



CAPACITY AND CONSENT

*Empowering Adolescents
to Exercise their
Reproductive Rights*

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Introduction

With adolescents and youth constituting a quarter of the global population – for a total of 1.8 billion people – it has never been more critical that their human rights be fully recognized and realized within global arenas and at the regional, national, and community level.

Despite increased attention to this issue over the past ten years, significant gaps remain in adolescents' knowledge about their sexual and reproductive health and rights and ability to access essential sexual and reproductive health services. Notably, the Committee on the Rights of the Child and the Special Rapporteur on the Right to Health have strongly affirmed the importance of adolescents' sexual and reproductive rights, urging states to take a host of specific measures to ensure the full exercise of these rights. Their renewed calls to action for states to prioritize these rights provides a strong foundation for states to build upon in strengthening their current laws, policies and practices to respect, protect, and fulfill adolescents' sexual and reproductive health and rights.

Currently, one in four adolescent girls aged 15-19 have an unmet need for contraception¹ - meaning that they are sexually active or considering becoming sexually active but do not have modern methods of pregnancy prevention. The failure to enable and empower adolescents to prevent pregnancy results in over 7 million girls under the age of 18 giving birth each year,² and nearly one-fifth of girls in the developing world becoming pregnant before the age of 18.³

Unintended pregnancy and childbearing can profoundly alter adolescents' lives, undermining their educational attainment, economic opportunities, and ability to participate in public and political life.⁴ These affects are exacerbated for girl children, who have greater sexual and reproductive health needs due to their reproductive capacities, are likely to face greater barriers in accessing sexual and reproductive health services, and must contend with gender roles and stereotypes surrounding childrearing. For many girls, bearing a child signifies the end of their formal education, either due to formal expulsion by the school as a sanction for becoming pregnant,⁵ or as a result of their childrearing obligations or need to work in order to support the child. Enabling girls to delay pregnancy is a key element of realizing their right to education, which in turn enables them to have greater economic opportunities, social empowerment and financial independence.⁶

At the same time, girls may face greater barriers in accessing sexual and reproductive health services. In part, this is due to the stigma surrounding girls' sexuality and social norms dictating that girls should only be sexually active for the purpose of procreation or only in the context of marriage. Gender norms and stereotypes can also result in girls

being denied access to family resources, such as the financial means to pay for health services; receiving less education, and therefore having less information about their sexual and reproductive health and rights; and having greater household responsibilities, resulting in less time to seek and access health services.⁷

Furthermore, pregnant adolescents may face inadequate access to quality maternal health care, paired with unique risks that can accompany early childbearing. As a result, 70,000 girls die each year as a result of complications during pregnancy or childbirth,⁸ making it the leading cause of death for girls aged 15-19 in developing countries.⁹ Furthermore, 3.2 million minors in developing countries undergo clandestine, unsafe abortions each year,¹⁰ placing their lives and health in jeopardy. In places with high rates of child marriage, girls – including young girls – who become married can face significant pressure to become pregnant almost immediately, in order to demonstrate their fertility, resulting in early pregnancies and their attendant health risks.¹¹ Further, although much of the research around adolescent pregnancy and childbearing has focused on developing countries, inadequate sexual and reproductive health services for adolescents is pervasive in both developed and developing countries, with disproportionate effects for poor adolescents, racial and ethnic minorities, and rural adolescents.¹²

This publication sets forth the barriers adolescents face in realizing their sexual and reproductive health and rights, discusses recent critical developments in the human rights framework underpinning these rights, and proposes a way forward for guaranteeing all adolescents the full exercise of their sexual and reproductive health and rights, including their right to make informed decisions about their sexuality and reproduction. In this regard, it urges that adolescents' physical and reproductive autonomy and bodily integrity must be understood as core pillars of their sexual and reproductive health and rights. It further calls for greater recognition of adolescents' agency and right to make decisions about their sexual and reproductive health and rights. Finally, it examines the barriers adolescents' face in seeking access to justice when their rights are violated.

***A note on terminology:** *This publication generally uses the term “adolescents” to refer to young people in discussing the right to access sexual and reproductive health information and services, recognizing that individuals’ physical and social maturation varies widely. The World Health Organization defines adolescents as ages 10-19, while the Committee on the Rights of the Child has not yet adopted a definition of when an individual is an adolescent, but has focused generally on ages 10-18. In certain instances, it was necessary to deviate from this term in order to maintain accuracy, such as where specific data encompassed a different grouping of young people or where laws or policies apply to all minors, and not only adolescents.*



*P's Story*¹

When P was 14, she became pregnant after being sexually assaulted by a classmate.

After deciding she did not want to carry the pregnancy to term, with the help of her mother she was able to obtain a certificate from a prosecutor, as required by Polish law. P and her mom went to three different hospitals, which deliberately provided her distorted information about the requirements for accessing abortion. One hospital informed her that she needed a priest – instead of an abortion – and violated her confidentiality in facilitating an unrequested meeting with a Catholic priest. When P went to another hospital, the priest had contacted the doctor and falsely claimed P was being coerced to have the abortion. This allegation ultimately led to P being removed from her mother's custody and placed in a juvenile center. The Ministry of Health finally intervened and P was able to obtain abortion services, just a few days before reaching the 12-week gestational limit for abortion in cases of rape. In finding that P's rights to respect for private and family life, liberty and freedom from ill treatment were violated, the European Court of Human Rights emphasized that throughout the ordeal, there was not proper regard for her "vulnerability and young age and her own views and feelings."² Although P and her mother agreed about terminating the pregnancy, the Court further noted that "legal guardianship cannot be considered to automatically confer on the parents of a minor the right to take decisions concerning the minor's reproductive choices, because proper regard must be had to the minor's personal autonomy in this sphere."³

I. Barriers to Adolescents' Access to Reproductive Health Services

Adolescents face a diverse range of barriers in accessing sexual and reproductive health services, significantly impacting their lives and health and hindering the realization of their human rights.

