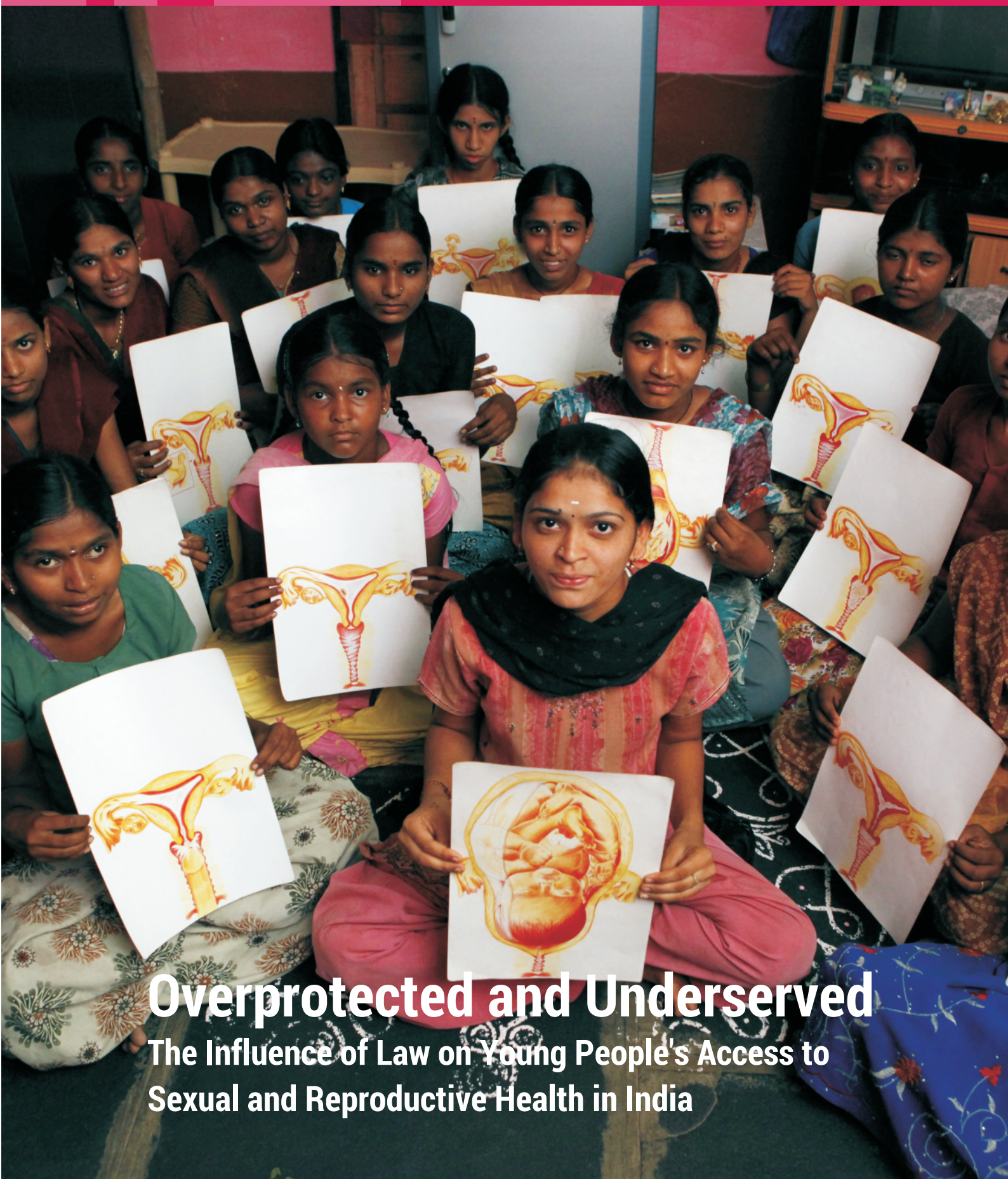
IPPF International Planned Parenthood Federation
South Asia Region

From choice, a world of possibilities



Overprotected and Underserved

The Influence of Law on Young People's Access to Sexual and Reproductive Health in India

Who We Are

The International Planned Parenthood Federation (IPPF) is a global service provider and a leading advocate of sexual and reproductive health and rights for all. We are a worldwide movement of national organizations working with and for communities and individuals in more than 170 countries. IPPF works towards a world where women, men and young people everywhere have control over their own bodies, and therefore their destinies. A world where they are free to choose parenthood or not; free to decide how many children they will have and when; free to pursue healthy sexual lives without fear of unwanted pregnancies and sexually transmitted infections, including HIV. A world where gender or sexuality are no longer a source of inequality or stigma. We will not retreat from doing everything we can to safeguard these important choices and rights for current and future generations.

Our Mission

To lead a locally-owned, globally connected civil society movement that provides and enables services and champions sexual and reproductive health and rights for all, especially the underserved.

Our Vision

All people are free to make choices about their sexuality and well-being, in a world without discrimination.

Acknowledgement

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This report was written by Elizabeth Yarrow; with support from Kara Apland, Jorun Arndt and Maurice Dunaiski at Coram International at the Coram Children's Legal Centre.

The methodology for this research draws and expands upon a pilot multi-country study conducted by Coram International and the International Planned Parenthood Federation in El Salvador, Senegal and the United Kingdom in 2012 - 2013.

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Foreword

Asia is home to 850 million young people in the age range of 10-24 years. Although living in very diverse realities they all share similar challenges in the form of lack of information and meaningful participation in accessing services for their health and well-being.

Every country has specific laws that regulate access to SRH services for different age groups in different contexts. However, research on young people to date, covers their lived experience more often in the context of social, cultural and economic influences on their well-being. The influence of existing laws, it's absence and the gaps in its implementation have very rarely been explored.

In the recent past there have been a few seminal works relating to the study of country laws in the Asia – Pacific Region, the understanding of the law by young people and service providers and the law's everyday implementation. This includes the 'Overprotected and Underserved' series conducted in El Salvador, Senegal and the UK by IPPF in 2014.

These knowledge products detail existing legal principles and provisions. Pertinently, the mixed methods (reviews, quantitative and qualitative research) used in the studies above provide hitherto unexplored insights into the interplay between academic, legal, social and cultural beliefs and practices that together encourage or impede a young person's access to sexual and reproductive health services.

In line with these series in Europe, Africa and parts of the Asia Pacific, the International Planned Parenthood Federation – South Asia Regional Office (IPPF – SARO) in partnership with UNFPA – Asia Pacific Regional Office (UNFPA – APRO) embarked on creating an evidence base specifically for the South Asia Region. In 2015, the studies have been conducted for India and Sri Lanka.

Informed by the methodologies used previously, this report includes an introduction to current academic discourse on laws that regulate SRH service provision and the diverse lived experiences of young people and service providers. Young people living in rural and urban spaces, young adolescents from in-school and out-of-school settings, members from young key populations, young people living in post-conflict settings and service providers practicing in government and Member Association run service delivery points were interviewed and surveyed. Uniquely their knowledge, attitudes and practice on consent to medical treatment; privacy, confidentiality and reporting; age of sexual consent; criminalisation of same-sex activity and gender based violence have been explored.

Specific legal provisions pertaining to these thematic areas are detailed below.

- In contradiction to the law in both countries, young people in India and Sri Lanka reported that they would have to be 18 years or above in order to access a SRH service. While service providers in India reported being hesitant to provide a service to a minor, service providers in Sri Lanka reported that they would provide services informed by the capacity of the young person.
- The study responses indicate that young people in India and Sri Lanka are not confident and lack clarity regarding doctor-client confidentiality as their right whilst seeking a service. More worrisome is the fact that neither country has a legal precedent for the same.
- The laws that penalize sexual assault and statutory rape have been observed to set the precedent on the age at which young people perceive it alright to access SRH services contraceptives.
- Same sex sexual activity in India and Sri Lanka is criminalised. In India section 377 has been upheld again and in Sri Lanka section 365 (a) still remains in the books. Young people, including young members of the LGBT community continue to face incredible amounts of violence and discrimination

from those very institutions that should be protecting and providing services to them, the police and health services.

- Marital rape even when the couple are not judicially separated, inclusion of 'sexual violence' of men as rape in legal precedents and the need to remove 'exceptions' in laws relating to sexual and gender based violence are required to overcome rape culture, impunity and reduced reporting of acts of violence by young people.

The IPPF- UNFPA partnership in the South Asia Region aims to ensure continued investment by all stakeholders to better understand, train and implement services and programming for young people. Knowledge products such as the 'Overprotected and Underserved' series provide information that can be used to improve the versatility of a broad range of services such as Comprehensive Sexuality Education, Child Protection, Values Clarification and Attitude Transformation and Behaviour Change Communication. It provides a strong and current evidence base for advocacy and accountable collaboration among networks, organisations and individuals working with young people in the region.

Importantly, we are confident that these initiatives provide voice to young people and their collective wisdom in ensuring that they experience happy, healthy, safe and fulfilling sexual and reproductive health and wellbeing.

Anjali Sen
Regional Director
IPPF South Asia Region

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USAID | INDIA

Executive Summary

This study exploring legal barriers to young people's access to sexual and reproductive (SRH) services in India contributes to filling an important gap in research. Whilst existing research has begun to explore the social, cultural and economic barriers to young people's access to SRH, much less is known about the influence of law, as well as knowledge and perceptions of law, on access to services.

The research included a legal and policy review of laws related to SRH, as well as the collection and analysis of qualitative and quantitative data from young people, parents and service providers in India.

Laws that regulate access to services

Consent to medical treatment

Indian statutes do not include any specific provisions in relation to young people's ability to consent to medical treatment, including SRH services. Nevertheless, three pieces of legislation have been used to interpret the law regarding young people's access to SRH services: the Penal Code, the Majority Act and the Contract Act. Together these pieces of legislation contain provisions that imply that children under 18 years may require parental consent in order to access medical services, including contraceptives and STI testing. Children under 12 years always require parental consent. The Government has developed specific guidelines in relation to HIV testing, such that children under the age of 18 years must have parental or guardian consent.

Participants in the research were unsure of the law concerning children and young people's access to SRH services. Most young people believe that legal access to services, especially for under-18s, is subject to the discretion of the service provider. Some service providers reported that they would not provide contraceptives, and STI testing to children under 18, expressing the view that young people lack capacity to make informed decisions about health services, and that providing SRH services to under-18s is inappropriate and may encourage 'underage' sex.

Abortion

Abortion is the most heavily regulated SRH service in India. The law in India is permissive in comparison to legislation in other states in South Asia; nevertheless, significant legal restrictions on access to abortion remain. Three pieces of legislation establish provisions for access to abortion: the Penal Code, the Medical Termination of Pregnancy Act (MTP Act), and The Preconception and Prenatal Diagnostic Techniques Act (PCPNDT Act).

The Penal Code criminalises abortion, but the MTP Act creates a number of exceptions to this, legalising abortion in the case that it is 1) necessary to preserve the life or (physical or mental) health of the pregnant woman or girl, or 2) if the foetus has developmental abnormalities. The law also clarifies that if the pregnancy is the result of rape, or if a married woman/ girl was using contraceptives, these factors are sufficient to satisfy condition 1). The final piece of legislation is the PCPNDT Act, which prohibits the practice of sex-selective abortion. Finally, and significantly, the MTP Act provides that written consent from a legal guardian is required for a girl under the age of 18 to access abortion. This rule creates a direct legal barrier to access to abortion for girls who are unwilling or unable to obtain parental or guardian consent to access abortion.

Whilst service providers were aware of the specifics of legal provisions regulating abortion, young people had less detailed knowledge. Many young people thought that abortion was completely illegal for girls under 18.

Comprehensive sexuality education

There is no national legislation mandating comprehensive sexuality education (CSE) in Indian schools. In 2005, the Ministry of Human Resource Development and the National AIDS Control Organisation launched an Adolescence Education Programme (AEP) for students in classes 9 – 11, which was implemented in 112,000 schools over the period of 2005-2006. Controversy over the sex-related content of the programme, however, resulted in several states subsequently banning the provision of AEP in state-run schools. In light of this, a revised and more limited curriculum was developed., which is now being implementing high schools and higher secondary schools.

Despite some basic SRH knowledge, the research findings indicate that young people lack accurate information about SRH, and that myths and misconceptions about sexuality, contraception, and STIs are rife, affecting service-seeking behaviour.

Whilst service providers emphasised the need for improved education; parents appeared reluctant to support the introduction of SRE in schools believing that it would encourage their children to experiment in sexual activity prior to marriage, which is unacceptable according to dominant cultural and religious norms.

Privacy, confidential and reporting

The Indian Medical Council Code of Ethics Regulations (2002) protect doctor-patient confidentiality. However, neither statute nor legal precedent clearly establish a minimum age at which a person has the right to access SRH services confidentially. Furthermore, mandatory reporting requirements contained in the Sexual Offenses Act require all legal persons, including health workers, to disclose any sexual activity involving a person under-18 years to the police. This provision undermines confidential access to SRH services for under 18s. Providers claimed not to be following this law in practice, regarding it to be onerous and unhelpful. Young people interviewed in the research did not trust that their confidentiality would be protected if they attempted to access SRH services, this was found to inhibit service-seeking.

Laws that regulate sexual identity, behaviour and relationships

Age of marriage

The India Prohibition of Child Marriages (PCM) Act of 2007 sets the minimum age for marriage at 18 years for girls and at 21 years for boys. Since dominant social and religious norms dictate that young people should not be having sex prior to marriage, many respondents felt that this SRH services are not available to young people who are under these legal ages.

Age of sexual consent (statutory rape and sexual assault of minors)

Respondents were also aware that the law provides that sex with a minor below a certain is a criminal offence. Most participants believed this age threshold to be the same as the minimum legal age for marriage. However, the minimum age of sexual consent is actually 18 for both boys and girls, as established by the Criminal Law (Amendment) Act 2013 (which applies to girls) and the Protection of Children from Sexual Offences (PCSO) Act 2012 (which applies to people of all genders).

Statutory rape and age-bound sexual assault laws were found to influence young people's ideas about the age at which it is acceptable to be sexually active, and to access SRH services: for example, many young people felt that it would be prohibited for a young person under the age of sexual consent to access contraceptives.

18 years is a comparatively high age at which to set the minimum age of sexual consent, and does not reflect actual sexual practices. According to the latest DHS data (2006), as many as 50.5% of females, and 14.4% of males who had ever had sex, first had sex prior to the age of 18 years.

Rape and sexual assault (over 18s)

There are several gaps in legislation in relation to protection of individuals from rape and sexual assault.

There are no provisions in law that protect male or third sex young people, over the age of 18 years, from rape or sexual abuse. (The Indian Criminal Law (Amendment) Act 2013 only applies to female victims of rape; meanwhile the Protection of Children from Sexual Offences Act 2012 is gender neutral but only applies to children under the age of 18 years). Whilst Section 377 of the Penal Code punishes 'carnal intercourse against the order of nature', this provision implies that male victims of rape are liable to be treated as perpetrators rather than victims under the law.

Penal law also contains an exception for the crime of rape, where forced sexual activity takes place in the context of marriage: section 376A of the Indian Penal Code provides that a married woman may be the victim of rape only if she is judicially separated from her husband. The Indian Domestic Violence Act Section 3 introduces a limited protections in law with regard to marital rape, however this section only covers marital rape under circumstances of life-threatening and grievously hurtful conduct, and further only provides civil remedies, thus still not criminalising the act.

Limited legal definitions of sexual violence and abuse create barriers to access to services for victims. Survivors of abuse may be unwilling and reluctant to seek out services where they perceive their experiences as lacking validity or recognition, and providers may be less willing to offer support.

Evidence from the research indicates that reporting of sexual and gender based violence (SGBV) and provision of support services may be limited. Exceptions in law for the crime of rape were found to underscore a 'rape culture' whereby some forms of sexual violence and coercion were regarded as excusable, normal or justified, creating a culture of impunity for acts of abuse, and serving as a barrier to access to services for survivors.

Recognition of third gender status

Up until 2014, legal identity was only available for two sexes: male and female. However, in April 2014 the Supreme Court in India ruled that transgender people should be legally recognized as a third gender, and that the anti-discrimination provisions under Articles 14 to 16 of the Indian Constitution apply to trans and hijra communities. The court directed the central and state governments to take necessary steps to allow for equal status for third gender individuals, including ensuring adequate healthcare, education and employment, separate public toilets and safeguards against discrimination. Further, the court directed that all identity documents such as birth certificates, passports and driver's licences must henceforth have the possibility for a person to identify as third gender.

Respondents in the research were aware of this ruling, however, evidence from the research suggests that discrimination, exclusion and abuse of trans people remains pervasive. Trans individuals said that they were not willing to access non-specialised SRH services due to poor treatment and prejudice displayed

by general health staff. Furthermore, the lack of legal and policy provisions establishing free and safe sex reassignment surgery in public health institutions denies access to a vital health service for young trans people, who may alternatively undergo dangerous and harmful ritual castrations.

Criminalisation of same-sex activity

The protection of third sex individuals against discrimination under the constitution is undermined by Section 377 of the Penal Code which criminalises 'carnal intercourse against the order of nature with any man, woman or animal'. This provision is generally understood as prohibiting same-sex activity amongst MSM, including gay and bisexual men, as well as trans women and hijras who have not undergone sex-reassignment surgery, even in private spaces. As the law refers particularly to penetration, it is not clear whether this provision criminalises same-sex sexual activity amongst women and girls.

In 2009, the Delhi High Court overturned section 377 of the Penal Code in a historic case, legalising consensual same-sex sexual activities between adults. However, this decision was subsequently overruled. In 2013, the Supreme Court upheld Section 377, stating that the law only applies to a 'miniscule minority', with fewer than 200 prosecution under Section 377 in the past 150 years. Nevertheless, the impact of the law stretches beyond the number of formal prosecutions. Findings from the research indicate that the criminalisation of same-sex activity promotes discriminatory attitudes and violence against gay, bisexual, and trans individuals; including by police, health providers and other authorities. It also creates significant barriers to access to SRH services for MSM individuals by reinforcing the shame and stigma associated with alternative sexual identities.

Sex work

Sex work in India is not illegal per se, however, under the Indian Immoral Traffic (Prevention) Act 1956, soliciting in a public place, curb crawling (driving around areas known for street prostitution in order to solicit prostitutes), owning or managing a brothel, prostitution in a hotel and pimping are all crimes. Prostitution is legal only if carried out in a private residence of a prostitute or others. Although the law contains no direct barrier to access to SRH services, criminalising the sale of sex places women at risk of prosecution; as well as violence and harassment by both clients and law enforcement; driving the practice of sex work and the selling of sex underground and potentially inhibiting access to formal services and justice mechanisms. The law may have a disproportionate effect on young people who sell sex, who by nature of their age and lack of experience are more vulnerable to abuse by both clients and law enforcement.

Conclusions

The research indicates that the law creates a number of direct and indirect barriers to young people's access to SRH services in India. However, laws need not only serve as a barrier to access to services: laws can also facilitate access, where they empower young people to make informed decisions about their own sexual health, and create a framework where young people's rights to sexual and reproductive health are protected and promoted without discrimination. The research points to the need for a number of legal and policy reforms, which have the potential to improve young people's access to SRH services in India.

Introduction

Whilst previous research has begun to explore the social, cultural and economic barriers to young people's access to SRH, much less is known about the influence of law, as well as knowledge and perceptions of law, on access to services. This is despite the fact that every state around the world, without exception, has developed legislation that is in some manner designed to regulate and restrict access to SRH for different groups of people, in different circumstances. In recent years there has been a growing interest among SRH advocates and activists in exploring the interplay between legal frameworks and access to SRH services. This research project contributes to efforts to build evidence and knowledge in this area, to guide future advocacy and programming work, with the ultimate aim of fulfilling young people's right to sexual and reproductive health.

The research builds upon a similar pilot multi-country study conducted in El Salvador, Senegal and the United Kingdom in 2012 – 2013.

Key Concepts and Definitions

A number of key terms are used throughout the report. These are defined as follows:

For the purposes of this study a young person is defined as anyone between the ages of 10 and 24 years. A child is defined as anyone under the age of 18 years old, in accordance with Article 1 of the UN Convention on the Rights of the Child (UNCRC). The word 'child' is used in the report as this is a legal term, with clear and defined implications under the law. Sometimes in the text the word 'adolescent' is used instead of child, to connote the social and biological stage of development that occurs between pre-pubescent childhood and adulthood.

Gender: refers to socially constructed ideas, norms, roles and identities associated with being 'male' or 'female'.

Sexuality: is a broad term that refers to the way an individual expresses themselves as a sexual being. It may include a person's feelings, thoughts, attractions, preferences, as well as behaviour.[1]

Third gender: describes people who identify as a gender/ sex other than man/ male or woman/ female.

Hijra: also known as aravani, are regarded as a "third gender" in India. Most hijras were identified as male at birth, and many have undergone a ritual emasculation operation, which includes castration. Becoming a hijra involves a process of initiation into a hijra family under a guru-teacher, who has a parental role.[2]

Transgender/trans: an umbrella term used to describe a wide range of distinct groups of individuals who do not identify with the sex that they were assigned at birth. Transgender identity is not limited to, but may include, those who have undergone medical or legal identity transformation. Transgender individuals may self-identify as transgender, transsexual, female, malehijra, kathoey, waria, or many others.

MSM: ('men who have sex with men') refers to all men who engage in sexual and/or romantic relations with other men. As used in this report and in line with the definition used by UNFPA, UNDP, UNAIDS, WHO and the World Bank, the term is "inclusive both of a variety of patterns of sexual behaviour by males with members of the same sex, and of diverse self-determined sexual identities and forms of sexual and social associations ("communities").

LGBTI: Is a broad term that refers to individuals who are either lesbian, gay, bisexual or transgender or intersex.

Sexual and reproductive health is understood as encompassing two related but distinct elements: health related to sexuality, and health related to reproduction.

- Sexual health implies that an individual has the freedom to have a pleasurable and safe sexual life, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.[3]

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[1] *The University of Western Australia, retrieved 18 December, 2015, from http://www.student.uwa.edu.au/life/health/fit/share/sexuality/definitions*

[2] *UK Home Office "Country information Country Information and Guidance India: Sexual orientation and gender identity", (London: UK Home Office, 2014), p. 20, accessed 10th October 2015. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/332640/India_CIG_LGBT_claims_2014_07_18.pdf*

[3] *World Health Organisation, "Defining Sexual Health", retrieved on 30 September 2015 from http://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/*

- Reproductive health implies that an individual has the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this is the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women and to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant".[4]

Sexual and reproductive health (SRH) services: in line with these definitions (above) the study considers young people's access to services that are relevant to promoting and protecting sexual health and reproductive health. These will include, but are not limited to: education and counselling in relation to sexual and reproductive health, contraception, family planning, abortion, pre-natal and postnatal care, maternal and infant mortality, gender/sex reassignment services, and services related to the prevention and treatment of sexually transmitted infections (STIs) and sexual violence.

Sexual and reproductive rights: refers to an individual's right to have control over and make informed and free decisions on matters related to sexual and reproductive health, as well as their sexuality and sexual and reproductive life, free of coercion, discrimination and violence.[5]

Sexual and gender-based violence (SGBV) is a broad concept that refers to any action that is perpetrated against an individual because of sex, gender or sexuality and that results in, or is likely to result in, physical, sexual or psychological harm or suffering; including threats of such action or coercion. SGBV is committed for the purposes of maintaining (heterosexual) male/ masculine privilege, power and control over women, and others whose identity and behaviour does not conform to dominant ideas about gender, sex and sexuality.[6]

Sex work: refers to the exchange of sexual practice for money, goods or services by male, female or transgender individuals, aged 18 and over, who consider this activity to be a source of income, irrespective of whether they identify as "sex worker" or consider the activity to be "work". The internationally recognised definition of sex work excludes where a person is coerced into selling sex or is selling sex involuntarily.

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[4] *World Health Organisation, "Reproductive Health", retrieved on 30 September 2015 from http://www.who.int/topics/reproductive_health/en/.*

[5] *For more detail on the range of sexual and reproductive rights, see the International Planned Parenthood's 'Charter Guidelines on Sexual and Reproductive Rights', available at: http://www.ippf.org/sites/default/files/ippf_charter_on_sexual_and_reproductive_rights_guidlines.pdf*

[6] *UNHCR, "Sexual and Gender Based Violence: Guidelines for Prevention and Response" Retrieved on Retrieved on 25 July 2015 from http://www.unicef.org/emerg/files/gl_sgbv03.pdf*

Conceptual Framework

This study was designed to examine the following:

1. the legal rules that regulate young people's access to SRH services, and how they are applied;
2. young people and health professionals' knowledge of law, and how they perceive or interpret such laws as pertaining to themselves;
3. and, importantly, how law, and knowledge and perceptions of law, impact on young people's opportunities to seek out, and be provided, SRH services.

The relationship between law and access to SRH services

Law may influence or impact on young people's access to SRH services in various ways: the law may act as a barrier to young people's access to services through both direct and indirect means. In other cases, the law may actively facilitate young people's access to services.

Direct legal barriers are laws which explicitly and purposefully restrict access to services either universally or for certain groups of people in certain circumstances. For example, laws that restrict access to abortion, except for married women, and/ or to preserve the health of the mother, constitute direct legal barriers.

Indirect legal barriers are laws that do not directly impose restrictions on access to SRH services, but nonetheless may function this way in a particular context. For example, statutory rape laws - which establish a minimum legal age for consent to sexual activity, minimum age of marriage laws, and law establishing a minimum age for legal majority, may create indirect legal barriers to young people's access to services. Young people and service providers may interpret these rules as forbidding persons under these legal ages from accessing SRH services. Furthermore, these laws may have a normalising influence on existing social taboos associated with childhood and youth sexuality, particularly among unmarried girls.

Limited legal definitions of sexual violence and rape, which fail to recognize sexual abuse in all the contexts within which it occurs, such as the failure to explicitly prohibit rape within marriage may also create indirect legal barriers to access to services. Individuals may be unable to access support services, in contexts where experiences are not recognized, or are seen as lacking validity or importance.

The criminalization of homosexuality within Indian law can be understood as creating both direct and indirect barriers to young people's access to sexual and reproductive health services. On the one hand, these legal restrictions may actively prohibit the provision of certain services (including access to education and information, and others) required by young people for them to be able to have a healthy and satisfying sexual life (direct barrier). On the other hand, even where services do exist or are made available, some young people may be unable to access them due to fear of being criminalized or suffering discrimination and abuse on account of their sexuality (indirect barrier).

Finally, laws do not only function as barriers to accessing SRH services. Laws can also facilitate access to services, where they empower young people to make informed decisions about their own sexual health, and create a framework where young people's rights to sexual and reproductive health are protected and promoted without discrimination. Confidentiality duties imposed on SRH services providers which mandate protection of young people's privacy and laws that promote comprehensive sexuality education are examples of facilitative laws.

Methodology

1. Research Questions

Understanding the influence of law and legal rules on young people's access to SRH services in practice is a complex task. It involves understanding both what the law is, and how it is applied; as well as what young people and service providers know and understand about the law, and if and how such perceptions shape their choices, expectations and practices accessing or providing SRH services. Finally, it involves understanding how the law interacts with other key social, political, personal, economic (etc.) factors, which play a role in determining young people's access to services.

The following set of research questions were developed to gather information relevant to the areas set out above:

1. What are the direct and indirect legal barriers that influence young people's access to SRH services and how do they impact on young people's access?
2. What do young people know about the law as it applies to SRH services?
3. What do they know about the law as it applies to sexuality and sexual activity?
4. How do young people perceive or interpret such laws as applying to themselves or their peers?
5. How does this knowledge and perception influence their access to SRH services?
6. What are their experiences accessing SRH services and how do they expect this process to occur?
7. What are the gaps in their information and access?
8. How do legal barriers interact with social, cultural or other barriers to accessing SRH services?

2. Research Methods

This study employed a number of methodological approaches to answer the above research questions. To begin with, a desk-based review and analysis of existing laws and regulations was carried out in order to establish the content of legal provisions regulating young people's sexuality and access to SRH services.

Qualitative data was collected through individual interviews with SRH service providers (nurses, doctors, counsellors, etc.) as well as focus group discussions (FGDs) with groups of young people and parents. These qualitative interactions aimed to provide a more in-depth and contextual understanding of young people's and service provider's experiences of accessing/providing SRH services, and the relevance, role and influence of law: whether, how and why law has an influence in practice. In total, 109 respondents were access during the qualitative field research, which took place between the 26th and the 30th October 2015.

Finally, two quantitative surveys were distributed in-country – one to young people and one to service providers – to gather a limited amount of standardised and objective data concerning knowledge of relevant law, and SRH services seeking/ provision practices. Overall, surveys were distributed to 696 young people and 57 service providers.

3. Sampling

3.1. Site Selection

Selection of sites was practically limited to include those locations where FPA were able to facilitate access to communities and respondents according to their existing networks.

