



Young people and the law

in Asia and the Pacific:

A review of laws and policies affecting
young people's access to sexual and
reproductive health and HIV services



UNAIDS



Youth LEAD

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Glossary of acronyms and terms

AFHS	Adolescent-friendly health services	MSM	“Men who have sex with men” or “males who have sex with males” (either term is intended to include adolescents)
ANC	Antenatal care	NACO	National AIDS Control Organization (India)
APN+	Asia-Pacific Network of People Living with HIV	NGO	Non-governmental organization
ARH	Adolescent reproductive health	NSP	Needle and syringe programme
ARSH	Adolescent reproductive and sexual health	OHCHR	Office of the High Commissioner for Human Rights
ART	Antiretroviral therapy	OST	Opioid substitution therapy
ARV	Antiretroviral	PDR	People’s Democratic Republic
ASEAN	Association of South East Asian Nations	PICTs	Pacific Island Countries and Territories
ASRH	Adolescent sexual and reproductive health	PLHIV	Person/people living with HIV
CBO	Community-based organization	PNG	Papua New Guinea
CEDAW	Convention on Elimination of all forms of Discrimination Against Women	PSI	Population Services International
CRC	Convention on the Rights of the Child	PWID	Person/people who inject(s) drugs
CRPD	Convention on the Rights of Persons with Disabilities	RA	Republic Act (Philippines)
DPRK	Democratic People’s Republic of Korea	RSH	Reproductive and sexual health
ESCAP	Economic and Social Commission for Asia and the Pacific	SAARC	South Asian Association for Regional Cooperation
FGD	Focus group discussion	SAR	Special Administrative Region (Hong Kong SAR China)
FHI	Family Health International	SRH	Sexual and reproductive health
FP	Family planning	SRHR	Sexual and reproductive health rights
ICCPR	International Covenant on Civil and Political Rights	STI	Sexually transmitted infection
ICESCR	International Covenant on Economic, Social and Cultural Rights	TG	Transgender
ICPD	International Conference on Population and Development	UDHR	Universal Declaration of Human Rights
IDLO	International Development Law Organization	UNAIDS	Joint United Nations Programme on HIV/AIDS
IDU/DU	Injecting drug user / Drug user	UNDP	United Nations Development Programme
IEC	Information, education and communication	UNESCO	United Nations Educational, Scientific and Cultural Organization
ILO	International Labour Organization	UNFPA	United Nations Population Fund
MARP	Most-at-risk population	UNICEF	United Nations Children’s Fund
MARYP	Most-at-risk young people	UNODC	United Nations Office on Drugs and Crime
MOEYS	Ministry of Education, Youth and Sports (Cambodia)	USA	United States of America
MOH	Ministry of Health	VCT	Voluntary Counselling and Testing
MOWA	Ministry of Women’s Affairs (Cambodia)	WHO	World Health Organization
		YP	Young people

Definitions of age groups

The report acknowledges that there are multiple understandings of the different phases of life, including definitions of 'adolescent', 'child' and 'young person', and that social and legal markers define adulthood at different points in different settings. The report uses the following age groups in its analysis:

Adolescent (UNICEF, state of the World's Children, 2011)ⁱ

Although there is no internationally-accepted definition of adolescence, the United Nations defines adolescents as individuals aged 10–19: in effect, those in the second decade of their lives.

Child (*UN Convention on the Rights of the Child, 1989*)

Person under 18 years of age, unless under domestic law the child reaches majority at an earlier age.

Young person (UNFPA definition)ⁱⁱ

Person aged 10 to 24 years.

Definitions of key terms

Child marriage (UNFPA, *Marrying too Young, 2012*)ⁱⁱⁱ

Used to describe a legal or customary union between two people, of whom one or both spouses is below the age of 18. While boys can be subjected to child marriage, the practice affects girls in greater numbers and with graver consequences. Child marriage is often referred to as "early" and/or "forced" marriage since children, given their age, are not able to give free, prior and informed consent to their marriage partners or to the timing of their marriage.

i United Nations Children Fund (UNICEF). 2011. *State of the World's Children 2011: Adolescence: An Age of Opportunity*. New York: UNICEF, p. 12. See also United Nations Population Fund (UNFPA) definition at: <http://web.unfpa.org/adolescents/overview.htm>

ii UNFPA definition at: <http://web.unfpa.org/adolescents/overview.htm>.

iii UNFPA. 2012. *Marrying too Young*. New York: UNFPA.

'Evolving capacities of the child' and 'mature minor'

These two concepts are linked. The concepts recognize the developmental changes that children experience as they mature, including progress in cognitive abilities and capacity for self-determination. The concepts recognize that as children acquire enhanced capacities, there is less need for protection and a greater ability of the child to take responsibilities for decisions affecting their lives. The concepts acknowledge that different children achieve competencies at different ages.

The concept of 'evolving capacities' first emerged in international law through the Convention on the Rights of the Child (CRC).^{iv} Article Five of the CRC states that:

States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention.

Article Twelve also addresses evolving capacities, stating that:

States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.

In its General Comment No.15, the Committee on the Rights of the Child explains the implications of the CRC in relation to the rights of children to make decisions about their health care as follows:^v

The Committee recognizes that children's evolving capacities have a bearing on their independent decision-making on their health issues. It also notes that there are often serious discrepancies regarding such autonomous decision-making, with children who are particularly vulnerable to discrimination often less able to exercise this autonomy. It is therefore essential that supportive policies are in place and that children, parents and health workers have adequate rights-based guidance on consent, assent and confidentiality.^{vi}

iv United Nations. 1989. *Convention on the Rights of the Child. A/RES/44/25*. New York: UN.

v Committee on the Rights of the Child. 2013. *General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24)*, CRC/C/GC/15.

vi Ibid, Para 21.

... In accordance with their evolving capacities, children should have access to confidential counselling and advice without parental or legal guardian consent, where this is assessed by the professionals working with the child to be in the child's best interests. States should clarify the legislative procedures for the designation of appropriate caregivers for children without parents or legal guardians, who can consent on the child's behalf or assist the child in consenting, depending on the child's age and maturity. States should review and consider allowing children to consent to certain medical treatments and interventions without the permission of a parent, caregiver, or guardian, such as HIV testing and sexual and reproductive health services, including education and guidance on sexual health, contraception and safe abortion.

National laws determine the 'age of majority', which is the age at which the law recognizes a person is able to exercise full responsibility for their own affairs. People who are under the legal 'age of majority' are referred to as minors. The 'mature minor' doctrine is a legal principle that recognizes the capacity of some minors to consent independently to medical procedures, if they are assessed by a health professional to be sufficiently mature to understand the meaning and consequences of the procedure and therefore are able to make a decision on their own. The gravity and nature of the procedure are also taken into account when assessing a minor's capacity to fully understand all aspects of the situation and to objectively consider treatment options. A parent's or guardian's consent is necessary if the minor is unable to make voluntary and informed decisions, judged by various indicators of maturity.^{vii}

This concept is sometimes referred to as the 'Gillick principle' or the 'Gillick competence' with reference to a 1986 English House of Lords judgment, *Gillick v Wisbech Area Health Authority*.^{viii} The case established that under English law that the "parental right to determine whether or not their minor child below the age of sixteen will have medical treatment terminates if and when the child achieves sufficient understanding and intelligence to understand fully what is proposed."

vii Kuther, T.L. 2003. Medical Decision-making and Minors: Issues of consent and assent. *Adolescence*, Vol. 38, pp. 343-357.

viii *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] 3 All ER 402.

The laws of some countries such as Australia, Canada, New Zealand, the United States of America (USA) and the United Kingdom apply the 'mature minor' principle to enable people under 18 years of age to consent to medical treatment independently of their parents if they are sufficiently mature. Aspects of the 'mature minor' principle have been introduced in statutory provisions relating to consent to HIV testing in some other countries of Asia and the Pacific.

Key populations / Key populations at higher risk of HIV exposure (UNAIDS Terminology Guidelines, 2011)^x

The term 'key populations at higher risk of HIV exposure' or 'key populations' refers to those who are most likely to be exposed to HIV or to transmit it, and whose engagement is critical to a successful response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender persons, people who inject drugs, sex workers and their clients, and sero-negative partners in sero-discordant couples are at higher risk of exposure to HIV than other people. These populations are not mutually exclusive. Many people have multiple factors that may contribute to HIV risk and vulnerability, e.g. a person may be living with HIV, transgender, sell sex and inject drugs.

Sexual exploitation (*UN Convention on the Rights of the Child, 1989*)^x

Article 34 of the CRC calls on States to protect children from all forms of sexual exploitation and sexual abuse with reference to preventing the:

- inducement or coercion of a child to engage in any unlawful sexual activity.
- exploitative use of children in prostitution or other unlawful sexual practices.
- exploitative use of children in pornographic performances and materials.

ix Joint United Nations Programme on HIV/AIDS (UNAIDS). 2011. *UNAIDS Terminology Guidelines*, Geneva: UNAIDS.

x United Nations. 1989. *Convention on the Rights of the Child*. A/RES/44/25. New York: UN. All States of Asia and the Pacific that are members of the UN have ratified, accepted, or acceded to the CRC. For more on relevant articles in the CRC see Annex IV.

Sex worker (UNAIDS, Guidance Note on HIV and Sex Work, 2009)^{xi}

Sex workers include consenting female, male, and transgender adults and young people over the age of 18 who receive money or goods in exchange for sexual services, either regularly or occasionally. Sex work takes many forms and varies between and within countries and communities. Children and adolescents under age 18 who are involved in selling sex are regarded as victims of sexual exploitation.

Transgender (UNAIDS, Terminology Guidelines, 2011)^{xii}

A transgender person has a gender identity that is different from his or her sex at birth. Transgender people may be male to female (female appearance) or female to male (male appearance).

Young key populations at higher risk of HIV exposure

The term 'key populations at higher risk of HIV exposure' (or 'key populations', see above) refers to those who are most likely to be exposed to HIV or to transmit it, and whose engagement is critical to a successful response. In all countries, key populations include people living with HIV. Young key populations are those under age 25. It is important to consider different needs, vulnerabilities and realities of different age ranges and how HIV risk may change across the lifecycle, from very young adolescents (aged 10-14), through older adolescents (aged 15-19) to young adults (aged 20-24).^{xiii}

xi UNAIDS. 2009, last updated 2013. *UNAIDS Guidance Note on HIV and Sex Work*. Geneva: UNAIDS, p 3.

xii UNAIDS 2011, op. cit.

xiii See, UNICEF, UNAIDS, UNESCO, UNFPA, ILO, WHO, World Bank. 2011. *Opportunity in Crisis: Preventing HIV from early adolescence to young adulthood*, New York: UNICEF, pp.1-2.

Executive summary

The Asia-Pacific region is home to the largest number of young people aged 10-24 globally, and the largest cohort of young people in the history of the world. While today's generation of young people in the region are generally healthier and better educated than in the past, sexual and reproductive health (SRH) and HIV are often-overlooked aspects of their well-being.

Poor access to SRH and HIV information, commodities such as condoms and contraceptives, and other services contribute to high levels of unplanned pregnancy and the spread of HIV and other sexually transmitted infections (STIs). Child marriage is common in parts of the region, often accompanied with family and community pressure to bear children at a young age. Adolescent girls with unplanned pregnancies often seek abortion services from untrained practitioners in hazardous circumstances and unhygienic conditions due to limited access to safe and legal abortion in most of the region. One-third of unsafe abortions in the region occur in young women under age 25.

There are multiple factors, including cultural, financial, logistical, institutional, legal and policy factors, that play a role in determining young people's access to services. Some issues facing adolescents overlap with those facing adults in similar contexts, such as concerns about the distance to services, or embarrassment about needing, wanting or asking for SRH information and commodities. Other obstacles facing young people are unique to them, and influenced by their age and stage of life. For example, many adolescents and young people lack access to independent finances to purchase commodities or cover health care fees, insurance or transportation costs to services. Some have limited autonomy in decision-making, with decisions on whether they should seek care largely made by parents, spouses, in-laws and other gatekeepers. And in many settings, conservative views regarding adolescent sexual behaviour create reluctance among health care workers to provide information or services to young people.

To-date, there has been no systematic review of how laws and policies govern young people's access to SRH/HIV information and services, and the ability of service providers to ensure these services are available and accessible to young people.

This review aims to do so. It assesses criminal laws, laws in relation to age, laws on health and HIV, law enforcement practices, and national policies relating to HIV, SRH and youth. In addition to describing laws, policies and practices that impede access to services, the review highlights examples of laws, policies and practices that are supportive of the rights of young people to access services.

The review also considers the international commitments and obligations of countries in the Asia-Pacific region relating to the rights of young people to the highest attainable standard of health. This includes obligations under international human rights law, and recommendations and commitments relating to young people in international instruments including the Convention on the Right of the Child (CRC), the Programme of Action of the International Conference on Population and Development (ICPD) and the recommendations of the Global Commission on HIV and the Law.

To supplement the literature review, focus group discussions (FGDs) were convened with young people aged 18 to 25 in Indonesia, Myanmar and the Philippines to explore their experiences, perspectives and opinions on barriers to accessing SRH and HIV services. The report includes extracts from the FGDs to illustrate the issues identified by the review.

Findings

Most countries of Asia and the Pacific have conservative legal traditions relating to sexuality and reproduction. Laws often reflect or reinforce views that deny adolescents' need for SRH and HIV services. Many laws often reflect the moral values of the colonial era rather than contemporary understandings of SRH rights, and many laws in relation to same-sex conduct, prostitution / sex work and abortion have not been updated since colonial times.

Some countries have taken steps to establish laws that provide legal protections for young people, and that enhance young people's access to SRH and HIV services. Even more countries have been found in this review to have national policies (including thematic policies on youth; HIV; or adolescent health and population) that guide actions to achieve improved SRH and HIV outcomes for young people.

The review finds that laws are often lagging behind policies, perhaps as the process for repealing restrictive laws and enacting new legislation supporting expanded access to services can take many years.

In practice, it appears that both service providers and young people are often confused about the legal rights of young people to access SRH and HIV information and services. Where unclear, and in the absence of service standards and guidelines, providers may follow conservative interpretations of the law, thereby restricting access to information and services.

Laws and policies in the Asia-Pacific region that were found in this review to support access to SRH/HIV services for young people include:

- Laws and policies that recognize the evolving capacity of young people to make independent decisions regarding their own health (e.g. HIV testing laws of Fiji, Lao People's Democratic Republic (PDR), Marshall Islands, Pohnpei State of Micronesia and Papua New Guinea (PNG));
- Laws and policies relating to child protection that facilitate access to SRH and HIV information, commodities and other services by clarifying the rights of children under 18 in relation to health care and the obligations of parents, guardians, caregivers and government agencies in respect of children's health (e.g. child protection laws in Indonesia and Viet Nam give children a legal right to health care);

- Laws and policies that protect against discrimination and stigma, and recognize privacy rights (e.g. laws that protect against HIV-related discrimination and offer some privacy and confidentiality protections exist in Cambodia, China, Fiji, Lao PDR, Mongolia, the Philippines, PNG and Viet Nam);
- Laws that give young people an enforceable legal right to access SRH and HIV services and commodities (e.g. laws in Fiji and PNG give people the legal right to access condoms and syringes as a means of protection from HIV);
- Laws and policies that provide a framework for a rights-based national SRH programme (e.g. Pakistan's *Reproductive Healthcare and Rights Act 2013*, and the Philippines' *National Policy and Strategic Framework on Adolescent Health and Development 2013*).

Laws and policies in the Asia-Pacific region that were found in this review impede young people's access to SRH and HIV services include:

- Laws and policies that restrict access to SRH services to married persons (e.g. Indonesia and Malaysia);
- Laws and policies that require parental consent for minors to access testing for HIV and other sexually transmitted infections (STIs), SRH treatment or other SRH services including contraceptives (e.g. parental consent to HIV testing is required for minors under 18 in Cambodia) without regard to the specific needs and circumstances of the young person seeking access to services;
- Laws and policies that restrict access to opioid substitution therapy (OST) and/or needles and syringes to people over a prescribed age (e.g. China imposes age restrictions on access to OST and needles and syringes);
- Laws that criminalize same-sex conduct, sex work and drug use that are enforced against young people from key populations;
- Police conduct such as confiscation of condoms and syringes, extortion, harassment and arbitrary detention of young people, particularly those from key populations;
- Lack of access to legal safe abortion (only China, Democratic People's Republic of Korea (DPRK), Mongolia, Nepal, Singapore and Viet Nam allow abortion on request); and
- Lack of birth registration or access to other forms of civil registration that are required to access health services. Lack of birth registration can prevent access to some government health services, particularly for young people without parents, refugees and internally displaced people.

Recommendations

The region stands to gain considerably from advancing the sexual and reproductive health of young people.

Creating an enabling environment for sexual and reproductive health requires working across multiple levels, focusing on young people themselves, their relationships (including with parents and caregivers), and society at-large. At the macro/societal level, actions are required to promote young people's rights to the highest attainable standard of health and protect them from harm through supportive policies, laws, law enforcement practices and access to justice.

Policies need to be supported by legislation that provides young people with enforceable rights to access SRH and HIV information, commodities and other services. For example, laws can provide penalties for conduct that impedes access and can compel services to comply with standards that ensure services are responsive to the needs of young people. Additionally, technical capacity is required to ensure that health workers understand their legal responsibilities to guarantee inclusion and equality, and operational guidance be in place for the implementation and enforcement of such laws.

This report recommends action in the following areas:

Youth leadership and participation

1. Governments should support young people and their organizations to engage in advocacy and decision-making on legal and human rights issues relating to SRH and HIV. Capacity-building of youth leaders should be supported including leaders from communities of young people from key populations, including young people living with HIV, young men who have sex with men, young transgender people, young people who sell sex and young people who use drugs.

Law reform

Rights of young people

2. Governments should enact comprehensive legislation guaranteeing young people's right to the highest attainable standard of health including: the right to access information and education essential to their health and development including on SRH and HIV; the right to access quality SRH and HIV services that are sensitive to their concerns; and freedom from violence and abuse, including coerced sterilization and abortion.

3. Governments should remove age restrictions and parental consent requirements that impede access to SRH and HIV services, including testing for HIV and other STIs, condoms and contraception, needle and syringe programmes and OST. Consistent with the Convention on the Rights of the Child, national laws should recognize the evolving capacity of adolescents to make independent decisions regarding their health. The consent of a parent or guardian to SRH and HIV services should not be required if a minor is considered to be sufficiently mature. A young person should be able to consent independently if the young person is capable of understanding the nature and consequences of the service and is able to assess their own best interests. If governments prefer to define a minimum age below which consent of a parent or guardian is required in all cases, this should be set at early adolescence. Children above such a minimum age should be able to consent independently if they are assessed by the health professional offering the service as sufficiently mature.
4. Marriage should not be a pre-condition for access to SRH services.
5. Young people, including adolescents, should have a legal right to access their medical records and to confidentiality of their medical records and health status. The law should prohibit disclosure by health care professionals delivering SRH and HIV services of personal information relating to a young person without the young person's consent, taking into account the mature minor principle and evolving capacities. This prohibition on disclosure of information to others (including parents and guardians) without the young person's consent should include information about the young person's health status, sexual behaviour and drug use history or other personal information. Exceptions to this duty of non-disclosure should be narrowly defined, and include consideration of the age and maturity of the adolescent, the gravity of the condition or treatment, and family factors. For example, exceptions should include:
 - in emergency situations with risk of death or serious injury;
 - where disclosure is required for the health care or treatment of the young person, e.g. sharing information with other health professionals involved in the care of the young person;
 - where the young person is assessed by the health professional as lacking sufficient capacity or competence to consent by reason of their age, and a parent or guardian consents to disclosure.

Operational guidance is required to assist health care workers to understand their legal and professional obligations, and training provided on policies and procedures.

6. The age of consent to sex should be set at an age that recognizes that many young people commence sexual activity during their early adolescence. Consensual sexual activity between adolescents who are similar in age should not be criminalized. Contradictions between age of consent to sex and age of consent to SRH services should be reconciled. The age of consent for autonomous access to SRH and HIV services should be equal to or lower than the age of consent for sexual relations.
7. Birth registration laws should address the needs of young people who were not registered at birth to obtain identification documents so they can access government health and welfare services.

General law reform recommendations applying to young people and adults

8. The recommendations listed above relate to legislative measures that will benefit young people specifically. In addition, law reforms should be considered that would improve the access of both adults and young people to SRH and HIV services. Governments should implement the following recommendations of the Global Commission on HIV and the Law¹:
 - Decriminalize private and consensual adult sexual behaviours, including same-sex sexual acts and voluntary sex work.
 - Reform approaches towards drug use. Rather than punishing people who use drugs but do no harm to others, governments must offer them access to effective HIV and health services, including harm reduction programmes and voluntary, evidence-based treatment for drug dependence.
 - Provide legal protections against discrimination based on actual or assumed HIV status, sexual orientation or gender identity.
 - Work with the guardians of customary and religious law to promote traditions and religious practices that promote rights and acceptance of diversity and that protect privacy.
9. Governments should also consider the recommendation of the UN Special Rapporteur on the Right to Health that abortion be decriminalized and measures be taken to ensure that legal and safe abortion services are available, accessible, and of good quality.²

Improvements to law enforcement practices

10. Governments should ensure that law enforcement abuses, including harassment, extortion and violence are punished. Criminal offences should not be applied against sexually exploited minors who sell sex or minors who use drugs as they should be seen as needing protection rather than offenders subject to prosecution.
11. Governments should provide independent monitoring and complaint mechanisms that can help prevent and respond to police abuses of young people.
12. In advance of law reform, governments can adopt a pragmatic approach by not requiring harmful laws to be enforced against young people. Governments can explore options such as not actively enforcing arbitrary age, marital status or parental consent restrictions. Governments can consider imposing a moratorium on the enforcement of punitive criminal law provisions concerning abortion against young women and girls, in recognition of the health harms caused by inflexible enforcement of abortion prohibitions.

SRH and HIV policies and programmes

13. Governments should ensure that the rights of young people are explicitly addressed in HIV, SRH and population and development policies, and that SRH and HIV issues are integrated into national youth policies and strategies. As a policy response, SRH and HIV services can be reoriented to young people's needs (particularly unmarried adolescents) through requiring service standards and guidelines to be developed that address their specific needs.
14. SRH and HIV policies and programmes should address the following:
 - Access to youth-friendly, evidence-based, gender-sensitive, non-discriminatory and confidential SRH and HIV services and information.
 - Access for young people living with HIV to condoms, contraceptives, reproductive services and sexual health services, as essential components of HIV care.
 - Recognition of the importance of ensuring SRH services are available to sexually active adolescents and unmarried young people, as well as married people.

- Support to programmes that respond to the specific needs of young people living with HIV and other young people from key populations.
- Access for young women and girls to services for abortion-related complications and post-abortion care, including in jurisdictions where abortion is criminalized. Where abortion is legal, services should be made accessible to young women and girls.
- Systematic collection of confidential data in relation to the progress towards universal coverage of SRH and HIV services for young people, particularly young key populations. Age-disaggregated data on young people who are at increased risk of HIV and other STIs are required as an evidence base to inform policies and planning of services.
- Rights of young people to participate in policy development and programme implementation and evaluation.
- Community mobilization, focused awareness-raising and public education to enable parents, community leaders, health care workers, and the broader society to learn about adolescent SRH and HIV issues in culturally-sensitive ways, thereby influencing the social norms and cultural practices that are key to a supportive environment for SRH and HIV information and service provision.
- Removal of financial barriers to access to services through waiver of fees, health insurance, voucher schemes or other financing options to ensure services are affordable to young people.

Legal services

15. Governments should ensure access to legal aid for young people who require legal advice and representation in relation to their rights to access SRH and HIV services, privacy rights, police abuses, discrimination or other rights violations.





1 Introduction

1.1 Objectives and methods

The aim of this review was to document the range of legal and policy issues that shape young people's access to sexual and reproductive health (SRH) and HIV information and services.

The review acknowledges that there are multiple understandings of the different phases of life, including definitions of 'adolescent', 'child' and 'young person', (see Glossary of Acronyms and Key Terms) and that social and legal markers define adulthood at different points in different settings. For the purpose of this review, young people were defined as persons aged 10 to 24 years.

This review addressed the following key questions:

- i. What national laws, policies and strategies exist in countries in the Asia-Pacific region that govern access to SRH and HIV information and services broadly, along with international and regional commitments and conventions?
- ii. How do these legal and policy frameworks impact on SRH and HIV service provision for young people?
- iii. What legal measures protect the rights to health of young people, and how do these measures address the needs and special circumstances of young key populations?
- iv. What approaches need to be taken (including policy, legal and intermediate operational measures) to address any gaps in the protection and promotion of the right to health of young people and to ensure access to SRH and HIV services?

A particular focus was given to the:

- impact on access to services of laws and policies that require people to be of a certain age for various purposes, e.g. age of consent to sex, age of legal capacity to consent to SRH services and other medical treatment, age of legal marriage, age of criminal responsibility, and age of majority.
- impact of laws that criminalize key populations of young people who are at higher risk of HIV and other STI exposure and the impact of law enforcement practices on these young people's access to services.

In addition to describing laws and policies that impede access to services, the review also aimed to highlight examples of laws and policies that support young people's access to SRH and HIV services.

The focus of the review was primarily on young people's access to services and information in the community, rather than in schools. A separate review has been undertaken of policies relevant to sexuality education in schools in Asia and the Pacific.³ The review did not seek to describe laws and policies relating to gender-based violence, although it is acknowledged that young people may be more willing to access SRH and HIV services in contexts where laws and policies provide an effective response to gender-based violence, including requiring services to respond to the specific SRH, HIV and violence protection needs of survivors of sexual assault.

The review was primarily a desk review of legislation, regulations, national policies, peer-reviewed articles and other published reports, including media reports, relevant to young people, SRH and HIV in Asia and the Pacific. Over 400 documents were analysed for this review. See Annex VII for a full list of citations.

The study also drew from focus group discussions (FGDs) with young people that were conducted to capture their views and experiences in accessing SRH and HIV services in three countries: Indonesia, Myanmar and the Philippines. Youth LEAD (a regional network of young people from key populations) convened the focus group discussions, which were held in November 2012. Interviews were also conducted with key informants involved in service delivery to young key populations in Myanmar and the Philippines. See Annex VI for more on the methodology of the FGDs and key informants.

Additional inputs were provided from UN partner agencies. This review was a joint effort between UNESCO, UNFPA, UNAIDS, UNDP and Youth LEAD.

1.2 International obligations and commitments

Most countries in the region have signed or ratified international conventions that recognize the rights of children and young people to the highest attainable standard of health. Governments have an obligation to protect and safeguard these rights, which includes the establishment and enforcement of laws and policies that increase access to information and services.

The human rights of young people are defined by the Convention on the Rights of the Child (CRC) and the International Covenant on Economic, Social and Cultural Rights (ICESCR). Human rights recognized by these instruments include the rights to the highest attainable standard of health, non-discrimination, privacy, autonomy and the rights of young people to participate in decisions that affect them.

The CRC provides for the protection of the right to health of children, which are defined in the CRC as a person under 18 years of age, unless under domestic law the child reaches majority at an earlier age.

The CRC establishes the principle that the best interests of the child shall be the primary consideration in all actions concerning children,⁴ the right of children to non-discrimination,⁵ birth registration,⁶ and to life, survival and development,⁷ the right to have views affecting the child heard and given due weight, in accordance to age and maturity of the child,⁸ and the right to privacy.⁹

The CRC provides that governments have an obligation to protect children from sexual exploitation including child prostitution.¹⁰ Consistent with this provision, governments should define minors involved in the sex industry as victims of sexual exploitation who require protection, rather than offenders subject to prosecution.

The Committee on the Rights of the Child has interpreted obligations of governments under the CRC to include the provision to adolescents of access to SRH information, including on family planning and contraceptives, the dangers of early pregnancy, the prevention of HIV and the prevention and treatment of STIs.¹¹ The Committee has indicated that:

[I]t is the obligation of States parties to ensure that all adolescent girls and boys, both in and out of school, are provided with, and not denied, accurate and appropriate information on how to protect their health and development and practise healthy behaviours. This should include information on...safe and respectful social and sexual behaviours.¹²

Importantly, the CRC calls on governments to take into account the particular stages of a child's development and the child's 'evolving capacities'.¹³ This recognizes that children experience developmental changes as they mature, including progress in cognitive abilities and capacity for self-determination. As children acquire enhanced capacities, they are better able to form and express their views, and take responsibility for decisions affecting their lives.

In its General Comment No.15, the Committee on the Rights of the Child explains the implications of the CRC in relation to the rights of children to make decisions about their health care as follows:¹⁴

The Committee recognizes that children's evolving capacities have a bearing on their independent decision-making on their health issues. It also notes that there are often serious discrepancies regarding such autonomous decision-making, with children who are particularly vulnerable to discrimination often less able to exercise this autonomy. It is therefore essential that supportive policies are in place and that children, parents and health workers have adequate rights-based guidance on consent, assent and confidentiality.¹⁵

... In accordance with their evolving capacities, children should have access to confidential counselling and advice without parental or legal guardian consent, where this is assessed by the professionals working with the child to be in the child's best interests. States should clarify the legislative procedures for the designation of appropriate caregivers for children without parents or legal guardians, who can consent on the child's behalf or assist the

child in consenting, depending on the child's age and maturity. States should review and consider allowing children to consent to certain medical treatments and interventions without the permission of a parent, caregiver, or guardian, such as HIV testing and sexual and reproductive health services, including education and guidance on sexual health, contraception and safe abortion.¹⁶

Finally, the Commission on Population and Development in 2012 issued some of the strongest language around the reproductive rights of young people to emerge from the UN. In its Resolution on Adolescents and Youth it recognizes that:

...reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents and rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, the right to attain the highest standard of sexual and reproductive health, the right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents, and the right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence...¹⁷

It urges governments to:

...protect and promote human rights and fundamental freedoms regardless of age and marital status, including, inter alia, by eliminating all forms of discrimination against girls and women, by working more effectively to achieve equality between women and men in all areas of family responsibility, in sexual and reproductive life, and in education at all levels, and by protecting the human rights of adolescents and youth to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health;¹⁸... [and to]

enact and enforce legislation to protect all adolescents and youth... and to provide social and health services, including sexual and reproductive health services, and complaint and reporting mechanisms for the redress of violations of their human rights...¹⁹

Annex IV includes more information about these obligations established under international law. Annex V provides a list of reservations or declarations made by countries in the Asia-Pacific region that qualify the application of these international instruments to their country, e.g. regarding inconsistency with religious principles or national laws.

International and regional commitments

Over the last twenty years, there has been increasing international recognition of the importance of ensuring SRH and HIV responses give priority to the needs and rights of young people. Commitments of governments relating to rights to access SRH and HIV services have been made in the following documents agreed at international and regional levels:

International

- The *International Conference on Population and Development (ICPD) Programme of Action* of 1994, ICPD+5, and ICPD+10.
- The *Beijing Platform for Action* of the Fourth World Conference on Women of 1995.
- The UN *Millennium Development Goals* of 2000.
- The UN General Assembly *Political Declaration on HIV and AIDS* of 2011.

Regional

- The UN Economic and Social Commission for Asia and the Pacific (ESCAP), *Fifth Asian and Pacific Population Conference Plan of Action on Population and Poverty* of 2002.
- The South Asian Association for Regional Cooperation (SAARC) *Social Charter* of 2004.
- The *Pacific Policy Framework for Achieving Universal Access to Reproductive Health Services and Commodities, including Condoms 2008-2015*.
- The *Pacific Regional Strategy on HIV and Other STIs 2009-2013*.
- Resolutions of UN ESCAP on HIV and AIDS of 2010 and 2011.
- The Association of South East Asian Nations (ASEAN) *Declaration of Commitment on HIV Declaration of Commitment on HIV* of 2011, and the *ASEAN Human Rights Declaration* of 2012.

Governments should also take into account the recommendations of the independent Global Commission on HIV and the Law when implementing these commitments. The Global Commission provided extensive recommendations in its final report issued in 2012. One recommendation of the Global Commission of particular importance is that "Sexually active young people must have confidential and independent access to health services so as to protect themselves from HIV. Therefore, countries must reform laws to ensure that the age of consent of autonomous access to HIV and sexual and reproductive health services is equal to or lower than the age of consent for sexual relations.²⁰ Countries are encouraged to consider the recommendations of the report relating to young people and key populations.²¹

More information about the above-listed commitments, the reservations and declarations made by some governments when the commitments were agreed, and some of the recommendations of the Global Commission of HIV and the Law of particular relevance for young people can be found in Annexes IV and V.



2 Background and context

2.1 Regional data on young people, SRH and HIV

In the Asia-Pacific region there are over 1.12 billion young people aged 10-24.²² The region is home to the largest number of young people globally and the largest cohort of young people in the history of the world. Young people form a highly heterogeneous population in any setting, and this is no less true in a region as diverse and vast as Asia and the Pacific.

While today's generation of young people in the region are generally healthier and better educated than in the past, sexual and reproductive health is often an overlooked aspect of their well-being.²³ This section explores SRH and HIV issues facing young people, drawing on the latest available data from international and national surveys, supplemented by research studies, where appropriate.

As evidenced in this chapter, SRH and HIV information is not widely available for adolescents (aged 10-19) or young people (aged 10-24) in many countries in the region. Where data are available for young people, particularly in the context of HIV, they are often not disaggregated by age cohort or other factors that could provide much-needed information. This is particularly the case regarding young adolescents between the ages of 10 to 14.

Gaps in data on young people pose one of the greatest challenges to promoting their rights, and are urgently required as a foundation for policies and laws, evidence-based programming, and to measure progress and trends across time.

2.1.1 The need for SRH services

Sexual health services

Sexual health services are required to respond to significant STI epidemics affecting young people in the Asia-Pacific region. The World Health Organization (WHO) estimates that in 2005 there were 179.5 million cases of the four STIs chlamydia, gonorrhoea, trichomoniasis and syphilis in WHO's South East Asia²⁴ and Western Pacific²⁵ regions.²⁶ The Asia-Pacific region has by far the greatest number of curable bacterial STIs of all the global regions.²⁷ In the Western Pacific region, the highest STI rates occur in persons aged less than 25 years.²⁸ On average, one in four sexually active young people in the Pacific has an STI, with a chlamydia prevalence in young people of up to 40 per cent – among the highest rates in the world.²⁹

Gonorrhoea is becoming a major public health challenge particularly in South and South East Asia, with the emergence of drug resistant strains presenting new challenges.³⁰ If left untreated, gonorrhoea can lead to pelvic inflammatory disease, ectopic pregnancy, stillbirths, severe eye infections in newborns and infertility. In the Pacific and many Asian countries, chlamydia is a priority concern.³¹ Chlamydia can lead to miscarriage, infertility, as well as eye and lung infections in newborns.

Contraceptives and family planning services

While the rates appear to be lower than in other regions, in Asia (excluding South Asia), 17 per cent of young men and 2 per cent of young women aged 15-24 report having experienced premarital sex.³² A study of contraceptive use among adolescents (aged 10-19) in nine Asian countries concluded that the vast majority of unmarried, sexually active adolescents either do not use any contraceptives or use traditional methods.³³

Data on contraceptive prevalence and adolescent fertility provide an indication of the countries where access to SRH services is particularly low (see Table 1, right). Access to family planning and the empowerment of women are reflected in the contraceptive prevalence rate, which is the proportion of women of reproductive age who are using (or whose partner is using) a contraceptive method, and the unmet need for family planning. When the use of contraceptives is low in a country, the fertility rate is often high.

A review of data from eleven countries of East Asia and the Pacific found that adolescent girls are less protected against unplanned pregnancy than older women, with contraceptive use considerably lower among adolescents (aged 15-19) compared to adult women under 45. In most countries adolescents in this age range also have higher unmet need for contraception, less knowledge, and poorer access to information and services than older women.³⁴ In South Asia and Southeast Asia, adolescents aged 15-19 who want to avoid pregnancy are more than twice as likely as women aged 20-49 to have an unmet need for modern contraception.³⁵

A study of young people aged 15-24 in Samoa, the Solomon Islands and Vanuatu found that about two-thirds of young people were sexually active, with the median age at first sex being 16 years. In some cases, age at first sex was recorded as low as ten years old.³⁶ Fewer than 20 per cent of girls aged 15-19 and less than half of adolescent boys in the Pacific report having ever used a modern method of contraception (including condoms). It is estimated 650,000 women have an unmet need for family planning in the Pacific.³⁷ The contraceptive prevalence rate in the Pacific is lower than most developing countries and in some countries has not changed significantly in over 20 years.³⁸ This inversely mirrors teenage pregnancy rates (15-19 years old) in the region with Marshall Islands having 85 births per 1,000, while Nauru, PNG and Solomon Islands all exceed 60.³⁹

Table 1: Adolescent fertility, unmet need for family planning and contraceptive prevalence rate

Country	Adolescent fertility rate, Births per 1,000 women, age 15-19, (2010)	Unmet need for family planning (% women who want to stop or delay childbearing but who are not using any method of contraception to prevent pregnancy) (2010)	Contraceptive prevalence rate (% females, 15-49)(2010)
ASIA			
Afghanistan	107.2	29.5	22.2
Bangladesh	72.5	12.9	60.5
Bhutan	59.0	12.5	48.0
Cambodia	48.0	16.6	35.0
China	8.8	3.4	84.4
DPRK	0.6	9.6	69.5
India	79.3	14.2	57.3
Indonesia	43.5	13.3	60.9
Lao PDR	33.6	23.0	46.5
Malaysia	11.6	17.0	55.6
Maldives	11.0	28.3	36.2
Mongolia	19.6	13.2	58.5
Myanmar	13.7	20.0	45.5
Nepal	93.1	26.3	48.8
Pakistan	29.5	25.9	32.4
Philippines	49.5	22.6	49.7
Thailand	39.5	5.3	79.4
Timor-Leste	57.7	29.0	23.6
Viet Nam	24.3	6.2	78.0
PACIFIC			
Cook Islands	24.0	18.5	56.0
Fiji	43.8	18.5	51.7
Marshall Islands	85.0	18.1	45.1
Micronesia (Federated States of)	21.2	19.1	49.5
Palau	27.0	24.3	38.5
Papua New Guinea	63.9	25.2	36.5
Samoa	26.6	46.4	29.0
Solomon Islands	66.9	22.4	36.3
Tonga	19.7	No data	23.6
Tuvalu	No data	29.4	31.5
Vanuatu	52.0	23.7	41.7

Sources: Adolescent fertility rate: Data were sourced from the World Bank's World Development Indicators data sets available at: <http://data.un.org>, and Secretariat of the Pacific Community National Minimum Development Indicators at <http://www.spc.int/nmdi/>. Cook Islands data is for 2009. Unmet need for family planning and contraceptive prevalence: with the exception of Bhutan, data were sourced from: Alkema, L. et al. 2013. National, regional, and global rates and trends in contraceptive prevalence and unmet need for family planning between 1990 and 2015: a systematic and comprehensive analysis. *The Lancet*, Vol. 11, No. 381, pp.1642-1645. For Bhutan, adolescent fertility rate was sourced from: National Statistics Bureau, UNICEF and UNFPA. 2011. *Bhutan Multi Indicator Survey 2010*. Thimpu: National Statistics Bureau, UNICEF and UNFPA; and contraceptive prevalence rate was provided by UNDP Country Office, Bhutan. For Cambodia, data were sourced by UNFPA from: National Institute of Statistics, Directorate General for Health, and ICF Macro.2011. *Cambodia Demographic and Health Survey 2010*. Phnom Penh and Calverton: National Institute of Statistics, Directorate General for Health, and ICF Macro.

Abortion services

There are approximately 5.4 million adolescent girls aged 15-19 giving birth annually in the Asia-Pacific region,⁴⁰ and 3.6 million unsafe abortions for women aged 15-24 in Asia (excluding Eastern Asia) per year.⁴¹ Young girls face greater risks than adults of complications and death as a result of pregnancy. The younger a girl is when she becomes pregnant, the greater the risks to her health. The lives of adolescent girls are often placed at serious risk due to delays in seeking abortion services and failure to access care for complications. Adolescent girls seeking abortions often have no choice but to seek the services of untrained practitioners in hazardous circumstances and unhygienic conditions.⁴² Rates of unsafe abortions are particularly high in South and South-East Asia (Table 2). Eleven per cent of the unsafe abortions that occurred in Asia (excluding East Asia) in 2008 were in young women aged 15-19, and 23 per cent were among those aged 20-24.⁴³

Table 2: Estimated safe and unsafe abortion rates by region and sub-region, 2008

	Total*	Safe	Unsafe	% Unsafe
Asia	28	17	11	40%
Eastern Asia	28	28	<0.5	<0.5%
South-Central Asia	26	9	17	65%
South-East Asia	36	14	22	61%
Oceania	17	14	2	15%

* Abortions per 1,000 women aged 15-44

Source: Sedgh, G., Singh, S., Shah, I., Ahman, E., et al. 2012. *Induced abortion: incidence and trends worldwide from 1995 to 2008*, *The Lancet*, Vol. 379, pp. 625–632.

