Barriers to Young People's Access to Healthcare

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Contents

A Note on Terminology

While there are no universally accepted definitions, in this report:

- **Children** means people below the age of 18 years old;[1]
- **Adolescents** are defined as individuals between 10 and 18 years old; [2] and
- **Young people** encompass individuals below 24 years old.[3]

Pursuant to international human rights law, in this report:

- **Best interests of the child** broadly refers to that which is best for each individual child, considering the child's views, identity, family environment and relationships, safety, health, education and overall development and well-being.[4] Every child has a right to have their best interests taken into account as a primary consideration in all actions that concern them.[5]
- **Evolving capacities** refers to children's growing abilities and maturity as they age. The term acknowledges children's gradual acquisition of skills, knowledge, and autonomy. The term emphasises the need to balance protecting children from abuse and exploitation with the need to empower each child to make their own choices, based on their age and maturity.[6]
- **Exploitation**, in this report, refers to sex with a child that involves abuse of power, manipulation, or coercion.[7] Exploitation can result from an adult taking advantage of a child's inability to consent to sex. It can also result from sex that involves force, threats, or deceit, including where a person uses their position of power, authority, or trust (e.g., teacher, caregiver, or employer) to pressure a child into sexual acts.

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Context

Too often, the people most in need of health services cannot access them due to stigma, discrimination, gender inequality or harmful laws and policies, including criminalisation.

Since 2020, the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) and the Thomson Reuters Foundation (TRF) have been working together to support young journalists and civil society actors to challenge human rights-related barriers that can prevent marginalised communities from accessing health services. The programme supports journalists to report on these issues with accuracy and authority, and strengthens the communication and media engagement skills of civil society organisations (CSOs) so that they can raise awareness of their work to remove these barriers.

From 2024 - 2026, we are providing training and mentorship to young civil society leaders and journalists in Africa and Asia to address mis- and disinformation around HIV, TB and malaria. Participants will join an alumni network of over 130 young journalists and CSO activists, connecting them to drive change in attitudes, practices and policy.

As part of the partnership between The Global Fund and TRF, TrustLaw facilitated this legal research for community-based and civil society organizations advocating in this space.

This report surveys the legal barriers that adolescents and young people face in accessing (i) HIV prevention and testing services, (ii) sexual and reproductive healthcare, and (iii) harm reduction services, in eight countries: Cameroon, Ghana, Nigeria, South Africa, Indonesia, the Philippines, Thailand, and Kyrgyzstan. The research focuses on the laws which facilitate or hamper access to these healthcare services – the extent to which the laws are enforced falls outside the scope of the research. The legal research focuses on countries, where the laws surrounding young people's access to healthcare and harm reduction have received less attention. Research on another selection of countries is planned to be published in 2025-2026.

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Executive Summary

Young people in Cameroon, Ghana, Nigeria, South Africa, Indonesia, the Philippines, and Kyrgyzstan all face barriers to accessing necessary healthcare services, increasing their risks of acquiring HIV, hepatitis, and other sexually and blood-borne infections, and contributing to numerous social and economic harms. In each country, laws around access to HIV prevention and testing, sexual and reproductive healthcare, and harm reduction services place unnecessary barriers. They restrict access both directly (e.g., by creating a minimum age to independent healthcare access that is not related to maturity and capacity) and indirectly (e.g., through laws around child marriage that allow for sex between individuals under the minimum age of consent to sex). Each country must adapt its laws to reflect the experiences of their young people. Until then, the laws will continue to contribute to unnecessary and preventable negative outcomes, many of which will follow young people into adulthood.

This report analyses the legal barriers that adolescents and young people face in accessing (i) HIV prevention and testing services, (ii) sexual and reproductive healthcare, and (iii) harm reduction services, in Cameroon, Ghana, Nigeria, South Africa, Indonesia, the Philippines, Thailand, and Kyrgyzstan. The research examines the laws which facilitate or hamper access to these healthcare services.

Barriers to Healthcare and Harm Reduction Faced by Young People

HIV, hepatitis, and other sexually transmitted infections (STIs) present significant global public health issues, despite medical advancements in their prevention, diagnosis, and treatment. In 2023, about 1.3 million people newly acquired HIV, while an estimated 39.9 million people were living with HIV.[8] To a significant extent these conditions persist due to health inequities, which leave vulnerable and marginalised populations unable to access healthcare. Young people are among such populations.

Young people face disproportionate rates of HIV. For instance, young people represent a growing share of people living with HIV globally.[9] In 2023, 2.38 million people under 19 years old were living with HIV.[10] That same year, among those under 14 years old, only 66% knew their HIV status and, of those who knew their status, only 86% were receiving treatment.[11] Notably, young people who are exposed to intersectional discrimination face even greater barriers to access to healthcare, and thus higher rates of HIV. For instance, in 2023, global HIV prevalence among individuals between 15 and 49 years old was 9.2% higher among transgender individuals; 7.7% higher among gay men and other men who have sex with men; and 5% higher among people who inject drugs.[12] That same year, 44% of all new HIV infections globally were among women and girls of all ages.[13]

Young people living with HIV bear the physical and psychological burdens associated with their health condition. The stigma, which contributes to anxiety, other mental health conditions, and social isolation, further deters and prevents young people from accessing the support and treatments they need.[14] This stigma can also contribute to missed school and work, which disrupt future opportunities.[15] HIV is one of the leading causes of death among young people globally.[16]

Countries must ensure that their laws balance protecting adolescents from abuse and exploitation while recognising their evolving capacity to make informed choices. As adolescents explore their identity and sexuality, they require guidance and autonomy, consistent with their evolving capacities, necessary to protect and promote their health.[17] A failure to recognise and balance their ongoing vulnerability with their growing maturity only increases the risk of harm. For instance, when young people engage in consensual sex but are prohibited by law from doing so, they may be less likely to approach healthcare for fear of punishment.

Countries that do not set a minimum age at which young people are deemed capable of consenting to sex – or set the minimum age of consent too low – leave young people vulnerable to exploitation by adults. Conversely, countries that set a high minimum age of consent to sex (i.e., above the average age at which young people engage in sex) may punish and criminalise young people who have the capacity to engage in consensual sex. They discourage young people from accessing necessary healthcare, such as contraceptives and testing. The criminalisation of same-sex sexual activity and drug use, as well as the failure to recognise and protect gender diversity, can have the effect of barring young people from essential care. Laws that require parents or guardians to be involved in their children's healthcare – either by requiring such adults to consent to healthcare or by giving those adults access to children's healthcare information – also prevent young people from accessing services.

Notably, laws must protect against harmful social and cultural norms that disproportionately affect adolescent girls and young women. Countries that allow individuals to be married before 18 years old, or that allow girls to be married before 18 years old, contribute to child marriages which often lead to adolescent pregnancies. Adolescent pregnancies contribute to negative health outcomes for both the mother and the child, as the mother's body is not yet developed for childbirth.[18] Complications in pregnancy and childbirth are among the leading causes of death among girls aged 15 to 19 years old.[19] Adolescent pregnancies also contribute to increased school dropout rates among girls, further limiting access to sexual and reproductive health information, future employment opportunities, and economic independence.[20]

Young People's Rights to Healthcare and Harm Reduction

A response to human rights-related barriers, as well as cultural, social, and economic barriers to the fulfilment of the right to health is crucial to eliminating HIV and related harm among young people. It centres a response on key marginalised and vulnerable populations and provides a standard against which, and a mechanism by which, to hold governments accountable to their promises.

The right to health is broadly recognised in international and regional human rights instruments.[21] It is viewed as central to the enjoyment of all rights. In other words, human rights law recognises that the enjoyment of the highest attainable standard of health is indivisible from the protection of all other rights, including the right to education, work, freedom from discrimination, and beyond. To protect and promote this right, states must ensure that health facilities and services are available to all without discrimination, in sufficient quantity and quality. They must adopt legislative measures to fully realise the right.

Accordingly, states must ensure that young people have access to necessary healthcare services, including sexual and reproductive healthcare and harm reduction services.[22] To do so, states must establish flexible age-based considerations in law that protect adolescents' special vulnerability, while recognising their evolving capacity to make their own informed decisions.[23] In other words, legal age restrictions must enhance protection for choices that adolescents do not yet have the capacity to fully understand, or from being taken advantage of by a power imbalance.[24] However, where adolescents have the capacity to understand their choices and take decisions, their right to do so, independent of a parent or guardian, must be protected.[25]

In practice, states must establish comprehensive sets of legal protections which complement each other, and do not leave room for abuse. For instance, international organisations, such as the United Nations Children's Fund (UNICEF), explain that states must not establish a minimum age of consent to sex that is higher than the minimum age of marriage, as that would allow marriage to act as a loophole to the minimum age of consent to sex.[26] The World Health Organization (WHO), among others, confirms that states must also decriminalise behaviours in which young people engage, to reduce harm and increase access to healthcare without fear of punishment. Specifically, states must decriminalise consensual sex between young people close in age, same-sex sexual activity, and drug use.[27] Finally, WHO also confirms that states must implement laws that promote equality and eliminate discrimination, to ensure that young people have access to healthcare regardless of gender, sexual orientation, gender identity, or drug use.[28]

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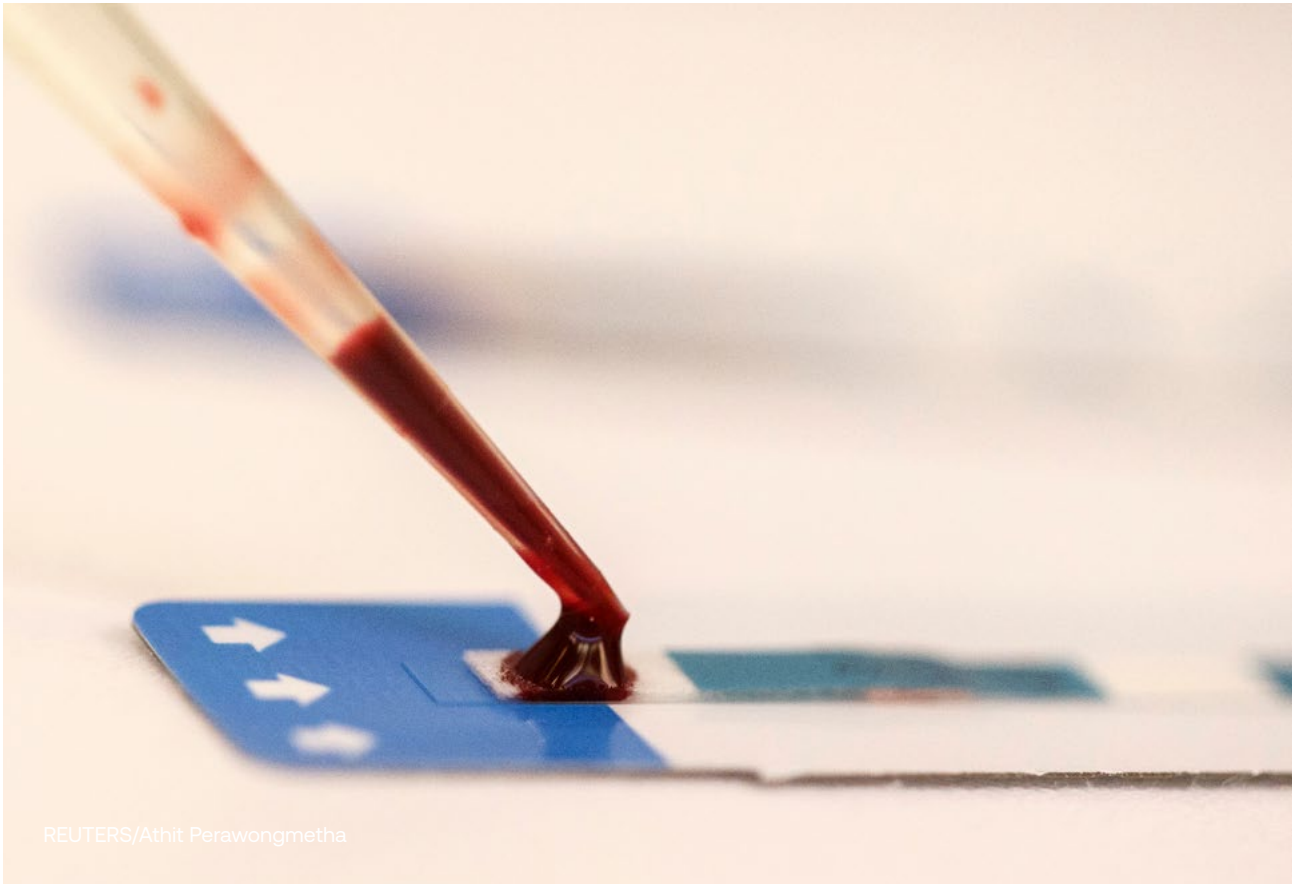
Findings



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1. Access to HIV Prevention and Testing

Access to PrEP and PEP

Pre-Exposure Prophylaxis (PrEP) and **Post-Exposure Prophylaxis (PEP)** are sets of antiretroviral drugs that prevent the transmission of HIV. PrEP prevents HIV transmission when taken regularly by individuals who are *not* living with HIV.[29] When taken daily, PrEP has been shown to significantly reduce the risk of transmission.[30] PEP prevents HIV transmission when taken *after* a possible exposure to HIV.[31] When taken as recommended, PEP has been shown to reduce the risk of HIV transmission by more than 80%.[32] PrEP and PEP are thus crucial for reducing HIV incidence and promoting sexual health and well-being among young people, particularly those who are at an increased risk of HIV transmission.

States' obligations under **human rights law** have been interpreted to require the provision of PrEP and PEP to everyone who is at risk of HIV acquisition, regardless of age, gender, sexual orientation, or other characteristic.[33] Both PrEP and PEP must be provided to young people, on a confidential basis, including against parents or guardians. PrEP and PEP must be provided based on informed consent, and thus must be available to individuals capable of understanding the implications of receiving the treatment and of making informed decisions concerning their healthcare. PEP must be available immediately following a potential HIV exposure, such as following a sexual assault or sex without adequate contraception.