Restrictive Legal and Policy Frameworks

In many contexts, the laws and policies, or lack thereof, on sexual and reproductive health services for adolescents act as barriers to accessing such services. For example, some laws and policies explicitly deny adolescents the right to access sexual and reproductive health services or require parental notification or authorization.¹³ Such restrictions may apply to all minors or just those under a certain minimum age.¹⁴ Where laws and policies are silent on whether adolescents can access specific services, stigma surrounding adolescent sexuality may result in health care providers interpreting this to mean that minors are not permitted to receive such services.¹⁵

Parental Authorization Requirements

Studies demonstrate that where adolescents are required to receive parental authorization for sexual and reproductive health services, they may opt to forgo such services, although they will still engage in sexual activity.¹⁶ Adolescents may not want to include their parents in decisions surrounding their sexual and reproductive health for a number of reasons. Stigma surrounding adolescent sexuality may make them fearful of a negative parental response, particularly for girls, who generally face greater stigma and discrimination surrounding their sexuality.¹⁷ In some instances, such a revelation about their sexual activity could result in violence at the hands of their parents or other family members,¹⁸ or being kicked out of the family's home, leaving the child without shelter or a way to support him or herself financially. Furthermore, where adolescents decide to disclose their reproductive health needs to their parents, they may simply refuse to provide consent, thereby resulting in the denial of sexual and reproductive health information and services.

Judicial Authorization

In some instances, in lieu of parental authorization, adolescents can seek judicial authorization to access particular sexual and reproductive health services by filing a petition and appearing before a judge.¹⁹ Judicial authorization requirements are particularly problematic for adolescents due to the range of barriers they face in accessing formal judicial mechanisms and the stigma surrounding sexual and reproductive health services.²⁰ Furthermore, judges are afforded significant discretion and may simply deny the request. For example, in 2012 in the U.S. state of Nebraska, a pregnant 16-year-old was denied judicial authorization to terminate a pregnancy,

Younger Adolescents

In addition to the need for greater provision of sexual and reproductive health services to adolescents, such services must also be recalibrated to take into account the increasing evidence of younger adolescents' need for such services. Many adolescents begin puberty between the ages of 10 and 14, making this a critical opportunity to provide adolescents with age-appropriate information about their sexual and reproductive health and rights and teach them about negotiating relationships and power dynamics.

Furthermore, a 2013 survey of over 30 countries found that 10% of children had sexual intercourse before the age of 15.¹ As such, in addition to the need to address these serious risks that younger adolescents face in order to prevent human rights violations, there is also a need to guarantee that they have access to the full range of sexual and reproductive health information and services, including comprehensive sexuality education, contraception, maternal health care and safe abortion services, in order to mitigate this harm and enable them to reclaim their rights.

thereby compelling her to carry the pregnancy to term against her will. Paradoxically, the court found that she was not “sufficiently mature and well-informed to decide on whether to have an abortion,”²¹ even though this meant that she would be forced to carry the pregnancy to term against her will and become a parent. The Court reached this decision despite her testimony that she planned to graduate high school early and attend college, and could not financially support a child, was not prepared to be a parent at that time, and was afraid of being kicked out of her home if it was discovered she was pregnant.²²

Practical Barriers

- ***Stigma:*** The stigma surrounding adolescent sexuality can prevent adolescents from seeking information about their sexual and reproductive health, discussing their sexual and reproductive health needs, and accessing sexual and reproductive health services.²³ This stigma can stem from the belief that adolescents and/or unmarried persons should not be sexually active or the prejudicial stereotype that adolescents lack the requisite maturity, capacity, or responsibility to consent to and engage in sexual activity. The development of adolescent sexuality is also inherently linked with puberty, which can be embarrassing or uncomfortable for adolescents to discuss while they are experiencing these emotional and physiological changes.
- ***Lack of Information:*** Where adolescents do not understand their sexual and reproductive health needs, they are unable to take measures to prevent unwanted pregnancy or sexually transmitted infections or disease. Comprehensive sexuality education is critical for informing adolescents about sexual and

reproductive health services, their right to access such services and the right to make decisions about their sexuality and reproduction free from violence, pressure or coercion.

