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Review Article

Reducing Age of Consent for HIV Testing for Minors (16–18 Years) Without Mandatory Parental Consent (in Special Situations) in India

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ABSTRACT

This article examines the existing provisions in various Acts related to child protection in the country with regard to consent. It delves into HIV (Human Immunodeficiency Virus) testing of minors in India. Simultaneously, it notes societal attitudes towards health and other issues which necessitate revisions in the existing laws, to allow adolescents to make informed decisions about HIV testing. It also brings forth the existing provisions in the laws of a few other countries in the world. Finally, it offers suggestions to revise the existing Indian legislation based on societal trends.

Keywords: HIV/ AIDS, Minors, Parental Consent, HIV Testing, ALHIVs

Introduction

Transmission of HIV occurs through sexual intercourse (vaginal, anal or oral), vertical transmission from mother to child (during pregnancy, childbirth, or by breastfeeding) and other routes such as blood transfusion, needle exchange or organ transplant. HIV testing, counselling and treatment services are provided at the Integrated Counselling and Testing Centres (ICTCs) run by the National AIDS Control Organization (NACO) in India. The national guidelines that outline the procedures for registration, counselling, testing, treatment and linkage of adults to HIV services also take into ambit adolescents in special circumstances/ minors/ incompetent patients under the guardian's consent. A person between the ages of 12 to 18 years who has sufficient maturity in understanding and managing the affairs of his HIV or AIDS-affected family shall be competent to act as a guardian of another sibling below 18 years of age.

However, adolescents and minors in special situations include (but are not limited to) adolescents living with HIV/ AIDS (ALHIVs) infected through sexual route, trafficked children, child labourers, slum and street adolescents or orphans. Adolescents in sex work, child trafficking, child labour, migrant population, childhood sexual abuse, coercive sex with an older person, as well as psychological vulnerability are among the various risk factors and situations for adolescents contracting HIV. Adolescents

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who are exposed to these factors must be protected from stigma, discrimination, and other negative effects in case of disclosure of their sexual identity, abuse or HIV status, particularly to guardians and family members. Due to patriarchal norms, adolescents in India and other South Asian countries may not be able to address issues of sex and sexuality with their parents or guardians. It is globally reported that many adolescents do not feel comfortable discussing sexual behaviours or other risk behaviours with their parents or guardians. Studies have shown that the potential for a negative reaction from a parent or guardian is an important reason why adolescents avoid HIV testing, even when they have been at risk of infection. If left untreated, this issue would aggravate and prevent minors from accessing HIV testing services offered by the government.

The legal right to autonomy and self-determination is enshrined within Article 21 of the Constitution of India. Currently, adolescents under 18 years of age (the age of majority) require parental consent or consent of a guardian to access medical services. Many similar societies are moving towards allowing health workers to make an assessment of an adolescent's ability to understand, retain, weigh and use information to give consent for medical interventions. Such readiness-for-consent assessment tools are being developed very rapidly all over the world, providing guidance and support for healthcare providers to be able to assess the maturity of an adolescent without duress or influence. This becomes even more relevant in the context where adolescents and young people represent a growing share of people living with HIV/ AIDS in the world.

Objectives

The paper aims to make the case that while parental consent at the time of HIV counselling, testing and treatment for adolescents is desirable, it should not be a paramount prerequisite. Adolescents between 16 and 18 years of age who do not have parents/ guardians or who do not wish to involve their parents/ guardians in decisions about their use of these services, should be permitted to consent under the guidance of healthcare providers. In other words, consent for adolescents and minors in special situations should be re-modelled in the true spirit of the best interest of the child and evolving capacities, along with parallel strengthening of the healthcare providers, in order to facilitate Provider-Initiated HIV testing and counselling (PITC) in India.

The article further tries to demystify consent for HIV testing in relation to the best interest of the child within the paradigm of the evolving capacity of a child, in the Indian socio-legal context. There is strong evidence for the immunological advantage of early suppression, which can be achieved by facilitating early and routine access to HIV testing services. Hence, there is a need to consider an urgent shift to lowering the age of independent consent, to promote greater inclusion of minors within the ambit of prevention and care services in India.

