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

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

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

AGE OF CONSENT
LEGAL, ETHICAL, CULTURAL AND SOCIAL REVIEW
## ACRONYMS

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<thead>
<tr>
<th>Acronym</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>ANC</td>
<td>Antenatal Care</td>
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<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
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<tr>
<td>EHP</td>
<td>Essential Health Package</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<tr>
<td>HCT</td>
<td>HIV Counselling and Testing</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HPV</td>
<td>Human Papillomavirus</td>
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<tr>
<td>MMC</td>
<td>Medical Male Circumcision</td>
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<td>MPR</td>
<td>Multiple-perpetrator Rape</td>
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<tr>
<td>MSP</td>
<td>Multiple Sexual Partners</td>
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<tr>
<td>PLWHA</td>
<td>People Living with HIV/AIDS</td>
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<td>PLWHIV</td>
<td>People Living with HIV</td>
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<td>PEP</td>
<td>Post-exposure Prophylaxis</td>
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<tr>
<td>PrEP</td>
<td>Pre-exposure Prophylaxis</td>
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<td>SRHS</td>
<td>Sexual and Reproductive Health Services</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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EXECUTIVE SUMMARY

Age of Consent to sexual intercourse according to Thai law is 15 years for both males and females provided the parties to the sexual intercourse are not married to each other. Section 277 of the Criminal Code B.E. 2499 (1956) provides that sexual intercourse with a person under the age of 15 years is an indictable offence (provided the parties are not married to each other and, in the case of 14-year-olds only, no punishment will be imposed on a male offender if the girl consents to sexual intercourse and the court grants its permission for the parties to marry.

There is no existing law that prohibits a person under the age of 20 years to access modern contraceptives without parental consent. Modern contraceptives are available over the counter and parental consent is not required. In general, access to modern contraceptives and reproductive health matters are addressed through a variety of laws and policies. The Government does not prohibit the use of emergency contraceptive pill (the “ECP”), which has been widely used in Thailand. It is relatively easy to gain access to the product, the ECP is available over the counter from a general pharmacy without a doctor’s prescription and no parental consent is required by young people under the age of 20 years.

Since October 2003, the Government has also embarked on universal access to antiretroviral drugs (ARVs) and contraceptive services. There are no age restrictions on access to ART and minors of any age can access ART without parental consent. Currently, there are 62% of the children who are eligible for treatment that are receiving ART in Thailand. Since 2005, people of all ages have been receiving access to free antiretroviral treatment and voluntary HIV testing and counselling as part of the country’s universal health insurance scheme. Between 2010 and 2014, coverage of people living with HIV receiving antiretroviral medicines increased from 42% to 61% which includes children and minors.

Access to Post-exposure Prophylaxis (PEP) and Pre-exposure Prophylaxis (PrEP) is not restricted to a specific age it is covered under the Universal Coverage Scheme – a minor of any age can receive PEP without parental consent. Any person that is “at risk” can access PrEP from the Thai Red Cross’s Anonymous Clinic at the cost of 30 Baht (about $1) per day.

Abortion is illegal in Thailand, only abortions which are performed to preserve the mother’s life are legal. Based on the WHO report, Thailand has the 2nd highest number of teenage births among ASEAN countries (UNICEF Thailand TOR for situational analysis of adolescent pregnancy). In 2010, there were an estimated 80,000 adolescent pregnancies and reportedly 14.4% of these pregnancies resulted in illegal abortions (Areemit R et al. Adolescent Pregnancy: Thailand’s National Agenda. Journal of the Medical Association of Thailand. July 2012. Pages 34 – 42). Further, more than 2,000 foetuses from illegal abortion clinics were found hidden in a Buddhist temple in Bangkok and an estimated 1,000 out of 400,000 women died in the abortion process.

Antenatal Care (ANC) is covered by the national scheme, Universal Coverage Scheme (UCS). Antenatal Care (ANC) is accessible to every pregnant woman regardless of their nationality and age. Recommendations set out in policy encourage the use of Human Papillomavirus (HPV) vaccine for immunisation. There are no age restrictions to access the HPV vaccine so parental consent is not a legal requirement.

A person at any age can access HIV testing without parental consent. If a minor does not understand the process of testing, the test results will be reported to the parent or guardian.
Chapter One: Introduction

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

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

Research conducted in many parts of the world shows that several legal and human rights barriers hinder access to, and uptake of, HIV services for adolescents. Key among these barriers are Age of Consent legislation and policies. Recent global guidelines have, therefore, explicitly called on countries to examine their current policies and consider revising them to reduce age-related barriers to access and uptake of the overall SRH services, HIV Counselling and Testing (HCT) and 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, 15.6% of young women are HIV positive, compared to 6.5% of young men.

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

All In To #EndAdolescentAIDS works through four workstreams. As part of workstream 1, global partners have prioritised joint action to take stock of the current situation in countries with respect to Age of Consent for services including HIV 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 globally and specifically within the 25 focus countries. This review will inform the development of a source or toolkit for learning on this theme and capacity building of experts and policymakers worldwide.

Why Age of Consent review?

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

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

Therefore, the main goal of the project was to conduct research on “Age of Consent” laws, regulations, and policies, as well as ESC factors, in relation to adolescents. This entailed collecting country experiences to address Age of Consent laws / polices and ESC factors that serve as potential barriers to adolescents accessing SRH services, including HIV prevention, care and treatment. The research explored implications for expanding SRHR services and HTC in adolescents aged 10–19 years.

Methodology

The Thailand legal, ethical, cultural and social review was prepared by SAT and is based on legal review research conducted by the 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 ECS component of the study 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 and 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.

Thailand’s analysis was conducted through a desk review of publically accessible sources, including works published by international agencies such as UNICEF, UNDP, UNAIDS, UNFPA, UNESCO, World Bank, Thai Government reports, and non-governmental research outputs.
Country overview

Thailand is situated in Southeast Asia and is the third largest Southeast Asian country after Indonesia and Myanmar. Thailand has a population of approximately 68 million people, of which 98.1% are Thai nationals and the majority of the balance comprising people of ethnic Chinese, Myanmar, and Lao origin. Buddhism is the country’s most dominant religion with approximately 93.6% of the population identifying as devotees, followed by Islam (5.4% of the population), and Christianity (0.9%). Administratively, Thailand is divided into 5 provinces and 878 districts. The official and commonly used language in the country is Thai.

Country context

- Thailand is classified as an upper middle income country with a GDP of 404.8 billion.
- It has an estimated population of 67.73 million people.
- Adolescents constitute 13% of the population. There are approximately 8,912,000 adolescents in Thailand.
- Thailand is one of the 12 Asian-Pacific countries with the highest levels of HIV prevalence.
- Thailand has approximately 440,000 PLWH. There are approximately 200,000 women living with HIV.

There are approximately 11,000 adolescents living with HIV in Thailand, of which 5,300 are boys and 5,700 are girls.
Chapter Two: Age of Consent to sexual intercourse

Thai law states that, provided the parties to the sexual intercourse are not married to each other, the Age of Consent to sexual intercourse is 15 years of age for both males and females. Section 277 of the Criminal Code B.E. 2499 (1956) provides that sexual intercourse with a person under the age of 15 years is an indictable offence (provided the parties are not married to each other and, in the case of 14 year olds only, no punishment will be imposed on a male offender if (1) the girl consents to sexual intercourse and (2) the court grants its permission for the parties to marry.