- ***Distance to Facilities:*** Even where adolescents know where to access sexual and reproductive health services, the location of such services can hinder access. Where sexual and reproductive health services are too far away, adolescents may be unable to access or afford the required transportation, or they may be unable to explain their whereabouts during the time it takes to access these services without disclosing their personal sexual and reproductive health needs.
- ***Cost:*** Many adolescents lack an independent source of income and due to the sensitive nature of sexual and reproductive health services may be unable to ask their parents for financial support. Many adolescents who do work are expected to turn their earnings over to their parents. Where adolescents are covered by their parents' health insurance or a public health insurance scheme, they may be prevented from using these to cover the cost out of fear that the administrative components, such as the paperwork associated with billing and processing, could unintentionally disclose their use of sexual and reproductive health services to their parents.
- ***Lack of Confidentiality:*** Where adolescents do not believe that their right to confidentiality will be maintained, they may forego sexual and reproductive health services.²⁴ Where health services are located in a small clinic where adolescents risk running into an adult they may know, this can also deter them from accessing such services.
- ***Disrespect, Abuse and Low Quality of Care:*** Adolescents' perceptions of the treatment and the care that they receive can heavily influence their decisions about accessing sexual and reproductive health services. Where they are mistreated by health care providers, such as when they are chastised or shamed for being sexually active, it may also deter them from seeking health services in the future.²⁵ The perceived quality of care within health facilities and their capacity to provide the services needed also impacts whether adolescents will seek care. The role of providers in ensuring adolescents access to sexual and reproductive health services is further explored below.

Choice, Agency and Autonomy: Preventing Pressure and Coercion of Adolescents in the Context of Sexual and Reproductive Health Services

In addition to facing denials of sexual and reproductive health services, adolescents are also at risk of facing undue pressure or coercion in the context of reproductive health care. This is particularly true for adolescents who are members of marginalized groups, who have historically been targeted by coercive policies surrounding reproduction. For example, the Special Rapporteur on Torture and other forms of Cruel, Inhuman

and Degrading Treatment has recognized that children who are born with intersex conditions may be subjected to irreversible surgeries aiming to “normalize” their gender before they are at an age where they can give informed consent to the procedure.²⁶ Such surgeries are commonly performed despite not being medically necessitated and can carry grave health risks, including infertility, and deprive children of their right to determine their gender identity.²⁷ Children with disabilities have also been forced to undergo treatments depriving them of their reproductive autonomy, including forced sterilization, forced contraception, and forced abortion.²⁸ This is commonly based on misconceptions and discriminatory attitudes about the ability of women with disabilities to take care of children.²⁹ Women and children with disabilities are particularly vulnerable to forced sterilizations performed under the auspices of legitimate medical care or as the result of decisions made by their parents, guardians, or doctors without the individual’s consent. There is also evidence that adolescents belonging to other marginalized groups, such as indigenous populations and racial minorities, have been forcibly sterilized as a result of coercive programs targeting women in these populations

Provider-Imposed Restrictions on Sexual and Reproductive Health Services

Studies from across the globe demonstrate that in a variety of different circumstances, healthcare providers may deny adolescents access to sexual and reproductive health services or require that they receive parental authorization even where laws and policies guarantee adolescents the right to independently access sexual and reproductive health services.¹ For example, a study of pharmacists in Managua, Nicaragua found that nearly three-quarters were unwilling to administer emergency contraception to a minor without parental consent, even though this is not required by law.² Provider-imposed restrictions on sexual and reproductive health services may stem from the misconception that denying adolescents sexual and reproductive health services will prevent them from engaging in sexual activity, providers’ personal opinions or beliefs about young or unmarried people being sexually active, or lack of understanding about the laws and policies surrounding adolescents’ right to access such services. Overcoming provider-imposed restrictions requires explicitly enshrining adolescents’ right to access such services into laws and policies, widespread training and sensitization of health providers on adolescents’ rights to access such services, and the implementation of mechanisms for minors to lodge complaints where they are denied such services.

more generally.³⁰

There are also examples of adolescents being pressured or forced to submit to certain sexual and reproductive health examinations or services by parents, teachers and school administrators. For example, there is evidence of primary and secondary schools routinely compelling girls to submit to mandatory pregnancy testing, which is conducted through a physical examination involving invasive and painful touching of the girls' abdomens.³¹ In 2014, reports surfaced of a school compelling girls studying abroad to go on long-term forms of contraception, out of fear that they would become pregnant.³² Furthermore, there is anecdotal evidence of parents surreptitiously giving their daughters hormonal birth control in order to negate the chance of an unintended pregnancy.³³ Adolescents may also be subjected to more subtle forms of pressure, as a result of social norms and other familial or societal pressure. For example, in places with high rates of child marriage, adolescent girls that are married can face significant



Wanjiku's Story

At age 14, Wanjiku became pregnant after being forced into sex by an older man.

Afraid that she would be stigmatized and rejected by her family for becoming pregnant, Wanjiku turned to a classmate for advice on terminating the pregnancy. Her friend led her to an unqualified abortion provider operating out of the backroom of a local pharmacy, who administered an unsafe abortion to Wanjiku. Two days later, she began vomiting and bleeding heavily. When she went to the hospital, they discovered that she was experiencing kidney failure as a result of the unsafe abortion. After she was stabilized, she was detained by the hospital because her mother—a poor tea picker—could not pay the hospital bills. There, Wanjiku was forced to sleep on a mattress on the floor, where her health again deteriorated. Wanjiku now has chronic kidney disease and requires routine dialysis, jeopardizing her ability to continue her education.

pressure not to take measures to delay or prevent pregnancy in order to immediately begin childbearing and prove their fertility.³⁴