Access to PrEP and PEP

Consistency with human rights norm: **consistent** | **some consistency** | **inconsistent**

COUNTRY	PRE-EXPOSURE PROPHYLAXIS	POST-EXPOSURE PROPHYLAXIS
Thailand	Accessible if at risk	Accessible if at risk
Ghana	Parent involvement until 15 years old unless mature	Accessible if at risk
Nigeria	Parent involvement until 18 years old or marriage	Accessible if at risk
Indonesia	Inaccessible until 17 years old	Accessible if at risk
South Africa	Parent involvement until 18 years old unless mature	Parent involvement until 12 years old
Kyrgyzstan	Parent involvement until 16 years old	Parent involvement until 16 years old
Cameroon	Parent involvement until 21 years old	Parent involvement until 16 years old
Philippines	Inaccessible	Inaccessible

Among the **countries** surveyed in this report, **Thailand** is the country that comes closest to the human rights standard. In Thailand, young people can independently access PrEP, even under 18 years old, if they are found to be at risk of acquiring HIV.[34] People who are considered to be at risk of acquiring HIV include people who use drugs, people who have repeatedly been treated for STIs, or people who are known to be in relationships with people living with HIV. Similarly, young people can access PEP without parent or guardian consent at any age.[35] In practice, however, some healthcare providers may require people under 18 years old to obtain parent or guardian consent to access PrEP or PEP, particularly if the young person does not appear to have the capacity to make decisions regarding their own healthcare.[36]

Ghana, South Africa, Kyrgyzstan, Nigeria, and Cameroon all set minimum ages below which young people need parent or guardian consent to access PrEP and/or PEP. In these countries, young people may be missing opportunities to prevent the transmission or acquisition of HIV due to a reluctance among young people to approach parents or guardians regarding their sexual activity.

Ghana sets the lowest minimum age for independent access. The law states that sexually active young people who are at risk of acquiring HIV – for instance, by being in a relationship with a person who is living with HIV or by having a history of PEP use – must have access to PrEP *unless* the person weighs less than 35 kg or is under 15 years old and has not met the requisite maturity level.[37] PEP, however, is independently accessible to any person, regardless of their age, if they have potentially been exposed to HIV.[38]

In **South Africa**, the decision to provide PrEP to adolescents under 18 years old depends on their ability to provide informed consent, assessed based on maturity and understanding of the medication's risks and benefits.[39] While parental or guardian consent is generally required for adolescents under 18, it may be waived if the adolescent is deemed capable of providing informed consent independently. PEP is accessible to adolescents of any age, but parental consent is required for those under 12 unless they are considered mature enough to understand the implications and provide informed consent.[40] The discretion, while flexible, can lead to inconsistent practices across service providers.

In **Kyrgyzstan**, the minimum age at which young people can access PrEP and/or PEP without parent or guardian consent is 16 years old, regardless of the person's capacity to make informed decisions.[41]

In **Nigeria**, the minimum age at which young people can independently access PrEP is even higher, at 18 years old.[42] The minimum age requirement can, however, be waived if the person requesting PrEP is married. PEP, however, is independently accessible to all, regardless of age.[43]

In **Cameroon**, barriers to access PrEP and PEP are highest, as the minimum age to independently access PrEP and/or PEP is 21 years old.[44] Thus, individuals under 21 years of age must ask their parents to obtain highly effective HIV prevention medications, even though they can consent to sex at 16 years old (see below).

In **Indonesia**, PrEP is only available to people over 17 years old who are also 'at risk.'[45] 'At risk' individuals include people who are in relationships with people living with HIV, who have had recurring STIs, or who use drugs. While young people under 17 years old cannot access PrEP, even with parent or guardian consent, individuals over 17 years old can access PrEP independent of their parents or guardians. PEP is generally accessible to young people in Indonesia, particularly among people who have survived sexual assault.

Finally, in the **Philippines**, access to PrEP and PEP is not protected in law or policy for individuals of any age.[46] PrEP and PEP are mostly administered by community organisations in the Philippines, who partner with the Department of Health to improve access throughout the country.[47] The law fails to facilitate further access to young people.

Access to Effective HIV Testing

Effective **HIV testing** for young people involves healthcare providers who are trained to work with young people, and pre- and post-test counselling.[48] Pre-test counselling refers to education about the testing process and the meaning of results, as well as obtaining informed consent. Pre-test counselling also often covers the benefits of knowing one's HIV status and dispels fears and misconceptions about the health condition. Post-test counselling for individuals who test negative for HIV covers advice on risk reduction. Post-test counselling for individuals who test positive for HIV includes emotional support, information on treatment options, and linkage to care. Counselling allows individuals to come to terms with the fear, guilt, and stigma that may accompany their results, and develop strategies to treat their condition.[49]

HIV testing that is consistent with **human rights law** is accessible and confidential to all, regardless of age, gender, sexual orientation, or any other characteristic.[50] Specifically, young people must have access to HIV testing that does not depend on parent, guardian, or spouse consent. Young people must receive their test results directly – and parents, guardians, or spouse must only receive results with young people's informed consent.[51] A young person's privacy must be protected at all times. Young people who test positive for HIV must be provided with prompt referral to youth-friendly treatment and care.

Access to HIV Testing

Consistency with human rights norm: **consistent** | **some consistency** | **inconsistent**

COUNTRY	MINIMUM AGE FOR INDEPENDENT ACCESS	DIRECT REPORTING TO TESTED PERSON
South Africa	12 Years old (unless capacity younger)	Yes (if capacity for testing)
Thailand	18 Years old (unless capacity younger)	Yes (if capacity for testing)
Indonesia	None	Yes (except if positive results and under is years old)
Philippines	None	Only if over 15 years old (with exceptions)
Kyrgyzstan	14 Years old	Only if over 18 years old
Ghana	16 Years old (some exceptions)	Only if over 16 years old
Nigeria	18 Years old	Only if over 18 years old (with exceptions)
Cameroon	21 Years old (unless married)	Only if over 21 years old (unless married)

Among the **countries** considered in this report, Thailand and South Africa alone approach the human rights standard. Specifically, in **Thailand**, young people of any age can access HIV testing without the need to first obtain parent or guardian consent, if they can understand the process and the implications of the testing themselves.[52] Only people who do not reach that capacity threshold need parent or guardian consent, if they are under 18 years old. The law states that individuals who are capable of consenting to HIV testing should have their results communicated directly to them.[53] HIV test results will only be communicated to parents or guardians if the individual tested is not able to understand the results, to the extent that doing so is in the best interest of the individual tested. Similarly, in **South Africa**, people at any age can consent to HIV testing.[54] People under 12 years old must demonstrate that they have the maturity and ability to understand the benefits, risks, and implications of a test. Furthermore, individuals who can consent to HIV testing themselves have a right to confidentiality and to have their HIV test results reported directly to them.[55] Healthcare providers have no obligation to inform parents or guardians of test results.

In Ghana, Kyrgyzstan, Indonesia, and the Philippines, the laws introduce significant barriers to HIV testing for young people. For instance, in **Ghana**, individuals can only independently access HIV testing if they are over 16 years old.[56] In some cases, individuals under 16 years old may be able to obtain HIV testing without parent consent if the healthcare providers find that such would be in the best interest of the person being tested. What is 'in the best interest' is not clearly defined, which means that healthcare providers have significant discretion and control over a young person's access to testing. The law states that any person who receives a positive result must undergo counselling and receive information on treatment.[57] Results must be kept confidential, except for people under 16 years old, whose parents receive the results.[58]

In **Kyrgyzstan**, the law also establishes a minimum age under which individuals must obtain parent or guardian consent to access HIV testing. While the general age at which an individual can access healthcare independently is 16 years old, in the case of HIV testing, the minimum age of independent access is 14 years old.[59] The law states that test results must be provided directly to the person tested during post-test counselling.[60] However, people under 18 years old must be accompanied by either a child psychologist, a parent, or a guardian, which may have the effect of undermining confidentiality.

In both Indonesia and the Philippines, individuals at any age may be tested for HIV with or without parent or guardian consent. Yet, the law does not protect the confidentiality of results for individuals under a certain age, which undermines the accessibility that the lack of minimum age for testing would otherwise guarantee. Specifically, in **Indonesia**, the law states that people as young as six years old may receive their test results directly.[61] However, the law requires parents of young people under 15 years old, who test positive to also undergo HIV testing. Thus, direct reporting only occurs for people who are over 15 years old, which is often carried out by a psychologist.[62] Moreover, independent access to treatment is only available after an individual turns 18 years old, which may contribute to delayed treatment.[63] In the **Philippines**, the law requires direct reporting for individuals who are over 15 years old.[64] Individuals who are under 15 years old may, however, have their test results communicated to their parents or guardians. Exceptionally, individuals who are under 15 years old may have their test results communicated directly if they consented to the testing themselves, are pregnant, or are involved in 'high risk behaviours,' which is not clearly defined by law.[65]

HIV testing is most restricted in Nigeria and Cameroon, where inflexible and high age limits require young people to obtain parent or guardian consent for access. In **Nigeria**, young people require parent or guardian consent to access HIV testing until they are 18 years old, unless they are married, pregnant, or a parent.[66] In exceptional circumstances, young people who can demonstrate sufficient maturity, or who are sexually active, may be able to access HIV testing independently. Young people under 18 years old will only have their testing results directly reported if they are considered mature, and are deemed capable of dealing with the implications.[67] In **Cameroon**, individuals under 21 years old must have parent or guardian consent to access HIV testing, unless they are married. The law does not guarantee privacy and confidentiality of test results to individuals under 21 years old.

REUTERS/Siphiwe Sibeko

2. Access to Sexual and Reproductive Health

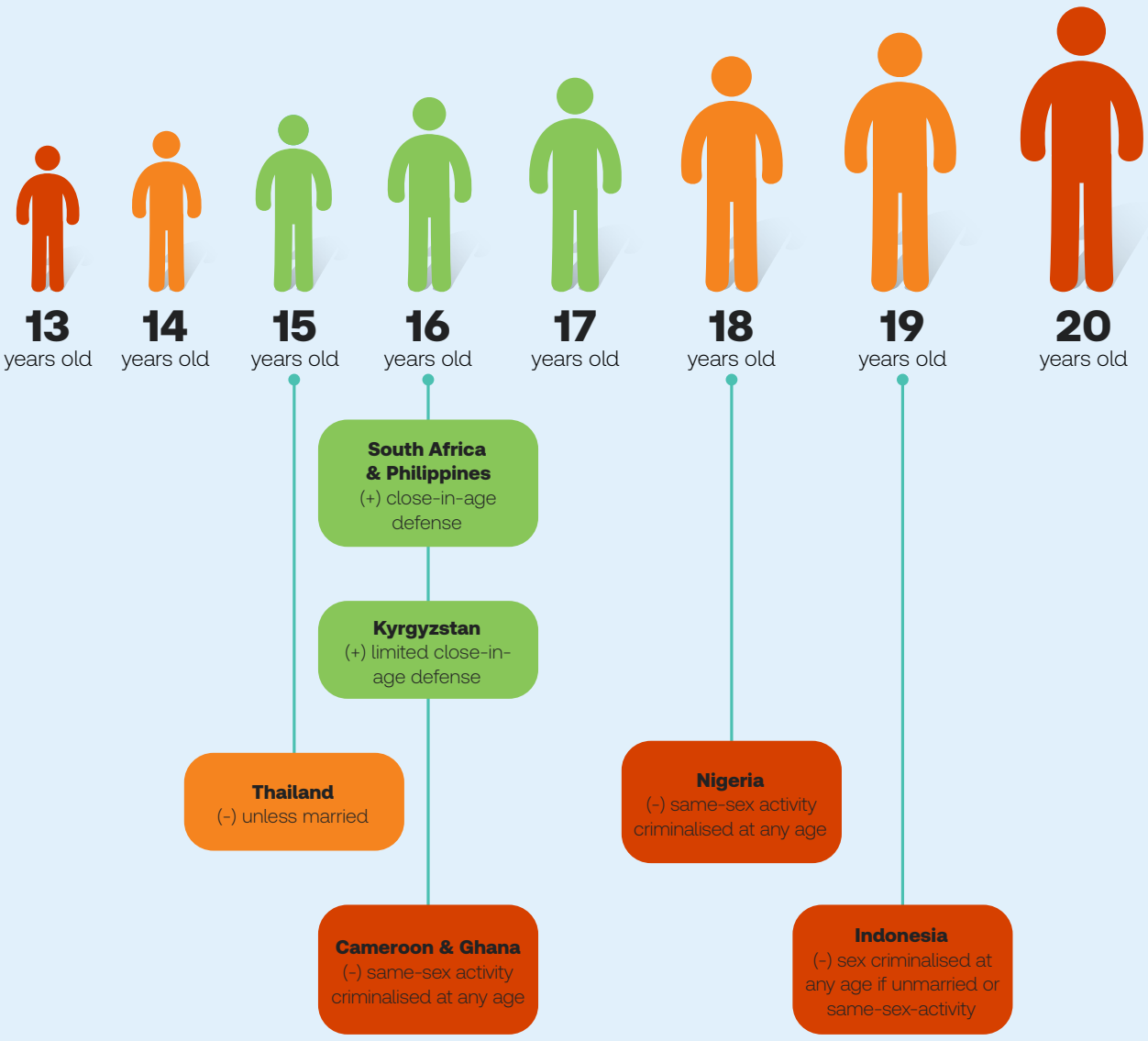
Minimum Age of Consent to Sex

The **minimum age of consent to sex** is the minimum age at which a young person is deemed capable of consenting to sex in law.[68] Individuals who engage in sex with individuals under the minimum age of consent to sex are deemed to have engaged in non-consensual sex and are therefore criminally liable. The aim of the minimum age of consent to sex is to prevent individuals from abusing their authority over young people and engaging in activity that adolescents may not yet have the capacity to understand. The aim is *not* to prevent sex among young people who have the capacity to understand sex and its implications, and thus to engage in sex with consent. When appropriately set, the minimum age of consent to sex helps to protect young people's health.[69]

Pursuant to **human rights law**, states must establish a legal minimum age of consent to sex, below which a person is deemed incapable of consenting to sex.[70] The legal minimum should be set at or around the age at which people become sexually active, and must not differ based on gender or sexual orientation.[71] A specific age is not stipulated in human rights law, but 13 years old is considered too low, according to the United Nations Committee on the Rights of the Child.[72] Additionally, states must not criminalise consensual sex between two individuals below the minimum age, unless one person is significantly older than the other, or uses power, threats, or some other form of pressure over the other.[73] States should establish 'close-in-age' defences, such that consensual sex is not criminalised between people who are close in age, even if only one is above the legal minimum age of consent to sex.[74]

Minimum Age of Consent to Sex

Consistency with human rights norm: **consistent** | **some consistency** | **inconsistent**



Among the **countries** in this report, South Africa and the Philippines come closest to the human rights standard. In **South Africa**, the minimum age of consent to sex is 16 years old regardless of gender or sexual orientation.[75] The law in South Africa avoids criminalising sex between adolescents under the minimum age of consent, or between adolescents who are close in age. Specifically, the law allows for sex between individuals who are both over 12 years old and under 16 years old, and allows for sex between individuals under 16 years old and either 17 or 18 years old, as long as they are not more than two years apart in age.[76] The law deems that individuals under 12 years old are not capable of consenting to sex, meaning that sex with anyone under 12 years old is criminalised.[77]

Similarly, in the **Philippines**, the minimum legal age to consent to sex is 16 years old, regardless of gender or sexual orientation.[78] A close-in-age defence exists such that when one individual is less than 16 years old, criminal liability will not result if the age difference between the individuals is less than three years, and the sex is otherwise consensual.[79] Sex between two individuals between 13 years old and 16 years old is not criminalised or otherwise punished. Much like South Africa, an individual who is not yet 13 years old is deemed incapable of consent to sex. Unlike South Africa, however, sex between a person who is under 13 years old and someone who is under 16 years old will not lead to criminalisation, but will lead to civil penalty. In such cases, adolescents are often required to undergo 'intervention programmes.'[80] Those programmes may include counselling, education on sexual and reproductive health, and life skills training, to which a parent or guardian must consent.[81] These programmes may deter adolescents from accessing necessary services, for fear of their sexual activities being exposed to their parents or guardians.