Legislation and policy framework

Criminal Code B.E. 2499 (1956)

Section 277 Whoever, has sexual intercourse with a girl not yet over fifteen years of age and not being his own wife, whether such girl shall consent or not, shall be punished with imprisonment of four to twenty years and fined of eight thousand to forty thousand Baht. If the commission of the offence according to the first paragraph is committed against a girl not yet over thirteen years of age, the offender shall be punished with imprisonment of seven to twenty years and fined of fourteen thousand to forty thousand Baht, or imprisonment for life.

If the commission of the offence according to the first or second paragraph is committed by participation of persons in the nature for destroying a girl and such girl is not consent, or by carrying the gun or explosive, or by using the arms, the offender shall be punished with imprisonment for life.

The offence as provided in the first paragraph, if the offender being the man commits against the girl over thirteen years but not yet over fifteen years of age with her consent and the Court grants such man and girl to marry together afterwards, the offender shall not be punished for such offence. If the Court grants them to marry together during the offender be still inflicted with the punishment, the Court shall release such offender.

Section 277 bis If the commission of the offence according to the first paragraph of Section 276, or the first or second paragraph of Section 277, causes:
Grievous bodily harm to the victim, the offender shall be punished with imprisonment of fifteen to twenty years and fined of thirty thousand to forty thousand Baht, or imprisonment for life;
Death to the victim, the offender shall be punished with death or imprisonment for life.

Section 277 ter If the commission of the offence according to the second paragraph of Section 276 or the third paragraph of Section 277, causes: Grievous bodily harm to the victim, the offender shall be punished with death or imprisonment for life Death to the victim, the offender shall be punished with death.

[NB: Only an unofficial translation of the relevant Thai law is available.]

Definition of statutory rape

The Criminal Code - Amendment Act (No.19) B.E. 2550 (2007) expanded the definition of statutory rape to cover sex with a person under the age of 15 years regardless of their gender and for the purpose of this law, consent is not a defence. There is an exception if the parties to the sexual intercourse are married to each other (whereby a minor will still be guilty of the offence, but will not be punished). While the legal age to get married in Thailand is 17 years old, couples may marry at a younger age with court approval.

Legislation and policy framework

Criminal Code B.E. 2499 (1956) and the Amendment Act (No.19), B.E. 2550 (2007)

Section 277 Title IX Offences Relating to Sexuality - Please see Q1 above

Civil and Commercial Code

Part II (Capacity)
Section 19 - A person, on the completion of twenty years of age ceases to be a minor and becomes sui juris.
Section 20 - A minor becomes sui juris upon marriage, provided that the marriage is made in accordance with
the provisions of Section 1448.

Section 1448 - A marriage can take place only when the man and woman have completed their seventeenth year
of age. But the Court may, in case of having appropriate reason, allow them to marry before attaining such age.

[NB: Only an unofficial translation of the relevant Thai law is available.]

Age of Consent and sexual debut

Thai law permits an individual to consent to sex from 15 years of age.7 However, the Penal Code Amendment
Act of 1997 outlines a number of amendments that ostensibly sets the Age of Consent at 18 years of age
(Penal Code Amendment Act, 1997).8

The national sexual surveillance system in Thailand highlighted that in 2008, 3% of 13 year olds, 15-24% of
16 year olds, and 37-43% of 17 year old adolescents had already initiated sexual activities. The average age
for Thai adolescents’ sexual debut is 13-15 years of age.9 Sexual initiation for adolescents is on the rise due to
the rapid development of information technology, ways of living, and social practices.10 Young people who are
in a pivotal phase of their development easily adopt to these changes.11

The majority of people in Thailand report their religious affiliation as Buddhist.12 The third Buddhist precept
addresses human sexuality.13 It cautions people to refrain from sexual misconduct.14 Thai people interpret
this to mean that one should not commit adultery, rape, sexually abuse children, and have sexual activities
that result in the sorrow of others.15 Buddhism does not explicitly mention premarital sex, prostitution, and
homosexuality.16 Buddhism does not have religious laws compelling a person to get married, remain a bachelor
or lead a life of chastity.17 It gives individuals the freedom to decide on all issues pertaining to marriage.18
Objections to premarital sex are perhaps grounded in other non-Buddhist beliefs such as classism, animism
or Western medical theories.19

Sex and gender

In Thailand, expression of sexuality is more widely accepted among males than females.20 Males have greater
freedom in their sexual lives and society accepts male sexual experimentation but takes a more restrictive
approach towards females.21 Adolescent males’ status as ‘smart boys’ is dependent on their sexual performance
and conquests.22 On the other hand, Thai society is against women engaging in premarital sex, although there
is wide acceptance for young males to indulge in sexual activities before marriage.23 However, there is now
increased acceptability of premarital sex among young women.24 Conservative Thai beliefs against premarital
sex is now being undermined by information technology, which is facilitating earlier sexual debut.25 The
trend of boys initiating sexual activity with commercial sex workers has now shifted to them debuting sexual
activity with girlfriends, lovers, casual acquaintances, and classmates.26 Studies suggest that the decline in
commercial sex patronage for adolescent boys has led to the decline in age of sexual initiation and an increase
in premarital sexual relations among adolescents. Evidence suggest that young MSM debut sex earlier than
their heterosexual peers.27

Technology

Technological advancements have led to massive social and cultural changes in Thailand.28 Thai adolescents
have a high smartphone ownership rate. One survey indicated that approximately 75% of Thai teens have a
smartphone, 70% have access to the Internet through another device, and 40% are active on Facebook.29
Thai teens spend an average of 5.3 hours a day on the Internet.30 Adolescents are exposed to rapid changes
in social norms, urban values, and intense sexual stimuli through the mass media and the Internet, leading
to greater sexual freedoms and fast-evolving norms in sexual behaviour and attitudes. This has also led to
greater sexual freedom for Thai women in the midst of rapid cultural and social transformations. Adolescents
in Thailand are exposed to sexually explicit material through the Internet and television, and such exposure
correlates with sexually risky behaviours and attitudes.31,32 Such material heightens sexual awareness and
curiosity, thus catalysing early sexual debut.33 The eruption of smart phone gay dating apps has expanded the
options for casual sex for adolescent MSM. Mobile apps allow users to locate each other and arrange for sexual encounters.

**Family characteristics**

Studies in Thailand have indicated that family dynamics contribute to how early adolescents debut sexual activity. Males whose parents do not live together tend to debut sexual activity earlier than those who are raised in a two-parent household. Females who lack confidants in the family and those who live far from home tend to initiate sex earlier. There is lack of discussion on sexual issues in Thai families. Thai adults are against sex education programmes for adolescents because they fear that it will promote earlier, or increase, sexual activity. Older generations remain ambivalent to the fact that adolescents are engaging in sexual relationships and do not acknowledge or address these realities. Hence, adolescents are reluctant to disclose that they are sexually active, and thus, conceal their sexual activities. Teachers and healthcare providers have the sole responsibility of educating adolescents. While the media also disseminates sexual information, such information is often sensationalized and has mixed messages. Such messaging can lead to confusion and hasten sexual activity as it can be viewed as normal for teens. Cultural ambivalences about sexual issues produce confusing messages for adolescents. This leads to adolescents obtaining inaccurate information from friends and peer groups.