II. International Human Rights Standards on Adolescents' Sexual and Reproductive Health and Rights

Right to Sexual and Reproductive Health Services

While numerous UN Treaty Monitoring Bodies have affirmed the importance of providing adolescents access to sexual and reproductive health services, the Committee on the Rights of the Child (CRC) has been at the forefront of establishing these international human rights norms. The CRC has urged states to “ensure that health systems and services are able to meet the specific sexual and reproductive health needs of adolescents.”³⁵ In this regard, the CRC has made clear that adolescents should have access to the full range of sexual and reproductive health services,³⁶ including maternal health care; contraceptive information and services, including short- and long-term methods of contraception and emergency contraception; safe abortion services and post-abortion care; and information and services to prevent and address sexually transmitted infections.³⁷ Further, the CRC has urged state to “decriminalize abortion to ensure that girls have access to safe abortion and post-abortion services.”³⁸

These standards have been reinforced by other treaty monitoring bodies, such as the Committee on the Elimination of Discrimination Against Women (CEDAW Committee), the Committee on Economic, Social and Cultural Rights (ESCR Committee), and the Human Rights Committee.³⁹ For example, these bodies have called on states to ensure girls access to safe abortion services;⁴⁰ affordable modern contraception, including emergency contraception;⁴¹ and proper care during pregnancy and childbirth.⁴²

Parental Consent, Evolving Capacities and Decision-Making

In 2016, two key documents were issued which significantly bolstered the understanding of adolescents' evolving capacities, autonomy and decision-making in the context of their sexual and reproductive health and rights: The Special Rapporteur on the Right to Health's Report on Adolescents and the CRC's General Comment on Adolescents. Both of these documents call on states to put in place appropriate measures to enable adolescents to exercise their sexual and reproductive rights and fill a critical gap in the human rights framework's conceptualization of evolving capacities as it pertains to adolescents' sexuality and reproduction.

A. Parental Consent Requirements

Notably, the CRC recognizes that there should not be any “barriers to

commodities, information and counselling on sexual and reproductive health and rights, such as requirements for third-party consent or authorization.”⁴³ The Special Rapporteur on the Right to Health further recognizes parental consent and notification requirements as a barrier to health services for adolescents, as they “make adolescents reluctant to access needed services so as to avoid seeking parental consent, which may result in rejection, stigmatization, hostility or even violence.”⁴⁴ These normative developments reinforce the CEDAW Committee’s recognition that parental authorization requirements constitute a barrier to health services.⁴⁵ While it may be suitable for a healthcare provider to encourage an adolescent to consult with his or her parent or guardian, compelling an unwilling adolescent to receive parental authorization or denying him or her sexual and reproductive health services does not advance the adolescents’ best interests and can expose adolescents to serious risks.

B. Presumption of Capacity for Sexual and Reproductive Health Services

While the CRC has indicated that adolescents’ evolving capacities impact their ability to make independent decisions about their health, until the adoption of the General Comment on Adolescents, states had little guidance on how to fulfill this obligation. In the CRC’s new General Comment, for the first time, the CRC has called on states to consider introducing a “**legal presumption that adolescents are competent to seek and have access to preventive or time-sensitive sexual and reproductive health commodities and services.**”⁴⁶ This approach is also endorsed by the Special Rapporteur on Health.⁴⁷ In this regard, the fact that an adolescent recognizes his or her need for such services and takes the initiative to seek them out evidences that he or she has the requisite capacity to make decisions about and use such services appropriately.⁴⁸

Furthermore, the CRC has urged states to review their legislation in order to **guarantee “the best interests of pregnant adolescents and ensure that their views are always heard and respected in abortion-related decisions.”**⁴⁹ The CRC has further called on states to ensure that “girls can **make autonomous and informed decisions** on their reproductive health.”⁵⁰ This normative development demonstrates the unique and critical nature of sexual and reproductive health services for adolescents and represents a shift toward recognizing that adolescents have an inherent right to make autonomous decisions about their reproductive health.

C. Preventing Force and Coercion in the Context of Sexual and Reproductive Health

Adolescents’ right to sexual and reproductive health services also includes their right **not** to have such services forced upon them.⁵¹ The CRC recognizes that children who are particularly vulnerable to discrimination are often less able to exercise their right to make autonomous decisions related to their health,⁵² and has called on states to ensure that the voluntary and informed consent of adolescents for all medical treatments and procedures.⁵³ For example, adolescents with disabilities may be at greater risk for human rights violations

related to their sexuality and reproduction, particularly including forced medical procedures such as forced sterilization, forced contraception, and forced abortion.⁵⁴ The CRC has emphasized respect for adolescents' physical and psychological integrity, and condemned forced treatments and surgeries, including for adolescents with intersex conditions.⁵⁵

To this end, the administration of all sexual and reproductive health services to adolescents must be **consented to voluntarily, free from pressure, violence or coercion**. States should ensure that adolescents are not being unduly induced or coerced to use certain sexual and reproductive health services as a means of controlling their fertility for demographic or economic aims, such as reducing rates of teenage pregnancy or population control. To enable adolescents to meaningfully exercise their right to make decisions about their sexual and reproductive health, states should guarantee them access to the **full range of sexual and reproductive health services and options**,⁵⁶ not just those that may be deemed the most economical or efficient.