	Ahmedabad	Bangalore
Geographical location	Western/ central	Southern

Data was collected in the following sites:

Both locations in India comprised diverse, urban communities; although in Bangalore researchers included one site that was outside of the Municipal Authority for Bangalore, and was under a local rural administration, and thus can be considered more 'peri-urban' in nature.

3.2. Qualitative interactions: Interviews and FGDs

Sampling for the qualitative research was purposive, to ensure the inclusion of the views and experiences of a large range of different groups of young people, parents/ carers, and health professionals. The sample of service providers included Doctors, nurses, midwives, and NGO providers (educators/ counsellors).

For the FGDs with young people and parents, participants were purposively sampled to capture to the greatest extent possible the views and experiences of individuals from different age-groups, socio-economic, educational and religious backgrounds. Researchers also selected fir diversity with regard to sexual behaviour, identity and relationships, ensuring to inclusion of individuals of minority sexual and gender identities and those engaged in sex work or the selling of sex. Respondents in focus group discussions were separated according to gender due to the sensitive nature of the issues under discussion.

3.3. Survey

Given time and resource constraints, it was not feasible to conduct a comprehensive, nationally representative survey. Nonetheless, two short survey tools were developed – one for young people and one for service providers – in order to collect some basic descriptive and standardised data that could be analysed objectively in relation to respondents' knowledge, understanding and perceptions of law, and experiences accessing or providing services.

Respondents for the survey were accessed through institutions including schools and health services. Schools and health services were divided into strata according to whether they were public or private institutions, and whether they provided general or specialised services. Individual institutions were selected from within these strata, and the survey was then distributed randomly to young people and service providers within these institutions.

For a more detailed discussion of the study methodology, including sampling design and data analysis techniques, please see Annex A. The 'interview schedule' used during the in-depth interviews with service providers can be found in Annex B. The 'group discussion schedule' used during the FGDs with young people and parents can be found in Annex C. The survey questionnaires are included in Annex D (service providers) and Annex E (young people).

4. Limitations

There are a number of methodological limitations in relation to the desk review, the qualitative interactions, as well as the quantitative surveys that need to be kept in mind when reading this report.

- The findings only reflect data from two (predominantly urban) sites in India. Given the size and diversity of India this limits the generalizability of research data.
- While the desk review of the relevant legislation aimed to be comprehensive, not all potentially relevant materials (especially regulations and sub-national legislation) were available publicly and in English language. As a result, it is likely that at least some potentially relevant materials were not captured by the desk review. Whenever possible, researchers used officially translated English versions of the relevant legislation. However, in a few cases, researchers needed to revert to unofficially translated versions of legislation or regulations. These English translations were read and interpreted by researchers with the necessary amount of caution.
- Whilst participants in focus groups were separated according to gender and also divided according to age groups, it is likely that power dynamics within each group biased the discussions (and findings) in favour of the more outspoken and assertive participants. Researchers took care to enable equitable discussions amongst participants; however, participants that were too shy or afraid to answer were never singled out by researchers.
- Translators were used throughout the qualitative interactions. While emphasis was placed on literal translation of every statement and simultaneous translation was avoided, it is likely that some nuances of the participant's responses were 'lost in translation'.
- The implementation of the surveys (both with service providers and with young people) also entailed a number of methodological limitations. In practice, it was difficult to ensure that individual institutions were selected randomly from within the pre-specified strata, and that the survey was then distributed on a purely random basis to young people and service providers within these institutions. Researchers often needed to rely on the connections of the local IPPF member associations in order to gain access to particular target groups/institutions. This is likely to bias the discussion/findings in favour of target groups/institutions that had pre-existing connections to the local IPPF member associations. While care was taken to distribute questionnaires to a random selection of individuals within each selected institution or target group, surveys were filled out on a voluntary basis which is likely to have introduced some bias into the sample.
- Lastly, due to time and resource constraints (but also in order to ensure the confidentiality of the respondents), the survey questionnaires were self-administered. While enumerators instructed survey respondents on how to fill out the survey, the self-administered survey format resulted in relatively large non-response biases, as respondents were either unsure how (or unwilling) to fill out all questions in the surveys. Non-response was particularly pronounced in the service provider survey, which may be due to the time constraints amongst health professionals.

5. Ethical protocol and tools

The research process was guided by Coram International's Ethical Guidelines for Research (annexed below). Prior to data collection taking place, the Director of International Programmes and Research, Professor Carolyn Hamilton, approved the research methodology, tools and ethical protocol. Ethical approval was also obtained from IPPF South Asia as well as the FPA India.

An Ethical Protocol and tools (consent forms and information sheets) are attached at Annexes A and B.

Youth and Sexuality

6. Cultural Context: love, marriage and sexual relationships

In communities included in the study, dominant social norms dictate that young, unmarried persons should not be having sexual relationships. Across research sites, the normative prohibition of sex prior to marriage was articulated strongly by young people of all religions. The stigma surrounding pre-marital sex was reflected in qualitative interactions where young people were frequently reticent to acknowledge that sex outside of marriage ever occurs: "as far as our community is concerned, I don't think it [sex before marriage] is possible….We don't have that in our culture."[7] According to the latest DHS data from India from 2006, as few as 1.1% of unmarried females (age 15 – 49) reported to have ever had sex, although this figure was found to be significantly higher for males at 13.7%.[8] A study conducted by the International Institute for Population Sciences and Population Council in six Indian states also found that as few as 5% of young women, and 11% of young men aged 15-24 reported to have engaged in pre-marital sex by the time they were 20 years old.[9]

Young people included in the research emphasised that sex before marriage is wrong, and 'indulging' in sex before marriage can damage a young person's reputation, along with the reputation of their family:

> *"Sex – it should happen after marriage. If you are a girl – and what if you have sex with that boy - and what if he leaves you? Then it will be very difficult for you in the society to go for a marriage, or for your parents to show face to other society members. As a friend, I would advise you – wait until after marriage. I wouldn't want my good friend to end up in such problems."*[10]

The prohibition on pre-marital sex ostensibly applies to all young people. However, it is young women's and girls' sexuality that is subject to the most social scrutiny and judgement; as a group of girls in Bangalore described:

> *"If anyone sees us talking to a guy – probably he's only our friend – but still society will think 'oh it's her boyfriend'. Or if we're on our mobile – 'it's her boyfriend'. And if we wear something with half sleeves, or sleeveless – that again people will be judgemental about that. And if we don't have our hair tied up, they will be judgemental about that…. The girls don't have freedom, but the boys do… Many of the older people in the family and the community – they believe that generally the girls are less [than a boy] – they have less knowledge about the world around them. So they consider the men to be dominant."*[11]

Conservative norms about pre-marital sex were reflected in participants' descriptions of traditional courting scenarios, according to which engaged couples are not permitted spend time alone together and may not meet in person prior to their wedding: "where I come from I cannot even look at a girl's face before marriage. When we decide on a girl the parents can see her face, but the bridegroom is not allowed to see her until the day of the marriage".[12]

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7 *Focus group discussion, girls, Bangalore, 29 October 2015*

8 *Data obtained from secondary analysis of the Demographic Health Survey Dataset, India, 2006.*

9 *International Institute for Population Sciences and Population Council, 2010*

10 *Focus group discussion, young men, Ahmedabad, 27 October 2015*

11 *Focus group discussion, girls, Bangalore, 29 October 2015*

12 *Focus group discussion, young men, Ahmedabad, 27 October 2015*

On the other hand, many other respondents described how these norms are changing in contemporary times; with parents increasingly recognising that young people may wish to spend time getting to know each other prior to marriage:

> *"Nowadays, parents first do an engagement to let the couple understand each other... in previous times parents didn't give time to children to understand their partner. It used to be that the girl only got to know her partner on the day of her wedding. [But] that is changing."*[13]

In addition, according to some participants, 'love marriages', where young people meet and choose a partner for themselves - as compared to traditional 'arranged' marriages, where a person is introduced to their spouse through their parents or other relatives – are becoming increasingly more prevalent and acceptable in communities:

> *"Love marriages are better [than arranged marriages]. In a love marriage they know the person much better – since the beginning [of the marriage] or for a long time. In an arranged marriage they come to know the girl later [after the marriage]."*[14]

Despite the increasing availability of love marriages, arranged marriages appear to remain the dominant norm; regarded as valuable for maintaining family networks and ensuring social security of the couple, and support for their marriage. A group of young women in Ahmedabad explained:

> *"We are not ok with love marriages…. [People] should only get married after taking advice from their parents. [Otherwise] if the marriage doesn't work, then the parents won't support them – they will say – you did a love marriage, so now you handle this yourself. So then it is difficult for the girl to survive."*[15]

Nevertheless, many young people emphasised that when it comes to their own marriage, they themselves would prefer to marry someone that they fell in love with, rather than a person chosen by their parents. The desire to reconcile traditional norms, with modern marriage practices is reflected in the emergence of a new 'category' of marriage, referred to as 'love-come-arranged' matches, whereby young people are able to choose their marriage partner, but do so in consultation with and with the approval of their parents:

> *"We have all types of marriages in our community – love marriages – where the couple decides; arranged marriages – where the parents decide; and 'love-come-arranged' marriage, where the children are in love but their parents [also] support them."*[16]

The increasing emergence of 'love' marriages, or 'love-come-arranged' marriages in communities in India is significant given that love marriages involve young people establishing a relationship prior to their engagement or marriage, and it is recognised that this relationship may entail engaging in pre-marital sex. A group of young women explained why pre-marital sex is more acceptable in the context of a love marriage:

> *"In the case of love marriages, the couple go out and they get into a sexual relationship… In the case of love marriage this is ok because the couple know each other well. But in the case of arranged marriage they don't know each other so that is not right."*[17]

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[13] *Focus group discussion, girls, Ahmedabad, 26 October 2015*

[14] *Focus group discussion, young men, Ahmedabad, 27 October 2015*

[15] *Focus group discussion, young women, Ahmedabad, 26 October 2015*

[16] *Focus group discussion, mothers, Bangalore, 29 October 2015*

[17] *Focus group discussion, young women, Ahmedabad, 26 October 2015*

As this extract illustrates, the increasing prevalence of love marriages appear to be associated with a subversion of traditional norms prohibiting pre-marital sex. As norms are shifting, young people in contemporary communities in India may experience disconnect between their personal desires and realities, and dominant religious and cultural narratives to which they also feel compelled to comply. One group of young women described their struggles and dilemmas:

> *"I aspire to become a doctor, but I worry – what if I fall in love with someone? I believe in arrange marriages and I am worried that if I fall in love with someone my parents will become embarrassed. We have seen a lot of cases in our society, but now that we know Karate this has increased our self confidence that we can be strong women too! And if our parents encourage us that can help us too."*[18]

Understanding the disconnect between dominant social norms and young people's realities is crucial to understanding how young people understand and negotiate their sexuality in contemporary communities in India; which has significant implications for access to SRH services, particularly for unmarried youth.

7. Legal context: law, marriage, and sexual consent

Just as marriage is a pre-condition for sexual activity, being of a sufficiently mature age is a pre-condition for marriage; and this is not only a matter of social norms, it is also a matter of law. The India Prohibition of Child Marriages (PCM) Act of 2007 sets the minimum age for marriage and 18 years for girls and at 21 years for boys. Whilst statutory law does not include a legal prohibition of sex before marriage - although this may be the case for Muslim communities according to some interpretations of sharia law - the minimum legal age of sexual consent is also set at 18 years[19] the same age as the minimum legal age for marriage for girls.

18 years is a comparatively high age at which to set the minimum age of sexual consent, and does not reflect actual sexual practices. According to the latest DHS data, as many as 50.5% of females, and 14.4% of males who had ever had sex, first had sex prior to the age of 18 years. The establishment of the legal minimum age for sexual consent at 18 years may rather reflect social norms that dictate that girls (at least) should not be eligible to be sexually active before they are legally eligible to marry. (Young men, on the other hand are legally able to consent to sex 3 years before they are legally eligible for marriage).

This can further be seen by the establishment of an exception to the minimum age of sexual consent (in the Criminal Law Amendment Act)for married girls: s375 of the Act provides that 'sexual intercourse, or sexual acts by a man with his own wife, the wife not being under 15 years of age is not rape'.[20] This provision legalises (statutory) rape by a husband of his wife in all circumstances as long as she is above 15 years of age.[21]

Whilst laws that establish a minimum age for sexual consent, and for marriage, are purported to fulfil a protective purpose (to guard young people from exposure to rights violations such as forced marriage or child sexual abuse), there can be no justification on protection grounds for differentiating between children based on their gender or marital status. Such rules highlight how - as well as serving a protective purpose -these laws function to describe and prescribe particular ideas and values concerning age, gender, sexuality and marriage.

[18] *Focus group discussion, girls, Bangalore, 30 October 2015*

[19] *The Protection of Children from Sexual Offences Act 2012 s 2.1 (d).*

[20] *Criminal Law (Amendment) Act 2013 s 375.*

[21] *Although, inconsistently, there is no such exception in the Protection of Children from Sexual Offences Act (PCSP Act). Section 3 of the PCSP act sets out the crime of "penetrative sexual assault" which includes the same actions as those defined as "rape" under Section 375 a)-d) of the Criminal Law (Amendment) Act 2013, as above, if committed against any child below the age of 18.*

The establishment of a younger age of eligibility for marriage for females than for males derives from stereotypes about gender and sexuality, and the differently perceived roles of men and women within marriage and society; it serves to institutionalise and entrench a discriminatory norm that it is appropriate for men to be older than their female partners, to reflect the hierarchical nature of the relationship that is supposed to exist between them.

Focus Group Discussion, Girls, Bangalore

> *What age do people get married in your community?*
>
> *The age is 21 years for girls, and 24-27 years for boys.*
>
> *Why is it that boys get married older than girls?*
>
> *Boys will be pursuing their studies, but girls will be at home.*
>
> *Why is that?*[22]

That's the mentality of parents. They will be so eager for their girls to get married. They won't think that it is important for them to be educated.

Additionally, the establishment of an exception to the minimum legal age of sexual consent for married girls[23] (and the legal exception excluding all married women above 15 years from legal protection from rape by their husbands) is especially revealing: such a provision implies that early sexual activity is only harmful to girls where it takes place outside of the sacrosanct institution of marriage, and that (statutory) rape of a girl is criminal on the grounds that it violates social norms about the appropriate context for sexual expression and not because it violates the sexual autonomy of a girl/ woman.[24]

This analysis is important: whilst on the one hand, laws prohibiting early sex and marriage have the potential to protect children from exposure to rights violations, such as rape, forced child marriage and a range of risks to their physical and mental health, including complications during pregnancy and heightened risk of HIV and other STI infection; on the other hand, they may function to deny children and young people basic human rights, including to sexual and reproductive health, as well as inhibiting their access to vital services, through reinforcing dominant and gendered norms which define what is considered acceptable and unacceptable (sexual) behaviour. These issues are explored further below.

Law both reflects culture, and reinforces ideas about what is 'acceptable' and 'unacceptable' (sexual) behaviour. Laws prohibiting early sex and marriage have the potential to protect children from rights violations such as rape, forced child marriage, and risks to their physical and mental health. On the other hand these laws may also function to deny children and young people basic human rights, including access to SRH services.

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[22] *Focus Group Discussion, Girls, Bangalore, 29 October 2015*

[23] *For sex or rape with or by their legal husband.*

[24] *Yarrow E. et al., 'Can a restrictive law serve a protective purpose? The impact of age restrictive laws on young people's access to sexual and reproductive health rights', Reproductive Health Matters, RHM44-001_002, December 2014.*

Access to Services

8. General access to services: contraception, STI testing and other basic services

8.1. The law: general access to medical treatment

Indian statutes do not include any specific provisions in relation to young people's ability to consent to medical treatment, including SRH services. Nevertheless, three pieces of legislation have been identified as relevant for determining the age at which a young person may independently consent to medical treatment: the Indian Majority Act, the Penal Code, and the Contract Act.

8.1.1. The Indian Majority Act

The first piece of potentially relevant legislation is the Indian Majority Act 1875; which provides that a person's legal capacity (in general) may not be restricted by virtue of their age after they have reached the age of 18 years – the age of majority. Prior to the age of 18 years, a person is considered a minor, and therefore their legal capacity is restricted.

8.1.2. The Penal Code

Secondly, sections 87-90 of the penal code have been used to interpret whether and in what circumstances a young person is able to consent to access medical treatment or services (in general). These articles set out the conditions under which a person can 'consent to suffer injury or harm', and the examples provided in the law (to elaborate the meanings of these provisions) refer to the case of a patient consenting to a surgical operation.

Penal Code: Consent to Medical Treatment

Sections 87 provides that a person above 18 years of age can give valid consent to suffer any harm which may result from an act not intended or not known to cause death or grievous harm.

Section 88 provides that a person can give valid consent to suffer any harm which may result from an act, not intended to cause death and done in good faith and for his benefit (even if known to cause grievous hurt). For example, if a surgeon operates on a patient in good faith and for his benefit, even though the operation is a risk, he cannot be held responsible if the patient dies.

Section 89 further establishes that a guardian can provide consent to cause harm resulting from an act done in good faith to a child under 12 years of age, while **Section 90** provides that no child under the age of 12 years can give valid consent to suffer harm even that which is done in good faith and for their benefit (in other words consent of the guardian is needed).

Together these provisions in the Penal Code appear to establish that consent to medical treatment in general,[28] including treatment related to SRH services, may always be provided by a young person above the age of 18 years, and may never be provided by a young person under the age of 12 years, but may be

[25] *A. Kohli, "Medical consent in India - Ethical and legal issues", Anil Aggrawal's Internet Journal of Forensic Medicine and Toxicology Vol. 8, No. 2 (July - December 2007), accessed 18th October 2015. http://www.anilaggrawal.com/ij/vol_008_no_002/papers/paper004.html.*

[26] *Indian Majority Act 1875 Art. 3.*

[27] *IPPF, ADVOCACY FOR ADOLESCENT ACCESS: India - A framework for identifying legal restrictions on young people's access to sexual and reproductive health services, information and education, 2012 (unpublished).*

[28] *'In general' in the sense of an absence of any specific provisions in relation to particular forms of treatment such as abortion or HIV testing.*

provided by their legal guardian. The position of young people aged 12-18 years is somewhat ambiguous. The penal code suggests that (provided that the action is done in good faith and for the young person's benefit and is not intended to cause death) a young person over 12 years may (in general) consent to medical treatment

8.1.3. The Contract Act

The final piece of potentially relevant information is the Contract Act. It has been argued that Section 11 of the Indian Contract Act - which provides that a person who has obtained majority (18) is able to enter into a contract - is relevant to consent to medical treatment because this is akin to a contract between two parties. The Indian Contract Act, however, does not specifically mention medical professionals, and rather governs issues such as marriage and financial agreements.

8.1.4. Consent to access HIV testing

Notably, the Indian Government has developed specific guidelines in relation to consent to undergo an HIV test.

These guidelines provide that 'HIV testing of a minor or of an incompetent patient can be undertaken with a guardian's consent.' (A 'minor' is defined as any person under the age of 18 years, as per the India Majority Act).

The requirement that a minor have parental/ guardian consent before accessing an HIV test is intended to serve a protective purpose; bearing in mind the far reaching consequences of receiving a positive HIV diagnosis. Nevertheless, this provision creates a direct policy barrier to access to an HIV test for children under 18 years who are unwilling or unable to seek consent from a legal guardian.

8.1.5. Conclusions

In sum, the law in India imposes partial barriers to children's access to SRH services; access to services are restricted (in part) to young people under the age of 18, and in full to young people under the age of 12 without parental or guardian consent.

It is worth noting that where there is ambiguity in law, health provisions are likely to err on the side of caution and seek parental consent before providing a child under 18 services, to ensure they are acting within the law.

Meanwhile, young people may be reluctant to reveal that they are in need of SRH services to their parents or guardians, particularly where this may indicate that they are sexually active. Requirements for parental consent may thus deter young people from seeking the services that they need.

Three pieces of legislation have been used to interpret the law regarding young people's access to SRH services: the Penal Code, the Majority Act and the Contract Act.

Together this legislation implies that children under 18 years may require parental consent in order to legally access basic SRH services including contraceptives and STI testing and treatment. Children under 12 years will always require parental consent.

The Government has developed specific guidelines in relation to HIV testing, which requires children under the age of 18 years to have parental/ guardian consent.

[29] *National Guidelines for HIV testing, National AIDS Control Organisation, Ministry of Health and Family Welfare, Government of India, http://naco.gov.in/upload/2015%20MSLNS/HIV%20Guidelines.pdf accessed February 2016.*

8.2. Service providers: knowledge of law, perceptions and practices

Service providers interviewed in the qualitative research expressed highly ambivalent ideas about whether, and in what circumstances, they may, in law, provide a young person access to SRH services. In general, service providers appeared to believe that in all circumstances young people may have access to types of services not directly related to being sexually active, including counselling, advice, services related to menstruation and others.

However, in the case of services related to being sexually active such as contraceptives and STI testing, and for more complex or invasive treatments, such as surgical procedures, providers appeared to generally believe that there is indeed an age below which they may not provide a young person to access to services without the consent of their parents. In fact, just over half, 51.8%, of providers in the survey claimed that they had at least once in the past denied access to a SRH service to a young person based on their age. Opinions were divided, however, as to what the minimum legal age for access specifically might be, and whether or not this is a formal legal rule, or a matter of good practice.

Consistent with the law, the field research revealed a general idea that a person should have achieved at least '18 years' for independent (without parental consent) access to services, although this was by no means the only age mentioned by respondents. Nevertheless, service providers were not at all clear about whether this is a legal rule or a matter of good practice.

Interview, Doctor, Ahmedabad

> *We can provide SRH services to people above 18.*
>
> *And what about people who are below 18 years?*
>
> *People under 18 must be accompanied by their parent or guardian in case they want to access services.*
>
> *Is that the law?*
>
> *I don't know about the law, but it is our common practice.*[30]

When asked why young people under 18 are not allowed access to services, providers often asserted that adolescents lack understanding or capacity to consent to treatment. One provider explained: "we decide for them because they are children and they can't decide for themselves,"[31] whilst another elaborated:

> *"if the child is 11 or 12 they will not be given treatment for fear that they will not use it in the right way. From 15 and above they are able to understand and we will prescribe the service. At this point they are already independent and are able to do daily tasks on their own. They are able…."*[32]

Although service providers did not always attribute their decisions on these matters to legal rules, the idea that young people below a certain age lack the ability or capacity to make an informed decision about health treatment is an idea that does indeed have basis in the law. The Age of Majority Act specifically references 'capacity' as an important concept for defining adulthood. Furthermore, Article 90 of the Penal Code, the article that specifies that a child under the age of 12 cannot 'consent' to treatment, brackets such children together with other individuals who are unable to provide consent because they

[30] *Individual interview, doctor at public clinic, Ahmedabad, 27 October 2015*

[31] *Individual interview, service provider, Ahmedabad, 27 October 2015*

[32] *Individual interview, doctor at public clinic (supervised but not administered by FPAI), Ahmedabad, 27 October 2015*

are 'insane', 'intoxicated', or otherwise unable to understand 'the nature and consequences of that to which he gives his consent'.[33]

In addition to competency, service providers also referenced dominant social and cultural norms that dictate that providing services to a child without consent of their parents is culturally inappropriate: "As per the Indian culture and context – if a young person comes to access medical services, it is not appropriate for them to come without parents."[34] Providers emphasised that according to culture, adolescents and young people who are under the age of sexual consent, should not be sexually active at all, and therefore 'don't need' and shouldn't be trying to access SRH services such as contraception.

Whilst as many as 96.5% of providers were aware that the law establishes a minimum age of sexual consent, only a minority, 21.8%, of providers felt that it was illegal to provide SRH services to a person under this legal age. In qualitative interactions, however, service providers explained, that although the law does not directly prevent them from providing contraceptives to young people under the age of sexual consent, they avoid this in practice, in order to 'prevent' or discourage young people from becoming sexually active:

Individual Interview, nurse, Bangalore:

> *Are you legally able to provide a young person with condoms?*
>
> *If they are under 18 years then we can't give them condoms.*
>
> *Why not?*
>
> *We don't want under-18s to get into a sexual relationship.*[35]

Many of the service providers interviewed for the study explained that they would lecture or counsel young people seeking services to try to discourage them from engaging in (illegal) sex; while they wouldn't deny a young person access to a service outright, they would only provide them with sex related services as a last resort:

Individual interview, doctor, Bangalore:

> *Do you know if there is a legal age at which young people can start having sex?*
>
> *Yes – according to the law it is 18 years.*
>
> *What would you do, in your professional capacity, if you knew a young person under the age of 18 years was sexually active?*
>
> *...firstly, we would encourage them to abstain from sex, but if that is not possible, we would tell them to use protection.*[36]

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[33] *Penal Code 1860.*

[34] *Individual interview, doctor at public clinic, Ahmedabad, 27 October 2015*

[35] *Individual interview, Nurse, Bangalore, 29 October 2015*

[36] *Individual interview, Doctor, Bangalore, 29 October 2015*

Individual interview, educator/counsellor, Ahmedabad:

> *How do you manage if a child comes to you and you learn that she is sexually active (I give the example of a 13 year old girl)?*
>
> *First, I would provide counselling to understand whether the age is appropriate or not (for sex). If she doesn't take my advice I will inform her about contraceptive options.*[37]

Service providers were unsure of the law concerning children and young people's access to SRH services. Many service providers noted that they would not provide contraceptives, and STI testing to children under 18, however, they weren't clear on whether this is a legal rule or a matter of good practice.

About half, 51%, of service providers, said that they had previously denied a young person access to a service based on their age. The explained that they were reluctant to provide services to children without parental consent, because children are thought to lack capacity to make informed decisions, because it would be culturally inappropriate and/ or because they did not want to encourage 'underage' sex.

As young people participating in the research confirmed, service providers' approach of questioning young people about their (sexual) behaviour reinforces the shame and embarrassment they may feel about accessing SRH services, discouraging young people from having the confidence to seek services out. Such practices by providers, therefore, strengthen restrictive norms concerning young people's sexuality, and reinforce barriers to access to SRH services. This in turn may influence young people's perceptions of legal rules that regulate their entitlement to access services, which is discussed further below.

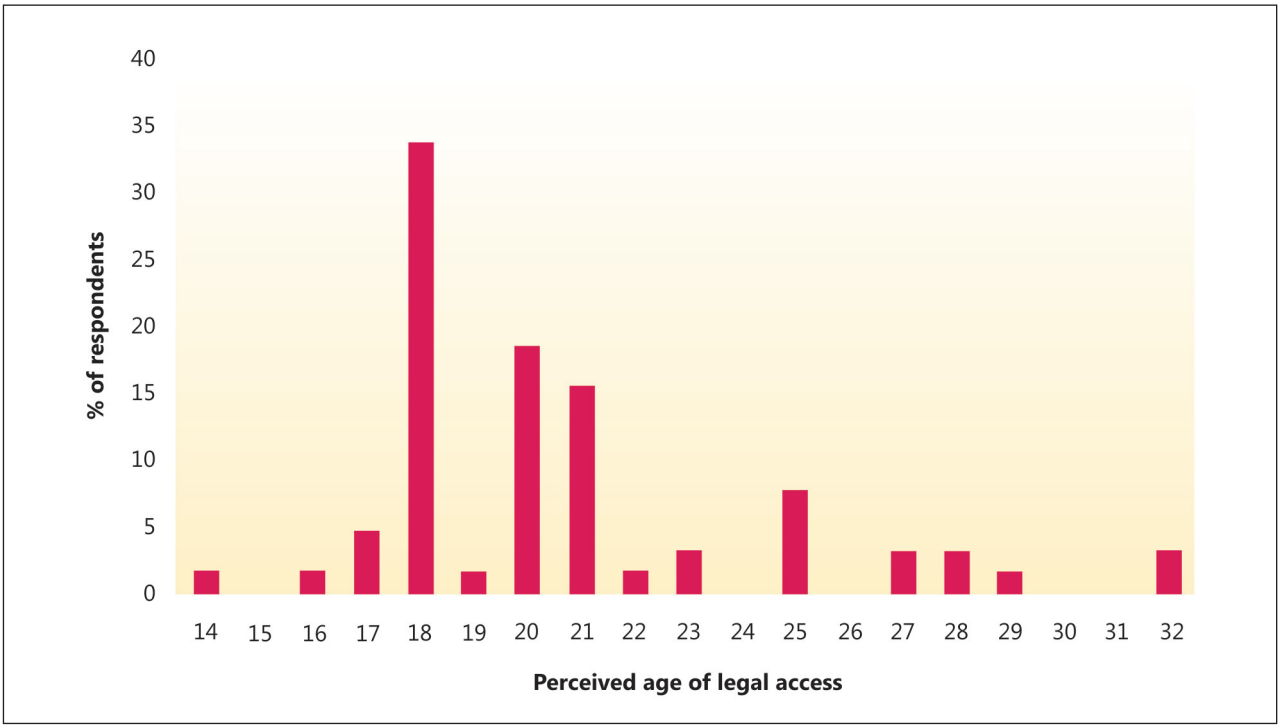
8.3. Young people: perceptions of law and access to services

A considerable majority, 71.3%, of young people in the survey believed there to be legal restrictions on young people's access to contraception, however, only about a fifth, 19.6% thought that these legal restrictions establish a precise age threshold for legal access. Rather, the majority of young people felt that legal access to contraception is based on the discretion of the service provider.