2.1.2 The need for HIV services

National HIV estimates indicate that there were 690,000, an increase of 140,000 young people aged 15-24 living with HIV in Asia and the Pacific at the end of 2012. In the same year, an estimated 110,000 young people aged 15-24 acquired HIV. Young people in this age range account for around one-third of new infections among adults (aged 15 and above) in the region.⁴⁴

The majority of new infections among young people, possibly as much as 95 per cent, are among young people from key populations, including young men who have sex with men, young transgender people, young people who are selling or buying sex, and young people injecting drugs.⁴⁵

Data on access to HIV-related services should be provided through countries' annual Global AIDS Response Progress Reports;⁴⁶ however less than half of the 38 countries in the Asia-Pacific reported key indicators for young people (under age 25) from key populations in their 2012 reports such as prevalence of HIV, condom use at last sex, safe injecting practice, getting tested for HIV and receiving the result, and access to prevention programmes.⁴⁷

For countries that are collecting and reporting on data among young people from key populations (under age 25), the regional median coverage levels for prevention services reported in 2012 were substantially below the targets needed to sustainably reverse and control the epidemic. These data indicate, for example, HIV prevention coverage of 57 per cent among young men who have sex with men, 51 per cent among young females selling sex and 37 per cent among young males selling sex.⁴⁸

Access to antiretroviral therapy (ART) has increased considerably in the region in recent years, and around 1.25 million people were receiving ART at the end of 2012.⁴⁹ Increases were largely driven by rapid programme expansion in China and India, progress in PNG and Viet Nam, and the consolidation of high ART coverage in Cambodia and Thailand.⁵⁰ There have been attempts to estimate HIV treatment coverage among young people aged 15-24 living with HIV and needing treatment, but these data are limited and not widely available.

Use of HIV prevention commodities and access to prevention programmes appears to be lower among young people from key populations (under age 25) than their adult counterparts (25 years and older) in many countries. For example, a review of country data made the following findings in the countries indicated:⁵¹

- Lower percentages of young people who inject drugs who used sterile injecting equipment during their last injection, compared to older people who inject drugs (China and Indonesia).

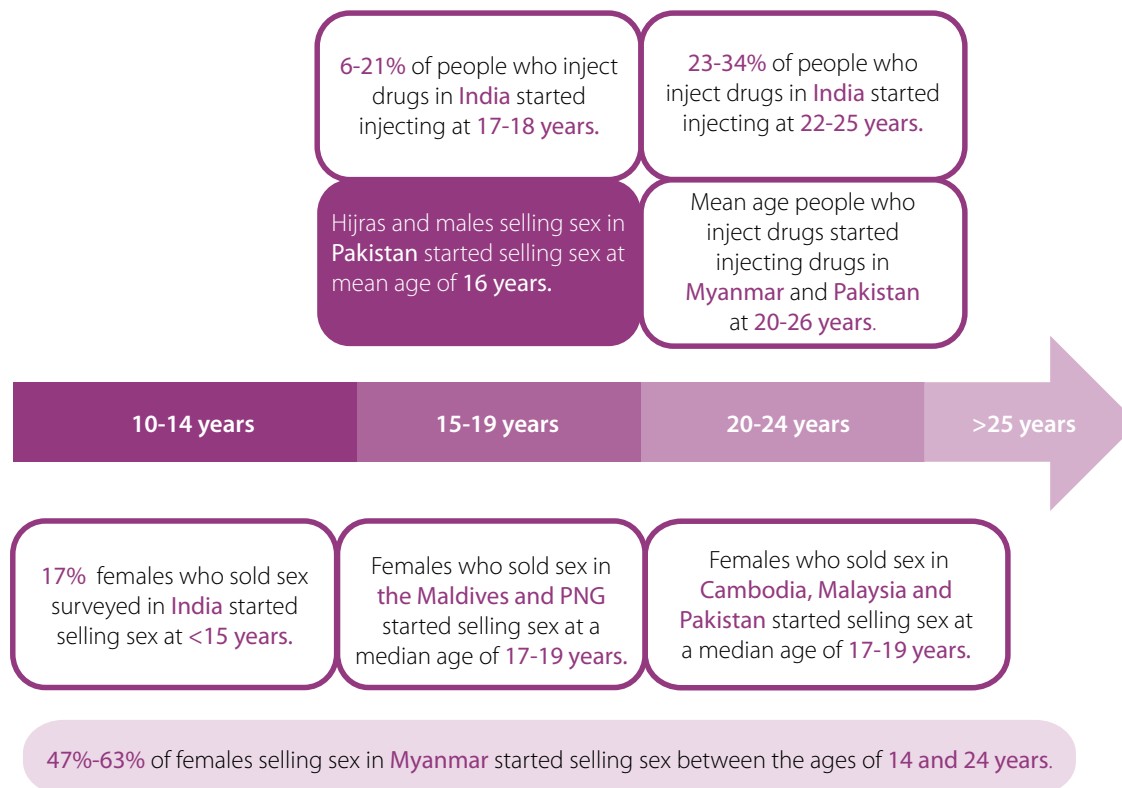


- Lower percentages of young women who sell sex who have had an HIV test, compared to older female sex workers (China, Lao PDR, Mongolia, Myanmar, PNG, the Philippines, Sri Lanka and Thailand).
- Lower percentages of young female and males selling sex who were reached by a prevention programme, compared to older sex workers (Mongolia, Myanmar and Viet Nam).
- Lower percentages of young men who have sex with men who have been reached by prevention programmes and therefore know where to obtain a test, compared to older men who have sex with men (China, Mongolia, Myanmar, Nepal, Sri Lanka and Thailand).

The age at which young people start to engage in behaviours that place them at risk of HIV is diverse and varies by country and within key populations. For example (see Figure 1):⁵²

- Among female sex workers in India, 17 per cent reported starting to sell sex under the age of 15. The median age reported among female sex workers in Maldives and Papua New Guinea ranged from 17-19 across surveyed sites, as compared to a range of 22-24 years of age in sites in Cambodia, Malaysia and Pakistan. In Pakistan, *hijras* (transgender persons) and male sex workers reported starting to sell sex at a mean age of 16.
- In a survey of people who inject drugs in India, 21 per cent reported initiating injecting drug use at 17-18 years of age across surveyed sites.
- The average age reported for initiating drug use in Myanmar and Pakistan was 20-26 years across surveyed sites.

Figure 1: Age of entry into risk behaviours



Source: Prepared by UNAIDS, <http://www.aidsdatahub.org>

More data are needed on risk behaviours including unprotected paid sex or same-sex and transgender-sex intercourse, and injecting drugs with contaminated equipment among young people in the region. As indicated in Table 3 (next page), evidence gaps also exist on protective behaviours including condom use at last sex and comprehensive and correct knowledge of HIV among young people. The data available suggest that knowledge levels, including how to prevent HIV infection, are woefully low among young people and hinder prevention efforts in many settings.⁵³

Table 3: HIV knowledge and condom use among young people (YP) aged 15-24

	% YP with comprehensive knowledge of HIV, 2005–2010*		% YP who used condom at last higher-risk sex, 2005–2010**	
	Male	Female	Male	Female
ASIA				
Bangladesh	18	8	-	-
Bhutan	-	21	-	62
Cambodia	45	50	84	-
India	36	20	37	22
Indonesia	15	10	-	-
Maldives	-	35	-	-
Mongolia	-	31	-	-
Myanmar	-	32	-	-
Nepal	44	28	78	-
Pakistan	-	3	-	-
Philippines	-	21	-	-
Thailand	-	46	-	-
Timor-Leste	20	12	-	-
Viet Nam	-	44	68	-
PACIFIC				
Marshall Islands	39	27	22	9
Nauru	10	13	17	10
PNG	-	-	50	35
Samoa	6	3	-	-
Solomon Islands	35	29	26	17
Tuvalu	61	39	44	-
Vanuatu	-	15	-	-

Notes: *, ** Data refer to the most recent year available during the period 2005-2010. ** Condom use at last higher-risk sex: Percentage of young men and women (aged 15–24) who say they used a condom the last time they had sex with a non-marital, non-cohabiting partner, of those who have had sex with such a partner during the past 12 months. - Data are not available.

Source: Adapted from UNICEF. 2012. *The State of the World's Children 2012*. New York: UNICEF, pp.100-101.

2.1.3 Implications for SRH and HIV programming in the region

To realise young people's right to health, in accordance with the CRC and other relevant human rights instruments, young people need access to a range of information and services.

This includes access to SRH and HIV information and education on a broad range of topics related to their physical, social, emotional and sexual development. Parents are an important source of sexuality education for children, and serve as role models for gender roles and relationships. Information and education targeted at both in-school and out-of-school young people should be non-judgmental and begin early, before children and young people are sexually active.⁵⁴ Peer education is often a critical source of information on issues relating to SRH and HIV, particularly for key populations, and can also be an important link to services.⁵⁵

Young people need access to comprehensive SRH and HIV service packages that have been described by international agencies, including the specific service packages that are required by key populations (e.g. SRH services for people living with HIV).⁵⁶

Their needs will obviously vary at different stages in their lives. For example, those who are not yet sexually active will not require access to certain commodities or services; however they will need information on the different options available to them, and how to access them if they need them in the future.

Services that young people need include clinical services, care and support, and advocacy services. Clinical services include access to contraceptive counselling, including emergency contraception; HIV and STI counselling and testing services; and HIV and STI treatment services; safe abortion care, where legal, and post-abortion care and support with regard to the consequences of unsafe abortion. Care and support services include peer support, psychological services, home and community care, advice on welfare rights, and services that address gender-based violence and sexual violence (including legal referrals). Advocacy services include peer advocacy services, legal advice services and agencies that can represent and advocate the rights of young people including challenging human rights violations related to refusal of access to SRH and HIV services, breach of privacy, discrimination and protection from gender-based violence or sexual violence.

SRH and HIV commodities required by young people include male and female condoms, contraceptives, clean needles and syringes methadone maintenance treatment and other forms of OST for young people using drugs, and treatments for STIs, HIV and opportunistic infections such as tuberculosis.

There is an increasing call for integrated health services that combine sexual and reproductive health (such as contraceptive services, condom promotion, prevention of unsafe abortion and management of post-abortion care, and maternal and newborn health), HIV (such as HIV counselling and testing, ART) and harm reduction services (such as needle and syringes) with the recognition that young people's needs are diverse and inter-linked.⁵⁷

Other linkages that can support improved SRH and HIV outcomes for young people include those between the health sector and the child protection and social welfare sectors.⁵⁸ An HIV-sensitive child protection response is a real opportunity for actors in both sectors to coordinate approaches, interventions and responses for improved outcomes for 'hidden' and often 'overlooked' children, adolescents and young people.⁵⁹

The next section reviews barriers facing young people to such information and services, including the legal environment, and positive actions that governments have taken – and can take – to overcome these barriers.

2.2 Overview of barriers to access faced by young people

There are multiple factors, including cultural, financial, logistical, institutional, legal and policy factors, that play a role in determining young people's access to information and services. Some issues facing adolescents overlap with those facing adults in similar contexts, such as concerns about the distance to services, or embarrassment about needing, wanting or asking for SRH and HIV information and commodities. Other obstacles facing young people are unique to them, and influenced by their age and stage of life. For example, many adolescents and young people lack access to independent finances to purchase commodities or cover health care fees, insurance or transportation costs to services. Some have limited autonomy in decision-making, with decisions on whether they should seek care largely made by parents, spouses, in-laws and other gatekeepers. And in many settings, negative views regarding adolescent sexual behaviour create reluctance among health care workers to provide information or services to adolescents and young people.

Moreover, broad structural factors beyond the individual or the couple can shape sexual and reproductive health outcomes.⁶⁰ For example, some researchers have called gender the 'gateway factor' to sexual and reproductive health outcomes.⁶¹ There is a growing body of research that suggests that young people with more egalitarian attitudes about gender roles or more equal relationships are more likely to delay sexual debut, use condoms, and practice contraception; they also have lower rates of STIs, HIV, and unintended pregnancy and are less likely to be in relationships characterized by violence than their peers without these characteristics.⁶²

Creating an enabling environment for adolescent sexual and reproductive health, therefore, requires working across multiple levels, focusing on individuals, their relationships, and society at-large, as suggested by ecological models.⁶³

2.2.1 Legal and policy barriers

Scaling up SRH and HIV services for young people requires an understanding of the laws and policies that govern the issues of informed consent, competency, identity, confidentiality and privacy, and how this framework regulates the ability of service providers to ensure services are available and accessible to young people. Legal and policy barriers include:

- Age restrictions on information, services (such as HIV or STI testing, methadone programmes), or commodities (such as contraceptives, condoms and lubricants), or that require consent of a parent or guardian.
- Requirements of marriage or spousal consent to access services.
- Lack of privacy rights. Young people who lack legally enforceable privacy rights may avoid services due to stigma, embarrassment and fear of disclosure of personal information to their family, community or police.
- Laws that criminalize same-sex conduct, drug use and sex work may also act as barriers, particularly for young people who fear that disclosure of risky practices to health authorities may lead to disclosure to police or their family.
- Fear of police abuses or prosecution for engaging in illegal conduct. Fear of police harassment or prosecution for behaviours such as sex work, drug use and same-sex conduct can be a powerful disincentive to accessing health services. Young people in many settings risk being charged with prostitution or soliciting for prostitution if they are found by the police

to be carrying condoms, or being charged with drug offences if they are found carrying needles and syringes.

- Laws that criminalize abortion result in young people being denied the option of termination of pregnancy. As a result, many young people access illegal abortion services at great risk to their health.
- Financial barriers. Many young people lack access to independent finances and cannot afford health care fees, health insurance or transport costs associated with travelling to a health services.⁶⁴ To improve access, laws and policies can address these financial obstacles through providing health insurance rights and rights of free access for essential SRH and HIV services, e.g. ART.
- Lack of services standards. Policies and regulations can require services to comply with quality standards that ensure comprehensive SRH and HIV services are offered to young people. Service standards can address practical issues affecting accessibility such as location and opening hours of services, and can also help to combat discrimination in delivery of health care services.
- Lack of birth registration.⁶⁵ In Asia and the Pacific, outside of China, the birth registration rate is only 44 per cent, with two out of three children in South Asia having no birth registration.⁶⁶ Lack of birth registration can prevent access to some government health services, particularly for young people without parents, refugees and internally displaced people. The registration of births is fundamental to the realization of a number of rights including access to health care, protection of young people from harassment by law enforcement officials and protection of girls from being coerced into marriage before they are legally eligible.

2.2.2 Stigma and discrimination

Young people may be reluctant to attend SRH or HIV services for fear of family criticism or social ostracism, or fear of violence or rejection from their spouse or parents. Young people may experience stigma and discrimination from health care providers if their identity or behaviour is outside of social norms, for example if they are a person who sells sex, uses drugs, or if they are a transgender person or a man who has sex with other men. These populations are often socially and legally marginalized and face stigma, criminalization, and violence, and as a result are driven underground and may be fearful to access services.

Stigma and discrimination also prevent young people from accessing education. Even if the young person attends school, the psychosocial effects of HIV-related stigma and discrimination may prevent any meaningful participation, resulting in further negative outcomes.⁶⁷

Many young people face discrimination in accessing services, or in the way services are provided, only by reason of their age (including SRH services, harm reduction services such as needle and syringe programmes and OST programmes, HIV testing, treatment, care and support services). Age restrictions on access to these services imposed by laws and policies are often applied without regard to the specific needs and circumstances of the young person seeking access to services.

Young people living with HIV may experience judgemental attitudes and discrimination by health care workers, as many may assume that people living with HIV either do not or should not engage in sex or seek to have children. In some countries, young people living with HIV have reported incidents of forced sterilization or coercion by medical professionals to terminate their pregnancy (See Chapter 3 at 3.2.4).

Young people living with HIV should have the same rights to SRH services as other young persons, and access to and availability of condoms, family planning, reproductive health and sexual health services should be regarded as essential components of HIV care. Laws in some countries provide legal protection from discrimination on the grounds of HIV status, but generally do not provide protection against age-related discrimination or discrimination on the basis of belonging to a key population (i.e. sex worker, person who uses drugs, transgender person, men who have sex with men) (see Chapter 4 at 4.1).

Finally, to make these laws real on the ground, governments must educate health care workers about their legal responsibilities to guarantee inclusion and equality, and establish operational guidance for the implementation and enforcement of such laws. This includes training health care workers to identify and refer children and adolescents whom they suspect are experiencing protection violations, including abuse, violence, exploitation or neglect.⁶⁸ Refusal of services or discriminatory behaviour towards young people must be seen as unacceptable in health care settings, and guidelines established for redress in case of violations including access to legal services and confidentiality of proceedings.⁶⁹

Reports of judgmental attitudes of health care workers

“The attitudes of many health care workers are judgmental when waria (transgender persons) go for an HIV test. It is particularly difficult to get access to a service when you are a young waria. The HIV doctor is good, but sometimes the nursing staff are judgmental and if the HIV doctor is not available the other doctors say they do not have the knowledge about HIV and refuse service.”

Indonesian focus group

“Some NGO staff discriminate against drug users. There was one NGO worker who would refuse to counsel drug users because he assumed they would not respond to counselling and would always continue to use drugs. He received other clients, but drug users did not get the opportunities they deserved.”

Myanmar focus group

“I knew a 17 year old girl in my town who became pregnant and went into labour. The superintendent of the hospital scolded her very badly and refused to hospitalize her for delivery because she was pregnant so young and had been promiscuous. She and her relatives begged the Township Medical Officer to hospitalize her because she was suffering pain before delivery. At last she was allowed to hospitalize for delivery. However there was no oxygen equipment available and she and her baby died during the birth.”

Myanmar focus group

“Some clients (of my CBO) who were in high school and fell pregnant, they told me that during their delivery, they were being scolded, “it’s your fault, you are so young but look what you’ve done!”... those who were in high school were 15-16. They were really scolded while in labour. The midwives were telling them, “You’re too young! You’re too young! Look what you’ve done!”

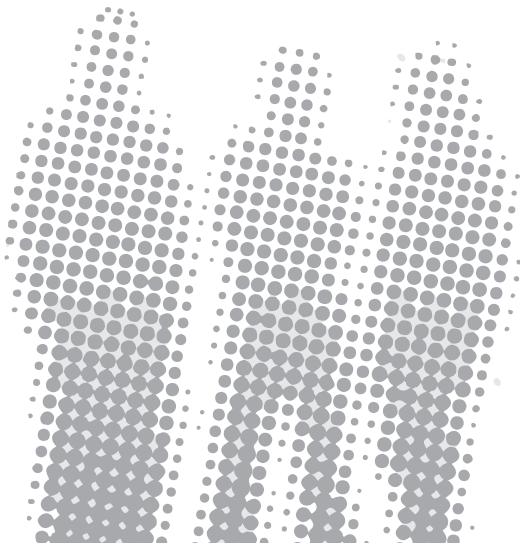
Philippine focus group

2.2.3 Social and cultural norms

Culture and religion can play a positive role, and help to break down barriers faced by young people in accessing services.⁷⁰ Values shared by the major faiths such as the importance of social justice, respect for human dignity and compassion are consistent with a human rights-based approach to health. Faith-based organizations play an important role in influencing public opinion and in delivering health services in many countries, so are key to addressing stigma and ensuring improved access to services by young people. For example:

- Christian organizations play a leadership role in delivering HIV and other health services in PNG (e.g. programmes provided by the PNG Catholic HIV/AIDS Services, the Salvation Army, Anglicare and the Baptist Union).⁷¹
- A Buddhist Leadership Initiative on HIV has been implemented in the Mekong, with activities in Cambodia, China and Lao PDR, and along the Thai-Myanmar border.⁷²
- Muslim leaders have played a role in advocating harm reduction approaches to prevent HIV among people who inject drugs in Xinjiang, China, and implementing mosque-based interventions against discrimination and stigma.⁷³
- In Malaysia, the Department of Islamic Development and the Ministry of Health have cooperated in institutionalizing HIV education into training of Muslim leaders and promote non-discrimination towards people living with HIV and key populations.⁷⁴

At the same time, social and cultural norms including customs and traditions regarding youth status, parental authority, marriage, reproduction and relationships and certain religious beliefs can create barriers to SRH and HIV services. For example, marriage has been key to being treated as an adult in many societies of Asia and the Pacific. It is common in societies across the region for there to be a taboo surrounding unmarried people (particularly women and girls) accessing SRH services, which particularly affects young women and girls in rural areas where traditional beliefs are strong. Negative views about sexual activity outside of marriage cause reluctance among some health care workers to provide SRH services to young unmarried people.



Parents, guardians, and extended families have always played a critical role in adolescent health and development. Parental involvement and community support are major influences on young people's use of services and on their attitudes and behaviours, particularly in more traditional settings.⁷⁵ Parents also may act as gatekeepers to services, particularly where the law specifies that services are only accessible to adolescents with parental consent. Married adolescents often lack the autonomy to access SRH and other

services; and the decision as to whether they should seek care is largely made by parents, spouses, in-laws and other gatekeepers.⁷⁶

There is some evidence that community mobilization can break taboos that surround adolescent sexual and reproductive health, and ease some of the barriers to access to services.⁷⁷ Focused awareness-raising and public education can enable parents, community leaders, and the broader community to learn about adolescent SRH issues in culturally-sensitive ways, thereby influencing the social norms and cultural practices that are key to a supportive environment for SRH information and service provision.⁷⁸

2.2.4 Legal traditions

Most countries of Asia and the Pacific have conservative legal traditions relating to sexuality and reproduction. Laws often reflect or reinforce conservative views that deny adolescents' need for contraception and STI prevention. Provision of services or commodities such as condoms and contraceptives is often viewed as encouraging immoral behaviours.

The laws of Pacific island states are influenced by Christian values and most Pacific island countries have statutory laws that have been inherited from the colonial era. Many countries of South Asia and South East Asia also have laws influenced by the British colonial era (e.g. Bangladesh, Brunei Darussalam, India, Malaysia, Myanmar and Singapore). These laws often reflect the moral values of the colonial

era rather than contemporary understandings of SRH rights, and many laws in relation to same-sex conduct, prostitution / sex work and abortion have not been updated since colonial times. In South East Asia, the law of the Philippines is heavily influenced by Christian values.

Customary and religious laws operate alongside these formal statutory laws, and apply traditional values to issues relating to marriage and family status. In some Asian countries Muslim personal law or principles of Sharia law are applied to Muslim communities at national or provincial level (Afghanistan, Bangladesh, India, Indonesia (Aceh Province), Malaysia, Maldives, Myanmar, Pakistan, the Philippines (Autonomous Region of Muslim Mindanao) and Sri Lanka). Customary and religious laws generally seek to protect young people within the context of family and community life. While the application of customary and religious laws can be helpful to young people, it may sometimes also be barriers to SRH and HIV services if young people are deterred from accessing such services for fear of punishment for conduct considered immoral or because parental or spousal consent is a strict precondition for access to services. (See more in 3.1.4, and Annexes I and II).

The HIV epidemic has drawn the attention of policy makers to social and behavioural changes affecting young people's risk and vulnerability, such as changes in drug use cultures, increased mobility and early age of sexual debut. The impact of the HIV epidemic on young people, the increasing incidence of STIs and changes in youth culture and sexual behaviours have highlighted the need for laws and policies to be updated to respond to the SRH and HIV needs of young people.

Since the Convention on the Rights of the Child was adopted by the UN General Assembly in 1989, and the ICPD Programme of Action was agreed in 1994, there has been a gradual process by which many countries have reviewed and modernized their laws and policies. As demonstrated in Chapter 4, national policies (including thematic policies on youth; HIV; or adolescent health and population) are increasingly including provisions that guide actions to achieve improved SRH and HIV outcomes for young people. However, law reform is a long-term process and legislation often lags behind policies in incorporating key principles of a rights-based approach established in international human rights frameworks and commitments, such as the centrality of the best interests of the child, recognition of the evolving capacity of a child to exercise consent and autonomy in decisions relating to their health care, and protection from all forms of discrimination, violence, abuse and exploitation.

2.2.5 Leadership and political factors

A range of political factors can create obstacles to services. A political environment that is open and welcomes youth participation in decision-making can help to break down barriers.

However, political conditions are often not conducive to youth participation in health policy and planning, particularly for young women. In contexts where the state is fragile, issues affecting young people's health may be marginalized. For example, in Afghanistan, which is experiencing significant social and political conflict and where women and young people have very limited political authority, SRH and HIV issues for young people receive very little attention.

The report of a parliamentary hearing conducted in 2012 on sexual and reproductive health rights in the Pacific observed:

*Young people's access to SRH is restricted when there is a lack of enabling contexts such as democracy and human rights...In times of crisis, systems that protect women break down or are removed, and increased stresses heighten rates of gender based and sexual violence...The submissions illustrated an environment for adolescent SRHR (SRH rights) in the Pacific that is lacking in many areas, including meaningful engagement with youth, comprehensive sexuality education, youth friendly service provision, access to safe abortion, limited funding and resources available for adolescent SRHR, and a lack of political will. Efforts to improve SRHR in the region are further burdened by gender inequality, geographical challenges, and governance and leadership structures which have been weakened by conflict...*⁷⁹

In other countries, politicization of SRH and HIV issues can create obstacles to improving young people's access to services. For example, in the Philippines SRH issues receive significant attention, but these issues are highly politicized. There have been heated political debates in relation to the Responsible Parenthood and Reproductive Health Act 2012.⁸⁰ This Act proposes improving access for all to family planning services, and improving young people's access to SRH education in schools. Young people's views were taken into account in the development of the Act and its Implementing Regulations.⁸¹ The Alliance of Young Nurse Leaders and Advocates International Inc., a youth-led nursing organization, joined the Technical Panel of Experts that reviewed and finalized drafts of the new law on reproductive health.⁸² However, a political campaign was waged to block the Act, and the implementation of the Act has been delayed by legal proceedings in the Supreme Court.⁸³

In the context of HIV, advocacy to improve access to services by improving the legal status of key populations is often politically controversial. Law reform proposals for decriminalization of sex work, drug use and same-sex conduct on public health grounds often meet with vehement political opposition. Taking a political stance in support of such issues can be contentious, and requires strong leadership. For example, as a Government Minister Dame Carol Kidu provided leadership in advocating for decriminalization of sex work and same-sex conduct in PNG to enable a stronger national HIV response. However, her efforts met with political obstacles that resulted in an indefinite delay of the consideration of proposals by parliament. She has been subject to media criticism for her advocacy.⁸⁴

Reported views on participation of young people in governance of health responses

"The composition of the local AIDS council, to address the issues of young people, should include representation from young people's organizations. I hope that we can include that provision in the local AIDS ordinance... We would be more effective in lobbying [for] the things that we want to see change. Changes will happen quicker, it would be easier to negotiate and we will be given a chance to address issues directly... it's [our] basic human right to participate and get involved... just imagine a city having a youth organization working on the issue of young people and HIV. They have issues in the community that need to be answered, but the local government does not recognize those issues. The youth organizations have to go out and push for a seat, to effect more changes."

Philippine focus group

"We want to be a member of Hlut-Taw [National Assembly of Myanmar] and we want to express our wish there. We can make law and [require] proper law enforcement... we would like to demand our rights there. The state is now making reforms. We firmly believe that by (participating) using negotiation, young key HIV-affected populations can be very beneficial for the country."

Myanmar focus group

3 Laws and policies that impede access to services

3.1 Age of legal capacity

3.1.1 Overview

The *Convention on the Rights of the Child* sets the upper limit of childhood at 18 years. The CRC states that, for the purposes of the Convention, a child is “every human being below the age of 18 years, unless under the law applicable to the child, majority is attained at an earlier age”.⁸⁵

National laws recognize that young people are legally treated as adults who are able to make autonomous decisions at different ages for different purposes, e.g.:

- Heterosexual sex
- Homosexual sex
- Consent to SRH services
- Consent to abortion
- Consent to HIV testing
- Marriage
- Criminal responsibility
- Capacity to enter legal contracts, including with health care providers
- Voting
- Driving
- Gambling
- Tobacco and alcohol consumption.

A variety of different rules may apply, and age requirements differ from country to country. Age requirements may be defined by legislation, government policies or guidelines, religious or cultural norms, and professional or ethical guidelines. In many countries, the position is governed by conflicting policies and laws, which in some cases are very dated, unsettled or contested.

The Committee on the Rights of the Child has stated that governments should consider allowing children to consent to certain medical interventions without the permission of a parent, caregiver, or guardian, such as HIV testing and SRH services, including education and guidance on sexual health, contraception and safe abortion. This is in recognition of a child’s evolving capacities and corresponding abilities to make decisions on issues that affect their health.⁸⁶

There is a generally accepted common law rule established by case law that the authority to consent to medical interventions on behalf of a child rests with the child's parent or guardian.

In practice, both service providers and young people are often confused about the legal rights of young people to access SRH and HIV services and information at specific ages without parental consent, particularly during adolescence. Where responsibilities are unclear, service providers often tend to follow conservative interpretations of consent requirements (such as parental or spousal consent), thereby restricting access to information and services.

3.1.2 Age of consent to medical interventions

The age of consent to medical interventions has relevance to HIV and STI testing and treatment, other SRH services provided in clinical contexts, and harm reduction services such as OST.

The law relating to age varies between jurisdictions. In most countries, persons aged 18 years and over are considered to have the legal capacity to give full consent to medical interventions, independent of their guardian, spouse or other family members (China is an exception, see discussion below).

National laws generally include a provision allowing consent to testing or treatment to be given by a parent or legal guardian of a person who is below the age of legal capacity. In some countries, an exception may apply that allows persons less than 18 to exercise consent for specific SRH services independent of their parents or guardians. Other countries allow consent to testing or treatment by a child provided certain conditions are met. These conditions generally require the child to have a certain level of understanding or maturity ('mature minor' exception) and in some cases also require the child to be over a prescribed minimum age. National laws also usually include a provision allowing services to be provided in medical emergencies without the consent of the young person or their parents or guardians.⁸⁷

In countries that have civil law legal systems, such as Cambodia, China, Indonesia, Lao PDR, Mongolia, Thailand and Viet Nam, the law is established by legislative codes. Some of these codes include specific provisions that define young people's rights to access certain health services (e.g. Cambodia, Lao PDR and Viet Nam have specific provisions on age of consent to HIV testing, see next page).

In common law countries (generally, former British or US colonies or territories), the law is determined by a combination of case law (law made by judges) and legislation (law made by parliaments). This enables a flexible approach to defining the law and its application in different circumstances. There is a generally accepted common law rule established by case law that the authority to consent to medical interventions on behalf of a child rests with the child's parent or guardian.⁸⁸ This general rule has been qualified in some common law countries by the 'mature minor' principle (see Box, next page).



Key concepts: 'Evolving capacities of the child' and 'mature minor'

These two concepts are linked. The concepts recognize the developmental changes that children experience as they mature, including progress in cognitive abilities and capacity for self-determination. The concepts recognize that as children acquire enhanced capacities, there is less need for protection and a greater ability of the child to take responsibilities for decisions affecting their lives. The concepts acknowledge that different children achieve competencies at different ages.

The concept of 'evolving capacities' first emerged in international law through the Convention on the Rights of the Child (CRC). Article Five of the Convention states that:

States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention.

Article Twelve also addresses evolving capacities, stating that:

States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.

In its General Comment No.15, the Committee on the Rights of the Child explains the implications of the CRC in relation to the rights of children to make decisions about their health care as follows:ⁱ

The Committee recognizes that children's evolving capacities have a bearing on their independent decision-making on their health issues. It also notes that there are often serious discrepancies regarding such autonomous decision-making, with children who are particularly vulnerable to discrimination often less able to exercise this autonomy. It is therefore essential that supportive policies are in place and that children, parents and health workers have adequate rights-based guidance on consent, assent and confidentiality.ⁱⁱ

ⁱ Committee on the Rights of the Child (2013), *General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24)*, CRC/C/GC/15.

ⁱⁱ Ibid. Para 21.

...In accordance with their evolving capacities, children should have access to confidential counselling and advice without parental or legal guardian consent, where this is assessed by the professionals working with the child to be in the child's best interests. States should clarify the legislative procedures for the designation of appropriate caregivers for children without parents or legal guardians, who can consent on the child's behalf or assist the child in consenting, depending on the child's age and maturity. States should review and consider allowing children to consent to certain medical treatments and interventions without the permission of a parent, caregiver, or guardian, such as HIV testing and sexual and reproductive health services, including education and guidance on sexual health, contraception and safe abortion.

National laws determine the 'age of majority', which is the age at which the law recognizes a person is able to exercise full responsibility for their own affairs. People who are under the legal 'age of majority' are referred to as minors. The 'mature minor' doctrine is a legal principle that recognizes the capacity of some minors to consent independently to medical procedures, if they are assessed by a health professional to be sufficiently mature to understand the meaning and consequences of the procedure and therefore are able to make a decision on their own. The gravity and nature of the procedure are also taken into account when assessing a minor's capacity to fully understand all aspects of the situation and to objectively consider treatment options. A parent's or guardian's consent is necessary if the minor is unable to make voluntary and informed decisions, judged by various indicators of maturity.ⁱⁱⁱ

This concept is sometimes referred to as the 'Gillick principle' or the 'Gillick competence' with reference to a 1986 English House of Lords judgment, *Gillick v Wisbech Area Health Authority*.^{iv} The case established that under English law the "parental right to determine whether or not their minor child below the age of sixteen will have medical treatment terminates if and when the child achieves sufficient understanding and intelligence to understand fully what is proposed."

The laws of some countries such as Australia, Canada, New Zealand, the United States of America (USA) and the United Kingdom apply the 'mature minor' principle to enable people under 18 years of age to consent to medical treatment independently of their parents if they are sufficiently mature. Aspects of the 'mature minor' principle have been introduced in statutory provisions relating to consent to HIV testing in some other countries of Asia and the Pacific.

ⁱⁱⁱ Kuther T.L. 2003. Medical Decision-making and Minors: Issues of consent and assent. *Adolescence*, Vol. 38, pp. 343-357.

^{iv} *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] 3 All ER 402 (Lord Scarman).

In some countries, there may be a disparity between the legal age at which parental consent is required for medical treatment and the legal age of consent to sex (both heterosexual sex and homosexual sex)(see Table 7 below, at 3.1.4). Adolescents who are sexually active and who are under the legal age of consent to sex may be fearful of accessing SRH or HIV services if they have no confidentiality rights, given the harms that may result in disclosure of their sexual behaviours to family members or police.

A review of sexual health laws of Asian countries argued that it is particularly important that the principles of 'evolving capacity' and rights to confidentiality are taken into account:

Persons under 18 years of age face particular barriers in accessing sexual health services, care, and information. The necessity of consent for health services and procedures is fundamental. While in regard to minors, parents or guardians may retain formal powers to consent, respect for the principles of the evolving capacity of the child and his or her best interest can result in under-18s accessing appropriate and necessary services without recourse to parental involvement or consent. The principle of evolving capacity suggests that older adolescents should be able to access services without consent of parents or guardians. In addition, the right to enjoy confidentiality in regard to sexual health services and care should be respected.⁸⁹

In New Zealand, specific SRH services are available without parental consent, and for other medical services as the principle of evolving capacity has been integrated into the law. Children can access contraceptive services and abortion without parental consent. For other services, different rules apply for minors below 16 and those who are 16 years and above. Persons who are 16 and above can exercise full independent consent to medical procedures. For someone under the age of 16, the health professional must determine whether the child has the understanding and maturity to form a balanced judgment about the proposed treatment. If so, the child can be treated without obtaining parental consent; if not, parental consent must be secured before treatment is given.⁹⁰

In many countries the legal position of minors in relation to SRH services and other medical treatment is unclear or subject to differing interpretations by lawyers. Where the law is unclear or undefined, medical practitioners may refer to ethical or professional guidelines. In practice, medical practitioners often err on the side of caution and apply older age requirements, rather than risk an allegation of unprofessional conduct or a lawsuit by applying a younger age requirement that might be challenged by parents or guardians in court.

Reported issues with health services

"In Sumatra, there are only hospital services, no specialist STI clinics. When young people attend a general service for STI care there are many searching questions that are embarrassing and there is little privacy, so other people can hear you being asked questions about sexuality and it is humiliating. This happened to me when I was 24 years old. It makes me reluctant to seek STI treatment."

Indonesian focus group

"I once had diarrhoea and blisters all over my body. So I went to see the doctor. But he told me without any test that I was HIV-positive because I'm drug-addicted. He never did a proper medical check-up. They told my family that I am positive. Some of my family felt deeply sorry and were crying. And then they asked to transfer me to the specialist AIDS treatment centre. There the doctors saw me and asked for the blood test result. I answered 'not yet'. The doctors said that such a patient should not be judged as HIV-positive without any medical check-up and added that it is necessary to demand the patient's agreement before the medical check-up. That doctor asked me to come again after the blood test."

Myanmar focus group

"With STIs, I feel so ashamed... [At the clinic they announce:] 'Everyone who has these numbers, go to this room.' Everyone will know who among you has an STI. At the STI clinic, if you have it, they will really announce it. But they will only say that you have *tulo* [discharge], they don't really know the different kinds of STIs. So me, I won't go there and get tested. Sometimes, when my number was called, I would think twice before going there. They won't announce the names, but your numbers. And those who have no findings, their numbers won't be called. It was really shameful, especially among my peers."

"I was shy to open my legs because there were a lot of people in the clinic...I was sixteen. And the provider was sarcastically telling me, 'This won't hurt! We just have to get something. If this was a penis, you probably won't complain!' [FGD facilitator: *Why do you think they would react that way?*] Maybe because they know who we are, that we are in prostitution... Sometimes too, one of the male staff would go inside the room while somebody is being smeared."

"Going to a social hygiene clinic you would see the counselling tables sitting in a row one after the other, pak, pak, pak! And if you undergo counselling, you could hear the counselling session on the other table. You would look on your right and you could also hear the counselling session going on there. I would then just leave."

Philippine focus groups

Customary and religious laws

Customary and religious laws operate alongside formal laws. This may mean that consent on behalf of children by adults other than parents (such as husbands of child brides, extended family members, village elders or religious leaders) may play a role in decisions regarding the health welfare of children.

A Malaysian analysis of Sharia law relating to age of medical consent found that parental or spousal consent is required for persons under 18 years of age:

When a minor has reached the age of 15 years the Prophet Muhammad then insists that the Hudud laws be imposed upon him. This saying indicates that at this age the minor is already capable of shouldering the responsibilities of being a Muslim. Hence the next question to ask is, is he/she capable of giving or rejecting consent to medical treatment?

On the basis of the traditions above, it could be argued that he is legally capable to do so because he is deemed an adult in the eyes of God. If that is the case, whether parental obligations cease to exist? . . . parents have a right to be respected and obeyed by children. They are duty bound to protect their children in every way either physically, intellectually or morally... Parental advice should be listened to and acted upon, even if against children's own wishes. In other words the opinion of the parents would be the prime consideration when it comes to medical treatment although it might differ from that of the children.

. . . The author fully concedes that by the age of 15, the degree of understanding and discerning good or bad is equivalent to that of puberty or maturity in the absence of the physical signs. As such, by analogy the person is capable of giving his own consent or rejecting any medical treatment. However, it could be argued that at this age, the person naturally would still be dependent upon the parents in terms of food, shelter, acquiring education, love and affection.