Furthermore, states should take measures to **empower adolescents to make healthy decisions** about their sexuality and reproduction, such as through the provision of comprehensive and non-discriminatory sexuality education, addressing the stigma surrounding sexuality, challenging gender stereotypes, and establishing programs for girls' empowerment and sensitization for men and boys.⁵⁷

Further Strengthening and Implementing the International Human Rights Framework

While the introduction of the presumption of capacity is an important step forward, situations may still arise where providers have concerns about administering specific sexual and reproductive health services to adolescents. While the human rights framework requires that children's best interests must always be the primary consideration in decisions affecting them, these norms could be further strengthened by providing some principles or factors that should be weighed in determining the proper course of action. The following principles were drafted in order to balance the need to guarantee adolescents access to the full range of sexual and reproductive health services while ensuring that decisions are informed and made free from violence, pressure or coercion, drawing from multiple consultations with experts in the fields of sexual and reproductive health and rights, disability rights, intersex rights, and children's rights, among other areas.⁵⁸

Where a provider has concerns about the capacity of an adolescent seeking sexual and reproductive health services, the provider should follow **the course of action that is in line with the adolescent's best interests, with this assessment weighted towards the course of action chosen by the adolescent**. This approach should take into account:

- why the adolescent is seeking particular sexual and reproductive health services;

- if the services are most appropriate for the adolescent's needs;
- whether the adolescent is capable of following the treatment regimen; and
- the consequences for the adolescent if the provider denies him or her these services.⁵⁹

Further, treaty monitoring bodies should make clear that providers' actions **must not be grounded in misconceptions or discriminatory beliefs surrounding sexuality and reproduction**, including the belief that providing sexual and reproductive health information and services increases the likelihood of engaging in sexual activity.⁶⁰ Treaty monitoring bodies should urge states to require that if a provider refuses to provide a specific service to an adolescents, there must be an **objective, justifiable reason that is grounded in scientifically-accurate information**. Even where other interventions may be needed – such as where a provider believes the adolescent may be the victim of abuse – this does not negate the adolescent's urgent need for appropriate sexual and reproductive health services.

Adopting the aforementioned standards would greatly strengthen adolescents' right to make autonomous decisions surrounding their sexual and reproductive health, which is critical for the realization of a broad range of their human rights. These standards help to overcome the unique barriers that adolescents face in exercising their sexual and reproductive health and rights, particularly for girls, who must contend with greater stigma and discriminatory stereotypes while bearing the physical, psychological, educational, and economic burden of being denied these services.

III. Guaranteeing Adolescents' Right to Make Decisions about their Sexual and Reproductive Health and Rights Reinforces the Full Spectrum of their Human Rights

In addition to being a human right in itself, adolescents' right to make decisions about their sexual and reproductive health and rights is critical for reinforcing and realizing a broad range of their human rights, including the rights to life, survival and development; equality and nondiscrimination; to be heard; and to be free from all forms of violence and cruel, inhuman and degrading treatment. Indeed, treaty monitoring bodies recognize that denying individuals the ability to make decisions about their sexual and reproductive health and access the necessary services to fulfill these decisions can constitute a human rights violation.

The Right to Life, Survival and Development

The Convention on the Rights of the Child provides expansive protection for the right to life, survival and development,⁶¹ going beyond those afforded the right to life in other international human rights treaties.⁶² The CRC interprets children's right to development broadly to include their physical, mental, spiritual, moral, psychological and social development⁶³ and has urged states to take measures to achieve the optimal development of all children.⁶⁴ In the context of realizing the right to life, survival and development in light of the HIV epidemic, the CRC has urged states to pay careful attention to adolescents' sexuality, behavior and lifestyles, even if they contravene prevailing cultural norms for a particular age group.⁶⁵ To this end, effective programs should "acknowledge the realities of the lives of adolescents, while addressing sexuality by ensuring equal access to appropriate information, life skills, and to preventive measures."⁶⁶

Guaranteeing all adolescents the right to autonomously make decisions about their sexual and reproductive health is a critical step towards realizing the right to life, survival and development. Treaty monitoring bodies have expressed concern about adolescents' lack of access to sexual and reproductive health services and the impact that this has on their lives and development, including by urging states to ensure adequate access to sexual and reproductive health services in order to reduce adolescent pregnancy and maternal mortality.⁶⁷ Enabling adolescents to access sexual and reproductive health services enables them to prevent pregnancy, protect



*LC's Story*¹

At age 13, after discovering she was pregnant as a result of sexual abuse, LC attempted suicide by jumping from a building.

Upon arriving at the hospital, it was determined that LC urgently needed spinal surgery – but doctors refused to perform the surgery because she was pregnant and they feared interrupting the pregnancy. As under Peruvian law, abortion is permitted where pregnancy poses a risk to the person's life or health, LC requested an abortion, as the pregnancy was both jeopardizing her physical health by delaying the surgery and endangering her mental health. A total of 42 days passed between her request for an abortion and the formal denial by the hospital's medical board. Soon thereafter, LC appealed this decision, but was informed nearly three weeks later that it was not subject to appeal. In the interim, LC had spontaneously miscarried and nearly three months after her injuries, she finally received spinal surgery. Unfortunately, LC remains paralyzed from the neck down, with only partial movement in her hands.

themselves against sexually transmitted infections, and make informed decisions about their sexual and reproductive health.⁶⁸ Where adolescents are unable to autonomously access sexual and reproductive health services, they may resort to unsafe methods to try to prevent pregnancy or to terminate an unwanted pregnancy, posing serious threats to their lives.⁶⁹ In addition to the threat to life posed by maternal death, maternal morbidity can severely hinder girls' right to development, as it may leave girls unable to complete school or pursue employment opportunities.⁷⁰