**Child marriages / cohabitation**

Child marriages are still prominent in Thailand. The legal minimum age at marriage without requiring parental consent is 17 years for both men and women in Thailand. Culturally, Thai women are expected to marry at a young age. Some parents arrange for their daughters to get married to men they do not know or love. They do this to get dowry in the form of money from the husband. Adolescents who are not in school and who receive less than primary education have a greater probability of being involved in child marriages. The 2010 National Population and Housing Census reported that 13.3% of girls 15-19 years of age were married or cohabitating with their partners. The Multiple Indicators Cluster Survey (MICS) conducted in 2005-2006 indicated that 19.7% of women aged 20-24 years reported that they had been married or cohabitating with their sexual partner before the age of 18 years. The subsequent MICS conducted in 2013 indicated an increment to 22.1%.

**Internal migration**

There is substantial growth in rural to urban migration amongst adolescents in Thailand. Young people migrate to urban areas in search of better education, facilities, and employment opportunities. Research has shown that there is a relationship between migration and sexually risky behavior. There are greater opportunities for adolescents to engage in sexual relationships in urban areas compared to rural areas. This can be attributed to having a larger pool of romantic partners, exposure to a broader set of values that are normative in city life, and independent living arrangements. When adolescents live in rural areas and with their parents they are closely monitored and have a social support network. On the other hand, many migrants live away from their parents and their traditional social network, which is a common feature of living in a new urban environment. Accordingly, young people who move to urban areas are more likely to debut earlier than their rural counterparts who do not migrate.

**Child abuse**

The high demand for sex with children and individuals wanting to commercially exploit vulnerable children has led to many children being victims of sex trafficking, prostitution, and pornography. Social factors, such as poverty and tourism, have also contributed to children being vulnerable to sexual exploitation. There is high prevalence of child abuse in Thailand. An estimated 60,000 children under the age of 18 are involved in child pornography and commercial sex exploitation. Approximately 40% of people involved in prostitution are under 18 years of age. The common age group for girls involved in commercial sexual exploitation is between 12 and 16 years of age. Child prostitution is mainly prominent in Pattaya, Patong in Phuket, and the northern city of Chai Mai. Children from the ethnic minority known as the “hill tribes” are particularly vulnerable. Every year an estimated 6,000-7,000 children are abused in Thailand. Child sex tourism (CST) is also prominent in Thailand. The Royal Thai Police reported a total of 4 CST offences in 2007 and 72 CST offences in 2008.
Ethical implications and recommendations

To address the relatively high rate of child marriage in Thailand, Thai authorities should engage closely with Thai society, including community and religious leaders with a view to discouraging such practices.

Given Thailand’s high internal migration rate, and the impact of such migration on the health of adolescent migrants, Thai authorities should consider devising strategies to reach migrant adolescents with a view to proving such adolescents with relevant support services and facilitating their access to SRHS, thereby deterring their early sexual debut.

While Thailand has a plethora of laws, policies, and programmes aimed at countering child abuse and exploitation, Thai authorities need to do more to encourage the reporting of such occurrences. Furthermore, authorities must demonstrate effective implementation on an ongoing basis to deter such practices.

Country experiences in addressing barriers

In order for Thai society to form positive values on the importance of sexuality education in schools, the Government has implemented policies to raise awareness on the importance of sexuality education.73 UNICEF has devised child protection programmes which help children who are vulnerable to, or victims of, abuse, exploitation and neglect.74 The programmes focus on strengthening and building capacity in families, communities and Government.75 To decrease sexual health risks among young vulnerable groups in Bangkok, PATH: Love Care Stations and services were established.76 The stations and services are aimed at increasing the demand and utilisation of SRHS, improve access and efficiency of SRHS, strengthening the network of service providers with the capacity to deal with sexual health issues and prevention.77 Thai authorities have established a strict legal framework which tackles various elements of sex crimes (sex with minors, prostitution, trafficking etc.).78

The Thai Penal Code Section 282 criminalizes luring, procuring, or trafficking persons for the purpose of sexual gratification and penalties are heightened if the person is under 18 years of age, with 20 years imprisonment for children under 15 years.79 The Thai Penal Code Amendment Act 1997 clarifies that the victim’s consent is no defence for children under 18 years of age. In an effort to monitor Internet safety following the Computer Control Act of 2007, the Ministry of Information and Communication has implemented a number of initiatives. UNODC provides assistance in legislative framework and law enforcement efforts against child sex tourism.80 Thailand is considering a draft law on the Prevention and Suppression of Material Inciting Dangerous Behaviour such as child sex abuse material.81 However, these laws need more effective implementation.82

Homosexuality and transgender expression

In 2010, there was an estimated 550,000 MSM in Thailand.83 Thailand has one of the largest transgender female populations in the Asian-Pacific area.84 Thai society is perceived to be accepting of gender and sexual diversity by both foreigners and some of its own population.85 Some Governmental organisations encourage LGBTI communities to visit Thailand because of its accepting nature.86 However, studies have shown that Thai society is not as accepting as advertised but, rather, tolerant.87 LGBTI people are tolerated as long as they remain within certain social confines. Thai societal norms do not accept LGBTI behavior and people who are viewed as deviant or abnormal.88 The LGBTI population in Thailand is often segregated and regarded as the ‘other gender’.89 Thai society is tolerant of the LGBT community but it lacks understanding about the struggles and needs of this particular group. A nationwide survey conducted in 2012 reported that 60% of Thais opposed same-sex marriages. A study on bullying of LGBTI adolescents in Thailand indicated that 56% of self-identifying LGBTI students were bullied because of their sexual orientation, and a further 25% of students who were perceived to be LGBTI were also bullied.90

LGBTI people in Thailand face discrimination and stigma when accessing healthcare services.91 Thai studies have reported that health providers are judgmental, impolite and unfriendly to the LGBTI community.92 Furthermore, the LGBTI community in Thailand receives unequal standards of care.93 For instance, some healthcare workers disclose sensitive and private health information.94 In some cases healthcare workers perceive that LGBTI people are mentally unstable and refuse to treat them.95 Despite efforts to sensitize media institutions about the LGBTI communities, the media still portrays MSM
negatively. They are stereotyped as excluded, unfortunate, and with no career prospects. This invokes fear and denial in parents when they learn of their child’s sexuality. Respecting parents’ wishes and upholding family reputation is important in how individuals conduct their life. This leads to many LGBTI people staying in the closet, moving away from home, and struggling with self-stigma for fear of shaming the family. However, some families accept their LGBTI children and do not disown their children based on their sexual orientation.

As indicated above, Thailand’s population is largely Buddhist. Theravada Buddhists regard all sexual relationships to be personal matters of mutual consent. When a relationship promotes happiness and well-being of both parties, it is considered positive and acceptable. Moreover, in Buddhism, what determines an act to be unskillful or not is the quality of emotions and intentions involved, but rather the object of one’s sexual desire. The Buddhist population in Thailand has two divergent views on same-sex activity. One is of the viewpoint that people born LGBTI are being punished for immoral sins – marriage transgressions – in their past lives. The other group believes LGBTI people are unable to control their sexual impulses and tendencies. This viewpoint is grounded in the acknowledgement of only males and females in Buddhism.