Due to these, the author is of the opinion that . . . the parental rights to give consent or reject treatment would prevail until the child has attained the maximum age of *baligh* (puberty), that is 18 years of age.⁹¹

Age of consent to HIV testing

Access to HIV testing is an entry point to counselling on HIV risk, to treatment and care for those who test positive and is an important component of prevention of parent-to-child transmission. Given the sensitivity of an HIV test result, careful consideration needs to be given as to whether laws that impose age restrictions on testing except with parental consent may act as a disincentive to young people knowing their HIV status. Age restrictions are by nature arbitrary and often do not recognize children's evolving capacities, their right to participate in decisions regarding their own treatment and wellbeing, and their best interests.⁹²

UNAIDS and WHO have issued HIV testing guidelines emphasizing the need to seek the views of adolescents independent from their parents:

Where the law does not allow a sufficiently mature adolescent to give his or her own informed consent to an HIV test, the health care provider should provide an adolescent patient with the opportunity to assent to HIV testing and counselling in private, without the presence or knowledge of his or her parents or legal guardians. The pre-test information should be adapted to the patient's age, developmental stage and literacy level. If the adolescent provides assent, indicating that he or she understands the risks and benefits of HIV testing and would like to receive the test, then the health care provider should seek the informed consent of the parent or legal guardian.

In some situations a parent or legal guardian may not be available to give consent on the adolescent's behalf. The health care provider may need to assess whether an adolescent can request and consent to testing alone. The provider must always work within the framework of local or national laws and regulations and be guided by the best interests of the patient.⁹³

In 2012-2013, WHO, UNESCO, UNFPA, UNICEF and the Global Network of People Living with HIV/AIDS (GNP+) collaborated in the development of *Guidance for HIV Testing and Counselling for Adolescents and Treatment and Care for Adolescents Living With HIV*.⁹⁴ This Guidance emphasizes the following points in relation to consent to HIV testing:

- In most settings globally, adolescents' rights to autonomy are limited, although the legal situation varies between countries. HIV testing and counselling should be accessible to all adolescents, including key populations, and be linked to prevention, treatment and care.

- Although 'age of consent' restrictions are intended to protect the interests of adolescents, they can inadvertently serve as barriers to access to health services. Policy-makers should ensure regulatory harmonization and facilitate linkage to care.
- A child who possesses the legal right to access HIV testing and counselling should have autonomous access to HIV prevention and treatment as part of linkage to comprehensive care. The Guidance notes that in South Africa, children can consent to an HIV test at age 12 or above or, if under 12 years of age, the child is of sufficient maturity to understand the benefits, risks, and social implications of a HIV test.
- Authorities should also consider the role of surrogate decision-makers in testing and counselling, with the recognition that the absence of a parent or guardian should not serve as a barrier to a child accessing HIV testing, if the child has a caregiver.
- Authorities should consider how to facilitate access to HIV testing and linkage to care for orphans and vulnerable children, including street children, children in child-headed households, adolescents from key populations, girls engaged in sex with older men and in multiple or concurrent sexual partnerships, and girls affected by sexual exploitation.

Workshops with young people were conducted in the Philippines and two African countries to inform the draft Guidance. Findings from these workshops included:

- Many adolescents felt that taking an HIV test signals that one is involved in what is generally viewed as bad behaviour. All workshop participants viewed this negative association with HIV testing as a result of society's view towards adolescent sexual activity, an association highlighted by the difficulty in engaging parents in discussions regarding sexual health. Almost 9 per cent of young men who have sex with men participating in the workshops who had taken an HIV test reported that they live with considerable fear that their parents will be informed. Filipino participants observed that HIV testing and counselling is "burdened with negatives", which can be a considerable deterrent to testing.
- Adolescents reported "*feeling ignored*" or "*looked down upon*". The concepts of being treated with respect and being accepted by service providers emerged as priorities, especially for adolescents from key populations.
- One of the main deterrents to testing is the potential to experience stigma and discrimination. Workshop participants repeatedly mentioned fear of being rejected by friends, family and the community as a reason for reluctance to seek a test.

The Secretariat of the Pacific Community has issued a *Regional HIV and STI Testing Policy* for the Pacific in 2012, which addresses special circumstances in which parental consent is not required:

If an "underage" child wishes to be tested for HIV infection without the informed consent of a parent or legal guardian, the child should be counselled and supported to discuss this need with parents/guardians and gain their informed consent. Where the child declares they may be at substantial risk, should their need/desire to test be disclosed to parents/guardians e.g. through domestic violence, advice from relevant legal bodies and child welfare authorities should be sought. Ultimately, health workers must protect the well being and safety of the child. In cases where a child is suspected of having been the victim of incest or sexual assault perpetrated by a guardian, HIV testing can be conducted without the consent of the parent/legal guardian.⁹⁵

UNICEF's *HIV Counseling Handbook for Asia-Pacific* (2009) states:

The age at which a child or adolescent may consent to HIV testing without parental or guardian permission varies from country to country. While most have national laws and policies related to counseling and testing for adults, most laws and policies are unclear or ambiguous and sometimes conflicting about HIV testing of minors, in particular about who is authorized to give informed consent and under what conditions. In some cases, age at which a minor may give consent to test is actually higher than the legal age for which they can consent to sex, consent for marriage, termination of pregnancy, or voting rights. Laws and policies on consent do not often give consenting rights to informational caretakers or medical staff, an issue in terms of HIV testing in case of orphans, abandoned infants, and street children.⁹⁶

At a 2007 Asia-Pacific regional consultation on HIV testing and counselling, a UNICEF presentation reported that few countries have specific policies and guidelines addressing HIV testing among children, how to elicit informed consent from children, or guidance on how to ensure the best interest of the child are considered.⁹⁷ UNICEF also reported that challenges for obtaining consent to testing include:

- laws and policies related to consent are absent or unclear, or contradictory;
- legal age of consent is set at a higher age than average age at which adolescents become sexually active or experiment with drugs, and therefore may inhibit willingness to test;
- appropriate arrangements may not exist for consent where no parent or guardian is available (orphans, abandoned children, street children);

- parents may refuse to provide consent for testing of a child for fear that the HIV positive status of an infant will indicate the HIV positive status of a parent.

For the purposes of the aforementioned regional consultation on HIV testing and counselling, a review of laws was conducted in five countries (China, Malaysia, PNG, the Philippines and Thailand).⁹⁸ The review recommended that countries develop specific and uniform policies and guidelines on HIV testing and counselling of the population groups which have been left out in previous policy and guidelines, such as: minors, minors unaccompanied or without a parent, legal guardian, and next of kin; and orphans and minors in institutional settings. The review reported the following findings:

- Persons 18 years and over are considered to have the capacity to give consent to HIV testing. In some countries, a mature minor exception applies.
- There are no legal provisions or policy guidelines regarding the HIV testing of unaccompanied minors (or those whose parent, legal guardian, or next of kin cannot be located), abandoned, orphaned, street children, or minors engaged in commercial sexual exploitation who are not in the custody of the appropriate government authority.
- There are no national statutory provisions or national policy guidelines regarding HIV testing of orphans or children in institutional settings.

The following tables provide examples of laws that address the age of legal capacity to consent independently to an HIV test. Table 4 provides examples of laws that are currently in force. Table 5 provides examples of law that have been proposed, but have not been introduced.

Table 4: Enacted laws that specify an age of consent for HIV testing

Country	Age	Legal restrictions
Cambodia <i>Law on the Prevention and Control of HIV/AIDS of 2002 Article 19.</i>	18, subject to exception if in minor's best interest.	All HIV tests shall be done with voluntary and informed consent. For minors, written informed consent must be obtained from a legal guardian. If the guardian's consent cannot be obtained and a test is in the minor's best interests, testing may be conducted with the minor's consent. The State makes HIV testing decisions on behalf of mentally incapacitated persons. The National AIDS Authority's <i>Implementing Guidelines on the Law on Prevention and Control of HIV/AIDS</i> state: "the appropriate definition of a minor for the purposes of HIV testing is a person who is under the age of 18 years".
Fiji <i>HIV/AIDS Decree 2011, Section 29(2)(b).</i>	A person under 18 can consent if he or she is capable of understanding the nature and consequences of the test.	A person under 18 may consent to an HIV test if, in the opinion of the person providing pre-test information, the minor is capable of understanding the nature and consequences of an HIV test. Section 27 requires provision of pre and post-test counselling.
Lao PDR <i>Law on HIV/AIDS Control and Prevention of 2010, Article 18.</i>	14	Consent of a parent, guardian or next of kin is required for the conduct of an HIV test on a person under 14 years.
Marshall Islands <i>Communicable Disease Prevention and Control Act 1988 (Marshall Islands Revised Code Ch.15, Section 1507(3)).</i>	14 / 15 ⁹⁹	Children over the age of 14 who may have come into contact with HIV may consent to testing.
Papua New Guinea <i>HIV/AIDS Management and Prevention Act 2003, Section 14(2).</i>	13	It is unlawful to request an HIV test except, where the person to be tested is aged 12 years or less, and is in the opinion of the person providing pre-test information, not capable of understanding the nature and consequences of an HIV test, with the voluntary informed consent of a parent or guardian of the person.
Philippines <i>Philippine AIDS Prevention and Control Act of 1998, Section 15</i>	18	The State shall encourage voluntary testing for individuals with a high risk for contracting HIV, provided that written informed consent must first be obtained. Such consent shall be obtained from the person concerned if he/she is of legal age or from the parents or legal guardian in the case of a minor. The Act's <i>Implementing Rules and Regulations</i> define a minor as a person under 18.
Pohnpei State (Federated States of Micronesia) <i>Pohnpei HIV Prevention and Care Act 2007, Section 130.</i>	14 / 15 ¹⁰⁰	No compulsory HIV testing is allowed. Minors aged above 14 years may consent for themselves if, in the opinion of the testing clinicians, they have been at risk of HIV acquisition and are able to understand the nature and implications of the test.
Viet Nam <i>Law on HIV/AIDS Prevention and Control of 2006, Article 27.</i>	16	HIV testing shall only be conducted on the basis of voluntariness of persons to be tested. Persons who voluntarily seek HIV testing must be full 16 years or older and have full civil act capacity. HIV testing of persons less than 16 years old or persons who have lost their civil act capacity may only be conducted when there is written consent of his/her parent or guardian.

Table 5: Legislative proposals on age of legal capacity to consent independently to an HIV test

Country / Draft law	Age	Proposed legal restrictions
India (proposed by <i>HIV/AIDS Bill 2007</i>)	12, unless health care provider assesses child as unable to consent.	16 years and over can consent independently; children between the ages of 12 and 16 years can consent, unless in the written assessment of a healthcare provider the child lacks the capacity to consent. "Capacity to consent" is defined to mean an individual's ability, determined on an objective basis irrespective of such individual's age, to understand and appreciate the nature and consequences of a proposed healthcare service, treatment, intervention, procedure or research, or of a proposed disclosure of HIV-related information, and to make an informed decision concerning such service, treatment, intervention, procedure or disclosure. In determining the capacity to consent of an individual, the following factors may be considered: whether or not they are responsible for their own financial care or that of their family or dependents and whether or not they are living on their own.
Pakistan (proposed by <i>HIV/AIDS Prevention and Treatment Bill 2007</i>)	18, or less if estranged and living independently from parents.	18 years or over can consent. Children living independently, who are not in contact with parents and who do not have a guardian, will also be able to consent to HIV testing after they have been provided with age-sensitive information and counselling.
Philippines (proposed by Revised Philippine HIV and AIDS Policy and Program Act of 2012)	15, if at higher risk of HIV.	HIV testing shall be made available to a child of 15 years or over if: (1) The child expresses the intention to submit to HIV testing and counselling and other related services; (2) Reasonable efforts were undertaken to locate, provide counselling to, and to obtain the consent of, the parents, but the parents are absent or cannot be located, or otherwise refuse to give their consent; (3) Proper counselling shall be conducted by a social worker, healthcare provider or other accredited healthcare professional; and (4) The licensed social worker, healthcare provider or other healthcare professional shall determine that the child is at higher risk of HIV exposure, and that the conduct of the testing and counselling is in the child's best interest and welfare.
Model Law on HIV in Southern Africa , Southern Africa Development Community Parliamentary Forum 2008. (Section 13(5))	16, or lower age if best interests of the child requires otherwise.	HIV tests performed on a child under [16 or any suitable age decided in the state but not above 16] or a mentally incapacitated person shall be conducted with the consent of the parents or the legal guardian of the child or that person. When the best interest of the child requires otherwise or if the child is an emancipated minor, the absence of parental or guardian's consent shall not constitute an obstacle to testing and counselling. In the event of a dispute, the [relevant court] has jurisdiction to decide. These provisions regarding consent to HIV testing for children and mentally incapacitated persons also apply to their consent to treatment and care.

National laws and policies regarding age of consent to medical interventions

China

The *Civil Law* of China states that a person has full legal capacity at the age of 18 years or above, and that a citizen who has reached the age of 16 but not the age of 18 and whose main source of income is his own labour shall also be regarded as a person with full capacity.¹⁰¹ The *General Principles of Civil Law* (1986) and the *Tort Liability Law* (2010) recognize citizens' rights to bodily integrity, health and privacy. However, in practice when a person under 18 seeks medical treatment the consent of family members is sought and can override a minor's objections. China's *Population and Family Planning Law* states: "husbands and wives bear equal responsibility for family planning." This provision may be interpreted to require a husband's consent in obtaining an abortion.¹⁰²

Family consent to medical treatment is commonly required for both minors *and* adults, and this approach is supported by some regulations.¹⁰³ The role that families play in medical decision-making in China is consistent with parental authoritarianism in traditional Confucianism. According to the practice of 'Confucian familism' a physician acting in concert with the patient's family may withhold diagnostic information from a patient, and may give it to the patient's family members without the patient's consent.¹⁰⁴

Reported rejection of young women by a
community health centre

"I was asked by the one who was smearing [for STIs] 'Where are your parents? Do your parents know your kind of work?' Of course, we didn't want them to know but they kept asking questions. We became awkward and walked out. They have so many questions – we were just going for a check-up. All of us wanted to go for smearing but we weren't accepted. There were eighteen of us. During that time [our parents] still didn't know [that we sold sex] and we didn't want them to know. We were about 16 or 15 years old. When we were rejected in the *barangay* health centre, we returned to the office [an NGO] and told the staff about the treatment they gave us. Why did they ask questions? We just wanted to have a check-up, it was our right."

Philippine focus group



Ding, a scholar on medical treatment in China, describes the law and practice of family consent as follows:

The State Council promulgated *Yiliao jigou guanli tiaoli* (Regulations on Administration of Health Care Institutions) in 1994. Its Section 33 introduces the rule of "dual consent", namely, both the patient and his family member or *Guanxiren* (the Related Party) shall grant written consent with signature prior to medical intervention.

...In 1998, the Standing Committee of National People's Congress released *Zhiyeyishi fa* (the Practising Physicians Law), introducing the rule of "optional consent" under Section 26. It provides that physicians shall honestly disclose to a patient or his family member all the information about the disease unless the disclosure may have a negative influence upon the patient's health.

...it is common practice for doctors to discuss the condition of the patient with family members instead of the patients themselves, especially when the patient has a serious illness or needs hospitalization or a major operation. Whether, when, and how much information should be conveyed to the patient virtually depends on the discretion of family members. In the opinion of most doctors, consent of the family members of a competent patient seems more important. A large number of doctors even insist that competent patients' decisions may be overruled by the decisions of their family members in the case of conflict.

In other words, though the current law literally confers the equal right to informed consent upon competent patients and family members, in reality the consent of family members plays a more substantial role in medical decision making.¹⁰⁵

China: Hong Kong Special Administrative Region (SAR)

There is some uncertainty in Hong Kong about a minor's legal capacity to consent to medical procedures because there is no legislation directly addressing the issue and the courts have not yet had to decide the issue. However, legal academics and professional bodies in Hong Kong¹⁰⁶ recommend that health care workers apply the English common law position, which recognizes the evolving capacity of minors to consent to medical procedures (the *Gillick* principle).¹⁰⁷ It is assumed that a child who is capable of understanding the nature and consequences of a test or procedure may give a legally valid consent, although under the relevant 'age of majority', i.e. 18.¹⁰⁸ The Hong Kong SAR Advisory Council on AIDS and the Scientific Committee on AIDS and STI in a joint statement recommended the application of the 'mature minor' principle as follows::

The capacity of a minor under 18 years of age to give consent on his own depends on his ability to understand the nature and implications of HIV testing and to weigh up options. Thorough explanation and discussion would be necessary to ensure that the minor has this capacity.¹⁰⁹

Similarly, a 2007 regional review found that the 'mature minor' principle is applied to HIV testing in Hong Kong.¹¹⁰

India

A patient has a legal right to autonomy and self-determination under the Indian Constitution, which guarantees the right to life and liberty.¹¹¹ Adulthood is achieved at the age of 18 years (*Age of Majority Act*). Some legal commentators argue that a child above the age of 12 years can give consent for medical treatment if they understand the nature and consequences of the treatment, based on the *Gillick* principle of English common law.¹¹² Section 89 of the *Indian Penal Code* states that a guardian may consent to medical treatment for a person under 12 years of age (the same provision exists in the Penal Codes of Brunei Darussalam, Malaysia, Myanmar and Singapore).¹¹³ This suggests that persons over 12 years may exercise their own independent right to consent to testing or treatment, if they are of sufficient maturity (i.e. they are considered a 'mature minor'). However, although Indian courts generally follow principles of English common law, the *Gillick* principle has not formally been adopted by Indian courts, so there is uncertainty as to how the principle might be applied in the Indian context.

No minor can enter into a legal contract until 18 years, the age of majority. As the relationship between doctor and patient is contractual, some professional bodies in India take the more conservative view, i.e. that a doctor should not test or treat a person under 18 without parental consent.¹¹⁴

India's National AIDS Control Organization (NACO) published Operational Guidelines on HIV testing in 2004 requiring an assessment of a minor's maturity prior to requesting consent to testing. However these Guidelines fall short of acknowledging that a mature minor can exercise independent consent. The 2004 Guidelines state:

Whenever possible, minors are encouraged to involve their parents/guardians in supervising their health care. However, unwillingness to inform parents/ guardians should not interfere with the minor's access to information and services. Access to VCT (voluntary counselling and testing) 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 counselor to assess these abilities. However, the informed consent of parents / guardians is required prior to testing of minors for HIV.¹¹⁵

HIV testing guidelines issued by NACO in 2007 update the 2004 Guidelines. The 2007 Guidelines simply state that a minor can be tested with parental consent.¹¹³⁶ The 2007 Guidelines do not address whether the 'mature minor' principle can be applied. In 2006 NACO published *HIV Counselling Modules*, which appear to give greater emphasis to child rights than the 2004 or 2007 Guidelines:

It is preferable that young people are allowed to provide consent (without parental consent) for VCT, as parental consent is a barrier to uptake of VCT by some young people. In testing for HIV, ensuring medical confidentiality is essential and the right to confidentiality is recognised by the UN Convention on the Rights of the Child.¹¹⁷

In the case of abortion, legislation requires written consent of a parent or guardian for women under 18.¹¹⁸ The *Medical Termination of Pregnancy Act* does not dispense with the need to obtain consent of the pregnant woman if she is below 18 years of age.¹¹⁹

Indonesia

The age of majority for most legal purposes such as entering contracts is 21.¹²⁰ However, the *Child Protection Law 2002* emphasizes consultation with children in all aspects of life. This suggests that health care workers need to consult both parents and children when a decision is being made about medical testing or treatment. The *Child Protection Law* defines a child as under 18 and provides:

- Every child is to have the right to healthcare services and social security pursuant to their physical, mental, spiritual, and social needs.¹²¹
- Every child is to be entitled to speak and have their opinions heard, receive, seek and impart information pursuant to their intellect and age for the purposes of their self-development in accordance with norms of morality and propriety.¹²²
- Parents and family members are responsible for maintaining the health of the child.¹²³

Malaysia

The *Patients' Charter* of the Malaysian Medical Association provides that the consent of a parent or guardian is required prior to any medical procedure on a minor.¹²⁴ The age of majority in Malaysia is 18 (*Age of Majority Act 1971*). However, as a common law country, the 'mature minor' principle arguably may apply in some circumstances in Malaysia, although the position is unclear because the Malaysian courts have not yet determined the issue.¹²⁵

Regulations governing private health facilities require that a written consent be obtained before any procedure or surgery is carried out on the patient of a private facility. For patients under 18 and unmarried, consent must be obtained from the parent or guardian.¹²⁶ Contravention of this Regulation is an offence punishable by a maximum fine of 10,000 Ringgit and/or 3 months imprisonment. This Regulation does not cover consent in public clinics, or obtaining consent for medical prescriptions as distinct from treatment.

Marshall Islands

Marshall Islands has a specific legislative provision establishing an age of legal capacity in relation to HIV and STI testing, treatment and counselling. Minor children over the age of 14¹²⁷ who may have come into contact with HIV or an STI may consent to testing, treatment or counselling. Such consent cannot be later dis-affirmed because of minority.¹²⁸

Myanmar

Provisions of the Myanmar *Penal Code* in relation to age of consent to medical treatment are similar to India and Singapore, which have very similar Penal Codes, i.e. parental consent is required for medical treatment on behalf of a child who is under 12.¹²⁹ In addition Myanmar's *Child Law 1993* states:

Every child who is capable of expressing his or her own views in accordance with his age and maturity has the right to express his own views in matters concerning children. The views of the child shall be given due weight in accordance with his age and maturity, by those concerned.¹³⁰

In practice, professional norms vary across the country as to whether parental consent is required prior to HIV testing.¹³¹

Reported refusal to conduct HIV test

"Some MSM become sexually active when they're very young, from 12 onward. A boy who was just about 13 years of age, he was selling sex and wanted to be tested at a clinic. He didn't have parents or relatives, so was open about his sexuality. The clinic still refused to do a blood test. They told me that he was too young to do a test and he was sent away."

Myanmar focus group

Nepal

Nepal's Ministry of Health has issued guidelines that effectively set 14 as the age of legal capacity to consent to an HIV test, provided that the child is assessed as sufficiently mature by a counsellor:

In Nepal the legal age of consent is 18 years. Anyone 18 years or older requesting VCT is deemed able to give full, informed consent. Generally, for children and minors without the legal capacity to consent, voluntary informed consent from parents or legal guardian is required.

When children are brought to the VCT center by their parents, the counselor determines the reasons for testing. VCT services are provided only if there is a clear potential benefit to the child and the counselor determines that there is no potential for neglect or abuse of a sero-positive child. . .

For young people 14 to 17 years, VCT may be provided without parental consent on a case-by case basis, if the counselor determines that the young person has sufficient maturity to understand the testing procedures and results. Alternatively, preventive counseling without testing should be offered. Children below 14 years may be given preventive counseling if requested, but should not be tested unless this is done for medical reasons. The counselor determines whether the VCT services have potential benefit for the child and this is clearly explained to the child.¹³²



Pakistan

There is no specific legal provision governing medical consent. The Pakistan Medical and Dental Council Code of Ethics states:

Children are entitled to considerate and careful medical care as are adults. If the doctor feels that a child will understand a proposed medical procedure, information or advice, this should be explained fully to the child. Where the consent of parents or guardians is normally required in respect of a child for whom they are responsible, due regard must be given to the wishes of the child. Also, the doctor must never assume that it is safe to ignore the parental/guardian interest.¹³³

Pakistan's *National HIV Counselling Guidelines* provide clearer guidance by establishing an age of consent to HIV testing. The Guidelines state:

The age of consent for HIV testing will be eighteen years. Children under this age will need the consent of their parents or guardians. In special cases, children living independently, who are not in contact with parents and who do not have a guardian, will be able to consent for HIV testing after they have been provided with age-sensitive information and counselling.¹³⁴

Pakistan's *VCT Guidelines* also address rights of young people:

Anonymous VCT services may be preferable to some young people. However, different cultures may have their own requirements and social expectations that prevent young people from accessing VCT services without parental consent. Although VCT services must always take into account any relevant laws regarding the rights and autonomy of minors and the responsibilities of parents for their children, they must also remember that the dignity and confidentiality of the young person must be protected and respected.¹³⁵

The *HIV/AIDS Prevention and Treatment Bill 2007* proposed to introduce a provision allowing minors who are living independently, who are not in contact with parents and who do not have a guardian, to consent to HIV testing after they have been provided with age-sensitive information and counselling. The Bill was not passed into law.

Consent to HIV testing in the Philippines Reports on the social worker consent process

"There was a problem with parental consent. My friends would approach me and tell me that they weren't able to get tested because they were young and they were asked for a parental consent. The past couple of years, we have informed them already that it is allowed without parental consent as long as they have consent from a social worker. But the counsellor would still ask for parental consent. They keep on saying that there is a law that requires parental consent. Information [about the process for a social worker to provide consent] has not yet been disseminated to all the social hygiene clinics.

The AO [administrative order] of the Department of Social Welfare and Development allows the social workers to sign on behalf of the parents in certain situations such as if the child is a young key affected population or is involved in prostitution or is an injecting drug user.

The process is working for those young key affected populations if the counsellors or the people at the social hygiene clinics have the knowledge of the existence of this particular administrative order. But if they do not know, they still do not allow the young key affected persons to access the testing.

... In addition to that, while there is an administrative order, the problem is there is no social worker available at the social hygiene clinic. So the problem is the same. It will follow that even if the services are available, there is no social worker to administer (provide consent)."

Philippine focus group

The Philippines

In the Philippines the strict legal position is that a minor (under 18) cannot provide independent consent to medical or surgical treatment. A physician is obliged to obtain the consent of the child's parent or guardian, except in emergencies. Specific provisions have been proposed for HIV testing (minors require written consent from a parent or guardian, with the exception that special new provisions are proposed for at-risk 15-17 year olds, see below) and family planning services

(minors require written consent from a parent or guardian, with the exception that special new provisions are proposed for situations where the minor is already a parent or has had a miscarriage).¹³⁶

As a matter of practice, physicians sometimes choose to treat adolescents without involvement of parents, particularly in relation to SRH issues. In these circumstances, disclosure to parents of the nature of the medical treatment may not be required, as there are no specific requirements for disclosure. A Philippine law professor offered the following advice:

... in some treatment situations such as care for sexually transmitted diseases or the side effects of birth control pills familial ties may be strained or broken following (parental) disclosure. In the absence of laws authorizing parental disclosure or notification, it is not advisable to provide them with information without permission from the minor patient. Physicians are put in a difficult situation when parents telephone to find out if their child has received medical care and for what purpose. The better policy in these circumstances is to let the minors decide whether they want to discuss their medical care with their parents. The best legal protection available to health care providers absent statutory directives, court orders, or written authorization by the minor is to refuse disclosure to a child's parent.¹³⁷

The *Implementing Rules and Regulations of the Philippine AIDS Prevention and Control Act of 1998* require written parental consent for HIV tests conducted on minors:

The State shall encourage voluntary testing for individuals with a high risk for contracting HIV: Provided that written informed consent must first be obtained. Such consent shall be obtained from the person concerned if he/she is of legal age or from the parents or legal guardian in the case of a minor or a mentally incapacitated individual. A minor is defined as a person who is below 18 years of age.¹³⁸

In some circumstances, the written consent of a social worker is considered acceptable in the place of parental consent. An Administrative Order of the Department of Social Welfare and Development issued in 2003 allows social workers to provide written consent for a minor's HIV test, in some situations where the minor is at risk of HIV, is under the care of the Department and parental consent is unavailable.¹³⁹

New legislation has been proposed to replace the 1998 AIDS Act. The Revised Philippine HIV and AIDS Policy and Program Act of 2012 (HB 6751) proposes to introduce the following provisions to allow minors aged 15-17 years to consent independently to an HIV test, provided they are assessed to be at high risk of HIV exposure.¹⁴⁰

Written consent from the person taking the test must be obtained before HIV testing.

If the person is below fifteen (15) years of age or is mentally incapacitated, such consent shall be obtained from the child's parents, legal guardian, or whenever applicable, from the licensed social worker, licensed health service provider, or a Department of Health-accredited health service provider assigned to provide health services to the child.

In keeping with the principle of "evolving the capacities of the child", HIV testing and counseling shall be made available to a child under the following conditions:

1. The child, who is above the age of fifteen years but below eighteen years, expresses the intention to submit to HIV testing and counseling and other related services;
2. Reasonable efforts were undertaken to locate, provide counseling to, and to obtain the consent of, the parents, but the parents are absent or cannot be located, or otherwise refuse to give their consent;
3. Proper counseling shall be conducted by a social worker, healthcare provider or other healthcare professional, accredited by the Department of Health or the Department of Social Welfare and Development; and
4. The licensed social worker, healthcare provider or other healthcare professional shall determine that the child is "at higher risk of HIV exposure", and that the conduct of the testing and counseling is in the child's best interest and welfare.

The Act defines 'Evolving capacities of a child' as:

(T)he concept enshrined in Article V of the Convention on the Rights of the Child recognizing the developmental changes and the corresponding progress in cognitive abilities and capacity for self-determination undergone by children as they grow up thus requiring parents and others charged with responsibility for the child to provide varying degrees of protection and to allow their participation in opportunities for autonomous decision-making in different contexts and across different areas of decision-making.¹⁴¹

Singapore

The legal position in Singapore is similar to the position in Hong Kong SAR. There is no specific legislation on age of consent to medical treatment and no court judgments directly address the issue. However, legal academics and professional bodies recommend that health care workers apply the English common law position, which recognizes the evolving capacity of minors to consent to medical procedures (the *Gillick* principle).¹⁴² It is assumed that a minor who is capable of understanding the nature and consequences of a test or procedure may give a legally valid consent.¹⁴³ For example, the Singapore Medical Association's legal counsel advises:

Under s.89 of the Penal Code of Singapore, the position of a minor under 12 years of age is clear. The consent of the guardian or other person having lawful charge must be obtained. The position is also clear for minors above the age of 18. Under s.87, they can consent to surgical treatment, even if it amounts to "grievous hurt". What is unclear in criminal law is for minors between the ages of 12 and 18. In construing the various sections in the Penal Code, it does not say that consent will not be a valid defence in criminal law, if given by a person below 18. Hence, as a matter of justice and good sense, the "maturity test" enunciated in *Gillick's* case can be used.¹⁴⁴

Sri Lanka

The law of Sri Lanka applies a principle whereby boys aged 16 and girls aged 14 years are considered to be competent to exercise choices in personal decisions affecting their lives.¹⁴⁵ There are no legislative provisions specific to consent to medical testing or treatment. General principles relating to 'age of discretion' apply:

The normal legal provisions on age of discretion apply, and indicate that "evolving capacity" of the child must be accommodated, and that consent must be obtained in the case of a child above the 'age of discretion' (14 / 16 years), and in the case of a child 'mature enough to express consent'. . . Ethical guidelines of the Sri Lanka Medical Council suggests that if a person under 18 has 'sufficient understanding and intelligence' they can demonstrate competence to make a medical decision. This reflects the discrepancy between law and medical practice.¹⁴⁶

However, the reality of medical practice means that young people's rights are often overlooked:

... medical practitioners administer 'consent' forms requiring written consent to adults and to parents in the case of children less than 18 years. There appears to be no awareness of the need to obtain 'informed consent' in the case of children of an 'age of discretion', or of adequate maturity and understanding. In State hospitals it is said that doctors are too busy to take time to explain procedures and obtain "informed consent" in the case of even adults, though there is a perception that 'informed consent is required by law.' This consent in the case of an adolescent is expressed by the parent, contravening the legal principles...¹⁴⁷

Regard should also be had to Sri Lanka's *International Covenant on Civil and Political Rights Act of 2007*, which incorporates a general statement on the best interests of the child as paramount in relation to all matters concerning children, "whether undertaken by public or private social welfare organizations, administrative authorities or legislative bodies."¹⁴⁸ This may provide a legal basis for recognizing the rights of a child to exercise medical consent independent of a parent if the child is sufficiently mature and it is in the child's best interests to do so.

Thailand

This review did not identify a specific provision of Thai law regulating age of consent to medical interventions. The *Civil and Commercial Code* states that the age of majority is twenty years,¹⁴⁹ with the exceptions that a minor can do the following:¹⁵⁰

- acts which are strictly personal;
- acts which are suitable to his condition in life, and actually required for his reasonable needs; and
- make a will, after completing fifteen years of age.

Thai Medical Council Regulations have required parental consent for HIV testing of persons under 18.¹⁵¹ However, in 2012 it was reported that a committee of the Thai Medical Council recommended that this regulation be changed to enable adolescents to test without parental consent, provided counselling is provided.¹⁵²

3.1.3 Rights to privacy and medical records

In addition to the right to consent to medical tests and treatment, other legal rights affecting young people's access to and enjoyment of health services include the rights of young people to:

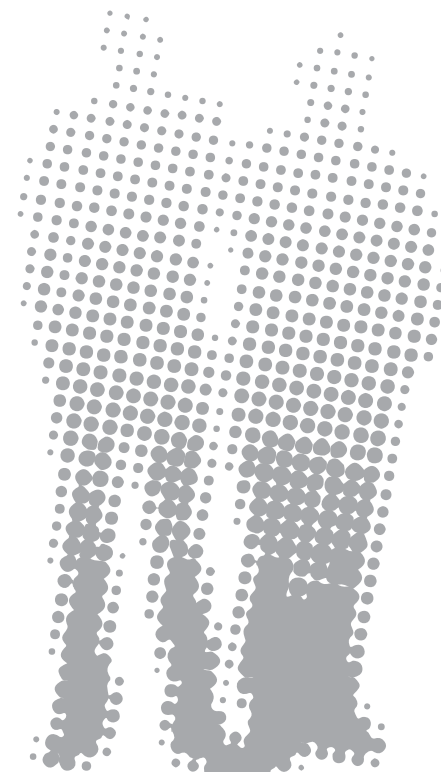
- confidentiality regarding their medical records and health status, including non-disclosure without consent to their parents; and
- access their medical records and obtain information on their health status.¹⁵³

Some countries have special provisions addressing the rights of minors to medical confidentiality. For example:

- The *Infectious Diseases Act* of Brunei Darussalam and the *Infectious Diseases Act* of Singapore have identical provisions stating that parental consent to disclosure of a child's HIV status is required if the child is under 16. These Acts provide that any person who, in the performance or exercise of his functions or duties under the Act, is aware or has reasonable grounds for believing that another person has AIDS or HIV infection or is suffering from an STI or is a carrier of that disease shall not disclose any information which may identify the other person, except with the consent of the other person, or if the person is below 16 years of age, with the written consent of a parent or guardian of that person.¹⁵⁴
- The *Communicable Diseases Prevention and Control Act 1988* of the Marshall Islands provides that health care workers may provide HIV and STI test results to young people aged over 14 years, rather than to their parent or guardian. The law provides that information that identifies persons infected with or tested for HIV or an STI can be released to a parent or guardian of a minor under the age of 14.¹⁵⁵ The provider of HIV and STI testing, treatment and counselling is authorized, but not required, to inform the parents or guardians of minors who are over the age of 14.¹⁵⁶ This places the decision whether to inform the parents/guardian of a minor 14 years or over in the hands of the health care provider, rather than the young person. The Act also permits disclosure of test results without consent of the person tested to schools, prisons, pre-schools and day care centres.¹⁵⁷

Some countries permit parents or guardians to be notified of a minor's HIV test result, without requiring the minor to also consent. For example:

- Cambodia's *Law on the Prevention and Control of HIV/AIDS 2002* permits notification of a minor's HIV test result to the minor's parent or guardian.¹⁵⁸
- Fiji's *HIV/AIDS Decree 2011* permits disclosure to a parent or guardian without the consent of the child if the child is assessed as not capable of understanding the meaning and consequences of an HIV test and the parent or guardian consented to the test on that basis.¹⁵⁹
- PNG's *HIV/AIDS Management and Prevention Act 2003* permits disclosure to a parent or guardian without the child's consent when the person tested is under 12, is not capable of understanding the meaning and consequences of a test, and the parent/guardian consented to the test on that basis.¹⁶⁰
- The *Philippine AIDS Prevention and Control Act 1998, Implementing Rules and Regulations* provide that the results of an HIV test shall be released only to the person who was tested or a parent of a minor (under 18) who was tested.¹⁶¹ The draft Revised Philippine HIV and AIDS Policy and Program Act of 2012¹⁶² also permits disclosure of HIV test results to a parent or guardian of a minor.
- Viet Nam's *Law on HIV/AIDS Prevention and Control, 2006* permits notification of a minor's HIV status to parents or guardians.¹⁶³



"An appropriate balance is required between the need for legal protection from exploitation and abuse on the one hand, and the need to respect the rights of young people to privacy and to make autonomous decisions (including about their sexual lives) on the other."

3.1.4 Age of consent to sex

Age of consent and access to health services

Age of consent laws that define a minimum age at which a child can consent to sex are an essential component of a legislative response to protection of children from sexual exploitation. Age of consent laws can also affect young people's access to SRH and HIV services, depending on how they are enforced by police and understood by health care workers and young people. Protecting young people's rights requires a balance to be struck between enabling them to assume adult roles and responsibilities (including in decisions regarding their own health and sexual lives) and ensuring their protection from exploitation and abuse.¹⁶⁴ Governments can ensure that age of consent laws do not adversely affect access to services through rights-based approaches to framing legislation and health service guidelines.

The ways in which age of consent laws may affect access to SRH and HIV services include:

- Sexually active young people may be deterred from attending SRH and HIV services if they fear that they or their sexual partners might be prosecuted for underage or extramarital sex. In most cases, age of consent laws aim to protect rather than punish minors, so ideally such fears should not arise.¹⁶⁵
- A high age of consent to sex (e.g. 18 or 19 years) could contribute to judgmental attitudes of health care workers towards sexually active young people, or a reluctance of some health care workers to provide SRH services to people under the age of consent because of the legal implications. Such attitudes can be addressed by guidelines and training on non-discriminatory service provision for young people.
- Difficulties may arise in countries where the age at which HIV testing can be sought without parental consent is higher than the age of onset of sexual activity. Adolescents may be deterred from attending

for HIV testing if the consent process requires disclosing to their parents that they are sexually active and may have acquired HIV. In the Philippines, age of consent is set at 12, recognizing that many adolescents experience consensual sex at a young age, yet a person must be 18 before she or he can consent independently to an HIV test (Table 6).

Table 6: Comparison of age of consent to sex and to an HIV test

	Age of consent to heterosexual sex	Age of consent to an HIV test without parental consent
Cambodia	15	18
Lao PDR	15	14
Marshall Islands	16	14
PNG	16	13
The Philippines	12	18 (proposed to reduce to 15 for children at higher risk of HIV)
Viet Nam	16	16

Note: The proposal to reduce the age of independent consent to an HIV test to 15 for children at higher risk in the Philippines is contained in Section 12 of the Revised Philippine HIV and AIDS Policy and Program Act of 2012 (HB 6751), Section 12(c); HB 6751 is expected to be considered by Congress in 2013-2014.

Source: Author's review of legislation. Legislation is listed at Annex I and Table 4.

Age of consent laws, statutory rape and consensual sex between adolescents

The legal age of consent to sex is generally established in laws relating to rape or sexual assault. The term 'statutory rape' refers to an offence committed by a person who has consensual sex with another person who is under the age that must be attained to have legal sex. As Table 7 below demonstrates, age of consent to sex varies throughout the region, ranging from as young as 12 up to 19.¹⁶⁶

The justification for laws regarding the age of consent is to protect children from sexual exploitation. An appropriate balance is required between the need for legal protection from exploitation and abuse on the one hand, and the need to respect the rights of young people to privacy and to make autonomous decisions (including about their sexual lives) on the other.

Some countries have sought to strike this balance by enacting laws that permit young people to have sex provided the age difference between the parties engaging in sexual conduct is not over a certain limit. For example:

- In Bhutan, the age of consent to heterosexual sex is generally 18; however consensual sex between minors 16 and above is also legal.¹⁶⁷
- In the Cook Islands, age of consent for girls is 16, with the exception that a girl aged 12 or more can consent to sex with a boy who is younger than her.¹⁶⁸
- In Fiji, it is a defence to a charge of indecent assault on a boy or girl under the age of 16 years to prove that that the offender was of a similar age to the boy or girl and that consent to the act of indecency was given in the context of a continuing friendship between the offender and the boy or girl.¹⁶⁹
- In PNG, a child aged 12 years or older can consent to sex with a person who is not more than two years older than the child¹⁷⁰ (with the exception of consensual male-to-male sex which is illegal for all ages).¹⁷¹
- In the Philippines, sex with someone 12 years or over but less than 18 is permissible provided that the age difference between the two persons is less than 10 years.¹⁷²
- Canada and some states of Australia do not criminalize consensual sex with a person over a prescribed age (12 or 10) if the accused is less than two years older than the other person.¹⁷³

In Cambodia, the Ministry of Justice has issued Explanatory Notes that address the situation in which minors of a similar age engage in voluntary sexual relationships, without use of any violence, coercion, threat, surprise or deception. The Explanatory Note recommends consideration be given to not prosecuting such cases taking into account “the circumstances of the offence or the character of the minor” or if a prosecution proceeds, to impose only minor, non-custodial penalties.¹⁷⁴

Age of consent: Reported impact of contradictions between policy, law and practice

“There is a contradiction between the law in respect of age of consent, which allows sex with persons over the age of 12, and the practices and professional norms in relation to contraceptives. The reality is that advice and services relating to contraception and STIs are often limited by health care services to people who are married or who are over 18 years. Many health care workers are reluctant to provide condoms or advice on contraception to persons who are not married, and even if a person is married, health care workers may discourage use of contraception if the person does not already have children...The most significant barrier is the judgmental attitudes of health care workers towards young, unmarried persons.”