Kyrgyzstan is close to the human rights standard, except for an incomplete close-in-age defence. Specifically, in Kyrgyzstan, the law establishes a minimum age of consent to sex of 16 years old, regardless of gender or sexual orientation.[82] The law provides that individuals who are 18 years old or less can engage in consensual sex with individuals who are 16 years old or less.[83] That close-in-age defence is limited in that it does not provide an absolute minimum age below which an individual cannot consent to sex (i.e., 12 years in South Africa and 13 years in the Philippines). The law thus leaves young adolescents, who may not be capable of consent, vulnerable to exploitation by individuals who are 18 years old or less.

The remaining countries fall further from the human rights standards by over-criminalising sex between young people, or by failing to protect adolescents from exploitation. For instance, in **Cameroon**, the legal minimum age of consent to sex is set at 16 years old regardless of gender, but not regardless of sexual orientation.[84] The law criminalises same-sex sexual activity, and imposes harsher penalties on people who engage in same-sex activity with people below the minimum age of consent to sex (compared to those who engage in heterosexual acts).[85] The law also fails to protect individuals who are just past the minimum age from criminal liability if they have consensual sex with someone who is close in age.

In **Ghana**, much like in Cameroon, the age of consent to sex is 16 years old, without a close-in-age defence, and with the criminalisation of same-sex behaviour.[86] Ghana's Parliament has also reintroduced a bill that, if enacted, would significantly increase criminal penalties for consensual same-sex conduct.[87]

In **Nigeria**, most states and the Federal Capital Territory have made the minimum age of consent to sex 18 years old, which may capture adolescents who are engaging in consensual, non-exploitative

sex.[88] The law applies equally to boys and girls, but does not apply to same-sex activity, which is criminalised.[89] The law also criminalises activity between young people who are close in age. For instance, a 19 year old individual who has consensual sex with a 17 year old individual can be held criminally liable.

In **Thailand**, the minimum age of consent to sex is 15 years old, regardless of gender or sexual orientation.[90] The law fails to provide a close-in-age defence, such that an adolescent who is 16 or 17 years old may be held criminally liable for consensual sex with an individual who is 15 years old. The protection that the law can provide to adolescents is also severely weakened by an exception provided to individuals who are married. That is, adolescents under 15 years old who are married are deemed to have the capacity to consent to sex with their spouse.[91] Marriage can thus be used to subvert the minimum age of consent to sex.

Finally, in **Indonesia,** the law criminalises sexual activity with individuals under 18 years old.[92] Additionally, Law No. 1 of 2023, which will come into force in 2026, will criminalise all sexual activity outside of marriage, regardless of age.[93] As a result, legal sexual activity will effectively be tied to the legal age of marriage, 19 years old (with parent consent).[94] Young people may be deterred from seeking sexual and reproductive healthcare due to fear of criminal or social consequences – even though prosecution for sex outside of marriage typically requires a complaint to be filed by a family member of one of the parties involved, along with supporting evidence.

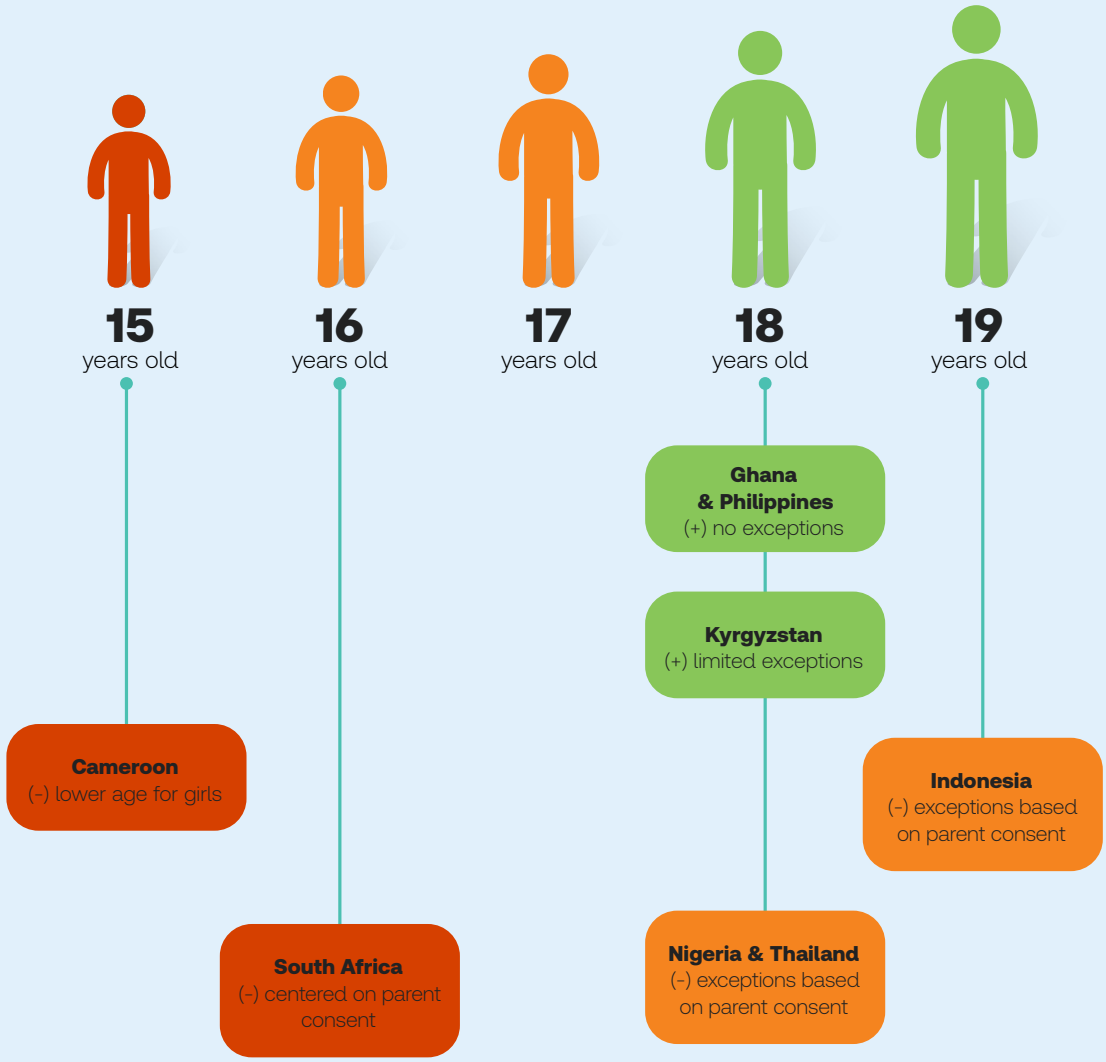
Minimum Age of Marriage

The **minimum age of marriage** refers to the age at which a young person can be married in law, with or without parent or guardian consent. A marriage involving an individual under the minimum age of marriage will usually have no legal effect.[95] The aim of the legal provision is to prevent child marriage, which has a disproportionate impact on adolescent girls and young women and perpetuates gender disparities.[96] Child marriages are associated with early pregnancies which have severe health risks for mother and child, and which contribute to less education among girls, limiting future economic independence.[97] Education that is cut short also contributes to less knowledge about sexual and reproductive health, as schools are often the vehicle through which people obtain that vital knowledge.[98]

Pursuant to **human rights law,** states must set a legal minimum age of marriage for both girls and boys at 18 years old, with or without parent or guardian consent.[99] On an exceptional basis, states may allow individuals as young as 16 years old to marry. However, such marriages must only be permitted by courts of law, based on the full, free, and informed consent of the individuals to be married.[100] Parent and/or guardian consent must never be the basis for marriage concerning individuals below 18 years old. Marriages involving individuals under the legal minimum age should have no legal effect.[101]

Minimum Age of Marriage

Consistency with human rights norm: **consistent** | **some consistency** | **inconsistent**



Among the **countries** in this report, Ghana and the Philippines alone meet the human rights standard, by providing a minimum age of marriage of 18 years old for both boys and girls.

In **Ghana**, girls and boys must be at least 18 years old to be married with parent or guardian consent, and at least 21 years old to be married without parent or guardian consent.[102] Similarly, in the **Philippines**, any marriage involving an individual under 18 years old is void from the beginning.[103] Individuals must obtain parent or guardian consent if they are between 18 and 21 years old, after which parent or guardian consent is not needed.

In **Kyrgyzstan**, individuals must also be at least 18 years old to be married, with or without parent or guardian consent.[104] Individuals under 18 years old may request a one-year reduction to the legal minimum from local governments for 'valid reasons.' 'Valid reasons' are not defined but usually entail a pregnancy or the birth of a child.[105] Kyrgyzstan falls short of meeting the human rights standard by

allowing local governments, rather than courts of law, to approve or deny marriages under the legal minimum age.

The remaining countries allow for child marriage, by either setting the absolute minimum age of marriage below 18 years old and/or by allowing parents or guardians to consent to marriages concerning individuals below 18 years old (rather than basing such marriages on young people's consent).

In **South Africa**, individuals can be married at 16 years old if they have parent or guardian consent, or through a court of law, if a parent or guardian refuses or cannot be found.[106] Moreover, a government minister or public service officer can authorise the marriage of a girl under 15 years old and a boy under 18 years old if they consider the marriage to be desirable, which is not clearly defined.[107] The law thus fails to restrict marriages involving children to exceptional circumstances and centres the legitimacy of such marriages on the consent of the parents, guardians, or governments, rather than the individuals to be married.

In **Cameroon**, the law also allows for marriage of girls at a younger age than boys. In criminal law, marriages of boys and girls under 18 years old are prohibited, and young people between 18 and 21 years old can only be married with parent or guardian consent.[108] However, civil law allows for marriages of 15 year old girls, with parent or guardian consent, or less than 15 years for 'compelling motives.'[109] 'Compelling motives' are not defined. These provisions weaken the protection offered by criminal law against child marriage, and promote inequity by providing for a younger age limit for girls than boys.

In **Nigeria,** individuals must be at least 18 years old to be married, with parent or guardian consent, and at least 21 years old, without parent or guardian consent.[110] The law is weakened by the constitutional protection of Islamic and customary law which allow for marriage of younger individuals.[111] For instance, in Islamic law, a child under 18 years old can be married if they have parent or guardian consent.

Similarly, in **Thailand**, individuals must be at least 18 years old to be married with parent or guardian consent.[112] Individuals can only be married without parent or guardian consent at 21 years old, unless they are over 18 years old, cannot obtain consent, and apply to the courts. As in Nigeria, the law allows for exceptions to the minimum age of marriage which is not centred on a young person's consent. For instance, with the consent of parents or guardians, courts can allow for marriages of individuals under 18 years old for 'appropriate reasons,' which includes a long period of cohabitation.[113] Courts can also allow the marriage of individuals under 18 years old, if a woman has become pregnant.[114]

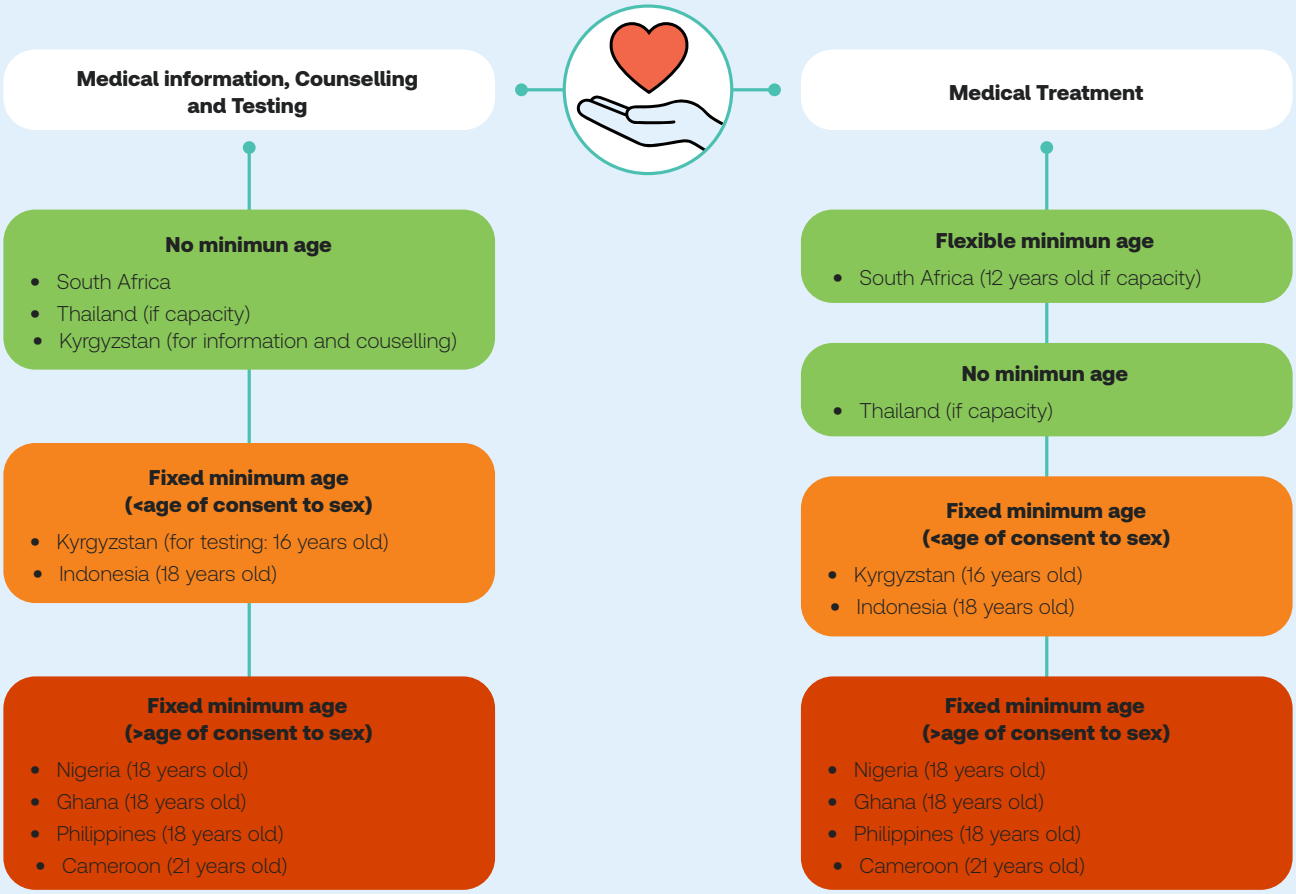
Finally, in **Indonesia**, the minimum age of marriage is 19 years old, with parent or guardian consent, and 21 years old, without parent or guardian consent.[115] Exceptions to the age requirement are permitted through court dispensation for 'urgent reasons,' such as pregnancy or prolonged cohabitation.[116] While the dispensation process requires parental request and court approval, the law does not specify an absolute minimum age for marriage. This absence raises concerns about child marriage, especially in cases where early marriage is used to legitimise relationships that would otherwise be criminalised under sex outside marriage provisions.

