while hearing the curative petition, the three-member bench headed by the Chief Justice of India said that all the 8 curative petitions submitted will be reviewed afresh by a five-member constitutional bench of the Supreme Court of India.

Ethical implications and recommendations

India is a signatory to various international human rights instruments – such as the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights and the International Covenant on Social and Economic Rights – all of which forbid unfair discrimination. Furthermore, India has ratified the United Nations Convention on the Rights of the Child, which also prohibits unfair discrimination against children, regardless of their sex or gender. Given the above, healthcare workers should be given sensitivity-training and reminded that they have an ethical (and legal) duty to provide care to any person in need and that this duty supersedes the healthcare professional’s personal moral biases regarding sexual orientation and lifestyle choice. Furthermore, policymakers, officials, and health professionals ought to note that they have a legal and ethical obligation to always act in the best interests of a child, regardless of that child’s sexual orientation.

Country experiences in addressing the barriers

In the 2009 case of NAZ Foundation v. Govt. of NCT of Delhi, the Delhi High Court struck down Section 377 of the Indian Penal Code of 1860 (IPC) which states the following:

"whoever voluntarily has carnal intercourse against the order of nature with any man, woman, or animal shall be punished with imprisonment for life, or with imprisonment of either description for term which may extend to 10 years, and shall also be liable to fine."

In spite of the ambiguous wording of the section, it has been interpreted to include the criminalization of consensual homosexual activity conducted privately between adults. Section 377 was struck down by the Delhi High Court for its violation of Article 21 of the Constitution, which afforded everyone the rights to life and liberty including dignity and privacy. The High Court found that Section 377 breached the right to equality under Article 14 because it needlessly targets homosexual people and the section further violates Article 15 of the Constitution which prohibits discrimination on several grounds, including sex. Despite this great victory for India’s LGBT community, the Supreme Court of India overturned the High Court’s decision in 2013, finding that Section 377 of the IPC was not unconstitutional. However, in February 2016 the Supreme Court, for the first time, acknowledged that an individual’s sexual orientation is a personal matter and more attention should be paid to the constitutionality of the section. Moreover, NACO, the Ministry of Health and Welfare and the Law Commission of India have expressed their support for the decriminalization of homosexuality in the country, and the promotion of equality and tolerance for LGBTI.
In the landmark judgment of *National Legal Services Authority v. Union of India & Ors [Writ Petition (Civil) NO. 400 of 2012 (NALSA)]*, the Supreme Court of India acknowledge the constitutional rights of the transgender community. The Supreme Court held, in keeping with Article 21 of the Constitution, which affords the right to personal autonomy, that the gender of an individual can only be determined by the individual concerned. Thus, it is a person’s prerogative and they are entitled to ascribe to a gender which correlates with them, whether it be male, female or third gender (transgender). The Court observed that in accordance with the right to freedom of expression and speech under Article 19(1)(a), the personal appearance and the way in which one chooses to express themselves through dress, cannot be restricted, therefore protecting gender expression, subject to the restrictions in Article 19(2). Further, the Court secured transgender people’s rights to equality, equal protection, and non-discrimination on the basis of gender identity under Articles 14, 15 and 16. Moreover, the Court broadened the definition of the term ‘sex’ in Article 15 to include ‘gender identity’ in addition to biological sex, which was restricted to male and female. Furthermore, the Court held that discrimination on the grounds of sexual orientation is unconstitutional.

The Rights of Transgender Person Bill No. 49 of 2014 was passed by the Rajya Sabha last year to ensure the development and welfare of transgender people in India. The Bill contains specific provisions pertaining to the prevention of abuse, exploitation and violence as well as the prohibition of discrimination of transgender people.

The fourth phase of India’s National AIDS Control Programme (NACP) endeavours to continue its commitment to the reversal of the country’s HIV epidemic. However, it seeks to pay special attention to hard-to-reach populations such as MSM, including transgender individuals, such as the Hijras, with regard to prevention interventions. The object of the new phase of the NACP is to provide enhanced access to care, disseminate information, educate, and reduce stigma and discrimination.
Chapter Three: Access to contraception services and commodities