The Rights to Equality and Nondiscrimination

The rights to equality and nondiscrimination are fundamental to the realization of all human rights and states must ensure that discrimination does not undermine the realization of children's rights.⁷¹ The CRC recognizes that children who are discriminated against "are more vulnerable to abuse, other types of violence and exploitation," and their health and development are put at greater risk.⁷² States are obligated to take affirmative measures to protect children's right to non-discrimination and diminish or eliminate conditions that cause discrimination through measures such as legislative changes, changes in administration and resource allocation, and educational measures designed to change attitudes.⁷³

Guaranteeing all adolescents the right to make autonomous decisions about their sexual and reproductive health and rights is a critical component of the right to equality and nondiscrimination, due to the disproportionate impact this has on girls. Treaty monitoring bodies recognize that restrictive laws on sexual and reproductive health services – such as laws restricting the legality of specific services and requiring third-party authorization – violate the right to nondiscrimination.⁷⁴ In the case of *LC v. Peru*, the CEDAW Committee recognized that the denial of abortion services to an adolescent was based on "the stereotype that protection of the foetus should prevail over the [girl's] health."⁷⁵ Denials of sexual and reproductive health services reinforce gendered social norms and stereotypes, often compelling girls to drop out of school and assume childrearing responsibilities.

Furthermore, rigid parental consent requirements perpetuate the discriminatory notion that adolescents are incapable of making informed decisions about their sexual and reproductive health, contradicting human rights norms recognizing that they must be enabled to make informed decisions about their sexual and reproductive health in line with their evolving capacities. Where adolescents' age or gender is coupled with another basis for discrimination, such as disability, race, or migration status, the discrimination they face in exercising their sexual and reproductive rights can be greatly exacerbated and also manifest in unique ways. States should proactively take targeted measures to ensure that adolescents facing multiple forms of discrimination are able to exercise their sexual and reproductive rights on the basis of substantive equality.

The Right to be Heard

Children have a right to freely express their views in all matters affecting them and, in accordance with children's age and maturity, their views must be given due

weight.⁷⁶ The right to be heard is both a right in itself and should be taken into account in interpreting and implementing all other rights.⁷⁷ The CRC has made clear that states have a “clear legal obligation,” without any discretionary leeway,⁷⁸ to take appropriate measures to fully implement all children’s right to be heard.⁷⁹ In according “due weight” to the child’s views, age alone cannot be the sole factor that determines the significance of a child’s views; the child’s maturity must also be taken into consideration. The CRC has indicated that maturity should be understood as the “capacity of a child to express her or his views on issues in a reasonable and independent manner”⁸⁰ and if a child can form his or her own views reasonably and independently, these views must be a significant factor in the outcome.⁸¹ In giving due weight to a child’s views, the CRC has noted that “the greater the impact of the outcome on the life of the child, the more relevant the appropriate assessment of the maturity of that child.”⁸² Recognizing that gender stereotypes and patriarchal values undermine the exercise of girls’ right to be heard, states are urged to pay special attention to this right for girls.⁸³

Adolescents’ right to freely express their views and have them taken into account is fundamental to the realization of their right to health.⁸⁴ In decisions about sexual and reproductive health, the right to be heard is of paramount importance. In the context of decisions about abortion, the CRC has gone further than just calling for an adolescent’s right to voice her opinion, indicating that **pregnant adolescents’ views should always be respected**.⁸⁵ This demonstrates an understanding that any girl who becomes pregnant should be enabled to make her own decision about that pregnancy. Human rights bodies should understand this to be true for adolescents’ views about their other sexual and reproductive health needs. The highly personal nature of these services requires that the right to be heard extend beyond just consideration of the adolescent’s views, and these views are in fact the primary consideration in determining the proper course of action.

The Right to be Free from all Forms and Violence and Cruel, Inhuman and Degrading Treatment

In accordance with the CRC, states must take “all appropriate legislative, administrative, social and educational measures to protect [children] from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation.”⁸⁶ The CRC has made clear that the term “violence” should be understood to include non-physical and non-intentional forms of harm, including neglect and psychological maltreatment.⁸⁷ The CRC has indicated that the failure to meet children’s physical and psychological needs can constitute neglect,⁸⁸ including the failure to obtain or the withholding of essential medical services.⁸⁹

Children also have the right to be free from all forms of cruel, inhuman or degrading treatment or punishment, and the CRC has noted that these all constitute forms of violence.⁹⁰ International and regional human rights bodies have found that the denial of sexual and reproductive health services to adolescents can amount to cruel, inhuman and degrading treatment. In *KL v. Peru*, the Human Rights Committee ruled that denying a 17-year-old access to abortion services and compelling her to carry to term

a fetus that had no chance of survival after birth amounted to cruel, inhuman and degrading treatment.⁹¹ Furthermore, in *P&S v. Poland*, the European Court of Human Rights found that the treatment of the 14-year-old petitioner, who was denied abortion services, had her confidential medical information revealed to the public, and was wrongfully removed from her mother's care, amounted to cruel, inhuman and degrading treatment.⁹²