Minimum Age of Independent Access to Healthcare

The **minimum age of independent access to healthcare** refers to the age at which young people can access healthcare information, counselling, testing, treatment and other services without the authorisation or accompaniment of a parent or guardian.[117] While parents and guardians are typically responsible for the healthcare of their children, as their children evolve and develop the ability to make more mature decisions concerning their lives, young people must have independent access to confidential and private healthcare.[118] The need is particularly acute in the context of sexual and reproductive healthcare, where young people may be deterred from seeking necessary care to avoid outing themselves to their parents or guardians, as sexually active or of a particular gender identity or sexual orientation, which may result in negative consequences within their family, community, or more broadly.

Minimum Age of Independent Access to Healthcare

Consistency with human rights norm: **consistent** | **some consistency** | **inconsistent**



Human rights law requires that no young person be deprived of access to healthcare.[119] With respect to sexual and reproductive healthcare, access must be granted to young people without the need for parent or guardian authorisation and/or accompaniment. Specifically, young people of all ages must have access to medical information, counselling and testing on a confidential basis, even from parents or guardians.[120] A minimum age of independent access to confidential medical treatment may be set – however, that minimum age should not be higher than the minimum age of consent to sex, and young people should be able to overcome the minimum age requirement by demonstrating sufficient capacity to form informed views about the treatment and consent to the medical treatment themselves.[121] Such a capacity will be based on an individual's age, maturity, and in accordance with their evolving capacity.[122]

Among the **countries** in this report, only South Africa and Thailand approach the human rights standard, by allowing young people to access medical information, counselling, and testing without the need for parent or guardian consent.

In **South Africa**, there is no minimum age for young people to independently access sexual and reproductive healthcare information, counselling, and testing. Instead, the law states that young people must be at least 12 years old, and demonstrate sufficient maturity and mental capacity to understand the benefits, risks and implications of the treatment, to independently access medical treatment.[123] The minimum age thus provides flexibility in allowing children, including those who fall below the minimum age of consent to sex (16 years old), to access healthcare treatment without involving their parents or guardians. The law is strengthened by protecting confidentiality from parents and guardians where young people are able to consent to their own healthcare. That is, where a young person is capable of consenting to their own treatment, healthcare providers have a duty of confidentiality towards the young person.[124] Healthcare providers may not share the young person's information with anyone, including the young person's parents or guardians, unless the young person consents to such. Conversely, the parents or guardians of children under 12 years old can obtain their children's medical information upon request (except regarding a pregnancy termination, which requires the child's consent).

In **Thailand**, the law does not specify a minimum age at which young people can access healthcare services without the involvement of their parents or guardians.[125] In practice, people under 18 years old usually need parent or guardian authorisation to access healthcare if they are incapable of understanding the healthcare information that is needed to provide consent.[126] In other words, independent access to healthcare is provided to people under 18 years old who have the capacity to consent. The law falls short of the human rights standard, however, in its ambiguity. The law grants healthcare providers a large degree of discretion in determining whether parent or guardian consent is required in any particular case, which leaves children vulnerable to personal biases or beliefs of healthcare practitioners. For young people who are able to access healthcare independently, the law protects their confidentiality from their parents or guardians.[127] Their health information may be shared with their parents or guardians only with their consent, or if there is a 'vital interest,' such as the young person no longer having the capacity to consent.

Similarly, in **Nigeria**, the law does not delineate the age at which individuals can independently access healthcare. However, the *Code of Medical Ethics* states that healthcare for people under 18 years old requires the consent of 'next of kin,' which usually means a parent or guardian.[128] As in Thailand, the legal ambiguity around age of access to healthcare services means that healthcare providers have a final say

in what services to provide to whom, and many service providers have a bias towards obtaining parent or guardian consent. The law also fails to meaningfully protect confidentiality. That is, the law states that health information must be confidential, except upon the request of a parent or guardian.[129]

The remaining countries pose greater barriers to independent access to healthcare. They set minimum ages where none are warranted, and/or set rigid and high minimum ages to healthcare.

In **Kyrgyzstan**, the law states that people under 16 years old need parent or guardian consent to obtain treatment.[130] An exception is made for individuals accessing sexual and reproductive health information.[131] Health information for individuals under 16 years old (the same as the legal minimum age of consent to sex) *must* be provided to parents or guardians following examination or treatment.[132] Thus, young people cannot access healthcare of any kind independently or with confidentiality, even if they have the maturity and capacity to make their own healthcare decisions.

In **Ghana**, people under 18 years old must obtain parent or guardian consent in order to access healthcare of any kind, regardless of their maturity or capacity.[133] Young people can thus only access healthcare independently two years after they can consent to sex (16 years old). While the law provides for the protection of every person's health information, with limited exceptions, the parent or guardian consent requirement to obtain healthcare defeats much of the confidentiality owed to people under 18 years old.[134]

Similarly, in the **Philippines**, individuals must be at least 18 years old to access healthcare services independent of parents or guardians, which is two years above the minimum age of consent to sex (with an exception for HIV testing, discussed below).[135] Young people who have children or who have experienced miscarriages are exempt from the 18 year old threshold.[136] The law protects privacy and confidentiality of health information of young people, but allows for parents to request that information.[137] Like in Ghana, the fact that young people must obtain parent or guardian consent to access healthcare significantly weaken confidentiality protections for young people.

In **Indonesia**, an individual must also be 18 years of age to access healthcare (including information, counselling, testing, or treatment) without the consent of their parents or guardians.[138] Married young people may also access healthcare without parent, guardian, or spouse consent.[139] The minimum age of marriage is set at 19 years of age, so in most cases marriage does not improve access to healthcare. However, as younger marriages are exceptionally allowed, including for pregnancy, marriage may afford some young people greater independent access to vital healthcare services. Notably, the law does not protect the health information of individuals under 18 years old. The law states that the health information for individuals under 18 years of age is their parents' or guardians' (but not their spouses'), meaning parents or guardians have access and control over their children's health information.[140]

Cameroon has established the highest age of independent access to healthcare among the countries in this report. Individuals must be at least 21 years old to access healthcare services of any kind without parent or guardian consent, unless married.[141] Spousal consent is not legally required to obtain healthcare services. However, many married people believe they must obtain their spouse's consent before obtaining sexual and reproductive healthcare, such as contraceptives.[142] Although, the law states that young people's privacy must be protected,[143] by virtue of young people's need to obtain parent or guardian consent to obtain healthcare, parents or guardians will have access to their health information.

Sexual and Reproductive Health Interventions

(i) Contraceptives

Contraceptives are methods of preventing or delaying pregnancy, allowing people to control the number of children they have and the time at which they have those children.[144] Certain types of contraceptives also prevent HIV and other STI transmission. Contraceptives thus play a critical role in providing young people with control over their reproductive and sexual health, promoting health and well-being, and promoting gender equity. Contraceptives take many forms, including barriers (e.g., condoms and diaphragms), hormones (e.g., birth control pills, patches, and injectables, and intrauterine devices (IUDs)), among others. **Emergency contraceptives** are methods of preventing pregnancy after sex without effective contraceptive, including 'morning after pills' (or 'Plan B') or copper IUDs.

Under **human rights law**, young people must have access to contraceptive information and services, including affordable, safe, effective, and confidential contraceptives and emergency contraceptives.[145] Access to contraceptives must not be hampered by requiring parent, guardian, or spouse consent.[146] Additionally, contraceptives must be provided without discrimination of any kind, including on the basis of gender or sexual orientation.[147] In short, laws must clearly state that all young people have a right to choose their preferred method of contraception, regardless of age or marital status, and should include a presumption that young people seeking contraceptives have the requisite capacity to consent to such sexual and reproductive healthcare.[148]

Contraceptives, including emergency contraceptives, are generally available throughout the **countries** considered in this report. Their accessibility, however, varies broadly. Few countries provide independent access to contraceptives – instead, requiring most young people below a set age to obtain parent or guardian consent. In some countries, the minimum age to access contraceptives without parent or guardian consent is set too high, well above the minimum age of consent to sex, posing a meaningful barrier to contraceptive access among young people.

Kyrgyzstan is the only country, among the eight assessed in this report, in which people of any age can access contraceptives, including emergency contraceptives, without parent, guardian, or spouse consent.[149] Children and young people can choose whether they want to use contraceptives, and their preferred method of contraceptives. In practice, the main barrier young people face in accessing contraceptives is their cost.[150] Contraceptives are not provided for free and are not affordable, particularly to people who are financially dependent.

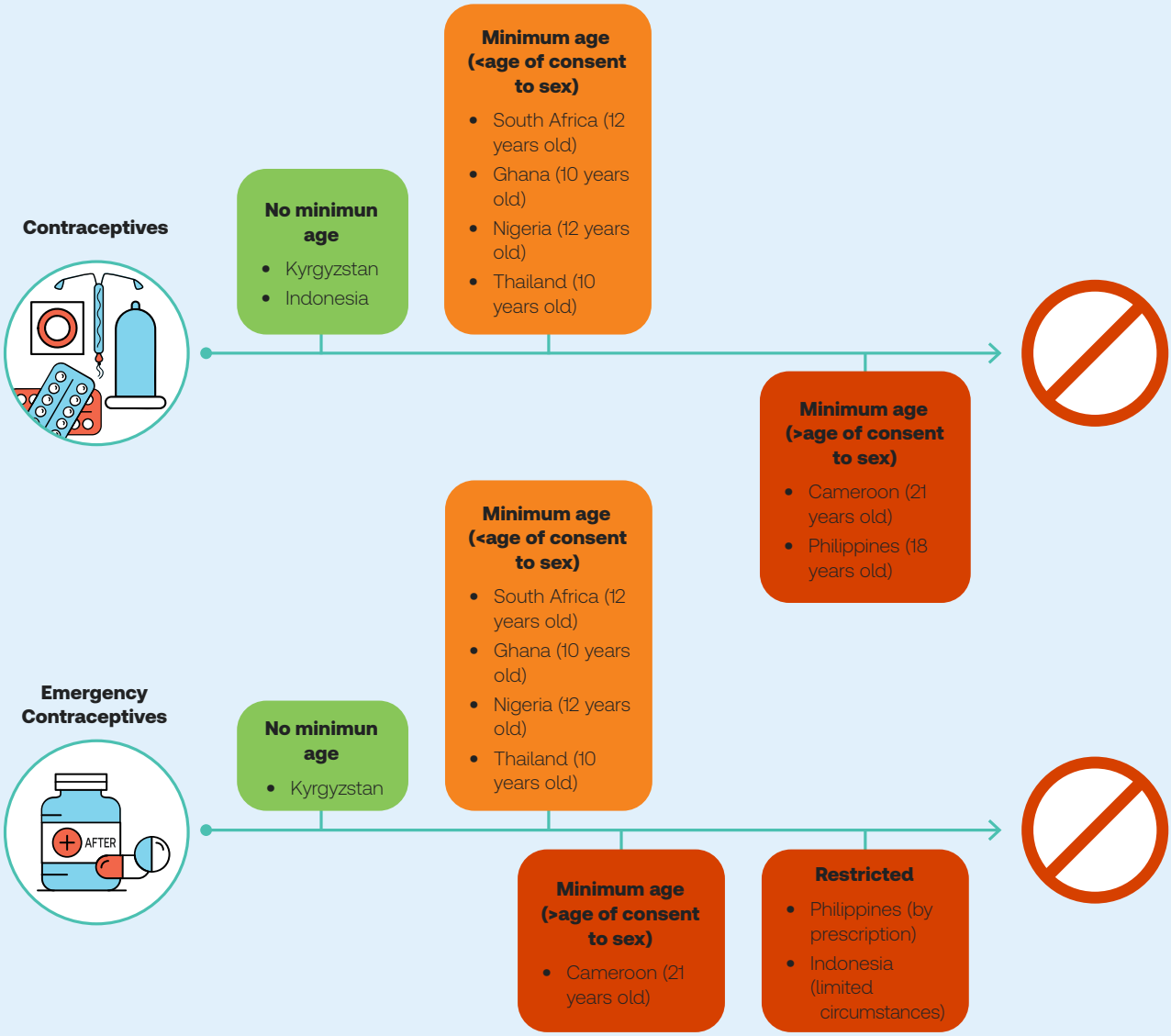
In **Indonesia**, contraceptives, such as condoms, are available without restriction and sold freely,[151] but emergency contraceptives are only provided in limited cases, such as for women who used

ineffective contraception or are survivors of sexual assault.[152] Tubectomy and vasectomy require spousal consent.[153] Despite the availability of some methods, strong cultural norms and the criminalisation of sex outside marriage act as significant barriers.