Those young people who did think that the law established a particular age threshold for legal access to contraception were asked to specify which age they thought this was: respondents gave widely variant responses to this question, ranging from 14 years to 32 years.

[37] *Individual interview, SRH Educator/ Counsellor, Ahmedabad, 26 October 2015*

Figure 1: At what age can a young person legally access contraceptive services? (Respondents who believed there to be a minimum age)



As the above graph demonstrates the mode response to this question was 18 years, consistent with the general perceptions of service providers, as well as evidence from qualitative interactions with young people: "only when I complete 18 years – only then can I access SRH services";[38] "wait till you become the age of 18 – then you go and access".[39]

Qualitative interactions with young people revealed that there is a considerable amount of uncertainty amongst young people about whether and in what circumstances they are able to access contraceptives, despite a general and vague sense that a person should have reached 18 years of age for legal access. Young people appeared to have very limited understanding about law as it related to access to SRH services. Conversations with young people on the subject of law were meandering and confused, with young people often changing their views and contradicting themselves throughout the course of interactions. The below extracts are illustrative:

Interview, Young women, Ahmedabad

Are young people able to access contraceptives legally?

You can access. You can access at any age – but not if you are really small.[40]

Focus group discussion, Young women, Ahmedabad

So in terms of getting contraceptives – does it ever cause a problem if you are below a certain age?

Yes. If the boy or girl is below 18 years of age, then accessing contraception is a challenge.

[38] *Focus group discussion, girls, Ahmedabad, 26 October 2015*

[39] *Focus group discussion, girls, Ahmedabad, 26 October 2015*

[40] *Individual interview, young woman, Ahmedabad, 27 October 2015*

Why? Why is that?

The problem is because they are below 18 years they are not mature.

And do you think they would be prevented – would they be refused – if they were under 18?

Yes. Nowadays if 10 or 11 year old boys and girls are having sex –they should not be provided [contraceptives] because they are very small and they do not understand.

And is there any law which says [that]?

We are not aware of any such law that says if a girl is above the age of 18 she can access contraceptives. But then if the girl is above 18 then she can access contraceptives.

So you are not sure about below 18?

We are not aware of any law but at the same time if the girl is above 18 then she can access contraceptives. But then we are not aware of any law.[41]

Part of the reason that young people who participated in the research seemed so ambiguous about whether or not they would be permitted access to SRH services, and the status of the law on this issue, may be related to the fact that few young people included in the research had ever actually attempted to access an SRH service in practice.

Focus Group Discussion, Boys, Bangalore

How old do you have to be to go to the hospital and ask for these things [SRH services] or does the doctor not mind about your age?

The doctor will definitely question your age if you go and purchase from them. [They really struggle to answer this]....We have never been to the doctor [for this].[42]

In fact, less than a quarter, 23.7% of young people included in the survey reported to have attempted to access a type of contraceptive service (including condoms, birth control pill, IUD or injections), and only 6.5% reported to have attempted to access an STI test. Male respondents (26.8%) were significantly more likely than female respondents (20.3%) to say that they had accessed contraceptives;[43] they were also more likely to say they had accessed and STI or HIV test, although the difference (for HIV and STI testing) was too small to have statistical significance.

Furthermore, and importantly, as many as 63.5% of young people who said that they had ever attempted to access contraceptives, and 40% of young people who tried to access an STI or HIV test, reported that they had previously been denied access to this service on at least one occasion. Importantly, respondents under the age of 18 years at the time of the survey were significantly more likely to report having been denied access to an SRH service than respondents over the age of 18 years:[44] as many as 84.8% of respondents under the age of 18 years who reported having tried to access contraception reported to have previously been denied access to these services. These findings suggest that age may constitute a significant barrier to young people's access to SRH services, particularly when young people are under the age of 18 years.

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[41] *Focus group discussion, young women, Ahmedabad 26 October 2015*

[42] *Focus group discussion, boys, Bangalore, 29 October 2015*

[43] *Chi-square test, p<.05*

[44] *Chi-square test, p<.01*

When young people were asked in qualitative interactions why children under the age of 18 years are not able to access contraceptives young people – like service providers -asserted that adolescents under this age lack maturity and competency to do so: "the problem is because they are below 18 years they are not mature. It's all about the maturity levels, so [that is] why there is a barrier in accessing contraceptives below a certain age, because they are not mature."[45]

Ideas about maturity did not only focus on intellectual competency, they were also anchored in narratives about the biological and physiological conditions of young people's bodies. There appeared to be a general sense that young people's bodies are not physically fit or 'strong' enough to be capable of handling access to certain types of SRH treatments, and that this is the basis on which they are denied access to services. Respondents explained: "if a person below the age of 18 years uses contraceptives there might be hormonal changes in their menstruation;"[46] "according to the government it is 18 years and above, but I think it should be 20 years, because by the time you are 20 years your body can handle contraceptives better."[47]

The notion that contraceptive and other SRH services are harmful to the health of adolescents has little basis in medicine, nor is it supported by any legal norm or rule that relates to access to medical services or consent to treatment. These narratives are better understood as being informed by legal and social norms that shape ideas about when it is appropriate for young people to start having sexual relationships: the two most influential areas of law in this regard being the minimum legal age for marriage, and of sexual consent.

Young people were very uncertain about whether there is a law that regulates access to SRH services. Most young people felt that legal access depends on the discretion of the service provider.

Only a minority of young people in the survey reported to have ever accessed an SRH service; boys were more likely to report accessing services than girls, and older respondents were more likely to report accessing services than those who were younger, suggesting that access to SRH services is affected by both gender and age.

8.4 Young and unmarried: age of marriage and consent laws as barriers

8.4.1 Influence of child marriage law

Many young people, as well as parents, appeared to believe that contraceptives and other SRH services related to being sexually active are not available to young people who are not yet married. When asked: 'in your view, at what age should a young girl be able to access contraceptives', nearly two-thirds, 64.1%, stated that she should not be able to do so until she is married. This may reflect the intensity of social stigma surrounding pre-marital sex. Accessing contraceptives would require a young person to acknowledge that he or she has transgressed a norm to an adult authority (service provider), an act that might seem unthinkable, particularly for girls; as one group of young women explained:"[an unmarried girls] will fear about going to the doctor... indulging in sex before marriage is a very bad thing. How is she going to explain this to the Doctor?"[48] And a group of mothers in Ahmedabad similarly noted:

[45] *Focus group discussion, young women, Ahmedabad, 26 October 2015*

[46] *Individual interview, young woman, Ahmedabad, 27 October 2015*

[47] *Individual interview, young woman, Ahmedabad, 27 October 2015*

[48] *Focus group discussion, young women, Bangalore, 29 October 2015*

> *"Basically the medicine is for the girls to prevent pregnancy. So if she is taking the medicine when she is unmarried it is a sign that she is going down the wrong direction – she is going down the wrong path."*[49]

Female respondents were more likely than male respondents to express the view that girls should only access contraceptives when married.[50] This may be due to the fact that stigma surrounding premarital sex is particularly strong for girls and young women; as a young woman in Ahmedabad explained: "there are relationships that young people have, but it is more the boys. Girls feel that they have to wait until they are married… Girls see it as part of their culture to wait".[51]

There is no legal rule that prohibits unmarried youths from accessing contraceptives and other SRH services; barriers are created by social, cultural and religious norms that prohibit sex prior to marriage. Nonetheless, the legal minimum age of marriage may serve as an indirect legal barrier: if social norms prohibit sex before marriage, and the legal minimum age for marriage is 18 years for females, and 21 years for males, it may seem reasonable to think that persons under this age should not be accessing SRH services. Indeed, evidence from qualitative interactions suggests that young people's perceptions on legal rules prohibiting adolescents' access to services are influenced by the law on the minimum age for marriage, as illustrated in the extract below:

Individual interview, young man, Ahmedabad:

> *Does the law ever make it difficult for young people to get the contraceptives they need?*
>
> *The law says that the person can access contraceptives after the age of 21, for boys, and for girls 18-19.*
>
> *Why those particular ages?*
>
> *Because they are the (legal) ages that are decided for marriage, so it should be based on that.*[52]

In another interaction, a young girl in Ahmedabad explained how, whilst the law doesn't explicitly prohibit an unmarried person from accessing contraceptives, the legal minimum age of marriage has resulted in a social expectation that young people should not access services before they are 18 (unless they are married):

Individual Interview, young woman, Ahmedabad:

> *Is there a law that says that you have to be married before accessing contraceptives?*
>
> *No.*
>
> *Can you access contraceptives if you are younger than 18 but you are already married?*
>
> *People used to get married at 13 or 14 years, and they could access services. But now the government has said 18 [for marriage] so their parents will not allow them to access that.*[53]

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[49] *Focus group discussion, mothers, Ahmedabad, 27 October 2015.*

[50] *This result was found to be statistically significant (chi-square test, p<.01)*

[51] *Individual interview, young woman, Ahmedabad, 27 October 2015*

[52] *Individual interview, young man, Ahmedabad, 27 October 2015*

[53] *Individual interview, young woman, Ahmedabad, 27 October 2015*

The findings suggest that, together with norms which prohibit sexual activity outside of marriage, the legal minimum age of marriage may create an indirect barrier young people's access to sexual and reproductive health services, by reinforcing the perception among young people that if you are unmarried and under 18 you should not be accessing services.

8.4.2 Influence of age of consent law

These barriers may also be reinforced by the minimum legal age of sexual consent. The vast majority, 79.4%, of participants in the young people's survey were aware that law establishes a minimum age at which it is legal to have sex, and that sexual activity with a person below this age is a criminal offence. However, only a strikingly low 1.2% of respondents correctly identified the minimum legal age as 18 years for both boys and girls. Most young people thought the legal age of consent was the same as the legal age of marriage.

Statutory rape and minimum age-based sexual assault laws were found to influence young people's ideas about the age at which it is acceptable to be sexually active and therefore to access SRH services. The normative influence of the law on sexual consent, and its role in shaping ideas about socially acceptable and unacceptable behaviour, as well as access to SRH services, was evident in the ways that respondents conflated restrictive and judgemental narratives concerning young people's sexuality with legal definitions and rules. For example:

Individual Interview, young woman, Ahmedabad:

At what age do young people start having sex?

Girls start having sex around 19 or 20 years.

Is there a law about that?

Yes it says that you have to be about that age.

Why does the law say that?

Because before that your body is young, and you don't have knowledge about diseases.

What happens when young people break that law? Does anything happen?

People get AIDs. But the government generally doesn't find out about it – so there is no government action.

Do you think when young people start having sex under that age they are able to access any SRH services?

It will be very hard for them to access. They will have to answer to their family misconceptions. They will get abuse.

What kind of misconceptions?

People will have misconceptions about that - that they are doing something wrong.[54]

In this extract the participant associates having sex under the legal age of consent with developing AIDs, 'doing something wrong', and consequent family shame and judgement; especially if a girl under the age of sexual consent attempts to access SRH services –"they will get abuse".

[54] *Individual interview, young woman, Ahmedabad, 27 October 2015*

Evidence that the law on sexual consent is primarily understood and applied as a measure to uphold socially dominant norms about appropriate sexual behaviour (rather than to protect a child from non-consensual sex) was also reflected in respondents' explanations of when and why the law on sexual consent/ statutory rape is typically enforced: participants raised examples of how the law is used by parents to maintain control over their children's relationships:

Interview, Doctor, Bangalore:

> *If someone is sexually active under the age of 18 years do you refer the case to the police?*
>
> *Well it depends on the relatives – if they don't want to disclose it then we do nothing. But if they want to disclose then we will refer.*[55]

There were accounts of how the threat of statutory rape law can be used to compel a couple to get married to preserve the honour of a girl who has engaged in pre-marital sex:

Focus group discussion, boys, Bangalore

> *Do you know if there is a law which says at what age people can start having sex?*
>
> *It is about 18 years.*
>
> *What is the penalty for having sex earlier? Is there a penalty?*
>
> *There are two options: they will either send them to the jail or arrange for their marriage.*[56]

Focus group discussion, young men, Bangalore:

> *If any of the older people in the family know the boy and the girl have indulged in sex they will make them get married. If the boy does not agree they will file a case – if the boy does not agree to marry they will be penalised.*
>
> *Who will be penalised?*
>
> *Generally they warn the boy and he will agree to marry the girl.*[57]

The two options – prosecution or marriage –support the analysis that sexual violence laws function to maintain norms about sexual activity and marriage such that all sexual activity outside of marriage is considered to be abuse and no sexual activity within marriage is considered to be abuse. The relevance of this analysis for shaping access to SRH services, particularly sexual and gender based violence (SGBV) services, is explored more in Section 13.3, below.

Evidence from the qualitative research indicates that the minimum legal ages for sexual consent and for marriage can function as indirect barriers to access to SRH services for children under these minimum ages.

[55] *Individual interview, Doctor, Bangalore, 29 October 2015*

[56] *Focus group discussion, boys, Bangalore, 29 October 2015*

[57] *Focus group discussion, young men, Bangalore, 29 October 2015*

8.5 Young and married

Although being young and single causes significant barriers to access to SRH services, there are also substantial - albeit different - barriers faced by young people, particularly girls, who are married, for reasons related to their marital status. Young brides are often under pressure to demonstrate their fertility by getting pregnant at the earliest opportunity. Furthermore, it may be difficult for young women to access contraceptive services without the knowledge and approval of their husbands.

8.5.1. Perceptions of (legal) requirements for spousal consent

Although, there are no legal requirements in India that a woman/ girl requires consent of her partner or spouse in order to access an SRH service, previous research has evidenced that informal demands for spousal consent remain a significant barrier to access to SRH services for married women/ girls.[58] For example a recent report by the Centre for Reproductive Rights referenced several studies that have demonstrated that many service providers believe that spousal consent is a mandatory requirement for access to abortion, often preventing woman without such consent from accessing safe and legal abortion.[59]

Evidence from the qualitative research lends support to these claims: many respondents mentioned that a young women/ girl should have the permission of her husband in order to access an SRH service, especially contraceptive and abortion services; as a group of married women in Bangalore explained:

> *"If we are married we generally go with the husband [to get contraception]…We definitely go with our husbands or the doctor will say, go with your husband the next time! Because I am a housewife I am dependent on him. In our culture we are taught that once you are a housewife you are definitely dependent on your husband. Even if you have the slightest problem you have to tell your husband."*[60]

As well as being a social norm, many respondents appeared to believe the need for spousal (husband) consent to be a legal requirement:

Focus group discussion, mothers, Bangalore:

> *Does the Doctor ask you any questions when you go to access contraception? Like your age or your marital status or anything?*
>
> *No they don't ask us anything. The one thing they will ask us is the permission from my husband.*
>
> *And if we only have 1 baby, they will suggest that we have 2 babies.*
>
> *Why do they ask for your husband's permission?*
>
> *According to the government it is compulsory to ask the husband's permission to access contraception – without the husband's permission you can't access. If it causes a problem later then the Doctor will be blamed and there will be fighting in the family.*

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[58] *Centre for Reproductive Rights, 'Supplementary Information on India, scheduled for review by the Committee on the Elimination of Discrimination against Women during its 58th Session (July 2014) http://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/Ind/INT_CEDAW_NGO_Ind_17511_E.pdf accessed February 2016.*

[59] *Centre for Reproductive Rights, 'Supplementary Information on India, scheduled for review by the Committee on the Elimination of Discrimination against Women during its 58th Session (July 2014) http://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/Ind/INT_CEDAW_NGO_Ind_17511_E.pdf accessed February 2016.*

[60] *Focus group discussion, young women, Bangalore, 29 October 2015*

Could any action be taken against the Doctor in such a case? What would happen to the Doctor?

Yes – you could file a complaint against the Dr, and send them to the jail. And you could blame the hospital. And you could fight with the Doctor.

What do you think about that rule – that you need your husband's permission?

It's the right law because the husband is the one to take care of the family, so you will only do anything with your husband's permission. We [the wives] are under our husband's authority. Otherwise it will create a problem in the relationship down the line – so we need our husband's permission.[61]

Participants typically explained that because women are under the authority and control of their husbands, they are expected to defer to their husbands on these matters, and that marital discord, and possibly violence, would be the consequence of a wife making decisions about fertility and reproduction without prior approval from her spouse: "At one point in time her husband will get to know. So as to avoid the fights later, you might as well stop it now and get his permission to take contraceptives."[62]

Focus Group Discussion, young men, Ahmedabad

What do you think the husband might do if he found out his wife was taking contraception without his knowledge?

A fight would break out. He would physically beat the wife, he might use swear words and might also leave you at your mother's place.[63]

Focus Group Discussion, young men, Ahmedabad

Can a young woman get an abortion without her husband's permission?

A lot of domestic violence and all of those things are likely to happen if she did that!

What is she went to the clinic in secret?

If the girl's mother is with her then it might be possible. Otherwise the doctor is going to question – who is with you? Where is your husband? Get somebody…[64]

Focus Group Discussion, mothers, Bangalore

It's the right law because the husband is the one to take care of the family, so you will only do anything with your husband's permission. We [the wives] are under our husband's authority. Otherwise it will create a problem in the relationship down the line – so we need our husband's permission.[65]

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[61] *Focus group discussion, mothers Bangalore, 29 October 2015*

[62] *Focus group discussion, young women, Bangalore 29 October 2015*

[63] *Focus group discussion, young men, Ahmedabad, 26 October 2015*

[64] *Focus group discussion, young men, Ahmedabad, 26 October 2015*

[65] *Focus group discussion, mothers, Bangalore, 29 October 2015*

Perceptions that consent of one's husband is required to access SRH services can create a barrier to access to services for all married women, but is likely to disproportionately affect younger wives who may be particularly susceptible to reproductive control by their husbands. A body of research has indicated that younger brides are relatively less able to negotiate power within different facets of married and domestic life, including sexual relations, condom use, childbearing and others.[66] Younger wives may lack access to reproductive health information;[67] are likely to suffer an increased risk of domestic violence, STI infection, maltreatment and rape;[68] and are more likely to internalise the idea that such treatment is acceptable and justified.[69]

Younger wives may not only be susceptible to sexual and reproductive coercion from their husbands: they may also face pressure to become pregnant quickly and often from their families and in laws. In fact, for many women and girls, early marriage means early and frequent pregnancies:[70] "In-laws have some expectations. They need a baby – they need a baby boy. And if we only have 1 baby, they will suggest that we have 2 babies;"[71]"In our house, older members of the household would like us to have more children and therefore don't want us to take contraception."[72]

In focus group discussions respondents were presented with a hypothetical scenario about a young woman who gets married soon after turning 18; after she marries she is under pressure from her husband to have a baby, but she doesn't feel ready. Respondents tended to have little sympathy for this young woman's predicament -"if she is not willing to give birth to a baby then why did she get married?"[73]- was a typical reaction to the scenario. Furthermore, respondents were clear that the wife would be ultimately subject to the decisions and wishes of her husband, and her only option would be to try to persuade him to wait:

> *"She can try to explain it to her husband… She can try to ask nicely…But what else can she do? It's fundamental in the society that you have a baby, and if you don't have a baby after a long period of time, people will look down upon you and say 'is she a woman at all?'*[74]

Therefore, although the legal minimum age of marriage can function as an indirect barrier to access to SRH services for 'underage' youth, it also serves a protective function: helping to ensure that women are sufficiently mature upon marriage to facilitate their capacity to negotiate autonomy over their reproductive lives and health.

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[66] *Hamilton, C., Anderson, K., Apland, K., Arndt, J., Barnes, R., Raoof, A., Yarrow., E, 'Legal protection from Violence: Analysis of Domestic Laws relating to Violence Against Children in ASEAN States', UNICEF, 2015, accessed 1st April 2014 http://www.unicef.org/eapro/ASEAN_VAC(1).pdf*

[67] *Centre for Reproductive Rights, Fact sheet: Accountability for Child Marriage: Key U.N. Recommendations to Governments in South Asia on reproductive health and sexual violence (New York: Centre for Reproductive Rights, 2013), p. 5, accessed 5th October 2015, http://www.reproductiverights.org/document/fact-sheet-accountability-for-child-marriage*

[68] *Save the Children, 'Every Woman's Right, How Family Planning Saves Children's Live', 2012, p.7.*

[69] *Jenson, R. and R. Thornton, 2003, 'Early female marriage in the developing world', Gender and Development, vol. 11, no. 2, 2003, pp. 9-19*

[70] *Centre for Reproductive Rights, Fact sheet: Accountability for Child Marriage: Key U.N. Recommendations to Governments in South Asia on reproductive health and sexual violence (New York, Centre for Reproductive Rights, 2013), p. 5, accessed 5th October 2015, http://www.reproductiverights.org/document/fact-sheet-accountability-for-child-marriage*

[71] *Focus group discussion, mothers, Bangalore, 29 October 2015*

[72] *Focus group discussion, mothers, Ahmedabad, 27 October 2015*

[73] *Focus group discussion, boys, Bangalore, 30 October 2015*

[74] *Focus group discussion, girls, Bangalore, 29 October 2015*

Although, there is no legal requirement that a wife obtain consent of her husband in order to access SRH services, evidence from the research indicates that in practice young married women and girls require permission from their husbands to access contraception and other services.

There is a dominant social norm that husbands have sexual and reproductive control over their wives; and this is likely to particularly affect younger brides who have less capacity to negotiate different facets of married life, and may be under pressure from their husbands and in-laws to have children.

Although the legal minimum age of marriage can function as an indirect barrier to access to SRH services for 'underage' youth, it also serves a protective function: helping facilitate reproductive autonomy amongst wives.

8.5.2. Patriarchal control of female reproduction: sterilisation, policy and practices

The dominance of the norm that female sexuality and reproduction is a matter for social control can arguably be seen most clearly in policies and practices surrounding sterilisation. Since the 1970s government policy in India has primarily relied on female sterilisation as its propounded method of fertility regulation; less has been invested in safer, non-permanent methods of family planning which empower women and girls to assume autonomy and control over their own reproduction.

Whilst many participants in the research expressed negative attitudes towards contraception; the majority were of the view, that sterilisation is an appropriate choice for women given that certain conditions are met: firstly she must have permission from her husband and in-laws and secondly she should already have at least 2 children: "after you have 1 or 2 babies it's ok to get sterilised. But only with family permission."[75]

These ideas reflect a widespread view that discounts the importance of women and girls being freely able to make ongoing and variable choices as to when to get pregnant. Rather, dominant norms dictate that a woman waits to have sex until married; then bears children until her family is 'complete' (and her husband and in-laws are satisfied); after which time she may undergo the permanent procedure of sterilisation.

respondents were not at all accepting of the idea that men/ boys should get sterilised, despite the fact that the male sterilisation operations are easier to perform, cheaper, and present a significantly lesser risk of harm to health.[76] Unlike for women, it is recognised as important and valuable for men to have choices and options concerning fertility and reproduction; choices that should not be permanently removed through an irreversible medical procedure; as participants explained: "men are not getting sterilised. They think in the future they might get married to another woman, and they might want to have more children;"[77] "the wife [should be the one get sterilised]! We might want to get married again to another woman."[78]

[75] *Focus group discussion, girls, Bangalore, 29 October 2015*

[76] *Quartz, 'vasectomies are cheaper and safe than female sterilization- so why don't more men get them?' accessed 1 April 2016; http://qz.com/296019/vasectomies-are-cheaper-and-safer-than-female-sterilization-so-why-dont-more-men-get-them/*

[77] *Individual interview, young women, Ahmedabad, 27 October 2015*

[78] *Focus group discussion, boys, Bangalore, 30 October 2015*

The dominance of the norm that female sexuality and reproduction is a matter for social control can arguably be seen most clearly in policies and practices surrounding sterilisation. Since the 1970s government policy in India has primarily relied on female sterilisation as its propounded method of fertility regulation; less has been invested in safer, non-permanent methods of family planning which empower women and girls to assume autonomy and control over their own reproduction.

Whilst respondents were accepting of female sterilisation, they were not at all accepting of male sterilisation: Unlike for women – it is recognised as important and valuable for men to have choices and options concerning fertility and reproduction; choices that should not be permanently removed through an irreversible medical procedure

Figure 2: Words associated with young people's access to SRH services in India

9. Access to confidentiality: age of consent and mandatory reporting requirements

9.1 The law

The Indian Medical Council Code of Ethics Regulations of 2002 asserts the principle of doctor-patient confidentiality, stating that:

> *'Confidences concerning individual or domestic life entrusted by patients to a physician...should never be revealed unless their revelation is required by the laws of the State or in cases where breaking confidentiality is a public health imperative.'*

Importantly, however, neither statute nor legal precedent clearly establishes a minimum age at which a person has the right to access contraceptive or other SRH services confidentially.[79]

Furthermore, sections 19-20 of the Protection of Children from Sexual Offences Act (2013) state that any person who is aware that an offence under the act – including (statutory) rape as defined in the Criminal Law (amendment) Act 2013 - is likely to be, or has been, committed must report this to the police. A failure to report is punishable with imprisonment of up to 6 months and/ or with a fine. This provision effectively places a mandatory reporting requirement on all legal persons who are aware that a child has had sex under the age of 18 years to disclose to the police that a crime has been committed.

If strictly implemented, this provision implies that a person under the age of 18 years seeking SRH services does not have the right to generally applied doctor-patient confidentiality, as, according to the laws of the state the service provider would be obligated to report the fact that they are sexually active to the police.

The India Medical Council Code of Ethics Regulations of 2002 protect doctor-patient confidentiality. However, neither statute nor legal precedent clearly establishes a minimum age at which a person has the right to access contraceptive or other SRH services confidentially.

Furthermore, mandatory reporting requirements established in the Sexual Offenses Act undermine children's legal right to have their confidentiality protected when accessing SRH services; this may serve as a significant barrier to access.

9.2 Data from service providers

Service providers included in the survey were asked a series of questions about the law and confidentiality as it relates to children accessing SRH services under the age of 18 years. Their responses to these questions yielded highly contradictory results, indicating that there is a considerable amount of confusion and uncertainty amongst service providers about the law on this matter.

It is clear from the results that service providers in both Ahmedabad and Bangalore do consider young people's confidentiality to be a legal priority. All 56 service providers who responded to the statement 'according to the law, I am required to protect a minor's confidentiality under all circumstances,' agreed with this statement with regard to access to condoms, injections, the oral contraceptive pill, IUDs, implants,

[79] *Karunakaran, Mathiharan, 'Law on consent and confidentiality in India: A need for clarity', National Medical Journal of India, November 2014*

STI and HIV testing. This view was echoed by service providers in qualitative interviews, who emphasised that maintaining young people's confidentiality is critical to promoting their access to services:

> *"I will maintain confidentiality because I do not want the young person to face any problems with his parents….It is very important for the young people that we ensure that whatever we tell them will be keep confidential, so that they come to us and speak up openly. There should be a private space where young people can come and talk to us openly. And in return we make sure that everything they tell us will be kept confidential with us. Young people are scared to talk freely in front of their elders…Young people are very open and frank with the service providers if there are no elders around."*[80]

Nevertheless, even while emphasising the importance of maintaining young people's confidentiality, service providers also agreed that the law permits them to compromise confidentiality in certain circumstances. Over a third, 37.5% of service providers, believed that they are required in law to inform a child's parents in the case that (s)he accesses contraceptives such as the oral birth control pill or injections, and an even greater proportion, 42.9%, stated they may legally do so at their discretion. Approaching half, 46.4%, of service providers agreed with these statements in the case of access to an IUD; similar proportions agreed in the case that a child accesses an STI test. Furthermore all service providers (who chose to answer the question) believed that they should inform a child's parents of their access to any of these services in the case of any risk to the minor's health. These findings appear to contradict the simultaneous claims by service providers that they are required to protect the confidentiality of children accessing SRH services at all times.

It is hard to make sense of these inconsistencies. Perhaps from the perspective of many service providers informing a child's parents of his or her access to SRH services is not considered a breach of confidentiality, because a child remains in the custody of his or her parents until the age of 18. Service providers' tendency to agree with conflicting statements about the law may also reflect recognition of competing priorities – balancing privacy against protection –which evokes a fundamental tension at the heart of child policy: on the one hand adolescents are considered to be young adults, with evolving capacity and autonomy, on the other hand they are still children, a socially subordinate group, defined by their dependency and need for protection.[81]

Service providers expressed highly ambivalent and contradictory ideas about whether and in what circumstances they are legally required to protect or break young people's confidentiality.