Contraception

According to NFHS-3, only 13% of (married) adolescent girls between 15-19 years of age use contraception in India. The most common modern contraceptive method was the condom (3.3%), followed by the pill (2.2%), and female sterilization (1.1%). Amongst traditional methods, the rhythm method (3.8%) was most common, followed by the withdrawal method (2.3%). The unmet need for family planning in adolescent girls 15-19 years of age stands at 27%. 18% of unmarried adolescents 15-19 years of age who experienced sex used any method of contraception. There is no information available on adolescents between 10-14 years of age and limited information on unmarried adolescents. This is unfortunate given that 27% of adolescent girls between 15-19 years of age are married. This is expected as India’s existing health system does not take cognizance of the diverse sexual and reproductive health needs of adolescents. Despite the unmet need for contraception, a 2015 survey revealed that main reason behind non-use of contraception in adolescent girls was opposition to a method (36%). The survey also revealed that 12% of married adolescent participants left sexual and reproductive health decisions up to their husbands and only 10% of adolescent girls could obtain condoms on their own.

Another survey conducted across six Indian states in married and unmarried young people (15-24 years of age) revealed that only 5% of women and 18% of men used condoms during first sex. Several misconceptions influenced non-use, including the erroneous belief that eating certain fruits prevents pregnancy, pregnancy does not occur after first or second intercourse, and condoms reduce pleasure. Other reasons for non-use included trusting their partner or believing their partner was a virgin, or the belief that the relationship would culminate in marriage, or at least presumably financial support, and thus any resulting pregnancy was not an issue. Some participants said that due to the unexpected nature of intercourse, they did not use condoms or did not have access to condoms.

Further, the Youth Study revealed that 95% of all Indian youths (15-24 years) surveyed were aware of at least one form of contraception. The most well-known forms of contraception amongst men and women was the pill (70% and 76%, respectively) and condoms (93% and 68%, respectively). Yet, condom-related misconceptions was prevalent, as only 46% and 24% of young men and women, respectively, knew that condoms could not slip off the male and disappear inside the female body. Moreover, only 31% of men and 25% of women felt that condoms did not deter sexual pleasure. Furthermore, a meagre 26% were aware that condoms could only be used once and the pill should be taken daily.

There is presently no law restricting a young person’s access to contraceptives in India. In fact, India’s policies on national health and family planning support the distribution and sale of contraceptives to all sexually active individuals, irrespective of age and marital status. Which is outlined in India’s National Population Policy, 2000, page 10 states that - Programmes should encourage delayed marriage and child bearing and education of adolescents about the risks of unprotected sex. Reproductive health services for adolescent boys and girls is especially significant in rural India, where adolescent marriage and pregnancy is widely prevalent. Their special requirements comprise information, counselling, population education, and making contraceptive services accessible and affordable.

Ethical implications and recommendations

Given low contraceptive use and misconceptions about contraceptives amongst Indian adolescents, Indian authorities need to intensify their efforts in educating adolescents on matters related to sexual and reproductive health. Furthermore, authorities should do more to encourage and empower female adolescents to take responsibly for their reproductive health by accessing SRHS without fear of prejudice and stigma.
Child labour

As of 2015, India has the highest number of child labourers 5-17 years of age in South Asia, with approximately 5.8 million children being subjected to such practices.107 Approximately 3.25 million Indian children aged between 5-14 years of age are child labourers.108 Children are forced into bonded labour, working strenuously for hours in appalling conditions, with those forced to work the brick kilns to relieve family debts, working as long as 16 hours a day.109 It is also common for children living in rural areas to migrate in order to undertake employment in different industries, including cotton production. Carpet and textile industries work from dusk to dawn under precarious conditions for a pittance in wages.110,111,112 Child trafficking for commercial sexual exploitation, forced labour in agriculture and domestic labour, as well as other begging and brick laying, is common in India, especially amongst children belonging to marginalized groups including religious minorities, tribal communities, and those considered low-caste.113

Ethical implications and recommendations

If adolescents are engaged in labour practices, it follows that they will likely be unable to access SRHS, especially if their working hours and the operating hours of SRHS correspond. India’s high prevalence of child labour may accordingly serve as a major barrier to working adolescents accessing SRHS. Authorities should consider ways of reducing or eliminating child labour, and facilitating SRHS access to adolescent labourers. Such measures may include the provision of community-based youth friendly SRHS mobile clinics with extended operating hours to cater for adolescent laborers.