Ethical implications and recommendations

Notwithstanding the apparent relaxed attitude of Thai society towards LGBTIs, Thai authorities need to do more to move Thai society from a position of tolerating LGBTIs, to accepting LGBTIs. Thai authorities also need to do more to deter discriminatory, judgemental, and stigmatising attitudes and behaviour on the part of health professionals, towards LGBTIs. 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 their personal moral biases regarding sexual orientation and lifestyle choice. Furthermore, that health professionals (and officials) 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 barriers

Schools in Thailand do not have specific policies to tackle and prevent bullying of perceived LGBTI and LGBTI people. Most schools do not perceive such bullying as a problem requiring specific measures. However, some schools now have ad hoc preventive measures due to the recurrent problem. Most schools offer standard measures such as relationship-building activities, morality promotion, and fraternity systems, and solve bullying conflicts through mediation. These measures, are however, not effective. In 2015, UNESCO and UNDP organised a three-day regional consultation aimed at addressing homophobic and transphobic bullying in schools. Delegates at the consultation pursued measures to raise awareness around bullying and introduce safeguards in the education system. The #PurpleMySchool online campaign was also launched. This campaign called out supporters to show solidarity through posting images on social media featuring the colour purple.

The Thai Red Cross Research Centre, the Rainbow Sky Association, and Population Services International have implemented a number of projects to deliver information about health, human rights, and services to young MSM. The Thai police is also engaged in programmes that strengthen their protection of communities that are vulnerable to human rights violations and HIV.
Chapter Three: Access to contraception services and commodities

Most adolescents access condoms from convenience stores and outreach workers. In the age group 15-24 years, 43.2% of urban females and 47.3% of rural females have comprehensive knowledge of HIV. Although surveys have shown a gradual increase in adolescents’ use of condoms, adolescents are still practicing unsafe sex. The family planning needs of Thai adolescents are neglected. Most Family Planning services such as modern contraceptives are targeted at married women. There is a dearth of reproductive health services catering for adolescents in Thailand. The Office of National Economic and Social Development Policy reported that less than 5% of adolescents have access to preventive services for STIs and HIV. Young adults between the age of 15 and 24 years of age account for 70% of reported STI cases in Thailand. The same age group has the highest number of unwanted pregnancies. This suggests that this age group is not receiving optimal safe sex messages.

Adolescents in Thailand are dissuaded from using healthcare facilities because of a perceived lack of respect for confidentiality. Thai adolescents are also faced with unfriendly healthcare providers and an absence of adolescent service system in network hospitals. The Thai Medical Council removed the 18 years of age restriction for having an HIV blood test without parental consent. Healthcare workers are encouraged to counsel individuals younger than 18 so they fully understand what an HIV test is and its implications.

Studies have indicated that Thai adolescents are ill-equipped to make sexual and reproductive choices. They are poorly informed about their sexuality and means of protecting themselves. Sexuality education is taught at both primary and secondary school levels. However, there are apparent limitations to the sexual education adolescents receive evidenced by the lack of correct knowledge and understanding of sexual intercourse.

There is no existing law that prohibits a person under the age of 20 years (a ‘minor’) to access modern contraceptives without parental consent. Modern contraceptives are available over the counter and parental consent is not required.

In general, access to modern contraceptives and reproductive health matters are addressed through a variety of laws and policies. The constitution of Thailand guarantees the equal rights of all Thais to access basic health services, and the right for low-income individuals to free medical treatment from public health facilities, as provided by law. In addition, there is no law specifically outlying whom or at what age a person can access contraceptives and from a legal standpoint, this remains unclear.

The Food and Drug Administrator is the main agency responsible for overseeing and making recommendations to the Public Health Minister on matters relating to contraceptives. The National Health Security Act was enacted in 2002 (the ‘NHSA’) making it one of the most important social tools for health systems reform in Thailand. Section 5 of the NHSA provides that the Thai population shall be entitled to Health services with such standards and efficiency as prescribed by the Act. Under the same section, all Thai people (including minors) should have access to services under the Universal Coverage Scheme (the ‘UCS’ or the 30 baht scheme). The UCS was established in 2001 to further expand health coverage to additional 18 million people. The THB 30 co-payment was abolished by the Government in November 2006, and the system is now free of charge to Thai nationals.<http://www.nhso.go.th/eng/Files/Userfiles/file/Thailand_NHS_Act.pdf>

The current Government is in the process of drafting the Reproductive Health Protection Act to promote and protect sexual and reproductive health. Moreover, the National Policy and Strategy on the Development of Sexual Reproductive Health (‘SRH’) and Thailand’s 1st National Sexual and Reproductive Health Plan 2009-2013 was developed to promote quality reproductive health for all ages. The plan includes the national strategy to ‘Develop a quality and efficient SRH service system.’ The national goal is set for 80 per cent of hospitals at all levels, providing youth-targeted reproductive health services. The Plan aims to develop the capacity of hospitals, schools, and relevant agencies to provide quality SRH services. These laws and policies are aimed at improving the current SRH services, to make contraceptives more accessible to all individuals regardless of their age or gender.
In addition, in February 2015, the Ministry of Public Health issued several policies to combat and reduce unplanned pregnancy, one of which is to make contraception available and provide quality family planning services. As a result, the National Health Security Office and Department of Health made available injectable contraception and Intrauterine device (IUD) to any female under the age of 20 free of charge.

Voluntary counselling and STI testing are available at approximately over 1,000 hospitals and clinics across the country. For example, the Thai Red Cross provides access to contraception and affordable testing for all people at any age. An officer at the Thai Red Cross confirmed that basic contraceptives such as condoms and birth control pills can be obtained by a minor without parental consent.

**Legislation and policy framework**

**Constitution of Thailand, Section 51 and Section 52**

*Please note that the current Constitution is suspended. The following is an unofficial translation.*

Section 51: A person shall enjoy an equal right to receive standard public health service, and the indigent shall have the right to receive free medical treatment from State’s infirmary. The public health service by the State shall be provided thoroughly and efficiently. The State shall promptly prevent and eradicate harmful contagious diseases for the public without charge.

Section 52: Children and youth shall have the rights of survival and to receive physical, mental, and intellectual development according to their potential in a suitable environment with vital regard to children and youth’s participation. Children, youth, women, and family members shall have the rights to be protected by the State against violence and unfair treatment, and have the rights to be cured and rehabilitated when such incident happens.

Intervention and restriction of the rights of children, youth, and family members shall not be permitted, except by virtue of law, specifically to conserve and maintain the status of family or for the greatest benefits of those individuals.

Children and youth with no guardian shall have the rights to receive appropriate care and education from the State.

**Drugs Act B.E. 2510 (1967), Subsections. 6-11**


**Civil and Commercial Code of Thailand, Subsection 19, 23-24**

Section 19. Age of Majority – Adulthood

A person, on completion of twenty years of age ceases to be a minor and becomes sui juris.

Section 22. Minors: No consent to accept a right or be release of a duty

A minor can do all acts by which he merely acquires a right or is freed from a duty.

Section 23. Minors: No consent needed for personal activities. A minor can do all strictly personal acts.