9.2.1. Perceptions of mandatory reporting requirements

Providers' ambiguity about their legal obligations concerning adolescents' confidential access to services is reinforced by the provision in the Sexual Offenses Act which (as discussed above) imposes mandatory reporting of all underage (18) sex to the police.:

[80] *Individual interview, NGO Provider, Ahmedabad, 27 October 2015*

[81] *Yarrow, E. et al., 'Can a restrictive law serve a protective purpose? The impact of age restrictive laws on young people's access to sexual and reproductive health rights', Reproductive Health Matters, RHM44-001_002, December 2014.*

Individual interview, educator/counsellor, Ahmedabad:

What is the age of sexual consent in India?

The age is 18... If they have sex below 18, legally, we are required to tell the police.

So are you legally required to tell the police if you are aware that someone is sexually active below the age of 18?

18 is the legal age for marriage and sexual consent. There are marriages below 18, but the sexual consent age is 18, so there is some confusion.

Are you aware of a case where sex under the age of consent was reported to authorities?

No, I am not aware of this.

Would you inform anyone of this (if a child came to you and you learned that she is sexually active)?

I would not inform anyone.[82]

The data revealed unclear results about service provider's perceptions of the mandatory requirement. Whilst a significant proportion, 43.6%, of service providers in the survey claimed to have previously reported a case of underage sex, probing in qualitative interactions suggests that this may be a rarer occurrence than this result implies. Providers interviewed in the qualitative research tended to say that they and their colleagues would not report underage sex to the police: "we won't report it to anyone. We would just counsel them."[83]

This inconsistency in the data may reflect the fact that whilst service providers are aware of the reporting requirement under the PCSO Act, they do not consider it to be realistic, and are aware that, if implemented, this provision would likely create barriers to young people's access to SRH services. The following passages are illustrative of this:

Individual interview, doctor, Ahmedabad:

What do you think about this law, which says you should report any cases where a child is having sex under-18?

I think the age in the law needs to be reduced. In reality young people are engaging in sex before the age of 18... So we have to provide services to these young people.[84]

Individual interview, Educator, Ahmedabad:

To directly refer to the police is not a good idea – if we directly go to the police the person will be scared that the information will spread. Because of that the person might go into a depression. The laws in India are very ... it comes in the limelight very soon. It is better to start out small. We sort it out to protect the information.'[85]

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[82] *Individual interview, SRH Educator/ Counsellor, Ahmedabad, 26 October 2015*

[83] *Individual interview, nurse, Bangalore, 29 October 2015*

[84] *Individual interview, Doctor, Ahmedabad, 27 October 2015*

[85] *Individual interview, SRH Educator/ Counsellor, Ahmedabad, 26 October 2015*

Individual interview, doctor, Bangalore:

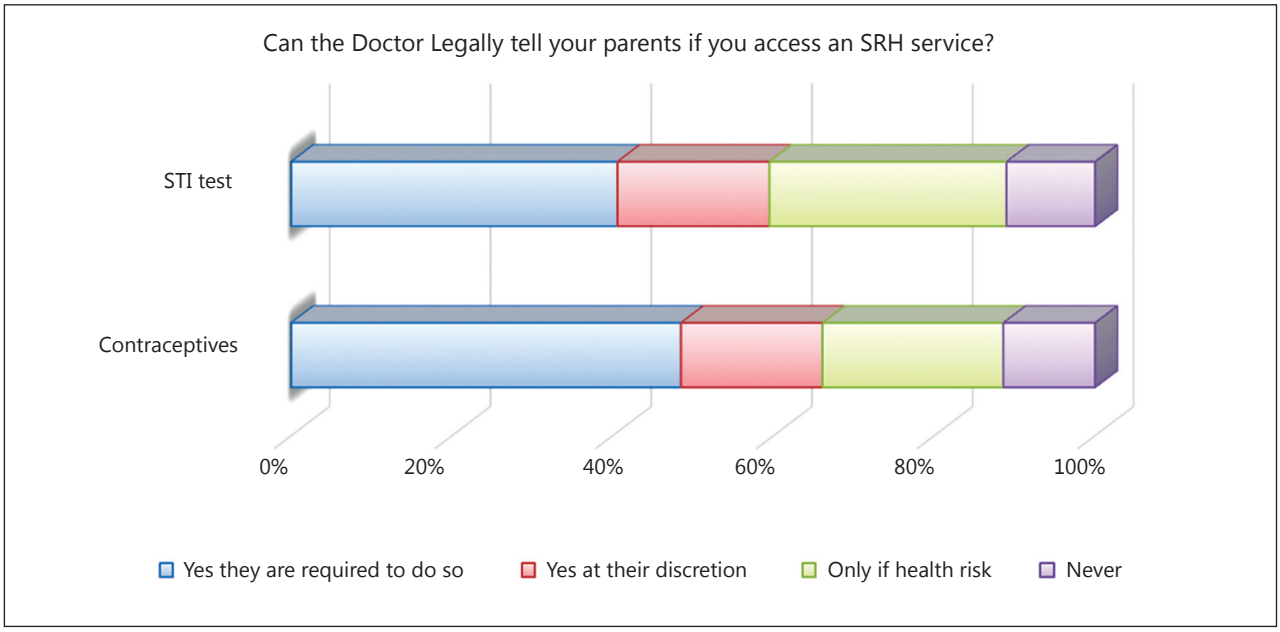
> *If someone is sexually active under the age of 18 years do you refer them to the police?*
>
> *Well it depends on the relatives – if they don't want to disclose it then we do nothing. But if they want to disclose then we will refer. But this is very rare.*[86]

These latter extracts also reflect the analysis, discussed in section 8.3.2 that when under-18 sexual activity is reported to authorities, this is typically done to uphold conservative social norms about inappropriate sexual behaviour - rather than addressing abuse or exploitation - and may result in public shame for the young person involved.

Whilst service providers are aware that they are legally required to report cases of underage (18) sex to the police, evidence from the research indicates that they are not always adhering to the law in practice, and do not consider this provision to be helpful or realistic.

9.3 Data from young people

The data revealed clearly that children and young people in research sites in India do not consider themselves to have a legal right to confidential access to SRH services. Only 11.4% of respondents in the young people's survey thought that a doctor could 'never' tell their parents if they were to access contraception, and even fewer, 11%, thought the same for STI testing; in fact almost half, 48.5% (contraception), and 40.6% (STI testing) felt that a doctor is required to tell their parents.



[86] *Individual interview, Doctor, Bangalore, 29 October 2015*

Importantly, responses to this question were significantly affected by both gender and age. Children over the age of 18 years,[87] and boys[88] were significantly more likely than children under the age of 18 years, and girls to think that the law protected their right to confidentiality when accessing SRH services.

These age-based differences make sense in the context of legal rules such as the legal age of majority, parental consent requirements and mandatory reporting requirements which compromise children's rights to privacy when accessing SRH services. Gender differentials, on the other hand, are likely the result of social norms: a consequence of the fact that the stigma surrounding sexual activity of (unmarried) young people is significantly greater for girls than for boys. It is also possible that these discrepancies relate to a tendency for sexual activity amongst underage girls to be more likely to be constructed as abuse (compared to boys), and therefore more likely to be reported (or expected to be reported) under the PCSO Act, to relevant authorities.

Importantly, evidence from the qualitative data suggests that young people's doubt about the confidentiality of their visit to a health care provider poses a significant barrier to their decision to access SRH services in the first place. Many participants explained that young people are not going to clinics for fear someone would find out – 'they gossip'.

Focus group discussion, young men, Bangalore

> *What about confidentiality – if a young person accesses SRH services, will the service provider tell the person's parents?*
>
> *Some tell the parents, some of them don't. If the doctor finds something wrong they will tell. Some will not tell but they will definitely give them a dig.*
>
> *Do you think fear stops young people from going to the doctor in the first place?*
>
> *If they are very suspicious that person will not go or will go to a different doctor. There are many people who fear.*
>
> *Do you think a 20-year-old person who was unmarried would still have that fear?*
>
> *…No matter who you are you fear you confidentiality won't be maintained… there is no law that protects your confidentiality!*[89]

Shame and embarrassment was one of the most common explanations given by young people as to why they were not willing to access services. Young people fear being seen going to a clinic in case others see them, assume they are sexually active and pass judgement, especially if they are not married: "before marriage young people won't access services because of the shame. [Young people] can only access services after marriage. They want to access services, but when they go there, people might look at them and they will feel ashamed."[90]

The failure to protect young people's privacy and confidentiality upon access to SRH services, therefore, creates a significant barrier to access to services. Confidentiality is important to young people; and where they don't feel their privacy will be protected, the shame and embarrassment of accessing services is compounded and can be prohibitive.

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[87] *Chi-square, p<.05*

[88] *Chi-square, p<.05*

[89] *Focus group discussion, young men, Bangalore, 29 October 2015*

[90] *Individual interview, young woman, Ahmedabad, 27 October 2015*

The data indicates that young people do not believe their confidentiality will be protected when they access SRH services. Failure to protect young people's access to confidentiality constitutes a significant barrier to access to services, particularly in an environment where intense stigma exists around youth sexuality.

10. Access to Sexuality Education

Another important barrier to young people's access to SRH in communities in India is the lack of legislation providing for free and universal comprehensive sexuality education.[91]

In 2005 the Ministry of Human Resource Development and the National AIDS Control Organisation launched an Adolescence Education Programme (AEP) for students in classes 9 – 11, which was implemented in 112,000 schools over the period of 2005-2006. Controversy over the sex-related content of the programme, however, resulted in several states subsequently banning the provision of AEP in state-run schools. In light of this, a revised and more limited curriculum was developed containing units on: (a) the passage from childhood to adolescence; (b) Adolescent Reproductive and Sexual Health (ARSH); (c) mental health and substance misuse; and (d) life skills and HIV prevention. According to the National Aids Control Organisation, the programme has been implemented in over 112,000 of the 145,000 high schools and higher secondary schools across the country.[92]

Evidence from the research, however, suggests that while the government has reported that a revised curriculum is now in place, it is not being implemented in all parts of the country. Only 48.2% of young people in the survey, 62.2% in Ahmedabad and 53.3% in Bangalore reported having received SRE at school; meanwhile, as many as 38.6% of the total sample reported to have never received any SRE. The findings were backed up by evidence from the qualitative data; one group of young women told researchers:

> *"Whatever things we have right now – and all the things we have discussed – it is only because of [the NGO] FPA. All the information that we have it's because of FPA. Before we were not aware of these things – we didn't know what a condom is – what the pill is. We were just like all the other girls out there who don't know anything."*[93]

And a representative from FPA interviewed in Ahmedabad similarly noted:

> *"I am not aware of any other organisation that provides SRE besides FPAI. A few years back the government made a programme for young people in which they trained teachers in an adolescent education programme, which was a government initiative. Now it has stopped… I don't know why. As of now, young people are accessing most of their information from the internet."*[94]

Even when young people do receive education and information about sexual and reproductive health in school evidence from the research indicates that it is often inadequate, and that consequently young people are profoundly misinformed about important issues concerning sexuality, reproduction and health:

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[91] *S. J. Jejeebhoy and K. G. Santhya. 2011. Sexual and reproductive health of young people in India: A review of policies, laws and programmes. New Delhi: Population Council. http://www.popcouncil.org/uploads/pdfs/2011RH_SexRHYoungPeopleIndia.pdf accessed 5th November 2015.*

[92] *National AIDS Control Organisation (NACO). 2010. Annual Report 2009–10. New Delhi: NACO.*

[93] *Focus group discussion, Young Women, Ahmedabad, 26 October 2015.*

[94] *Individual interview, NGO Provider, Ahmedabad, 27 October 2015*

> *"There are many myths and misconceptions. The information [young people] get is not correct… Sometimes teachers do not have correct information – if students ask, 'will masturbation make us weak?' they say yes. Girls don't maintain hygiene because parents don't teach their girls. They will wear their pads for too long. Or they don't use pads, they use cloth. They are not aware of what they need to do for hygiene".*[95]

In one FGD with young women in an urban slum in Ahmedabad, two teenage girls spoke of the shock that they received when they first started menstruating, because no one had taught them what to expect:

> *"When it happened to me for the first time I was not aware of it. I didn't know. So then I came to speak to my mother and my mother told me – 'don't worry. Now this will happen every month'."*[96]

> *"When I first saw my vagina bleeding I got scared. I was very nervous about it. And then I told my mother. She comforted me and told me 'don't worry now. This happens to every girl. So just don't worry about it.'"*[97]

In several FGDs one or more young participants claimed not to know what sexual intercourse is and hadn't heard about contraceptives.

Focus group discussion, girls, Bangalore:

> *Do you know if it ever happens, that two people who are engaged, or maybe who are in a girlfriend/ boyfriend relationship, ever have sex before they are married?*
>
> *(The group look uncomfortable and confused and look at each other)… I do not understand what sex means.*
>
> *Okay. Where do you learn about things like your period and changes in your body and sex?*
>
> *(One girl in the group does not know about her periods). It is a change in our body where for seven days the woman excretes the dirty blood from her body. And during that period they generally feel like sleeping a lot because they aren't comfortable moving around and the face becomes pale because you are tired… we learn about this in science.*
>
> *Can you tell me what else you learn in science?*
>
> *(A girl in 10th standard shyly responds) I don't remember much now.*
>
> *Outside of school how do you learn about these things? Do you learn from your parents?*
>
> *No one has taught us.*
>
> *Have you heard of the oral contraceptive pill?*
>
> *No.*
>
> *Have you heard of condoms?*
>
> *No.*[98]

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[95] *Individual interview, SRH Educator/ Counsellor, Ahmedabad, 26 October 2015*

[96] *Focus group discussion, young women, Ahmedabad, 26 October 2015*

[97] *Focus group discussion, young women, Ahmedabad, 26 October 2015*

[98] *Focus group discussion, girls, Bangalore, 30 October 2015*

Young people's descriptions of the content of the SRE that they receive in schools suggests that education focuses on explaining biological functions associated with puberty and the science of reproduction –"apart from science we did not have such classes…" - rather than broader learning and discussion about the social and relationship contexts of sexual and reproductive health; as one girl in Ahmedabad explained: "sex is to produce a child. When the male sperm enters the female's vagina - that is the point when the baby takes place in the woman's body. That is called 'sex'."[99] Furthermore, there is a clear focus on discouraging young people from becoming sexually active, through characterising doing so as harmful and inappropriate:

Focus group discussion, boys, Bangalore:

> *At school do you have any education about sex and reproduction?*
>
> *Yes – we have had it.*
>
> *Can you tell me some of the things you've learned? What do they teach you?*
>
> *They teach you about maturing. And about early marriage. And protection – self-defence. Good touch and bad touch.*
>
> *What is good touch and bad touch?*
>
> *Good touch means anything below the knee or hands and face. And for girls below the knees and the face is good touch and everything else is bad touch.*
>
> *Do they teach you about things you can do to prevent getting pregnant?*
>
> *To not have sex.*[100]

The education and information that young people access about sexual and reproductive health appears to reflect a series of hierarchical ideas concerning acceptable and unacceptable forms of sexual behaviour: acceptable sex takes place within marriage and has a reproductive purpose. Unacceptable sex takes place at a young age, prior to, or outside of marriage, and is associated with STIs, unwanted pregnancy and the destruction of a child's education and even their future 'career'. The following extracts are illustrative:

Focus group discussion, boys, Bangalore

> *What do you think sexual and reproductive health means?*
>
> *Doing that [sex] is a wrong thing. You have to concentrate on your career. That's a very bad thing. If someone does that it will spoil his career.*[101]

Focus group discussion, young women, Ahmedabad

On TV they observe all about love and attraction – they don't have the maturity when they see it and the go ahead without telling their parents about it. Many times I've had mothers come with daughters who miss their period and have not been married.[102]

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[99] *Focus group discussion, girls, Ahmedabad, 26 October 2015*

[100] *Focus group discussion, boys, Bangalore, 29 October 2015*

[101] *Focus group discussion, boys, Bangalore, 29 October 2015*

[102] *Focus group discussion, young women, Ahmedabad, 26 October 2015*

Focus group discussion, young women, Ahmedabad

> *I will tell her – you wait – wait till you become the age of 18…If the girl is using the contraceptives, abortion will be safe, but she can't protect herself from STIs, and this thing will go on. So if today the boy is having sex with her, tomorrow he will go and be having sex with another girl and this will spread.*[103]

Abstaining from sexual activity is therefore presented as the endorsed or preferred method of preventing STI transmission and pregnancy: to encourage young people to avoid the moral pitfalls of unacceptable sex. Framing sexuality education in this way may have a detrimental influence on young people's access to SRH services: it reinforces gendered and aged constructions of sexuality; reducing sexual health to a discussion about reproductive roles, and solidifying taboos and stigma associated with being sexually active whilst young and unmarried.

Indeed, the research clearly evidenced that lack of comprehensive sexuality education is a significant barrier to accessing sex-related services. Many respondents attributed young people's lack of access to services to a dearth of knowledge and information:

Individual interview, doctor, Ahmedabad:

> *Why are young people not using contraceptives?*
>
> *It is because they do not know.*[104]

Individual interview, doctor, Ahmedabad:

> *What more do you think could be done to improve young people's access to SRH services?*
>
> *Sex education should be provided to young people at the earliest point.*[105]

In a focus group discussion, girls living in an urban slum area of Ahmedabad explained that improved education and information could have prevented an instance in their community where a 16 year old girl tried to access an abortion following an unplanned pregnancy:

> *"If the girl would have been informed about the contraceptives this kind of thing would not have happened. But there was a gap in the thinking and the girl was not able to access…in the first place she was not aware about the contraceptives, that is why she underwent such consequences."*[106]

10.1 The role of parents

Importantly, when asked how young people's access to SRH services could be improved, several health workers emphasised the importance of providing education for parents and communities, in addition to young people themselves:

> *"It is most important to give education to the parents rather than to the children. Parents are important – without them there will be no one to take care of young people or tell them what is right or wrong."*[107]

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[103] *Focus group discussion, young women, Ahmedabad, 26 October 2015*

[104] *Individual interview, Doctor, Ahmedabad, 27 October 2015*

[105] *Individual interview, Doctor, Ahmedabad, 27 October 2015*

[106] *Focus group discussion, girls, Ahmedabad, 26 October 2015*

[107] *Individual interview, Nurse, Bangalore, 29 October 2015*

In fact, the research indicates that a lack of parental support may be one of the biggest barriers to implementing comprehensive sexuality education in schools. Many respondents explained that access to sexuality education is limited due to pressure from parents - "parents don't allow girls to access this information"[108]- who are resistant to providing their children with information for fear it will encourage them to become sexually active at an earlier age. One young woman in Ahmedabad explained the reaction in her community to the sexuality education being providing by FPAI:

> *"In FPA they have this curriculum – comprehensive sexuality education… I brought along my cousin's sister to that session but the girl went home and she discussed with her mother that 'all these things were taught to us in the session' so her mother said 'what is this? FPA is teaching all these things'. Then her mother came and told me 'what is this – where did you take my daughter? What kind of discussion did you have over there?' She told me, 'All of these things - these things are not good - this advice that you gave to my daughter. This is wrong, this is dirty! All these things are dirty' she said: 'whatever discussions you were having in those sessions; you don't take my daughter henceforth'."*[109]

The resistance reflects a dominant narrative which appeared to be prevalent across research sites, according to which restricting young people from accessing information is an effective strategy for preventing them from engaging in sex at a young age or before marriage. In fact, this idea is likely to be a significant, if not the main, factor contributing to the policy decision to roll back the SRE curriculum. A group of parents contended:

> *"The education we already have is enough. It's not good for the young people to know about that. We don't want any more education or any more services. We don't want young people to get any ideas about that. It is not good. Whatever they already have is enough."*[110]

The data suggest that a lack of legal guidance in India mandating comprehensive, objective and value-neutral comprehensive sexuality education in schools is creating a barrier to access to education and information for young people, as well as to SRH services more broadly.

11. Access to abortion

11.1 General Conditions for legal access to abortion

Abortion is by some margin the most heavily regulated SRH service in India. Three pieces of legislation set out the law in relation to abortion in India including the Penal Code, the Medical Termination of Pregnancy Act, and The Preconception and Prenatal Diagnostic Techniques Act.

The law in India is permissive in comparison to legislation in other states in South Asia; nevertheless, significant legal restrictions on access to abortion remain.

[108] *Focus group discussion, girls, Ahmedabad, 26 October 2015*

[109] *Focus group discussion, girls, Ahmedabad, 26 October 2015*

[110] *Focus group discussion, mothers, Bangalore, 29 October 2015*

11.1.1 General Criminalisation of abortion under the Penal Code

Under the Indian Penal Code 1860, 'causing a miscarriage', including if caused by the pregnant woman herself, is a criminal offense, unless it is undertaken to save the life of the woman. Causing a miscarriage is punishable by imprisonment for 3 years, and/ or a fine; or up to 7 years if the woman is 'quick with child'[111] (generally understood as the later stages of pregnancy).

11.1.2 Exceptions granting legal access: the Medical Termination of Pregnancy Act

However, the Medical Termination of Pregnancy (MTP) Act 1971 provides for exceptions to this rule, and permits legal access to abortion within a 20 week gestational period, if the continuation of a pregnancy would involve (a) 'a risk to the life of the pregnant woman or /.../grave injury to her physical or mental health' or where there is a (b) 'substantial risk that the child will suffer from physical or mental abnormalities' making him or her 'seriously handicapped'.[112]

The Act further clarifies that (1) if the pregnancy is 'alleged by the woman to have been caused by' rape, this should be understood to constitute a grave injury to the mental health of the woman and that (2) if the pregnancy occurs as a result of failure of any device or method, used by any married woman or her husband to limit the number of children, 'the anguish caused by such unwanted pregnancy may be presumed to constitute a grave injury to the mental health of the pregnant woman'.[113]

11.1.3 Regulation of facilities providing legal abortion

The MTP Act also establishes regulations concerning the facilities where an abortion can be undertaken and concerning who, legally, may perform abortions. Section 4 (a) provides that terminations may only be performed in (a) a hospital established or maintained by the Government or (b) in a place approved for the purpose by the Government or a District Level Committee.[114] Terminations undertaken by someone who is not a registered medical practitioner is an offence punishable by imprisonment of between 2 and 7 years.[115]

However, under the amended MPT rules and regulations 2002, medical abortion was introduced. The regulations allow an obstetrician/gynaecologist or another certified medical practitioner to provide mifepristone and misoprostol (drugs used for medical abortion) in a clinic setting until the seventh week of pregnancy.[116] In these cases the clinic does not necessarily have to be certified under the MTP Act, provided that it has access to a certified facility, should the need arise.[117]

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[111] *Penal Code 1860 s 312. Note the term "quick with child" is not defined but generally refers to a later stage in pregnancy when there is perception of foetal movement.*

[112] *Medical Termination of Pregnancy Act 1971 s 1 (2).*

[113] *Medical Termination of Pregnancy Act 1971 s (3).*

[114] *Medical Termination of Pregnancy Amendment Act 2002 s 4.*

[115] *Medical Termination of Pregnancy Amendment Act 2002 s 5.*

[116] *Boler T, Marston C, Corby N and Gardiner E. Medical Abortion in India: A model for the rest of the world? (London: Marie Stopes International, 2009). p. 11, accessed 13th October 2015 https://mariestopes.org/sites/default/files/Medical_abortion_in_India_research_and_analysis_low_res_FINAL_03_09.pdf*

[117] *Boler T, Marston C, Corby N and Gardiner E. Medical Abortion in India: A model for the rest of the world? (London: Marie Stopes International, 2009). p. 11, accessed 13th October 2015 https://mariestopes.org/sites/default/files/Medical_abortion_in_India_research_and_analysis_low_res_FINAL_03_09.pdf*

11.1.4 Minors' access to abortion: parental consent requirements

Finally, and significantly, the MTP Act provides that written consent from a legal guardian is required for a girl under the age of 18 (or a woman who suffers from mental illness) to access abortion.[118] Although this measure may be intended to be protective, this rule creates a direct legal barrier to access to abortion for girls who are unwilling or unable to obtain parental or guardian consent to access abortion.[119]

Although the MTP Act does not require judicial authorisation for an abortion, even in the case that a young woman is a minor (if she has parental consent), it is evident from recent cases before the Supreme Court and state-level High Courts that judicial authorisation has been sought in cases where the young woman is a minor.[120] The fact that the Courts have failed to dismiss these cases has perpetuated the (mis) perception that a minor can only access abortion with judicial authorisation creating further barriers to access to abortion for girls.[121]

The Medical Termination of Pregnancy Act provides that written consent from a legal guardian is required for a girl under the age of 18 years to access an abortion. This creates a direct legal barrier to access to abortion for girls who are unwilling or unable to obtain parental or guardian consent.

11.2 Perceptions of law: adolescents' and young people's access to abortion

Abortion appears to be one of the areas of law in which the existence of legal restrictions on access are most well-known: 92.7% of service providers and 95.2% of young people in the surveys identified at least some circumstances in which young people's access to abortion is prohibited in law.

11.2.1 Perceptions of absolute prohibition on young people's access

Whilst service providers tend to have a solid and detailed understanding of legal provisions, including provisions related to consent, regulating access to abortion services; young people were much less certain. A number of young people in qualitative interactions appeared to think that abortion is prohibited all together for girls under the age of 18 years.

Focus Group Discussion, young women, Ahmedabad

> *If a girl is below 18 and she gets pregnant and she goes for an abortion there will be legal enforcement on her and the person who made her pregnant. It is illegal.*
>
> *What about if her parents consent to the abortion?*
>
> *Even if her parents accept it, the society will not accept it. And there are laws in India which do not allow a young woman to access an abortion when the girl is below 18.*[122]

[118] *Medical Termination of Pregnancy Act 1971 s 4 (a). However, there is an exception to the parental consent requirement in the case that a medical professional determines that an abortion is immediately necessary to save a woman's life.*

[119] *Medical Termination of Pregnancy Act 1971 s 5.*

[120] *Centre for Reproductive Rights and Human Rights Law Network, Supplementary Information on India, scheduled for review by the Committee on the Elimination of Discrimination against Women during its 58th Session, 19 June 2014, Geneva. Accessed 30th October 2015.http://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/Ind/INT_CEDAW_NGO_Ind_17511_E.pdf*

[121] *Centre for Reproductive Rights and Human Rights Law Network, Supplementary Information on India, scheduled for review by the Committee on the Elimination of Discrimination against Women during its 58th Session, 19 June 2014, Geneva. Accessed 30th October 2015.http://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/Ind/INT_CEDAW_NGO_Ind_17511_E.pdf*

[122] *Focus group discussion, young women, Ahmedabad, 26 October 2015*

Being unmarried was also raised as a factor: as one group of girls explained: "When they come to realise that you are not married – if they come to know this – they won't be willing to do the abortion."[123]

18.2% of respondents in the survey thought that a girl under the age of 18 years could 'never' access an abortion: even with parental consent, to save her life, or in the circumstance that her pregnancy was the result of rape. Furthermore, more than a quarter, 26.8%, thought this to be true of a girl under the age of 15. Age was found to be a significant predictor of a young person's perceptions of law related to abortion: younger adolescents were significantly less likely to believe it legal for a minor to access an abortion in any circumstance than were older respondents, even when controlling for other factors:[124] almost a quarter,23%, of adolescents under the age of 18 thought that it was illegal in all circumstances for a 17 year old to access an abortion, and other a third, 37.7%,thought this to be true for a child under 15.