Interview with Mara Quesada-Bondad, Executive Director, Action for Health Initiatives (ACHIEVE), Inc., Philippines

Islamic laws

In countries and provinces where Islamic law applies (e.g. Aceh Province of Indonesia, Afghanistan, Malaysia, Maldives and Pakistan), regard is had to Sharia principles in determining when sexual conduct is permitted. Under Sharia law, consensual sexual relations outside of marriage (premarital or extra-marital sex) may attract penalties for the offence of *zina* (fornication).¹⁷⁵ Homosexual conduct attracts penalties for the offences of *liwat* (sodomy) or *musahaqah* (sex between women). A female may be charged with ‘*khalwat*’ (unlawful premarital or extramarital sexual relations) if she has reached puberty and is found in close proximity with a member of the opposite sex who is not a relative. See also the discussion of religious laws under 3.1.2.

For example, the *Syariah Criminal Offences Enactment 1995* of the Malaysian State of Sabah provides:

Any female person who is found living together or cohabiting or confining or hiding in any place with a male person who is not her mahram (close family member) other than her husband which arouses suspicion that they are committing a sinful act shall be guilty of an offence of khalwat and shall, on conviction, be liable to a fine not exceeding two thousand ringgit or to imprisonment for a term not exceeding one year or to both.¹⁷⁶ Nothing is an offence which is done by a child who has not attained puberty. A person under twelve years of age shall be presumed as not having attained puberty.¹⁷⁷

Similar provisions apply in the other States of Malaysia.

Table 7: Age of consent to sex

Country	Age at which a male can consent to sex with female	Age at which a female can consent to sex with male	Age at which male can consent to sex with male	Age at which female can consent to sex with female
ASIA				
Afghanistan	Males can only have sex after marriage.	Females can only have sex after marriage.	Illegal	Illegal
Bangladesh	No specific age of consent for males defined by law.	14	Illegal	No specific age of consent defined by law.
Bhutan	18	18	Illegal	No specific age of consent defined by law.
Brunei Darussalam	No specific age of consent for males defined by law.	14	Illegal	Illegal
Cambodia	15	15	15	15
China	14	14	14	14
DPRK	No data	15	No data	No data
India	18	18	18	18
	19	15		
Indonesia	Aceh Province: Muslim males can only have sex after marriage.	Aceh Province: Muslim females can only have sex after marriage.	18	18
Lao PDR	15	15	15	15
Malaysia	Muslim males can only have sex after marriage.	16 for all female citizens, Muslim females must also be married.	Illegal	Illegal
Maldives	Males can only have sex after marriage.	Females can only have sex after marriage.	Illegal	Illegal
Mongolia	16	16	16	16
Myanmar	No specific age of consent for males defined by law.	14	Illegal	No specific age of consent defined by law.
Nepal	No specific age of consent for males defined by law.	16	No specific age of consent defined by law.	No specific age of consent defined by law.
Pakistan	Males can only have sex after marriage.	16 for all female citizens, Muslim females must also be married.	Illegal	Illegal
Philippines	12	12	12	12
Sri Lanka	16	16, or 12 if married.	Illegal	Illegal
Thailand	15	15	15	No specific age of consent defined by law.
Timor-Leste	17	17	17	17
Viet Nam	16	16	16	No specific age of consent defined by law.
PACIFIC				
Cook Islands	No specific age of consent for males defined by law.	16	Illegal	Ambiguous: 16 if sex between females is considered intercourse.
Fiji	16	16	16	16
Marshall Islands	16	16	16	No specific age of consent defined by law.
Palau	No specific age of consent for males defined by law.	15	Illegal	No specific age of consent defined by law.
PNG	16	16	Illegal	No specific age of consent defined by law.
Samoa	16	16	Illegal	16
Solomon Islands	No specific age of consent for males defined by law.	15	Illegal	Illegal
Tokelau	16	16	16	No specific age of consent defined by law.
Tonga	No specific age of consent for males defined by law.	16	Illegal	No specific age of consent defined by law.
Vanuatu	15	15	15	15

Source: Author's review of legislation. See Annex I for further explanation and references to legislative sources.

Notes:

(i) **Explanation of the situation in countries where: 'no specific age of consent for males defined by law'**

Some countries have statutory rape provisions that specify an age of consent for females but do not specify an age of consent for males. The focus of these laws is on the minimum legal age at which the female person can exercise consent to sex with males. The relevant offences in these countries only relate to the culpability of a male who has sex with an underage female. However, these countries' age of consent laws do not address the reverse situation: the culpability of a female for having sex with a male minor. For example, the statutory rape provision in the Penal Code of Myanmar is gender-specific: it is an offence of rape for a man to have sexual intercourse with a woman, even with her consent, if she is under 14 years old. There is no similar provision criminalizing a woman who has sex with a male who is under 14 years old.

Therefore, under this model there is no specific predefined 'age of consent' restriction on a male minor's ability to consent to legal sex with an adult female. Based on the review of legislation undertaken for this study, this appears to be the situation in Bangladesh, Brunei Darussalam, Cook Islands, Myanmar, Nepal and Palau. There is no specific statutory rape offence for females who have sex with consenting male minors in these countries. However, depending on the circumstances, a female who has sex with a minor may commit other offences, e.g. if a court finds that the minor male was too young to exercise real consent and therefore an assault or child abuse has occurred. This would require consideration of the circumstances of the case, rather than applying a predefined fixed 'age of consent'.

By contrast, some countries have statutory rape provisions that apply to both sexes, and to sex between persons of the same or different sexes (e.g. Thailand).¹⁷⁸ Some countries have gender-neutral rape provisions, e.g. the Criminal Code of Mongolia provides an offence for sexual intercourse with 'a person' who knowingly is under the age of 16.¹⁷⁹

(ii) **Explanation of: 'age at which female can consent to sex with females': 'no specific age of consent is defined by law'**

Sex between females is not specifically criminalized in the countries where Table 7 notes that 'no specific age of consent is defined by law'. Therefore adolescent girls engaging in consensual sexual conduct and their female sexual partners do not risk prosecution. However, in some countries, the scope of general legal prohibitions regarding sexual conduct is ambiguous and may arguably prohibit some forms of sexual conduct between females, as explained in the notes in Annex I. Examples of ambiguous provisions that arguably may criminalize some forms of sexual conduct between females include:

- In Myanmar the offence of 'unnatural sex' applies to carnal intercourse against the order of nature. It could be argued that some forms of sex between females are 'against the order of nature'. However, no prosecutions of women are known under this provision in Myanmar or equivalent 'unnatural sex' provisions in other countries in the Asia-Pacific region.
- In the Cook Islands, consensual penetrative sexual intercourse with a girl under 16 is criminalized. It could be argued that some forms of sex between females are within the definition of penetrative sexual intercourse. However, no prosecutions are known to have occurred based on such an argument.

3.1.5 Marriage as a requirement to access services

Table 8 below shows the minimum legal age of marriage without parental consent. Many countries permit marriage at much lower ages than the ages specified in Table 7 provided parental consent and the endorsement of courts, local government and/or religious authorities is obtained. Child marriage is traditionally common in South Asia and there can be family and community pressure on girls to marry and bear children at a young age. Laws often reflect local customs and traditions. For example, in India with appropriate consent Muslim girls may legally marry at 15, in Sri Lanka Muslim girls may marry at 12 and in Bangladesh child marriages are legally permitted under Muslim personal laws (see Annex II). Many countries have lower minimum ages of legal marriage for females than males.

Table 8: Minimum legal age of marriage without parental consent

ASIA	Males	Females
Afghanistan	18	16
Bangladesh	21	18
Bhutan	18	16
Cambodia	20	18
China	22	20
India	21	18
Indonesia	21	21
Lao PDR	18	18
Malaysia	21	21
Maldives	18	18
Mongolia	18	18
Myanmar	18	18
Nepal	20	20
Pakistan	18	16
Philippines	21	21
Sri Lanka	18	18
Thailand	21	21
Viet Nam	20	18
PACIFIC		
Cook Islands	21	21
Fiji	18	18
Kiribati	18	18
Marshall Islands	18	18
Micronesia (Federated States of)	18	16
PNG	18	16
Samoa	21	19
Solomon Islands	18	18
Tonga	18	18
Vanuatu	21	21

Source: Author's review of legislation. See Annex II for further explanation and references.

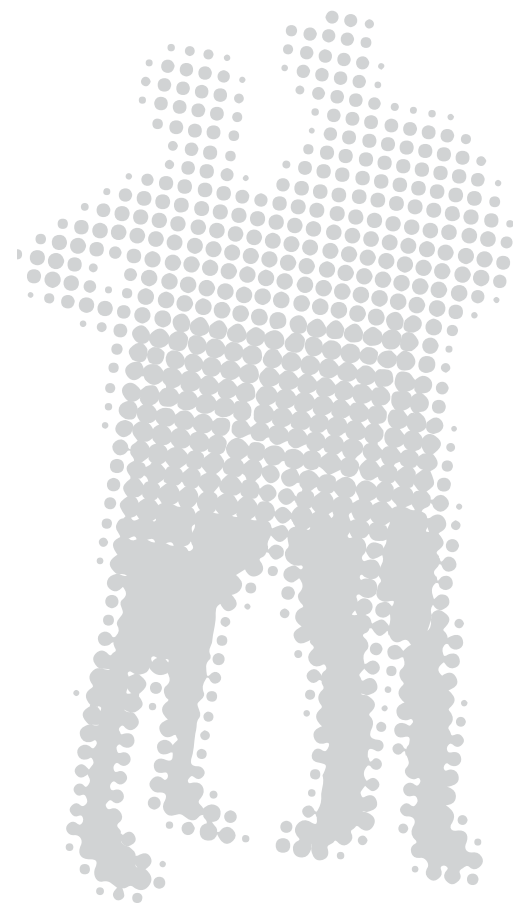
Reported perceptions of age and marital status as requirements to access services

"The reason why I didn't access condoms..., in class, contraceptives and pills are being taught ... condoms and pills are only seen in clinics and among couples and you have to consult a doctor first. I [presumed] that if I am young, I shouldn't because I have to talk to a doctor first. [Facilitator: What do you think would be the reason for the doctor not to give you pills and condoms?] Because I'm young and those are only for couples. Anyway, you don't really know."

Philippine focus group

"For women who are already married, it's easier to get access to contraceptives. But if we request access as a young woman, it's still hard, even to obtain condoms to protect us from STI, HIV and unplanned pregnancy. But for adults, it's much easier to access."

Indonesian focus group



A rights-based approach requires abolishing legal or policy requirements that discriminate against young people on the grounds of marital status.

A rights-based approach requires abolishing legal or policy requirements that discriminate against young people on the grounds of marital status. In many countries of Asia and the Pacific, sex outside of marriage is culturally taboo. Some governments have been reluctant to allocate resources to provide SRH services to people who engage in conduct that is regarded as immoral, such as premarital sex.

In South Asia, SRH services are often strongly oriented towards the needs of married couples with little attention to the needs of unmarried young people. For example, in Bangladesh, SRH service delivery systems generally do not cater to the needs of unmarried adolescents,¹⁸⁰ and public facilities only provide contraceptives to married couples.¹⁸¹ Similarly, a review of adolescents' access to SRH services in Sri Lanka found:

The largest element of government preventive health sector comprises of reproductive health related services. However, these services almost exclusively cater to married people.

...(A)dolescents and unmarried are not served in a fair manner by preventive reproductive health services as these services are defined for married people. The health workers are not being trained to cater for adolescent needs.¹⁸²

In China and South-East Asia, the legal age of marriage is comparatively higher than in South Asia. As in South Asia, access to SRH services is often also provided mainly or exclusively to married couples, particularly in China, Indonesia and Malaysia.¹⁸³

China's SRH services also tend to be oriented to the needs of married couples. China's Population and Family Planning Law provides that "couples of reproductive age" who practice family planning are able to obtain technical services free of charge.¹⁸⁴ Unmarried young people often seek SRH services from private clinics, rather than government services. Gao Ersheng and Lou Chaohua of the Shanghai Institute of Planned Parenthood Research describe the situation in China:

Although there have never been formal documents explicitly prohibiting the delivery of SRH services to China's unmarried youth, including contraceptives, there has never been any explicit provisions to legislate that SRH services are provided to unmarried youth, nor what those services should look like. There is a distinct lack of purposeful and specific policies, laws and regulations in this area. For example, current reproductive health services define the target clientele to be married couples, including for contraceptive services. Among service providers, a good proportion of them do not consider unmarried youth to be part of the target population for SRH services.¹⁸⁵

In **Indonesia**, the law *Health Law, 2009* states that every individual has the right to a healthy and safe reproductive life and sexual life free from coercion and/or violence, however this is only with a lawful partner, and the right to determine one's reproductive life is subject to respecting "noble values and religious norms".¹⁸⁶ The *Law on Population Development and Development of Family, 2009* provides that national family planning policy will be implemented to assist candidate (betrothed) or husband wife couples in making decisions and realizing reproductive rights responsibly on the ideal age of marriage, ideal age for childbirth, ideal interval of childbirth and reproductive health counselling.¹⁸⁷ The Law requires the government to improve access to information, education, counselling, and contraceptive services requested by husband-wife couples.¹⁸⁸

Amnesty International describes the impact of the Indonesian law as follows:

Government midwives and doctors...confirmed that they normally do not provide reproductive health services, including contraception and family planning, to unmarried women and girls. . . other government officials told Amnesty International in March 2010 that contraception and family planning services are intended solely for married people in accordance with laws and policies.

This situation leaves unmarried women and girls at risk of unwanted pregnancies, sexually transmitted diseases, and human rights abuses. For example, unmarried adolescents who become pregnant are often forced to stop schooling. Instead of risking rejection by the wider community, some women and girls may decide – or be forced – to marry when they become pregnant, or else to seek an unsafe abortion, which puts them at risk of serious health problems and maternal mortality.

For unmarried women and girls who want to continue pregnancy, it remains unclear how they can access reproductive health services during pregnancy and at the time of the birth, without getting married first. Amnesty International's research suggests that the fear of stigmatisation can discourage pregnant unmarried women and girls, especially if they are from poor and marginalised communities, from seeking antenatal and postnatal services.

Unmarried women and girls who are rape victims may also not receive access to reproductive health services, either because they do not know they are entitled to these services or due to the fear of stigmatisation. The government has in place various information programmes on reproductive health for adolescents; however, there are substantial gaps in what is covered by these programmes.

These gaps to some extent reflect cultural attitudes and legal restrictions on access to reproductive health services for unmarried people, and on providing information on sexuality and reproduction. In particular, there appears to be great reluctance to include information on contraceptives, such as condoms, as part of reproductive health programmes targeting unmarried adolescents for fear of being seen as promoting “free sex”. Although some schools provide information on reproductive health to adolescents, the impact of these programmes remains limited. Access to government programmes on sex education is made more difficult for adolescents who have left the education system, although there are also limits to the information provided to adolescents within the education system.¹⁸⁹

Local experts addressing a workshop in 2012 described how young people nevertheless are able to access condoms in this environment:

Although family planning services are not provided to the unmarried young people by the Indonesia government clinics or hospitals, condoms are easily available at small mini-markets and super-markets, many of which are open 24 hours a day. Study also showed that mini-markets were increasingly becoming the main outlets for condom purchases among youths in Indonesia. NGOs like the Indonesian Planned Parenthood Association (IPPA) also provide SRH services from a “rights” perspective and do not ask for marital status as a condition for SRH services. Contraceptive pills and condoms are also easily available from pharmacies throughout the country.

According to the Indonesian “Family Welfare” Law, family planning programs are only available to married couples or families...Thus, providing family planning services to single people is considered illegal. The existing family planning programs, consequently, have concentrated on married women of reproductive age (between 15-49). Considering the rapid increase of risks related to sexual behavior among single young Indonesians, many youth experts have strongly asked for a review of this law.¹⁹⁰

In **Malaysia**, government clinics provide SRH services to some unmarried persons, but only on an exceptional basis:

Very limited contraceptive services are discreetly provided for young and unmarried people in government and NGO reproductive health services; “discreetly”, meaning this is not openly talked about. The MOH clinics provide contraceptives to unmarried people on a case-by-case basis for “high-risk young people”, who are sexually-active, drug users or HIV positive. Nine of the 12 FPAs (family planning associations) who responded to the FPA questionnaire also provide contraceptives discreetly. This is definite progress for both government and NGOs in beginning to responding to the contraceptive needs of youth.

Most unmarried people are therefore thought to obtain contraceptives from private sector outlets including pharmacies which can legally provide contraceptives irrespective of marital status and not on a restricted case by case basis and retail shops for condoms. Even for married couples, twenty seven per cent of current oral contraceptive users obtained the pill from pharmacies in 2004.¹⁹¹

Some countries have introduced policies that encourage reorientation of services to unmarried young persons. For example:

- The *Bangladesh Adolescent Reproductive Health Strategy 2005-2015* states the need for strategies for provision of easy access of all adolescents to reproductive health services. The Strategy states: "Introducing and expanding adolescent friendly health services. Besides appropriate information, the other most critical need is that of easily accessible adolescent reproductive health services. While married adolescents still have some access, the unmarried ones with STI or other reproductive health problems have almost no option for accessing services."¹⁹²
- India's *Adolescent Reproductive and Sexual Health Strategy* recognizes the need to reach unmarried adolescents and that an increased focus on adolescent SRH will "yield dividends in terms of delaying age at marriage, reducing incidence of teenage pregnancy, prevention and management of obstetric complications including access to early and safe abortion services and reduction of unsafe sexual behaviour."¹⁹³
- The *Strategic Plan for Adolescent Health in Myanmar 2009 to 2013* states: "Unmarried girls and young women are especially vulnerable to unwanted pregnancies because currently the services are not targeted to them and are limited to married women."¹⁹⁴ Similarly, the *Myanmar Strategic Plan for Reproductive Health 2008-2013* supports provision of contraceptives and reproductive health services to unmarried persons.¹⁹⁵
- The Philippines has issued a *National Policy and Strategic Framework on Adolescent Health and Development*,¹⁹⁶ which addresses the reproductive health rights of adolescents without discriminating between married and unmarried adolescents. Additionally, in the Philippines, the implementing rules of the *Responsible Parenthood and Reproductive Health Act* of 2012 state that provision of reproductive health care shall not discriminate between married or unmarried individuals.¹⁹⁷
- The *Population Policy of Tuvalu* gives partial recognition to the SRH needs of unmarried persons. The Policy notes: "Government operated clinics that primarily cater for married women and mothers are not always the best locations for addressing the needs of unmarried youth." The Policy supports provision of contraceptives to youth: "The provision of reproductive health information and contraceptives to youth through specifically tailored NGO programmes appear to be the best approach, even if some parents are uncomfortable with it." This Policy also includes

a statement that indicates the concept of recognition of the evolving capacity of an adolescent to consent independently to SRH services is not supported: "Teenagers, as not yet fully adult members of society, cannot be expected to have fertility 'preferences' or make informed choices." This denial of recognition that sufficiently mature adolescents can exercise informed SRH choices may reinforce barriers to service access faced by unmarried youth.

3.1.6 Age restrictions on access to harm reduction services

Harm reduction services for people who use drugs generally target adults, even though many people initiate drug injecting during their adolescence. For example, a survey of 2,231 people who inject drugs in Thailand identified age of first injecting ranging from 15 to 27, and a survey of 200 people who inject drugs in India identified age of first injecting ranging from 13 to 26.¹⁹⁸

In recent years, the Committee on the Rights of the Child has asked States to ensure that their criminal laws do not impede access to specialized and youth-friendly harm-reduction services, including the amendment of laws that criminalize children for possession of drugs.¹⁹⁹ The remarks by the Committee reflect Article 33 of the CRC which calls on States to take all necessary legislative, administrative, social and educational measures to protect children from drug-related harm,²⁰⁰ along with the General comment No. 4 (CRC/C/GC/4, 2003) from the Committee on the Rights of the Child placing actions to address adolescent drug use in the broader context of promoting their health and development.²⁰¹

Civil society groups have argued that there has been a consistent lack of focus on young people in policies and programmes relating to injecting drug use.²⁰² Guidance issued by WHO, UNODC and UNAIDS states that there should be no minimum age requirement for people who inject drugs accessing harm reduction services; however, with the qualification that "in the case of children and young people who inject drugs, special provisions may be required where parental consent is ordinarily required for children to obtain medical or other services."²⁰³

A review conducted for *The Global State of Harm Reduction 2012* report concluded that:

Despite a scale-up in services overall in the last two years, it was reported that harm reduction services in Asia almost always target male, adult PWID (persons who inject drugs). A major barrier to service provision targeted at youth in the region appears to be their relative invisibility as a drug-using population. Few or no data are collected on this population in most countries in the region at present. Young people are, therefore, rarely

a focus for intervention, and the vast majority of programmes lack any clear strategy for reaching and engaging under-18s.

Even in Bangladesh, which has relatively high levels of NSP (needle and syringe programme) coverage in South Asia according to recent reviews, there are no data on, or provision for, younger PWID. Furthermore, many young injectors in Asia are using methamphetamine and pharmaceutical drugs (e.g. benzodiazepines), and their needs will not be addressed through OST.

Legal age restrictions are also a barrier in the region. For example, in Nepal and Pakistan harm reduction projects can only work with those aged 18 and above, despite Article 33 of the UN Convention on the Rights of the Child requiring that state parties take ‘appropriate measures’ to protect under-18s from drug-related harms. This is of particular concern in Pakistan, where the age of initiation into drug injecting is decreasing, according to a recent rapid assessment exercise.

Meanwhile, in China ... despite an expansion of harm reduction service provision overall, age restrictions prevent under-18s from accessing these new services.

It was reported that legal age limits are a common reason for refusal by services, as they provide an objective way of rationing limited supply in the region. Stigma was also reported to be a major barrier, and many young PWID in the region deny they are dependent on drugs and need harm reduction services. At present, there is a mandate to disclose one’s identity, and service-users often have to effectively ‘register’ with authorities, as is the case in China.

This is a clear impediment to accessing OST services and may disproportionately affect younger people. Furthermore most OST clinics have yet to be integrated into general health services, with the consequence that those accessing treatment can easily be identified and stigmatized.²⁰⁴

In Viet Nam, the 2007 *Decree on Implementation of the Law on HIV/AIDS Prevention and Control* states that treatment of addiction with substitution drugs is provided only to persons who voluntarily commit in writing to adhere to the treatment guidelines. For persons aged under 16 years, their parents or lawful guardians shall express their consent and commit in writing to adhere to the treatment guidelines.²⁰⁵ Viet Nam’s *Decree Regulating Substitution Treatment of Opioid Addiction* of 2012 provides further detail in relation to parental consent for OST for opiate dependent persons under 16 years.²⁰⁶

Table 9: Age restrictions on access to harm reduction services

Country/territory with at least one reported NSP or OST site	Legal age restriction for accessing needle and syringe programmes	Legal age restriction for accessing OST services
Afghanistan	No data	No
Bangladesh	No data	18
Cambodia	No	18
China	18	20
China: Hong Kong SAR	No	No
China: Macau	No	No
India	18	18
Indonesia	Discretion may be exercised to provide access to persons under 18.	18; persons under 18 years can access OST if supported by a second opinion from a medical professional (child specialist).
Malaysia	No	No
Maldives	(no NSP)	No
Mongolia	No data	(No OST)
Myanmar	No	No
Nepal	No	18
Pakistan	18	(No OST)
Philippines	No data	(No OST)
Thailand	No	No
Viet Nam	18	16 (under 16 with parental consent)

Sources: For all countries except China, Indonesia and Viet Nam this table draws from data collated for *The Global State of Harm Reduction 2012* report, see: Fletcher, A. and Krug, A. 2012., *Excluding youth? A global review of harm reduction services for young people*. C. Stoicescu (ed.) 2012. *The Global State of Harm Reduction 2012: Towards an integrated response*. London: Harm Reduction International, pp. 137-146. Fletcher and Krug drew their findings from a global survey of civil society organizations and researchers working in the harm reduction field. Additional sources: For China, the needle and syringe programme age restriction is reported by Fletcher, A. and Krug, A., *op cit.*; the source of the OST age restriction is UNAIDS correspondence to UNESCO (July 2013) confirming that the National Methadone Maintenance Therapy Guidelines issued by Ministry of Health, Public Security, and Drug Administrative Bureau include the requirement that persons must be aged 20 years or over to access the programme, which may be waived if the person is HIV-positive. For Indonesia, see: Larasati, A. 2012. *Harm reduction and young injecting drug users in Indonesia*. *Caveat*, Sept-Oct 2012, p.15. For Viet Nam, see text above Table 9.

3.2 Criminal laws and police practices

3.2.1 Overview

Criminalization of sex work, same-sex conduct, drug use and abortion restricts young people's access to SRH and HIV services, education and information. In some countries, access to information on sexuality or reproductive health is also restricted by criminal laws relating to censorship or obscenity.

Age of criminal responsibility

The age of criminal responsibility is the age at which, according to the law, a child is considered capable of committing a crime and therefore old enough to stand trial and to be convicted of a criminal offence. Young people whose behaviours are criminalized by laws relating to involvement in selling sex, same-sex conduct and drug use may be particularly disadvantaged in countries that set a low age of criminal responsibility. In some countries, children as young as seven may be convicted of a crime. A low minimum age of criminal responsibility may affect law enforcement practices, such as policing of street children.

In its General Comment No. 10, the UN Committee on the Rights of the Child noted that the minimum age level of criminal responsibility varies from “a very low age level of 7 or 8 to the commendable high level of age 14 or 16.” The Committee concluded “that a minimum age of criminal responsibility below the age of 12 years is considered by the Committee not to be internationally acceptable.” The Committee encouraged States to raise the minimum age level to at least 12.²⁰⁷

Table 10: Minimum age of criminal responsibility

Age of criminal responsibility	Country
7	Brunei Darussalam, ²⁰⁸ India, ²⁰⁹ Myanmar, ²¹⁰ PNG, ²¹¹ Pakistan, ²¹² Singapore, ²¹³ Tonga ²¹⁴
8	Solomon Islands, ²¹⁵ Sri Lanka ²¹⁶
9	Bangladesh ²¹⁷
10	Bhutan, ²¹⁸ Cook Islands, ²¹⁹ Fiji, ²²⁰ Kiribati, ²²¹ Malaysia, ²²² Maldives, ²²³ Marshall Islands, ²²⁴ Nepal, ²²⁵ Palau, ²²⁶ Samoa, ²²⁷ Thailand, ²²⁸ Tokelau, ²²⁹ Tuvalu, ²³⁰ Vanuatu ²³¹
12	Afghanistan, ²³² Indonesia ²³³
14	Cambodia, ²³⁴ China, ²³⁵ Federated States of Micronesia, ²³⁶ Mongolia ²³⁷ (14 for listed serious crimes, 16 otherwise), Viet Nam (14 for very or particularly serious crimes, 16 otherwise)
15	Lao PDR, ²³⁸ Philippines ²³⁹
16	Timor-Leste, ²⁴⁰ Viet Nam ²⁴¹

Sources: Where available, applicable country legislation was reviewed to compile this table. References to the relevant laws are provided by country.

3.2.2 Criminalization of the conduct of key populations

Young people from key populations including young men who have sex with men, young transgender people, young people who use drugs and young people who sell sex may be subject to arrest, prosecution and detention due to laws that criminalize their conduct. The power imbalance between police and young people means that these populations are often also vulnerable to police abuses, such as police harassment, extortion and violence.

Criminalization of same-sex conduct

As Table 11 indicates, nineteen countries of Asia and the Pacific have laws on the statute books and/or religious laws that in effect criminalize male-to-male sexual conduct. At least seven countries also have laws that may in effect criminalize sexual relations between females.

Table 11: Criminalization of same-sex conduct

States where sexual conduct between males (including between adult males) may be punished under criminal laws	Asia: Afghanistan, Bangladesh, Bhutan, Brunei Darussalam, Malaysia, Maldives, Myanmar, Singapore, Pakistan, Sri Lanka. Pacific: Cook Islands, Kiribati, Nauru, PNG, Palau, Samoa, Solomon Islands, Tonga, Tuvalu.
States where consensual sex between females (including between adult females) may be punished under criminal laws	Asia: Afghanistan, Brunei Darussalam, Malaysia, Maldives, Pakistan, Sri Lanka. Pacific: Solomon Islands

Source: Table 7 above, and Godwin, J. 2010. *Legal Environments, Human Rights and HIV Responses among Men who have Sex with Men and Transgender People in Asia and the Pacific*. Bangkok: UNDP.

Most of these countries inherited criminal laws from the colonial era that include sodomy or ‘unnatural sex’ offences. Many of these countries were either British colonies or have legal systems strongly influenced by common law and nineteenth century British Penal Codes. These offences include sodomy, gross indecency and ‘unnatural’ sex offences, which in effect criminalize consensual male-to-male sexual conduct (including between consenting adults).²³⁶ Although many of these laws can in theory be applied against females as well as males (e.g. to punish ‘unnatural’ (anal) heterosexual sex), the existence of these offences has primarily been of concern to men who have sex with men, many of

whom fear that these offences can be used as a basis for harassment or police abuses.²⁴³ Some countries apply Islamic law prohibitions on sex outside of marriage and same-sex conduct (the *Sharia* offences of *liwat* (sodomy) and *musahaqah* (sex between women) (e.g. Afghanistan, Aceh Province of Indonesia, the Maldives, Malaysia and Pakistan).

The existence of such offences compounds the stigma associated with homosexuality and can act as a deterrent to young lesbian, bisexual, gay and other men who have sex with men, and transgender people from accessing HIV or SRH services, particularly if they fear arrest or breach of privacy and disclosure of their sexuality or gender identity to their family and community. In addition to sodomy and unnatural sex offences, other criminal offences such as vagrancy and public order offences are sometimes selectively enforced by police against men who have sex with men and transgender people. There are reports of selective enforcement of public order offences against men who have sex with men and transgender people in many countries of the region, including those that do not have sodomy or unnatural sex offences, such as in Cambodia, China, India, Indonesia, Mongolia, the Philippines, Thailand and Viet Nam.²⁴⁴ Young people may be vulnerable to police abuses because of lack of knowledge of their rights and the age difference between themselves and police officers.

Laws that criminalize sex outside of marriage or same-sex conduct can have the effect of restricting young people's access to information on SRH and HIV, commodities such as condoms and lubricant, and other services. Authorities may be reluctant to support publication of SRH and HIV health promotion information or dissemination of condoms targeted at populations other than adult married heterosexual couples.

There are some recent examples of the establishment of protective and enabling laws for men who have sex with men. For example, Hong Kong SAR has established legal equality for homosexual men under criminal law,²⁴⁵ and homosexuality has been decriminalized in Fiji.²⁴⁶ The Office of the High Commissioner for Human Rights (OHCHR) has called on all States to end violence and discriminatory laws and practices based on sexual orientation and gender identity.²⁴⁷

Reported police abuses

Myanmar focus group

"One of my friends, a 16 year old MSM, was walking home and was interrupted by a policeman. He was waiting for a trishaw, but the police officer wasn't satisfied with his explanation. The policeman shouldn't have arrested him because of his young age. He threatened him, took his cash and sentenced him to three months instead of one month as a suspected criminal. He was too young to be held in an adult prison."

"Police are able to arrest young MSM who are out at night either for breach of Section 377 of the criminal law that criminalizes sex between males, or for suspicious conduct or disorderly conduct after dark. If they are arrested they either have to provide sex to the police or they will be imprisoned for about one to three months. For MSM who have HIV, they are not be able to access HIV drugs when they are in prison, their immune system is weakened so they become sick or may even die."

Indonesia focus group

"The conservative local public order law in Tangerang (Java) is enforced against *waria* [transgender people], beggars, road singers, and street children who can be arrested for being on the street. This law is used to harass people and extort money. We are often apprehended and treated badly."

"Police monitor spas and massage parlours where MSM go, and some parks such as in Bogor where MSM meet. Once I was assaulted by police in the park in Bogor. There is some harassment and occasionally police will request money from MSM if they are caught."

Laws that criminalize sex outside of marriage or same-sex conduct can have the effect of restricting young people's access to information on HIV and SRH, commodities such as condoms and lubricant, and other services.

Criminalization of cross-dressing

Laws in Malaysia and Tonga criminalize cross-dressing or female impersonation.²⁴⁸ In some Malaysian states, transgender persons (*mak nyah*) have been subject to prosecution under such laws.²⁴⁹ The Tonga offence is not actively enforced.

Reported issues with criminalization: a service provider's perspective

"Because of stigma and the criminality of sex work and MSM, some young people are unwilling to attend clinics. Because of Section 377 - the sodomy law - young MSM don't want to 'come out' and be visible, there are no 'pride' events. Police can threaten arrest based on this law and other laws, and some police use this as a money making machine, a basis for extortion. If the law was changed, young people would be better able to access services and there would be more opportunities for health promotion."

Nay Oo Lwin, Programme Manager, Population Services International Targeted Outreach Program (PSI TOP), Yangon, Myanmar

The impact of criminalization of sex work on young people aged 18 years and over

For young people aged 18 years and over who sell sex, the criminalization of the sex industry and law enforcement practices such as confiscation of condoms and harassment of young peer educators and outreach workers can create barriers to accessing SRH and HIV services. In countries that criminalize the sex industry, police abuses of sex workers are often reported, including harassment, extortion and assault.²⁵⁰

All low- and middle-income countries of Asia and the Pacific criminalize sex work or activities associated with the sex industry, such as soliciting or keeping a brothel.²⁵¹ Young people who sell sex may also be arrested for other offences relating to vagrancy and public order, particularly if they work on the streets, in parks, at bus or train terminals or other public spaces. In some cases, this may lead to arrest and detention in special 'rehabilitation' facilities.²⁵² Violence by law enforcement officers, clients, and partners also appears to be more common among young people selling sex who are inexperienced, socially isolated and operating independently.²⁵³

Indonesia is unique in Asia in that it does not have a national law criminalizing the sex industry. The legal situation varies by province. In many Indonesian provinces, sex work may be legally conducted in designated areas known as *lokalisasi*. However, selling sex on the street is illegal and some provinces and districts have passed regulations making all forms of sex work illegal (e.g. Aceh Province). In some other Asian countries, police tolerate sex work in some specific red-light areas, despite the fact that the sex industry is technically illegal (e.g. the Philippines, Singapore and Thailand). Regular sexual health checks are generally required of sex workers operating in tolerated red-light districts in these countries.²⁵⁴

In the Pacific region, the former British colonies generally do not criminalize sex work in private, but the sex industry is effectively criminalized because offences exist for associated activities such as soliciting for sex work or keeping a brothel (e.g. Cook Islands, Fiji, Kiribati, Nauru, Niue, Samoa, Solomon Islands, Tokelau, Tonga and Tuvalu).²⁵⁵ Repeatedly selling sex is illegal in PNG because a person who regularly sells sex to earn a living (as distinct from a single act of selling sex) is regarded as 'living on the earnings of prostitution' in breach of PNG's *Summary Offences Act*.²⁵⁶ The Pacific island countries that have legal systems influenced by laws of the USA criminalize sex work itself, as well as activities associated with sex work (e.g. American Samoa, Marshall Islands, Northern Mariana Islands, Federated States of Micronesia and Palau).²⁵⁷

Exploitation of minors: Young people aged under 18 who sell sex

The Convention on the Rights of the Child provides that governments have an obligation to protect children from sexual exploitation including child prostitution.²⁵⁸ Consistent with this provision, governments are required to define minors involved in the sex industry as victims of sexual exploitation or sexual abuse who require protection, rather than offenders subject to arrest and prosecution.

The *UNAIDS Guidance Note on HIV and Sex Work* affirms that all forms of the involvement of children under the age of 18 in sex work and other forms of sexual exploitation or abuse contravene United Nations conventions and international human rights law.²⁵⁹ Moreover, the International Labour Organization's (ILO) Convention on Worst Forms of Child Labour 1999 also requires governments to prohibit the use of persons below the age of 18 years in prostitution.²⁶⁰ This requirement applies even if the legal age of consent to sex is below 18. See Annex IV for more information about the requirements of these Conventions and the countries that have signed or ratified these Conventions

Many countries in the region have introduced protective anti-trafficking laws that define persons under 18 who sell sex as victims of sexual exploitation, and provide that such persons cannot be prosecuted, even when the child consents to involvement in selling sex. Some of these anti-trafficking laws also provide victims with a legal right to health care.²⁶¹ However, children who sell sex independently on the street (with no involvement of a pimp, tout, procurer or other person) may not have the protection of anti-trafficking laws if their situation does not meet the technical legal definition of trafficking or exploitation under the applicable national law.²⁶² Further, some countries do not have specific anti-trafficking laws that address sexual exploitation of minors (e.g. Maldives). Young people under 18 who sell sex may be at risk of arrest and prosecution, and detained in juvenile justice centres or 'rehabilitation centres' for people engaged in sex work,²⁶³ in countries that do not have specific laws that protect the rights of child victims of trafficking and sexual exploitation.

Even in countries that have ostensibly protective anti-trafficking laws, young people selling sex on the street may be vulnerable to police abuses such as harassment, extortion and confiscation of condoms, and detention.²⁶⁴ Street children who are over the minimum age of criminal responsibility may be targeted for arrest under soliciting, loitering, vagrancy or other public order offences. Such police practices may deter young people who sell sex from accessing health services, and impede health workers from offering commodities and services.

Criminalization of drug use

Possession or use of illicit drugs attracts criminal and/or administrative penalties in all countries in the region, and in some countries may lead to compulsory detention in detoxification or rehabilitation centres, e.g. Cambodia, China, Indonesia, Lao PDR, Myanmar and Viet Nam. Possession of needle and syringes is also illegal in some countries. Fear of arrest and detention leads many young people who use drugs to avoid health services and to avoid carrying clean injecting equipment. Human Rights Watch has documented the practice of detaining boys under the age of 18 alongside adults in drug detention centres in Cambodia and Viet Nam.²⁶⁵ In Viet Nam, the law requires boys under 18 to be detained separately from adults in drug detention and treatment centres.²⁶⁶

UN Joint Statement on compulsory detention and rehabilitation centres

UN agencies issued a Joint Statement in 2012 calling on countries to end the practice of admission into compulsory drug detention and rehabilitation centres of people who use drugs, people who have engaged in sex work and children who have been the victims of sexual exploitation.²⁶⁷ The Joint Statement includes the following recommendation in relation to children:

In the case of children under the age of 18 years, the most effective and appropriate responses are those that are family-based and build on the strengths of local communities. These should be the first option in full compliance with their rights to welfare, protection, care and justice. Children who are, or have been, involved in sex work should be treated as child survivors of commercial sexual exploitation... Those children who are dependent on drugs should benefit from rights-based and evidence-informed programmes to facilitate their recovery and reintegration into families and communities.

Reported police abuses of young people who use drugs

"The police still apprehend us if they find us with syringes. Nobody dare carry their syringes for fear of the police."

"If someone needs medication for a heroin overdose at the private pharmacy, we are never allowed to buy it. For such a serious situation, they should sell us such antidotes. One kind is Naloxone. If you want to buy this antidote, you must use a secret code: antidote for snakebite".

Myanmar focus group

Reported police abuses of young people involved in the sex industry

Myanmar focus groups

"Some sex workers and MSM are arrested if police find them with condoms. We have been told that there is a Ministerial Order prohibiting arrest for possessing condoms, but the lower-level police abuse their authority. The power is in their hands. Their desire may be either to extort money or sex or both."