Contraceptives are relatively accessible in **South Africa**, though the laws fail to meet the human rights standards. Contraceptives are legally accessible to young people in South Africa, but implementation challenges limit full alignment with human rights standards. Adolescents aged 12 and older may independently access contraceptives, including emergency contraception, without requiring parental or guardian consent. Emergency contraceptive pills and condoms are legally available free of charge at public health facilities, school-based services, and some NGOs.[154] However, adolescents under the age of 12 may be denied access based on provider discretion, as the law does not clearly authorise independent access for this age group.[155]

Access to Sexual and Reproductive Health Interventions

Consistency with human rights norm: **consistent** | **some consistency** | **inconsistent**



Contraceptives are relatively accessible in Thailand, Ghana, and Nigeria, though these countries also fail to meet the human rights standards by imposing a minimum age at which young people can independently access contraceptives and emergency contraceptives. The minimum ages are only moderately restrictive, as they are set above the legal age of consent to sex in each country.

Specifically, in **Thailand**, young people over 10 years old can access contraceptives, including emergency contraceptives, without parent or guardian consent.[156] The law specifies that individuals over 10 years old are entitled to make their own decisions regarding reproductive healthcare services, and that reproductive healthcare services are part of standard healthcare services to which every person is entitled.

In **Ghana**, parent or guardian consent is required to obtain contraceptives, including emergency contraceptives, for individuals under 10 years old.[157] The law imposes an additional barrier by requiring individuals under 19 years old to undergo counselling to access contraceptives.

Finally, in **Nigeria**, contraceptives, including emergency contraceptives, are only available to individuals who are 12 years or older without parent or guardian consent.[158] For more invasive forms of contraception, parent or guardian consent may be required for individuals under 14 years old – or 18 years old, if surgery is required.

In the remaining countries, contraceptive access is particularly difficult for young people. In **Cameroon**, for instance, young people under 21 years old need parent or guardian consent to access contraceptives, including emergency contraceptives, unless they are married.[159] That means that until the age of 21 years, young people must have parent or guardian permission to access contraceptives, despite the fact that they can consent to sex from the age of 16 years. For married individuals, spouse consent is not legally required. However, many married young people in Cameroon are encouraged to obtain spouse consent before accessing certain healthcare services, including contraceptives.[160]

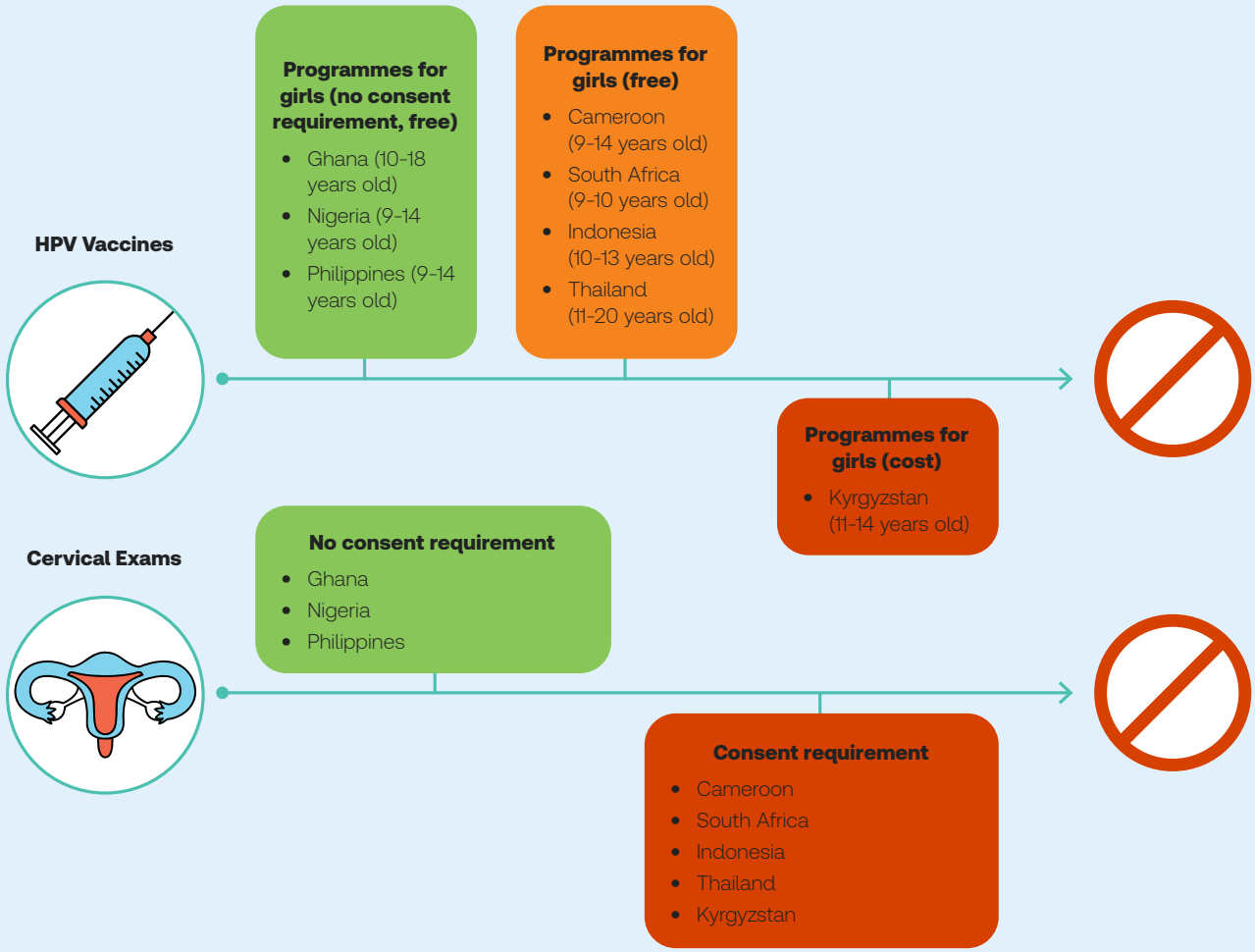
In the **Philippines**, law requires that individuals under 18 years old obtain parent or guardian consent to access contraceptives - two years above the minimum age at which people can consent to sex.[161] Emergency contraceptive pills are available by prescription, only through private healthcare providers, further restricting reproductive autonomy.[162]

(ii) HPV Vaccines & Cervical Exams

The **Human Papillomavirus (HPV) vaccine** protects against HPV infections, which can cause certain kinds of cancers and other conditions. In fact, HPV is responsible for a high rate of cervical cancer among young women.[163] The vaccine is safe and highly effective in preventing infections and reducing the risk of developing HPV-related cancers and other health conditions among both women and men.[164] Accordingly, widespread vaccination programmes, targeting young boys and girls aged 9 to 14 years, are considered crucial in efforts to reduce the burden of cervical cancers and other conditions. Notably, access to the vaccine among boys is often limited, and/or not documented, as the health benefits are seen to be more significant for girls than for boys. **Cervical exams** also promote sexual and reproductive health among young girls and women.[165] Specifically, these exams are considered crucial to detect and prevent various health issues, including cervical cancer, STIs, and other gynaecological conditions.

Access to Sexual and Reproductive Health Interventions

Consistency with human rights norm: **consistent** | **some consistency** | **inconsistent**



Human rights law has been interpreted to require states to make HPV vaccines and cervical exams accessible to young people, without discrimination based on age, sexual orientation, or any other characteristic.[166] They must be provided based on informed consent, and with confidentiality and privacy protections against their parents or guardians. HPV vaccines should be included in national immunisation programmes, targetting boys and girls, aged 9 to 14 years old.[167] For young people living with HIV, cervical exams should be accessible as soon as they become sexually active, regardless of age.[168]

Among the **countries** considered, few protect independent access to HPV vaccine and cervical exams for young people. No country appears to guarantee access to HPV vaccines for boys. Ghana, Nigeria, and the Philippines are the only countries to provide HPV vaccines and cervical exams to young girls without the need for parent or guardian consent.[169] In **Ghana**, the government has developed pilot programmes offering the HPV vaccine for free to girls aged 10 to 18 years old.[170] In **Nigeria**, the government has programmes to provide HPV vaccines to girls aged 9 to 14 years old at no cost.[171] In the **Philippines**, the government has programmes to provide HPV vaccines to girls aged 9 to 14 years old at no cost.[172]

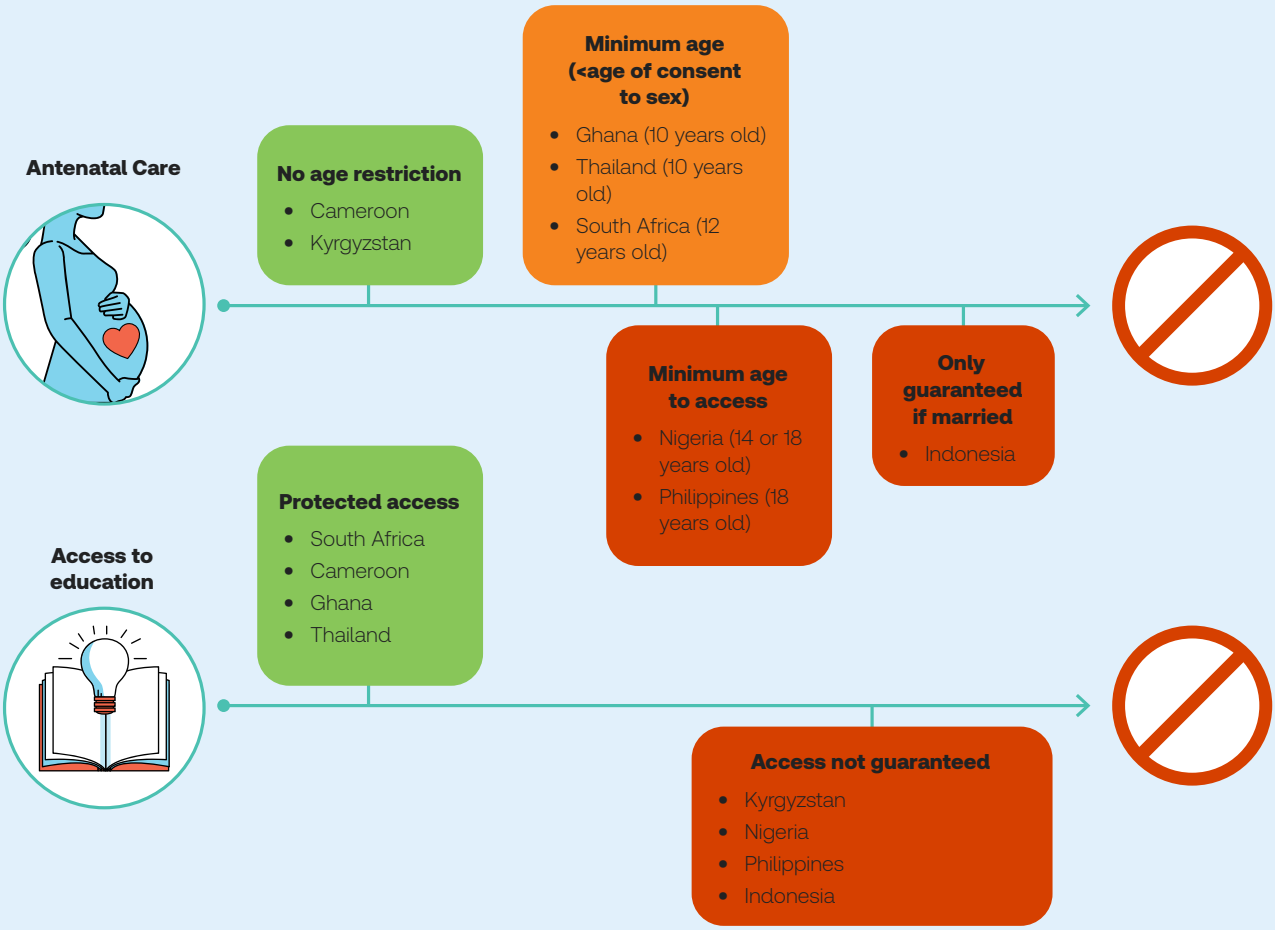
In the remaining countries, access to HPV vaccines and cervical exams are dependent on parent or guardian consent, based on each country's minimum age of independent access to healthcare. In **South Africa** and **Thailand**, independent access to HPV vaccines and cervical exams depends on a young person's capacity to consent to the healthcare service, if they are at least 12 years old in South Africa and under 20 years old in Thailand.[173] This provides a broad degree of discretion to healthcare providers to require adult or guardian consent. In South Africa, government programming provides HPV vaccines to girls in public school who are at least 10 years old.[174] Girls under 12 years old are only able to access the HPV vaccines independently if they demonstrate a sufficient capacity to consent to the healthcare. In Thailand, the programming aims to provide HPV vaccines to girls between 11 and 20 years old during school visits and through certain public healthcare offices.[175] In **Kyrgyzstan**, girls must be at least 16 years old to access HPV vaccines and cervical exams without parent or guardian consent.[176] The government promotes HPV vaccinations among girls aged 11 to 14 years old. In **Indonesia**, individuals must be at least 18 years old to access HPV vaccines and cervical exams independently.[177] However, HPV vaccines are mandatory for female students aged 10 to 12 and are administered through school-based programmes.[178] There is no equivalent access for boys. In **Cameroon**, individuals must be at least 21 years old to access HPV vaccines and cervical exams independently – past the age at which most people become sexually active and may be exposed to HPV.[179] Government programmes provide HPV vaccines for girls between 9 and 14 years old, provided they obtain parent or guardian consent.

(iii) Antenatal Care & Access to Education

Antenatal care (ANC) refers to medical and other support services provided to pregnant individuals throughout their pregnancy, including comprehensive health assessments and ongoing monitoring of mother and foetus, birth preparedness, and complications readiness.[180] ANC is crucial for young pregnant individuals, given the heightened risks associated with pregnancies among adolescents. ANC for young people is thus tailored to the special healthcare needs of young people, as well as their particular social and emotional needs. Continuous **access to education** is one such need, as young pregnant individuals face higher dropout rates and lower levels of education. Ensuring pregnant individuals have ongoing access to education helps to combat gender inequities, break cycles of poverty, and support long-term academic and employment opportunities. Educated mothers are better able to make informed health decisions, which leads to better health outcomes for themselves and their children.[181]

Access to Sexual and Reproductive Health Interventions

Consistency with human rights norm: **consistent** | **some consistency** | **inconsistent**



Pursuant to **human rights law**, states must ensure that pregnant individuals have access to ANC, regardless of age, marital status, or other characteristic.[182] In other words, states must not impose minimum age requirements, or other consent requirements, on young pregnant individuals. Additionally, states must enact laws that ensure that pregnant individuals are supported in continuing their primary and/or secondary education during and after pregnancy.[183] Young people must not be expelled from education on the basis of pregnancy. They must be provided with adequate maternity leave during and following pregnancy, and must have their re-entry into school facilitated.[184] Schools must be flexible in accommodating pregnant or mothering students, for instance, by offering part-time schedules.