Lack of adolescent and youth friendly health services

India’s estimated adolescent population stands at approximately 243 million persons, equating to roughly 21% of the country’s total population.114 Boasting the world’s largest adolescent population,115 India’s adolescent SRHS needs are immense. Health programmes targeted towards adolescents are implemented by the Indian Government via a number of its ministries. The Ministry of Health and Family Welfare offers ARSH services,116 while the National AIDS Control Programme Phase III aims to end HIV/AIDS in India by scaling-up preventative care and treatment, in addition to other measures, for adolescents.117 However, despite the availability of such programmes to adolescents, a number of barriers prevent adolescents from accessing the much-needed services provided by these programmes. Such barriers include lack of financial resources, lack of staff, inadequate healthcare provider training, lack of privacy, services not being comprehensive, relevant health needs of adolescents not being addressed, and, given that a number of ministries offer such services, duplication of irrelevant services.118 Furthermore, publicly provided SRHS is usually targeted towards married women and adolescents; consequently, unmarried adolescents are reticent to access SRHS because they fear breach of confidentiality, and judgmental attitudes of healthcare providers.119 One survey revealed that India had amongst the lowest proportion of adolescent girls that sought access to treatment for STI, of 70 countries globally (26%).120

Ethical implications and recommendations

Given the growing rate of Internet usage amongst Indian adolescents, Indian authorities, international agencies, and NGO should consider mounting online SRHS campaigns targeted at adolescents, in a non-judgemental manner. Such campaigns and information provision should encourage adolescents to access SRHS. Furthermore, authorities should provide information on where adolescents can access SRHS.
Orphanhood

India has the largest number of AIDS orphans in the world\textsuperscript{121,122} In 2005, the World Bank estimated the number of AIDS orphans in India to be 2 million, by 2010 it was estimated to be 4 million, and this number has continued to substantially increase throughout the years.\textsuperscript{123} India is home to more than 25 million orphans and abandoned children, who are subjected to high risks of poverty and unequal opportunities, as well as stigma and discrimination.\textsuperscript{124} The latter continues to be one of the significant challenges facing orphans on a regular basis,\textsuperscript{125} thereby impeding their access to the provision of vital healthcare services.\textsuperscript{126} Furthermore, female maternal orphans are specifically prone to being sexually active, contracting STIs, being pregnant, and contracting HIV, while paternal orphans who are more inclined to homelessness and truancy.\textsuperscript{127} The loss of their parents leaves orphans without protection and a proper education, as well as increases the risk of child-headed households and homelessness, the latter of which exposes such children to the worst forms of child labour, including sex work and exploitation for commercial purposes.\textsuperscript{128}

Ethical implications and recommendations

Given its large orphan population, Indian authorities should consider devising strategies targeted at orphan adolescents to mitigate their vulnerability and deter their early sexual debut. Such a strategy may require inter-ministerial collaboration and close engagement with other stakeholders.

Stigma and discrimination

The detrimental implications of HIV related stigma and discrimination of PLWHIV is well-documented\textsuperscript{129,130} The ramifications of HIV-related stigma often extends not just to the families and friends of PLWHIV, but the communities to which they belong.\textsuperscript{131} HIV-related stigma and discrimination is systemic in India, with those affected being left without employment, forced into homelessness, and denied access to medical treatment.\textsuperscript{132,133} HIV-related stigma and discrimination is a major barrier that impedes access to HIV preventative care and services, particularly HCT, as research has shown that those patients with fairly substantial concerns regarding HIV-related stigma, are less likely to be inclined towards HCT.\textsuperscript{134,135} Stigma and discrimination also influences the use of PrEP and its access. PrEP use is usually accompanied by stigma relating to high-risk sexual activity and HIV, which hinders access to the drug despite its efficacy.\textsuperscript{136} Matters concerning sex and sexuality is not discussed publicly and is considered taboo in India.\textsuperscript{137} In such instances, the social stigma attached to the sexuality of an adolescent inhibits their access to SRHS, including contraception. Young people are reticent to access SRHS because they do not want to be shamed or embarrassed for being sexuality active.\textsuperscript{138,139}

Ethical implications and recommendations

Healthcare workers should be given sensitivity-training and reminded that they have an ethical (and legal) duty to respect the confidentiality of their adolescent patients. Furthermore, they have a duty to provide care to any person in need and that this duty supersedes their personal moral biases. Authorities should also sensitise health workers on an ongoing basis regarding the harmful impact of stigma and discriminatory and how these prejudices impact on adolescent health.
Social class