"We're always evading the police. Sometimes we [young sex workers] wander around looking for clients while carrying condoms hidden on our breasts. No one dares carry condoms in their purse because the police can find them. If the police find the condom, we have to make up stories that we have a lover or husband and we're living together, or that we have an allergy to other contraceptives."

"Young MSM are particularly vulnerable because they lack skills and experience in standing up to police abuses. They fear exposure to their families if they don't cooperate and provide the police with money or sex. The younger ones are afraid, they fear exposure and become victims of the police."

"When sex workers meet the police on patrol, they have to have sex with them without being paid and without using condoms to avoid arrest. For MSM as well, when the police ask for sex without a condom, they have to cooperate because they are afraid of arrest."

"I have been scolded by the police for distributing condoms when I was doing peer outreach to sex workers. The police accused me of encouraging prostitution, but actually I was giving the young sex workers education and letting them know the safe way to use condoms."

"In my town the [reproductive health] clinic is located near the police station. Sex workers avoid going there for fear of being seen by the police. They have been cowed into total submission by fear of the police. They are getting pregnant as a consequence of this and then they have [illegal] abortions."

"When we were younger and selling ourselves on the street, the police would bully us and force us to sleep with them. We were so frightened that we slept with them. Sometimes, we were beaten by the police. When we met to discuss our issues, the police arrived and asked what we were doing and assaulted some of us. I was around twenty-two."

Philippine focus groups

"In Quezon City, [the police] used condoms as an evidence of prostitution... in establishments, what usually happens is they don't display condoms, even the staff don't carry condoms because they told me that police would arrest them. If police saw condoms in the establishment, that can be an evidence."

"[Our group of young women selling sex had] a member who had a customer who was a policeman. When they were about to have sex, she said that they should use a condom but the policeman pointed a gun at her and said that he doesn't like to use a condom."

"We were supposed to distribute condoms [to young peers selling sex] in a *barangay* but when the *barangay* officer found out, they confronted us. We explained to them the purpose of our visit and the kind of education that we will provide but immediately the *barangay* guards shooed us away with their sticks. [Our role as peer educators with young people selling sex] was properly communicated to the *barangay* captain but when the *barangay* guards found it, they refused to accept us. There was this one guard who was really pushing us out of the *barangay*."

"Sometimes [the police] even plant the condoms in your bag or on your things for them to just have their way and harass you. So if ever there is not involvement from the police, distribution of condoms to the [sex work] establishments would be smoother and easier."

Indonesian focus group

"My first experience selling sex was at a *lokalisasi* [brothel complex] hidden in the forest at Purwakarta. I was 15 years old. Many policemen were our customers. If there is a new worker, the police will have sex with her first. All the police had sex with me when I arrived, one by one. That was my first time being a sex worker. It was very hard. They did not pay me."

3.2.3 Criminalization of abortion

Abortion is criminalized in many countries of Asia and the Pacific. The laws of other countries allow abortion only in strictly defined circumstances (see Annex III).

Health harms associated with legal restrictions on abortion

Deaths from abortion-related complications are common among adolescents, particularly if they are unmarried. This is primarily because they are more likely to have second trimester abortions that carry greater risk than earlier abortions, they are more likely to access services of an unskilled provider or self-induce, and they are less likely to seek early care for complications.²⁶⁸

Health risks to adolescents are amplified in countries where abortion is criminalized, because of the lack of safe options. Legal restrictions increase the occurrence of unlawful and unsafe procedures. At the global level, abortion-related mortality is found to be higher in sub-regions with restrictive abortion laws.²⁶⁹ Rates of unsafe abortions are particularly high in South and South-East Asia (Table 2). Where abortion laws are the least restrictive (e.g. Eastern Asia), there are generally low rates of unsafe abortion.²⁷⁰

Law reform to decriminalize abortion is associated with health benefits. For example, liberalization of abortion laws in Nepal in 2004 contributed to a dramatic fall in maternal complications. There was a decline in the number of women admitted for complications of unsafe abortion, severity of those complications and pregnancy-related deaths.²⁷¹ A study in eight districts of Nepal found that abortion-related complications accounted for 54 per cent of facility-treated maternal illnesses in 1998, but only 28 per cent in 2008-2009.²⁷²

Even in countries where legal abortion is widely available on request, perceptions about the legality of minors having sexual intercourse delay some adolescents from seeking care. In many cultures, perceptions of legality are affected by the stigma attached to premarital or extramarital sex.²⁷³

There is a gradual trend towards introducing more liberal abortion laws that provide a right to abortion in a broader category of cases. For example, Indonesia introduced rape as a ground for legal abortion in 2009. However, across the region many highly restrictive provisions remain. Young women who experience unwanted pregnancies are particularly affected by criminalization of abortion and many turn to illegal services at great risk to their physical and psychological health.

Cohen describes the impact of criminalization of abortion on poor women in developing countries:

Restrictive laws have much less impact on stopping women from ending an unwanted pregnancy than on forcing those who are determined to do so to seek out clandestine means. In countries with such restrictive laws, women who can pay can sometimes find a qualified provider willing to perform an abortion; however, the vast majority of women in poor countries are too poor to avail themselves of this underground network... in Pakistan, 66 per cent live on less than \$2 a day, and the average fee for a doctor-assisted abortion is \$50–104.

The measurable effect of these economic realities, which relate directly to the secrecy and stigma attached to abortion where the law and culture are disapproving, shows up in the high rates of death and disability that women suffer from taking the decision into their own hands. Women themselves or untrained providers use a variety of traditional and often dangerous methods to end an unwanted pregnancy, such as inserting sticks into the vagina, drinking bleach or applying extreme pressure to the abdomen, which often result in severe complications, such as haemorrhage. Fear of being discovered breaking the law or being accused of promiscuity causes many women to choose secrecy over their own safety. The shaming and blaming of women who have abortions in many of these cultures is an impediment to their seeking out the necessary post abortion medical care to save their lives.

*About 40 per cent of women who have a clandestine abortion experience complications that require treatment. Yet, even if a woman makes it to a medical facility, too many health centers in developing countries simply do not have the capacity to deliver quality care for the complications resulting from an unsafe abortion.*²⁷⁴

A Government of Myanmar / UNICEF joint report notes:

*...a significant proportion of unwanted pregnancies in Myanmar result in induced abortions under unsafe conditions, leading to complications, maternal morbidity and mortality, which are exacerbated by delays in seeking qualified care. Abortion is legally restricted and permitted only to save a woman's life, but the 2004–2005 Maternal Mortality Survey found abortion-related causes to be responsible for 9.8 per cent of all maternal deaths. The traditional birth attendant's home was found to be the most common place for inducing abortion.*²⁷⁵

A report of a parliamentary hearing on SRH rights in the Pacific observed:

Whilst research and data around unsafe abortions in PICTs (Pacific Island Countries and Territories) is virtually non-existent, many of the submissions to the Open Hearing raised this as an important issue to be addressed. Most Pacific countries have very restrictive abortion laws which allow the procedure only in cases where the mother's life is at risk from the pregnancy or impending birth. As such, in order to get an abortion, women (usually young women) are forced to seek alternatives that lie outside of the safety of a surgery or clinic, such as traditional abortifacients, many of which result in unnecessary complications.

Some NGOs provide counselling and post-abortion care but are forced to do so surreptitiously as the service itself is illegal. As a result, many Pacific women die from infection and sepsis associated with incomplete abortion. According to anecdotal evidence, many of these are young women and adolescents. Papua New Guinea has the highest maternal mortality rate in the Pacific, and many hospital admissions are diagnosed as 'incomplete abortion/miscarriage', but often go unrecorded in official hospital records in order to protect patients.

Abortion: Parental consent requirements

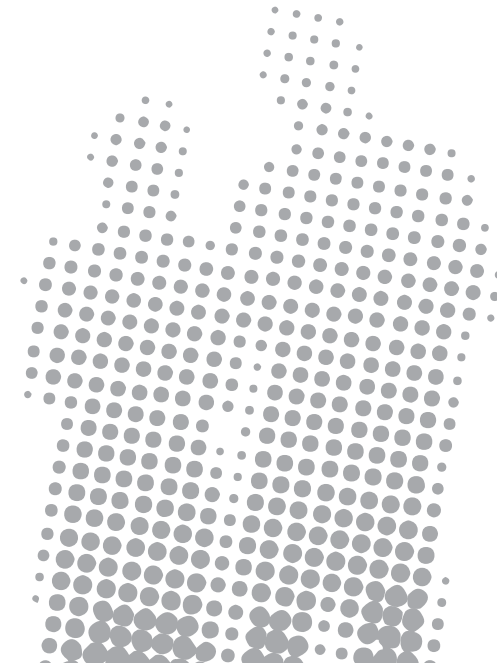
In countries where abortion is permitted on request, young people may request an abortion but in most cases medical practitioners will also require parental consent where the young person is under 18. Asian countries that permit abortion on request (if the foetus is under 12 weeks)²⁷⁶ are Cambodia, China, DPRK, Mongolia, Nepal, Singapore and Viet Nam.

In most countries, parental consent to an abortion is required for minors because of the general legal provisions relating to parental consent to all medical procedures (see 3.1.2). Some countries have specific provisions in relation to parental consent to abortions. For example:

- In Fiji abortion is legal in the case of rape, incest, or if there is a risk of serious danger to health of the woman. Informed consent of the woman is required. Parental consent is usually required for girls under 16. However, special provisions enable girls under 16 to apply for a court order allowing an abortion without parental consent. A girl who has not reached the age of 16 years and is being supported by a custodial parent shall not be regarded as having given informed consent unless the custodial parent has been informed that the performance of an abortion

is being considered and has been given the opportunity to participate in a counselling process and in consultations between the woman and her medical practitioner as to whether the abortion is to be performed. A girl under 16 may apply to a magistrate for an order that a custodial parent not be told the abortion is being considered and not participate in counselling.²⁷⁷

- In India the *Medical Termination of Pregnancy Act 1971* requires parental consent for abortion procedures for all persons under 18 years or persons who are mentally ill.²⁷⁸ Under the Act, a pregnancy can be terminated if its continuation would involve risk to the life or grave injury to the physical or mental health of the pregnant woman or if there is substantial risk that, if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped. The Act also presumes that the anguish caused by a pregnancy resulting from rape or from the failure of any contraceptive method used either by a *married* woman or her husband for the purpose of limiting the number of children constitutes grave injury to the mental health of the woman. Therefore, the Act discriminates against unmarried women by not permitting abortion for unmarried women where the pregnancy results from failure of any contraceptive method.



Reported harmful effects of abortion laws on young women

Indonesia focus group

"It is difficult for a young person to access contraception in a *puskesmas* [community health centre], let alone information on abortion. Instead, young people access traditional methods that may endanger them. As there is little information about abortion, women opt for traditional methods. The regulations require women who request abortion to be married and to have her husband's agreement. A young woman who wants to access health services is usually asked about her ID card, marriage certificate, consent letter from husband and parents. These obstacles discourage young women, so they use traditional methods instead."

"My friend [a sex worker] was rejected by the hospital when she went for an abortion. The hospital requirement is for consent from parents and husband. Some Jakarta hospitals will conduct abortions with the consent of parents, but many will not because of the law. As a result, many single women use traditional methods that result in bleeding. When young people who have had a traditional illegal abortion attend hospital for bleeding afterwards, they are often rejected. Only one hospital in Jakarta provides care for post-abortion complications. The *Health Law* creates these problems for young women seeking abortion."

"Medicine used for stomach problems may be used for abortion but it is difficult to acquire. Medical abortions should be young people's right, so that the health risks to young people of abortions are reduced."

Myanmar focus group

"A seventeen year old girl was working selling sex in the video bar, she had no knowledge about sexual or reproductive health. She fell pregnant and went to see a retired nurse for a home abortion. Her boss would not allow her to be away from the video bar for long so she had to return to work immediately. She kept bleeding and had to go to hospital. Soon after she died."

"A large number of the women having abortion are university students and there is no place at all to have legal abortion. People with money can go to expensive private clinics. Those who are poor have to do it illegally with the midwife. Some people use sharp articles like the stem of an umbrella to have an abortion. There are many lost lives, infections and loss of reproductive ability due to these procedures."

Philippine focus group

"One of my friends, a 15 year old sex worker, fell pregnant after having sex with a client who was a police officer. He pressured her to have the pregnancy aborted. The police officer assaulted her and she was admitted to hospital and she miscarried."

"A popular choice of synthetic drug for abortion is cytotec (Misoprostol). It costs only 60 pesos if you have a prescription (for stomach ulcers) but is expensive (1,500 pesos) on the black market. You need two tablets so it's between 3,000 and 3,500 or USD\$ 75-85 for an abortion."

"Information on safe sex should be provided to young people including sex workers so that the abortion decision does not arise. It is very hard being a 15 year old, it is hard physically and emotionally to have an abortion at an age when we should be enjoying our lives instead of the harrowing experience of abortion. The emotional and physical pain is hard, and young people also face stigma and discrimination if they fall pregnant from their families and peers. It is very hard for young people to access services, especially abortion after-care services. Young people turn to the black market for abortion options but are afraid of being judged so don't attend clinics for abortion after-care. Older women are more prepared for the experience of abortion, but for young women it is very difficult and painful."

"My friend, a 16 year old Muslim girl, fell pregnant when she was in prostitution. Her family didn't know that she was selling sex and pregnant. Her options were *hilot* [traditional methods], using a herbal medicine and massaging the stomach. This did not work, so she tried a synthetic drug. After these attempts, she fainted with bleeding and was taken to hospital. The doctor kept asking her how many sexual partners she had, the questions were asked in the public area of the hospital and she was embarrassed. She had to take another drug to stop the bleeding. She was bleeding for two weeks. She didn't want to return to the hospital for after-care procedures. My best friend was 16 years old and selling sex, but she had no knowledge of condoms. It's very easy to get herbal medicines off the street for 40 pesos. After the illegal abortion she was pale, thin and fatigued, but she went back to selling sex after 2 weeks because she was the breadwinner of the family."

3.2.4 Forced abortions and sterilization of young women

Forced abortions and sterilization of young women are reported in several countries including India and Indonesia. Such policies and practices violate human rights to autonomy, bodily integrity and privacy.

The Indonesian Positive Women's Network conducted peer-based research among 122 women living with HIV in eight provinces in 2011. Fourteen per cent of participants reported forced sterilization.²⁷⁹ In another study, 44 of 109 Indonesian women living with HIV surveyed said they were encouraged to consider sterilization.²⁸⁰

Some target-driven family planning campaigns in India have been criticized for providing conditions in which forced sterilizations may occur. This contradicts the National Population Policy, which states the Government of India's commitment to voluntary and informed choice and consent of citizens in availing reproductive health care services.²⁸¹ The minimum age for sterilization in India is 22 years and the maximum is 49 years.²⁸² According to Human Rights Watch, pressure to achieve targets can result in young people being sterilized under pressure from health workers:

(H)health workers said pressure from supervisors was strongest when it came to female sterilization. Two health workers said they felt constrained to present women only with the choice of female sterilization and emphasize that option over other methods of contraception. Alokabein said she risked the ire of her supervisor by discussing other contraceptive options:

To fulfill targets they operate [sterilize] really young women—20, 22, 24, 25 years. These women are really young and then their bodies gain weight after a few years and they find it very hard to work... They [supervisors] tell us not to tell women these things. But women can see for themselves that this happens so they are reluctant. So I tell young women to use Copper T [IUD] if they don't want to go for operation. If my supervisor finds out I've been saying this in the slum she will shout at me. Maybe I'll lose my job, but maybe she won't be that angry because I can tell her I've fulfilled my Copper-T target.²⁸³

3.2.5 Other criminal offences

Censorship and public order laws are sometimes enforced broadly so as to interfere with health promotion efforts such as distribution of safe sex information at clubs or venues, or dissemination of health promotion information via internet sites targeting specific populations such as men who have sex with men or sex workers (e.g. China, Malaysia).²⁸⁴

Indonesia's Anti-Pornography Law of 2008, which criminalizes depictions of homosexuality, has given rise to concerns of increased policing of communities of men who have sex with men and increased stigma undermining HIV prevention efforts.²⁸⁵

Reported concerns about Indonesia's Pornography Law

"The *Pornography Law* is a barrier to services because it adds to stigma experienced by MSM and it discourages media from discussing sexuality in a positive way. In mainstream media it restricts the information available to us on sexuality. The law maintains sex and sexuality as taboo subjects and refers to homosexuality as deviant. So, homosexuality equals pornography. With the *Pornography Law* criminalizing portrayal of homosexuality, the law generates stigma and discrimination towards us. It creates confusion and promotes stereotypes that MSM are the reason for pornography, and other social problems. We are affected by this, the law considers homosexuality as a sin and this contributes to self-stigma, which discourages us from accessing health services and information."

Indonesian focus group

Some countries have enacted laws that criminalize HIV transmission or failure to disclose HIV status to sexual partners (e.g. Cambodia, Lao PDR, PNG and Viet Nam).²⁸⁶ Such laws add to the stigma associated with HIV. Young people living with HIV may be reluctant to access health services if they fear that they risk prosecution if they disclose that they have been engaging in sex or injecting drugs. In most instances it is more effective to address sexual behaviour through voluntary education, counselling and health promotion, rather than legal penalties. Where exceptional cases of deliberate HIV transmission arise, these can be dealt with under general criminal laws relating to assault. UNAIDS and the Global Commission on HIV and the Law recommend that governments prosecute HIV transmission that is both actual and intentional, using general criminal law, rather than HIV-specific laws.²⁸⁷

4 Legislative and policy approaches to promoting access to services

4.1 Protective laws

Laws that provide legal protections for young people and that can enhance the rights of young people to access SRH and HIV services include:

- child protection laws;
- laws that give people rights to access SRH and HIV services;
- laws that prohibit breach of confidentiality in delivery of health services; and
- anti-discrimination laws.

It should be noted that young people may face a range of practical challenges in enforcing their legal rights under these protective laws. Barriers to accessing the justice system to enforce legal rights may include lack of access to independent legal advice and legal aid services, the cost and complexity of legal proceedings, lack of confidence and trust in the formal legal system and concerns regarding disclosure of identity or health status during legal proceedings (of particular concern for young people living with HIV).

4.1.1 Child protection laws

Child protection laws provide children with rights to protection from abuse, neglect, exploitation and violence. They can also facilitate access to SRH and HIV information, commodities and other services by clarifying the rights of children under 18 in relation to health care and the obligations of parents, guardians, caregivers and government agencies in respect of children's health. Child protection laws can provide a framework for addressing the needs and rights of children who have experienced sexual exploitation or abuse or who are using harmful drugs, including access to SRH, HIV and other health services (see e.g. *Child Welfare Decree 2010*, Fiji; *Protection of Children from Sexual Offences Act 2012*, India; *Child Protection Law 2002*, Indonesia; *Child Act 2001*, Malaysia; *Law on Child Protection, Care and Education 2004*, Viet Nam).

For example:

- Fiji's *Child Welfare Decree 2010* provides that a medical officer may make a care and treatment order to ensure health care for a child who has been harmed.²⁸⁸ The Decree is to be administered subject to a series of principles including that: at all times the welfare and interests of the child are paramount; every child has a right to protection from harm or likely harm; and families have the primary responsibility for the physical, psychological and emotional wellbeing of their children.²⁸⁹
- Indonesia's *Child Protection Law 2002* provides that every child is to have the right to healthcare services and social security pursuant to their physical, mental, spiritual, and social needs,²⁹⁰ and that parents and family members are responsible for maintaining the health of the child.²⁹¹ This Law requires the Government or an authorized State institution to be responsible and accountable for providing special protections to a child who misuses drugs, including supervision, prevention, care, and rehabilitation efforts.²⁹²
- Viet Nam's *Law on Child Protection, Care and Education 2004* provides that children have the right to health care and protection; parents and guardians have the responsibility to implement the regulations on health checks, medical examination and treatment for children; public

medical establishments have the responsibility to organize primary health care, disease prevention and treatment for children; and the State encourages organizations and individuals involved in humanitarian and charity activities to contribute to medical treatment funding for children suffering serious diseases.²⁹³

Child protection laws can also provide a framework for community-level action to promote young people's right to health. A comparative analysis of community-based child protection mechanisms in Asia made the following findings:²⁹⁴

- The main purpose of community-based child protection mechanisms is to protect children in the community from all forms of abuse, neglect, violence and exploitation. These mechanisms have a primary focus on prevention work through awareness-raising and early interventions, and coordinate a response either through direct action by their members or through referrals to higher-level child protection bodies.²⁹⁵
- In some countries, community-based mechanisms are mandated by law. For example, in the Philippines, Republic Act 4881 of 1967 created the Council for Protection of Children in every city or municipality and Article 87 of *Presidential Decree 603 on the Child and Youth Welfare Code* (1974) encourages every Barangay Council to organize a local Council for the Protection of Children, which should coordinate with the Council for the Welfare of Children and youth in drawing and implementing plans for the promotion of child and youth welfare.²⁹⁶
- Child protection committees in most countries involve seven to twenty members including: village chiefs/administrative leaders, teachers, health workers, leaders from existing women's groups, community-based organizations and children or youth groups, and other interested community volunteers.²⁹⁷
- There is evidence of only "very initial collaboration" between community-based child protection mechanisms and SRH and HIV services in Bangladesh, Cambodia, Nepal and Thailand. Cross-sectoral collaboration between community-based child protection mechanisms and SRH and HIV services was not found in the other eight countries studied: China, Indonesia, Lao PDR, Pakistan, the Philippines, Sri Lanka, Timor-Leste and Viet Nam.²⁹⁸
- Considering the care and protection needs of children affected or infected by HIV, surprisingly few programme linkages were found between community child protection programmes and programmes addressing

SRH, including HIV prevention, care and treatment in the countries considered. Links with health programmes are only made explicit in a few country programmes.²⁹⁹

4.1.2 Legal rights of access to SRH and HIV services

Some countries have enacted laws providing general rights of access to services for all persons in need. For example, Cambodia, China, Fiji, Lao PDR, PNG, the Philippines and Viet Nam have enacted national HIV laws that define rights of access to HIV services.

In Fiji and PNG, national HIV laws provide that it is unlawful to deny any person access to the means of protection from HIV including condoms, lubricant and needles and syringes.³⁰⁰ In Cambodia, the national HIV law provides that people living with HIV have a right to free primary health care.³⁰¹ A legal right of access to antiretroviral drugs (ARVs) is included for prescribed populations in the national HIV laws of China and Viet Nam.³⁰² The Viet Nam law states that children under 16 should be given first priority in access to free ARVs.³⁰³ The national HIV law of the Philippines includes a right to basic health services for people living with HIV in government hospitals.³⁰⁴



Sri Lanka's *International Covenant on Civil and Political Rights Act 2007* gives every citizen a right to access basic services provided by the State, which, read in conjunction with Sri Lanka's accession to the *International Covenant on Economic, Social and Cultural Rights*, can be interpreted to cover health services.³⁰⁵

Some SRH laws are only, or primarily, of benefit to people who are married or considering marriage. For example, married persons have legal rights to access family planning services in China³⁰⁶ and the legal entitlement to family planning services in Indonesia only applies to married or engaged couples.³⁰⁷

Pakistan's *Reproductive Healthcare and Rights Act 2013* provides a framework for a rights-based national SRH programme. The Act promotes non-discrimination and does not impose any specific restrictions on access to services relating to marriage or age. As this is a new law, it is unclear how this Act will affect interpretation of older laws that may be inconsistent with a rights-based approach. Key provisions of the new Act include:

The right to reproductive healthcare information can be promoted:

- b. by providing reproductive healthcare information, which provides awareness regarding the mental and physical health and well being of individuals and families;
- c. through the exercise of parental responsibility which assures the right of parents as educators; and
- d. by taking into consideration the religious norms and cultural environment.³⁰⁸

The right to gender-neutral information can be promoted:

- a. by access to information related to reproductive rights and responsibilities within a gender perspective, which is free from stereotypes, discriminatory and obscurantist customs, and is presented in an objective and pluralistic manner;
- b. by recognition that all couples have the right to information and to ensure reproductive life decisions are made with informed consent; and
- c. by public awareness on the prevalence and impact of morbidity and mortality and availability of medical science to prevent this suffering.³⁰⁹

The need for reproductive healthcare shall be accepted in order to reach the underserved by increasing access to the disadvantaged, hard to reach, and vulnerable including poor women and remote marginalized areas by strengthening Primary Health Units in addition to other responsibilities, the provision of family planning maternal and neonatal healthcare.³¹⁰

The facilitation of reproductive healthcare services shall focus on the following, namely:

- a. the full range of services which address maternal mortality and morbidity shall be encouraged;
- b. reproductive health system shall be strengthened so that the competencies of reproductive health providers ensure quality services which encourage choice and are given in an environment of dignity and continuity;
- c. for access and affordability, focus and priority shall be given to the primary health care sector;
- d. It shall be recognized that all persons shall have the benefit of and access to available reproductive healthcare technology, including that relating to infertility, which is safe and free from gender discrimination...
-
- g. All persons must be free to manage their reproductive life, having regard to the rights of others;
- h. No person shall be subjected to forced pregnancy, sterilization, abortion or birth control.³¹¹

The Philippine *Magna Carta of Women of 2009* requires State agencies to provide sexuality education and health services to young girls and to provide women with appropriate, timely, complete, accurate information and education on family planning methods and HIV prevention and management. This obligation is subject to important qualifications. In providing education and information in these areas, the government is required to pay due regard to the following factors:³¹²

- i. the natural and primary right and duty of parents in the rearing of the youth and the development of moral character and the right of children to be brought up in an atmosphere of morality and rectitude for the enrichment and strengthening of character;
- ii. the formation of a person's sexuality that affirms human dignity; and
- iii. ethical, legal, safe, and effective family planning methods including fertility awareness.

In the Philippines, the *Responsible Parenthood and Reproductive Health Act* of 2012³¹³ has been approved by the Congress but is subject to a constitutional challenge in the Supreme Court, which has delayed the Act's commencement.³¹⁴ The Act provides for a national policy on responsible parenting and reproductive health. Under the Act, reproductive health rights do not include access to abortion. The Act makes a declaration of policy, which is explicitly human rights-based. For example, it declares the following policies:

The State recognizes and guarantees the human rights of all persons including their right to equality and non-discrimination of these rights, the right to sustainable human development, the right to health which includes reproductive health, the right to education and information, and the right to choose and make decisions for themselves in accordance with their religious convictions, ethics, cultural beliefs and the demands of responsible parenthood.³¹⁵

The Act confirms that adults have a legal right to access family planning services, and health services are prohibited from discriminating on the grounds of age. However this is subject to the exception that minors (young persons under 18) are not allowed access to modern methods of family planning without written consent from their parents or guardians, except when the minor is already a parent or has had a miscarriage.³¹⁶

The Act provides that hospitals owned and operated by religious groups are not required to provide family planning services.³¹⁷ A conscientious objection to provision of services based on ethical or religious beliefs shall be respected; however, the objector must immediately refer the person seeking services to another health service provider.³¹⁸ It is an offence for a health care service to refuse to perform legal and medically safe reproductive health procedures on any person of legal age on the ground of lack of consent or authorization of a spouse.³¹⁹

The *Implementing Rules and Regulations* of the *Responsible Parenthood and Reproductive Health Act* declare guiding principles, including "respect for protection and fulfilment of reproductive health and rights which seek to promote the rights and welfare of every person particularly couples, adult individuals, women and adolescents." The *Implementing Rules and Regulations* define reproductive health care to include adolescent and youth reproductive health guidance and counselling at the point of care, and age and development-appropriate education and counselling on sexuality and reproductive health, and age and development-appropriate reproductive health education for adolescents in formal and non-formal educational settings.³²⁰

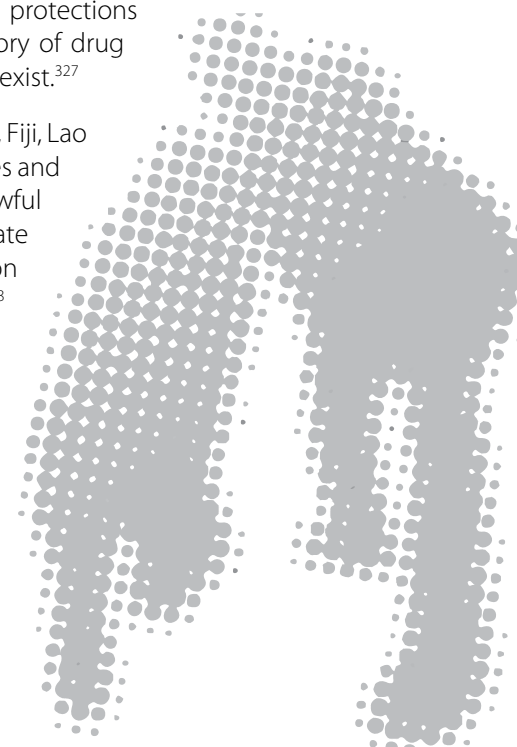
4.1.3 Laws that prohibit breach of confidentiality in the delivery of health services

The national HIV laws of Cambodia, Fiji, Lao PDR, Mongolia, PNG, the Philippines and Viet Nam provide rights to confidentiality of HIV-related health information, subject to exceptions. The laws of Cambodia, Fiji, PNG, the Philippines and Viet Nam permit disclosure of HIV test results relating to a minor to their parent or guardian in prescribed circumstances (see 3.1.3).³²¹

4.1.4 Anti-discrimination laws

Laws that make it unlawful to discriminate against a person in delivery of health care services can support young people to access services. Anti-discrimination laws are particularly helpful for young people if the legislation specifies the prohibited grounds of discrimination to include age, marital status, HIV status, health status, disability, pregnancy, sexuality, gender or gender identity. While several countries in the region have introduced laws addressing discrimination on the grounds of HIV, only Australia,³²² three cities in the Philippines (Davao City, Cebu City and Angeles City),³²³ Fiji,³²⁴ Hong Kong SAR,³²⁵ and New Zealand³²⁶ have introduced laws prohibiting discrimination by health services on the grounds of sexuality. Legal protections from discrimination due to a history of drug use or selling sex generally do not exist.³²⁷

The national HIV laws of Cambodia, Fiji, Lao PDR, Mongolia, PNG, the Philippines and Viet Nam provide that it is unlawful for health services to discriminate against a person living with HIV on the grounds of their HIV status.³²⁸ These laws enable people living with HIV to challenge stigma and discrimination that they may experience in accessing HIV or SRH services, and to seek a legal remedy through court action if necessary.



Very few jurisdictions include a specific prohibition of discrimination on the grounds of being a young person. Discrimination on the grounds of a person's age arguably falls within the broad provisions of Pakistan's *Reproductive Healthcare and Rights Act 2013*, which provides that the right to be free from all forms of discrimination can be promoted by ensuring that no person shall be discriminated against in their reproductive lives, in their access to services and information on the grounds of race, colour, sex, creed or "other criteria of discrimination".³²⁹ The *Constitution of Timor Leste* includes an article stating that children shall be entitled to special protection against all forms of discrimination.³³⁰

In the Philippines, the *Responsible Parenthood and Reproductive Health Act* of 2012³³¹ also includes broad language promoting non-discrimination. The Act provides that the State shall eradicate discriminatory practices, laws and policies that infringe on a person's exercise of reproductive health rights.³³² The Act's *Implementing Rules and Regulations* state that provision of reproductive health care shall not discriminate between married or unmarried individuals, and that all individuals regardless of their civil status have reproductive health concerns.³³³

In Indonesia, the *Health Law* includes a statement that every individual shall have the right to "determine his/her reproductive life and to be free from discrimination, coercion and/or violence, that respects noble values and not degrading human dignity in accordance with religious norms."³³⁴ However, other provisions restrict access to SRH services to married persons.³³⁵

An example of an age non-discrimination law is Australia's *Age Discrimination Act 2004*, which makes it unlawful to discriminate on the basis of a person's age including in access to facilities, goods, services, premises, requests for information and the administration of government laws and programmes.

The Constitution of Thailand provides that unjust discrimination on the grounds of age and health condition is unlawful.³³⁶

The *Draft Constitution of Fiji* of 2013 states that a person must not be unfairly discriminated against on numerous grounds including age, gender, sexual orientation, gender identity, health status, disability, age, religion, marital status or pregnancy.³³⁷

4.2 Protective policies

As part of this study, a review was undertaken of national policies of countries in the Asia-Pacific region with a focus on:

- National HIV policies, strategies and plans (4.2.1);
- National youth policies (4.2.2);
- National SRH, adolescent health and population policies (4.2.3);
- Policies on youth-friendly national service standards (4.2.4).

In some cases, these policies are intended to improve access to services for all citizens including unmarried adolescents. In other cases, although laws and policies have been updated to strengthen access to SRH and HIV services, restrictions still remain affecting young people, such as requirements to orient services towards married persons (e.g. Indonesia) or for parental consent in order for minors to access SRH services in most situations (e.g. the Philippines).

Policy differs from law. While a law can compel or prohibit conduct, policy merely guides actions to achieve a desired outcome. In many countries, even with progressive policies in place, there is a significant gap between the policy intent of promoting access to services, and the reality of services on the ground. Access for young people often continues to be restricted by cultural and religious norms, stigma and discrimination, resource constraints, police practices and lack of clarity caused by conflicting laws and policies. Laws often lag behind policies, as the process for repealing restrictive laws and enacting new legislation supporting expanded access to services can take many years. Ideally, policies that promote service access should be supported by legislation that provides young people with enforceable rights to access SRH and HIV services, including penalties for conduct that impedes access.

In many countries, even with progressive policies in place, there is a significant gap between the policy intent of promoting access to services, and the reality of services on the ground.

4.2.1 National HIV policies, strategies and plans

Bhutan's *National Strategic Plan for the Prevention and Control of STIs and HIV and AIDS 2008* makes the following statements relating to young people's access to services:

The lack of youth friendly health services limits access to adequate and correct health information, including proper sexual information. It is important to involve young women and men in designing and implementing strategies to prevent and control the spread of HIV and AIDS in this special group. Target interventions include availability of youth friendly reproductive health services at all levels, both health and social services, including appropriate counselling services and condom promotion.³³⁸

Cambodia's *National HIV and AIDS Strategic Plan 2011-2015* is an example of well-targeted policy that emphasizes most-at-risk young people. The plan provides:³³⁹

Objective: Increase coverage of quality prevention programs for young people aged 10-24 years, both in and out of school. In the setting of a concentrated epidemic, the main focus for youth interventions is targeted toward most-at-risk young people (MARYP), defined as those who are practicing high-risk behaviours. There is little evidence of high risk sexual behaviours among the general population of young people in Cambodia and studies have shown that life skills education has little effect on HIV risk reduction. Since 2009, MoEYS (Ministry of Education, Youth and Sports) has moved from a vertical project-based approach to HIV education to an integrated Life Skills Education curriculum.

Interventions:

- Development and implementation of interventions that are age-appropriate, gender-equitable, and accessible to disabilities, to address the needs of young EWs (entertainment workers / sex workers), MSM/TG (men who have sex with men and transgender people), IDU/DU (people who use drugs) and HRM (high risk males/clients of sex workers); integrated into other MARPs programs.
- Focus on young people who are most likely to or already are engaging in behaviours that put them at risk for HIV transmission.
- Continued integration of age-appropriate, gender-equitable sexual and reproductive health and rights education into the Education Sector Support Program.
- Development of policy, legislation and strategies to provide an enabling environment for MARYP (most at risk young people's) access to services for their needs.
- Participation of MARYP in HIV prevention forums and activities, including commune development planning.³⁴⁰

Objective: Strengthen access to tailored services for most-at-risk populations (MARPs) and their sexual partners. Although they are at the highest risk and have the highest likelihood of HIV infection, most-at-risk populations (MARPs) often do not access services due to real or perceived stigma, discrimination and other structural barriers. Tailored approaches are needed to provide appropriate counselling and treatment, and to increase utilization of services by MARPs.³⁴¹

China's *Action Plan to Prevent and Control HIV/AIDS (2011-2015)*³⁴² aims to reduce new HIV infections by 25 per cent, and decrease the mortality of AIDS patients by 30 per cent. The indicators include to ensure the proportion of young people who have correct knowledge about HIV/AIDS reach more than 90 per cent, and to ensure 4-6 sessions of education exclusively on HIV/AIDS prevention or health education at high schools, secondary vocational schools and colleges. The strategies include strengthening information, education and communication (IEC) among children and youth:

Departments of education, public security, health and Youth League etc. at all levels shall carry out IEC (information, education and communication) activities among children and youth, covering HIV/AIDS, drug, non-remunerated blood donation, etc. Education and health authorities shall develop and enhance school-based HIV/AIDS working mechanism, and develop HIV/AIDS training and education at junior high schools and schools/colleges at higher levels, proactively promoting health education appropriate to youths and children, encouraging youths and children to participate in HIV/AIDS education, and incorporating the education on HIV/AIDS into the annual assessment at the schools. The roles of students' societies, the Internet and students' periodicals shall be fully leveraged to extensively carry out IEC on HIV/AIDS.

Fiji's *National Strategic Plan on HIV and STIs 2012 – 2015* notes that support to young people to know their rights to access services is an "ongoing challenge for prevention".³⁴³ The Strategic Plan states there will be a focus on prevention amongst young people from 15-39 years of age because those identified as HIV positive in their early 20s are likely to have been infected at earlier ages.³⁴⁴ The Strategic Plan emphasizes key populations:

Because there are high reported rates of stigma and discrimination against people living with HIV and people from key populations, prevention will be integrated with the promotion of human rights and respect for all Fijians, including sex workers, transgender people and men who have sex with men...Prevention will maintain and develop recent advances in recognising the human rights of these groups and protecting them from stigma and discrimination. Most of the focused prevention for these key affected populations will be conducted through peer education.³⁴⁵

India's *Policy Framework for Children and AIDS* includes objectives and targets for HIV prevention among adolescents. Targets include: 25 million students to be reached through the adolescent education programme, 70 million young people not in the school system reached by HIV prevention skills, education and related services, and 100 per cent coverage of young people who sell sex, injecting drug users and men who have sex with men.³⁴⁶

Indonesia's *National HIV and AIDS Strategy and Action Plan 2010-2014* states that the key populations to be reached by prevention are injecting drug users, sex workers, men who have sex with men, transgender people, and sexual partners of these key populations. Prevention programmes will reach out to young people who are vulnerable or at risk of HIV infection. Strategies in relation to HIV prevention for young people include:³⁴⁷

- Training for adolescents to protect themselves against HIV infection.
- Training of peer educators on HIV for adolescents.
- Development and dissemination of youth-friendly IEC (information, education and communication) materials on HIV and reproductive health targeting young people through appropriate and effective communication channels.
- Integration of life skills education programmes into general health education to empower young people with knowledge and capacity to protect themselves from HIV.
- Increased availability of youth-friendly health clinics where young people can receive comprehensive information and services.
- Enhanced structural interventions and involvement of all stakeholders in programme implementation, particularly communities of key populations.
- Policy development to ensure a supportive environment and human rights and gender-based approaches.

Lao PDR's *National Strategic and Action Plan on HIV/AIDS/STI 2011-2015* identifies the need for following innovations:

Focusing on young MARP (most-at-risk population), instead of targeting all young people. Interventions will be designed age-appropriately for sex workers and transgenders, recognizing that many of these people are very young and extra vulnerable. Young people will be targeted based on evidence of vulnerability, while the education sector will further integrate HIV into existing life skills education initiatives.³⁴⁸

Strategies for policy and advocacy include:

Advocacy and capacity-building of social service providers to eliminate discriminatory practices and increase access of services for PLHIV and marginalized groups like sex workers, men who have sex with men, drug users, migrant workers, ethnic groups etc. . .