Section 24. Minors: No consent needed for basic life decisions. A minor can do all acts which are suitable to his condition in life, and required for his reasonable needs.

**National Health Security Act BE 2545 (2002) Chapter 1 Right to Health Service**

The Thai population shall be entitled to a Health service with such standards and efficiency as prescribed in this Act. The Board shall have beneficiaries jointly pay cost sharing as prescribed by the Board to the Healthcare unit per visit, except such persons as prescribed by the Board who shall be entitled to Health service without joint payment.
Types and limits of Health service for beneficiaries shall be as prescribed by the Board. DLA: Contraceptive services in covered under the UCS. Please note that the UCS is not available in English and nor is the full guide is publicly available.

**Draft Act on Child Protection and Child Protection Procedure, Section 8**

Children shall have the right to openly express their views on any decision, measures or action which will affect them. When a decision is to be made or an act to be taken pursuant to the foregoing sentence, these views of children shall be taken into account appropriately according to the age and maturity of relevant children.

Children may exercise their rights pursuant to paragraph one in legal and administrative proceedings either by themselves or via appropriate representatives or organisations in accordance with relevant laws.


Article 6, emphasises the principle of the best interest of the child and youth and guarantees their right to standardised health services.

Article 6 The Ministry of Social Development and Human Security shall be responsible for the development of children and youth and for finding solutions to problems that may impact adversely upon their development, based on the following principles:

1. Development of children and youth, enforcement and implementation of provisions under this Act or other acts relating to children and youth in any case shall give primary importance to the best interests of the child;
2. Every child and youth has the rights to education and to receive basic education of the highest quality as stipulated under the Constitution;
3. Children with disabilities, children with learning difficulties, and gifted children have the rights to education specially provided by the state that is appropriate to their needs and characters;
4. Children and youth have the rights to receive healthcare services of the highest available standard;
5. Children and youth have the rights to play, rest and participate in recreational activities that are appropriate to their age and maturity and to participate freely in culture and art; In the implementation of the above clause, the following guidelines shall be applied:
   1. Instil in children and youth a sense of familial bonding, pride in Thai identity and democratic way of life, enable them to lead their lives safely as well as respect the rights of others and society’s rules and regulations;
   2. Ensure healthiness and knowledge of self - protection against diseases and addictive substances;
   3. Ensure emotional maturity appropriate to age, ethics and morality;
   4. Develop skills and positive attitudes to doing work as well as dignity and pride in honest work;
   5. Enhance rational thinking and determination to continuously improve oneself;
   6. Enhance awareness on giving, volunteerism and participation in the development of community and nation;
   7. Enhance age - appropriate sense of responsibility towards oneself and others.


**Draft Protection and Resolution to Unplanned Adolescent Pregnancy Act**, ss 3-5 as at 3 February 2016.


Thailand 1st National Sexual and Reproductive Health Plan 2009-2013, [unofficial translation], UNFPA Thailand Country Office

Ibid at p. 67

Ministry of Public Health Policy of 25 February 2016 on the Prevention and Solving the Problem of Unplanned Pregnancy Amongst Adolescents and Women in their Prime Reproductive Age and the Protection of Unsafe Pregnancy in Thailand

**Access to emergency contraceptives**

The Government does not prohibit the use of emergency contraceptive pill (the “ECP”), which has been widely used in Thailand. It is relatively easy to gain access to the product, the ECP is available over the counter from a general pharmacy without a doctor’s prescription and no parental consent is required by minors (under the age of 20). An employee at the Thai Red Cross Society clinic staff at the National Health Security Office confirmed that the ECP is available over the counter at a general pharmacy to any individual (including minors) without parent consent.

**Legislation and policy framework**

Division of Family Planning and Population, Ministry of Public Health, Services and Counselling on Emergency Birth Control: Handbook for Health Provider [The source is in Thai]

Ministry of Public Health, Ministerial Order No. 1037/2543 (27 Dec 2000) on the Alteration to Registered Birth Control Pills with Progestogen High Dose, Royal Gazette Item 117, Special section 132d [Not available in English.]

National Health Security Office, information received from an employee of the National Health Security Office Also see an article written by Pitchaya Dirommongkol, MD, Mahidol University access on 25 February 2016. http://www.pharmacy.mahidol.ac.th/knowledge/files/0054.pdf

Emergency contraception - the truth that all females should know <http://www.pharmacy.mahidol.ac.th/knowledge/files/0054.pdf>

Information received on 1 February 2016 from staff of The Thai Red Cross Society, Tel. 02-256-4107 or 1664, and National Health Security Office, Tel. 1330) confirmation on access to ECP

**Ethical implications and recommendations**

Given the high rate of Internet usage amongst Thai adolescents, the Thai Government, international agencies, and NGOs working in the field of Thai adolescent health should consider mounting online SRHS campaigns targeted at adolescents (including LGBTI adolescents), in a non-judgemental manner. Such campaigns and information provision should include information on SRHS and where adolescents can access SRHS. Furthermore, authorities should sensitise health workers on an ongoing basis regarding the detrimental impact discriminatory and stigmatising behaviour has on adolescents accessing SRHS.
Non-Thai migrants

Thailand has over 3 million migrant workers\(^\text{129}\) of whom over 1.4 million are residing illegally in the country.\(^\text{130}\) Some sectors attract a disproportionate number of migrant workers. For example, of the 700,000 workers in Thailand’s shrimp sector alone, 80% are migrants, primarily from Myanmar.\(^\text{131,132}\) Many of these workers travel to Thailand with their families, particularly to the country’s coastal provinces, where the shrimp and seafood processing industries are based.\(^\text{133}\) A large numbers of children in the shrimp and seafood industry, both migrant and Thai, are not attending school. Despite Thai law guaranteeing access to education for all children to age 15 years, regardless of citizenship or registration status, approximately 25% of migrant children drop out at the end of sixth grade (around age 12 years), and nearly half of those that remain dropped out when they reach the legal working age of 15 years.\(^\text{134}\) One study on this issue found that many families also withdraw children – particularly girls – from school after age 12 years so that they can care for younger siblings, thus freeing up parents and children over 15 years of age for work.\(^\text{135,136}\) Migrant workers (including adolescents) are faced with many challenges in accessing healthcare services.\(^\text{137}\) These include language barriers, location, and time constraints.\(^\text{138}\) Migrant workers often live in segregated areas which are closer to where they work but far from healthcare centres.\(^\text{139}\) Organising trips to access medical services poses challenges for migrant workers because they have to obtain the consent of their employer, organise transport, and sometimes are at risk of losing their wages and jobs.\(^\text{140}\) Reports indicate that migrants in Thailand lack comprehensive HIV knowledge.\(^\text{141}\)

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. Thailand’s prevalence of child labour, especially amongst migrant communities, serves as a major barrier to affected adolescents accessing SRHS. Thai authorities need to address the health and safety needs of migrant workers, including adolescent workers, who are particularly vulnerable because of their age and illegal emigration status. To this end, authorities should consider ways to facilitate access to SRHS for adolescent labourers. This may include the provision of community-based youth friendly SRHS mobile clinics with extended operating hours to cater for adolescent labourers. If such services are being targeted at immigrant communities, such services should be provided in the native language of the patient. Furthermore, stakeholders, including Government, private sector, civil society, and the international community need to do more to incentivise immigrant families to send / keep younger children to/in school, where they may receive exposure to sex education and life orientation skills. In such instances, authorities should consider bridging courses for immigrant students to acquire Thai language competency. Authorities may also wish to consider the use of school-based clinics or mobile clinics to facilitate access to SRHS for migrant adolescents.