Among the **countries** considered in this report, Cameroon alone ensures that young pregnant individuals have access to ANC regardless of their age, and ensures continuous access to education throughout and following pregnancy.

Specifically, in **Cameroon**, young people can access ANC, without first obtaining parent or guardian consent, regardless of age.[185] In practice, barriers related to the cost of some services and the lack of healthcare providers and centres may provide significant barriers to access.[186] With respect to education, the law protects the rights of young pregnant people to continue their education, without discrimination based on pregnancy.[187] The law provides that young people must be allowed to continue their education throughout their pregnancy and following their pregnancy. Students must obtain 26 weeks of leave, and be allowed to return to school following medical confirmation that it is safe for student and child to do so.

In **Kyrgyzstan**, pregnant young people also have access to ANC, without the need to first obtain parent or guardian consent.[188] In some cases, parent or guardian consent may, however, be necessary if the pregnant individual does not have the capacity to make informed decisions regarding their own healthcare. Additionally, the law does not comprehensively protect the right to education. The law states that every child has a right to education, and guarantees access to free primary and secondary education.[189] However, local governments are able to establish school policies which allow for the expulsion of students over 15 years for illegal behaviour or breaching a school's charter.[190] Pregnancy can be considered against schools' charters, meaning that individuals may face expulsion as a result of their pregnancies.

In South Africa, Ghana, Thailand, Nigeria, and the Philippines, access to ANC is more restricted, as each country establishes a minimum age at which young people can access ANC without parent or guardian consent. Each country takes a distinct approach to the right to education, providing for varying levels of access.

In **Ghana** and **Thailand**, young people must be above 10 years old to access ANC without parent or guardian consent.[191] In both countries, the law protects young pregnant students' right to education, requiring pregnant individuals to be provided with leaves of absence to give birth and return to school following childbirth.[192] Both countries require that schools be flexible in responding to the needs of pregnant students during and following childbirth.

In **South Africa**, individuals do not need to obtain parent or guardian consent to access ANC if they are above 12 years old and demonstrate sufficient capacity to consent to treatment.[193] Health information can only be shared with an individual's parent or guardian if it is considered to be in

the person's best interest (e.g., if they are deemed incapable of consenting or suffering from a life-threatening condition).[194] In practice, however, stigma among healthcare providers can pose a barrier.[195] With respect to education, the law specifies that children cannot be discriminated against on the basis of pregnancy, and that pregnant young people have the right to continue and complete their education.[196] Teachers are bound to keep a young person's pregnancy confidential, unless the pregnant student consents to the information being shared.[197]

In Nigeria and the Philippines, access to ANC is more limited, as the minimum ages to independent access to ANC are set higher. In **Nigeria**, young people can only access ANC without parent or guardian consent if they are over 14 years old – and if that care requires surgery, they need parent or guardian consent until they are 18 years old.[198] Moreover, the protections that pregnant young people have to continue their education are limited, as the law simply *allows* (rather than guarantees) for pregnant individuals to continue their education during and following pregnancy.[199] Similarly, in the **Philippines**, young people need parent or guardian consent until they are 18 years old to access ANC.[200] The country's protection of pregnant young people's access to education is similarly weak, as it provides supports for young people returning to school following childbirth, without clearly protecting the right to remain in and/or return to school.[201]

In **Indonesia**, the law broadly protects ANC, regardless of marital status.[202] In practice, however, ANC is widely available to married adolescents, while unmarried adolescents may receive care depending on the discretion of providers. However, the absence of an explicit legal guarantee for unmarried adolescents leads to inconsistent access and reinforces stigma. The law also offers only weak protection for access to education. The law broadly protects every child's right to education, but does not specifically detail how individuals are supported in accessing education during and after pregnancy.[203] In practice, many young people stop attending school because it is considered taboo to enrol in school while pregnant or caring for a child.[204]

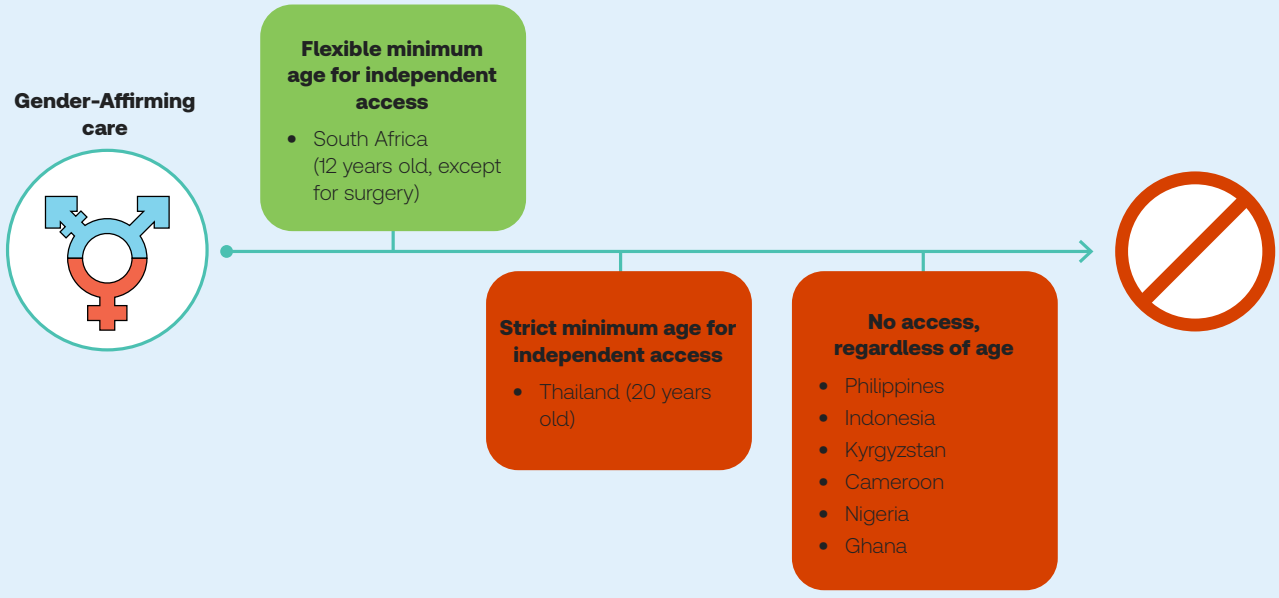

REUTERS/Francis Kokoroko

(iv) Gender-Affirming Care

Gender-affirming care refers to a broad range of medical, mental health, and other supports designed to affirm people's gender identities, particularly for those whose identity differs from the sex they were assigned at birth.[205] Medical interventions can include hormone therapy, which help to induce physical changes that align with a person's gender identity; puberty blockers, which delay the onset of puberty to allow individuals more time to explore their identity; and surgical interventions, which further help to align physical appearance with gender identity. Mental health support can include counselling and peer support groups, to help individuals explore and affirm their gender identity or cope with gender dysphoria. Other supports include social and legal support, such as creating inclusive environments or changing names on legal documents. This care is crucial for the well-being of transgender and gender-diverse individuals, helping them to achieve congruence between their gender identity and their physical appearance and social role, and improve health outcomes. It is also an important entry point for HIV prevention, diagnosis, and treatment, and other healthcare services.[206]

Access to Sexual and Reproductive Health Interventions

Consistency with human rights norm: **consistent** | **some consistency** | **inconsistent**



States' obligations under international human rights law have been interpreted as requiring them to ensure that young people have access to gender-affirming care, as part of their broader healthcare.[207] States must ensure that young people have access to hormone therapy, puberty blockers, surgical interventions, mental health supports, and other supports without discrimination based on the basis of age, sexual orientation, gender identity, or other characteristic. There is no

set age when young people should be able access gender-affirming care without parent or guardian consent. Access must instead be based on evolving capacities to make independent decisions.[208] Even if a young person does not yet have the capacity or maturity to make independent decisions, their views should always be given significant consideration.[209] Young people must be able to make fully informed decisions and provide informed consent regarding gender-affirming care.

Among the **countries** considered in this report, **South Africa** is the only country to approach the human rights standards. Specifically, in South Africa, young people can access gender-affirming care without the need for parent or guardian consent above the age of 12 years old, if they can demonstrate maturity and capacity to understand the benefits, risk, and implications of the desired treatment.[210] An adolescent who reaches that threshold cannot have their desired gender-affirming care denied based on their parent's or guardian's opposition to the care.[211] In practice, however, gender-affirming care is not consistently accessible to young people.[212] Access is particularly limited outside of urban centres, where most gender-affirming care is concentrated. Moreover, affordable gender-affirming care through the public healthcare system involves long waitlists, while the private healthcare sector entails high fees.[213] Access to gender-affirming surgery is particularly restricted as healthcare workers often refuse to provide the surgery to anyone who is under 18 years old.

The only other country to offer gender-affirming care is **Thailand**, though on a much more limited basis. In Thailand, hormone therapy, counselling, surgery, among other forms of gender-affirming care, are only available to individuals above 18 years old.[214] Young people must have parent or guardian consent to obtain gender-affirming care until they are 20 years old. Married individuals must have the consent of their spouse to obtain such care. In effect, gender diverse young people in Thailand cannot access essential care without the consent of others, unless they are over 20 years old and happen to be unmarried. As of 2025, Thailand's Universal Health Coverage now includes hormone therapy and gender-affirming surgeries for those meeting medical criteria, such as a psychiatric diagnosis of gender dysphoria.[215] While this represents an important step forward, younger adolescents remain excluded from independently accessing care, and there is no legal gender recognition process, which perpetuates broader barriers to equality and dignity for transgender youth.

In each of the remaining countries, gender-affirming care is not available and thus not accessible to young people. In these countries, gender diversity is not legally recognised, leaving gender diverse individuals without access to care, as well as open to abuse and discrimination, including accessing healthcare more broadly. Specifically, in the **Philippines**, the law does not recognise gender diversity or gender reassignment.[216] In **Indonesia**, gender-affirming care is not guaranteed in law. Hormone therapy is available through private providers but often approached as part of mental health treatment based on guidance from the Indonesian Psychiatrists Association, which classifies gender dysphoria as a mental disorder.[217] Legal gender change is possible under Presidential Regulation No. 96 of 2018 with court approval, typically limited to cases of intersex traits or post-surgical transition abroad. There is no clear access pathway for minors, and stigma remains high. In **Kyrgyzstan**, the law is silent regarding gender-affirming care.[218] Access to gender-affirming care depends on finding a healthcare provider who offers such care. In **Cameroon, Nigeria** and **Ghana**, gender diversity is not recognised and thus gender-affirming care is not available or accessible. Moreover, the criminalisation of same-sex sexual activity, together with a lack of understanding of gender diversity, exposes gender-diverse individuals to increased discrimination in accessing healthcare. In **Ghana**, a law has been introduced to Parliament, which, if passed, would expressly prohibit gender-affirming surgeries, or any other care meant to affirm someone's gender that differs from the sex they were assigned at birth.[219]

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3. Access to Harm Reduction Services

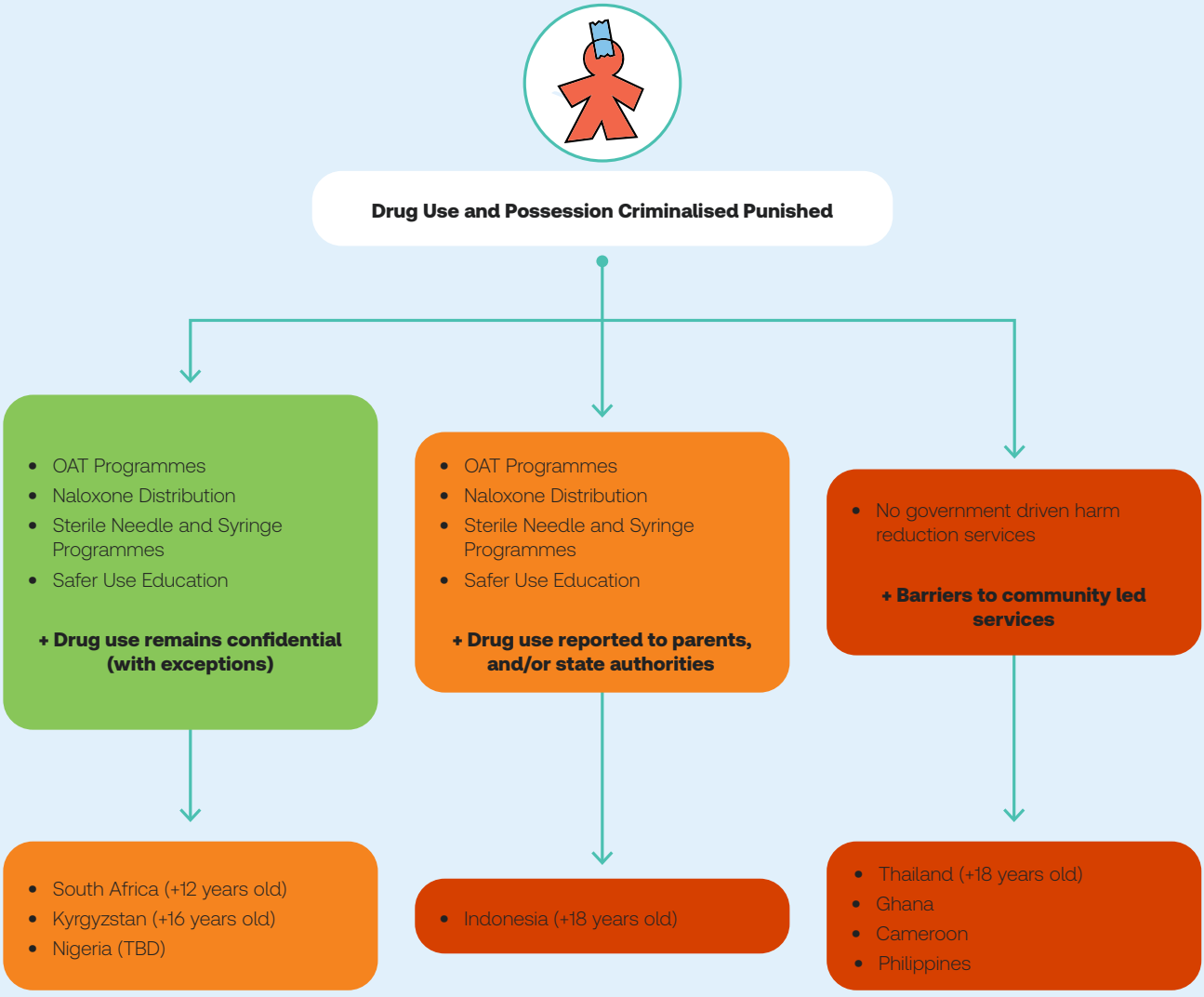
Harm reduction refers to policies, programmes, and practices that aim to minimise the negative health, social, and legal impacts associated with drug use, drug policies, and drug laws, without judging or punishing people who use drugs or focusing exclusively on preventing drug use.[220] Harm reduction strategies are highly effective in reducing the negative health impact of drug use, such as HIV and other sexually transmitted and blood-borne infections (STBBIs), as well as social marginalisation. Harm reduction measures include education on safer drug use (e.g., by emphasising the importance of using sterile needles or syringes for injections), supervised consumption sites (i.e., a supervised facility where individuals can consume drugs in a safe and sterile environment), Opioid Agonist Therapy (OAT) (i.e., medication-based treatment for individuals dependent on opioids, which reduces withdrawal symptoms),[221] naloxone distribution (i.e., a medication that quickly reverses the effects of opioid overdose if administered in time), among others.[222] Harm reduction programmes may include abstinence-based programmes but only for those individuals wishing to abstain from drug use.