Provide organisational and technical support to community-based organizations of marginalized groups and young people, so that they can contribute to the national response and advocate for their needs.³⁴⁹

Mongolia's *National Strategic Plan on HIV, AIDS and STIs* emphasizes the need to address stigma and discrimination in delivery of health services and policing:

Negative attitudes by health-care providers limit MARP (most-at-risk population) clients' access to a range of HIV and STI prevention services, including VCT, STI diagnosis and treatment, basic medical services, and management of related infections such as HBV, HCV and TB. Similarly, negative attitudes and harassment by police officers hamper harm reduction interventions among sex workers and drug users. In addition, the current legal environment is often not supportive of working with marginalized groups such as SWs (sex workers), IDUs (injecting drug users) and MSM (men who have sex with men), and fails to provide adequate protection of their human and health rights. Hence, reducing stigma and discrimination of MARP groups is a key component of comprehensive HIV and STI-prevention programmes... Special attention will be given to attitudes among health care and law enforcement staff, as well as the need to prepare legal amendments to strengthen the human rights position of MARP groups.³⁵⁰



The Plan aims to increased coverage of young people by HIV and STI programmes through

implementation of a health-education curriculum in the formal education sector, strengthening capacity of the health education teachers, and HIV and STI prevention and condom promotion programmes for young people in non-formal education.³⁵¹

Myanmar's *National Strategic Plan on HIV and AIDS 2011-2015* has a strong emphasis on the rights of young key populations, out-of-school young people and street children to access HIV services. The Plan seeks to “ensure availability and equitable access to a combination of programmes and services that are highly effective because they are flexible, tailored and targeted by location, age, gender and transmission behavior”.³⁵² There is a focus on young people-friendly services for those out-of-school. The Plan also aim to “strengthen the enabling environment through advocacy”, and to “promote meaningful involvement and empowerment of out-of-school young people and street children so that they are able to participate in programme design, development, implementation and evaluation”.³⁵³

Nepal's *National HIV/AIDS Strategy 2011-2016* states that the focus of the Strategy will be on most-at-risk young people and out of school youth. Youth-friendly approaches will be designed in HIV prevention services and linkages will be strengthened with SRH services.³⁵⁴ Actions are defined as:³⁵⁵

1. Support generation of disaggregated data and evidence on vulnerability and risks of adolescents.
2. Ensure an accessible and affordable HIV prevention package for young people with an emphasis on most-at-risk and out of school young people into the existing prevention intervention approaches with linkages to SRH, condom services as well as non-health services such as protection, HIV related information, skills and legal services.
3. Ensure adolescent friendly services in health and other related facilities for most at risk adolescents to increase access and utilization of services. The establishment of these services will be done in consultation with adolescents and young people during the development and implementation of the programme.
4. Build capacity of different levels of service providers to ensure adolescent friendly health and non-health related services including access to information and services.

5. Advocate and support functional collaboration among relevant ministries, departments and other stakeholders to bring comprehensive impact, to build support and to raise issues related to vulnerability of adolescents and young people.
6. Develop effective advocacy materials focusing on situation analysis, needs, rights, gaps in services, policy and programmes required for most at risk adolescents and young people affected by HIV and AIDS.
7. Develop and implement age and gender sensitive sexual and reproductive health package.
8. Provide psychosocial support and counselling to adolescent key affected populations.

Pakistan's *National HIV and AIDS Strategic Framework 2007–2012* defines a strategic objective for out-of-school young people: “Scale up programme delivery; expand, design and implement services for out of school youth”.³⁵⁶ The Strategic Framework refers to the *National HIV Prevention Strategy for Young People* (2006), which classifies youth into: (i) most at risk young people (young people living on the street, sex workers, injecting drug users); (ii) vulnerable young people (adolescent labourers and out of school youth, and young married); and (iii) the general population of young people (at home and in school). The Framework notes: “sexual and reproductive health services are not easily accessible by young people, due to constraints on their mobility, denial by caregivers that such services are needed, and/or the stigma attached to care seeking for issues related to sexual and reproductive health.”³⁵⁷

PNG's *National HIV and AIDS Strategy, 2011-2015* notes that young people are vulnerable to HIV as a result of lack of access to youth-friendly SRH services and education. The Strategy states:³⁵⁸

Young people who are particularly vulnerable include the unemployed, those exchanging sex, those who are illiterate, street youth, *raskols* (rascals / gangs) and young men and women living with HIV. Approaches will also address the roles that adults play in influencing the sexual health of young people. This can often be seen in the way adults deny young people their right to access services, information and condoms.

Strategic objectives include:

- i. Young people, both in and out-of-school, have access to quality information and resources for STI and HIV prevention including sexuality, sexual and reproductive health, gender-based violence and life skills education.
- ii. Young people are meaningfully involved in the design, management, implementation and monitoring of HIV, STI and sexual and reproductive health (SRH) programs, especially those that target young people.
- iii. Young people have access to quality youth-friendly sexual and reproductive health services and condoms.
- iv. Programs targeting out-of-school youth for STI and HIV prevention are established and expanded.
- v. Young people in schools, colleges and universities have access to quality and accurate education and resources on HIV, STIs, sexuality, life skills and SRH.
- vi. Cultural, political, economic, social, educational, religious and institutional factors that contribute to the vulnerability of young people to HIV are identified and addressed.

PNG's Strategy requires reform to legislation to reduce stigma and discrimination and improve the environment for effective HIV and AIDS prevention, treatment and care: "Laws that criminalize sex work and same-sex practices create barriers to people accessing services and reinforce vulnerability, stigma and discrimination."³⁵⁹

In the **Philippines**, the *5th AIDS Medium Term Plan 2011- 2016* includes a *Strategic Framework on the HIV Response on Children and Young People*.³⁶⁰ The Framework states:

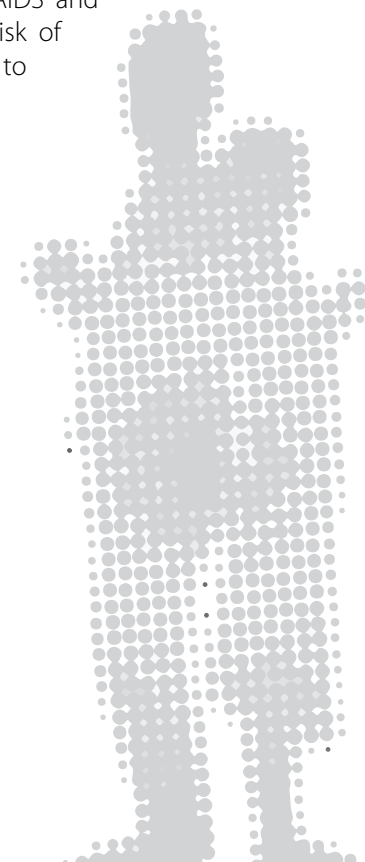
The lack of consistency in the interpretation and implementation of the pertinent provision of the AIDS Law;... the presence of punitive laws (e.g. The Dangerous Drugs Act, the Sanitation Code, and relevant provisions of the Revised Family Code and the Penal Code, among others) negatively affecting access to good health; the lack of trained service and care providers; and the absence of an active referral system of relevant social protection services are just some of the realities that have yet to be addressed so that more doors would open and serve these children and young people.³⁶¹

The *Strategic Framework* defines four strategies:

- Implement effective age-appropriate HIV prevention interventions for children and young people, with a strong focus on children and young people most at risk for HIV infection, in order to reduce sexual and injection-drug use transmission risk of HIV.
- Ensure access of children and young people, particularly those living with and affected by HIV, to an agreed minimum set of appropriate services.
- Develop and implement policies that promote effective age-appropriate and gender-sensitive HIV responses that protect children and young people from all forms of abuse, exploitation, and violence and increase their access to essential HIV-related health and other services, at all levels.
- Improve coordination mechanisms, capacity of child caring institutions, and strategic information based on jointly agreed standards of quality for HIV prevention programming for children and young people, particularly those most-at-risk for HIV infection.³⁶²

Sri Lanka's *National HIV/AIDS Strategic Plan 2007-2011*

recognizes "the intimate link between HIV/AIDS and human rights. People who have a higher risk of HIV exposure are often the most difficult to reach, because homosexuality, soliciting and drug use and trafficking are illegal, and drives them underground."³⁶³ The *National Strategic Plan* and the *National AIDS Policy* state as guiding principles universal human rights and dignity of all Sri Lankans: "There should be no discrimination on the basis of gender, HIV status, sexual behaviour or sexual orientation. HIV testing without prior informed consent is never acceptable (unless anonymous unlinked for screening purposes), and each HIV test result has to be confidential."³⁶⁴



Thailand's *National AIDS Strategy 2012-2016* includes a specific objective relating to youth and commits to reviewing laws and policies to promote access to services. The Strategy requires creation of a system of integrated, youth-friendly services for in and out of school youth in the areas of reproductive health, adolescent health, sexual health, and HIV, in ways that are participatory and youth-strengthening.³⁶⁵

Viet Nam's *National Plan of Action for Children affected by HIV and AIDS* includes all children affected by HIV including those living with HIV as well as child drug users, children who sell sex or who are sexually exploited, children of sex workers and people who use drugs, trafficked children and street children.³⁶⁶ The Plan of Action notes the following challenges:

Young people's changing lifestyles and perceptions on, friendship, love, sex, marriage and family, are factors that may increase high risk behavior. Knowledge about reproductive health, including HIV, among young people is limited, as is the uptake of services. Research has shown that adolescents dislike the unfriendly attitudes of service providers, and – particular to HIV testing – fear exposure, isolation and social stigmatization that often results from a lack of confidentiality with test results. Non facility-based adolescent-friendly HIV counselling and testing services are being piloted. If successful, they should be scaled up as well. What remains to be addressed is the lack of confidentiality of test results which anecdotal evidence suggests is a major obstacle to the uptake of HIV testing amongst young people.³⁶⁷

Objectives of the Plan of Action are to:³⁶⁸

- Increase accessibility to and adequacy of health care and education services and social policies for children affected by HIV.
- Ensure that services specifically required by children affected by HIV/AIDS are available, of good quality, and child-oriented.
- Improve mechanisms for providing information, education, care, treatment and counseling for children affected by HIV/AIDS.
- Create an enabling social environment for the protection and care of children affected by HIV/AIDS.
- Improve systems for supervision, monitoring, and evaluation of the situation of children affected by HIV/AIDS.

The Plan of Action requires the Ministry of Health to expand adolescent reproductive health care services that include HIV counseling and testing, and expand access to quality treatment services. The Plan of Action requires actions to be taken to ensure children affected by HIV are not discriminated against by health or social services and includes the following indicators:

- Number of provinces that have child-centered substance abuse counselling and treatment services;
- Number of provinces that have drug addiction counselling and treatment services for children;
- Per cent of education facilities including schools and vocational training centres that incorporate age-appropriate HIV, RH, and life skills education.³⁶⁹

4.2.2 National Youth Policies

Several countries have included consideration of access to SRH and/or HIV services in their national youth policies.

Bhutan's *Youth Policy 2010* identifies the critical issue: "knowledge and awareness of sexual and reproductive health especially among most at-risk young people" and proposes the strategic objective: "To provide access for all young people to health and information services that are youth friendly".³⁷⁰

Cambodia's *National Policy on Youth Development 2011* states the key strategy of "enhancement of health education, health care and health service provision" supported by the following activities:³⁷¹

- Develop and enhance health education and improve access to information on education and preventive measures in areas such as reproductive health;
- Develop mechanisms for youth participation in health education activities and community outreach programmes that benefit youth;
- Facilitate access by youth to quality health services including providing physical and mental health, and social services to young victims of violence, trafficking, and sexual exploitation;
- Strengthen social safety nets to ensure that the poorest youth can access health services and continue to prioritize prevention interventions, treatment and care to the target group of the most vulnerable youth;

- Provide quality education, support and care for teenage pregnancy before married age by appropriately trained health staffs with the participation of relevant stakeholders and communities; and
- Improve communications with parents or guardians and counselling experts on health services, on sexual attitude, and related sexual practices.

China's *Development Outline for Chinese Children (2011-2020)*³⁷² includes the objectives of controlling HIV among children and increasing their level of knowledge about SRH. The strategies include strengthening SRH services for children by integrating SRH into the compulsory education system, increasing the number of SRH service organizations and building their capacity in providing child-friendly services to meet counselling and treatment needs. It includes a strategy to establish an alternative care system for children affected by HIV to ensure their equal opportunity in life, education, health and employment.

Fiji's *National Youth Policy 2011* provides that the government will support adolescent and reproductive health education in schools and out of schools.³⁷³

India's Draft *National Youth Policy 2012* provides an important model because it addresses the needs of key populations that are often ignored in other government policies. The Policy states the following objective: "Facilitate access to all sections of youth to basic nutrition and health especially related to reproductive and sexual health information, facilities and services including access to mental health services; promote a healthy lifestyle, free of substance abuse and other unhealthy addictions, and dissuade them for engaging in harmful sexual practices."³⁷⁴ The draft Policy notes: "Youth engaged in sex trade / sex work are vulnerable and stigmatised community with little access to health, education and other services and facilities."³⁷⁵ The Policy also notes the prejudices and stereotypes that affect transgender persons, gays, lesbians and young people infected and affected by HIV and tuberculosis (TB). The Policy states the importance of free counselling and medication for TB, HIV, and other STIs at government clinics.³⁷⁶

Kiribati's *National Youth Policy 2012-2016* under the Health and Safety policy area identifies these strategies:

- Provide access to improved and youth-friendly health services including sexual and reproductive health and counselling services for both young men and young women, in both rural and urban areas, as well as to young people in positions of greater risk and vulnerability. Young men and women should be involved in the process of development and implementation.
- Develop communication strategies with the involvement of both young men and young women to reduce alcohol and substance abuse, address violence, abuse and exploitation issues, and promote healthy sexual and reproductive behaviour. Communication strategies should involve the delivery of messages through the school curricula, extra-curricula activities of advisory/support services in schools, as well as through community-based and non-government organizations.³⁷⁷

Maldives' *National Youth Health Strategy: Healthy Youth, Healthy Future* states a strategic direction: "Provide age and gender-appropriate ASRH, STI and HIV/AIDS prevention and support services to youth with special focus on vulnerable and high risk youth".³⁷⁸

The *National Youth Policy 2004-2010* of the **Federated States of Micronesia** provides that adolescent reproductive health, HIV and STIs, and family planning counselling services should be available daily upon request.³⁷⁹

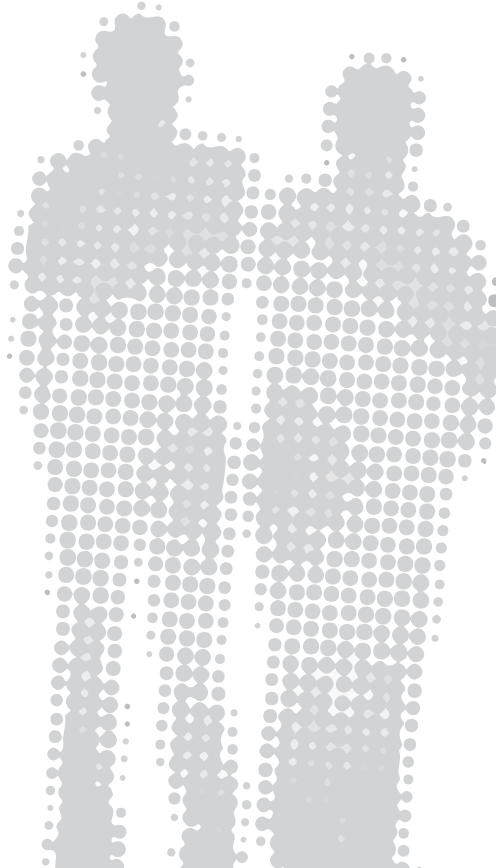
Nepal's *Youth Policy 2010* provides:³⁸⁰

(An) environment shall be created for the youths who are infected from HIV/AIDS to live a dignified and easy life in the society, by running special counselling service centers, regularly providing anti-retroviral medicines to such youths in an easily accessible manner, and providing the infected youths with skills-oriented education, while freeing such youths from all kinds of social discrimination being made against them . . .

Special programmes shall be launched in order to bring about improvement in the status of reproductive health of women, while establishing the right of women to reproductive health.

In **Pakistan**, the *National Youth Policy* refers to: “raising the awareness in youth about marriage law (e.g. minimum age of marriage, *nikah nama* etc.), reproductive health, Islamic tradition and values in the realm of family.”³⁸¹ The *Punjab Youth Policy 2012* goes further towards supporting young people’s access to services in that it includes the objective of increasing availability of integrated SRH information and services for adolescents and youth, especially the most marginalized, and helping to prevent HIV, AIDS and STIs. ‘Non-binding’ actions for ‘Adolescents and Youth Health Rights’ are defined as:³⁸²

- i. Adopt policies to address holistic health needs of the youth;
- ii. Protection, survival and development of children and youth;
- iii. Establish a “Youth Helpline” for counselling of adolescents on their health and
- iv. reproductive issues;
- v. Undertake education and communication activities in reproduction rights at the school level with cultural sensitivities of the regions in view;
- vi. Portrayal of equality of boys and girls through all public messages and curricula; and
- vii. Initiate life-skill programmes for children and youth.



Papua New Guinea’s *National Youth Policy 2007-2017* states that reproductive health services and information/education should be made widely available and easily accessible to young people without any form of discrimination. The Policy sets the target of establishing 500 counselling services for adolescent reproductive health by 2017.³⁸³

Samoa’s *National Youth Policy 2011-2015* states a policy outcome on health and wellbeing, which aims to increase availability of appropriate and relevant health services and in particular SRH information and services at the national and community level for protection of young people.³⁸⁴

Viet Nam’s *Youth Development Strategy 2011-2020* states the target:

... by 2020, at least 80 per cent of Vietnamese young people to be equipped with sound life skills and awareness of gender equality, reproductive health, building a happy family and domestic violence control... For implementation the Ministry of Health shall, as a lead agency, work with the Ministry of Home Affairs and relevant ministries, line agencies and municipal People’s Committees to implement and achieve the strategy targets on health care and reproductive health for young people and adolescents.³⁸⁵

4.2.3 National SRH, health and population policies

Afghanistan’s *National Reproductive Health Strategy 2012-2016* states the strategy of reaching community youth and married couples with birth spacing/family planning services.³⁸⁶ Indicators for monitoring include:

- Percentage of health service delivery points providing youth-friendly services;
- Percentage of health providers trained in youth-friendly service provision.³⁸⁷

Afghanistan’s *National Child and Adolescent Health Strategy, 2009-2013*³⁸⁸ describes adolescent health services to include: provision of condoms and information on emergency contraception, risk reduction counselling for prevention of STIs, contraceptive services for delaying pregnancy, antenatal care for pregnant adolescents, referrals for ectopic pregnancies, counselling on menstrual problems, syndromic management of STIs and referral, counselling on birth spacing and contraception, counselling on myths and misconceptions on sex related issues and problems, and harm reduction counselling.

The **Bangladesh Adolescent Reproductive Health Strategy 2005-2015** provides strategies for introducing and expanding adolescent-friendly health services. Priority activities are:³⁸⁹

- Needs assessment and development of a national plan: “The process would be consultative, involving adolescents, their gatekeepers and the policy makers. Based on the needs assessment, a plan for developing such services across the country, and covering all different adolescent groups including the hard to reach and marginalised ones, would be developed.”
- Capacity-building for rendering of adolescent-friendly health services.
- Scaling up adolescent-friendly services in government and NGO service delivery infrastructure.

A Bangladesh *National Communication Strategy for Family Planning and Reproductive Health* has also been published. Objectives include:³⁹⁰

- To improve the attitudes of service providers toward adolescents and youth with regard to family planning and reproductive health seeking behaviour.
- To increase sensitivity toward client privacy and confidentiality (i.e. the need to counsel clients in private areas, keep confidential records).
- To increase the effectiveness of communication between client and provider.
- To encourage providers to create an environment in which adolescents feel comfortable seeking information and services.

Cambodia's National Strategy for Reproductive and Sexual Health 2012-2016 states:³⁹¹

Young people's knowledge and understanding of sexuality and RSH (reproductive and sexual health) services is multi-dimensional, encompassing cultural values, education, self-worth and dignity. The large number of young people is affecting rapid social change in the country. Attitudes seem to be changing in Cambodia. A current series on prime time TV has teams of university students debating issues such as contraception, HIV knowledge, and sexual intercourse before marriage. It is clear that young people are becoming more open, at least among their peers.

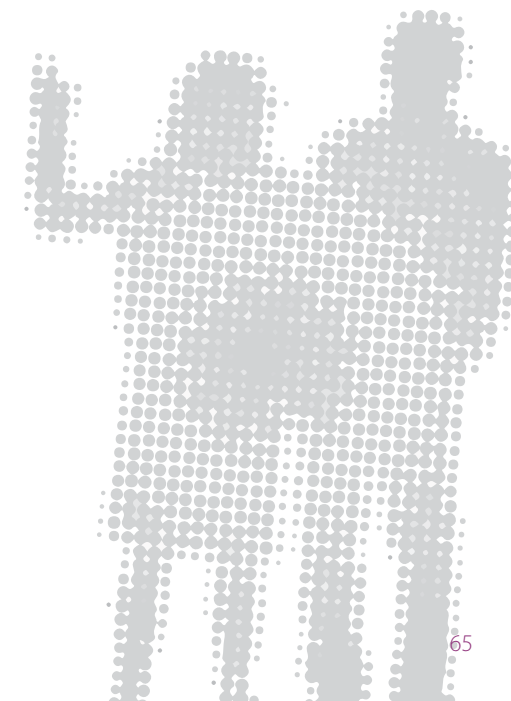
Current low levels of RSH knowledge among young people, especially most at-risk young people, are worrying. Young people in Cambodia tend not to use conventional services because of concerns about confidentiality and staff attitudes, preferring easy-to-use “One Stop Shops” in unthreatening, non-governmental environments. The unmet need for RSH information and services for young people in Cambodia is mainly met by NGOs, which have worked hard to understand young people's RSH information and service requirements and the differing needs of young men and women, and develop youth-friendly services.

Successfully providing RSH services for young people will require an intersectoral approach, including the Ministry of Education, Youth and Sports (MOEYS), the Ministry of Women's Affairs (MOWA), and building on work already done by MOH, NGOs and civil society.

MoEYS has developed a Comprehensive Sexuality Education and Life Skills Curriculum on Sexuality and HIV Education, which includes information about SRH rights, HIV, STIs, drug use, gender and gender-based violence, communication/negotiation skills for age-appropriate sexuality education. Capacity-building of trainers, teachers, school directors and non-formal education officials has taken place and these curricula are being rolled out to provinces.³⁹²

Fiji's Health Strategic Plan 2011-2015 identifies improved adolescent health and reduced adolescent morbidity and mortality, and beginning to reverse the spread of HIV, as key health outcomes, and includes the following performance indicators:³⁹³

- Reduced prevalence rate of STIs among 15 to 24 year olds by 5 per cent;
- Increase proportion of young people 15 to 29 years of age using condoms at last higher risk sex;
- Increase proportion of STI patients receiving appropriate treatment and care, advice on condom use and partner notification and referral to VCT services;
- Reduce the rate of teenage pregnancy by 5 per cent;
- Increase the number of adolescents aware, served or reached by the AHD (adolescent health and development) programme by 25 per cent;
- Increase proportion of young people who have adequate knowledge about SRH to 80 per cent; and
- Increase proportion of sexually active, unmarried adolescents who consistently use condoms to 90 per cent.



India's *Adolescent Reproductive and Sexual Health Strategy* states:

Adolescents are not a homogenous group. Their situation varies by age, sex, marital status, class, region and cultural context. This calls for interventions that are flexible and responsive to their disparate needs... This strategy focuses on reorganizing the existing public health system in order to meet the service needs of adolescents. Steps are to be taken to ensure improved service delivery for adolescents during routine sub-centre clinics and ensure service availability on fixed days... in tune with outreach activities. A core package of services includes preventive, promotive, curative and counselling services. Further, addressing adolescents will yield dividends in terms of delaying age at marriage, reducing incidence of teenage pregnancy, prevention and management of obstetric complications including access to early and safe abortion services and reduction of unsafe sexual behaviour.

Since service provisions for adolescents are influenced by many factors, wherein for example, at the level of the health system, lack of adequate privacy and confidentiality and judgmental attitudes of service providers, who often lack counseling skills, are barriers that limit access to services, a package of training modules have been prepared... for orienting programme managers and training health care providers on ARSH.³⁹⁴

Indonesia's *National Policy and Strategy on Adolescent Health in Indonesia (2004-2009)* provides that the government and the community are obliged to support and create a conducive environment for adolescent reproductive health (ARH). Strategies included in the Strategy are:

Improving availability and utilization of quality health services for the adolescents. Increased role of the local government, particularly in the procurement of Adolescent Friendly Health Services (AFHS) facilities and infrastructure. Adolescent Friendly Health Services (AFHS) is health services addressed to and affordable for adolescents, congenial, accepting adolescents with open arms, respecting them, confidential, sensitive to the needs related to health, and effective and efficient in meeting those needs. AFHS is an appropriate intervention in providing services to youth, so that access to and quality of adolescent health services can be achieved optimally. Activities include: ...Providing adolescent health services without discrimination and gender, on all targets, including marginalized groups. The provision of health services performed at all locations where young people are both in school and outside of school, including on the streets, refuge and work.³⁹⁵

Lao PDR's *National Reproductive Health Policy (2005)* provides:

Strategies: Health Service Delivery: Ensure access to youth friendly information, counseling and reproductive health services for both single and married young people that are confidential, do not require parental consent, are affordable or free of charge and accessible in a variety of settings.³⁹⁶

Malaysia's *Country Health Plan 2011-2015* states:

(R)eproductive health is the key to keep our adolescents and adults well prepared to lead a healthy and economically productive life, solid in preparation for the elderly years to come. The 'rights approach to health' will be given emphasis to ensure that gender equity and equality in health issue will be continuously addressed and the Convention on Rights of the Child related to health will be pursued.³⁹⁷

Malaysia's *National Adolescent Health, Plan of Action 2006-2020* has the following objectives:³⁹⁸

- Promoting the development of resilient adolescents through promotion of health and responsible living;
- Preventing the health consequences of risk behaviours through promotion of wellness and provision of health care services;
- Promoting active adolescent participation in health promotion and preventive activities.

SRH is one of five priority areas. Strategies include health promotion, access to appropriate health services and adolescent health information.

Maldives' *Health Master Plan 2006-2015* includes reference to the policy goal of developing and enforcing legislation to promote access to contraceptives skills building and behaviour change programmes for adolescents and young people on reproductive health.³⁹⁹

Mongolia's *National Reproductive Health Programme 2012-2016* includes attention to adolescent reproductive health and the objective of increasing access to and improving quality of reproductive health services. The following measures support improved access to young people:

- Updating of guidelines and standards on youth-friendly health services to be implemented in the public hospitals and NGO clinics.
- Upgrading of existing or establishment of new youth-friendly clinics at selected sites in the public sector.

WHO, the Ministry of Health and UNFPA have agreed to develop a strategy for integrated youth-friendly health services, so that all three levels of healthcare services become youth-friendly. The Ministry of Health has conducted trainings for family health centres and 'future threshold adolescent health centres', which are referral centres for specialized adolescent services, and is upgrading the youth services of the National Centre for Maternal and Child Health.⁴⁰⁰

Myanmar's *Strategic Plan for Reproductive Health (2008-2013)* states the goal of the attainment of a better quality of life by improved reproductive health status of women, men, adolescents and youths. The Plan supports provision of contraceptives and reproductive health services to unmarried persons and adolescents.⁴⁰¹ The *Strategic Plan for Adolescent Health in Myanmar 2009 to 2013* states: "Unmarried girls and young women are especially vulnerable to unwanted pregnancies because currently the services are not targeted to them and are limited to married women".⁴⁰² To encourage young people to access services:

...service environments and health staff attitudes need to be adolescent friendly. Providing services alone is not sufficient to increase access and utilization. It is necessary to create demand among young people by both informing them that comfortable and convenient services are available and ensuring they understand the benefit of such services...Existing primary health care services are to be reoriented with introduction in a phased way adolescent friendly standardized service package...⁴⁰³

Pakistan's *National Health Policy (2009)* provides for the development of essential health services package for all primary care outlets and more comprehensive packages for higher levels of care. Family planning services are defined as a priority area for health facilities. The services are required to "gain the trust of communities by ensuring community participation in their governance and by removing all barriers to access."⁴⁰⁴

Papua New Guinea's *Population Policy 2000–2010* includes a reproductive health goal of "ensuring that reproductive health services, including family planning, are accessible, affordable, and available in forms which are consistent with community values and norms".⁴⁰⁵ The PNG *National Health Plan 2011–2020* outlines key results areas to improve service delivery and health outcomes, including to improve maternal health through:⁴⁰⁶

- Increasing family planning coverage;
- Increasing the capacity of the health sector to provide safe and supervised deliveries;
- Improving access to emergency obstetric care; and
- Improving SRH for adolescents.

The Philippines has issued a *National Policy and Strategic Framework on Adolescent Health and Development*,⁴⁰⁷ which includes SRH as one of seven key health outcome areas. The Policy defines the goals of the national Adolescent Health and Development Programme as: "to improve the health status of adolescents and to enable them to fully enjoy their right to health". Reproductive health rights of adolescents are defined to include the human right to have control over and decide freely and responsibly on matters related to SRH. Programme strategies include:

- Health promotion and behaviour change for adolescents to utilize health services, practice healthy behaviours, avoid risks, and participate in governance and policy decisions affecting their health and development;
- Improving access to quality and adolescent friendly health care services and information for adolescents (applying national standards).

Guiding principles for the national programme are based on the CRC and include the best interests of the child, non-discrimination, privacy, meaningful adolescent participation in the programme, and "involvement, commitment, accountability, and responsibility in all areas of sexual and reproductive health".⁴⁰⁸

Thailand's 1st *National Sexual and Reproductive Health Plan 2009-2013* includes the strategy: "Develop a quality and efficient SRH service system". A goal is set of 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.⁴⁰⁹

Timor-Leste's *National Reproductive Health Strategy 2004-2015* provides:⁴¹⁰

The Government of Timor-Leste will ensure that young people receive accurate, culturally acceptable, gender-sensitive, age-appropriate information to enable them to cope with their health and development, to make responsible and informed choices and decisions regarding their sexual and reproductive health needs. All channels of communication including young people's organizations, schools, peer and other inter-personal communication, mass media, and relevant institutions will be utilized for dissemination of accurate, culturally acceptable, gender-sensitive information on young people's health and development.

The Government will ensure that youth-friendly health services are accessible, equitable, acceptable, appropriate, comprehensive, confidential, effective and efficient and available in both public and private sectors where the latter complement government services. General private services will also be encouraged to adhere to the general policy direction of young people's reproductive health services where appropriate. These services will address each adolescent's physical, social and psychological health and development needs, provide a comprehensive package of health care and counseling services for healthy development, gender equality, healthy sexuality, desired reproductive behaviour and healthy relationships; will be guided by evidence-based protocols and guidelines.

Tonga's *Reproductive Health Policy* has an adolescent sexual and reproductive health (ASRH) component, which provides:⁴¹¹

Policy goal: Improved sexual and reproductive health of adolescents and young people in Tonga through reduction of teenage pregnancy and STI cases and strengthened HIV prevention. Strategies for achieving policy goal:

- To increase access and utilization of Youth Friendly Services.
- To empower adolescents and young people with Life Skills Based Education and Information.
- To enhance dissemination of ASRH information through an enabling environment.
- To ensure youth representation and active participation at all levels on ASRH.

Tuvalu's *National Population Policy 2010-2015* provides:⁴¹²

Policy Goal: Couples and individuals achieve their reproductive choices and reduce fertility, including teenage fertility. Strategies for achieving policy goal are:

- Stronger focus on family planning in the Reproductive Health Programme.
- Further training of family planning nurses to improve their counselling skills to address women's fears.
- Focus-group research on perceptions and concerns regarding the side effects of contraception.
- Improve adolescent SRH services to cater for the specific needs of young persons
- Introduce Family Life Education into the school curriculum.

Vanuatu's *National Population Policy 2011-2020* provides:⁴¹³ Policy Goal: Reduce fertility and unintended pregnancy particularly among target population groups. Strategies:

- Implementation of reproductive health strategy at all levels (national, provincial and area council) applying the primary health care approach with adequate resourcing.
- Improve access to reproductive health services including family planning applying gender responsive and human rights approaches.
- Improved access to reproductive health services and knowledge for specific target groups such as men, adolescents, single mothers and other vulnerable groups.
- Integration of health and family life education in the school curriculum.
- Community education and health promotion on family planning to increase contraceptive use.
- Strengthen multi-sectoral partnerships of line ministries and other relevant stakeholders.

Objectives of the adolescent sexual and reproductive health (ASRH) component of *Reproductive Health Policy*⁴¹⁴ include:

- To increase access to and utilization of Youth Friendly Services.
- To establish school-based Family Life Education programme.
- To develop and disseminate ASRH information.
- To create and strengthen a supportive and enabling environment.
- To ensure youth representation and participation at all levels of ASRH.

Viet Nam's *Population and Reproductive Health Strategy for 2011-2020*⁴¹⁵ includes the objective of improvement of the reproductive health of adolescents and youth. The following targets are set:

- Increase the rate of adolescent/youth-friendly RH service provision facilities to 50 per cent by 2015 and 75 per cent by 2020.
- Reduce the rate of unwanted pregnancies among adolescents by 20 per cent by 2015 and by 50 per cent by 2020.

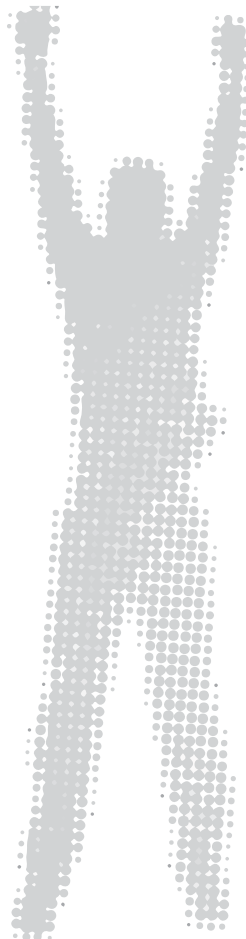
The Strategy calls for a televised population-reproductive health education programme to disseminate knowledge and develop skills related to reproductive health for young people. It calls for strengthening linkages between schools, families, mass organizations, social agencies and professional societies in conducting educational activities for adolescents and youth on population and reproductive health issues, sex ratio imbalance at birth, HIV prevention and gender equality, both in and outside schools.

4.2.4 National SRH and adolescent health service standards

The **Bangladesh** *Adolescent Reproductive Health Strategy* defines strategies for provision of easy access of all adolescents to reproductive health and related services by “ensuring good quality of care in adolescent friendly outlets”. The priority activities include developing quality standards and guidelines: “Service standards should be determined as part of defining adolescent friendly services and put in place in all new adolescent friendly service centres.”⁴¹⁶

Cambodia has developed *National Guidelines for Adolescent Friendly Reproductive and Sexual Health Services*. These guidelines specify criteria for youth-friendly services including:⁴¹⁷

- Baseline and follow up studies of adolescent reproductive and sexual health (ARSH) needs, both quantitative and qualitative.
- Training and sensitization of all providers to ARSH needs.
- Provision of services at times convenient to adolescents.
- IEC (information, education, communication) materials/messages specific to the needs of adolescents and developed with youth input.
- Involvement of adolescents in the planning of health care and development of IEC.
- Advocacy with parents, teachers and local officials on behalf of ARSH.
- Training of Village Health Support Groups, Community Based Distribution agents and other community resource persons to refer youth to services. (Community Based Distribution is used in Cambodia to describe community-based sales of contraceptives).
- Routine screening of adolescent clients for signs/symptoms of sexual abuse, substance abuse and mental health problems.



The **Philippine** *National Standards for Adolescent-Friendly Health Services* define four standards, as follows:⁴¹⁸

- **Standard 1:** Adolescents in the catchment area of the facility are aware about the health services it provides and find the health facility easy to reach and obtain services from it. Rationale: Adolescents are generally not aware about the availability of health services that cater to their needs. They either do not know about the location of the facility that provides health services in an adolescent friendly manner or the type of services that are available from the facility. Thus despite the availability of these services and competent personnel to provide such services, there is a low utilization rate of such services. Some of the reasons for low utilization could be the lack of informational activities to promote the adolescent services provided by these facilities; accessibility of the facility in terms of distance, cost and time; or the affordability of services. Actions are to be taken to ensure that adolescents are well-informed about the availability of health services.
- **Standard 2:** The services provided by health facilities to adolescents are in line with the accepted package of health services and are provided on site or through referral linkages by well-trained staff effectively. Rationale: Some of the health needs of adolescents may appear to be similar to those of adults (example: antenatal care services, services for STIs, etc.) yet the unique characteristics of this age group in terms of their physical, physiological, psycho-emotional, and even socio-cultural aspects necessitates that the needed services be provided in line with the required package effectively. In many cases the services that meet the adolescents' needs are either not fully provided from the health facilities or the services that are provided are not effective. This standard ensures that protocols, guidelines as well as services as per the accepted package that cater to the special needs of individuals in this age group are available from the designated health facilities. This standard also ensures that the staff of adolescent-friendly health facilities possesses the necessary knowledge, attitude, skills and behaviour to deal with their target clients.

- **Standard 3:** The health services are provided in ways that respect the rights of adolescents and their privacy and confidentiality. Adolescents find surroundings and procedures of the health facility appealing and acceptable. Rationale: Adolescents will not seek services if the physical environment and procedures are not appealing to them. While ensuring the adolescents' comfort and ease at the facility, it is crucial that the privacy and confidentiality of adolescents should be preserved and maintained throughout. Aside from the quality of services and attitude of personnel, the condition and features of the facility will also help contribute to client satisfaction and quality of care. It is important to get feedback, suggestions and recommendations from adolescents to be able to design facilities, procedures and protocols that will appeal to adolescents as well as suit their needs and taste.
- **Standard 4:** An enabling environment exists in the community for adolescents to seek and utilize the health services that they need and for the health care providers to provide the needed services. Rationale: In many situations, the community members are not aware of the importance of providing health services to adolescents. At times, there is reluctance, reservations and even opposition to ensuring access to such services. This deters not only adolescents from availing the services but also the service providers from delivering the needed health services to adolescents. This standard encompasses community actions including educational campaigns that are aimed to increase the awareness of the community to the need and importance of providing health services to adolescent including those that aim to improve the sexual and reproductive health of adolescents. This standard seeks the assistance of individuals, agencies and organizations in the community to assist in providing the resources needed to be able to deliver the services.

India and **Bhutan** have introduced service standards for adolescent health services (the standards are in most respects identical although in the case of Bhutan the standards apply to both adolescent and 'youth' services).⁴¹⁹ The standards require services to be accessible, acceptable, appropriate, comprehensive, effective and equitable. Six standards are defined:

- Health facilities provide the specified package of health services that adolescents need.
- Health facilities deliver effective health services to adolescents.
- Adolescents find the environment at health facilities conducive to seek services.
- Service providers are sensitive to the needs of adolescents and are motivated to work with them.
- An enabling environment exists in the community for adolescents to seek the health services they need.
- Adolescents are well informed about the availability of good quality health services from the service delivery points.
- Management systems are in place to improve/sustain the quality of health services.

Timor-Leste has published National Guidelines for the Provision of Youth Friendly Health Services in Timor-Leste. The Guidelines address the characteristics of a youth-friendly clinical service, including issues relating to privacy, opening hours, location, free provision of condoms, outreach activities, and staffing skills including training on youth-friendly communication and non-judgmental attitudes towards adolescents.⁴²⁰

Young people's vision for youth-friendly services

"A youth-friendly health service is a health service based on young people's human rights, with a reasonable price, strategic location and which is friendly and convenient with service opening times that are accessible for school-age clients and youth of all backgrounds including members of key populations. It should provide young people with access to STI and HIV services, pap smears and abortion."

"What we want is comprehensive youth-friendly services. This will only happen if young people are actively involved in the services, participating not just as passive service recipients."

Indonesia focus group

5 Conclusion and recommendations

The region stands to gain considerably from advancing the sexual and reproductive health of young people. Their sheer demographic numbers, the preventability of much of the ill-health affecting them, and the commitments that governments have made to promote their health and development all call for urgent action. Doing so will lead to better outcomes for them, their families and their countries.

Creating an enabling environment for sexual and reproductive health requires working across multiple levels, focusing on young people themselves, their relationships (including with parents and caregivers), and society at-large. At the macro/societal level, actions are required to promote young people's rights to the highest attainable standard of health and protect them from harm through supportive policies, laws, law enforcement practices and access to justice. This has been the focus of this review.

Policies need to be supported by legislation that provides young people with enforceable rights to access SRH and HIV information, commodities and other services. For example, laws can provide penalties for conduct that impedes access and can compel services to comply with standards that ensure services are responsive to the needs of young people. Additionally, technical capacity is required to ensure that health workers understand their legal responsibilities to guarantee inclusion and equality, and operational guidance be in place for the implementation and enforcement of such laws.