Country experiences in addressing barriers

Thailand has demonstrated an on-going commitment to sexual and reproductive health in its policies.\(^\text{142}\) However, these policies have had uneven effect across the population.\(^\text{143}\) Vulnerable groups such as youth, migrants, ethnic minorities, and transgender population need improved outreach and inclusion in these services.\(^\text{144}\) In an attempt to tackle the issue of adolescent sexuality, the Thai Government has implemented targeted policies and programmes.\(^\text{145}\) Among these are (a) the National Reproductive Health policy; (b) the National Youth policy; (c) the National Health Development plan, and (d) the National AIDS Prevention plan.\(^\text{146}\)

To respond to the sexual and reproductive needs of adolescents in Thailand UNICEF and the Path2Health Foundation launched the first Thai comprehensive online sexuality and reproductive health clinic in February 2016.\(^\text{147}\) On this platform young people chat to doctors, nurses and trained staff about issues ranging from love and relationships, sexual behaviours, sexual reproductive health to HIV testing, contraception and unplanned pregnancies.\(^\text{148}\)

The PPAT organises countrywide educational and motivational activities. It also provides contraceptive services to vulnerable groups.\(^\text{149}\) Furthermore, the association also runs a programme of information, education and communication via radio and television on family planning, STIs, reproductive health and environmental issues.\(^\text{150}\) The programmes reach approximately 10 million people. In 2011, PPAT delivered 245,000 services to young people under 25 years of age.\(^\text{151}\)
Chapter Four: Age of Consent and HIV testing

In Thailand a person of any age can access HIV testing. The clinical guidelines for HIV testing and counselling in young people have been successfully changed so that persons aged under 18 years are no longer required parental consent for HIV testing.

Legislation and policy framework

A person at any age can access HIV testing without parental consent (Reference: A covering letter of The Medical Council dated 12 December 2014 sent to any hospital and the attached Clinical Practice Guideline dated 9 October 2014) This article is only available in Thai.

1. A person who requests HIV-related testing under 18 years of age no longer requires parental consent. The individual must have the capacity to understand the information related to HIV infection and the meaning of a positive test result.

A foreigner who is at risk can also access HIV testing at the Thai Red Cross Society, Public Health, Anonymous Clinics and public hospitals under the Universal Coverage Scheme of National Health Security Office in accordance with Cabinet Resolution dated 23 March 2010 (Reference: 1. Universal Coverage Scheme of National Health Security Office regarding AIDS patient - Cabinet Resolution dated 23 March 2010) This is only available in Thai.


In relation to the disclosure of test results, if a minor could not understand the process of testing, parental or guardian involvement would be required and the test results will be reported to the parent or guardian.

The National AIDS programme is a database programme for antiretroviral treatment of the National Health Security Office (NAP) which also produced operational guidelines (Clinical Practice Guidelines) on disclosure of test results. These measures are intended to help youth with HIV risk to enter the diagnosis and treatment system sooner, and help providers create a youth-friendly service.

Regulations

Clinical Practice Guideline dated 9 October 2014

2.1 …

2.2 …

2.3 Disclosure of test results and consultation post-testing

2.4 The duty of confidentiality applies to the patient and disclosing the test results to a related party where the patient does not have the capacity to understand or make a decision as to the next steps post-testing.

The medical practitioner are able to disclose the test results to the parent or guardian if the patient is incapable to manage points 2.1-2.4 referred to above. ‘Parent’ or ‘Guardian’ means father, mother, guardian appointed by law or carer who has a good relationship with the patient and an individual who is trusted by the patient.

3.3 Disclosure of test results is strictly confidential and can only be disclosed to the patient, including any consultation post-testing.

3.4 The duty of confidentiality is strict and only relates to the patient only and test results must not be disclosed to any other person without the consent of the patient, unless required by law.
Chapter Five: Age of Consent and access to Anti-retroviral Therapy (ART)

There are no age restrictions on access to ART and minors of any age can access ART without parental consent.

Currently, there are 62% of the children who are eligible for treatment that are receiving ART in Thailand. Access to care and treatment for HIV/AIDS for disadvantaged or other marginalised groups is being promoted with financial support from other sources such as the Global Fund to Fight AIDS, Tuberculosis and Malaria. Since 2005, people of all ages have been receiving access to free antiretroviral treatment and voluntary HIV testing and counselling as part of the country’s universal health insurance scheme. Between 2010 and 2014, coverage of people living with HIV receiving antiretroviral medicines increased from 42% to 61% which includes children and minors. The last version of Thai national guidelines for ART in HIV-1 infected adults and adolescents was published in 2010 which includes the national guidelines for children. In 2012, Thailand revised its policy for initiating ART by increasing eligibility from a CD4 count of 200 to 350 cells/mm3. This was done so that ART could be initiated faster, improve efficacy in the delivering process and reduce deaths from AIDS-related illnesses. Since October 2003, the Government has also embarked on universal access to antiretroviral drugs (ARVs) and contraceptive services. In addition, the draft Protection and Resolution to Unplanned Adolescent Girls Pregnancy Act provides that adolescent girls are entitled to make their own decision to receive sexual reproductive health services. Furthermore, the draft Act also provides a definition of an ‘adolescent’ to be a person over the age of 10 and under 18 years of age.

This would provide more clarity on who can access contraceptives with the aim to reduce stigmatisation amongst adolescents. The objective of the draft Act is to develop an efficient sexual reproductive health system in Thailand. Making contraceptives more available to minors.

In October 2014, Thailand has implemented the new guideline of antiretroviral treatment which extended the programme to all HIV positive individuals in line with the most recent World Health Organisation (WHO) HIV treatment guidelines. More thorough identification of new cases was introduced to ensure that people could start receiving treatment as soon as possible after diagnosis. An officer from the National Health Security Office confirmed that all people including minors can receive antiretroviral treatment under the national scheme without parental consent.

Legislation and policy framework

Thai national guidelines for the use of antiretroviral therapy in paediatric HIV infection in 2010
http://www.asianbiomed.org/htdocs/previous/A20104505.pdf

The National Child and Youth Development Plan B.E. 2555-2559 (2012-16)

The antiretroviral therapy - a new life for people living with HIV
http://www.redcross.or.th/article/50961

Risk of First-line Antiretroviral Therapy Failure in HIV-infected Thai Children and Adolescents
Children’s Rights to Health

The National Access to Antiretroviral Programme for PHA (NAPHA) in Thailand
Chapter Six: Age of Consent and access to Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP)

Pre-Exposure Prophylaxis (PrEP)

There is no age restriction on accessing Pre-Exposure Prophylaxis (PrEP). Director of AIDS Research Center of the Red Cross Society stated that PrEP is available at 650 THB and to individuals that are considered a high-risk/ to men who have sex with men for free funded by Royal Highness Princess Chomsuwalee. This includes minors who are identified as at risk.