Such (mis)perceptions of the law clearly have implications for young people's access to abortion services. Should an adolescent girl become pregnant, her subsequent choices and actions may be directly affected by her belief that she is entirely prohibited from accessing legal abortion. However, there may also be a wider affect. The notion that abortion is entirely prohibited for adolescents under 18 years, may serve to solidify taboos and stigma associated with sexual activity amongst young people; for instance, by contributing to the attitude that becoming pregnant is the worst thing that can happen to an (unmarried) girl, if it is thought that she will not have the option of abortion available to her, at least through legal or safe means. Indeed, interactions with young women revealed just how intense and affecting the stigma associated with early pregnancy can be; such that abortion may be the only option to an unmarried pregnant girl who wishes to 'survive':

> *"In cases where you are not married and you are pregnant – these kinds of cases…If [a girl] thinks that she wants to survive then she will definitely go to the Doctor to get the abortion pill. Otherwise she will just commit suicide."*[125]

Focus Group Discussion, boys, Ahmedabad

> *If she is 16 years old abortion will not be allowed because she is a minor*
>
> *What about with her parents' permission?*
>
> *Boy 1: Then it might be possible.*
>
> *Boy 2: If she were my friend I would tell her not to tell anyone at home – somehow get yourself aborted.*
>
> *Why do you think that she shouldn't tell her parents?*
>
> *It depends on what kind of parents they are. If they are very rigid with the customs and social norms they might kill the girl.*[126]

When asked why adolescents and young people are prohibited from accessing an abortion, respondents often contended that abortion is harmful to health and bodies of young women and girls. Such narratives do not form the basis for consent rules in law; however, they fit with dominant ideas about 'childhood',

[123] *If you want to get an abortion in hospital then you need permission from your husband and from your parents. When they come to realise that you are not married – if they come to know this – they won't be willing to do the abortion.*

[124] *Including gender, wealth group, level of education and place of residence (logic regression, $p<0.05$).*

[125] *Focus group discussion, girls, Bangalore, 29 October 2015*

[126] *Focus group discussion, young men, Ahmedabad, 27 October 2015*

which designate childhood as a period of sexual and reproductive immaturity, underdevelopment and 'innocence':[127] "age matters. Girls who are less than the age of 18 – the body is not ready to undergo an abortion;"[128] "[To get an abortion] young people definitely need permission from their parents because of the health problems. After 25 years the girls are more mature, but before that the body is not ready – that's why parents' permission is necessary."[129]

11.2.2 Attitudes towards abortion: intersection of legal and social norms

In qualitative interactions young people expressed negative and disapproving attitudes towards abortion: "it is a good as murder. It is like we are killing our own children with our own hands. It is wrong. It is something you should be penalised for."[130] The normative influence of law, and its role in shaping ideas about access to abortion was evident in the ways that respondents conflated restrictive and judgemental narratives concerning abortion with (their perceptions of) legal rules:

Focus Group Discussion, girls, Bangalore

> *There is a rule that you cannot do abortion – where you cannot kill the child.*
>
> *Is it correct that abortion is generally illegal?*
>
> *As per the law, yes it is definitely wrong. The law says abortion is wrong. But if something is harmful to the mother she can get the permission of the doctor or some higher authority and get the abortion.*[131]

Few respondents, however, regarded abortion as wrong in each and all circumstances. When reasoning about the circumstances in which abortion is acceptable or allowable, respondents tended to explain their position through one or two justifications: the question of whether the girl was to blame for the situation she found herself in – "if a girl came for abortion services, I would ask the history – was it rape? Did she want to get pregnant?"[132] -or through balancing the (potential) risks to the health or wellbeing of the pregnant woman/ girl, against the life of the unborn foetus. For example:

> *"[Abortion] is definitely wrong. But if something is harmful to the mother she can get the permission of the doctor or some higher authority and get the abortion;"*[133]
>
> *"[Abortion] is wrong, but if a girl got raped or something it is good, because [otherwise] she can't go before society";*[134]
>
> *"If the girl is married then there is no problem to go to access abortion, but if she is not married then if she goes and seeks abortion services then that is not correct".*[135]

The law, especially the MTA, evidently both reflects and reinforces such narratives. According to the law, a woman/ girl is not permitted to access abortion solely on request: in fact this is criminalised, and heavy penalties are set out in law for both those who seek out and who provide such services. Rather, the law

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[127] *Yarrow, E. et al., 'Can a restrictive law serve a protective purpose? The impact of age restrictive laws on young people's access to sexual and reproductive health rights', Reproductive Health Matters, RHM44-001_002, December 2014.*

[128] *Individual interview, young man, Ahmedabad, 27 October 2015*

[129] *Individual interview, young woman, Ahmedabad, 27 October 2015*

[130] *Individual interview, young woman, Ahmedabad, 27 October 2015*

[131] *Focus group discussion, young women, Bangalore, 29 October 2015*

[132] *Individual interview, service provider, Ahmedabad 26 October 2015*

[133] *Focus group discussion, girls, Bangalore, 29 October 2015*

[134] *Focus group discussion, girls, Bangalore, 30 October 2015*

[135] *Focus group discussion, girls, Ahmedabad, 26 October 2015*

establishes a limited number of circumstances in which a woman/ girl may legally access an abortion based upon precisely the types of justifications provided by respondents: a balance of the right to life of the foetus, against the health and life of the pregnant woman/ girl, and an analysis of whether the pregnancy was the fault of the woman/ girl: i.e. was the pregnancy the result of rape? Or was she married and taking birth control?

The law on abortion in India, whilst comparatively permissive, and enabling access to safe and legal abortion in some circumstances, is not founded in an unmitigated acknowledgment of a woman's right to choose whether to terminate or continue her pregnancy. This reflects a synergy with findings from the qualitative research concerning respondents' attitudes towards abortion and perceptions of when and in what circumstances it is (un)acceptable. In fact, only one respondent in the research, a young man volunteering with FPAI, expressed agreement with abortion in terms of the rights of the mother: "if [a woman] decides to get an abortion she should go for an abortion and nobody should deny her because it is her decision to get an abortion."[136]

Abortion law in India is permissive relative to other jurisdictions in South Asia. Nevertheless, significant restrictions on access to abortion remain. Many young people were of the view that abortion is entirely prohibited for adolescents under 18; believing that a young woman's 'body' is not ready for abortion.

11.3 Restrictions on abortion based on gestational period

As discussed above, abortion is only legal within a 20 week gestational period. According to the MTP Act the decision to terminate a pregnancy may be taken by one registered medical practitioner up until the 12th week of pregnancy (if he or she is convinced that the above mentioned criteria for access to legal abortion are met).[137] Between 13 and 20 weeks, two registered medical practitioners must make the same decision.[138] However, Section 5 of the MTPA does provide an exception to this if a medical professional finds that an abortion is immediately necessary to save the life of the woman or girl.[139]

In addition, there is some interesting and recent case law concerning abortion after 20 weeks. In 2015 the Supreme Court granted a 14-year-old rape survivor in her 24th week access to legal abortion, on the grounds of preserving her physical and mental health.[140] This decision potentially opens up the possibility of access to legal abortion in a broader range of circumstances than currently provided for in the MTPA. On the other hand, in 2008, the Bombay High Court rejected an application from a couple for the abortion of a foetus with complete congenital heart blockage, because the woman was 24 weeks pregnant when the court was approached.[141]

Evidence from the field research indicates that few people, including service providers, are aware of exceptions in law that allow abortion after 20 weeks; as a Doctor in Ahmedabad explained:

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[136] *Individual interview, young man, Ahmedabad, 27 October 2015*

[137] *Medical Termination of Pregnancy Act 1971s 2.*

[138] *Medical Termination of Pregnancy Act 1971s 2.*

[139] *Medical Termination of Pregnancy Act 1971 s 5.*

[140] *Nina Wolpow "India to allow abortion for 14-year-old rape victim" Refinery 29, July 30, 2015. http://www.refinery29.com/2015/07/91561/india-supreme-court-abortion-case, accessed 21st October 2015.*

[140] *Times of India "Mumbai abortion case: Niketa Mehta suffers miscarriage." Aug 14, 2008. http://timesofindia.indiatimes.com/city/mumbai/Mumbai-abortion-case-Niketa-Mehta-suffers-miscarriage/articleshow/3363293.cms?referral=PM, accessed 19th October 2015.*

> *"You can provide the medical termination pill from a girl's last period up until 63 days. Then from 12 weeks to 20 weeks you can undergo surgery (the procedure requires two surgeons). After 20 weeks it is too late."*[142]

Interestingly, the same provider went on to note that:

> *"According to the law it is mandatory to have two surgeons [for abortion from 12-20 weeks]. Now gynaecologists are scared of providing abortion after 12 weeks because they are scared of being accused of breaking the law. Not many are doing it – they are not providing it."*[143]

As this quote illustrates gestational limits may have knock on effects, hampering access to abortion beyond the specific restrictions in the law. India's National Commission on Women (NCW) has also expressed concern that gestational limits in the MTPA create barriers to access to abortion for poorer women, as they are less likely to receive an ultrasound and find out about any potential health risks early in pregnancy;[144] at the point at which they do have access to such services, abortion may no longer be legal in the majority of circumstances due to restrictions under the law.

11.4 The Preconception and Prenatal Diagnostic Techniques Act

In India there is an additional restriction on access to abortion: namely the Preconception and Prenatal Diagnostic Techniques Act (PCPNDT), passed in 1994to prohibit the practice of sex- selective abortions.[145]

Whilst, as discussed above, it is legally permissible under the MTP Act to abort a foetus at risk of serious physical or mental disabilities, the PCPNDT Act prohibits the abortion of foetuses on the grounds of their sex, and precludes the use of pre-natal diagnostic techniques for this purpose. Medical practitioners, persons owning genetic counselling centres, clinics or laboratories, in which such services are provided and employees of such places, are punishable under the act; as are any persons seeking out such services. Any person who advertises techniques capable of sex-selection before or after conception is also liable for punishment.[146]

Specific regulations have also been imposed on abortion providers and chemists in some districts and states in India based on the belief that the skewed sex ratio may be best addressed by limiting the availability of abortion services altogether. In some instances this may have resulted in providers ceasing to provide legal abortion services, particularly in the second trimester.[147] A study conducted by IPAS in Maharashtra in 2012 found that 58% of chemist shops reported that they stopped stocking medical abortion drugs after the government began enforcing new regulations.[148]

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[142] *Individual interview, Doctor, Ahmedabad, 27 October 2015*

[143] *Individual interview, Doctor, Ahmedabad, 27 October 2015*

[144] *Centre for Reproductive Rights and Human Rights Law Network, Supplementary information on India, scheduled for review by the Committee on the Elimination of Discrimination against Women during its Pre-Sessional Working Group, October 1, 2013, Geneva. Accessed 30th September 2015. http://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/Ind/INT_CEDAW_NGO_Ind_15400_E.pdf*

[145] *Mary Philip Sebastian, M.E. Khan and Daliya Sebastian, Unintended Pregnancy and Abortion in India with Focus on Bihar, Madhya Pradesh and Odisha, (New Delhi: Population Council, 2013), p. 15, accessed 19th October 2015. http://www.popcouncil.org/uploads/pdfs/2014STEPUP_IndiaCountryProfile.pdf*

[146] *Center for Enquiry Into Health and Allied Themes (CEHAT) The pre-conception and pre-natal diagnostic techniques (Prohibition of sex-selection) Act 1994, answers to frequently asked questions; a handbook for the public. (New Delhi: UNFPA, 2007), accessed 22nd October 2015.http://countryoffice.unfpa.org/india/drive/FAQsforThe_Public.pdf*

[147] *Melissa Stillman, Jennifer J. Frost, Susheela Singh, Ann M. Moore and Shveta Kalyanwala Abortion in India a literature review (New York: Guttmarcher Institute, 2014), p. 28, accessed 21st October 2015. https://www.guttmacher.org/pubs/Abortion-India-Lit-Review.pdf*

[148] *Melissa Stillman, Jennifer J. Frost, Susheela Singh, Ann M. Moore and Shveta Kalyanwala Abortion in India a literature review (New York: Guttmarcher Institute, 2014), p. 29, accessed 21st October 2015. https://www.guttmacher.org/pubs/Abortion-India-Lit-Review.pdf*

Although implemented as a protective measure to reduce the harmful impact of son preference, previous research has demonstrated that the strong messaging around the illegality of sex-selective abortion has influenced wider misperceptions that all abortions are illegal,[149] which in turn has impacted on women's service seeking behaviour, and led to confusion among providers regarding the legality of abortion.[150]

These findings are supported by evidence from qualitative interactions with respondents. Young people, parents and carers consistently justified beliefs that abortion is altogether illegal and/ or wrong, on the grounds of the wrongfulness of 'sex'-selection. For example:

Focus Group Discussion, girls, Bangalore

> *It is wrong to do an abortion.*
>
> *Why do you say that?*
>
> *Due to the gender discrimination – when it's a girl baby they do an abortion.*[151]

> *Focus Group Discussion, boys, Bangalore*
>
> *Is that legal – for a teenager to get an abortion?*
>
> *No.*
>
> *Why not?*
>
> *Because of sex discrimination.*[152]

In addition studies have repeatedly found that the focus on sex selective abortion has led to excessive scrutiny around abortions, making abortions harder to obtain.[153] Once again, evidence from the qualitative research lends some credibility to this assertion; as one Doctor in Ahmedabad explained:

> *"[The law on abortion] is very strict now. We have to fill out a form with the details of the woman having the sonogram, and write down the gender of the child. We have to complete form F in 3 copies – 1 for the parents, 1 for the doctor and 1 to go to a higher level. If the doctor has used this measure (a sonogram) for more than 50 patients - that would go on record with the high doctor. The government has a list of all doctors who have a machine and we have to report the number of scans. The auditors will conduct visits. The also send a 'patient' [an auditor posing as a patient] to ask to know the sex of the baby… If the mother has 3 previous girl children and gets a termination this is a red flag – even if there is no scan!"*[154]

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[149] *Melissa Stillman, Jennifer J. Frost, Susheela Singh, Ann M. Moore and Shveta Kalyanwala Abortion in India a literature review (New York: Guttmarcher Institute, 2014), p. 35, accessed 21st October 2015. https://www.guttmacher.org/pubs/Abortion-India-Lit-Review.pdf*

[150] *Melissa Stillman, Jennifer J. Frost, Susheela Singh, Ann M. Moore and Shveta Kalyanwala Abortion in India a literature review (New York: Guttmarcher Institute, 2014), p. 35, accessed 21st October 2015. https://www.guttmacher.org/pubs/Abortion-India-Lit-Review.pdf*

[151] *Focus group discussion, girls, Bangalore, 29 October 2015*

[152] *Focus group discussion, boys, Bangalore, 29 October 2015*

[153] *Centre for Reproductive Rights and Human Rights Law Network, Supplementary Information on India, scheduled for review by the Committee on the Elimination of Discrimination against Women during its 58th Session, 19 June 2014, Geneva, p. 4, accessed 30th October 2015. http://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/Ind/INT_CEDAW_NGO_Ind_17511_E.pdf*

[154] *Individual interview, Doctor, Ahmedabad, 27 October 2015*

The PCPNDT Act prohibits the practice of sex-selective abortion. This legislation was introduced to reduce the harmful impact of son preference. However, there is evidence that the strong messaging around the illegality of sex-selective abortion has reinforced stigma associated with abortion more broadly, and led to increased scrutiny around abortion, potentially creating further barriers to access to abortion.

12. Access and privilege: private vs. public clinics

The research findings indicate that access to SRH services is a function of privilege: evidence from the research suggests that legal barriers to access to SRH services may have a disproportionately negative effect on people from poorer backgrounds, and participants who lack independent access to income, particularly affecting younger people and adolescents. In qualitative interactions young people consistently claimed that money plays a major factor in determining whether children under the age of 18 years would be granted access to SRH services:

> *"Below 18 they are not giving, but if we bribe them, then…they will give;"*[155]
>
> *"If you find 10-15 rupees extra, maybe it's available. They will find different means… if you really want it";*[156]
>
> *"If you give them money they will keep it confidential. Otherwise they will complain to your parents".*[157]

Many respondents drew distinctions between the barriers young people experience when accessing services in public clinics, where services are free, and those they experience in private clinics, which require fees. Some respondents claimed that at public clinics young people are more likely to be denied access to services, and that their information is less likely to be kept confidential; whilst services at private clinics were considered more accessible:

"When people are 14-15-16, they will not come to a government clinic – they will access a private clinic. In a government clinic they will be recorded as 12/15. In a private clinic they are not require to keep records, and there will be under table transactions. They would not take so big a risk – [government clinics] might require the parents!"[158]

Numerous respondents in the qualitative research noted that access to SRH services is more available to young people in 'private' facilities, where consent requirements are not enforced, and clients can just pay the required money without further fuss or scrutiny: "In hospitals they ask for your details, but in medical stores they don't. They just take your money. They are not so bothered about your details;"[159]"In government hospitals they are following the law, but in private hospitals they are money-minded. If you give them money, they will just do it."[160]

One service provider in Bangalore explained that women and girls from wealthier backgrounds are more likely to be able to access safe abortion, whilst, women and girls from poorer backgrounds may be compelled to pursue more dangerous means. As a nurse in Bangalore described:

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[155] *Focus group discussion, young men, Ahmedabad, 26 October 2016*

[156] *Focus group discussion, young men, Ahmedabad, 26 October 2016*

[157] *Focus group discussion, girls, Bangalore, 29 October 2016*

[158] *Individual interview, Doctor, Ahmedabad, 27 October 2015*

[159] *Focus group discussion, girls, Bangalore, 29 October 2015*

[160] *Focus group discussion, mothers, Bangalore, 29 October 2015*

Interview, Nurse, Bangalore

> *A lot of people are going to medical shops and doing unsafe abortions. It is a big problem. They go to the medical shops and eat papaya. They eat Yellu– it's like a black seed – to stimulate abortion.*
>
> *Does it work?*
>
> *They have a misconception that if they eat that it will cause an abortion. But actually it causes incomplete abortion. It causes heat in the body, and they bleed a lot, but it doesn't fully work.*
>
> *Why do you think that people are accessing these unsafe abortions, rather than coming to the hospital?*
>
> *They are not ready to spend their money to get a safe abortion. Also they are trying to hide from their family. In some families – the family will not allow them to get an abortion – they want more children in the family. So if they want to get an abortion they have to hide it.*
>
> *Why is it difficult to hide it if you go to a government hospital?*
>
> *If you come to a government hospital you need permission from your husband – your family – your relatives. When it comes to the private hospital you can just pay the money and go.*[161]

Interestingly the survey data revealed a significant relationship between respondents' wealth score and their tendency to have been denied access to services. Young people who said that they had 'never' been denied access to a service had significantly higher wealth scores than those who said that had been denied access, and this remained true even when controlling for a young person's gender, age and marital status.[162]

While laws apply in the same way to private and public clinics, it seems plausible that if public clinics are indeed taking a more restrictive approach, this may be related to the fact that they are run by the government, and less independent from public institutions constrained by legal, political and social norms and influences. Meanwhile, private clinics are likely to be accessed by young people from more privileged backgrounds, who are less likely to identify with 'traditional' or socially conservative identities associated with restrictive narratives regarding young people's sexuality.[163]

The research findings suggest that legal barriers to access to SRH services have a disproportionate impact on individuals from poorer backgrounds who lack disposable income - a factor which is likely to particularly affect young people. Respondents suggested that money plays a major role in determining access; claiming that public clinics are more likely to deny children services, and less likely to keep information confidential, than private facilities.

[161] *Individual interview, Nurse, Bangalore, 29 October 2015*

[162] *Logistic regression, $p<0.05$*

[163] *Individual interview, Nurse, Bangalore, 29 October 2015*

Sex, Violence and The Law

Limited legal definitions of sexual violence, and the failure in law to protect individuals from sexual and gender based violence (SGBV) in all contexts, creates barriers to access to SRH services for those survivors who are not protected in law. On the one hand limited legal definitions exclude some survivors from being eligible for support services; on the other hand, survivors of violence may be less likely to recognise violence when it occurs, and to identify themselves as having been subject to abuse. In circumstances where survivors would like to access help and support, they may fear that their claims will be viewed as lacking legitimacy and justification.

13. Limitations in law and its implementation

13.1. Rape of men/ boys and third gender individuals

In India there are no provisions in law that protect male or third gender young people, over the age of 18 years, from rape or sexual abuse. The Indian Criminal Law (Amendment) Act 2013 only applies to female victims of rape; meanwhile the Protection of Children from Sexual Offences Act 2012 is gender neutral but only applies to children under the age of 18 years. Whilst Section 377 of the Penal Code punishes 'carnal intercourse against the order of nature', this provision implies that male victims of rape are liable to be treated as perpetrators rather than victims under the law.[164]

13.2. Rape within marriage

Critically, penal law also contains an exception for the crime of rape, where forced sexual activity takes place in the context of marriage. Section 376A of the Indian Penal Code provides that a married woman may be the victim of rape only if she is judicially separated from her husband. Further, as set out in Section 7 above, penal laws in India set a lower age of sexual consent for girls who are married: a married girl cannot be raped by her husband as per the law unless she is under 15 years old. The Indian Penal Code also establishes reduced penalties for spousal rape of a wife aged 12-15 years; for which the penalty is imprisonment for a maximum of 2 years, a fine, or both.[165]

The Indian Domestic Violence Act Section 3 introduces a limited protections in law with regard to marital rape, however this section only covers marital rape under circumstances of life-threatening and grievously hurtful conduct, and further only provides civil remedies, thus still not criminalising the act.

Allowing for marital rape and rape of male or third gender individuals within the law constitutes a direct violation of the sexual and reproductive rights of survivors of abuse. In addition, these laws are liable to have significant consequences for access to SRH services. In the cases where a woman or girl's husband is the perpetrator of violence, or where victims of abuse are male or transgender, survivors may not consider themselves eligible to access services, and practitioners may be less likely to provide support.

[164] *Penal Code including as amended 1995 and 2006 s 364.*

[165] *Penal Code 1860 s 376 (1).*

In India there are no provisions in law that protect male or third gender young people (over 18 years) from rape or sexual abuse. Furthermore, penal law contains an exception for the crime of rape where it takes place in the context of marriage. These rules can create barriers to access to SRH services for survivors, who are less likely to access and receive support if their experiences of abuse are not recognised.

13.3. Statutory rape

As discussed, the Protection of Children from Sexual Offences Act 2012 establishes the age of sexual consent in India at 18 years for both males and females. This law purports to protect children from sexual predators; acknowledging that children's age, lack of experience, heightened impressionability and subordinate social status, places them in a position of relative powerlessness which renders them especially vulnerable to grooming and exploitation by others..

Notwithstanding the protective purpose of these laws, and as has been argued throughout this report, the establishment of a minimum age for sexual consent also serves as a mechanism for regulating children and young people's sexual activity, (gendered) identity and behaviour. Unfortunately, evidence in the data indicates that the law is typically applied with the latter function in mind, reflecting the fact that as discussed in **Section 8.5.2** statutory rape laws may be enforced to compel children into marriage, or in circumstances where the parents of a couple object to the nature of their relationship:

Individual interview, doctor, Bangalore:

> *What do you think about the law [on sexual consent]? Do you think it protects young people?*
>
> *No. There is no privacy for young people. The authorities listen to the relatives rather than the victim [of violence]... It creates an emotional and developmental problem.*[166]

As this quote illustrates, the application of statutory rape laws may not only function to deny adolescents in consensual sexual relationships the right to sexual autonomy and access to services; significantly, they may also serve to deny children who are indeed victims of rape and violence, protection and privacy under the law. This may be particularly problematic in circumstances where a child is being abused at home by family members; as is often the case in situations of childhood sexual abuse.

13.4.Providing and accessing SGBV services in practice

Only 1.8% of service providers surveyed in India reported to provide SGBV related services. Perhaps this is due to the fact that, as was the case at one clinic in Ahmedabad, providers tend to refer cases of SGBV brought to their clinic to larger hospitals or clinics equipped to handle such cases:

> *"There was a case once. It was brought to the urban hospital but was referred to the civil hospital because they have the medical reports that are required for such a case... to find out whether a rape has happened they have to take a sample from the vagina to prove if it is rape or not. If a case like that comes to our attention we just send it to the big hospital, nowhere else. The hospital will inform the police.'*[167]

Alternatively, few providers may be offering SGBV services due to low rates of reporting resulting in diminished demand for services. Whilst 50 respondents in the young people's survey reported having

[166] *Individual interview, Doctor, Bangalore, 29 October 2015*

[167] *Individual interview, Doctor, Ahmedabad, 27 October 2015*

been previously forced into sex, only 2 said that they had accessed an SGBV-related service, and both of these respondents were male.

Data from the qualitative research suggests that prevalent social attitudes that hold women and girls responsible for their own abuse function as a significant barrier to access to SGBV services for female survivors. These attitudes were articulated by respondents across research sites, including young girls themselves:

> *"If a girl goes and files a rape case she will be humiliated…If we are badly behaved then these things are bound to happen. That is the reason why we have been taught karate...We have to be cautious and have our eyes everywhere… I have a friend, and she is very scared – that is why she carries things like chilli powder to keep herself safe."* [168]

> *"Even if a woman is facing such a kind of violence, she doesn't report to police because of fear that people will taunt her, because this is an internal matter of the family. If she reports outside the family will taunt her and abuse her and because of that fear, she doesn't report."*[169]

Respondents explained that a women or girl who has been subject to sexual violence is not only liable to bring shame and humiliation upon herself as an individual; she may also undermine the honour of her entire family:

Individual interview, young man, Ahmedabad:

> *In most cases (of sexual violence) women don't go and speak to the police.*
>
> *Why not?*
>
> *She is afraid of spoiling the name of her parents and husband. Because of that fear she doesn't go… she is afraid of the respect of her parents.*[170]

The harmful impact of such norms may particularly affect younger women and girls who are under the authority of their parents, especially if they are not yet married, and have thus transgressed social norms prohibiting pre-marital and underage sex. The danger presented by such norms was articulated most powerfully and disturbingly by a number of respondents who declared they would be prepared to kill a female relative who dishonoured their family by engaging in pre-marital sex: "If it was my daughter, I would beat her and kill her."[171] A group of boys in Bangalore imagined what they would do to their sister in such a circumstance:

> *"I would hit her. If it were my brother I would tell him that what he is doing is wrong and that he should not do that. But I wouldn't hit my brother. But my sister is like a god – she is luxury in the family…[So] I would hit her, and give poison and kill her."*[172]

This passages illustrates how the objectification of female members of the household, and a sense of entitlement of ownership over their bodies and persons displayed by (male) family members, drives violence against women and girls.

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[168] *Focus group discussion, girls, Bangalore, 30 October 2015*

[169] *Individual interview, young woman, Ahmedabad, 27 October 2015*

[170] *Individual interview, young man, Ahmedabad, 27 October 2015*

[171] *Focus group discussion, mothers, Ahmedabad, 27 October 2015*

[172] *Focus group discussion, boys, Bangalore, 29 October 2015*

Such attitudes were also displayed by FGDs with parents; a group of mothers in Ahmedabad, for example, stated that they would be willing to kill any daughter of theirs who damaged their family honour. Although they appeared to make an exception for the circumstance that their daughter had been a victim of rape -"[if she was raped] we would fight with the community and say that our daughter did not do it on purpose and that she was forced"[173] - their willingness to support their daughter appeared to only apply in the case that she had been raped by a stranger; a person who was unknown to her and her family. If, on the other hand, their daughter had a prior relationship with the assailant, the mothers were not able to conceive of the scenario as rape.

Such perspectives are revealing as they shed light on cultural constructions and representations of 'rape'; which - as with legal definitions of rape - do not necessarily include all types of forced sex, but rather consider the context in which sex is compelled, as well as the relationship between the victim and her assailant, when deciding whether the action should be considered violent. Consider the following extract:

Individual interview, young woman, Ahmedabad:

> *The law is very strict…. For those who do rape in public.*
>
> *What do you mean 'do rape in public?'*
>
> *Like if you rape a girl in public – if you don't know that girl…*
>
> *Why is the law more strict on that?*
>
> *Because we are more comfortable with those things [forced sex] when they are between husband and wife. We can understand how those things could happen. But a rapist who rapes a girl he doesn't know in public – those rapists are 'different' – they have a different mentality. They are not like normal people. That is why they get the death sentence.*[174]

Here the respondent clearly links her attitudes towards rape, with legal rules and penalties. She also draws a distinction between different types of forced sex: that between husband and wife which is normalised and accepted, and that which occurs in a different context – rape by a stranger in public – which is not normal and not acceptable: "those rapists are different". This extract highlights the normalising influence of limited legal definitions of SGBV, which underscore a 'rape culture' whereby some forms of sexual violence and coercion against women and girls are regarded as normal and justified.

Evidence from the qualitative research highlights the normalising influence of limited legal definitions of rape; which underscore a 'rape culture' whereby some forms of sexual violence and coercion against women and girls are regarded as normal and justified.

In FGDs respondents were asked to discuss a hypothetical scenario concerning a young woman who is forced into sex by her husband. Whilst respondents did not condone the actions of the husband, they did not necessarily consider his actions to be violent; as a group of boys contended: "that is not rape – because she is already his wife. How can that be rape?"[175] And a group of young women expounded:

[173] *Focus group discussion, mothers, Ahmedabad, 27 October 2015*

[174] *Individual interview, young woman, Ahmedabad, 27 October 2015*

[175] *Focus group discussion, boys, Bangalore, 30th October 2015*

> *"It is a compromise. When you get married you have to adjust to the situation. You can't do anything. If such a situation occurred before marriage there are a lot of things that can be done. But after marriage there is nothing you can do you just have to adjust."*[176]

Similarly, a young woman in Ahmedabad explained:

> *"If sex is forced then this is violence… But rape within marriage happens less in India, because in India girls are calmer about these issues. In India the husband means permission – so whatever he wants to do he can do it. But abroad they might think 'what is a husband?' So they have many more cases [of rape within marriage]."*[177]

In this passage the respondent draws attention to something important about the implications of limited legal definitions of SGBV: that it is not simply a question of how survivors are treated at the point of trying to access justice and services; the law also has implications for survivor's empowerment to seek services in the first instance. In a context where young women do not expect to have choices in relation to their own sexuality, then they are less likely to define and recognise their experiences as constitutive of violence, and more likely to tolerate abusive treatment in silence.