Recommendations

Youth leadership and participation

1. Governments should support young people and their organizations to engage in advocacy and decision-making on legal and human rights issues relating to SRH and HIV. Capacity-building of youth leaders should be supported including leaders from communities of young people from key populations, including young people living with HIV, young men who have sex with men, young transgender people, young people who sell sex and young people who use drugs.

Law reform

Rights of young people

2. Governments should enact comprehensive legislation guaranteeing young people's right to the highest attainable standard of health including: the right to access information and education essential to their health and development including on SRH and HIV, the right to access quality SRH and HIV services that are sensitive to their concerns, and freedom from violence and abuse, including coerced sterilization and abortion.
3. Governments should remove age restrictions and parental consent requirements that impede access to SRH and HIV services, including testing for HIV and other STIs, condoms and contraception, needle and syringe programmes and OST. Consistent with the Convention on the Rights of the Child, national laws should recognize the evolving capacity of adolescents to make independent decisions regarding their health. The consent of a parent or guardian to SRH and HIV services should not be required if a minor is considered to be sufficiently mature. A young person should be able to consent

independently if the young person is capable of understanding the nature and consequences of the service and is able to assess their own best interests. If governments prefer to define a minimum age below which consent of a parent or guardian is required in all cases, this should be set at early adolescence. Children above such a minimum age should be able to consent independently if they are assessed by the health professional offering the service as sufficiently mature.

4. Marriage should not be a pre-condition for access to SRH services
5. Young people, including adolescents, should have a legal right to access their medical records and to confidentiality of their medical records and health status. The law should prohibit disclosure by health care professionals delivering SRH and HIV services of personal information relating to a young person without the young person's consent, taking into account the mature minor principle and evolving capacities. This prohibition on disclosure of information to others (including parents and guardians) without the young person's consent should include information about the young person's health status, sexual behaviour and drug use history or other personal information. Exceptions to this duty of non-disclosure should be narrowly defined, and include consideration of the age and maturity of the adolescent, the gravity of the condition or treatment, and family factors. For example, exceptions should include:
 - in emergency situations with risk of death or serious injury;
 - where disclosure is required for the health care or treatment of the young person, e.g. sharing information with other health professionals involved in the care of the young person;
 - where the young person is assessed by the health professional as lacking sufficient capacity or competence to consent by reason of their age, and a parent or guardian consents to disclosure.

Operational guidance is required to assist health care workers to understand their legal and professional obligations, and training provided on policies and procedures.

6. The age of consent to sex should be set at an age that recognizes that many young people commence sexual activity during their early adolescence. Consensual sexual activity between adolescents who are similar in age should not be criminalized. Contradictions between age of consent to sex and age of consent to SRH services should be reconciled.

7. Birth registration laws should address the needs of young people who were not registered at birth to obtain identification documents so they can access government health and welfare services.

General law reform recommendations applying to young people and adults

8. The recommendations listed above relate to legislative measures that will benefit young people specifically. In addition, law reforms should be considered that would improve the *access of both* adults and young people to SRH and HIV services. Governments should implement the following recommendations of the Global Commission on HIV and the Law⁴²¹:
 - Decriminalize private and consensual adult sexual behaviours, including same-sex sexual acts and voluntary sex work.
 - Reform approaches towards drug use. Rather than punishing people who use drugs but do no harm to others, governments must offer them access to effective HIV and health services, including harm reduction programmes and voluntary, evidence-based treatment for drug dependence.
 - Provide legal protections against discrimination based on actual or assumed HIV status, sexual orientation or gender identity.
 - Work with the guardians of customary and religious law to promote traditions and religious practices that promote rights and acceptance of diversity and that protect privacy.
9. Governments should also consider the recommendation of the UN Special Rapporteur on the Right to Health that abortion be decriminalized and measures be taken to ensure that legal and safe abortion services are available, accessible, and of good quality.⁴⁰²

Improvements to law enforcement practices

10. Governments should ensure that law enforcement abuses, including harassment, extortion and violence are punished. Criminal offences should not be applied against minors selling sex or using drugs as they should be seen as needing protection, rather than offenders subject to prosecution.
11. Governments should provide independent monitoring and complaint mechanisms that can help prevent and respond to police abuses of young people.

12. In advance of law reform, governments can adopt a pragmatic approach by not requiring harmful laws to be enforced against young people. Governments can explore options such as not actively enforcing arbitrary age, marital status or parental consent restrictions. Governments can consider imposing a moratorium on the enforcement of punitive criminal law provisions concerning abortion against young women and girls, in recognition of the health harms caused by inflexible enforcement of abortion prohibitions.

SRH and HIV policies and programmes

13. Governments should ensure that the rights of young people are explicitly addressed in HIV, SRH and population and development policies, and that SRH and HIV issues are integrated into national youth policies and strategies. As a policy response, SRH and HIV services can be reoriented to young people's needs (particularly unmarried adolescents) through requiring service standards and guidelines to be developed that address their specific needs.

14. SRH and HIV policies and programmes should address the following:

- Access to youth-friendly, evidence-based, gender-sensitive, non-discriminatory and confidential SRH and HIV services and information.
- Access for young people living with HIV to condoms, contraceptives, reproductive services and sexual health services, as essential components of HIV care.
- Recognition of the importance of ensuring SRH services are available to sexually active adolescents and unmarried young people, as well as married people.
- Support to programmes that respond to the specific needs of young people living with HIV and other young people from key populations.
- Access for young women and girls to services for abortion-related complications and post-abortion care, including in jurisdictions where abortion is criminalized. Where abortion is legal, services should be made accessible to young women and girls.
- Systematic collection of confidential data in relation to the progress towards universal coverage of SRH and HIV services for young people, particularly young key populations. Age-disaggregated data on young people who are at increased risk of HIV and other STIs are required as an evidence base to inform policies and planning of services.

- Rights of young people to participate in policy development and programme implementation and evaluation.
- Community mobilization, focused awareness-raising and public education to enable parents, community leaders, health care workers, and the broader society to learn about adolescent SRH and HIV issues in culturally-sensitive ways, thereby influencing the social norms and cultural practices that are key to a supportive environment for SRH and HIV information and service provision.
- Removal of financial barriers to access to services through waiver of fees, health insurance, voucher schemes or other financing options to ensure services are affordable to young people.

Legal services

15. Governments should ensure access to legal aid for young people who require legal advice and representation in relation to their rights to access SRH and HIV services, privacy rights, police abuses, discrimination or other rights violations.



Endnotes

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- 127 The phrase 'over the age of 14' used in the relevant law may arguably be interpreted as either 14 years and above, or 15 years and above. It is not known whether a judge has been required to clarify this ambiguity.
- 128 *Communicable Diseases Prevention and Control Act 1988*, Section 1507(3).
- 129 *Penal Code*, Section 89.
- 130 *Child Law 1993*, Section 13. The *Child Law* currently applies to children under 16 years. The combined Third and Fourth CRC Periodic Report states the intention to change the age of childhood to 18 years, the minimum age of criminal responsibility to 10 years and of employment to 15 years, but these changes have yet to be enacted: Ministry of National Planning and Economic Development and UNICEF. 2012. *Situation Analysis of Children in Myanmar*. Nay Pyi Taw: Government of Myanmar and UNICEF, p.4.
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- 144 Soe, M., op. cit.
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- 155 Section 1506.
- 156 Section 1507(3).
- 157 Section 1506(2).
- 158 Article 35(b).
- 159 Sections 34 and 29(2)(c).

- 160 Section 15(3) and 14(2)(b).
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- 163 Article 30(1)(b).
- 164 WHO South-East Regional Office (SEARO). 2006. *Consent and Confidentiality: Increasing adolescents' access to health services for HIV and sexual and reproductive health*, Report of the Regional Consultation, New Delhi, India, 25-27 July 2006. New Delhi: SEARO.
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- 167 *Penal Code of Bhutan 2004*, Section 183.
- 168 *Crimes Act 1969*, Sections 147.
- 169 *Crimes Decree 2009* (Fiji), Section 212.
- 170 *Criminal Code* (PNG), Section 229F.
- 171 *Criminal Code* (PNG), Section 210.
- 172 *Special Protection of Children Against Abuse, Exploitation and Discrimination Act 1992*, Section 10.
- 173 See e.g. Australia: In the state of Victoria and the Australian Capital Territory, there is a defence if the defendant was not more than 2 years older than the person against whom the offence is alleged to have been committed (*Crimes Act 1958* (Vic), Section 45 (sex with persons 12 years or over); *Crimes Act 1900* (ACT), Section 55 (sex with persons 10 years or over)). See also *Criminal Code Act 1924*, Section 124 (Tasmania). Canada: *Criminal Code 1985*, Section 150 provides that a 14 or 15 year old can consent to sex if the partner is less than five years older, and a 12 or 13 year old can consent to sex with another young person who is less than two years older. These provisions generally do not apply if the younger person is dependent on the older person, the older person is in a position of trust or authority towards the younger person, or the older person is in an exploitative relationship with the younger person.
- 174 Ministry of Justice. 2013. *Explanatory Notes for the Law on Suppression of Human Trafficking and Sexual Exploitation*. Phnom Penh: Ministry of Justice.
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- 176 Section 84(2).
- 177 Section 10.
- 178 E.g. Thailand's *Criminal Code Amendment Act (No.19), 2007* expands the definition of rape to cover female and male offenders, homosexual rape, raping of people of all sexes, and all types of sexual penetration: Juaseekoon S. 2012. *Recent Developments of Legal System in Thailand*. Ha Noi: ASEAN Law Association.
- 179 *Criminal Code*, Article 122.
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- 183 See: Sciortino, R. 2010. *Achieving Contraceptive Security and Meeting Reproductive Health Needs in South East Asia*. Bangkok: Asia Pacific Alliance for Sexual and Reproductive Health and Rights, p.viii.
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- 187 Article 21.
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- 194 Ministry of Health. 2009. *Strategic Plan for Adolescent Health in Myanmar 2009 to 2013*. Yangon: Ministry of Health, p.6.
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- 206 *Decree No:96/2012/ND-CP*, Articles 5, 7 and 8.
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- 208 *Penal Code 1951*, Section 82.
- 209 *Indian Penal Code 1860*, Section 82.
- 210 *Child Law 1993*, Section 28. A new Child Amendment Law proposes to raise the age of criminal responsibility in 2013, see: Myanmar revises Child Law, childhood status extended to 18, Myanmar Times, 24 November 2012.
- 211 *Criminal Code Act 1974*, Section 30; *Juvenile Courts Act 1991*, Section 16. There is a presumption that a child between 7 and 14 years is not capable of committing an offense unless it can be proved that the child knew that he or she was doing wrong.
- 212 *Pakistan Penal Code 1860*, Articles 82, 83. The *Child Protection (Criminal Law) Amendment Bill 2009* proposes to increase the age of the criminal responsibility from 7 to 12 years. The Bill has been approved by Cabinet, but has not yet been enacted by the National Assembly. See: Author unknown. 2013. Cabinet meeting: Age of criminal responsibility raised from 7 to 12 years. *Tribune*, 14 March 2013.
- 213 *Penal Code*, Cap 224, Section 82.
- 214 *Criminal Offences Act*, Cap 18, Section 16.
- 215 *Penal Code*, Cap 26, Section 14.
- 216 *Penal Code 1883*, Articles 75 and 76. A child above 8 and under 12 is not criminally responsible if the child has not attained sufficient maturity to judge the nature and consequence of his conduct: Article 76.
- 217 *Penal Code (Amendment) Act 2004*.
- 218 *Bhutan Penal Code 2004*, Article 114. It is proposed to raise the age to 13, see: Department of Youth and Sports, Ministry of Education. 2010. *National Youth Policy*. Thimpu: Ministry of Education, p.8.
- 219 *Crimes Act 1969*, Section 24.
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- 223 Children are criminally responsible at 7 years with regard to some Islamic law offences, as well as for certain serious secular offences: UNICEF. 2005. *South Asia and the Minimum Age of Criminal Responsibility Raising the Standard of Protection for Children's Rights*. New Delhi: UNICEF Regional Office for South Asia, p.5.
- 224 *Criminal Code, 2004*, Section 107.
- 225 *Children's Act 2048 (1992)*, Section 11.
- 226 Committee on the Rights of the Child. 2001. *Concluding Observations of the Committee on the Rights of the Child*, CRC/C/15/Add.149.
- 227 *Young Offenders Act 2007*, Section 3.
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- 229 *Crimes, Procedure and Evidence Rules 2003*, Rule 114.
- 230 *Penal Code*, Cap 8, Section 14.
- 231 *Penal Code*, Cap 135, Section 17.
- 232 *Juvenile Code 2005*, Article 10(1).
- 233 *Juvenile Court System Law*, no.11/2012.
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- 235 *Criminal Law*, Article 17.
- 236 *Code of FSM*, Title 11, Chap 3, Section 301A sets a minimum age of 14, unless there is clear proof at the time of engaging in the wrongful conduct they knew it was wrong; Title 12, Chap 11, Section 1101 states that an offender 16 years or older may be treated in all respects as an adult if the physical and mental maturity so justifies.
- 237 *Criminal Code*, Article 21
- 238 *Penal Law of 2005*, Article 7, Persons 14 to 16 years of age are subject to criminal liability for homicide, deliberate infliction of a severe bodily injury, rape, theft in aggravating circumstances, misappropriation, robbery, deliberate destruction or damage of property and hooliganism in aggravating circumstances.

- 239 *Juvenile Justice and Welfare Act of 2006*, RA 9344, Section 6.
- 240 *Penal Code*, Article 20.
- 241 *Penal Code of 1999*, Article 12.
- 242 The applicable offences apply to persons of all ages.
- 243 See: Godwin, J. 2010. *Legal Environments, Human Rights and HIV Responses among Men who Have Sex with Men and Transgender People in Asia and the Pacific*. Bangkok: UNDP.
- 244 Ibid.
- 245 Ibid, p.56.
- 246 Ibid, p. 93.
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- 248 Malaysia: some State Syariah Enactment laws that apply to Muslim citizens criminalize cross-dressing, e.g. *Syariah Criminal (Negeri Sembilan) Enactment 1992*, Section 66 (State of Negeri Sembilan). Tonga: *Criminal Offences Act*, Section 81(5) makes it an offence for any male person, who is soliciting for an immoral purpose, to impersonate or represent himself as a female with the intention of deceiving any other person as to his true sex.
- 249 See: Equal Rights Trust. 2012. News: Malaysian High Court Upholds a Ban on Cross-dressing, 26 October 2012. London: Equal Rights Trust.
- 250 See: Godwin J. 2012. *Sex Work and the Law in Asia and the Pacific*. Bangkok: UNDP, p.22.
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- 252 Ibid. UN agencies issued a Joint Statement in 2012 calling on countries to end the practice of admission into compulsory drug detention and rehabilitation centres of people who use drugs, people who have engaged in sex work and children who have been the victims of sexual exploitation. See: ILO, OHCHR, UNDP, UNESCO, UNFPA, UNODC, UN Women, WFP, WHO and UNAIDS. 2012. *Joint Statement: Compulsory Drug Detention and Rehabilitation Centres*, available at: <http://whothailand.healthrepository.org/handle/123456789/1369>.
- 253 See Silverman, J.G. 2011. Adolescent Female Sex Workers: Invisibility, Violence and HIV. *Arch Dis Child*, Vol. 96, No. 5:pp. 478-81. HIV Young Leaders Fund (HYLF), et al. 2013 (forthcoming). Access to Sexual and Reproductive Health and Other Services for Adolescents Engaged in Selling Sex in Asia and the Pacific.
- 254 Ibid., pp.148, 154ff.
- 255 See Godwin J. 2012., p.173ff.
- 256 See Godwin J. 2012., p.187.
- 257 Ibid., p.173ff.
- 258 Article 34. Article 35 also protects children from abduction, the sale of or traffic in children from any purpose or in any form, including sexual exploitation. Article 39 requires States Parties to take all appropriate measures to promote physical and psychological recovery and social reintegration of child victims in an environment that fosters health, self-respect and dignity. The Optional Protocol to the CRC on the Sale of Children, Child Prostitution and Child Pornography further refines the protections offered by the CRC, and requires State to criminalize these child rights violations as offences (see, in particular, Article 3) and to provide adequate support to child victims (see, in particular, Article 8) in: UN. 2000. *Optional Protocol to the CRC on the Sale of Children, Child Prostitution and Child Pornography*. A/RES/54/263. New York: UN.
- 259 UNAIDS. 2012. *UNAIDS Guidance Note on HIV and Sex Work*. Geneva: UNAIDS, p.3.
- 260 International Labour Organization (ILO). 1999. *Worst Forms of Child Labour Convention, 1999 (No. 182)*. Geneva: ILO.
- 261 See e.g. Indonesia: *Law on the Eradication of the Criminal Act of Human Trafficking 2007*; Lao PDR: *Law on Women's Development and Protection 2004*; Myanmar: *Anti-Trafficking in Persons Law*, No. 5/2005; the Philippines: *Anti-Trafficking in Persons Act*, RA No. 9208 of 2003; Viet Nam: *Law on Prevention, Suppression Against Human Trafficking 2011*.
- 262 E.g. Indonesia's anti-trafficking law protects the rights of children who are victims of trafficking for the purposes of sexual exploitation. The anti-trafficking law applies where a person recruits, transports, transfers, harbours, delivers or receives another person with the intention of exploitation, with or without consent of the person, see: *Law on the Eradication of the Criminal Act of Human Trafficking 2007*. However, children who have not been recruited, transported, transferred, harboured, delivered or received by another person do not fall within this law's definition of persons trafficked for sexual exploitation and may be subject to arrest under local regulations if they sell sex on the street. See: Farid, M. et al 2004. *Comments on the First Periodic Report of the Government of Indonesia to the Committee on the Rights of the Child*. Jakarta: Indonesian NGO Coalition for CRC Monitoring, p.7.
- 263 A joint UN Statement has called for the closure of these sites, and recognizes that "Children who are, or have been, involved in sex work should be treated as child survivors of commercial sexual exploitation, in accordance with the Convention on the Rights of the Child (1989) and the ILO Worst Forms of Child Labour Convention, 1999 (No 182), not as offenders liable to criminal penalties. See: ILO, OHCHR, UNDP, UNESCO, UNFPA, UNODC, UN Women, WFP, WHO and UNAIDS. 2012. *Joint Statement: Compulsory Drug Detention and Rehabilitation Centres*, available at: <http://whothailand.healthrepository.org/handle/123456789/1369>. See also: Global Commission on HIV and the Law. 2012. *Risks, Rights and Health*. New York: UNDP, pp. 39-40.
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- 265 Human Rights Watch. 2011. *The Rehab Archipelago, Forced Labor and Other Abuses in Drug Detention Centers in Southern Vietnam.*, New York: Human Rights Watch, pp.66-68; Human Rights Watch. 2010. *Skin on the Cable: The Illegal Arrest, Arbitrary Detention and Torture of People Who Use Drugs in Cambodia*. New York: Human Rights Watch, p.6.
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Annex I: Age of consent to sex

This Annex provides further detail including legislative sources to assist understanding of Table 7, which appears at 3.1.4 in the report.

Country	Age of Consent to Sex			
	Age at which a male can consent to sex with female	Age at which a female can consent to sex with male	Age at which male can consent to sex with male	Age at which female can consent to sex with female
ASIA				
Afghanistan (<i>Sharia offences</i>) ¹	Males can only have sex after marriage (<i>Zina</i>)	Females can only have sex after marriage (<i>Zina</i>)	Illegal (<i>Liwat</i>)	Illegal (<i>Musahaqah</i>)
Bangladesh (<i>Penal Code of Bangladesh 1860, Women and Children Repression Prevention Act 2000</i>) ²	No specific age of consent for males defined by Penal Code	14	Illegal ³	No specific prohibition or age of consent provision ⁴
Bhutan (<i>Penal Code of Bhutan 2004</i>) ⁵ Exceptions apply for sex where the parties are both 16 or 17	18	18	Illegal ⁶	No specific prohibition or age of consent provision ⁷
Brunei Darussalam (<i>Penal Code of Brunei 1951</i>) Sharia offences restrict sexual relations between unmarried Muslims ⁸	No specific age of consent for males defined by Penal Code, male Muslims can only have sex after marriage	14 ⁹	Illegal ¹⁰	Illegal between Muslims ¹¹
Cambodia ¹²	15	15	15	15 ¹³
China (<i>Criminal Law of China 1977</i>) ¹⁴	14	14	14	14
DPRK (<i>Criminal Code</i>) ¹⁵	Not known / law not available	15	Not known/ law not available	Not known/ law not available
India (<i>Penal Code 1860, Protection of Children from Sexual Offences Act 2012</i>) ¹⁶	18	18	18	18
Indonesia (<i>Penal Code</i>) ¹⁷	19, ¹⁸ except Aceh Province: Muslim males can only have sex after marriage.	15, ¹⁹ except Aceh Province: Muslim males can only have sex after marriage.	18, ²⁰ except Aceh Province (illegal)	18, except Aceh Province (illegal)
Lao PDR (<i>Penal Code</i>) ²¹	15	15	15	15 ²²
Malaysia (<i>Penal Code</i>) ²³ ('Syariah' offences restrict sexual relations between Muslims) ²⁴	No provision in Penal Code, sex outside of marriage illegal for Muslims	16 for all female citizens, and Muslim females must also be married.	Illegal ²⁵	Illegal between Muslims ²⁶
Maldives (<i>Zina, Islamic law</i>) ²⁷	Males can only have sex after marriage	Females can only have sex after marriage	Illegal ²⁸	Illegal ²⁹
Mongolia (<i>Criminal Code</i>) ³⁰	16	16	16	16 ³¹
Myanmar (<i>Penal Code 1860</i>)	No specific age of consent for males defined by Penal Code	14 ³²	Illegal ³³	No specific prohibition or age of consent provision ³⁴
Nepal (<i>National Code or Muluki Ain 2020</i>) ³⁵	No specific age of consent for males defined by Penal Code	16	Not illegal, no statutory age of consent	Not illegal, no age of consent provision
Pakistan (<i>Pakistan Penal Code</i>)	Muslim males can only have sex after marriage ³⁶	16 for all female citizens, ³⁷ and Muslim females must also be married ³⁸	Illegal ³⁹	Ambiguous under national law, illegal in tribal areas if Sharia applies ⁴⁰
Philippines (<i>Revised Penal Code</i>), an offence is also committed if a man has sex with another person under 18 if the age difference is more than 10 years) ⁴¹	12	12	12	12

Country	Age of Consent to Sex			
	Age at which a male can consent to sex with female	Age at which a female can consent to sex with male	Age at which male can consent to sex with male	Age at which female can consent to sex with female
ASIA				
Sri Lanka (<i>Penal Code</i>) ⁴²	16	16, or 12 if married	Illegal ⁴³	Illegal ⁴⁴
Thailand (<i>Penal Code</i>) ⁴⁵	15	15	15	No specific prohibition or age of consent provision
Timor-Leste (<i>Penal Code</i>) ⁴⁶ Exceptions apply for sex where the parties are both between 14 and 16	17	17	17	17
Viet Nam (<i>Penal Code</i>) ⁴⁷	16	16	16	No specific prohibition or age of consent provision ⁴⁸
PACIFIC				
Cook Islands (<i>Crimes Act 1969</i>)	No specific age of consent for males defined by Crimes Act	16 ⁴⁹	Illegal ⁵⁰	Ambiguous ⁵¹
Fiji (<i>Crimes Decree 2009</i>), ⁵² Exceptions apply to sex between friends who are similar in age	16	16	16	16
Marshall Islands (<i>Revised Criminal Code</i>) ⁵³	16	16	16	No specific prohibition or age of consent provision
Palau (<i>Palau National Code</i>) ⁵⁴	No specific age of consent for males defined by the National Code	15 ⁵⁵	Illegal ⁵⁶	No specific prohibition or age of consent provision
PNG (<i>Criminal Code 1974</i>), ⁵⁷ exceptions apply permitting a child aged 12 years or older to consent to sex with a person who is not more than two years older than him or her.	16	16	Illegal ⁵⁸	No specific prohibition or age of consent provision
Samoa (<i>Crimes Act 2013</i>) ⁵⁹	16	16	Illegal ⁶⁰	16
Solomon Islands (<i>Penal Code 1968</i>) ⁶¹	No specific age of consent for males defined by the Penal Code	15	Illegal ⁶²	Illegal ⁶³
Tokelau (<i>Crimes Procedure and Evidence Rules 2003</i>) ⁶⁴	16	16	16	No specific prohibition or age of consent provision
Tonga (<i>Criminal Offences Act</i>)	No specific age of consent for males defined by the Criminal Offences Act	16 ⁶⁵	Illegal ⁶⁶	No specific prohibition or age of consent provision
Vanuatu (<i>Penal Code</i>) ⁶⁷	15	15	15	15

Sources:

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- 2 *Penal Code 1860*, Section 375 & *Women and Children's Repression Prevention Act 2000*, Section 9(1), provide that consent of girls under 14 is not a defence to rape.
- 3 *Penal Code 1860*, Section 377 criminalizes carnal intercourse against the order of nature.
- 4 It is unclear whether any forms of sex between women fall within the definition of unnatural sex in Section 377. No prosecutions are known.
- 5 Section 183 *Penal Code* provides it is an offence to have sexual intercourse with a child between the ages of 12 and 18 years. However, consensual sex between children 16 and above shall not be deemed to be rape.
- 6 Section 213 criminalizes sodomy and other sexual conduct that is against the order of nature.
- 7 It is unclear whether any forms of sex between women falls within the definition of unnatural sex in Section 213. No prosecutions are known.
- 8 Offences of zina and khalwat may apply in religious courts. Sharia offences may be introduced by the *Syariah Criminal Penal Code Order 2013*.
- 9 *Penal Code*, Section 375.
- 10 *Penal Code*, Section 377 (unnatural offences).
- 11 Sharia offences may be introduced by the *Syariah Criminal Penal Code Order 2013*.
- 12 *Law on Suppression of Human Trafficking and Sexual Exploitation of 2008*, Article 44; *Penal Code*, Article 239. See: Ministry of Justice. 2013. *Explanatory Notes for the Law on Suppression of Human Trafficking and Sexual Exploitation*. Phnom Penh: Ministry of Justice.
- 13 The relevant provision is not gender-specific, i.e. it is an offence for a person to have sexual intercourse with another person less than fifteen years. However, penetration is required: *Law on Suppression of Human Trafficking and Sexual Exploitation of 2008*, Article 44. The term "sexual intercourse" means the insertion of one person's genital into another person's genital, mouth or anus, or the insertion of any tools or instruments into a person's genital. Sexual intercourse can take place between two or more persons of the same or opposite sex, including between females: Ministry of Justice. 2013, *ibid*.
- 14 Article 236 (sex with female under 14); Fingering or sodomy of minors under fourteen is child sexual abuse offence, 'minor' includes boys and girls under fourteen; see reference to Interpol database for China at: <http://www.ageofconsent.com/china.htm>
- 15 Article 153 states that a man who has sexual intercourse with a girl under the age of 15 shall be "punished gravely": US State Department. 2011. *Bureau of Democracy, Human Rights and Labor Country Reports on Human Rights Practices for 2011: Korea, Democratic People's Republic of*, <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/index.htm#wrapper>.
- 16 *Indian Penal Code*, Section 375 (sexual assault) (amended by the *Criminal Law (Amendment) Act 2013* so as to define age of consent as 18 for women). See also *Protection of Children from Sexual Offences Act*, 2012, Section 2 defines a child as under 18 for the purposes of sexual assault laws. Section 3 (penetrative sexual assault) applies to male offenders, Section 7 (sexual assault) is not gender specific.
- 17 Age of consent of 19 for males is consistent with the male legal age of marriage for males, however the *Penal Code* only provides for statutory rape for sex with girls under 15 years (Article 287). In Aceh, Sharia offences were introduced by the Qanun Jinayat (criminal bylaws) in 2009. Enforcement of sharia offences by Aceh's Sharia Courts has been delayed pending consultation.
- 18 See also *Penal Code*, Article 290, child under 15 years cannot consent.
- 19 See also *Penal Code*, Article 287, child under 15 years cannot consent.
- 20 See also *Penal Code*, Article 292, homosexual sex with minor. Minors are under 18, according to *Child Protection Law 2002*.
- 21 Article 129.
- 22 Assumes sex between women falls within this law's definition of 'sexual intercourse'.
- 23 Section 375.
- 24 *Zina* (fornication) is a Sharia offence. Each state and the Federal Territories has a 'Syariah Offence' law e.g. *Syariah Criminal Offences (Federal Territories) Act*, Act 559 of 1997.
- 25 *Penal Code*, Section 377A (carnal intercourse against the order of nature).
- 26 *Musahaqah* is a Sharia offence.
- 27 129 fornication (*zina*) cases were filed in 2011 and 104 people sentenced, out of which 93 were female. This included 10 girls below 18. One male minor was sentenced. A person found guilty of fornication is subjected to 100 lashes and sentenced to one year of house arrest or banishment while a minor's flogging is postponed until she or he reaches 18: Lubna, H. 2012. Judicial statistics show 90 percent of those convicted for fornication are female, *Minivan News*, 1 October 2012.
- 28 Offence of *Liwat*, *Sharia law*.
- 29 *Musahaqah* is a Sharia offence.
- 30 Article 122.
- 31 Assumes sex between women falls within definition of 'sexual intercourse' in Article 122.
- 32 Section 375
- 33 Section 377 (unnatural sex).
- 34 Some types of sexual conduct between women may fall within the offence of 'unnatural sex': i.e carnal intercourse against the order of nature. No prosecutions are known.
- 35 Chapter 14, Article 1: sexual intercourse with an unmarried girl, a widow or someone's wife under sixteen years of age with or without her consent is statutory rape.
- 36 *Pakistan Penal Code*, Section 496B (fornication).
- 37 *Pakistan Penal Code*, Section 375.
- 38 *Pakistan Penal Code*, Section 496B (fornication).
- 39 *Pakistan Penal Code*, Section 377 (unnatural offences) may arguably apply to some forms of sex between females provided there is penetration, although prosecutions are not known. In tribal areas where *Sharia* law principles may be applied by Jirga, sex between females may be regarded as the *Sharia* offence of *musahaqah*.
- 40 *Sharia* offence of *musahaqah*.

- 41 *Revised Penal Code*, Article 266A, inserted by R.A. No. 8353, *Anti-Rape Law of 1997*, provides that the offence of rape occurs when the victim is under 12. Special Protection of Children Against Abuse, Exploitation and Discrimination Act 1992, Section 10 provides that it is an offence for a person to have in his company a minor 12 years or under or who is 10 years or more his junior in any public or private place, hotel, motel, beer joint, discotheque, cabaret, pension house, sauna or massage parlor, beach and/or other tourist resort or similar places.
- 42 Section 363 provides that it is an offence of rape to have sexual intercourse with a woman with or without her consent if the woman is under 16 years of age unless the woman is the accused man's wife, she is over 12 years of age, and she is not judicially separated from him. Section 366(aa) provides an offence of grave sexual abuse, which is committed with or without the consent of the other person when the other person is under 16 years of age.
- 43 *Penal Code*, Sections 365 (unnatural offences) and 365A (gross indecency).
- 44 *Penal Code*, Section 365A (gross indecency).
- 45 *Criminal Code*, Section 277. The *Criminal Code Amendment Act* (No.19) B.E. 2550 (2007) expanded the definition of statutory rape to cover sex with a person under 15 year old of any sex, consent is no defence. See: Finch, J. and Tangprasit N. 2011. Criminal law in Thailand: Underage sex, another example, *Bangkok Post*, 26 June 2011, p.21. Employees of establishments regulated by the *Act on Entertainment Places*, B.E. 2509 (1966) (i.e. sex work venues) are required to be at least 18 years old, and customers are required to be at least 20 years old.
- 46 Article 177 provides that it is an offence to practice a sexual act on a minor aged under 14. Article 178 provides that it is an offence for a person who, being an adult, practices a sexual act with a minor aged between 14 and 16 years, taking advantage of the inexperience of the same. Other provisions of the Code refer to minors as being under 17 years (e.g. Article 144, 155, 163), suggesting the phrase "between 14 and 16" in Article 178 is inclusive of 14 and 16, i.e. 17 is the age of consent to sex (e.g. Articles 144, 155, 163, 164).
- 47 *Penal Code* Article 115 creates an offence for sexual intercourse with children under 16.
- 48 Article 115 may apply in certain circumstances depending on the scope of the definition of sexual intercourse.
- 49 *Crimes Act 1969*, Sections 147. If the girl consented and is aged 12 or more, it is a defence if the offender is younger than the girl.
- 50 *Crimes Act 1969*, Section 154 (indecency), 155 (sodomy).
- 51 *Crimes Act 1969*, Section 147 (sexual intercourse with a girl) arguably may apply, depending on whether sex between females is regarded as falling within the definition of sexual intercourse. If Section 147 applies, the age of consent is 16. Section 140 states that sexual intercourse requires penetration, but does not specify penile penetration.
- 52 Section 212 (indecent assault, consent is no defence if victim is under 16). Section 207 (rape, consent is no defence if victim is under 13).
- 53 *Criminal Code 2004*, 31 MIRC Cap 1, Section 152.
- 54 *Palau National Code Annotated* 17 PNCA.
- 55 *Palau National Code* § 2804 creates the offence of carnal knowledge: Whoever shall have carnal knowledge of the person of a female under 15 years of age who is not his wife.
- 56 *Palau National Code* § 2803 creates the offence of sodomy: Every person who shall unlawfully and voluntarily have any sexual relations of an unnatural manner with a member of the same or the other sex., shall be guilty of sodomy, ...the term "sodomy" shall embrace... "abominable and detestable crime against nature."
- 57 Section 229A provides that a person who engages in an act of sexual penetration with a child under the age of 16 years is guilty of a crime. Section 229F provides that consent is not a defence, unless the child was aged 12 years or older, and the accused was no more than two years older than the child.
- 58 *Criminal Code 1974*, Section 210 (unnatural sex).
- 59 It is an offence to have sexual connection with a young person under 16: *Crimes Act 2013*, Section 59.
- 60 *Crimes Act 2013*, Section 67 (sodomy).
- 61 *Penal Code*, Section 141.
- 62 *Penal Code*, Section 160 (buggery) and 162 (gross indecency between persons of the same sex).
- 63 *Penal Code*, Section 162 (gross indecency between persons of the same sex).
- 64 *Crimes Procedure and Evidence Rules 2003*, Rule 19.
- 65 *Criminal Offences Act*, Section 124.
- 66 *Criminal Offences Act*, Section 136 (sodomy).
- 67 *Penal Code (Amendment) Act 2006* repealed the provision that set age of consent for homosexual sex at 16. Section 97 provides that no person shall have sexual intercourse with a child under 15. Sexual intercourse is defined by Section 89A to include heterosexual and homosexual sex.

Annex II: Minimum legal age of marriage

This Annex provides further detail including legislative sources to assist understanding of Table 8, which appears at 3.1.5 in the report.

	Males (minimum age without parental consent)	Females (minimum age without parental consent)	Notes
ASIA			
Afghanistan	18	16	<i>Civil Code 1977</i> , Article 70 defines age of marriage and provides penalties for child marriage. A girl of 15 may be married with the permission of her father or guardian. Permission is not required once she is 16.
Bangladesh	21	18	<i>Child Marriage Restraint Act 1929</i> , Article 4. Religious marriages under these ages are also recognized as legally valid under Personal Law. See <i>Muslim Marriage and Divorce Registration Act</i> , and <i>Muslim Family Laws Ordinance Act of 1961</i>
Bhutan	18	16	<i>Marriage Act 1980</i> Section (Kha) 1-14
Brunei Darussalam	14	14	<i>Marriage Act</i> (Cap. 76) Section 3(1) states the age for marriage is 14. The Act does not apply to Muslim marriages, which are governed by Sharia laws.
Cambodia	20	18	Younger persons may marry with parental consent if the female becomes pregnant. <i>Law of the Marriage and Family 1989</i> , Article 5.
China	22	20	<i>Marriage Law 1981</i> , Article 6.
India	21	18	<i>Prohibition of Child Marriage Act 2006</i> , Section 2(a) defines age of marriage and Section 3 states child marriage is voidable at the option of the contracting party to the marriage, who was a child at the time of marriage. Lower ages may be valid under religious personal laws. Child marriages under the <i>Hindu Marriage Act</i> are valid and neither void nor voidable. In 2012, the Delhi High Court declared that Muslim women can legally marry at 15 under Muslim Personal Law, provided that the girl has reached puberty. ¹
Indonesia	21	21	<i>Marriage Law 1974</i> , Article 7, defines age of marriage as 19 for males and 16 for females. Article 6 requires parental consent if either party is under 21. Article 7 provides that parents may apply to a court for permission for marriage below the minimum age. ²
Lao PDR	18	18	<i>Family Law, 1990</i> , Article 9. The limit may be lowered to 15 in special cases.
Malaysia	21	21	The <i>Law Reform (Marriage and Divorce) Act 1976</i> defines the age of civil marriage for males at 18 and females as 16. This Act regulates non-Muslim marriages and requires parental consent for marriages under 21 (Section 22(3)). Marriage of girls 16-18 is with consent of Chief Minister (Section 10). Muslim girls can marry at 16, or under 16 with the permission of a <i>Sharia</i> court. ³
Maldives	18	18	<i>Family Act</i> , no.4 of 2000, Section 4(a). Persons under 18 who have attained puberty may apply to the Registrar of Marriages for permission to marry.
Mongolia	18	18	<i>Family Law 1999</i> , Article 6.1.
Myanmar	18	18	The <i>Special Marriage Act of 1872</i> regulates mixed marriages, and requires that males be 18 and females be 14. Persons marrying within their religion follow religious laws. ⁴ According to Section 3 of the <i>Majority Act</i> , the age of majority to make a contract is 18 years. Those who attained 18 years of age may legally marry at the court by signing the affidavit of marriage. ⁵ The right of females under 18 years of age to marry with the consent of their parents or guardian is accorded protection by religious law.
Nepal	20	20	<i>Marriage Registration Act, 2028 (1971)</i> , Section 4, as amended by <i>Amending Some Nepal Acts to Maintain Gender Equality Act, 2063</i> .
Pakistan	18	16	The <i>Child Marriage Restraint Act 1929</i> states the minimum age of marriage for a male is 18 and for a female is 16. However, although penalties apply, the marriages of persons under these ages are not rendered invalid. A marriage contracted after the attainment of puberty and before the age of 16 years for females and 18 for males is valid under Muslim law. ⁶

	Males (minimum age without parental)	Females (minimum age without parental)	Notes
Philippines	21	21	<i>Family Code of the Philippines</i> , 1987, Article 5 defines the minimum age of marriage as 18. Parental consent is required for persons under 21: Article 14. <i>Muslim Personal Laws Code</i> 1977 applies in Mindanao Province. A Muslim male at least fifteen years of age and a Muslim female of the age of puberty or upwards may marry. A female is presumed to have attained puberty upon reaching the age of fifteen. The Sharia Court may order the solemnization of the marriage of a female who, though less than fifteen but not below twelve years of age, has attained puberty. (Article 16).
Sri Lanka	18	18	<i>Marriage Registration Ordinance</i> , Section 15. The <i>Muslim Marriage and Divorce Act 1951</i> (Section 23) applies to Muslim marriages and states the minimum age for girls is 12, although marriage of a girl under 12 may be authorized by a <i>Quazi</i> .
Thailand	21	21	<i>Thailand Civil and Commercial Code Book V Family Title</i> , Section 1435, defines the minimum age of marriage as 17. Parental consent is required if under 21 (Section 1436). A Court may approve a marriage at younger age than 17 (Section 1448).
Timor-Leste	17	17	<i>Civil Code (2011)</i> , Article 1490, defines the minimum age of marriage as 16. Parental consent is still required when aged 16 (but below 17) (Article 1500). The registrar can waive the requirement of parental consent if reasons justify an exception and if the minor has the necessary physical and psychological maturity (Article 1500-2).
Viet Nam	20	18	<i>Law on Marriage and the Family</i> of 1986, Article 5.
PACIFIC			
Cook Islands	21	21	<i>Marriage Act 1973</i> , Section 17. Parental consent is required for marriage of persons between 16 and 21.
Fiji	18	18	<i>Marriage Act</i> , Cap. 50, Section 12, as amended by the <i>Marriage Act (Amendment) Decree 2009</i> .
Kiribati	18	18	<i>Marriage Act</i> Cap. 54, Section 5.
Marshall Islands	18	18	<i>Births, Deaths and Marriages Registration Act</i> 1988, Section 428(a). Females aged 16-18 must obtain parental consent.
Micronesia, Federated States of	18	16	General rule is that if the female is less than 16 she must obtain the permission of one parent: Chuuk State Code, Title 23 on Family Law; Kosrae State Code, Title 16 on Family and Minors Section 16.101; and Pohnpei Code, Title 51 on Domestic Relations and Title 52 on Minors; Yap State Code, Title 27 for Domestic Relations.
PNG	18	16	<i>Marriage Act 1963</i> , Section 7. Dual system recognizes civil and customary marriage. Section 7 provides that a male person who has attained the age of 16 years but has not attained the age of 18 years, or a female person who has attained the age of 14 years but has not attained the age of 16 years, may apply to a Judge or Magistrate for an order authorizing him or her to marry. Section 3 provides a person who is not already a party to a statutory marriage may enter a customary marriage in accordance with the custom of either of the parties. Age requirements vary depending on local custom.
Samoa	21	19	<i>Marriage Act 1961</i> , Section 9, defines the minimum age of marriage as 18 for males and 16 for females. Section 10 provides that parental or a guardian's consent is required for females under 19 and males under 21.
Solomon Islands	18	18	<i>Islanders' Marriage Act</i> , Cap 171, defines the minimum age of marriage as 15. Section 10. Parental or guardian's consent is required if under 18.
Tonga	18	18	<i>Births, Death and Marriages Registration Act</i> , Cap 42, Section 6 defines the minimum age of marriage as 15. Parental consent is required if under 18.
Vanuatu	21	21	<i>Control of Marriage Act</i> , Cap. 45, Section 2 defines the minimum age of marriage as 18 for males and 16 for females. Section 3 states that parental consent is required if the person is under 21.