International human rights bodies have interpreted the right to health to include access to harm reduction services – such as sterile needle and syringe programmes, supervised consumption sites,

naloxone distribution, among others – as essential components of fulfilling states' human rights obligations. Young people must have access to harm reduction services, regardless of drug use, age, gender, sexual orientation, or other characteristics.[223] Young people must be able to access these services in a confidential manner, and in a manner that meets their specific needs. They must be able to access these healthcare services without the risk of repercussion or punishment, including criminal sanctions. While engaging parents or guardians in harm reduction programming may help to ensure support for a young person, parent or guardian involvement must never occur without young person's consent.[224]

Access to Harm Reduction Services

Consistency with human rights norm: **consistent** | **some consistency** | **inconsistent**



Among the **countries** in this report, only South Africa and Kyrgyzstan provide some harm reduction services, and protect confidentiality in doing so – thus limiting the risk of negative repercussions for individuals wishing to access such services. No country considered in this study, however, meets the human rights standard, by continuing to punish and criminalise drug use and possession.

In **South Africa**, harm reduction programming includes needle and syringe programmes, OAT, naloxone, and education on safer drug use practices.[225] The country is in the process of developing supervised consumption sites, and currently running pilot programmes in some areas.[226] That said, the availability of the services varies widely across the country.[227] For young people, services may be particularly difficult to access because the minimum age of consent to medical treatment applies to harm reduction services. Young people must be at least 12 years old to independently access harm reduction services, as well as demonstrate sufficient maturity and capacity to understand the service.[228] For young people who access services, confidentiality is promised.[229] However, healthcare providers may share a young person's health information with others, 'for any legitimate purpose within the ordinary course and scope of his or her duties where such access or disclosure is in the interests of the user'.[230] Confidentiality is thus not strictly protected, and may, for instance, be shared pursuant to any law that requires disclosure or if a healthcare provider believes that withholding disclosure would present a threat to public health.

In **Kyrgyzstan**, harm reduction services are also generally available. The country's national strategy treats harm reduction services as integral to addressing HIV among people who use drugs – and access to harm reduction is protected by law.[231] Specifically, there are sterile needle and syringe programmes, OAT programmes, naloxone distribution programmes, and outreach and peer education initiatives on safer drug use practices. For young people, access is restricted by the minimum age to independently access healthcare services.[232] Young people must obtain parent or guardian consent to access harm reduction services if they are under 16 years of age. Accordingly, young people under 16 years of age cannot access harm reduction services privately or confidentially. Young people over 16 years old can do so, and generally have the right to confidentiality.[233] However, their healthcare information, including their drug use, may be provided to state authorities on request, such as in the context of a criminal prosecution for a drug-related offence.

In **Indonesia**, the government has similarly recognised the importance of harm reduction strategies to address health issues associated with drug use, particularly HIV among people who inject drugs. The country has established sterile needle and syringe programmes, OAT programmes, naloxone distribution programmes, and outreach programmes to provide education on harm reduction strategies.[234] Young people are entitled to access these services, but face restrictions in doing so. Specifically, young people may require parent or guardian consent to access harm reduction services if they are under 18 years old, which is left to the discretion of institutions.[235] Moreover, harm reduction providers are required to report drug use to government authorities.[236] Given that drug use and possession are criminalised, the minimum age of independent access, together with the lack of confidentiality, serves as significant deterrents.

In **Nigeria**, harm reduction is currently centred on the prevention, diagnosis, and treatment of HIV – and does not specifically address the harms associated with drug use.[237] In fact, some harm reduction services that centre on drug use, such as sterile needle distribution programmes, are criminalised in the country.[238] However, the Ministry for Health is in the process of developing a comprehensive harm reduction framework and has established a *National Technical Working Group on Drug Demand and Harm Reduction*.[239] Once implemented, the harm reduction framework will provide access to sterile needle and syringe programmes, OAT programmes, and naloxone distribution programmes. The government has not established a legal minimum age for independent access, suggesting that young people of any age may have broad access to the

services. Moreover, healthcare and harm reduction providers are seemingly not required to report drug use to parents, guardians, or government authorities. Healthcare providers are only required to report drug use to the police where a person poses a risk to their own safety or the safety of others.[240]

In **Thailand**, the government, with the support of NGOs and international organisations, has implemented some harm reduction services, including sterile needle and syringe programmes, OAT programmes, naloxone distribution programmes, and outreach initiatives providing education on safer drug use practices.[241] However, these programmes are not uniformly available throughout the country, and there is a lack of clear guidelines supporting access to harm reduction services. Moreover, the country harshly criminalises drug use and possession, which acts as a significant deterrent.[242] The country emphasises rehabilitation, such that individuals who enter and complete drug addiction treatment can avoid criminal liability. While rehabilitation may be a valid option for many people, the coercive nature of the framework in Thailand is contrary to harm reduction principles that emphasise meeting people's healthcare needs without judgment. Young people face additional challenges in accessing harm reduction services, as they must be at least 18 years old to do so without parent or guardian consent.[243] Thus, young people under 18 years old cannot access harm reduction services, including rehabilitation services, with privacy and confidentiality.

In Ghana, Cameroon, and the Philippines, access to harm reduction services is generally limited, and thus generally inaccessible to young people. In **Ghana**, for instance, harm reduction policies include mostly education on safer drug use and drug addiction treatment.[244] Even these limited measures are not fully implemented. Some local organisations provide harm reduction education, information, and support to individuals who use drugs. Young people can access healthcare services, regardless of their drug use. However, healthcare providers have a right to share information about a person's drug use with parents, guardians, or state authorities if they deem it to be in the public interest.[245] Healthcare providers have broad discretion to disclose a person's drug use, thus opening them up to penalties for seeking healthcare.

Similarly, in **Cameroon**, harm reduction initiatives are limited to outreach programmes that educate people on safer practices, which are often run by non-governmental and community-based organisations.[246] The country does not have specific laws that govern or require harm reduction services. Young people who seek healthcare services related to their drug use are further hampered by the laws on minimum age of independent access to healthcare. As noted above, young people in Cameroon can only access healthcare independent of parents or guardians at 21 years old, unless married. Healthcare providers are entitled to report drug use to spouses of married individuals, which may open the individual up to criminal consequences.

Finally, in the **Philippines**, harm reduction services are severely limited, as the focus on drug use prioritises rehabilitation and abstinence-based solutions.[247] The country takes a very punitive approach to drug use.[248] People who use drugs are harshly punished, and some harm reduction services, such as sterile needle and syringe programmes, are illegal. Local advocacy groups continue to push for harm reduction and have made some services discretely available, such as education on safer practices.[249]

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Conclusion

The charts below summarise the findings of this report. They highlight the *legal* barriers that must be overcome for each country to meet the human rights standards, and to protect and promote the right to health among young people in their countries.

Access to HIV Prevention and Testing

	Cameroon	Ghana	Nigeria	South Africa	Indonesia	Philippines	Thailand	Kyrgyzstan
Access to Pre-Exposure Prophylaxis	Parent consent until 21 years old	Parent consent until 15 years old (+) unless mature	Parent consent until 18 years old	Parent consent until 18 years old (+) unless mature	Only if over 17 years old	No access	No parent consent requirement (based on risk)	Parent consent until 16 years old
Access to Post-Exposure Prophylaxis	Parent consent until 21 years old	No parent consent requirement (based on risk)	No parent consent requirement (based on risk)	Parent consent until 12 years old	No parent consent requirement (based on risk)	No access	No parent consent requirement (based on risk)	Parent consent until 16 years old
Access to HIV Testing	Parent consent until 21 years old	Parent consent until 16 years old (some exceptions)	Parent consent until 18 years old	Parent consent until 12 years old (+) unless mature	No minimum age requirement	No minimum age requirement	Parent consent until 18 years old (+) unless mature	Parent consent until 14 years old
Direct Reporting of HIV Test Results	Parent consent until 21 years old	Only if over 16 years old	Only if over 18 years old (with exceptions)	Yes (+) if capacity to consent to testing	Yes (-) unless positive test and under 15 years old	Only if over 15 years old (with exceptions)	Yes (+) if capacity to consent to testing	Only if over 18 years old

Red highlights a failure to meet human rights standards. **Orange** highlights moderate barriers to meeting the human rights standard. **Green** highlights minimal barriers to meeting the human rights standard.

Access to Sexual and Reproductive Health

	Cameroon	Ghana	Nigeria	South Africa	Indonesia	Philippines	Thailand	Kyrgyzstan
Minimum age of consent to sex	16 years old (-) same sex activity criminalised	16 years old (-) same sex activity criminalised	18 years old (-) same sex activity criminalised	16 years old	18 years old (-) sex criminalised if unmarried or same-sex activity	16 years old	15 years old (-) unless married	16 years old
Minimum age of marriage	15 years old (-) lower age for girls	18 years old	18 years old (-) exceptions based on parent consent	16 years old (-) centered on parent consent	19 years old (-) exceptions based on parent consent	18 years old	18 years old (-) exceptions based on parent consent	18 years old
Minimum age of independent access to medical info, counselling, and testing	21 years old (-) higher than age of consent to sex	18 years old (-) higher than age of consent to sex	18 years old (-) higher than age of consent to sex	No minimum age	18 years old	18 years old (-) higher than age of consent to sex	No minimum age (based on capacity)	No minimum age for info and counselling (-) 16 years old for testing
Minimum age of independent access to medical treatment	21 years old (-) higher than age of consent to sex	18 years old (-) higher than age of consent to sex	18 years old (-) higher than age of consent to sex	12 years old (if capacity)	18 years old	18 years old (-) higher than age of consent to sex	No minimum age (based on capacity)	16 years old
Access to contraceptives	21 years old (-) higher than age of consent to sex	10 years old	12 years old	12 years old	No minimum age	18 years old (-) higher than age of consent to sex	10 years old	No minimum age
Access to emergency contraceptives	21 years old (-) higher than age of consent to sex	10 years old	12 years old	12 years old	By prescription	Limited circumstances	10 years old	No minimum age
Access to the HPV vaccine	Free for girls (-) parent consent requirement	Free for girls	Free for girls (-) parent consent requirement	Free for girls (-) parent consent requirement	Free for girls (-) parent consent requirement	Free for girls (-) parent consent requirement	Free for girls (-) parent consent requirement	Paid for girls (-) parent consent requirement

	Cameroon	Ghana	Nigeria	South Africa	Indonesia	Philippines	Thailand	Kyrgyzstan
Access to cervical cancer screenings	(-) Parent consent requirement	No parent consent requirement	(-) Parent consent requirement	(-) Parent consent requirement	(-) Parent consent requirement	(-) Parent consent requirement	(-) Parent consent requirement	(-) Parent consent requirement
Access to antenatal care	No parent consent requirement	10 years old	14 or 18 years old (-) higher than age of consent to sex	No parent consent requirement	(-) marriage requirement	18 years old (-) higher than age of consent to sex	10 years old	No parent consent requirement
Access to education	Protected access	Protected access	Access not guaranteed	Protected access	Access not guaranteed	Access not guaranteed	Protected access	Access not guaranteed
Access to gender-affirming care	No access	No access	No access	12 years old (if capacity)	No access	No access	20 years old	No access

Red highlights failure to meet the human rights standard. **Orange** highlights moderate barriers to meeting the human rights standard. **Green** highlights minimal barriers to meeting the human rights standard.

Access to Harm Reduction Services

	Cameroon	Ghana	Nigeria	South Africa	Indonesia	Philippines	Thailand	Kyrgyzstan
Harm Reduction Services	Very limited	Very limited	In develop-ment	Some	Some	Very limited	Very limited	Some
Reporting of Drug Use	Yes	Yes	No (-) some exceptions	No (-) some exceptions	Yes (-) mandatory	No	No	No (-) some exceptions

Red highlights failure to meet the human rights standard. **Orange** highlights moderate barriers to meeting the human rights standard. **Green** highlights minimal barriers to meeting the human rights standard.

Young people across Cameroon, Ghana, Nigeria, South Africa, Indonesia, the Philippines, and Kyrgyzstan all face barriers to accessing critical healthcare services. In each of these countries, the laws around access to sexual and reproductive healthcare, HIV prevention and testing, and harm reduction services place unnecessary barriers on young people. These laws restrict access both directly (e.g., by creating a minimum age for independent healthcare access that is not related to maturity and capacity) and indirectly (e.g., by allowing laws around child marriage to allow for sex between individuals under the minimum age of consent to sex). It is thus crucial that each country studied here establish comprehensive laws that reflect the experiences of young people in their countries – rather than laws that reflect morality and judgment. Until then, these laws will continue to contribute to unnecessary and preventable negative outcomes for young people, many of which will follow them into adulthood.

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Endnotes

1 See, e.g., *Convention on the Rights of the Child*, 20 November 1989, United Nations Treat Series, vol. 1577, p. 3 (entered into force 2 September 1990), Article 1 [*CRC*].

2 See, e.g., *comment No. 20 on the implementation of the rights of the child during adolescence*, Committee on the Rights of the Child, CRC/C/GC/20 (2016), at para 5 [*GC 20*].

3 UNESCO, Youth, available at https://www.unesco.org/en/youth.

4 *CRC, supra* note 1, Article 3(1); *General comment No. 14 on the right of the child to have his or her best interests taken as a primary consideration (art. 3, para. 1)*, Committee on the Rights of the Child, CRC/C/GC/14 (2013), at paras 52-79.