This analysis may also help to explain evidence from the research which suggests that women and girls from more privileged backgrounds are more able to seek justice and services for experiences of SGBV. For example, when asked what options are available to a survivor of partner violence, a group of young men in Ahmedabad cogently responded:

> *"The outcome depends - if the girl is uneducated and from an economically poor background, then she will suffer all these things and she will still be with her husband and give birth to his child. [But] if she is educated, she might bring a case against her husband. She will sue him!"*[178]

Here the respondents suggest that women from educated and privileged backgrounds are more empowered to seek access to justice than those who are less advantaged. As a consequence, impunity for perpetrators increases when the survivor is from a more disadvantaged backgrounds, exposing more vulnerable young women and girls to increased risk of exposure to SGBV; as one responded explained:

Individual interview, young women, Ahmedabad:

> *There are cases of domestic violence against women. It is not common, but in some communities it happens. In rural areas it is very common.*
>
> *Why do you think it is more common in rural areas?*
>
> *In rural areas people are not aware and they still follow age old beliefs…People in rural areas believe that girls should stay home and do the household work, and girls are not allowed out of the house. Also practices of dowry are still prevalent. Because of dowry there is a lot of domestic violence against women.*[179]

[176] *Focus group discussion, young women, Bangalore, 29 October 2015*

[177] *Individual interview, young woman, Ahmedabad, 26 October 2015*

[178] *Focus group discussion, young men, Ahmedabad, 26 October 2015*

[179] *Individual interview, young woman, Ahmedabad, 26 October 2015*

Significant associations were observed in the survey data between demographics indicators of disadvantage and experiences of forced sex: young people with lower levels of education, from poorer households, and living in slum neighbourhoods, were significantly more likely to report being subject to forced sex, than those from more privileged backgrounds.[180] Furthermore, respondents from social and ethnic minority groups (16.4%) and those with disabilities (26.7%) were significantly more likely to say that they had previously been forced into sex than were other respondents (7.8%).[181]

Data from the research indicates that young women and girls from disadvantaged backgrounds are more likely to be subject to SGBV; meanwhile those who are relatively privileged may be more empowered to access support services.

[180] *Chi-square tests, $p<.05$ in all cases.*

[181] *As above.*

Law, Heteronormativity and LGBTI Individuals

One of the most important ways in which law may impact on young people's access to services, is through the regulation of young people's gender and sexual identities and behaviours. Individuals who fail to conform to dominant categories established in law, or who directly violate provisions that criminalise certain sexual identities and behaviours, are likely to face significant barriers to access to services, either because they fear prosecution, or because government services fail to contemplate and provide for their needs.

14. Recognition of third gender status

Up until 2014 legal identity was only available for two genders: male and female. However, in April 2014 the Supreme Court in India ruled that transgender people should be legally recognized as a third gender.[182]

The Court ruled that that the anti-discrimination provisions under Articles 14 to 16 of the Indian Constitution included the right not to be discriminated against on the grounds of sexual orientation and gender, and that the word "sex" in Articles 15 and 16 also covered other self-identified gender identities.[183] It further stated that the determination of the gender to which a person belonged 'is to be decided by the person concerned' and that this should be determined by 'follow[ing] the psyche of the person in determining sex and gender.'[184] The bench stated that since those identifying as transgender were neither male nor female, treating them as belonging to either gender would amount to denial of their constitutional rights.[185]

In its judgement, the court directed the central and state governments to take necessary steps to allow for equal status for those adhering to the third gender, ensuring adequate healthcare, education and employment as well as separate public toilets as well as other safeguards against discrimination.[186] All identity documents such as birth certificates, passports and driver's licences will now have the possibility for a person to identify as third gender.[187]

> In April 2014 the Supreme Court in India ruled that transgender people should be legally recognised as third gender.

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[182] *Human Rights Watch, "India: Enforce Ruling Protecting Transgender People, Court Directive Recognizes 'Third Gender' But Stigma Continues", 5th February 2015, accessed 13th October2015, https://www.hrw.org/news/2015/02/05/india-enforce-ruling-protecting-transgender-people*

[183] *Dhananjay Mahapatra, "SC gives legal status to gender after sex change surgery", Times of India, 16th April 2015, , accessed 13th October 2015, http://timesofindia.indiatimes.com/india/SC-gives-legal-status-to-gender-after-sex-change-surgery/articleshow/33795257.cms*

[184] *Mark E. Wojcik "Male. Female. Other. India Requires Legal Recognition of a Third Gender" International Law News, Vol. 43 No. 4 2014 accessed 6th October 2015, http://www.americanbar.org/publications/international_law_news/2014/fall/male_female_other_india_requires_legal_recognition_a_third_gender.html.*

[185] *Dhananjay Mahapatra, "SC gives legal status to gender after sex change surgery", Times of India, 16th April 2015, accessed 13th October 2015, http://timesofindia.indiatimes.com/india/SC-gives-legal-status-to-gender-after-sex-change-surgery/articleshow/33795257.cms.*

[186] *Mark E. Wojcik "Male. Female. Other. India Requires Legal Recognition of a Third Gender", International Law News, Vol. 43 No. 4 2014 accessed 6th October 2015, http://www.americanbar.org/publications/international_law_news/2014/fall/male_female_other_india_requires_legal_recognition_a_third_gender.html.*

[187] *Ask Kotak "India's transgender law is no help to its lesbian, gay and bisexual communities", The Guardian, 17th April 2015, accessed 6th October 2015 http://www.theguardian.com/commentisfree/2014/apr/17/india-transgender-laws-lbg-gay-communities*

15. Criminalisation of 'acts against the order of nature'

15.1. Status of the law

Despite, this progressive ruling by the Supreme Court regarding third sex status, the protective power of the law is undermined by Section 377 of the Indian Penal Code which states:

> *'Whoever voluntarily has carnal intercourse against the order of nature with any man, woman or animal shall be punished with imprisonment for life, or with imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine.*[188]
>
> *Explanation: Penetration is sufficient to candidate the carnal intercourse necessary to the offence described in this section.'*[189]

This provision is generally understood as prohibiting same-sex activity amongst MSM, including gay and bisexual men, as well as trans women and hijras who have not undergone sex-reassignment surgery – even in private spaces.26 As the law refers particularly to penetration, it is not clear whether this provision would be interpreted as criminalising same-sex sexual activity amongst women/ girls.[190]

In 2009, the Delhi High Court overturned section 377 of the Penal Code in a historical case, legalising consensual same-sex sexual activities between adults. However, this decision was subsequently overruled. In 2013, the Supreme Court upheld Section 377, stating that the law only applies to a 'miniscule minority' as there had been less than 200 persons prosecuted under Section 377 in the past 150 years,[191] and contending that any amendment in law must be left to the Parliament.[192]

Nonetheless, the potential impact of a legal provision which criminalises individuals on the basis of their sexuality reaches far beyond the number of cases formally prosecuted in the court system. Even if the number of actual prosecutions is low, individuals who engage in criminal sexual acts may live in constant fear of the potential threat of arrest and prosecution, and may be unwilling to reveal to others, including service providers, that they have engaged in same-sex sexual activities; this has implications for their health treatment and care in relation to SRH.

Section 377 of the Penal Code criminalises 'carnal intercourse against the order of nature'. This provision is generally understood to apply to same-sex activity amongst MSM even in private spaces.

15.2. Impact of law

Although researchers were not able to access any lesbian communities during the field research, the team were able to collect data through FGDs with bisexual (male), gay, hijra and transgender individuals (17 participants total participated in FGDs in Ahmedabad and Bangalore). Furthermore, 25 individuals included in the quantitative survey identified their gender as 'other'.

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[188] *Penal Code 1860 s 377.*

[189] *Penal Code 1860 s 377.*

[190] *Lucas Paoli Itaborahy & Jingshu Zhu, State-Sponsored Homophobia, A world survey of laws: Criminalisation, protection and recognition of same-sex love. (Geneva: ILGA, 2014), p. 56, accessed 5th October 2015.http://old.ilga.org/Statehomophobia/ILGA_SSHR_2014_Eng.pdf*

[191] *UK Home Office "Country information Country Information and Guidance India: Sexual orientation and gender identity", (London: UK Home Office, 2014), p. 6, accessed 10th October 2015. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/332640/India_CIG_LGBT_claims_2014_07_18.pdf*

[192] *Lucas Paoli Itaborahy & Jingshu Zhu, State-Sponsored Homophobia, A world survey of laws: Criminalisation, protection and recognition of same-sex love. (Geneva: ILGA, 2014), p. 56, accessed 5th October 2015. http://old.ilga.org/Statehomophobia/ILGA_SSHR_2014_Eng.pdf*

Gay and transgender individuals spoke of the difficulties that they faced achieving acceptance, from their families as well as their communities:

Focus group discussion, Young transgender individuals, Ahmedabad:

> *I come from a Hindu Brahmin family that does not accept transgender easily. But I decided to undergo sex surgery and I convinced my parents. Initially they were not okay with it. But I was feeling I was not made for the male body, and after I underwent the surgery the community did not accept me easily. It was very hard for me to establish myself as a transgender within the community. Initially I was facing difficulties because I was facing stigma. But now I have had my surgery and I am feeling very happy with it.*[193]

Accounts of discriminatory attitudes towards trans individuals were triangulated with evidence from FGDs with other groups of young people who ,in general, expressed very limited understanding of issues related to sexuality and LGBT identity, and spoke in discriminatory and judgemental ways about such groups:

> *"They talk very rudely, very badly. They misbehave - these transgenders. Whoever encounters them will feel ashamed of them;"*[194]

> *"They are not men, nor [are they] women - that's why society will not let them live or survive - and they themselves are confused whether they are to live like men or whether they are to live like women."*[195]

> *"I know that there are males, females, gays and lesbians. It is not acceptable. I don't understand it. It's not illegal but it should be."*[196]

> *"When we see them we get a doubt about whether they are a girl or boy. We think – 'why do they act like that'? If you treat those people in a good way - then it will encourage them to become transgender. That's why society discriminates against them. It is right."*[197]

15.2.1. Limited protection of LGBT communities from violence

> *"Because of our different behaviour and our attitude they keep calling us names. They use offensive words. Because of the way we talk, the way we move, the way we use our hands. They don't understand. They are uneducated people. They think I have AIDS. On the bus where we have a lady's seat and a man's seat, they will send us from one to the other."*[198]

The research revealed evidence that LGBT groups face limited legal protection from violence, extortion and other types of discrimination, both by state and non-state actors. A young volunteer with FPAI in Ahmedabad explained: "there are many cases where transgender people face violence from the police, or they are even forced to have sex with police during the night. They do face a lot of violence from the police;"[199]and a group of MSM and transgender youth in a FGD in Bangalore spoke of how they would

[193] *Focus group discussion, young MSM and transgender people, Ahmedabad, 26 October 2015*

[194] *Focus group discussion, young men, Ahmedabad, 26 October 2015*

[195] *Focus group discussion, girls, Bangalore, 29 October 2015*

[196] *Individual interview, young woman, Ahmedabad, 27 October 2015*

[197] *Focus group discussion, boys, Bangalore, 29 October 2015*

[198] *Focus group discussion, MSM and transgender youth, Bangalore, 30 October 2015*

[199] *Individual interview, young man, Ahmedabad, 27 October 2015*

often be harassed and attacked by mobs of people in public places: "the police will come and put the blame on us. The 'normal' people call the police and the police beat us up".[200]

Respondents explained that the criminalisation of same-sex sexual activity amongst men/ boys under section 377 has the effect of aggravating and perpetuating police and other harassment.[201] Interestingly, participants often specifically referred to "article 377" of the Penal Code during qualitative interactions; there was no other area of law concerning which respondents were able to recall legal provisions with such detail or accuracy.

A group of MSM and transgender people accessed through a youth centre in Bangalore explained how one of the main types of assistance and support they are provided at the centre is assistance by the 'crisis team' when they are 'rounded' up an arrested by the police, which allegedly takes place on a relatively regular basis: "the police get hold of us and take us to the bus station."[202] They explained that they are arrested "because of section 377 of the Penal Code":

> *"The police - when they see us standing there [on the street] talking to one of our own [another MSM] - they will assume that we are going to indulge [in gay sex]. The take us to the station under section 377 and we are treated as a criminal."*[203]

When asked how they are treated by the police when arrested they disturbingly replied: "the cop will indulge in sexual activity with you, and also physically assault you".[204]

When probed further, however, a more complex story of these arrests emerged. It appears that police harassment of these groups was not the simple or direct consequence of the implementation of article 377 of the penal code, but rather a reflection of the structural discrimination and exclusion that MSM and transgender groups face from society more broadly. Respondents went on to clarify that, in fact, they are rarely arrested under article 377, but rather they tend to be picked up on accusations of 'pick-pocketing' or theft. Some respondents attributed this to discrimination, generalising and stereotyping on the part of the police; as one youth explained:

> *"The first doubt always goes on us. If we dress like a woman, doubt will come on us, but if we dress like a man it will not. When it comes to robbery – if 2 people are dressed in a Sari – the other has done this thing, but the police will assume everyone [in the TG community] is the same – and they will arrest you."*[205]

Other members of such communities asserted that in practice many MSM, transgender people and hijras do 'earn a living' partly through petty criminality, including engaging in begging, sex work and petty theft – described by some as 'field work'. They explained that, since they face so much discrimination including barriers to access to employment, 'field work' is typically the means through which their community survives: "If I dress up like a woman my only options are sex work or begging. If I wear pants they can't recognise me too easily and I might be able to do that work."[206] A group of hijra accessed in Ahmedabad described the pressure that they are under, and the violence that they might be exposed to from their own community if they don't bring enough money home at the end of the day:

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[200] *Focus group discussion, MSM and transgender youth, Bangalore, 30 October 2015*

[201] *Kajal Bhardwaj and Vivek Divan, Sexual health and human rights: A legal and jurisprudential review of select countries in the SEARO region: Bangladesh, India, Indonesia, Nepal, Sri Lanka and Thailand, p. 47, (Geneva: World Health Organisation, 2011) accessed 3rd November 2015 http://www.ichrp.org/files/papers/182/140_searo_divan_bhardwaj_2011.pdf*

[202] *Focus group discussion, MSM and transgender youth, Bangalore, 30 October 2015*

[203] *Focus group discussion, MSM and transgender youth, Bangalore, 30 October 2015*

[204] *Focus group discussion, MSM and transgender youth, Bangalore, 30 October 2015*

[205] *Focus group discussion, MSM and transgender youth, Bangalore, 30 October 2015*

[206] *Focus group discussion, MSM and transgender youth, Bangalore, 30 October 2015*

> *"We have to go begging and we have to bring a certain amount of alms back to the guru. And if we don't bring it we face violence from the guru… If we do not bring enough money the guru will beat us up."*[207]

Respondents explained that in practice – in keeping with the findings of the Supreme Court in 2014 - prosecutions under Section 377 of the penal code are very rare. Researchers learned of only one case in Bangalore where a police officer had tried to bring a charge against someone under section 377 because: "they had identified [the defendant] as homosexual".[208] However, rather than the case leading to a prosecution, the police officer himself was found to be in the wrong for his actions, and was consequently transferred out of his post to another area.

Therefore, Section 377 is perhaps best understood as an indirect barrier to access to legal protection from violence and abuse; although Section 377 is rarely directly enforced, it does serve to underscore the intense marginalization faced by MSM and transgender communities, including exclusion from mainstream employment and police harassment.

Although respondents were aware of the 2014 Supreme Court judgement ruling that hijras are now protected under the Constitution, communities explained that there is still a long way to go:

> *"I am aware of a law that say that transgenders are now accepted, that has recently been passed. The government has accepted us and given us identities and all rights of voting and working and getting government jobs – we have been given equal rights. [But] Still there are challenges – we are not accepted as a part of the community. We face stigma and discrimination because the community doesn't see us as a part of it."*[209]
>
> ---
>
> *"[The law] gives us voting rights, and equal jobs. But it does not make us equal citizens of the country."*[210]

Evidence from the survey underscores findings from the qualitative data about the intense vulnerability and marginalisation of transgender people. Individuals in the survey who identified as 'other' had significantly lower 'wealth scores' than individuals who had a 'binary' gender identification (identified as either male or female).[211] 'Other' individuals were also significantly less likely to have reached secondary or tertiary levels of education.[212] Finally, individuals who identified as 'other' were significantly more likely to report having been subject to rape: 1 in 5 (20%) of individuals in the survey who listed their gender as 'other' said that they had been raped, and a further 32% said they would 'rather not say' whether they had been raped or not (as opposed to selecting the 'no' option on the survey).[213]

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[207] *Focus group discussion, MSM and transgender youth, Ahmedabad, 27 October 2015*

[208] *Focus group discussion, MSM and transgender youth, Ahmedabad, 27 October 2015*

[209] *Focus group discussion, young MSM and transgender, Ahmedabad, 26 October 2015*

[210] *Focus group discussion, young MSM and transgender, Ahmedabad, 26 October 2015*

[211] *Focus group discussion, MSM and transgender, Bangalore, 30 October 2015*

[212] *Focus group discussion, MSM and transgender, Bangalore, 30 October 2015*

[213] *Respondents were provided three options on the survey in response to the question "has anyone ever had sex with you or committed sexual acts with you through force or against your will? For example through pressure, coercion, physical force, or because you were unable to say no?" the options were 'no', 'yes', and 'rather not say'.*

15.2.2. Impact of criminalisation: access to SRH services

As discussed, Legal criminalisation underscores the stigma associated with sexual behaviours that are considered 'deviant'. MSM and transgender groups face general stigma and discrimination in society; deepened and amplified by criminalisation of their behaviours and identities under the law. They are also likely to experience feelings of shame about their sexuality that may make them less confident in seeking out SRH services, and they may be concerned about facing ill-treatment or discrimination by service providers if and when they do so.[214] They may fear that seeking services could lead to their sexuality or sexual activities being exposed to parents/ guardians, other relatives, and/or the wider community.

Criminalisation of same-sex sexual activity is also likely to have an impact both on information and education provided around sexual and reproductive health as well as on what services are provided within the public health sector and how these cater (or do not cater) for a diversity of sexual and gender preferences and identities. Information on SRH issues is likely to be biased and discriminatory against individuals who do not conform to dominant ideas about sexuality, and may include misinformation and inaccuracies. Furthermore, the ability of health providers to provide services in line with these group's specific needs is unlikely to be readily available.[215] As a result, these persons may not choose to engage with the public health care system because their needs are not being met.

Indeed a World Bank report from 2012 found that persons identifying as gay, lesbian or transgender in India prefer not to access mainstream health services due to stigmatization faced by health service providers. In addition, those interviewed in the study also felt that service providers were not well oriented in relation to the health issues faced by the LGBT community, which has an impact on their service seeking behaviour.[216]

Evidence from the field research firmly supports such conclusions. Gay and transgender young people interviewed in the qualitative research explained that as a result of discrimination they felt unable to access 'mainstream', or non-specialised health services, due to fear of discrimination: from other patients at the centre - "the people around the centre will give us a different look"[217] - as well as from health staff:

> *"The doctors treat us differently because of our identity. They identify me as a boy, but they do not believe that I am a boy. Nurses will point at me and say 'are you a male or a female? Why do you dress like that and act like a woman?"*[218]

One young person, who identified himself as a homosexual 'Kothi'[219] described his experience when he went to a health centre for an injection. He described how the doctor 'jabbed' the needle hastily into his back. He claimed the doctor was 'rough' with him and 'hesitant to touch him at all', saying "don't touch

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[214] *Kajal Bhardwaj and Vivek Divan, Sexual health and human rights: A legal and jurisprudential review of select countries in the SEARO region: Bangladesh, India, Indonesia, Nepal, Sri Lanka and Thailand, p. 47, (Geneva: World Health Organisation, 2011) accessed 3rd November 2015 http://www.ichrp.org/files/papers/182/140_searo_divan_bhardwaj_2011.pdf*

[215] *The Women's Support Group, Sri Lanka, The Status of Lesbians, Bisexual Women and Transgendered Persons in Sri Lanka NGO Shadow Report to the Committee on the Elimination of All Forms of Discrimination Against Women, January 2011, p. 3, accessed 14th October 2015 http://www2.ohchr.org/english/bodies/cedaw/docs/ngos/WSG_SriLanka48.pdf*

[216] *UK Home Office, Country Information and Guidance India: Sexual orientation and gender identity, (London: UK Home Office, 2014), p. 17, accessed 10th October 2015. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/332640/India_CIG_LGBT_claims_2014_07_18.pdf.*

[217] *Focus group discussion, young MSM and transgender, Ahmedabad, 26 October 2015*

[218] *Focus group discussion, MSM and transgender, Bangalore, 30 October 2015*

[219] *They then go on to explain that there are two 'types' of 'homosexual': "Kothi" and "Double-decker". Kothi's have sex with Double-deckers, and double deckers have sex with both Kothi and men. My understanding is that "Kothi" have a more 'feminine' oriented identity, it may also relate to roles in sex…*

"For the Kothi the female role is dominant". They also explain that Kothi's use the female pronoun.

me, don't touch my hand'".[220] The young person added: "they don't treat us like a human being; they treat us like a slave."[221]

20% of the individuals who identified as 'other' in the survey reported that they had experienced being denied access to a SRH service as a specific consequence of their sexuality/ gender identity.

Section 377 of the Penal Code constitutes an indirect barrier to access to SRH services for young MSM in research sites in India. Although Section 377 is rarely enforced, criminalisation under the law reinforces intense marginalisation and discrimination faced by MSM and transgender communities; who face harassment and abuse by both state and non-state actors, including health providers and the police.

16. Sex reassignment

16.1. The law

The legislation around sex reassignment surgery in India is unclear as no comprehensive national policy or guidelines exist.[222]

Section 320 of the Penal Code criminalises the 'emasculation' of a person, and falls under the definition of grievous hurt; however, Section 88 of the Penal Code (discussed above in Section 8) provides an exception to this rule in the case that an action is undertaken in "good faith" and the subject gives consent to suffer that harm, and this could potentially apply to sex reassignment surgeries as well as ritual castrations. As previously discussed, consent cannot be given by a child under the age of 12 years, but maybe provided by a legal guardian, and the position of a child aged 12-18 years is unclear.[223]

To date there have been no documented cases of health practitioners prosecuted for carrying out sex reassignment procedures and a number of hospitals in India provide these facilities.[224]

In Tamil Nadu, the State government has introduced specific provisions protecting Aravani (Hijra), including establishing an Aravani (Hijra) Welfare Board in 2008, and providing free sex reassignment[225] surgery in public health institutions.[226] The legal review did not identify any equivalent legislation in the two states (Ahmedabad, and Karnataka) from which data was collected for the primary research element of this study.

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[220] *Focus group discussion, MSM and transgender, Bangalore, 30 October 2015*

[221] *Focus group discussion, MSM and transgender, Bangalore, 30 October 2015*

[222] *Yadavendra Singh et al, "Understanding Barriers Faced by Transgender and Hijra Communities in India to Accessing Gender Reassignment Services", (New Delhi: India HIV/AIDS Alliance, 2014), accessed 18th October 2015, http://119.9.77.229/allianceindia/portfolio-item/understanding-barriers-faced-transgender-hijra-communities-india-accessing-gender-reassignment-services/.*

[223] *UK Home Office, Country information Country Information and Guidance India: Sexual orientation and gender identity, (London: UK Home Office, 2014), p. 12, accessed 10th October 2015. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/332640/India_CIG_LGBT_claims_2014_07_18.pdf.*

[224] *UK Home Office, Country information Country Information and Guidance India: Sexual orientation and gender identity, (London: UK Home Office, 2014), p. 12, accessed 10th October 2015. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/332640/India_CIG_LGBT_claims_2014_07_18.pdf.*

[225] *However, according to some sources this is only for Male to Female surgery.*

[226] *UK Home Office, Country information Country Information and Guidance India: Sexual orientation and gender identity, (London: UK Home Office, 2014), p. 13, accessed 10th October 2015. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/332640/India_CIG_LGBT_claims_2014_07_18.pdf*

16.2. Field research findings

16.2.1. Availability of sex reassignment surgeries

Evidence from the research indicates that sex reassignment surgery is only available to a privileged few. Of the respondents who had undergone 'surgery' included in the study, only a small minority had accessed sex reassignment through a hospital; the majority had undergone ritual castration at home: "most of us had this surgery done at home, in the presence of the guru and the goddess".[227] One participant explained the difference between traditional methods of castration and sex reassignment surgery:

> *"Sex reassignment surgery gives us the shape of a vagina. I want to save up the money to do this operation in the future. The sex reassignment operation is safe and hygienic. It will make me safe from STIs in the future. It is available in private hospitals. It is quite expensive – 4-5 lakhs."*[228]

Participants who underwent traditional castration explained how the procedure can be dangerous and painful, however, they also emphasised that they believed in the power of the goddess to protect them.[229] Participants explained that people may die in the process: "if the person survives they are in the name of the goddess. They are divine. If the person dies then they are buried."[230] Respondents' accounts of the procedure are revealing of the significant risk and harm that these practices entail when undertaken without medical assistance and support:

Focus group discussion, young men, Ahmedabad:

> *What does the surgery entail?*
>
> *In the presence of the goddess, the guru heats a knife and the person is tied up with his hands behind him and the penis and testicles are tied with a thread and the person recites the name of the goddess, and the guru chops off the penis and testicles with a knife.*
>
> *How do you stop the bleeding?*
>
> *Once the castration is performed the person goes unconscious. The guru immerses cotton balls in hot oil and places it on the wound. Now since the parts are chopped off to make sure the hole where they urinate does not get closed they insert a small rod into the hole.*
>
> *Are there any complications that result from this surgery?*
>
> *No, there are no complications. But later in life we face problems with urination because the hold gets covered up. And after the castration is performed for six months we cannot undergo sexual activity.*
>
> *Is there anything to stop the pain?*
>
> *There is a skin cream we apply afterwards. Before the castration we are given lots of sour buttermilk to stop the bleeding – we are full so when it is cut there is less bleeding.*[231]

[227] *Focus group discussion, young MSM, Ahmedabad, 26 October 2015*

[228] *Individual interview, young trangender, Ahmedabad, 26 October 2015*

[229] *Focus group discussion, young MSM, Ahmedabad, 26 October 2015*

[230] *Focus group discussion, young MSM, Ahmedabad, 26 October 2015*

[231] *Focus group discussion, young MSM, Ahmedabad, 26 October 2015*

The findings suggest that the lack of legal or policy provision for free sex assignment in public institutions constitutes a barrier to access for many young hijra and transgender people in Ahmedabad and Karnataka, who may alternatively undergo dangerous and harmful ritual castrations.

No comprehensive national policy or guidelines concerning sex reassignment surgery exist in Indian Law. Tamil Nadu is the only State government which has introduced specific provisions establishing free sex reassignment surgery in public health institutions. Findings from the research indicate that the lack of a similar provision in Ahmedabad and Karnataka constitute a barrier to access to such services for many young people, who may alternatively undergo dangerous and harmful ritual castrations.

16.2.2. Perceptions of law and access to sex reassignment and castration for under 18s

In keeping with the findings from the legal review, no participants were of the view that castration is illegal per se, however, they all felt that it was illegal prior to the age of 18 years, at least without parental consent:

> *"We have to take permission from our parents. If our parents do not permit us, then our own permission will be taken – after 18 years we are independent to take our own permission. It is illegal for us to do this before 18 years. The person who does this will be taken to the jail."*[232]

Participants appeared somewhat uncertain about whether castration is completely illegal prior to 18, or whether it is only illegal in the absence of parental consent. After discussion, the group came to the consensus that performing castration is always illegal for a person under 18 years, but that a child may join the hijraor transgender community prior to 18, but only with consent of their parents:

> *"In some cases the parents may allow the child to go because they believe he is from the holy community, so they send the child to become transgender. But the castration is done only when he turns 18. After 18 the castration is done."*[233]

Interestingly participants were not only of the view that castration services are illegal before the age of 18 years, they also appeared to believe that these provisions apply to access to specialist services for transgender and MSM groups more broadly. A group of participants accessed through a youth centre in Bangalore told researchers: "they say you have to be 18 years old to come to the centre. Before 18 I couldn't come. When I was 17.5 I wanted to come…"[234]

Participants were in general agreement with restrictions on access to services to young transgender people below 18 years old; they emphasised that 18 years is the age at which a person become mature and responsible, and is able to handle the consequences of transgender identity and ways of living; as one respondent explained: "it is a good thing that we couldn't come to the centre before we were 18. Otherwise I wouldn't have finished my studies because I would have been out doing 'field work'."[235]

[232] *Focus group discussion, young MSM, Ahmedabad, 26 October 2015*

[233] *Focus group discussion, young MSM, Ahmedabad, 26 October 2015*

[234] *Focus group discussion, MSM, Bangalore, 30 October 2015*

[235] *Focus group discussion, MSM, Bangalore, 30 October 2015*

17. Lesbianism

This section has largely focused on the experiences of MSM and transwomen in India. Unfortunately researchers were not able to access any lesbian communities during the field research. The limited evidence gathered in relation to lesbianism in research sites in India, indicates that it is largely hidden identity. As one girl explained: "for girls you can't make out they are lesbians; for the boys their bodies are different – so it's easier to notice them… Not many people know about the existence of lesbians".[236]

The lack of visibility of lesbian women and girls is mirrored in the law, which (as far as the legal review was able to determine) is altogether silent on the subject of lesbianism; reflecting a widespread failure of dominant institutions, as well as social, cultural and legal norms, to recognise the identities and experiences of lesbian women and girls.