Sources:

- 1 Author unknown. 2012. Muslim girl can marry at 15 if she attains puberty: Delhi High Court. *Times of India*, 5 June 2012.
- 2 Soewondo, N. 1977. The Indonesian Marriage Law and its implementing regulation. *Archipel*, Vol. 17, No. 13, pp. 283-294, p.287.
- 3 Nemat, O.A. 2006. *Comparative Analysis of Family Law in the Context of Islam. Report of a Roundtable Conference, 15-17 August 2006*, Kabul, Afghanistan. Kabul: Afghanistan Independent Human Rights Commission & Heinrich Böll Foundation.
- 4 See: Sen, B.K. 2001. Women and law in Burma. *Legal Issues on Burma Journal*, No. 9, August 2001. Mae Sod: Burma Lawyers' Council.
- 5 CEDAW, CEDAW/C/MMR/CO/3/Add.1 2010. Response by Myanmar to the recommendations contained in the concluding observations of the Committee following the examination of the combined second and third periodic reports of Myanmar on 3 November 2008, Progress report submitted by Myanmar in relation to paragraphs 29 and 43 of the concluding observations of the Committee.
- 6 Yilmaz, I. 2005. *Muslim Laws, Politics and Society in Modern Nation States: Dynamic legal pluralisms in England, Turkey and Pakistan*. Ashgate: Aldershot, p.135.

Annex III: Abortion laws

This Annex provides further detail in relation to the grounds for legal abortion in each country, to assist understanding of the discussion of criminalization of abortion at 3.2.3 of the report.

	Grounds for legal abortion in Asia and the Pacific						
	To save a woman's life	To preserve a woman's physical health	To preserve a woman's mental health	In case of rape or incest	Because of foetal impairment	For economic or social reasons	On request
ASIA							
Afghanistan	X	-	-	-	-	-	-
Bangladesh	X	-	-	-	-	-	-
Bhutan	X	-	X	X	-	-	-
Brunei Darussalam	X	-	-	-	-	-	-
Cambodia	X	X	X	X	X	X	X
China	X	X	X	X	X	X	X
DPRK	X	X	X	X	X	X	X
India	X	X	X	X	X	X	-
Indonesia	X	-	-	X	X	-	-
Lao PDR	X	X	-	-	-	-	-
Japan	X	X	-	X	-	X	-
Malaysia	X	X	X	-	-	-	-
Maldives	X	X	-	-	-	-	-
Mongolia	X	X	X	X	X	X	X
Myanmar	X	-	-	-	-	-	-
Nepal	X	X	X	X	X	X	X
Pakistan	X	X	X	-	-	-	-
Philippines	X	-	-	-	-	-	-
Republic of Korea	X	X	X	X	X	-	-
Singapore	X	X	X	X	X	X	X
Sri Lanka	X	-	-	-	-	-	-
Thailand	X	X	X	X	X	-	-
Timor-Leste	X	-	-	-	-	-	-
Viet Nam	X	X	X	X	X	X	X
PACIFIC							
Cook Islands	X	X	X	X	-	-	-
Fiji	X	X	X	X	X	-	-
Kiribati	X	-	-	-	-	-	-
Marshall Islands	X	-	-	-	-	-	-
Micronesia (Federated States of)	X	-	-	-	-	-	-
Nauru	X	X	X	-	-	-	-

	Grounds for legal abortion in Asia and the Pacific						
	To save a woman's life	To preserve a woman's physical health	To preserve a woman's mental health	In case of rape or incest	Because of foetal impairment	For economic or social reasons	On request
Niue	X	X	X	-	-	-	-
Palau	X	-	-	-	-	-	-
PNG	X	X	X	-	-	-	-
Samoa	X	X	X	-	-	-	-
Solomon Islands	X	-	-	-	-	-	-
Tonga	X	-	-	-	-	-	-
Tuvalu	X	-	-	-	-	-	-
Vanuatu	X	X	X	-	-	-	-

Note: 'X' indicates the specified ground applies in the specified country. '-' indicates the specified ground does not apply in that country.

Source: Adapted from United Nations Department of Economic and Social Affairs, Population Division. 2011. *World Abortion Policies 2011*. New York: United Nations. In addition, in relation to Indonesia regard was also had to the Law Concerning Population and Family Development 2009, Article 75.

Annex IV: International obligations and commitments

The human rights of children and young people are defined by the *International Covenant on Economic, Social and Cultural Rights* (ICESCR) and the *Convention on the Rights of the Child* (CRC). All States of Asia and the Pacific that are members of the UN have ratified, accepted, or acceded to the CRC. Most have also signed or ratified the ICESCR. States of Asia and the Pacific that have neither signed nor ratified the ICESCR are: Bhutan, Brunei Darussalam, Fiji, Malaysia, Marshall Islands, Micronesia (Federated States of), Myanmar, Nauru, Samoa, Singapore, Tuvalu and Vanuatu.

Some states have expressed reservations or made declarations that qualify the application of these international instruments to their country. Annex V provides a list of relevant reservations and declarations relating to the international instruments discussed below, e.g. regarding inconsistency with religious principles or national laws.¹

Convention on the Rights of the Child (CRC)

The CRC provides for the protection of the right to health of children. The CRC defines a 'child' as a person under 18 years of age, unless under domestic law the child reaches majority at an earlier age. The CRC urges governments to ensure prenatal and post-natal care for mothers, develop family planning education and services, and ensure the elimination of traditional practices that are prejudicial to the health of children.²

The CRC establishes the principle that the best interests of the child shall be the primary consideration in all actions concerning children,³ the rights of children to non-discrimination,⁴ birth registration,⁵ and to life, survival and development⁶ The right to have views affecting the child heard and given due weight, in accordance to age and maturity of the child,⁷ and a right to privacy.⁸

The CRC provides that governments have an obligation to protect children from sexual exploitation including child prostitution.⁹ Consistent with this provision, governments should define minors involved in the sex industry as victims of sexual exploitation who require protection, rather than offenders subject to prosecution.

The Committee on the Rights of the Child has interpreted obligations of governments under the CRC to include the provision to adolescents of access to SRH information, including on family planning and contraceptives, the dangers of early pregnancy, the prevention of HIV and the prevention and treatment of STIs.¹⁰

The CRC requires governments to take into account the particular stages of a child's development and the child's 'evolving capacities'. The CRC requires governments to respect the rights and responsibilities of parents, guardians and the extended family to provide guidance to the child as appropriate to the child's evolving capacities.¹¹ The CRC requires governments to assure to a child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child. These views must be given due weight in accordance with the age and maturity of the child.¹²

General Comment No.15 of the Committee on the Rights of the Child makes the following observations and recommendations relating to the right to health in its interpretation of the CRC:¹³

The Committee underscores the importance of the best interests of the child as a basis for all decision-making with regard to providing, withholding or terminating treatment for all children. States should develop procedures and criteria to provide guidance to health workers for assessing the best interests of the child in the area of health, in addition to other formal, binding processes that are in place for determining the child's best interests. The Committee in its general comment No. 3¹⁴ has underlined that adequate measures to address HIV/AIDS can be undertaken only if the rights of children and adolescents are fully respected. The child's best interests should therefore guide the consideration of HIV/AIDS at all levels of prevention, treatment, care and support.¹⁵

The Committee recognises that children's evolving capacities have a bearing on their independent decision-making on their health issues. It also notes that there are often serious discrepancies regarding such autonomous decision-making, with children who are particularly vulnerable to discrimination often less able to exercise this autonomy. It is therefore essential that supportive policies are in place and that children, parents and health workers have adequate rights-based guidance on consent, assent and confidentiality.¹⁶

Children's right to health contains a set of freedoms and entitlements. The freedoms, which are of increasing importance in accordance with growing capacity and maturity, include the right to control one's health and body, including sexual and reproductive freedom to make responsible choices. The entitlements include access to a range of facilities, goods, services and conditions that provide equality of opportunity for every child to enjoy the highest attainable standard of health.¹⁷

In accordance with their evolving capacities, children should have access to confidential counselling and advice without parental or legal guardian consent, where this is assessed by the professionals working with the child to be in the child's best interests. States should clarify the legislative procedures for the designation of appropriate caregivers for children without parents or legal guardians, who can consent on the child's behalf or assist the child in consenting, depending on the child's age and maturity. States should review and consider allowing children to consent to certain medical treatments and interventions without the permission of a parent, caregiver, or guardian, such as HIV testing and sexual and reproductive health services, including education and guidance on sexual health, contraception and safe abortion.¹⁸

Given the high rates of pregnancy among adolescents globally and the additional risks of associated morbidity and mortality, States should ensure that health systems and services are able to meet the specific sexual and reproductive health needs of adolescents, including family planning and safe abortion services. States should work to ensure that girls can make autonomous and informed decisions on their reproductive health. Discrimination based on adolescent pregnancy, such as expulsion from schools, should be prohibited, and opportunities for continuous education should be ensured.¹⁹

Sexual and reproductive health education should include self-awareness and knowledge about the body, including anatomical, physiological and emotional aspects, and should be accessible to all children, girls and boys. It should include content related to sexual health and well-being, such as information about body changes and maturation processes, and designed in a manner through which children are able to gain knowledge regarding reproductive health and the prevention of gender-based violence, and adopt responsible sexual behaviour.²⁰

Family planning services should be situated within comprehensive sexual and reproductive health services and should encompass sexuality education, including counselling. They can be considered part of the continuum of services described in article 24, paragraph 2 (d), and should be designed to enable all couples and individuals to make sexual and reproductive decisions freely and responsibly, including the number, spacing and timing of their children, and to give them the information and means to do so. Attention should be given to ensuring confidential, universal access to goods and services for both married and unmarried female and male adolescents. States should ensure that adolescents are not deprived of any sexual and reproductive health information or services due to providers' conscientious objections.²¹

Short-term contraceptive methods such as condoms, hormonal methods and emergency contraception should be made easily and readily available to sexually active adolescents. Long-term and permanent contraceptive methods should also be provided. The Committee recommends that States ensure access to safe abortion and post-abortion care services, irrespective of whether abortion itself is legal.²²

International Covenant on Economic, Social and Cultural Rights (ICESCR)

Article 12 of the ICESCR addresses the right to the highest attainable standard of physical and mental health. General Comment No. 14 of the Committee on Economic, Social and Cultural Rights interprets Article 12 to apply to children and adolescents as follows:

Children and adolescents have the right to the enjoyment of the highest standard of health and access to facilities for the treatment of illness... States parties should provide a safe and supportive environment for adolescents, that ensures the opportunity to participate in decisions affecting their health, to build life skills, to acquire appropriate information, to receive counselling and to negotiate the health-behaviour choices they make. The realization of the right to health of adolescents is dependent on the development of youth-friendly health care, which respects confidentiality and privacy and includes appropriate sexual and reproductive health services.²³

General Comment No. 14 states that the right to health includes measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, prenatal and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information. It notes that women's right to health requires the removal of all barriers interfering with access to SRH services.²⁴

Article 13 of the ICESCR addresses the right to education. General Comment No. 13 does not contain recommendations specifically on SRH education. However, the Committee on Economic, Social and Cultural Rights has stated that education must be flexible and must "adapt to the needs of changing societies and communities and respond to the needs of students within their diverse social and cultural settings... the best interests of the student shall be a primary consideration."²⁵

Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)

CEDAW requires States to take action to ensure that women are afforded equality in access to health care. The Convention provides for access to family planning information, and the elimination of discrimination against women in marriage and family relations. Women must be provided rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise those rights.²⁶ All countries of Asia and the Pacific have ratified CEDAW except Palau and Tonga.

ILO Worst Forms of Child Labour Convention, 1999 (No. 182)

The Worst Forms of Child Labour Convention calls for the elimination of sexual exploitation of children, including the use, procuring or offering of any person under the age of 18 years for prostitution. The Convention in effect requires governments to prohibit the use of persons below the age of 18 years in prostitution. This requirement applies even if the legal age of consent to sex is below 18. The Convention defines a child as under 18. This is a stricter definition than the CRC. The CRC recognizes that domestic laws may define 'child' as younger age than 18. The Worst Forms of Child Labour Convention defines child as under 18 without exception. States of Asia and the Pacific that have not ratified this Convention are India, Marshall Islands, Myanmar, Palau and Tuvalu.²⁷

International commitments

International commitments relating to young people's access to SRH and HIV services including the following:

- **The Millennium Development Goals (MDGs)²⁸**

The MDGs include targets that aim for universal access to HIV services (Target 6B) and reproductive health services (Target 5B) by 2015. All countries in the Asia-Pacific region have signed on to the MDGs.

- **UN General Assembly Political Declaration on HIV and AIDS**

The 2011 Political Declaration reaffirmed that the full realization of human rights and fundamental freedoms for all is an essential element in the global response to HIV. The Declaration notes that laws and policies in some instances exclude young people from accessing sexual health-care and HIV services.²⁹ The Political Declaration commits States to "expanding good quality youth-friendly information and sexual health education and counselling services, strengthening reproductive and sexual health programmes, and involving families and young people in planning, implementing and evaluating HIV and AIDS prevention and care programmes."³⁰ All countries in the Asia-Pacific region have endorsed the Political Declaration on HIV and AIDS of 2011.

International Conference on Population and Development (ICPD)

Reproductive health rights feature prominently in the ICPD Programme of Action (1994). States of Asia and the Pacific have committed to ICPD, ICPD+5, and ICPD+10.³¹ The Programme of Action requires States to remove legal barriers to access to services for adolescents:

... (C)ountries must ensure that the programmes and attitudes of health-care providers do not restrict the access of adolescents to appropriate services and the information they need, including on sexually transmitted diseases and sexual abuse. In doing so, and in order to, inter alia, address sexual abuse, these services must safeguard the rights of adolescents to privacy, confidentiality, respect and informed consent, respecting cultural values and religious beliefs. In this context, countries should, where appropriate, remove legal, regulatory and social barriers to reproductive health information and care for adolescents.³²

The UN Commission on Population and Development, which monitors progress on the ICPD Programme of Action, passed a resolution in 2012 stating that the Commission:

Urges Governments to protect and promote human rights and fundamental freedoms regardless of age and marital status, including, inter alia, by eliminating all forms of discrimination against girls and women, by working more effectively to achieve equality between women and men in all areas of family responsibility, in sexual and reproductive life, and in education at all levels, and by protecting the human rights of adolescents and youth to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health.³³

• Beijing Platform for Action³⁴

The *Beijing Platform for Action of the Fourth World Conference on Women* affirms the rights of women to control all aspects of their health, to respect bodily autonomy and integrity and to decide freely in matters relating to their sexuality and reproduction, free of discrimination, coercion and violence.³⁵ The Platform for Action states that States should consider removing punitive measures related to sexual and reproductive health, and requires States to:

design and implement programmes with the full involvement of adolescents as appropriate, to provide them with education, information and appropriate, specific, user-friendly and accessible services without discrimination to address effectively their reproductive and sexual health needs taking into account their right to privacy, confidentiality, respect and informed consent and the responsibilities, rights and duties of parents and legal guardians to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognised in the Convention on the Rights of the Child and in conformity with CEDAW and ensuring that in all actions concerning children, the best interests of the child are a primary consideration.³⁶

Young people who use drugs must also have legal and safe access to HIV and health services.

• Global Commission on HIV and the Law recommendations

The Global Commission on HIV and the Law puts forward a number of relevant recommendations. These include "To ensure an effective, sustainable response to HIV that is consistent with human rights obligations:

5.1. Countries must enact and enforce laws that:

- 5.1.1 Ensure that the birth of every child is registered. This is crucial for supporting children's access to essential services. Ensure that their rights are protected and promoted, as per the Convention on the Rights of the Child.
- 5.1.2 Ensure that every orphaned child is appointed an appropriate adult guardian. This includes provisions for transfer of guardianship of AIDS orphans from deceased parents to adults or older siblings who can ensure their well-being. In selecting a guardian, preference should be given to adults from the biological or extended families. HIV-positive adults who are otherwise in good health should not be prohibited from adopting children.
- 5.1.3 Support community-based foster care for children orphaned by AIDS as an alternative to institutionalisation, when formal adoption is not possible or appropriate.
- 5.1.4 Ensure HIV-sensitive social protections as required, such as direct cash transfers for affected children and their guardians.
- 5.1.5 Prohibit discrimination against children living with or affected by HIV, especially in the context of adoption, health and education. Take strict measures to ensure that schools do not bar or expel HIV-positive children or children from families affected by AIDS.

5.2 Countries must enact and enforce laws to ensure that children orphaned by AIDS inherit parental property. Children orphaned by AIDS should inherit regardless of their sex, HIV status or the HIV status of family members. Such enforcement includes:

- 5.2.1 Collaboration with the enforcers of religious and customary laws to ensure justice for children orphaned by AIDS.
- 5.2.2 Reconciliation of conflicts between discriminatory customary laws and traditional practices and international human rights standards to ensure compliance with international law.

5.3. Countries must enact and enforce laws ensuring the right of every child, in or out of school, to comprehensive sexual health education, so that they may protect themselves and others from HIV infection or live positively with HIV.

5.4. Sexually active young people must have confidential and independent access to health services so as to protect themselves from HIV. Therefore, countries must reform laws to

ensure that the age of consent for autonomous access to HIV and sexual and reproductive health services is equal to or lower than the age of consent for sexual relations. Young people who use drugs must also have legal and safe access to HIV and health services.”³⁷

Regional and sub-regional commitments

Regional and sub-regional commitments relating to young people’s access to SRH and HIV services including the following:

- **UN Economic and Social Commission for Asia and the Pacific (ESCAP)**

ESCAP *Resolution 66-10* (2010) calls on member states to ground universal access to HIV services in human rights and to address legal barriers to HIV responses. ESCAP *Resolution 67-9* (2011) requires states to initiate reviews of national laws, policies and practices to enable the full achievement of universal access targets with a view to eliminating all forms of discrimination against people at risk of infection or living with HIV, in particular key affected populations.³⁸ The ESCAP *Fifth Asian and Pacific Population Conference Plan of Action on Population and Poverty* (2002) urges Governments to:

Provide adequate access to youth-friendly, age-appropriate, evidence-based sexual and reproductive health information, education, counselling and services on the sexual and reproductive health of adolescents; (and to) strengthen service provision for adolescents,... particularly to ensure availability and access as there is a need to take proactive measures to ensure that the provision of reproductive health care is both youth-friendly and appropriate.³⁹

- **Association of South East Asian Nations (ASEAN)**

The ASEAN Charter states that members must “accelerate actions to increase accessibility to sexual and reproductive health information and friendly health services, and educate society, especially parents and adolescents on reproductive and sexual health education.” The ASEAN *Declaration of Commitment on HIV*⁴⁰ commits countries to scaling up HIV prevention programmes for key populations including people who use drugs, sex workers, MSM and transgender people. The Declaration also includes a “pledge to eliminate gender inequalities and gender-based abuse and violence especially by protecting and promoting the rights of women and adolescent girls, strengthening national social and child protection systems, empowering women and young people to protect themselves from HIV, and have access to health services, including, inter alia, sexual and reproductive health, as well as full access to comprehensive information and education.” The *Ha Noi Declaration on Enhancement of the Welfare and Development of ASEAN Women and Children* (2010) states the need to foster

concerted efforts to address poor reproductive health; to enable access to safe contraception, safe family planning methods and emergency maternal obstetrical care facilities; and to promote education and information activities to reduce the prevalence rate of HIV among women and children and facilitate their access to HIV treatment and care.⁴¹

- **South Asian Association for Regional Cooperation (SAARC)**

The SAARC *Social Charter* (2004)⁴² affirms that national, local or provincial policies and strategies should aim to bring stabilization in the growth of population in each country, through voluntary sustainable family planning and contraceptive methods, which do not affect the health of women and that all States shall take action to ensure reproductive health. The *Social Charter* is signed by Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka.

- **Pacific regional commitments**

The Pacific region has a *Pacific Regional Strategy on HIV and Other STIs 2009-2013*, endorsed by Pacific island leaders. The Strategy notes the low rates of condom use among young people in the region and that religious beliefs may be interpreted in a way that discourages the use of condoms, which contributes to unsafe sex and unwanted pregnancies. The Strategy states as a principle the need for linkages between HIV, STI, adolescent SRH services and maternal, newborn and child services. A review of the first *Pacific Regional Strategy on HIV and STIs 2006-2009* endorsed by Ministers of Health made the recommendation that countries “strengthen primary prevention, aiming at adolescent and youth population groups at higher risk of transmission through targeted and sustained behaviour change interventions and condom promotion.”⁴³ There is also a *Pacific Policy Framework for Achieving Universal Access to Reproductive Health Services and Commodities, including Condoms 2008-2015*.⁴⁴

- **Western Pacific STI Strategy**

WHO Western Pacific Region Office (WPRO) has developed a *Regional Strategic Plan of Action for the Prevention and Control of Sexually Transmitted Infections 2008-2012*, which encompasses Pacific island states as well as Brunei Darussalam, Cambodia, China, Lao PDR, Malaysia, Mongolia, the Philippines, Republic of Korea, Singapore and Viet Nam.⁴⁵ The Strategy states that development of youth-friendly STI services for adolescents should be a priority. A face-to-face consultation was held in 2007 where 18 countries discussed the Strategy. During the consultation participating countries discussed their individual action plans and ways of achieving the identified priority objectives. For each priority objective, regional targets were agreed upon and indicators were identified as guidance to countries.

Sources:

- 1 States that expressed reservations to the CRC relevant to Articles 2, 3, 6, 7, 12, 13 and 24 were Afghanistan, Brunei Darussalam, Indonesia, Kiribati, Malaysia, Maldives, Singapore and Thailand. See Annex V.
- 2 Article 24: right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.
- 3 Article 3.
- 4 Article 2.
- 5 Article 7.
- 6 Article 6.
- 7 Article 12 and 13.
- 8 Article 16. See: Committee on the Rights of the Child. 2003. *General Comment No. 3, HIV/AIDS and the Rights of the Child*, CRC/GC/2003/3.
- 9 Article 34.
- 10 Committee on the Rights of the Child. 2003. *General Comment 4, Adolescent health and development in the context of the Convention on the Rights of the Child*, CRC/GC/2003/4, para. 21.
- 11 Articles 5 and 14.
- 12 Article 12.
- 13 Committee on the Rights of the Child (CRC). 2013. *General Comment No.15. The Right of the Child to the Enjoyment of the Highest Attainable Standard of Health*, 17 April 2013, CRC/C/GC/15.
- 14 Committee on the Rights of the Child. 2003. *General Comment No. 3 on HIV/AIDS and the rights of the child, Official Records of the General Assembly, A/59/41, Annex IX.*
- 15 Para 14.
- 16 Para 21.
- 17 Para 24.
- 18 Para 31.
- 19 Para 56.
- 20 Para 60.
- 21 Para 69.
- 22 Para 70.
- 23 UN Committee on Economic, Social and Cultural Rights (CESCR). 2000. *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 11 August 2000, E/C.12/2000/4.
- 24 Ibid., paras.14, 21.
- 25 United Nations Committee on Economic, Social and Cultural Rights (CESCR). 1999. *General Comment 13: The Right to Education, Art. 13 of the Covenant*, 8 December 1999, E/C.12/1999/10, paras. 6, 7.
- 26 Article 16.1(e).
- 27 As at 15 August 2013: http://www.ilo.org/dyn/normlex/en/f?p=1000:11300:0::NO:11300:P11300_INSTRUMENT_ID:312327.
- 28 See: <http://www.un.org/millenniumgoals/poverty.shtml>
- 29 United Nations. 2011. *Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS*. A/Res/65/277. New York: UN, Paragraph 25.
- 30 Ibid., paragraph 43.
- 31 Asia-Pacific States participating in the Conference were Afghanistan, Australia, Bangladesh, Bhutan, Brunei Darussalam, Cambodia, China, Cook Islands, Democratic People's Republic of Korea, Fiji, India, Indonesia, Japan, Kiribati, Lao PDR, Malaysia, Maldives, Marshall Islands, Micronesia (Federated States of), Mongolia, Myanmar, Nepal, New Zealand, Niue, Pakistan, Papua New Guinea, Philippines, Republic of Korea, Samoa, Singapore, Solomon Islands, Sri Lanka, Thailand, Tonga, Tuvalu, Vanuatu and Viet Nam. Some States expressed reservations on the ICPD Programme of Action. See Annex V.
- 32 United Nations. 1994. *Report of the International Conference on Population and Development*, Cairo 1994 (A/CONF.171/13), paragraph 7.45.
- 33 United Nations. 2012. *Commission on Population and Development, Resolution 2012/1*. New York: UN, paragraph 7. <http://www.un.org/en/development/desa/population/commission/resolutions/index.shtml>
- 34 United Nations. 1995. *Beijing Platform for Action of the Fourth World Conference on Women*, A/CONF. 177/20 (1995) and A/CONF. 177/20/Add. 1 (1995). New York: UN.
- 35 Paragraph 96.
- 36 Para. 79(f).
- 37 Global Commission on HIV and the Law. 2012. *Risks, rights and health*, New York: UNDP, p. 75.
- 38 ESCAP. 2011. *ESCAP Resolution 67/9: Asia Pacific Regional Review of the Progress Achieved in Realizing the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS*, 27 May 2011. Bangkok: Escap.
- 39 ESCAP. 2002. *Fifth Asian and Pacific Population Conference Plan of Action on Population and Poverty*, ST/ESCAP/2264, 2002. Bangkok: Escap.
- 40 ASEAN. *ASEAN Declaration of Commitment: Getting to Zero New HIV Infections, Zero Discrimination, Zero AIDS-Related Deaths*, 19th ASEAN Summit, Bali, 2011.
- 41 ASEAN. 2010. *Ha Noi Declaration on Enhancement of the Welfare and Development of ASEAN Women and Children*, 17th ASEAN Summit, Ha Noi, 2010.
- 42 South Asian Association for Regional Cooperation (SAARC). 2004. *Social Charter of the South Asian Regional Association for Cooperation*, SAARC/SUMMIT.12/SC.29/27. Islamabad: SAARC.
- 43 WHO and SPC. 2007. *Vanuatu Commitment*. Manila: WHO WPRO.
- 44 Pacific Health Ministers. 2008. *The Pacific Policy Framework for Achieving Universal Access to Reproductive Health Services and Commodities 2008-2015*. Nadi, Fiji.
- 45 WHO. 2008. *Regional Strategic Plan of Action for the Prevention and Control of Sexually Transmitted Infections 2008-2012*. Manila: WHO Western Pacific Regional Office.

Annex V: Declarations and reservations to international instruments

This Annex provides examples of relevant reservations and declarations made by governments that may affect State obligations to address the rights of young people to access SRH and HIV services.

(i) Convention on the Rights of the Child

Afghanistan

The Government reserves the right to express, upon ratifying the Convention, reservations on all provisions of the Convention that are incompatible with the laws of Islamic Shari'a and the local legislation in effect.

Brunei Darussalam

The Government of Brunei Darussalam expresses its reservations on the provisions of the Convention which may be contrary to the Constitution of Brunei Darussalam and to the beliefs and principles of Islam, the State, religion, and without prejudice to the generality of the said reservations, in particular expresses its reservation on articles 14, 20 [foster care] and 21 [adoption] of the Convention.

Indonesia

Reservation: The Constitution of the Republic of Indonesia guarantees the fundamental rights of the child irrespective of their sex, ethnicity or race. The Constitution prescribes those rights to be implemented by national laws and regulations. The ratification of the Convention by the Republic of Indonesia does not imply the acceptance of obligations going beyond the Constitutional limits nor the acceptance of any obligation to introduce any right beyond those prescribed under the Constitution. With reference to the provisions of articles 1, 14, 16, 17, 21, 22 and 29 of this Convention, the Government of the Republic of Indonesia declares that it will apply these articles in conformity with its Constitution.

Kiribati

Reservation: In respect of article 24 paragraphs (b, c, d, e and f), article 26 and article 28 paragraphs (b,c and d), in accordance with article 51 paragraph 1 of the Convention. Declaration: The Republic of Kiribati considers that a child's rights as defined in the Convention, in particular the rights defined in articles 12-16 shall be exercised with respect for parental authority, in accordance with the Kiribati customs and traditions regarding the place of the child within and outside the family.

Malaysia

Reservation: The Government of Malaysia accepts the provisions of the Convention but expresses reservations with respect to articles 1, 2, 7, 13, 14, 15, 28, [paragraph 1 (a)] 37, of the Convention and declares that the said provisions shall be applicable only if they are in conformity with the Constitution, national laws and national policies of the Government of Malaysia.

Maldives

Upon signature & ratification: Reservations: (2) The Government of the Republic of Maldives expresses its reservation to paragraph 1 of article 14 (freedom of religion), since the Constitution and the Laws of the Republic of Maldives stipulate that all Maldivians should be Muslims.

Singapore

Declarations: (1) The Republic of Singapore considers that a child's rights as defined in the Convention, in particular the rights defined in article 12 to 17, shall in accordance with articles 3 and 5 be exercised with respect for the authority of parents, schools and other persons who are entrusted with the care of the child and in the best interests of the child and in accordance with the customs, values and religions of Singapore's multi-racial and multi-religious society regarding the place of the child within and outside the family.

(2) The Republic of Singapore considers that articles 19 (protection from abuse etc.) and 37 of the Convention do not prohibit -

- a. the application of any prevailing measures prescribed by law for maintaining law and order in the Republic of Singapore;
- b. measures and restrictions which are prescribed by law and which are necessary in the interests of national security, public safety, public order, the protection of public health or the protection of the rights and freedoms of others; or
- c. the judicious application of corporal punishment in the best interest of the child.

Reservations: (3) The Constitution and the laws of the Republic of Singapore provide adequate protection and fundamental rights and liberties in the best interests of the child. The accession to the Convention by the Republic of Singapore does not imply the acceptance of obligations going beyond the limits prescribed by the Constitution of the Republic of Singapore nor the acceptance of any obligation to introduce any right beyond those prescribed under the Constitution.

Thailand

Reservation: The application of articles 7 (birth registration), 22 (child refugees) of the Convention on the Rights of the Child shall be subject to the national laws, regulations and prevailing practices in Thailand.

(ii) CEDAW

Bangladesh

Reservation: The Government of the People's Republic of Bangladesh does not consider as binding upon itself the provisions of article 2 (non-discrimination) as they conflict with *Sharia* law based on Holy Quran and Sunna.

Brunei Darussalam

Reservation: Expressed a general reservation regarding "those provisions of the said Convention that may be contrary to the beliefs and principles of Islam, the official religion of Brunei Darussalam".

India

Declaration: With regard to articles 5(a) and 16(1), India declares that it shall abide by and ensure these provisions in conformity with its policy of non-interference in the personal affairs of any Community without its initiative and consent. (Article 5 provides: States shall take all appropriate measures: (a) To modify the social and cultural patterns of conduct of men and women, with a view to achieving

the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women; (b) To ensure that family education includes a proper understanding of maternity as a social function and the recognition of the common responsibility of men and women in the upbringing and development of their children, it being understood that the interest of the children is the primordial consideration in all cases. Article 16(1) provides for equal rights regarding entering into marriage and access to information and material on family planning.)

Malaysia

Reservations were entered with respect to Article 5(a) regarding modifying stereotypical roles of men and women, to eliminate prejudices, customs and practices based on the inferiority or superiority of either of the sexes, Article 16.1(a) (same right to enter into marriage) and 16.2 (nullification of legality for child marriages). The Government of Malaysia declares that Malaysia's accession is subject to the understanding that the provisions of the Convention do not conflict with the provisions of the Islamic Sharia' law and the Federal Constitution of Malaysia. The reservation was made on the basis that the " Government of Malaysia declares that under the Syariah law and the laws of Malaysia the age limit for marriage for women is sixteen and men is eighteen."

Pakistan

Declaration: The accession by [the] Government of the Islamic Republic of Pakistan to the [Convention] is subject to the provisions of the Constitution of the Islamic Republic of Pakistan.

Singapore

Reservation: In the context of Singapore 's multi-racial and multi-religious society and the need to respect the freedom of minorities to practice their religious and personal laws, the Republic of Singapore reserves the right not to apply the provisions of articles 2 and 16 where compliance with these provisions would be contrary to their religious or personal laws.

Thailand

Reservation: The Royal Thai Government does not consider itself bound by the provision article 16. (Article 16 includes the right to "decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights").

(iii) ICPD

Afghanistan

The delegation of Afghanistan wishes to express its reservation about the word 'individual' in chapter VII and also about those parts that are not in conformity with Islamic Sharia.

Brunei Darussalam

According to our interpretation, one aspect of reproductive rights and reproductive health, referring specifically to paragraphs 7.3 and 7.47 and subparagraph 13.14(c) of the Programme of Action, contradicts Islamic law and our national legislation, ethical values and cultural background. My country wishes to place on record its reservation on those paragraphs.

(Paragraph 7.3 includes a definition of reproductive rights and includes "meeting the education and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality" Paragraph 7.47 details the responsibilities of Governments, in collaboration with NGOs, to meet the special needs of adolescents and to establish programmes to respond to those needs. Paragraph 13.14 relates to inclusion in the national sexually transmitted diseases and HIV prevention programme of a component on mass media and in-school education, promotion of voluntary abstinence and responsible sexual behaviour and expanded distribution of condoms.)

(iv) ESCAP 5th Asia and Pacific Population Conference, Plan of Action on Population and Poverty (2002)

The Conference Plan of Action included Section F on reproductive rights and reproductive health and Section G on Adolescent reproductive health.

Australia, China, Indonesia, Iran, Lao, Maldives, Pakistan, Papua New Guinea, the Philippines, Solomon Islands, Viet Nam:

"The delegation [...] reaffirms the ICPD Programme of Action and recognises that its implementation is the sovereign right of each country. We have, therefore, voted in favour of all paragraphs in sections F and G of the official Conference draft Plan of Action, because neither of these paragraphs and sections nor the ICPD Programme of Action promote abortion or underage sex."

Bangladesh

Bangladesh has voted in favour of sections F and G of ICPD.

Cambodia

Cambodia's position is to support ICPD principles and the principles reproductive rights, sovereign right of each country in implementing the ICPD Programme of Action, and the ICPD concept on reproductive right is excluding abortion from family planning. The ICPD concept on abortion is the necessity of safety.

Fiji

Fiji would like to join all other country delegations to reaffirm the Programme of Action of ICDP (sic). In Fiji, abortion is illegal and as such views sections F and G as complementary to its policies on reproductive health.

India

We voted in favour of inclusion of sections F and G because the concerns of reproductive rights and adolescent health are of vital concern for us in the view of the high maternal mortality, of which 8 per cent is unsafe abortion, and the emerging epidemic of HIV and AIDS. So, we do reaffirm the ICPD plan of action, which does not promote abortion or under-age sex.

Malaysia

When Malaysia voted in support of paragraphs F and G in the Plan of Action, the vote signifies that we reaffirm our support for the ICPD Programme of Action. At the same time, we emphasise that the Plan of Action recognises that its implementation is the sovereign right of each country, consistent with national laws and development priorities, with full respect for the religion, ethical values and cultural background of our people. It is also our firm understanding that neither sections F and G in the Plan of Action nor the ICPD Programme of Action promote abortion or under-age sex.

Mongolia

The National Reproductive Health Programme for 2002 and 2006 have already reflected the principles and agreements of ICPD and ICPD+5. Therefore, Mongolia voted for the section F and G. So, we will continue to implement the ICPD Programme of Action.

Thailand

Thailand welcomes the adoption of the Plan of Action of this meeting. We voted in favour of all paragraph in sections F and G, because we believe that these paragraph and sections do not promote either abortion or under-age sex.

Annex VI: Focus group methodology

Focus group discussions (FGDs) were convened in Jakarta (Indonesia), Yangon (Myanmar) and Manila (Philippines). FGDs were conducted in national languages and the transcripts translated for analysis. Male, female and transgender persons aged 18-25 participated in the groups.

The methods employed included the use of a standardized guide, and participatory methods including brainstorming, ranking, and prioritizing. The discussions were transcribed and translated into English. Informed consent and confidentiality procedures were followed.

FGDs were held on the following dates:

Yangon: Wednesday 21 – Thursday 22 November, 2012.

Manila: Saturday 24 – Sunday 25 November, 2012.

Jakarta: Thursday 29 – Friday 30 November, 2012.

For Manila and Jakarta, separate focus groups were convened for (i) males and transgender people, and (ii) females. Transgender people opted to participate in groups with males, the majority of whom were men who have sex with men. Staff of the NGO Youth LEAD co-facilitated the FGDs.

Yangon, Myanmar:

30 people participated in 2 mixed gender groups (one of 13 and one of 17 participants).

Of this total, 14 were male, 12 female and 4 transgender.

Manila, the Philippines:

One group of 5 females.

One group of 10 males and 2 transgender persons.

Included participants from Manila / Luzon, Mindanao, Palawan and Visayas.

Jakarta, Indonesia:

One group of 10 females.

One group of 4 males and 2 *waria* / transgender persons.

Most participants were from Java and Sumatra.

FGDs progressed through three issues over a two-hour period:

1. Services: Identifying the range of HIV services and SRH services (including information and commodities) that young people need.
2. Barriers: Concrete examples and case studies of the access barriers faced by young people.
3. Change: Ideas on how young people can be involved in improving access to services.

In addition to the FGDs, interviews were conducted with the following informants:

- Mara Quesada-Bondad, Executive Director, Action for Health Initiatives (ACHIEVE), Inc., Philippines; and
- Nay Oo Lwin, Program Manager, Population Services International Myanmar Targeted Outreach Program (PSITOP).

Annex VII: References

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To date, there has been no systematic review of how laws and policies govern young people's access to sexual and reproductive health and HIV information and services, and the ability of service providers to ensure these services are available and accessible to young people.

This review aims to do so for the Asia-Pacific region. It assesses criminal laws, laws in relation to age, laws on health and HIV, law enforcement practices, and national policies relating to HIV, SRH and youth. In addition to describing laws, policies and practices that impede access to services, the review highlights examples of laws, policies and practices that are supportive of the rights of young people to access services.

The review also considers the international commitments and obligations of countries in the Asia-Pacific region relating to the rights of young people to the highest attainable standard of health. This includes obligations under international human rights law, and recommendations and commitments relating to young people in international instruments including the Convention on the Rights of the Child, the Programme of Action of the International Conference on Population and Development (ICPD) and the recommendations of the Global Commission on HIV and the Law.

This review is a joint effort between UNESCO, UNFPA, UNAIDS, UNDP and Youth LEAD, the Asia-Pacific Network of Young Key Populations.