5 *CRC, ibid.*

6 See, e.g., *CRC*, *supra* note 1, Articles 5, 14(2); *GC 20*, *supra* note 2, paras 18-20.

7 See, e.g., *CRC*, *supra* note 1, Article 34; *General comment No. 13 on the right of the child to freedom from all forms of violence*, Committee on the Rights of the Child, CRC/C/GC/13 (2011), at para 25 [*GC 13*].

8 See, e.g., The Joint United Nations Programme on IHV/AIDS (UNAIDS), Global HIV & AIDS Statistics – Fact Sheet 2024, available at www.unaids.org/en/resources/fact-sheet.

9 See, e.g., United Nations Children's Fund (UNICEF), *Adolescent HIV Prevention*, July 2024, available at https://data.unicef.org/topic/hivaids/adolescents-young-people/#:~:text=Adolescents%20and%20young%20people%20represent,ages%20of%2015%20and%2019.

10 UNICEF, *Global and regional trends*, July 2024, available at https://data.unicef.org/topic/hivaids/global-regional-trends.

11 UNAIDS, supra note 8.

12 UNICEF, *supra* note 10.

13 UNICEF, *supra* note 10.

14 See, e.g., A. Robinson et al., 'Examining the Relationship Between HIV-Related Stigma and the Health and Wellbeing of Children and Adolescents Living with HIV: A Systematic Review', *AIDS and Behaviour* (2023) 27:3133-3149.

15 UNICEF, *supra* note 10.

16 UNICEF, *supra* note 10.

17 See, e.g., *GC 20*, *supra* note 2, paras 18-20.

18 World Health Organization (WHO), *Adolescent pregnancy*, available at www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy#:~:text=Adolescent%20mothers%20(aged%2010%E2%80%9319,birth%20and%20severe%20neonatal%20condition.

19 WHO, Adolescent health, available at www.who.int/health-topics/adolescent-health/pregnancy-and-childbirth-complications-are-the-leading-cause-of-death-among-15-19-year-old-girls#tab=tab_1.

20 UNICEF, *Early childbearing,* January 2024, available at https://data.unicef.org/topic/child-health/adolescent-health/#:~:text=Globally%20in%202022%2C%20an%20estimated,their%20education%2C%20livelihoods%20and%20health..

21 See, e.g., *International Covenant on Economic, Social, and Cultural Rights*, 19 December 1966, United Nations Treaty Series, vol. 993, p. 3 (entered into force 23 March 1976), Article 12; *CRC*, *supra* note 1, Article 24; *African Charter on Human and Peoples Rights*, Organisation of African Unity (OAU), 27 June 1981, CAB/LEG/67/3 re. 5, 21 I.L.M. (1982), Article 16; *African Charter on the Rights and Welfare of Children*, OAU, 11 July 1990, CAB/LEG/24.9/49 (1990), Article 14. For a comprehensive list of all international and regional treaties protecting the right to health, please see United Nations Special Rapporteur on the Right to Health, *International standards on the right to physical and mental health,* available at www.ohchr.org/en/special-procedures/sr-health/international-standards-right-physical-and-mental-health.

22 *CRC*, *supra* note 1, Article 24.

23 United Nations Office of the High Commissioner for Human Rights (OHCHR), *Manual on Human Rights Reporting*, 1997, available at www.ohchr.org/sites/default/files/Documents/Publications/manualhrren.pdf, at pp. 414-416; see also, World Health Organization (WHO), *Global Accelerated Action for the Health of Adolescents (AA-HA!): Guidance to Support Country Implementation*, 2017, available at https://iris.who.int/bitstream/handle/10665/255415/9789241512343-eng.pdf?sequence=1, at p. xii.

24 OHCHR, *ibid.*

25 OHCHR, *ibid.*

26 See, e.g., UNICEF, *Legal minimum ages and the realization of adolescents' rights*, January 2016, available at www.unicef.org/lac/media/40681/file/Legal-minimun-ages.pdf., at p. 56.

27 See, e.g., WHO, *Consolidated Guidelines on HIV Prevention, Testing, Treatment, Service Delivery and Monitoring: Recommendations for a Public Health Approach*, July 2021, available at www.who.int/publications/i/item/9789240031593, at pp. 66-68; International Commission of Jurists (ICJ), *The 8 March Principles for a Human Rights-Based Approach to Criminal Law Proscribing Conduct Associated with Sex, Reproduction, Drug Use, HIV, Homelessness and Poverty,* March 2023, available at www.icj.org/icj-publishes-a-new-set-of-legal-principles-to-address-the-harmful-human-rights-impact-of-unjustified-criminalization-of-individuals-and-entire-communities, at pp. 20-24.

28 WHO, *ibid*, at pp. 66-68.

29 CATIE, *Pre-exposure prophylaxis (PrEP)*, 2023, available at www.catie.ca/pre-exposure-prophylaxis-prep-0.

30 See, e.g., Government of Canada, *HIV factsheet: Biomedical prevention of HIV – PrEP and PEP*, 16 January 2021, available at www.canada.ca/en/public-health/services/publications/diseases-conditions/hiv-factsheet-biomedical-prevention-prep-pep.html.

31 *Ibid.*

32 WHO, *WHO Recommendations on adolescent sexual and reproductive health and rights*, 2018, available at https://iris.who.int/bitstream/handle/10665/275374/9789241514606-eng.pdf?sequence=1.

33 *Ibid.*

34 *Thailand National Guidelines for Pre-Exposure Prophylaxis (2021)*; *Thailand National Guidelines on HIV/AIDS Treatment and Prevention 2021/2022 (2022).*

35 *Notification of the National Health Security Board Re: Type and Scope of Healthcare Service (2022)*; *Thailand National Guidelines on HIV/AIDS Treatment and Prevention 2021/2022 (2022).*

36 Confirmed by Allen & Overy.

37 *Ghana Health Services Consolidated Guidelines for HIV Care (2022).*

38 *Ghana Health Services Consolidated Guidelines for HIV Care (2022).*

39 *Children's Act 38 (2005),* s. 129; see also, National Department of Health, *National Consolidated Guidelines for the Prevention, Management and Treatment of HIV, TB and STIs* (2023).

40 *Children's Act 38 (2005),* s. 129; see also, A. Ajayi et al., 'Low awareness and use of post-exposure prophylaxis among adolescents and young adults in South Africa: implications for the prevention of new HIV infections,' *Afr J AIDS Res* 19(3): 242-248 (2020).

41 *Law on HIV/AIDS in the Kyrgyz Republic No 149 (2015)*, Articles 5-6; *Clinical Protocol on HIV (2022)*, Chapters I-II.

42 *National Guidelines for HIV Prevention, Treatment, and Care (2020)*; *National Health Act (2014)*; *Young Persons' Participation in Research and Access to Sexual and Reproductive Health Services (2014).*

43 *National Guidelines for HIV Prevention, Treatment, and Care (2020).*

44 *Cameroon Civil Code*, s. 488.

45 *Minister of Health Regulation No 23 (2022).*

46 See, e.g., *Department Memorandum No. 2021-0017, Interim Guidelines on Pre-Exposure Prophylaxis (PrEP) for the Prevention of HIV Infection in the Philippines (2021),* which details interim guidelines on how to deliver PrEP, but focused on use of service providers and people who administer PrEP. No similar regulation exists for the provision of PrEP nationwide. See also *Republic Act 11166 (2018),* which defines PEP and mandates the National AIDS Council to educate people about it, but does not contain specific language to make PEP readily available to affected people nor mandating its rollout on a nationwide scale.

47 See, e.g., LoveYourself, *About LoveYourself,* available at https://loveyourself.ph/about-us/.

48 WHO, *Consolidated guidelines on differentiated HIV testing services*, 2024, available at https://iris.who.int/bitstream/handle/10665/378162/9789240096394-eng.pdf?sequence=1.

49 *Ibid.*

50 WHO, *WHO Recommendations on adolescent sexual and reproductive health and rights*, 2018, available at https://iris.who.int/bitstream/handle/10665/275374/9789241514606-eng.pdf?sequence=1; WHO, *Global Accelerated Action for the Health of Adolescents (AA-HA!)*, 2023, available at www.who.int/publications/i/item/9789240081765.

51 *Ibid;* WHO, *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*, 2016, available at www.who.int/publications/i/item/9789241511124.

52 *Notification of the National Health Security Board Re: Type and Scope of Healthcare Service (2022)*; *Guidelines for Doctors' Practice Regarding HIV (2014)*; *Thailand National Guidelines on HIV/AIDS Treatment and Prevention 2021/2022 (2022).*

53 *Guidelines for Doctors' Practice Regarding HIV (2014).*

54 *Children's Act 38 (2005),* s. 130.

55 See, J. Lane et al., 'Policy considerations for scaling up access to HIV pre-exposure prophylaxis for adolescent girls and young women: Examples from Kenya, South Africa, and Uganda', available at https://pmc.ncbi.nlm.nih.gov/articles/PMC8908770/.

56 *Ghana Aids Commission Regulations (2020),* r. 23; *Ghana Health Services Consolidated Guidelines for HIV Care (2022).*

57 *Ghana Aids Commission Regulations (2020).*

58 *Ghana Aids Commission Regulations (2020),* r. 23.

59 *Law on HIV/AIDS in the Kyrgyz Republic No 149 (2015)*, Article 9.

60 *Rules for medical examination for the detection of human immunodeficiency virus, medical registration and monitoring of persons with positive and questionable HIV test results (2006)*, paras. 10, 14.

61 *Ministry of Health Regulation No 23 (2022)*, Annex, p. 57.

62 *Ministry of Health Regulation No 23 (2022)*, Annex, p. 57; *Ministry of Health Directive HK.01.07/MENKES/90/2019*, Annex, p. 29. Confirmed by Norton Rose Fullbright, based on conversation with Kelompok Dukungan Sebaya Pandawa.

63 Law No 1 (1974), Article 47(1) & (2).

64 *Republic Act 11166 (2018)*, s. 29.

65 *Republic Act 11166 (2018)*, s. 29.

66 *National Guidelines for HIV Counselling and Testing (2011).*

67 *National Guidelines for HIV Counselling and Testing (2011).*

68 See, e.g., UNICEF, *supra* note 26, at p. 22.

69 See, e.g., UNICEF, *supra* note 26, at p. 22; see also *General Comment No 4 on adolescent health and development in the context of the Convention on the Rights of the Child*, Committee on the Rights of the Child, CRC/GC/2003/4 (2003), at para. 16 [*GC 4*].

70 *CRC*, *supra* note 1, Articles 4, 34; *GC 4*, *ibid*, at para. 5.

71 See, e.g., *GC 20*, *supra* note 2, at para. 40; ICJ, *supra* note 27, Principle 16; ICJ, *Yogyakarta Principles: Principles on the application of international human rights law in relation to sexual orientation and gender identity,* March 2007, available at https://data.unaids.org/pub/manual/2007/070517_yogyakarta_principles_en.pdf, Principle 2 [*Yogyakarta Principles*].

72 See, e.g., *Concluding observations: Costa Rica*, Committee on the Rights of the Child, CRC/C/CRI/CO/4 (2011), at paras 27-28; *Concluding observations: Guyana*, Committee on the Rights of the Child, CRC/C/15/Add.224 (2004), at paras. 20-21.

73 See, e.g., *supra* note 2, at para. 40; see also ICJ, *supra* note 27, Principle 16.

74 See, e.g., *supra* note 2, at para. 40; see also ICJ, *supra* note 27, Principle 16.

75 *The Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 (2007)*, ss. 15-16 [*Criminal Law Amendment Act*].

76 *Criminal Law Amendment Act, ibid,* ss. 1(3)(d), 57.

77 *Criminal Law Amendment Act, supra* note 75, ss. 15-16.

78 *Republic Act 116481: An Act Providing for Stronger Protection Against Rape and Sexual Exploitation and Abuse, Increasing the Age for Determining the Commission of Statutory Rape, Amending for the Purpose Act No 3815, as Amended, Otherwise Known as 'The Revised Penal Code,' Republic Act No 8353, Also Known as 'The Anti-Rape Law of 1997,' And Republic Act No 7610, as Amended, Otherwise Known as the 'Special Protection of Children Against Abuse, Exploitation and Discrimination Act (2022)'.*

79 *Ibid.*

80 *Republic Act No. 9344: Juvenile and Justice Welfare Act (2006).*

81 *Republic Act No. 9344: Juvenile and Justice Welfare Act (2006)*; see also, e.g., J. Sanchez, *Overview of Philippine Juvenile Justice and Welfare*, 2017, available at www.unafei.or.jp/publications/pdf/RS_No101/No101_17_IP_Philippines.pdf.

82 *Criminal Code of the Kyrgyz Republic No. 127 (2021)*, Article 157.

83 *Criminal Code of the Kyrgyz Republic No. 127 (2021)*, Article 157

84 *Law No 2016/007 relating to the penal code (2016)*, s. 346(1).

85 *Penal Code*, *ibid*, s. 347(1); see, e.g., Human Dignity Trust, *Cameroon*, 11 October 2023, available at www.humandignitytrust.org/country-profile/cameroon.

86 *Act 29, Criminal Offences Act (1960),* ss. 14(a), 101-102.

87 *Act of the Parliament of Ghana entitled Human Sexual Rights and Family Values Act, 2024, an act to provide for human sexual rights and family values and related matters*; see also, 'Ghana's parliament passes anti-LGBTQ bill,' *Al Jazeera*, 28 February 2024, available at www.aljazeera.com/news/2024/2/28/ghanas-parliament-passes-anti-lgbtq-bill; M. A. Adombila, "Ghana lawmakers reintroduce anti-LGBTQ legislation," *Reuters*, 3 March 2025, available at www.reuters.com/world/africa/ghana-lawmakers-reintroduce-anti-lgbtq-legislation-2025-03-03.

88 *Act No 26, Child's Rights Act (2003)*, s. 31.

89 *Criminal Code Act (1990)*, ss. 214-352; *Same-Sex Marriage (Prohibition) Act (2013)*, s. 4(2); see also, Human Dignity Trust, *Nigeria,* 21 August 2024, available at www.humandignitytrust.org/country-profile/nigeria.

90 *Penal Code of Thailand (1956),* s. 277.

91 *Civil and Commercial Code of Thailand (1925),* s. 1448 [*Civil and Commercial Code*].

92 *Law No. 23 (2002).*

93 *Law No. 1 (2023).*

94 *Law No. 1 (1974).*

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