Overall only 2 individuals out of 109 people included in the qualitative research, spoke about lesbianism: both of these were social work students volunteering with FPAI in Ahmedabad. When researchers pressed respondents on the issue of lesbianism, they were very reluctant to discuss the topic, and expressed highly discriminatory and prejudiced views: "that's not acceptable"; "I don't know about that"; "I've never heard that word before"; "that's something disgusting," were typical responses provided when researchers attempted to raise the topic.

[236] *Individual interview, young woman, Ahmedabad, 27 October 2015*

Law and Sex Work

Another group of individuals who experience significant barriers to access to SRH services, including legal protection from violence and abuse, due to the law and legal restrictions, are individuals who engage in sale of sex.

18. Criminalisation of actions connected to sex work

Sex work in India is not illegal per se, however, under the Indian Immoral Traffic (Prevention) Act 1956, soliciting in a public place, curb crawling (driving around areas known for street prostitution in order to solicit prostitutes), owning or managing a brothel, prostitution in a hotel and pimping are crimes.[237] Prostitution is legal only if carried out in a private residence of a prostitute or others. Although this law contains no direct barrier to access to SRH services for people engaged in sex work, it may have a significant indirect impact in practice.

18.1. Criminalisation and fear of disclosure

Even if not criminalised per se, criminalisation of actions connected to sex work may deter sex workers, as well as other individuals who are engaged in the selling of sex, from disclosing their status to authorities; as one woman in Bangalore explained: "we will never tell the doctor that we do commercial sex work. In case of any issue we have, we will say that it is related to our husband or boyfriend."[238] The individual quoted in this case was able to access services, however, in many cases fear of disclosure may have implications for service seeking behaviour, and the nature of the health care provided, particularly if clients are unable to be fully honest with providers. Young people who sell sex may be reluctant to visit a health centre out of fear that their activities might be revealed to others, they wish to keep it secret from; an issue which is exacerbated by the fact that (as discussed above) service providers may often seek consent from a young women's partner or guardian before providing her access to SRH services, such as contraceptive or abortion services.

One woman told researchers that although she was selling sex, she had little knowledge about the contraceptive pill, and her clients refused to use condoms. She explained that she tries to abstain from sex during her fertile days, but that recently she had ended up pregnant and had needed the abortion pill. She explained how she needed to hide the fact that her pregnancy was the consequence of sex work: although she was able to access an abortion, this was only because she was married, and because the doctor, in this case, did not ask her too many questions:

Focus Group Discussion, women who sell sex, Bangalore

> *I was pregnant and I went to get the abortion pill. I did not tell them I am a sex worker, I just told them that I was pregnant with my husband and wanted an abortion.*
>
> *Would they have provided you with an abortion if you weren't married?*
>
> *No! That is illegal. If you go to a private hospital they will ask you lots of questions. But at the government hospital they don't care – they just speak nothing. If my husband got to know [I am a sex worker] he will probably kill me! No on in my family knows. Who would let me in the house if they came to know about this?*[239]

[237] *Immoral Traffic (Prevention) Act 1956, s 3,4& 7.*

[238] *Focus group discussion, women who sell sex, Bangalore, 30 October 2015*

[239] *Focus group discussion, women who sell sex, Bangalore, 30 October 2015*

This extract highlights how women who engage in sex work and the sale of sex are vulnerable as result of their activities; they may face significant risks to their sexual and reproductive health which may be exacerbated by lack of (legal) protection, stigma and criminalisation under the law.

18.2. Criminalisation and risk of harassment and violence

Legal criminalisation of sex work reinforces the deep shame and stigma associated with such activities. This places women who sell sex at risk of harassment and violence: from their clients, their families, broader society, as well as law enforcement authorities; reducing their likelihood of seeking access to services, especially in the case that they have been victims of sexual violence and abuse. Respondents in the research relayed numerous disturbing accounts of the abuse that they are subject to from others, including by police, and explained that they have no recourse to justice or support because of the illegal status of their activities:

Focus Group Discussion, women who sell sex, Bangalore

> *The police hit us. In the case they catch us, they arrest us and make sure they get money out of us. If we don't pay the money we will go to court. If we get caught by the cops, default they will take our phone, our money, our jewellery.*
>
> .....
>
> *Researcher: Have you ever been in a situation where you were treated badly by a client?*
>
> *Respondent 1: If the men [our clients] are drunk then they are bound to be rude. They force things and it feels like they are raping us. We suffer in silence and then we move on.*
>
> *Respondent 2: There was a client who hit me. There is one area where people come in a car and they grab you – they pull you into their car and indulge. Some will tie us to a tree – and force us – and then just more on. Some will even take our clothes. They don't pay us – they just leave us tied to a tree.*
>
> *Researcher: If a client treats you in this way is there anyone you can complain to?*
>
> *Who? First of all the thing that we are doing is wrong. How will we complain? We ourselves will get into trouble. Sometimes women do complain and they just end up in jail.*[240]

This last statement highlights the double standard implicit in a law which criminalises women who engage in sex work, but not the men who buy it, and the vulnerable position that this places women in. The law reinforces feelings of disempowerment and shame amongst women who sell sex. As a result women may feel that they do not deserve assistance or support, holding themselves responsible for the abuse that they suffer: "I am the one who is doing something wrong. It is because of me that the client is coming to me – it's natural that I am the one who gets the punishment".[241] Significantly, women included in the research who were engaged in sex work or the selling of sex had very limited understanding of legal provisions as they apply to sex work, appearing to believe that sex work is altogether and completely illegal.

[240] *Focus group discussion, women who sell sex, Bangalore, 30 October 2015*

[241] *Focus group discussion, women who sell sex, Bangalore, 30 October 2015*

The criminalisation of actions connected to sex work affects all women who sell sex. However, the law may have a particularly harmful impact on younger women and girls; who by nature of their age and lack of experience are be more vulnerable to abuse by both clients, and law enforcement personnel.

The Indian Immoral Traffic (Prevention) Act 1956 criminalises soliciting in a public place, curb crawling, owning or managing a brothel, prostitution in a hotel and pimping. Although this law contains no direct barrier to access to SRH services for people engaged in sex work or the selling of sex, evidence from the research suggests it may have a significant indirect impact. Legal criminalisation of sex work reinforces the deep shame and stigma associated with sex work; placing women who sell sex at risk of harassment and potentially deterring them from accessing SRH services.

The law may have a disproportionate impact on young sex workers and other young women who sell sex, who by nature of their age and lack of experience, are more vulnerable to abuse by both clients and law enforcement.

Conclusions and Implications

This research was designed to investigate the influence of law and legal norms on young people's sexual and reproductive rights, and, in particular, young people's ability to seek and be provided with sexual and reproductive health services in India. The study explored a range of legal provisions relevant to young people's access, including laws that impact on access to services directly, through explicitly restricting the delivery of and/or access to specific services for certain groups of young people in certain circumstances; laws that impact on access to services indirectly, through functioning to limit young people's access in practice; and laws that facilitate young people's access through explicitly providing young people with legal rights and protections.

Research findings suggest that significant barriers prevent young people from seeking and accessing SRH services in India, some of which relate to the law. The study identified several direct legal barriers, including provisions in the Penal Code and other legislation that restricts children under the age of 18 from accessing medical services without parental consent, and legislation which imposes significant restrictions on access to abortion services.

Additionally, findings suggest that in the context of highly restrictive socio-cultural norms regarding extramarital sexual activity, legal provisions which establish the age of sexual consent and minimum age(s) of marriage, as well as definitions of sexual violence that fail to criminalise rape within marriage, serve as indirect barriers to young people's seeking of services by shaping young people's (and to a lesser extent service providers') understandings and expectations about when they can legally access services. These barriers are intensified by a lack of facilitative legal provisions that clearly establish when young people are entitled to access services independently and confidentially, or guarantee them access to general services, such as sexual and reproductive health education.

Analysis of the interactions between law and socio-cultural barriers suggest that social norms often drive the interpretation and implementation of law: for instance the operation of indirect legal barriers such as the legal minimum age of marriage were often found to be a reflection or symptom of underlying restrictive norms, rather than the driving force behind them.

In this context, addressing barriers to access to SRH services is not simply a question of removing specific restrictive legal provisions, but of addressing underlying norms themselves. At the same time facilitative legal provisions that explicitly promote and protect young people's rights and access may be particularly important. Indeed, findings from the study suggest that in light of restrictive social norms relating to young people's sexuality and sexual activity, silence and ambiguity in the law may result in the assumption by both service providers and young people themselves that access to services should be / will be restricted. In other words, where the law does not explicitly state that young people have the right to access a service independently and confidentially, they are likely to assume that they do not and refrain from accessing services at all.

Finally, findings suggest that in a restrictive context it is essential for young people to receive education about sexual and reproductive health, their rights, and the services that are available to them. Education is particularly important as confusion and contradictions surrounding law and policy can serve to restrict young people's access; where young people experience doubt about their right to confidential advice and services they are likely to be discouraged from attempting to access services in practice.

19. Recommendations for legal reform

The research findings suggest that a number of legal reforms have the potential to improve young people's access to SRH services in India:

19.1 Age of sexual consent

- *The research reveals that age of consent laws, which establish the minimum age of sexual consent at 18 years may create indirect barriers to young people's access to SRH services.* Accordingly, the law on the age of sexual consent should make a distinction between (1) factually consensual sexual activity taking place in the context of a child's sexual development, and (2) sexual activity that by its very nature is exploitative. Consensual sexual activity between adolescents who are close in age should not be criminalised, in recognition of the fact that many young people commence sexual activity during early adolescence.
- **We recommend a 'close-in-age' approach to sexual consent, which considers the age difference between parties, rather than criminalising all sexual activity below a specific age.** The law should also consider whether one of the parties to the relationship is in a position of power, trust, authority, or dependency in relation to the other (e.g. the relationship between a teacher and student; a doctor and patient etc.). In such cases the age of sexual consent should be higher than in cases where there is not a power dynamic at play. It is important to provide health professionals with a certain amount of discretionary power to distinguish between cases of consensual sexual activity and cases that raise child protection concerns.
- It is important to provide health professionals with a certain amount of discretionary power to distinguish between cases of consensual sexual activity and cases that raise child protection concerns. Finally, young people and service providers should be made aware that the age of sexual consent does not mean the age of consent to medical treatment and does not imply restrictions on young people's access to services.

19.2 Consent to medical treatment, including SRH services

- *Indian statutes do not include any specific provisions in relation to young people's ability to consent to medical treatment, including SRH services. Other legislation, particularly, the penal code has been used to interpret when a young person can consent to treatment without parental consent. However, this legislation is unclear and includes some restrictive elements.*
- **We recommend the adoption of a positive provision in primary legislation, which clearly establishes young people's right to access SRH services, and recognises their capacity / competency to do so independent of parental or other consent.** Such a provision is important in order to avoid ambiguity and the risk that informal restrictions will be applied at the discretion of service providers.

19.3 Confidential access to services

- *The Indian Medical Council Code of Ethics Regulations of 2002 protect doctor-patient confidentiality. However, neither statute nor legal precedent clearly establishes a minimum age at which a person has the right to access SRH services confidentially. Furthermore, mandatory reporting requirements established in the Sexual Offenses Act require all legal persons (including health workers) to disclose any sexual activity involving a person under-18 years to the police. This provision undermines adolescents' (under the age of 18) confidential access to SRH services under the law.*

- **We recommend that mandatory reporting requirements in the Sexual Offences Act are repealed;** evidence suggests that their protective function is week and that they create barriers to access. Clear child protection guidelines should be put in place to ensure that instances of abuse are identified and addressed at the discretion of service providers.
- In addition, **young people's right to specifically access SRH services (including consultations, contraceptives and testing) confidentially should be provided for in legislation or legislative guidance to ensure that it is respected and taken seriously by service providers in all cases, including within schools.** Young people should also be informed of their right to access services confidentially, including through comprehensive sexuality education (recommendation 19.4).
- Where a child reveals abuse and provides consent, a service provider may share information as far as it is necessary in order to facilitate a formal child protection response. Young people should always be informed of what information will be shared, who will receive it and for what purpose. Additional measures should be put in place to protect children from further harm during that process
- **It may be useful to develop industry specific guidelines that inform service providers and practitioners about how to implement existing primary and secondary legislation protecting confidentiality rights,** or to deliver capacity building to service providers on the implications of legislation for their work.

19.4 Access to comprehensive sexuality education

- *There is currently no national legislation mandating universal comprehensive sexuality education in Indian schools.* **Comprehensive sexuality education should be a mandatory part of school curricula according to law or legislative guidance, and should be introduced before the age of puberty.**
- In all cases, sexuality education should avoid propagating dominant stereotypes about sex and gender, and should seek to present information as objectively and accurately as possible. This curriculum should include information on diverse gender and sexual identities. It should also clearly explain the SRH services that are available for young people, as well as their rights to access these services, and the content and implications of relevant provisions in law.
- Sexuality education should not focus on promoting abstinence, as this is likely to contribute to stigma and other social barriers to young people accessing SRE. It should go beyond a narrow focus on biological and reproductive aspects of sexual health, and empower young people with skills in decision making and communication.

19.5 Access to Abortion

- *The law in India is permissive in comparison to legislation in other states in South Asia; nevertheless, significant legal restrictions on access to abortion remain.* **Abortion services should be made free, safe, accessible and confidential for all women and girls. Any restrictions in the law relating to the circumstances which led to the pregnancy, or the age or marital status of the woman or girl should be removed.** A woman or girl should never be criminalised for accessing an abortion.
- *Findings suggest that young pregnant women who become pregnant outside of marriage suffer severe social discrimination.* **Legal provisions prohibiting discrimination against pregnant women in school, in the workplace and in access to services, should be developed.** All policy interventions aimed at reducing rates of teenage pregnancy must be framed with respect for a young women's choice and autonomy (including her choice to become pregnant), need for services, and absolute right to live in freedom from discrimination. This is essential to avoid reinforcing harmful cultural

narratives that expose young pregnant girls to stigmatization and discrimination, in ways that have a significant impact on SRH and access to services.

19.6 Heteronormativity

- **All criminal provisions prohibiting same-sex sexual activity should be removed from law, including Section 377 of the Penal Code.**
- **Strong legal provisions protecting LGBTI identified persons from discrimination should be developed, and equality laws should be extended to apply specifically to LGBTI people.**
- Specialized services such as gender reassignment surgery and hormone supplements should be made available and accessible.

19.7 Sexual and gender based violence

- There are several gaps in legislation in relation to protection of individuals from rape and sexual assault, including women and girls who are raped within marriage, as well as young men and transgender individuals. The failure to implement laws can have a serious impact of SRH and access to services for survivors of abuse.
- The law should be amended to recognise all forms of GBV regardless of the context (e.g. in the home, school community or within other institutions) or relationship (e.g. whether married or not) within which it occurs; **the law should specifically criminalise rape within marriage.**
- Sexual abuse should be defined in terms of absence of consent, rather in terms of 'force' or violence.
- **All acts of sexual violence, including both physical and non-physical acts of violence, should be criminalized within law.**

Annex A: Data Collection Tools

Survey Young People

Location of survey (where respondent was accessed):

(*IPPF MA to fill out*): _____

Please number the survey and fill in your initials here:_____

Instructions: Our organisation [fill in name of MA] is conducting some research about children and young people's access to sexual and reproductive health services, and we're interested to hear about your ideas and experiences.

We would like to ask you some questions. It should only take 10 - 15 minutes. Please be as honest as you can in your answers: there are not right or wrong answers to most of the questions and we want to learn from you! We promise that we will never tell anyone how you have answered these questions. All of the information you give us will be kept strictly anonymous, and we will not ask you your name.

The purpose of the research is to identify any barriers, which make it difficult for young people to access sexual and reproductive health services, such as contraceptives or other health services they need. Based on what we learn through the survey, we will make recommendations on how service providers can improve young people's access.

You do not have to fill out this survey form if you don't want to, and you can choose not to answer any or all of the questions. We don't mind if you prefer not to take the survey, and it won't affect your interactions with [fill in name of MA] in the future. Would you like to take the survey?

Yes ☐ No ☐

We would like to use some of what you tell us in our report but we will never use your name. Is that ok?

Yes ☐ No ☐

PART 1: Basic personal and household information		
1.1	Gender (circle one)	Female / Male / Other _____
1.2	Age (fill in):	_____ (number)
1.3	Where do you live? (fill in)	_____ (village)/ _____ (district)
1.4	How would you describe the area where you live? (circle the best response)	1 Rural area 2 Town (semi-urban) 3 Urban neighbourhood 4 Urban slum 5 Suburban area 6 Refugee camp
1.5	Total size of household (fill in):	_____ (# females)/ _____ (# males)
1.6	Who do you live with / who looks after you? (circle the best answer)	1 I live with both my parents 2 I live with a single parent 3 I live with relatives (not a parent) 4 I live with other adults (not relations) 5 I live with my partner

1.7	How many siblings do you have in total? How many of these siblings are older than you? (fill in)	Number of siblings_____ (number) Number of older siblings_____ (number)
1.8	Level of education (select the best answer):	1 no formal education 4 secondary 2 elementary 5 college / university 3 primary 6 other
1.9	Do you do any work for a wage? (circle the best answer)	1 Yes, full time 2 Yes, part time 3 No
1.10	Religion (select the best answer):	1 Hindu 4 Sikh 2 Muslim 5 Christian 3 Buddhist 6 Other
1.11	Do you identify as an individual belonging to a social/racial/ ethnic minority group? (circle the best answer)	Yes / No
1.12	Do you believe that you have any form of partial or permanent disability? (circle the best answer)	Yes / No
1.13	Which of the following is present in your household? (circle all that apply)	1 a refrigerator 6 piped water 2 a mattress 7 a flush toilet 3 a television 8 a gas cooker 4 a computer 9 a car 5 a mobile telephone 10 internet
1.14	What is the occupation of the head of your household?	1 Farmer 2 Casual labourer 3 Government employee 4 Factory worker 5 Shopkeeper 6 Employee of private company 7 NGO 8 Hospitality 9 Household help 10 The head of my household does not engage in any income earning activities 11 Other
1.15	Marital status (select the best answer):	1 never married 4 widowed 2 married now (living together) 3 separated/divorced 5 other
PART 2: Knowledge and perceptions of norms and law		
2.1	In your view, at what age is it appropriate for young people to become sexually active? (select the best answer)	1 At the age of : _____ (fill in age) 2 When he or she is married 3 It depends (no particular age)
2.2	In your view, at what age is it appropriate to get married? (select the best answer)	1 At the age of : _____ (fill in age) 2 It depends (no particular age)
2.3	Does the law say that it is illegal to have sex if you are below a certain age? (select your best guess)	Yes / No

2.4	If so, what is the age? (fill in with your best guess or circle 'no age')	____ (for boys) ____ (for girls)/ No age
2.5	Does the law say that it is illegal to have sex with someone else who is below a certain age? (circle your best guess)	Yes / No
2.6	If so, what is the age ¬¬? (fill in with your best guess or circle 'no age')	____ (for boys) ____ (for girls)/ No age
2.7	In your view, at what age should a young girl be able to access contraceptives? (circle the best answer)	1 At the age of: _____ 2 When she is married (regardless of whether or not she has already had a child) 3 Once she is married (but only after she has already had her first child) 4 At any age
2.8	Does the law set an age at which young people are able to access any forms of contraceptives / birth control? (circle the best answer)	1 Yes 2 No 3 No age, but legal access is at the discretion of the service provider
2.9	If yes, what is that age? (fill in with your best guess)	_____
2.10	According to the law, can the doctor tell your parents without your permission if you go to access contraceptives? (circle the best answer)	1 Yes; the law requires her to tell my parents when I access a service 2 Yes; she is not required to tell my parents, but the law says she can do so at her discretion 3 Only if there is a risk to my health 4 Never under any circumstances
2.11	According to the law, can the doctor tell your parents without your permission if you go to access STI testing? (circle the best answer)	1 Yes; the law requires her to tell my parents when I access a service 2 Yes; she is not required to tell my parents, but the law says she can do so at her discretion 3 Only if there is a risk to my health 4 Never under any circumstances
2.12	According to the law, can a 17 year old girl access an abortion? (circle 1 OR 5 OR any combination of 2, 3 and/or 4)	1 Yes, always 2 Only with her parent's permission 3 Only if she was raped 4 Only if her life is in danger 5 Never under any circumstances
2.13	According to the law, can a 14 year old girl access an abortion? (circle 1 OR 5 OR any combination of 2, 3 and/or 4)	1 Yes, always 2 Only with her parent's permission 3 Only if she was raped 4 Only if her life is in danger 5 Never under any circumstances

PART 3: Experiences accessing services		
3.1	At what age did you first have sex? (fill in your age OR circle 55 OR 99)	Age_____ 99 Never had sex 55 I don't want to answer
3.2	If you ask a doctor or midwife for advice about contraception or STI testing, do you feel confident that they will they keep this information confidential? (circle the best answer)	Yes / No / Maybe
3.3	Have you ever tried to access any of the following services? (circle all that apply)	1 Condom 2 Oral contraceptive pill 3 Injections 4 Implant/IUD 5 STI testing (non HIV) 6 HIV testing 7 Abortion 8 Emergency contraception 9 Sterilisation 10 Ante natal services 11 Post natal services 12 SGBV related services
3.4	Where have you tried to access the services you just mentioned? (circle all that apply)	1 Public clinic 2 Private (fee-paying) clinic 3 School health centre 4 Clinic specialising in SRH 5 Pharmacy 6 Community member 7 Other (please specify)
3.5	Have you ever been denied access to any of the following services? (circle all that apply)	1 Condom 2 Birth control pill 3 Injections 4 Implant/IUD 5 STI testing (non HIV) 6 HIV testing 7 Abortion 8 Emergency contraception 9 Sterilisation 10 Ante natal services 11 Post natal services 12 SGBV related services

3.6	Have you been denied access to a service because of your age? (circle all that apply)	1 Condom 2 Oral contraceptive pill 3 Injections 4 Implant / IUD 5 STI testing (non HIV) 6 HIV testing 7 Abortion 8 Emergency contraception 9 Sterilisation 10 Ante natal services 11 Post natal services 12 SGBV related services
3.7	If you have ever been denied access to a service because of your age, please specify the age at which this occurred (fill in, or circle 99)	Age ____ 99 I have never been denied access because of my age
3.8	Have you been unable to access an SRH service because of your sexual/gender identity?(circle the best answer)	Yes / No
3.9	Has anyone ever had sex with you or committed sexual acts with you through force or against your will? For example through pressure, coercion, physical force, or because you were unable to say no?(circle the best answer)	Yes / No / I prefer not to say
3.10	Have you received any education about sexual and reproductive health services? (circle all that apply)	1 Yes, at school 2 Yes, from a religious/community leader 3 Yes, from an NGO 4 No, never

Survey Service Providers

Location of survey (where respondent was accessed):

(*IPPF MA to fill out*): _____

Please number the survey and fill in your initials here:_____

Instructions: Our organisation [fill in name of MA] is conducting some research about children and young people's access to sexual and reproductive health services, and the way that access is regulated by law.

We would like to ask you some questions. It should only take 10 - 15 minutes. Please be as honest as you can in your answers: we want to learn from your knowledge and experiences. We promise that we will never tell anyone how you have answered these questions. All of the information you give us will be kept strictly anonymous, and we will not ask you your name.

You do not have to fill out this survey form if you don't want to, and you can choose not to answer any or all of the questions. Would you like to take the survey?

Yes ☐ No ☐

We would like to use some of what you tell us in our report but we will never use your name. Is that ok?

Yes ☐ No ☐

PART 1: Basic personal and household information		
1.1	Gender (circle one)	Female / Male / Other _____
1.2	Age (fill in):	_____ (number)
1.3	Which of the following best describes your place of work? (circle one)	1 Public clinic 2 Private (fee-paying) clinic 3 School health centre 4 Clinic specialising in SRH 5 Pharmacy 6 Hospital
1.4	Where is your place of work located?	_____ (village)/ _____ (district)
1.5	How would you describe this area? (circle the best answer)	1 Rural area 2 Town (semi-urban) 3 Urban neighbourhood 4 Urban slum 5 Suburban area 6 Refugee camp
1.6	Which of the following services do you provide? (circle all that apply)	1 Condom 2 Oral contraceptive pill 3 Injections 4 Implant / IUD 5 STI testing (non HIV) 6 HIV testing 7 Abortion 8 Sterilisation 9 Ante natal services 10 Post natal services 11 SGBV related services 12 Gender reassignment treatment

PART 2: Laws regulating sexual activity		
2.1	Does the law say that it is illegal to have sex if you are below a certain age? (select your best guess)	Yes / No
2.2	If so, what is the age ¬¬? (fill in or circle 'no age')	____ (for boys) ____ (for girls)/ No age
2.3	Is it legal to provide contraceptives to young people under this age?	Yes / No / It depends
2.4	Does the law say that it is illegal to have sex with someone else who is below a certain age? (circle your best guess)	Yes / No
2.5	If so, what is the age ¬? (fill in or circle 'no age')	____ (for boys) ____ (for girls)/ No age
2.6	Is it legal to provide contraceptives to young people under this age?	Yes / No / It depends

PART 3: Laws regulating provision of services to young people

This section lists a number of sexual and reproductive health services (in the columns) and possible ways in which young people's access to the services is regulated by the law (in the rows). Circle the best answer – 'yes' or 'no' – in the box below each service to indicate whether or not the statement about the law is true in relation to that particular service.

	Condom, oral contraceptive pill, injections	Implant/ IUD	STI testing (non HIV)	HIV testing	Abortion	Hormonal treatment (gender reassignment)	Gender reassignment surgery	Sterilisation
It is only legal to provide this service to young people 18 years and above:	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
It is only legal to provide this service to young people 15 years and above:	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
It is only legal to provide this service to a minor with their parent's consent:	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
According to the law, I may only provide this service to a minor based on my assessment of their competence:	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
According to the law, I may only provide this service to a minor if he or she is married:	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
There are no legal restrictions on the provision of this service:	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No

PART 4: Laws regarding confidentiality of young people's access to services **This section is about the confidentiality and reporting requirements that apply to the provision of services to young people. Again, circle the best answer – 'yes' or 'no' – in the box below each service to indicate whether the statement about the law applies to that service.**								
	Condom, oral contraceptive pill, injections	Implant/ IUD	STI testing (non HIV)	HIV Testing	Abortion	Hormonal treatment (gender reassignment)	Gender reassignment surgery	Sterilisation
According to the law, if a minor (under the age of 18) accesses this service I am required to inform his or her parents (even if he or she does not consent to my doing so):	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
According to the law, if a minor accesses this service I am not required to inform her parents, but I may do so at my discretion:	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
According to the law, I am only permitted to inform a minor's parents (without her consent) if there is a risk to her health:	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
According to the law, I am required to protect a minor's confidential access under all circumstances	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No

PART 5: Service provision in practice (circle the best answer to each question in relation to each service listed below)								
	Condom, oral contraceptive pill, injections	Implant/ IUD	STI testing (non HIV)	HIV Testing	Abortion	Hormonal treatment (gender reassignment)	Gender reassignment surgery	Sterilisation
Have you ever denied someone access to the following services because of their age?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Have you ever denied someone access to the following services because of their gender/ sexuality?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
In your capacity as a service provider, have you ever reported a case to the police/child protection services because you learned a minor was sexually active under the age of 18?	Yes / No							
What happens if you fail to do so?	1 I risk going to jail 2 I risk losing my job 3 Nothing at all							
Is it ever your responsibility to encourage someone to be sterilised? (circle all that apply)	1 Yes, if they have a severe disability 2 Yes, if they already have too many children 3 Yes, if they have (or are planning to) change their gender ever under any circumstances 4 In none of these circumstances							

Questionnaire Schedule (service providers)

Interview details

Interviewer's name:

Date:

Location (please give details):

Information about interviewee

Position in the organisation:

Number of years in position:

Previous work?

Have you received any training or education which helps you in your work?

Any other information:

Information about the service

Name of the service:

Introductory questions

1. Could you tell me a little about your organisation? What is your role at the organisation? What SRH services do you provide (contraception, sexual testing, abortion, etc.), and to whom?
2. Do you provide services to young people? Do many young people access your services? Is it easy or difficult for young people to access your services? Why? Are there any difference in services you provide to young people and those you provide to adults? Do you do outreach services? What kinds/ where (i.e. in schools?)

SRE

3. In your experience, how well informed are young people about SRH? Where do they learn about these issues?
4. Are there any laws/ policies that regulate SRE for young people? Are they implemented in practice? What do you think of these?