In spite of the Indian Government's official rejection of the caste system, caste remains entrenched in Indian culture and society and continues to be one of the principal social determinants of health, as well as a household marker that can be used to accurately identify underprivileged and destitute households in India. ‘Socially backward classes’ (SBC) is a collective term often used to describe several of India's most disadvantaged social groups, including the ‘scheduled castes’ (SC) and ‘scheduled tribes’, (ST) as well as ‘other backward castes’ (OBC). These groups are subject to social seclusion and marginalization, in addition to living in poverty, and usually inhabit the most economically disadvantaged areas of India. Being a member of an OBC is usually an indicator of poor use of SRHS. Women belonging to SC and ST have less access to healthcare in comparison to males of the same classes, and those members of society living in poverty and subjected to social marginalization have the least access to health services, whether it be preventative or curative. This is likely due to the lack of funds and availability of resources, as well as low perceived need. 31.2% of India’s population for the year 2005 (just over 1 trillion) belonged to SC and ST, and 43% belonged to the OBC.

Ethical implications and recommendations

The Indian Government needs to do more to eradicate the country’s caste system, beyond rhetoric and the passage of laws. Authorities should meaningfully engage with Indian society at a grassroots level and educate people about child rights and adolescent health needs.

Country experiences in addressing the barriers

The Child Labour (Prohibition and Regulation) Act 61 of 1986 was enacted by India’s parliament to prohibit children from engaging in certain forms of employment and to regulate the work conditions of children engaged in employment. According to the Act, the term ‘child’ refers to any individual under 14 years of age. According to the legislation, children are prohibited from working longer than 6 hours a day, not permitted to work overtime, and are barred from working between 7pm and 8am. Every working child is entitled to a weekly day’s leave, and a work environment that is safe and salubrious to their health. Anyone who employs a child in contravention of the legislation faces up to a year’s imprisonment or a fine of 10,000 rupees which could extend up to 20,000 rupees, or both.

The National Policy on Child Labour (NCLP) was established in 1987 by the Government and places emphasis on the rehabilitation of children employed in hazardous industries. In addition to the NCLP, the Ministry of Labour and Employment implemented a number of National Child Labour Projects targeting specific industries, with the aim of rehabilitating child labourers.

The National Policy on Children was adopted by India in 1974, and again in 2013, with the intention of providing equal opportunities for children. India signed the World Declaration on the Survival, Protection and Development of Children, and consequently, the National Plan of Action for Children was developed by the Department of Women and Child Development to address health, nutrition and education, as well as other areas affecting children. Further, the National Plan of Action for the Girl Child formulated by the Indian Government, strives to eradicate gender-based discrimination and to protect young girls from abuse and exploitation, as well as provide them with rehabilitation. The Scheme for Welfare of Orphan and Destitute Children is a Government-sponsored programme that aims to provide children with healthcare, education, shelter, nutrition, and guidance in order to prevent them from becoming destitute in Odisha. The Integrated Programme for Street Children was developed to assist street children and orphans realize their rights, and provides shelter, education, healthcare, and nutrition to needy children, and protects them from abuse and exploitation.

The emphasis of the National Strategy on Adolescent Health is to provide adolescent with health services that will address their specific needs via the Public Health System by incorporating “preventative, promotive, curative and counselling services.” The Reproductive Child Health Phase-II (RCH-II) Programme and National Rural Health Mission incorporated the ARSH strategy to try to increase adolescent use of public health services and to discourage early marriage and child bearing, as well reduce STI and HIV prevalence in adolescents.
In order to address the diverse health needs of adolescents in India, the country's Ministry of Health and Family Welfare (MoHFW) formulated a comprehensive strategy which endeavours to provide adolescents with the ability to make autonomous and responsible decisions about health and well-being. The sexual and reproductive health of adolescents is one of the strategy's focus areas. The strategy seeks to provide greater accessibility and availability of information on adolescent health, and enhance accessibility to adolescent health and counselling services. The strategy aims to do so bearing in mind the social determinant creating barriers to adolescent health, such as discrimination, gender, marriage, lack of education and poverty. The Ministry of Youth Affairs and Sport has also developed the National Youth Policy 2014, which strives to identify key areas concerning youth development requiring action by Government and all stakeholders. One of the priority areas is the health of the youth, the policy aims to raise awareness about contraception and family planning and HIV/AIDS particularly in rural India.