Ensuring all adolescents access to the full range of sexual and reproductive health services is a critical component of ensuring freedom from all forms of violence and cruel, inhuman and degrading treatment. This is particularly true due to the rampant rates of sexual violence across the globe,⁹³ which subjects girls to serious physical and psychological harm, as well as putting them at great risk of unwanted pregnancy and sexually transmitted infections or diseases, including the transmission of HIV. Human rights bodies have urged states to ensure that victims of sexual violence have access to the full range of sexual and reproductive health services, including post-exposure prophylaxis, emergency contraception, safe abortion services,⁹⁴ and psychological and mental health services.⁹⁵ The Committee against Torture has framed the denial of access to sexual and reproductive health services under such circumstances as a potential form of ill-treatment.⁹⁶

Even outside the context of sexual violence, the denial of sexual and reproductive health services can expose girls to the risks associated with early pregnancy; indeed, complications from pregnancy and childbirth are the second leading cause of death among 15-19 year olds worldwide.⁹⁷ Where restrictive abortion laws are in place, girls facing an unwanted pregnancy may be exposed to grave health risks from unsafe abortion. The Committee against Torture has urged states to ensure adolescents access to sexual and reproductive health services in order to prevent unwanted pregnancy, indicating that the denial of access to sexual and reproductive health services for minors could potentially amount to ill-treatment.⁹⁸

Special Measures of Protection

In recognition of their unique vulnerabilities and evolving capacities, states are required to take special measures of protection for children.⁹⁹ This includes taking “all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation...”¹⁰⁰ States should pay particular attention to the forms of abuse, neglect, violence and exploitation that have a greater effect on minors.¹⁰¹ Within this context, children's dignity and integrity must be respected and promoted, by viewing them as rights-bearers, as opposed to as “victims.”¹⁰²

Through individual cases, treaty monitoring bodies have found that the denial of sexual and reproductive health services to adolescents can violate their right to special measures of protection. In *KL v. Peru*, wherein an adolescent carrying an anencephalic fetus was denied legal abortion services and forced to carry the pregnancy to term, the Human Rights Committee recognized KL's special vulnerability as a minor, finding

The Right to Confidentiality and Mandatory Reporting Requirements

Human rights bodies recognize that adolescents have a right to confidentiality in the provision of health services, including sexual and reproductive health services, and that violations of this right implicate the rights to health and privacy.¹ The CRC has called on states to ensure health care providers keep adolescents' medical information confidential² and the CEDAW Committee recognizes that lack of confidentiality deters women and girls from seeking health services, particularly sexual and reproductive health services and in instances of physical or sexual violence.³ In *P&S v. Poland*, the European Court of Human Rights addressed the disclosure of a minor's confidential medical information, finding that she "was entitled to respect for her privacy regarding her sexual life,"⁴ and recognizing that this can result in ostracism and deter people from seeking health services.⁵

At the same time, human rights bodies have urged states to put in place mandatory reporting laws, which either permit or compel health care providers to breach confidentiality in the case of minors where they either know or believe the child is at risk of or is being harmed – such as in instances of physical or sexual violence.[FN6] However, where the law does not recognize adolescents' ability to consent to sex until they reach a certain age, disclosing to a provider that they are sexually active before reaching that age can trigger mandatory reporting requirements.[FN7] Human rights bodies have not yet reconciled the tension between guaranteeing adolescents confidential sexual and reproductive health services and protecting minors from perceived or actual instances of physical or sexual violence. This apparent tension is particularly complex in cases where the age of consent for sexual activity is relatively high, meaning that even older adolescents who voluntarily become sexually active may have their sexual activity disclosed as a result of mandatory reporting laws.[FN8] In this regard, the CRC has called on states to "take into account the need to balance protection and evolving capacities" in determining the legal age for sexual consent and to "avoid criminalizing adolescents of similar ages for factually consensual and non-exploitative sexual activity." [FN9]

that the state's failure to provide her with the requisite medical and psychological support during and after her pregnancy amounted to a violation of the right to special measures of protection as a minor.¹⁰³ In *LC v. Peru*, where a minor was denied urgent spinal surgery due to her pregnancy as well as abortion services, in finding a violation of the right to health, the CEDAW Committee recognized the heightened severity of the violation due to LC's status as a minor and a victim of sexual abuse.¹⁰⁴ Finally, in *P&S v. Poland*, wherein a 14-year-old who became pregnant as the result of rape was denied abortion services and subjected to intimidation and harassment, in finding a violation of the right to be free from ill-treatment, the European Court of Human Rights noted that P's status as a minor was of "cardinal importance,"¹⁰⁵ and the fact that she had been sexually abused placed her in a position of great vulnerability.¹⁰⁶

Due to the stigma and discrimination surrounding sexual and reproductive health services and the lifelong impacts that denials of access to such services have on adolescents, treaty monitoring bodies should urge states to put in place special measures of protection in order to guarantee adolescents access to such services. Furthermore, states should also put in place special measures to protect against violations of adolescents' reproductive rights, such as measures to control girls' sexuality, harmful traditional practices, and forced or coerced medical interventions.

Rights and Responsibilities of Parents, Guardians and other Adults working with Adolescents

Parents, caregivers and other adults in adolescents' lives play critical roles in developing their capacities and enabling them to exercise their human rights. While parents and other legal guardians are afforded particular rights and responsibilities in relation to adolescents, the primary aim is to enable adolescents to exercise their rights.¹⁰⁷ In further elaborating parents' rights and interests in relation to their adolescent children, it is critical that treaty monitoring bodies recognize that the best interests of the adolescent must be the prevailing consideration where adolescents' decisions conflict with what their parents believe should be the course of action. In the context of sexual and reproductive health services, this should be interpreted to mean that a parent's beliefs, wants, or interests cannot automatically trump the child's. Decisions surrounding adolescents' sexual and reproductive rights must reinforce their evolving capacities and reflect the broad range of adolescents' human rights, including their right to be heard, right to health and right to non-discrimination.