Law and Consent

5. Are there any legal restrictions on access to your services based on age? (probe on access to particular types of services, e.g. contraception, STI testing etc.)
6. Do you require consent from parents/ legal guardians for young people/ children to access your services below a certain age?
7. What is the age of sexual consent in India? What is the legal age of marriage? Does this have any impact on accessing services? How/ why?
8. If a child comes to you under the legal age of sexual consent, and reveals they are sexually active – how would you manage this? Would you take any action/ what? What does the law say about this? Are there any obligations on you as a service provider to take any action under the law? Do you agree with this? Why/ why not?

Law and confidentiality

9. If a young person comes to access your service is it ever appropriate to tell anyone about this? When and who? What, if anything, does the law have to say about this? Is confidentiality important for young people's access to services? Why/why not?

Law and abortion

10. Do you provide any abortion services? Who is legally able to access abortion services and under what conditions? What are the legal restrictions on access to abortion? Do you think this creates any barriers to access to services? For whom? What are the reasons that the law is this way? What are your views on this?
11. At what age can you have a legal abortion? Are there any age restrictions? If a young girl needs to access an abortion, does she require consent from anyone? Who? Does a married woman need the consent of her husband? What are the reasons that the law is this way? What are your views on this?
12. Can you tell me a little about the Preconception and Prenatal Diagnostic Techniques Act (law prohibiting sex-determination/ selective abortion). What are the reasons for this law? What are your views on this? Does this impact (and if so how) on women's ability to access particular tests and scans? Does this law have an impact on women's access to abortion more broadly? How?
13. In your experience, is there social stigma about getting an abortion? Who/where does this come from? Do you think this currently affects how girls use SRH services?

Law and sterilisation

14. Do you provide sterilisation services? Are these services common? Who are these services generally provided to?
15. Are there any government policies (or laws) that provide for/ regulate/ restrict sterilisation services? Can you tell me about these? What do they say? What do you think of these? (If they don't bring up the 2-child policy probe).
16. What are your views on sterilisation? Would you ever recommend/ encourage someone to get sterilised? Who? Why/ why not?
17. Are there any age restrictions on access to sterilisation? Whose consent is required for sterilisation? (e.g. person being sterilised/ parent/ guardian/ partner etc.)
18. Would you ever consider providing sterilisation services to someone without their consent? Who? (probe: e.g. people with disabilities, mental health problems etc.)

Law, gender and sexuality

19. Do you provide any services for trans-gender/ third sex individuals? Do you provide any sex reassignment services? If not, why not? Where would a person go to access these services?
20. Do you know about any laws or policies that regulate these services/ access to services for these groups? What are they? What do you think of them?
21. Are there any additional hurdles/ challenges, do you think, for third sex/ trans people to access mainstream SRH services (e.g. family planning services, STI testing/ treatment, general health care services etc.)
22. Does the law say anything about same-sex relationships/ sexual activity? What? Is this law implemented? What is the impact of this law in practice?

23. Does this create any barriers to access to services for homosexual people? Why/ why not?
24. Is there any obligation on you as a service provider to report children engaged in homosexual relationships/ sex?

Law and sexual violence

25. Do you ever find that your patients / people accessing your services have been victims of sexual violence
26. Do you provide any services for victims of sexual violence? What are these?
27. What are the main forms of violence related to sex and gender that predominantly affect young people in your experience?
28. Do you think the law effectively protects young people against violence? In your experience are young people reporting incidents of violence believed?
29. Do you think laws in relation to sexual violence have any impact on access to SRH services, especially for young people? If so, how/ why?

Conclusion

30. Do you think that young people in this have access to the SRH services they want and need?
31. What do you think are the biggest challenges in ensuring comprehensive and equitable access to SRH services for young people?
32. Are there any problems specifically with the law? Is there anything that should be different?
33. What are your recommendations for improving young people's access to SRH?

Focus Group Discussion Guide

Interview details

Interviewer's name:

Date:

Location (please give details):

Introduction:

Briefly explain research/confirm consent.

Introduce researcher: name, age, where from, religion, gender/sexual identity.

Ask the participants if they would like to introduce themselves. Say they can give as little or as much information about themselves as they like, depending on what they think is most relevant.

General Questions:

At what age do young people in your community get married?

Is there a law about this? What does it say?

At what age do young people in your community start having sex?

Is there a law about this? What does it say?

Where do you learn about SRH? Who do you speak with about it?

Scenarios:

Your friend/sister is 15 years old. She has a boyfriend. He keeps asking her to have sex with him.

- What do you think she should do? What advice would you give her?
- Would your feelings/advice be different if your friend was a boy/your brother?

What if she says no, but he won't stop pressuring her and eventually she gives in:

- Does this happen in your community?
- How do you feel about this situation? What advice would you give your friend/sister?

See if they bring up contraception. If not, prompt them.

- Do you think they would use contraception? What kind/type?
- Where would they get contraception from? (If respondents bring up more than one type of contraception, probe to get details about each type).
- Would it be difficult for them to get contraception? Yes, No, Why?
- Does it matter how old they are?
- How much would it cost?
- Would they need anyone's permission (e.g. parents)?
- Who would be more likely to seek contraception? The boy or the girl? Why?
- Is there a law about this? What does it say?

A couple of months later your friend/sister comes to you and tells you she is pregnant…

- What advice would you give to her?
- Would she tell her family or anyone else? Who would she tell? Why?
- What would her options be? Can she have an abortion? What factors would influence her choice?
- Would there any costs?
- Does her age matter?
- Does it matter if she's married?
- Is there a law about this? What does it say?

Now imagine your friend/ sister has the baby…

- Is she likely to seek any other medical services? What type?
- If she's in school, how might her school react? Would she be able to continue studying?
- Is there a law about this? What does it say?

Another good friend of yours has just gotten married. She confides in you that she is not ready to have a baby (even though her husband wants one) just yet because she is still young…

- How do you feel about this situation?
- What advice would you give her?
- Could she access contraception if she wanted to?
- Would she need her husband's permission? Why/ why not?
- Is there a law about this? What does it say?

Your friend decides that the best thing to do to avoid pregnancy is to abstain from sex during certain times of the month. On one of these days that she refuses, her husband forces her to have sex with him anyway…

- How do you feel about this situation?
- What advice would you give your friend?
- Your friend says she was raped by her husband and she wants to seek medical advice/go to the police. Is this an option?
- Does it matter whether her husband was physically violent?
- If your friend did seek help, how do you think she would be treated by health workers/ police?
- Is there a law about this? What does it say?

(Boys) your friend comes to saying that he is having some problems with his penis and sex..

(Girls) your husband is having some problems having sex..

- What advice would you give him?
- Do you think he would seek advice? Where from?
- Would help/services cost money?
- Is there a law about this? What does it say?
- What are the main sexual health problems that men/boys in your community face? Why? What do you think causes these problems?

Now imagine the person experiencing health issue is a women/girl…

- What are the main sexual health problems that women/girls in your community face? What do you think causes these problems?
- Do women/girls seek help/service for sexual health problems? From who?
- Do these services cost money?
- Is it difficult for young women to access these services? Why/why not? Do they need anyone's permission? E.g. parents/ husbands.
- Is there a law about this? What does it say?

If they don't bring up HIV prompt them…

- Have you heard about FGM? What do you think about this practice? What does the law say about FGM?
- What about HIV and AIDS – is this a problem in your community? Do young people worry about HIV? What do they do to protect themselves? Is there a law about HIV?

Questions about gender and identity:

I now have a few strange questions. They are not "trick questions". Just say what you think…

Have you ever heard of being homosexual? Do you have these groups in India/Sri Lanka? Have you ever heard of being transgendered? Do you have these groups in India/Sri Lanka? What problems (if any) do these groups of people face? Are there any laws related to these things? What does the law say? Is it legal to be homosexual in India / Sri Lanka? Is it legal to change your sex?

Is there such a thing as "good" and "bad" behaviour when having sex? Where do these ideas come from? Do you agree? How do you think these ideas effect young people when they try to access sexual and reproductive health services?

Final Questions:

Do you think that young people in India / Sri Lanka have access to the SRH services they want and need?

What do you think are the biggest problems (if any) that young people face with SRH?

Are the any problems specifically with the law?

Is there anything that should be different?

Annex B: Ethical Protocol

Coram Children's Legal Centre

Ethical Guidelines for Field Research with Children

Each research project carried out by Coram Children's Legal Centre should be ethically reviewed and Guidelines should be developed that are tailored and relevant to each piece of research. The reason for this is that different types of research will raise unique, context-specific ethical issues and it will be necessary to identify and address these issues on a project-specific basis. However, these Guidelines should be applied when carrying out all project-specific ethical reviews.

1. Application of Ethical Guidelines

The Ethical Guidelines will apply to all field research carried out by Coram Children's Legal Centre and organisations and individuals carrying out research on behalf of Coram Children's Legal Centre. The Guidelines will not apply to the consideration and selection of research projects. They will apply to: methodology selection and design; the design of data collection tools; the collection, storage, collation and analysis of data; and the publication of research.

2. Ethics review

All research project methodologies and data collection, collation and analysis tools must be approved by the Director, International and Research or the Legal Research and Policy Manager, before they are deployed. The Professional Director or Legal Research and Policy Manager will review the methodologies and tools in light of these Guidelines and best practice, and make revisions accordingly, which will then be incorporated into revised methodologies and tools.

3. Selecting researchers

Coram Children's Legal Centre will ensure that all external researchers have the necessary experience to carry out the research required. Where necessary, training will be provided to external researchers by Coram Children's Legal Centre staff on these guidelines and best practice issues for carrying out the relevant research.

4. Guiding principles

All research projects will be subject to the following ethical principles.

4.1 Do no harm and best interests of the child

It is of paramount importance that Researchers protect the physical, social and psychological wellbeing, and the rights, interests and privacy of research participants. The welfare and best interests of the participants will be the primary consideration in methodology design and data collection. All research will be guided by the UN Convention on the Rights of the Child, in particular Article 3.1 which states: "In all actions concerning children, whether undertaken by public or private social welfare institutions, courts or legislative bodies, the best interests of the child shall be a primary consideration."

It is the obligation of the Researcher to identify and avoid harmful effects. If Researchers identify that they are causing harm to a participant/s, the research must be stopped.

Particular care will be taken to ensure that questions are asked sensitively and in a child-friendly, manner that is appropriate to the age, gender, ethnicity and social background of the participants. Clear language

will be used which avoids victimisation, blame and judgement. Where it is clear that the interview is having a negative effect on a participant, the interview will be stopped. Any child protection concerns will be identified and dealt with appropriately (see 4.8, below).

Children will be provided with the opportunity to participate in data collection with a trusted adult or friend if this would make them feel more at ease. Researchers should identify staff at institutions (e.g. schools, community groups, detention centre staff) that are available to accompany participants, if requested.

Interviews may cover particularly sensitive or traumatic material, and it is important to ensure that participants feel empowered and not solely like victims. Interviews should finish on a 'positive or empowering note' (e.g. through asking questions about what would improve the situation of children in the relevant study sample). This will help to ensure that children do not leave the interview focusing on past experiences of abuse. Where children reveal past experiences of violence or abuse, researchers will convey empathy, but will not show shock or anger, as this can be harmful to children who have experienced violence.

4.2 Data collection must be necessary

It is important to ensure that unnecessary intrusion into the lives of participants is avoided. Researchers must ensure that the data being collected is necessary to address the research questions specific to each project. Data collection for extraneous purposes must be avoided.

Where possible and appropriate, participants may be provided with material incentives to compensate them for time spent contributing to the research.

4.3 Researchers must not raise participants' expectations

Researchers must carefully explain the nature and purpose of the study to participants, and the role that the data will play in the research project. Participants should also be informed that the purpose of the Researcher's visit is not to offer any direct assistance. This is necessary to avoid raising expectations of participants that the Researcher will be unable to meet.

4.4 Ensuring cultural appropriateness

Researchers must ensure that data collection methods and tools are culturally appropriate to the particular country, ethnic, gender and religious context in which they are used. Researchers should ensure, where possible, that data collection tools are reviewed by a researcher living in the country context in which research is taking place. Where possible, data collection tools should be piloted on a small sample of participants to identify content that lacks cultural appropriateness and adjustments should be made accordingly.

4.5 Voluntary participation

Researchers must ensure that participation in research is on a voluntary basis. Researchers will explain to participants in clear, age-appropriate language that participants are not required to participate in the study, and that they may stop participating in the research at any time. Researchers will carefully explain that refusal to participate will not result in any negative consequences. Incentives may be provided; however, researchers must ensure that these would not induce participants to participate where doing so may cause harm.

4.6 Informed consent

At the start of all data collection, research participants will be informed of the purpose and nature of the study, their contribution, and how the data collected from them will be used in the study, through an information and consent form, where possible and where this would be appropriate and not intimidating for young people. The information and consent form should explain, in clear, age appropriate language, the nature of the study, the participant's expected contribution and the fact that participation is entirely voluntary. Researchers should talk participants though the consent form and ensure that they understand it. Where possible and appropriate, parents / carers should also sign an 'information and consent form'. The needs for this will depend on the age and capacity of participants. Where possible, parental consent should be obtained for all children aged under 13 years. For children aged over 13, the decision on whether consent from parents / carers is needed will be made on a case-by-case basis, depending on the nature and context of the research and the age and capacity of participants.

Where it is not possible for the participant to sign an information and consent form (e.g. due to illiteracy), researchers will explain the nature and purpose of the study, the participant's expected contribution, and the way the data they contribute will be used, and request the verbal consent of the participants to conduct research and then record that permission has been granted. Special effort must be made to explain the nature and purpose of the study and the participant's contribution in clear, age-appropriate language. Researchers will request the participant to relay the key information back to them to ensure that they have understood it. Participants will also be advised that the information they provide will be held in strict confidence (see below, 4.6).

Special care must be taken to ensure that especially vulnerable children give informed consent. In this context, vulnerable children may include children with disabilities or children with learning difficulties or mental health issues. Informed consent could be obtained through the use of alternative, tailored communication tools and / or with the help of adults that work with the participants.

4.7 Anonymity and confidentiality

Ensuring confidentiality and anonymity is of the upmost importance. The identity of all research participants will be kept confidential throughout the process of data collection as well as in the analysis and writing up study findings. The following measures will be used to ensure anonymity:

- Interviews will take place in a secure, private location (such as a separate room or corner or outside space) which ensures that the participant's answers are not overheard;
- Researchers will not record the name of participants and will ensure that names are not recorded on any documents containing collected data, including on transcripts of interviews and focus group discussions;
- Researchers will delete electronic records of data from personal, unprotected computers;
- CCLC will store all data on a secure, locked server, to which persons who are not employed by the Centre cannot gain access. All employees of the CCLC, including volunteers and interns, receive a criminal record check before employment commences; and
- Research findings will be presented in such a way so as to ensure that individuals are not able to be identified.

All participants will be informed of their rights to anonymity and confidentiality throughout the research process. Participants should be informed where it is possible that their confidentiality will be compromised. This may occur where, in a particular, named setting, the background information relating to a participant may make it possible for them to be identified even where they are not named.

4.8 Addressing child protection concerns

During the data collection process (e.g. in individual interviews and also possibly group interviews), participants may disclose information that raises child protections concerns (i.e. information indicating that they are currently at risk of or are experiencing violence, exploitation or abuse). Prior to the data collection taking place, researchers should be provided with copies of the child protection policies and procedures of each institution from which participants are recruited (i.e. schools, community groups, detention facilities) and should familiarise themselves with child protection referral mechanisms and child protection focal points.

In the event that the child interviewee reveals that they are at high risk of ongoing or immediate harm, or discloses that other children are at high risk of ongoing or immediate harm, the researcher will prioritise obtaining the child's informed consent to report this information to the appropriate professional as set out in the child protection policy, or, in the absence of such a policy, the person with authority and professional capacity to respond. If the child declines, the researcher should consult with an appropriate designated focal point, as well as the lead researcher and other key persons in the research team (on a need to know basis), concerning the appropriate course of action in line with the child's best interests. If a decision is made to report this information to the designated professional, the child interviewee is carefully informed of this decision and kept informed of any other key stages in the reporting and response process.

In some cases, it will be more likely that child protection concerns may arise. Where this is the case, Researchers should ensure that research is carried out with a social or support worker who is able to give assistance and advice to the participant where necessary.

4.9 Ensuring the physical safety and well-being of researchers and participants

Researchers must ensure that data collection takes place in a safe environment. Participants will always be interviewed with at least two persons present (two researchers; one researcher and one translator; one researcher and a social worker; or one researcher and a note taker).

Researchers will be provided with a Code of Conduct, attached to each contract of employment.

Annex C: Findings at a glance

Laws which influence access to SRH services		
Type/ area of law	Legal Provision(s)	Knowledge, perceptions and influence of law
General consent to medical treatment including SRH services	Indian statutes do not include any specific provisions in relation to young people's ability to consent to medical treatment, including SRH services. Nevertheless, three pieces of legislation have been used to interpret the law regarding young people's access to SRH services: the Penal Code, the Majority Act and the Contract Act. Together this legislation implies that children under 18 years may require parental consent in order to legally access basic SRH services including contraceptives and STI testing and treatment. Children under 12 years will always require parental consent. The Government has developed specific guidelines in relation to HIV testing, which requires children under the age of 18 years to have parental/ guardian consent.	Service providers were unsure of the law concerning children and young people's access to SRH services. Many service providers noted that they would not provide contraceptives, and STI testing to children under 18, however, they weren't clear on whether this is a legal rule or a matter of good practice. Service providers expressed the view that young people lack capacity to make informed decisions about health services; and that providing SRH services to under-18s would be inappropriate and could encourage 'underage' sex. Young people were also very uncertain about whether there is a law that regulates access to SRH services based on age. Most young people felt that legal access to services, especially for under-18s, depends on the discretion of the service provider.

Abortion	Three pieces of legislation regulate access to abortion: the Penal Code, the Medical Termination of Pregnancy Act (MTP Act), and The Preconception and Prenatal Diagnostic Techniques Act. (PCPNDT Act). The Penal Code criminalises abortion, but the MTP Act creates exceptions if: the termination is necessary to preserve the life or (physical or mental) health of the mother, the foetus is found to have developmental abnormalities; the pregnancy was a result of rape; the woman/ girl was married and taking birth control. The MTP Act also establishes gestational limitations on access to abortion, and regulates how and where abortions may be carried out. Importantly, the MTP Act establishes that a child under the age of 18 must have legal consent of her parent/ guardian in order to access legal abortion. The PCPNDT Act prohibits the practice of sex-selective abortion.	Participants were aware that the law creates restrictions on access to abortion. However, whilst service providers tended to have an accurate and detailed understanding of the law regarding abortion; young people had much less knowledge. Many young people thought that abortion was completely illegal for girls under 18. The normative influence of law, and its role in shaping ideas about access to abortion was evident in the ways that respondents conflated restrictive and judgemental narratives concerning abortion with (their perceptions of) legal rules: associating the idea that abortion is 'illegal' with the idea that it is 'wrong'. The PCPNDT Act was introduced as a protective measure to reduce the harmful impact of son preference. However, there is some evidence that the strong messaging around the illegality of sex-selective abortion has reinforced stigma associated with abortion more broadly, and led to increased scrutiny around abortion, potentially creating further barriers to access to abortion. Despite these restrictive factors, it is important to note that the law in India is permissive relative to other jurisdictions in the region, permitting safe and legal access to abortion for many women and girls.

Sexual and Reproductive Health Education	There is no national legislation mandating comprehensive and universal sexual and reproductive education (SRE) in Indian schools. In 2005 the Ministry of Human Resource Development and the National AIDS Control Organisation launched an Adolescence Education Programme (AEP) for students in classes 9 – 11, which was implemented in 112,000 schools over the period of 2005-2006. Controversy over the sex-related content of the programme, however, resulted in several states subsequently banning the provision of AEP in state-run schools. In light of this, a revised and more limited curriculum was developed; this programme is being implementing in the majority of high schools and higher secondary schools across the country.	The research findings indicated that young people lack accurate knowledge about SRH, and that myths and misconceptions about sexuality, contraception, and STIs are rife; solidifying taboos around SRH and preventing service-seeking behaviour, amongst young people. Whilst service providers emphasised the need for improved education, information and awareness, the research indicates that parents and communities are reluctant to introduce SRE in schools in case it encourages young people to engage in sexual activity prior to marriage.

Sex reassignment	The legislation around sex reassignment surgery is unclear as no comprehensive national policy or guidelines exist. Section 320 of the Penal Code criminalises the 'emasculation' of a person; however, Section 88 of the Penal Code provides an exception to this rule in the case that an action is undertaken in "good faith" and the subject gives consent to suffer that harm, and this could potentially apply to sex reassignment surgeries as well as ritual castrations. As previously discussed, consent cannot be given by a child under the age of 12 years, but maybe provided by a legal guardian, and the position of a child aged 12-18 years is unclear. To date there have been no documented cases of health practitioners prosecuted for carrying out sex reassignment procedures and a number of hospitals in India provide these facilities. In Tamil Nadu, the State government has introduced specific provisions protecting Aravani (Hijra), including establishing an Aravani (Hijra) Welfare Board in 2008, and providing free sex reassignment surgery in public health institutions. The legal review did not identify any equivalent legislation in the two states (Ahmedabad, and Karnataka) from which data was collected for the primary research element of this study.	No participants thought that castration/ sex reassignment was illegal, however, they did think that a young person should have reached 18 years of age in order to access such services, and respondents were broadly supportive of such a rule. Findings from the research indicate that the lack of provisions establishing free and safe sex reassignment surgery in public health institutions constitutes a barrier to access to such services for the majority of young people, who may alternatively undergo dangerous and harmful ritual castrations.

Laws related to privacy, confidentiality and reporting		
Area of law	Legal Provision(s)	Knowledge, perceptions and influence
Protection of confidentiality / reporting requirements	The Indian Medical Council Code of Ethics Regulations of 2002 protect doctor-patient confidentiality. However, neither statute nor legal precedent clearly establishes a minimum age at which a person has the right to access SRH services confidentially. Furthermore, mandatory reporting requirements established in the Sexual Offenses Act require all legal persons (including health workers) to disclose any sexual activity involving a person under 18 years to the police.	Mandatory reporting requirements under the sexual offences act undermine children's confidential access to SRH services under the law. Participants in the research appeared unclear about the law concerning children's confidential access to SRH services. Whilst participants thought that confidentiality is important, they also thought that providers are legally permitted to break confidentiality in some circumstances, including by informing a child's parents. Fear that access to SRH services would not be confidential was found to affect young people's service-seeking behaviour; with young people being reluctant to access SRH services due to fear of gossip and pubic shame. Whilst service providers are aware that they are legally required to report cases of underage (18) sex to the police, evidence from the research indicates that they are not always adhering to the law in practice, and do not consider this provision to be helpful or realistic.

Laws which regulate sexual behaviour and relationships		
Area of law	Legal provision(s)	Knowledge, perceptions and influence
Age of marriage	The India Prohibition of Child Marriages (PCM) Act of 2007 sets the minimum age for marriage and 18 years for girls and at 21 years for boys.	Participants were aware of minimum age of marriage laws, and many respondents felt that sex related services are not available to young people who are not legally married. This implies that minimum age of marriage laws may serve as an indirect barrier to access to services for 'underage' adolescents.
Age of sexual consent/ statutory rape/ penetrative sexual assault of a minor	The age of consent to sexual activity in India is established at 18 years of age by the Criminal Law (Amendment) Act 2013 (for girls) and the Protection of Children from Sexual Offences (PCSO) Act 2012 (for both boys and girls). The Criminal Law Amendment Act establishes an exception to this rule for sexual activity (or rape) within marriage, of girls aged 15 years and above (although there is no such exception in the PCSO Act.	Most respondents were aware that the law establishes an age below which it is illegal for a person to have sex, and that sex with a person under this age is a criminal offence. Most participants believed this age to be the same as the minimum legal age for marriage. Statutory rape and minimum age-based sexual assault laws were found to influence young people's ideas about the age at which it is acceptable to be sexually active and therefore to access SRH services.

Rape and sexual assault (over 18s)	There are several gaps in legislation in relation to protection of individuals from rape and sexual assault. There are no provisions in law that protect male or third sex young people, over the age of 18 years, from rape or sexual abuse. The Indian Criminal Law (Amendment) Act 2013 only applies to female victims of rape; meanwhile the Protection of Children from Sexual Offences Act 2012 is gender neutral but only applies to children under the age of 18 years. Whilst Section 377 of the Penal Code punishes 'carnal intercourse against the order of nature', this provision implies that male victims of rape are liable to be treated as perpetrators rather than victims under the law. Penal law also contains an exception for the crime of rape, where forced sexual activity takes place in the context of marriage. Section 376A of the Indian Penal Code provides that a married woman may be the victim of rape only if she is judicially separated from her husband. The Indian Domestic Violence Act Section 3 introduces a limited protections in law with regard to marital rape, however this section only covers marital rape under circumstances of life-threatening and grievously hurtful conduct, and further only provides civil remedies, thus still not criminalising the act.	Limited legal definitions of sexual violence and abuse create barriers to access to services for survivors. Survivors of abuse may be unwilling and reluctant to seek out services where they perceive their experiences as lacking validity or recognition, and providers may be less willing to offer support. Evidence from the research indicates that reporting of sexual and gender based violence (SGBV) and provision of support services may be limited. Limited legal definitions of rape were found to underscore a 'rape culture' whereby some forms of sexual violence and coercion are regarded as excusable, normal or justified. This culture of impunity creates direct barriers to access to services and support for survivors of abuse.

Recognition of third gender status	Up until 2014 legal identity was only available for two sexes: male and female. However, in April 2014 the Supreme Court in India ruled that transgender people should be legally recognized as a third gender. The Court ruled that that the anti-discrimination provisions under Articles 14 to 16 of the Indian Constitution included the right not to be discriminated against on the grounds of sexual orientation and gender, and that the word "sex" in Articles 15 and 16 also covered other self-identified gender identities. In its judgement, the court directed the central and state governments to take necessary steps to allow for equal status for those adhering to the third gender, ensuring adequate healthcare, education and employment as well as separate public toilets as well as other safeguards against discrimination. Further, the court directed that all identity documents such as birth certificates, passports and driver's licences must henceforth have the possibility for a person to identify as third gender.	Although respondents were aware of the 2014 Supreme Court judgement ruling that hijras and trans individuals are now protected under the Constitution, evidence from the research indicates that discrimination, exclusion and abuse of trans people is still rife. This discrimination was found to impact on trans individuals' service-seeking behaviour. Trans communities included in the research said that they were not willing to access 'mainstream'/ non-specialised SRH services due to the poor treatment that they received at the hands of general health workers. The protection of third sex individuals against discrimination under the constitution is undermined by Section 377 of the Penal Code which criminalises 'carnal sexual knowledge'; generally recognised as referring to the act of sodomy.

Criminalisation of same-sex activity	Section 377 of the Indian Penal Code criminalises 'carnal intercourse against the order of nature with any man, woman or animal'. This provision is generally understood as prohibiting same-sex activity amongst MSM - including gay and bisexual men, as well as trans women and hijras who have not undergone sex-reassignment surgery – even in private spaces.As the law refers particularly to penetration, it is not clear whether this provision would be interpreted as criminalising same-sex sexual activity amongst women/ girls. In 2009, the Delhi High Court overturned section 377 of the Penal Code in a historical case, legalising consensual same-sex sexual activities between adults. However, this decision was subsequently overruled. In 2013, the Supreme Court upheld Section 377, stating that the law only applies to a 'miniscule minority' as there had been less than 200 persons prosecuted under Section 377 in the past 150 years, and contending that any amendment in law must be left to the Parliament.	Findings from the research indicate that the criminalisation of same-sex activity is well-known and has a normative influence: promoting discriminatory attitudes and violence against gay, bisexual, and trans individuals; including by police, health providers and other authorities. The research indicates that criminalisation creates a barrier to access to SRH services for individuals engaged in offending behaviour, who may fear discrimination, disclosure and even prosecution under the law. Furthermore, SRH services cannot properly cater for the needs and education of MSM groups due to criminalisation in the law.
Sex work	Sex work is not illegal per se, however, under the Indian Immoral Traffic (Prevention) Act 1956, soliciting in a public place, curb crawling (driving around areas known for street prostitution in order to solicit prostitutes), owning or managing a brothel, prostitution in a hotel and pimping are crimes. Prostitution is legal only if carried out in a private residence of a prostitute or others. Although this law contains no direct barrier to access to SRH services for people engaged in sex work, it may have a significant indirect impact in practice.	Although this law contains no direct barrier to access to SRH services for people engaged in sex work, evidence from the research suggests it may have a significant indirect impact. Legal criminalisation of sex work reinforces the deep shame and stigma associated with sex work; placing women who sell sex at risk of harassment and potentially deterring them from accessing SRH services. The law may have a disproportionate effect on young sex workers, who by nature of their age and lack of experience, are more vulnerable to abuse by both clients and law enforcement.

Disclaimer:

The contents of this document are the sole responsibility of the author/s and do not necessarily reflect the official policy or position of IPPF and UNFPA

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