There is presently no law restricting a young person’s access to contraceptives in India. In fact, India’s policies on national health and family planning support the distribution and sale of contraceptives to all sexually active individuals, irrespective of age and marital status. Which is outlined in India's National Population Policy, 2000, page 10 states that - Programmes should encourage delayed marriage and child bearing and education of adolescents about the risks of unprotected sex. Reproductive health services for adolescent boys and girls is especially significant in rural India, where adolescent marriage and pregnancy is widely prevalent. Their special requirements comprise information, counselling, population education, and making contraceptive services accessible and affordable.

Access to emergency contraceptives

Any young person in India can access emergency contraceptives. There is no age restriction in this regard. This means an individual under 18 years of age may purchase emergency contraceptives for his/her own use.

Further, contraceptives such as the ‘day after pill’ are available without medical prescription, as ‘over the counter’ (OTC) products.

Legislation and policy framework

Reference is made to the ‘Guidelines for Administration of Emergency Contraceptive Pills by healthcare Providers’ published by the Ministry of Health and Family Welfare, Government of India (“Guidelines”). Paragraph 2.2 of the Guidelines expressly provide that Levonorgestrel 0.75mg tablets (“LNG”) should be not be denied to clients who are within the reproductive years, irrespective of their age and/or marital status. LNG has been approved by the Drug Controller of India, under the National Reproductive and Child Health Programme, as a ‘dedicated product for emergency contraception’, access to which would not require a prescription from a registered medical practitioner. Which is shown in the ‘Guidelines for Administration of Emergency Contraceptive Pills by healthcare Providers’ published by the Ministry of Health and Family Welfare, Government of India, November, 2008

Paragraph 2.2 – ECPs should be not be denied to clients within the reproductive years irrespective of their age and marital status.
Chapter Four: Age of Consent and HIV testing

India does not have legislation to deal with HIV testing without parental consent. The National AIDS Control Organisation has issued guidelines on Voluntary Counselling and Testing, which is the process by which an individual undergoes confidential counselling to learn about his/her HIV Status and to exercise informed choices in testing for HIV followed by further appropriate action.

As per the Operational Guidelines for Integrated Counselling and Testing Centres issued by the National AIDS Control Organisation, issued in July 2007, access to counselling and testing centres is accessible to children and young people under the age of 18 years without parental consent based on their evolving capacity and ability to comprehend the nature of HIV and AIDS and an HIV Test.

In the context of HIV and AIDS, disclosure refers to the act of informing any individual or organisation (such as a health authority, an employer or a school) of the HIV status of an infected person, or it refers to the fact that such information has been transmitted, by any means, by the infected person or by a third party, with or without consent. Except in circumstances when disclosure to another person is required by law or ethical considerations, the person with HIV has the right to privacy, and also the right to exercise informed consent in all decisions about disclosure in respect of his/her status. In all other cases, the right to privacy is protected. The right to privacy has been held to be a fundamental right protected under Article 21 of the Indian Constitution. As per Article 21 of the Constitution of India, “No person shall be deprived of his life or personal liberty except according to procedure established by law”. The Supreme Court of India in the case of Unnikrishnan vs. State of AP, stated that several un-enumerated rights fall within Article 21, since the expression “personal liberty” is of the widest amplitude. These include the right to privacy.

Legislation and policy framework on HIV testing


Informed consent for HIV testing of minors

“The law gives paramount importance to the best interests of the child. In the context of HIV/AIDS, the best interests of the child are served by promoting access to information and services including counselling and testing services. Whenever possible, minors are encouraged to involve their parents/guardians in supervising their healthcare. However, unwillingness to inform parents/guardians should not interfere with the minor’s access to information and services. Access to ICTC services should be available to children and young people under the age of 18 years based on an assessment of their evolving capacities and their ability to comprehend the nature and implications of HIV/AIDS and an HIV test result. It is the role of the trained counsellor to assess these abilities.

However, the informed consent of parents/guardians is required prior to testing minors for HIV. There is a more general view on healthcare assistance in Article 21 of the Indian Constitution. ‘No person shall be deprived of his life or personal liberty except according to procedure established by law.’


Age of consent to report HIV status directly to adolescents

Information relating to a child’s HIV status is personal information and is protected under the India Constitution from disclosure. Though the law does not distinguish between the privacy rights of minors and those of adults so a minor would be entitled to the same protections as an adult and his/her HIV status could not be reported to another person without his/her consent, in practice, as consent is required at the stage of HIV testing, the privacy of the minor may not be protected with respect to the parent.
Chapter Five: Age of Consent and access to anti-retroviral therapy (ART)

Currently India does not have legislation that restricts access to antiretroviral therapy (“ART”) by a child in India. There is no legal requirement to obtain parental consent in order to administer ART to a minor.