Vulnerability to HIV/ AIDS among Minors in India

Almost a decade back, the National AIDS Research Institute (NARI) highlighted the need for introducing targeted interventions among adolescents. It is estimated that children (< 15 years) account for 12% (10.4 thousand) of total new infections and the remaining (75.9 thousand) new infections are among people in the age group of 15 years and above.[1] Evidence indicates that risk behaviour (before the age of 18 years) is a significant predictor of preventing HIV infections among many adolescents, especially those from key populations.[8] Sexual mode is currently the leading cause of HIV transmission among adolescents and young adults in India. In addition, there is an increasing number of children, vertically infected as infants who are now surviving adolescence.[3] The toll of adolescents being exposed to this virus by injection drug use is also on the rise.[3] Nationally, the median age at first sexual experience among men who have sex with Men (MSM) is 16 years.[10] About a third of Female Sex Workers (FSWs) had sexual initiation between the ages of 15 and 17 years.[10] Around 6% of Injecting Drug Users (IDUs) reported that they had their first drug use experience by the age of 14 years.[10] HIV counselling, testing and treatment services are generally available for adults but not for minors (without parent or guardian consent), therefore by the time adolescents transition to adulthood and are able to receive HIV services, many of them who were previously infected with HIV at a young age develop Opportunistic Infections (OIs) or are suffering from AIDS.

Parents do not easily accept that their child is an MSM. Sometimes they take their child to a psychiatrist. MSMs are also scared of their parents and of being teased. Therefore, a lot of young MSMs do not access HIV services because they have to take their parents'/ guardian's consent for HIV testing.[11]

Consent and HIV Testing among Minors

In India, a minor is defined as a person who has not completed 18 years of age.[12] Minors are encouraged to involve their parents/ guardians in supervising their health care. HIV testing is voluntarily done at ICTCs/ private facilities through a mechanism of independent and obligatory informed consent.[1] The informed consent of a parent or a guardian is required prior to testing minors for HIV. The National HIV Testing Guidelines (2015) indicate that guardians' approval is required for HIV testing of minors.[1] However, the policy makes no mention of whether it is unethical or illegal for a healthcare practitioner to make such a decision in order to offer life-saving HIV counselling,

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testing, or treatment. Health and human rights advocates argue that counsellors should be trained and empowered to assess adolescents' ability to decide whether or not to test for HIV if they are threatened or afraid of reporting the need for HIV testing to their parents or guardians. It is also worth considering the factors, aside from age alone, that make a minor susceptible to acquiring HIV, like poor education, psychological issues, lack of parental guidance and support (especially for those living on streets or in institutions), poverty, exploitation, sexual abuse, etc.

Laws and Policies Protecting the Rights of Minors in India

1. In India, a number of policies, laws, and legislations have accepted the notion that age (typically 18 years) is one of many components for consent and that it cannot be assigned as the single most important criterion in determining the best interests of the child. The WHO Mental Health Policy and Service Guidance Package, 2003 provide guidelines,[13] and has also emphasised that there should be provisions in the legislation to encourage the relevant professionals to take minors' opinions into consideration in matters of consent, depending on their age and maturity. The specific examples in the Indian context include:
2. The National Population Policy 2000 enunciates the need for promoting education programmes about the risks of unprotected sex.[14] It makes special mention of requirements such as information, counselling, population education, and making contraceptive services accessible and affordable.
3. The Protection of Children from Sexual Offences Act, 2012 (POCSO) outlines the three main elements of consent as information, comprehension and voluntariness.[15]
4. The Juvenile Justice (Care and Protection of Children) Act, 2006 broadens the ambit of the to include children who may need care and protection in view of the fast-changing socio-economic conditions including children affected by drugs and HIV/ AIDS. The Juvenile Justice system in India is based on the principle of promoting, protecting and safeguarding the rights of children up to the age of 18 years.[7] Under the Act, the Centrally Sponsored Integrated Programme for Street Children (2006) initiated by the Ministry of Women and Child Development (MWCD) mandates special attention to children in the age group of 6–18 years. The provisions include shelter, nutrition and health care (including HIV & AIDS) among other critical protection measures including abuse and exploitation of destitute and neglected street children in the country.[16]
5. Other laws and policies are also in place that address early marriage and promote gender equity and empowerment. Special mention must be made of the Prohibition of Child Marriage Act 2006, the National Policy for Empowerment of Women 2001, and the National Plan of Action for Children 2005.
6. Recently launched Rashtriya Kishor Swasthya Karyakram, 2014, fully recognised the need to address adolescents and enable them to realise their full potential by making informed and responsible decisions related to their health and well-being.
7. More recently, the HIV and AIDS (Prevention and Control) Bill 2012 (still pending), has tabled provisions for orphans and vulnerable children. It has been proposed to lower the age of consent for HIV testing to 12 years unless a healthcare provider assesses a child as unable to consent.[17]

Can We Learn from Countries that have Provisions for HIV Testing for Minors?