One of the key objectives of the national policy against HIV/AIDS is to change the legal environment to make treatment and services more accessible. The key focus has been on how to best deliver the anti-retrovirals other treatments to the affected/ high risk groups and to overcome its AIDS epidemic. However, the law concerning the Age of Consent remains unclear.

Legislation and policy framework

**PrEP a new life for people who are living with HIV** - the article discusses PEP and PrEP. Also, where PrEP can be obtained. <http://www.redcross.or.th/article/50961>

**National AIDS prevention and control strategies for 2014-2016** – Strategic plan number Thailand’s response to HIV/AIDS - strategy number 1 (increase the protection and sexual reproductive health (groups at risk) - strategy 1.3.1 PEP treatment and prevention with Pre-Exposure Prophylaxis with preventative measures. prevention among young people. This report is not available in English.

**Progress and Challenges Thematic MDG Report** http://www.hivpolicy.org/Library/HPP000242.pdf

**The promises and challenges of Pre-Exposure Prophylaxis as part of the emerging paradigm of combination HIV prevention** http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4509895/

**Information received on 2 February 2016 from staff of Red Cross Society, Tel. 02-256-4107 or 1664)** - confirmed to researchers that there is no age restriction and young people can access PrEP from Anonymous Clinic, Thai Red Cross Society

Young people's access to PrEP

Any person that is ‘at risk’ can access PrEP from the Thai Red Cross’s Anonymous Clinic at the cost of 30 Baht (about $1) per day. Currently, Thailand is undergoing the PrEP-30 project at the Thai Red Cross AIDS Research Centre (TRC-ARC). We were informed by the staff at the TRC-ARC that the project is available to individuals at risk for acquiring HIV infection as part of a combined HIV prevention programme. To participate in the programme the individual will need to make an appointment to consult with the counsellors and doctors at the TRC-ARC. The individual does not need to disclose his or her age and parental consent is not required. The counsellors and doctors will make a decision whether the individual is at risk and whether he or she is eligible to participate in the study and obtain the PrEP free of charge.

Dr Nittaya Phanuphak is currently leading a Thai Red Cross study on the uptake and efficacy of PrEP among Thai MSM. She hopes that the findings from her research will encourage the Thai Government to cover the cost of PrEP under the UCS. The study, which began enrolling participants in May, will look at PrEP uptake among up to 600 MSM in Bangkok, Pattaya, and Pathumthani, and evaluate which delivery models most effectively encourage adherence to HIV prevention regimens. http://www.amfar.org/expanding-pre-exposure-prophylaxis-for-hiv-thailand/
Post-Exposure Prophylaxis (PEP)

There are no age restrictions on access to PEP and it is covered under the UCS. A representative at the National Health Security Office confirmed that a minor of any age can receive PEP without parental consent.

Cabinet Resolution dated 23 March 2010 provides the eligibility guidelines for non-Thai nationals who can receive PEP under the national scheme.

Access to PEP under the national scheme is available to the following individuals:

- Any Thai nationals;
- Non-Thai nationals under the Cabinet Resolution who have access to services under the Universal Coverage Scheme;
- Patients who are involved with Thailand’s National Access to Antiretroviral Programme for People living with HIV/AIDS (NAPHA) and who registered before 1 October 2005; and
- A person who has been referred by a medical practitioner under the clinical criteria and/or immunological criteria to receive PEP.

Legislation and policy framework

Information received on 2 February 2016 from staff of National Health Security Office, Tel. 1330

Thai Civil Rights and Investigation Journalism, 2014, ‘30-baht scheme for HIV positive patients’, access on 5 February 2016

Cabinet Resolutions on 23 March 2010 accessed on 3 April 2016

Young people’s access to PEP

There is no prohibition on access to PEP by minors. Consent considerations are the same as in the answer to question 7. An officer at the National Health Security Office verbally confirmed to researchers that minors/young person of any age can receive PEP without obtaining parental consent. In addition, according to the national AIDS prevention and control strategies for 2014-16 efforts must be made to meet the needs of different communities and populations affected by HIV/AIDS including women, infants, youth, children and families. This includes the national efforts to improve accessibility of PEP and reduce the cost of treatments. Also, efforts must be made to provide education and support services for youth and children living with HIV related diseases.
Legislation and policy framework on access to PEP

**The National AIDS Prevention and Control Strategies for 2014-2016 – An Innovation and Change •**
Expanding the protective social and legal environment essential for HIV prevention and care
- Change Laws and Policies which hinder access to Prevention and Care Services
- Establish mechanisms to effectively implement and monitor laws and policies which support HIV prevention and care

**Strategic plan number 5(v) HIV treatment, care and support -**
Prevention among Young People
- Harmonize and standardize the treatment protocol and service entitlements for all health insurance schemes
- Integrate and strengthen services provided by PLHIV networks into the prevention to care continuum
- Ensure adequate and easily accessible treatment, care and support services for key affected populations
- Improve and increase HIV counselling and testing (HCT) in order to enable early diagnosis and treatment.
- Implement a quality assurance and quality control system for school based sexual and reproductive health education
- Strengthen Youth friendly services for in and out-of-school youth through increased youth participation and human resource development
- HIV prevention for young people is an integral part of youth development programme
- Use IT and modern communication channels for better service delivery

This document is not available in ENG. This particular part outline the Government objectives to combat HIV related diseases with a focus
Chapter Seven: Age of Consent and access to safe abortions and/or post-abortion care

Abortion is illegal in Thailand regardless of consent unless where Section 305 of the Penal Code applies (abortion is performed by a medical practitioner and concerns a pregnancy that either (i) threatens the health of the pregnant woman or (ii) is the result of a rape of the pregnant woman). Illegal backyard abortions are one of the major issues due to the lack of clarity in the law.

Based on the WHO Report 2014, Thailand has the second highest number of teenage births among ASEAN countries (UNICEF Thailand TOR for situational analysis of adolescent pregnancy). In 2010, there were an estimated 80,000 adolescent pregnancies and reportedly 14.4% of these pregnancies resulted in illegal abortions (Areemit R et al. Adolescent Pregnancy: Thailand’s National Agenda. Journal of the Medical Association of Thailand. July 2012. Pages 34 – 42). Further, more than 2,000 foetuses from illegal abortion clinics were found hidden in a Buddhist temple in Bangkok and an estimated 1,000 out of 400,000 women died in the abortion process. Following the media coverage of the discovery of foetuses, religious leaders and politicians spoke out to reaffirm their opposition to more liberalised abortion laws.

Legislation and policy framework

Chapter 3 of the Penal Code - Offence of Abortion

Section 301
Any woman, causing herself to be aborted or allowing the other person to procure the abortion for herself, shall be imprisoned not out of three years or fine not out of six thousand Baht, or both.

Section 302
Whoever, procures abortion for a woman with her consent, shall be punished with imprisonment not exceeding five years or fined not exceeding ten thousand Baht, or both. If such act causes other grievous bodily harm to the woman also, the offender shall be punished with imprisonment not exceeding seven years or fined not exceeding fourteen thousand Baht, or both. If such act causes death to the woman, the offender shall be punished with imprisonment not exceeding ten years and fined not exceeding twenty thousand Baht.