The ‘Antiretroviral Therapy Guidelines for HIV-infected Adults and Adolescents’ (‘ART Guidelines’) published by the National AIDS Control Organisation, Ministry of Health and Family Welfare, Government of India (‘NACO’) expressly provides that all persons living with HIV/AIDS are eligible for ART under the national ART program. No restriction on age is prescribed in this regard. There is only a reference to written informed consent.

Legislation and policy framework on access to ART

There currently is no legislature on ART in India, however there is the ‘Antiretroviral Therapy Guidelines for HIV-infected Adults and Adolescents’ (‘ART Guidelines’) published by the National AIDS Control Organisation, Ministry of Health and Family Welfare, Government of India (“NACO”) in May, 2013.

Section 1.2 –

1.2 Eligibility for ART

The national programme offers ART to the following groups of persons:

- All persons with HIV infection who are medically eligible to receive ART (as per national guidelines);
- Those who are already on ART (outside the national programme) and want to enrol with the National programme for the available ART regimens, after written informed consent.
Chapter Six: Age of Consent and Access to Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP)

Pre-exposure Prophylaxis (PrEP)

Currently there is no specific prohibition on HIV PrEP in India. However, the approval for HIV PrEP by the Drug Controller General of India (DGCI) - head of the Central Drugs Standard Control Organisation (CDSCO) is awaited. Approval will usually be for either testing or marketing, but there is currently no information available in the public domain to confirm which form of approval is under consideration in this case.

In terms of the current regulatory landscape, clinical trials need to be carried out on Indian populations, thus trials conducted on populations of any other country would not suffice. India has detailed regulations on the conduct of clinical trials, which have to be followed prior to this approval also. Recently, in November 2015, the National AIDS Control Organisation (NACO) and Union Health Ministry have cleared an experimental project to study the effect of PrEP on a select group of women in Sonagachi (West Bengal) a red light district. Additionally, in respect of clinical trials, special conditions are laid down in Schedule Y of the Drugs and Cosmetics Rules.

Young people’s access to PrEP

As explained above, the DGCI is yet to grant approval in respect of commercial sale of HIV PrEP in India. Therefore, it is currently illegal to provide PrEP treatment to anyone of any age. In addition, there are no efficacy or safety studies published on the use of PrEP among individuals younger than 18 years of age, although studies in this age group are underway. Explained in the Drugs and Cosmetics Act, 1940 Section 33 of Drugs and Cosmetics Act, 1940 (as amended up to December 5, 2008), read with Rules 33 & 122A (2) of the Drugs and Cosmetics Rules, 1945 (as amended from time to time).

Under the existing legal framework, studies and/or research would not be a substitute for an approval by the CDSCO under Section 33 of Drugs and Cosmetics Act, 1940. Additionally, following receipt of the aforesaid approval, the terms and conditions (if any) set out under the approval would need to be complied with. At this stage, one cannot rule out the possibility of the authorities imposing a restriction on sale of HIV PreP drugs to individuals younger than 18 years of age.

Even if PrEP were to be made available in India without age restrictions, one cannot rule out the possibility of access to the same being made available subject to parents’ and/or doctors’ consent.
Legislation and policy framework on PrEP

At present, there is no legislation or policy specially enabling PrEP use in India. Nevertheless, as with other drugs, HIV PrEP would have to undergo the procedure established for approving introduction of new drugs into the Indian market.

The stages involved in obtaining approvals are set out under:

- Manufacturing License for test, analysis and examination (Form 30 – Application, and Form 29- Approval)
- Clinical Trial (Form 44 – Application, ‘Permission Letter’ – approval)
- Manufacturing and Marketing permission (Form 44 – Application, and Form 45/46- Finished product)
- Manufacturing license (Form 27D – Application, and Form 28D- Approval)
- Registration & Import License (Form 40/8-Application, and Form 41/Form 10 - Approval)

* Note: ‘Manufacture’ in relation to any drug includes the entity responsible for packing, and/or labelling a drug with a view to its sale or distribution.

Drugs and Cosmetics Act, 1940 Section 33 of Drugs and Cosmetics Act, 1940 (as amended up to December 5, 2008), read with Rules 33 & 122A (2) of the Drugs and Cosmetics Rules, 1945 (as amended from time to time).