According to the International Human Rights standards, the Convention on the Rights of the Child (CRC), for all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interest of the child shall be a primary consideration.[18] In the context of HIV, it is in the best interest of the child that an independent decision should be allowed with regard to HIV counselling, testing and treatment, based on an assessment of their evolving capacities (which is one of the underlying principles of CRC). Guidance should take into consideration the range of adolescents' needs and issues and allow early testing and diagnosis followed by a continuum of care regimen of the Government of India.

Drawing upon the analogy of the best interest of the child and a clear need to catch the infection early, many countries have proposed/ started to allow minors to consent independently or to strengthen the PITC, under special/ prescribed circumstances. The Revised Philippines HIV and AIDS Policy and Programme Act of 2012 (HB 751) proposes to allow minors aged 15–17 years to independent consent for HIV testing.[19] In Pakistan (proposed by HIV/ AIDS Prevention and Treatment Bill 2007),[1] under special cases, children living independently, who are not in contact with parents or who do not have a guardian, will be able to consent to HIV testing.[19] In Nepal, for young people (14–17 years), HIV testing may be provided without parental consent, if the counsellor determines that the young person has sufficient maturity to understand the testing procedures and results.[19] Ethical guidelines of the Sri Lanka Medical Council suggest that if people under 18 years of age have sufficient understanding and intelligence, they can demonstrate competence to make a medical decision.[19] Nigeria's 2011 National Guidelines for HIV Counselling and Testing permit certain mature minors to consent to HIV testing and counselling.[20] Lesotho and South Africa have

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lowered the age of consent to 12 years and have seen an increase in HIV testing and counselling without adverse effects.[21] In a study[22] by the London School of Hygiene & Tropical Medicine, London, results of PITC among children (6–15 years) in primary health care settings in Zimbabwe (age of consent to HIV testing and counselling is 16 years)[23] showed significant improvement (CD4 count < 300 cells/µl) than that reported in another study of children (10–18 years) that tested HIV-positive recruited from acute admissions in Harare (CD4 count > 200 cells/µl).

Recommendations for Provider-Initiated Testing for HIV for Adolescents

Under the Juvenile Justice (Care and Protection of Children) Act, 2006, the Centrally Sponsored Integrated Programme for Street Children (2006) initiated by the Ministry of Women and Child Development (MWCD) mandates special attention to children in the age group of 6–18 years.[24] The provisions include shelter, nutrition, health care (including HIV/ AIDS and STDs), sanitation and hygiene, education, recreational facilities and protection against abuse and exploitation of destitute and neglected street children. By replicating the provision of special attention, perhaps it may be possible to include the provision of provider-initiated consent for minors and adolescents in the National HIV testing guidelines (2015).[1] This would dramatically expand early identification and inclusion of all eligible and at-risk minors into the fold of HIV service provision.

Issuance of HIV testing and counselling Adolescent Competency Forms may be considered for incorporation into the existing screening mechanism for adolescents, who would like to be tested, but who are below the age of independent consent. The competency form can be developed taking into account a ‘most at-risk’ index, adapting some of the critical indicators co-designed by the government and civil society advocates. For the first few years, this may be implemented through national guidelines and health professional/ counsellor training, with close monitoring. This will serve as a symbol of the country’s commitment to protecting minors’ health and rights, as well as removing the ban on their unique understanding of their own lives.

Conclusion

Adolescents and minors can get an HIV infection through various means, specifically through the sexual route. Trafficked children, child labourers, slum and street adolescents or orphans may have a higher chance of getting infected. Adolescents who are exposed to these factors must be protected from stigma, discrimination, and other adverse effects in case of disclosure of their sexual identity, abuse or HIV status, particularly to guardians and family members. Adolescents in India and other South Asian countries may not be able to address issues of sex and sexuality with their parents or guardians due to various factors, specifically patriarchy. Thus, it is significant to build a capacity for minors between the ages of 16 and 18 years to make decisions regarding testing for HIV-AIDS. We have discussed the need for minors to make decisions regarding HIV-AIDS testing by analysing existing laws and provisions and the need to bring appropriate amendments to the existing laws.

Conflict of Interest: None

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