Section 305
If the offence mentioned in ss. 301 and 302, be committed by a medical practitioner, and (i) necessary for the sake of the health of such woman; or (ii) the woman is pregnant on account of the commission of the offence as provided in ss. 276 (rape), 277, 282, 283 or 284 the offender is not guilty of the offence of abortion.

The study examines two main issues of the abortion debate in Thailand: the beginning of human life and the right to abortion. The religious and cultural views are somewhat in contrast with women’s personal rights.

Chapter Eight: Age of Consent on access to Antenatal Care (ANC)

There are no age restrictions to access Antenatal Care in Thailand. Any pregnant woman, regardless of their nationality and age can access ANC under the UCS for free. There is no law or policy that clearly specifies the Age of Consent and parental consent to access ANC. However, we have been confirmed verbally by staff of the National Health Security Office that any pregnant woman who is an AIDS patient at any age can access Ante Natal Care without parental consent. A member of the Thai Red Cross AIDS Research Centre confirmed that any pregnant woman who is HIV positive can access ANC regardless of her age.

Legislation and policy framework

*Universal Coverage Scheme of National Health Security Office regarding AIDS patient* - ANC is covered under the national scheme

*Cabinet Resolution dated 23 March 2010* The cabinet resolutions are in Thai. The resolutions can be access via <http://www.eppo.go.th/admin/cab/cab-2553-03-23.html>
Chapter Nine: Access to HPV vaccine, and cervical cancer screening and treatment

There are no age restrictions to access the Human Papillomavirus (HPV) vaccine and no parental consent is required. Under the UCS, a person at the age between 21-40 years old who has Human Papillomavirus can access HPV vaccine, and cervical cancer screening and treatment.

The HPV vaccine was approved by the Food and Drug Administration of Thailand in 2007. The Royal Thai College of Obstetricians and Gynaecologists and the Thai Gynaecologic Cancer Society recommend that young women aged 11-26 years receive HPV vaccine.

Policy regulations

Chapter Ten: Conclusions

Compared to most countries, Thai adolescents, including LGBTI adolescents, have a greater degree of sexual freedom and access to SHRS. In some respects, Thailand represents an example of a developing country that is undergoing rapid social and economic transformation, and where technology and Internet penetration is having a transformative impact on the country’s adolescent and youth populations. Given the high mobile phone and Internet penetration rate amongst Thai adolescents and youth, authorities and other stakeholders should consider increasingly using social media and other online platforms to engage with heterosexual and LGBTI adolescents on sexual and reproductive health issues. Authorities, policymakers, scientists, civil society should also engage with Thai society (including adolescents) regarding the social and cultural factors that facilitate early sexual debut and child marriages, and the health risks implicit therein. Authorities should take tangible measures to sensitize health professionals regarding their ethical duties towards patients, including LGBTI adolescents. To this end, health professionals should be reminded that their professional ethics duties supersede personal moral biases. Authorities should work towards realizing gender equality. Further, authorities should devise strategies to encourage and facilitate SRHS access to adolescent labourers and their siblings, the latter of whom may be deprived of an education to care for younger siblings so as to enable the rest of the family to work. Thai authorities have developed a commendable range of interventions aimed at improving the health of adolescents in the country. Only the sustained implementation of these measures will address the sexual and reproductive health needs of adolescents in the country.

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 Eleven: Recommended intervention on legal and policy framework

<table>
<thead>
<tr>
<th>Area</th>
<th>Category of regulation</th>
<th>Required intervention</th>
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</thead>
<tbody>
<tr>
<td>Age of sexual intercourse</td>
<td>L</td>
<td>GR</td>
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<tr>
<td>Definition of statutory rape</td>
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<td>GR</td>
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<tr>
<td>Exceptions on Age of Consent - For example 'gay sex'</td>
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<td>Young people’s access to contraceptive services</td>
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<td>Young people’s access to emergency contraceptives</td>
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<td>Minister should sign off on new regulations</td>
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<td>Policy and legislation on young people’s access to PEP</td>
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<td>Policy and legislation on young people’s access to PrEP</td>
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<td>Customary Law LR</td>
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<td>GR</td>
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<td>Legal and policy framework on the Age of Consent HIV status will be reported directly to an adolescent</td>
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</table>

Legislation (L)  | Policy (P)  | Law Reform (LR)  | Government to pass new regulations (GR)  | Regulation (R)
References


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83 Mahidol University, Plan International Thailand, and UNESCO Bangkok. Bullying targeting secondary school students who are or are perceived to be transgender or same-sex attracted: Types, prevalence, impact, motivation and preventative measures in 5 provinces of Thailand 2014. Available: http://unesdoc.unesco.org/images/0022/002275/227518e.pdf
84 Mahidol University, Plan International Thailand, and UNESCO Bangkok. Bullying targeting secondary school students who are or are perceived to be transgender or same-sex attracted: Types, prevalence, impact, motivation and preventative measures in 5 provinces of Thailand 2014. Available: http://unesdoc.unesco.org/images/0022/002275/227518e.pdf
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86 Mahidol University, Plan International Thailand, and UNESCO Bangkok. Bullying targeting secondary school students who are or are perceived to be transgender or same-sex attracted: Types, prevalence, impact, motivation and preventative measures in 5 provinces of Thailand 2014. Available: http://unesdoc.unesco.org/images/0022/002275/227518e.pdf
87 Mahidol University, Plan International Thailand, and UNESCO Bangkok. Bullying targeting secondary school students who are or are perceived to be transgender or same-sex attracted: Types, prevalence, impact, motivation and preventative measures in 5 provinces of Thailand 2014. Available: http://unesdoc.unesco.org/images/0022/002275/227518e.pdf
90 Mahidol University, Plan International Thailand, and UNESCO Bangkok. Bullying targeting secondary school students who are or are perceived to be transgender or same-sex attracted: Types, prevalence, impact, motivation and preventative measures in 5 provinces of Thailand 2014. Available: http://unesdoc.unesco.org/images/0022/002275/227518e.pdf


106 Mahidol University, Plan International Thailand, and UNESCO Bangkok. Bullying targeting secondary school students who are or are perceived to be transgender or same-sex attracted: Types, prevalence, impact, motivation and preventative measures in 5 provinces of Thailand 2014. Available: http://unesdoc.unesco.org/images/0022/002275/227518e.pdf

107 Mahidol University, Plan International Thailand, and UNESCO Bangkok. Bullying targeting secondary school students who are or are perceived to be transgender or same-sex attracted: Types, prevalence, impact, motivation and preventative measures in 5 provinces of Thailand 2014. Available: http://unesdoc.unesco.org/images/0022/002275/227518e.pdf

108 Mahidol University, Plan International Thailand, and UNESCO Bangkok. Bullying targeting secondary school students who are or are perceived to be transgender or same-sex attracted: Types, prevalence, impact, motivation and preventative measures in 5 provinces of Thailand 2014. Available: http://unesdoc.unesco.org/images/0022/002275/227518e.pdf

109 Mahidol University, Plan International Thailand, and UNESCO Bangkok. Bullying targeting secondary school students who are or are perceived to be transgender or same-sex attracted: Types, prevalence, impact, motivation and preventative measures in 5 provinces of Thailand 2014. Available: http://unesdoc.unesco.org/images/0022/002275/227518e.pdf


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 the 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 the status to her/his parents?
18. Please explain any inconsistencies between the answers above.