**Post-Exposure Prophylaxis**

There are no specific prohibitions on HIV Post-exposure Prophylaxis (PEP). The National AIDS Control Organisation provides guidelines enabling PEP use in India. The guidelines do not address the question of Age of Consent specifically and only speaks of informed consent.

In practice, minors are encouraged to involve parents/guardians in supervising their healthcare. However, the absence of parental supervision and/or consent would not interfere with the minor’s access to information and/or treatment. In the absence of an express prohibition, minors and adolescents can access PEP facilities even in the absence of parental consent. The consent becomes necessary only at the stage of HIV testing (see answer to question 16).

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

There is no specific Legislation enabling PEP use in India. Only the guidelines of the National AIDS Control Organisation addresses PEP. It does not specifically deal with Age of Consent. Post-Exposure Prophylaxis (PEP) NACO Guidelines- (http://upsacs.nic.in/PEP.pdf)
Chapter Seven: Age of Consent and access to safe abortions and/or post-abortion care

India has a specific piece of legislation, the Medical Termination of Pregnancy Act, 1971 (MTP Act) that regulates termination of pregnancies in India. The Age of Consent under the MTP Act is 18 years. In case of a minor (someone under the age of 18 years) or a mentally ill person (a person who is in need of treatment by reason of any mental disorder other than mental retardation), written consent of a guardian is required.

Legislation and policy framework on safe abortion and post care

**Medical Termination of Pregnancy Act, 1971 (‘MTP Act’)**

Section 3 of the MTP Act: When pregnancies may be terminated by registered medical practitioners

2. Subject to the provisions of sub-section (4), a pregnancy may be terminated by a registered medical practitioner, -
   a. Where the length of the pregnancy does not exceed twelve weeks if such medical practitioner is, or
   b. Where the length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks, if not less than two registered medical practitioners are, of opinion, formed in good faith, that –
      i. the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health; or
      ii. there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities to be seriously handicapped.

Explanation 1 - Where any pregnancy is alleged by the pregnant woman to have been caused by rape, the anguish caused by such pregnancy shall be presumed to constitute a grave injury to the mental health of the pregnant woman.

Explanation 2 - Where any pregnancy occurs as a result of failure of any device or method used by any married woman or her husband for the purpose of limiting the number of children, the anguish caused by such unwanted pregnancy may be presumed to constitute a grave injury to the mental health of the pregnant woman.

3. In determining whether the continuance of a pregnancy would involve such risk of injury to the health as is mentioned in sub-section (2), account may be taken of the pregnant women’s actual or reasonable foreseeable environment.

In section 2(a) of the MTP (Medical Pregnancy Termination) Act defines ‘guardian’ as a person having the care of the person of a minor or a mentally ill person. As per Section 6 of the Hindu Minority and Guardianship Act, 1956 (applies to Hindus, Buddhists, Jains and Sikhs, subject to conditions), the father is the natural guardian of a child and after him, the mother is the natural guardian. In case of a child under the age of five years or a child born out of wedlock, the mother is the natural guardian. In case of a married minor female child, her husband is the natural guardian. Under Muslim personal laws (uncodified), the father is the sole guardian of a child and the mother only has custodial rights of her son until the age of 7 years and of her daughter until she attains puberty.

Section 7 of the Guardians and Wards Act, 1890 empowers courts in India to appoint a guardian towards guardianship of the person or property of a minor child. Courts in India have also acted under Parens Patriae doctrine and have applied the ‘substituted judgement’ test relying on the ‘best interests’ of the concerned woman in order to decide the issue of termination of pregnancy.
Chapter Eight: Age of Consent on access to Antenatal Care (ANC)

There is no law governing Antenatal Care in India and the provision of access to ANC is discretionary. However, there are certain guidelines (brought in by the Government of India in April, 2010) governing the provision of maternity care by health workers like midwives and nurses during pregnancy, childbirth and thereafter. Additionally, the Federation of Obstetric and Gynaecological Societies of India (‘FOGSI’) has put in place certain Good Clinical Practice Recommendations which require minimal levels of care during pregnancy.

Legislation and policy framework

Here are the guidelines as stated:
Guidelines for Antenatal care and Skilled Attendance at Birth

Essential:
- Early registration of the patient to ensure the first check-up occurs within the first 12 weeks of the pregnancy
- Administer two doses of tetanus toxoid injection
- Provide at least 100 iron/folic acid tablets
- Take patient’s history and conduct physical examination such as measuring weight, blood pressure
- Check abdominal palpation for foetal growth, foetal lie and auscultation of Foetal Heart Sound (FHS)
- Conduct haemoglobin estimations and urine tests
- At least 4 follow-up ante natal check-ups

Desirable:
- Check blood group including Rh factor
- Check for syphilis, HIV and Hepatitis B Surface Antigen

The Guidelines also stress the need for counselling on various issues such as sex during pregnancy, diet to be followed and family planning.

As well as The Good Clinical Practice Recommendations, ‘Routine Antenatal Care for the Healthy Pregnant Women’, The Federation of Obstetric & Gynaecological Societies of India (FOGSI).

Essential:
- One visit is a must in the first trimester followed by monthly visits until 30 weeks, 2 weekly visits until 36 weeks and weekly visits until delivery
- Blood investigations (follow up test in third trimester)
- Administer two doses of tetanus toxoid
- Prescribe Iron, Folic Acid and Calcium supplements
- Check for congenital abnormalities
- Counselling on contraception and nutrition

Supplementary care:
- Counselling for HIV, Hepatitis B Surface Antigen, Hepatitis C Virus testing
- Screening for Thalassaemia and Down's syndrome
- Ultrasound, blood tests and urine tests every trimester
- Screening for infections, thyroid dysfunctions and growth retardation
Chapter Nine: Access to HPV vaccine and cervical cancer screening and treatment

There is currently no legislation or policy framework in place for enabling/disenabling Human Papillomavirus (HPV) vaccines or for cervical cancer screening and treatment. Minors and adolescents are not expressly prohibited by law or policy from accessing HPV vaccines, cervical cancer screening or treatment even in the absence of parental consent.

Legislation and policy framework

The Advisory Committee on Immunization Practices currently recommends routine vaccination of females aged 11–12 years with three doses of the HPV vaccine.

HPV vaccines are used for preventing cervical cancer. Due to the deaths of some female children and adolescents in Khammam district of Andhra Pradesh, which are alleged to be linked to the HPV vaccination trials conducted by an American agency, PATH International, there is strong opposition to these vaccines. A public interest litigation has been filed before the Supreme Court of India for a thorough investigation of the incident. The decision of the court would impact access to these vaccines.
Chapter Ten: Contradictions and inconsistencies

The legal review of the Age of Consent in India noted three main inconsistencies discovered:

1. Although the minimum age to consent to sexual intercourse is 18 years old, an exception exists for wives who are not younger than 15 years. This exception is in effect contrary to the provisions contained in the Protection of Children from Sexual Offences Act, 2012, which does not provide for any such exception.

2. Also, while adult men and women 18 years of age and older are considered to be capable of consenting to heterosexual intercourse, the provision IPC 377 disregards consent and criminalizes even consensual sexual acts between two adults if it is considered to be against the order of nature.

3. Finally, policies regarding access to contraceptives clearly contradict the provisions of law regarding the Age of Consent for sexual intercourse. The policy on access to emergency contraceptives expressly says 'irrespective of their age,' which means persons under 18 years of age are able to access contraceptives in India even though they are under the Age of Consent for sexual intercourse.
Chapter Eleven: Conclusion

Authorities and other stakeholders should engage with communities (including adolescents) on the social and cultural factors that facilitate early sexual debut and child marriages, and the health risks implicit in such practices. Such engagement should include focused campaigns in communities where early sexual debut is deemed socially acceptable, with the goal of discouraging such norms and values. Authorities should take tangible steps to sensitize health professionals regarding their ethical duties in respect of all patients, including heterosexual adolescents who are sexually active and LGBTI adolescents. Health professionals should be reminded that their professional ethics duties supersede personal moral biases. Authorities should work towards gender equality, eradicating gender-based violence, and devising strategies to encourage and facilitate SRHS access to adolescent labourers and particularly vulnerable adolescents, such as orphans.

A limitation of this work is that data sources were limited to publically-accessible documents in English, and not based on original qualitative or quantitative research. Relevant studies may have been overlooked if they were not included in the databases reviewed for this report.
## Chapter Twelve: Recommended intervention on legal and policy framework

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### Legislation: L  Policy: P  Policy Reform: PR  Any interventions that is listed above: IL  Guidelines: G
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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.