Human rights bodies have enumerated a number of obligations and responsibilities to which different professionals whose work involves children and adolescents must adhere. In the context of healthcare settings, the CRC has made clear that healthcare professionals and other State actors must "observe the best interests of the child and ensure his or her rights to protection, well-being and development."¹⁰⁸ Furthermore, states are required to "develop and implement professional ethics codes, protocols, memoranda of understanding and standards of care for all childcare services and settings," including hospitals.¹⁰⁹ States should adopt educational measures to increase the capacities of professionals who work with children.¹¹⁰ For professionals

and institutions, states should provide training on the child rights approach and its application in practice, including for health professionals such as doctors and nurses¹¹¹ and develop certification schemes recognizing such training.¹¹²



Rahema's Story¹

While Rahema was growing up in Tanzania, she did not receive any sexuality education in school and therefore had no idea how to prevent pregnancy.

As a result, her entire life was interrupted when she became pregnant at age 16. Formal expulsion of pregnant schoolgirls is rampant throughout Tanzania, as it is believed that these girls are a bad influence and expulsion is used as a punishment for engaging in sexual activity. Recognizing Rahema was pregnant, the school's matron pressured her to drop out before the headmaster learned of the pregnancy, believing that leaving willingly might make it easier for Rahema to return to school later. Although Rahema considered terminating the pregnancy, Tanzania's highly restrictive abortion law would have meant undergoing an unsafe procedure, which would have put her life and health at risk. After giving birth, Rahema wanted to go back to school, but she did not have access to the information or resources that would have enabled her to do so. Rahema lives with her parents and works part-time as a cook. She firmly believes that if she had been able to finish secondary school, she would have had greater job opportunities and perhaps even be self-employed.

IV. Establishing Adolescent-Friendly Sexual and Reproductive Health Services

In accordance with international human rights norms, sexual and reproductive health services for minors should be youth-friendly,¹¹³ meaning that they are designed to meet the unique needs of adolescents and address the barriers they face in accessing health services. In designing and implementing youth-friendly health services, states should recognize and address how adolescents' access to services differs from that of adults.

For example, states should ensure that health services:

- are geographically accessible, such as by ensuring they are located near where adolescents congregate;
- are open during convenient hours for adolescents, such as evenings and weekends, and offer drop-in times, if possible; and
- are affordable or free: the Special Rapporteur on Health has urged states to develop a core package of interventions, including sexual and reproductive health services, that will be available free of charge.¹¹⁴

Guaranteeing Confidentiality

Youth-friendly services should also guarantee minors confidentiality throughout the full spectrum of their health care, from when the minor arrives at the clinic through follow-up care, such as by:

- having designated times and spaces specifically for adolescents, in order to reduce the likelihood of running into a known adult.¹¹⁵
- providing privacy when adolescents explain why they are seeking care;
- guaranteeing confidentiality during their actual visit with the provider;
- storing health records in a secure, safe place; and
- ensuring patients that their medical information and history will not be improperly disclosed.¹¹⁶

Role of Healthcare Workers

Healthcare workers often play a critical role in enabling adolescents to access sexual and reproductive health services, but proper training is essential to ensure they fulfill – and do not undermine – adolescents' rights. States should ensure that health care workers:

- do not discriminate against adolescents, including on the basis of age, sex, or social status, among others.¹¹⁷ This includes overcoming prejudices against adolescent girls' sexuality;¹¹⁸
- are respectful of adolescents, meaning that they be nonjudgmental, friendly and considerate of their needs, and do not criticize them;¹¹⁹
- administer adolescent-friendly sexual and reproductive health services, including on client privacy, confidentiality and respecting minors' needs;¹²⁰
- provide scientifically-accurate and comprehensive information on adolescents' sexual and reproductive health and rights, including on the full range of reproductive health options; and
- communicate effectively with adolescents to ensure they understand their sexual and reproductive health needs. This communication should also establish an interpersonal relationship built on trust, enabling the youth to be open and honest.¹²¹

States should further take steps to ensure that providers have accurate information on adolescents' right to access sexual and reproductive health services, including by establishing and disseminating clear, written guidelines on this issue and instituting training and awareness programs as needed.

Meaningful Participation

States must also guarantee adolescents **meaningful participation** in the design, implementation, monitoring and evaluation of youth-friendly sexual and reproductive health programs.¹²² This will ensure that the youth perspective is incorporated into such programs and enhance transparency and accountability. States should take special measures to ensure the meaningful representation of marginalized groups that may face additional barriers in access to sexual and reproductive health services. For example, girls may have lower rates of school attendance, requiring that information on where to access sexual and reproductive health services be disseminated outside of school.

Comprehensive Sexuality Education

While youth-friendly services are critical to realizing adolescents' rights, without the proper information about sexuality and reproduction, adolescents will be unable to recognize their health needs and seek appropriate care. The CRC has called on states to ensure that age-appropriate, comprehensive and inclusive sexual and reproductive health education is part of the mandatory school curriculum.¹ It should be based on scientific evidence and human rights standards, and cover a range of issues including "gender equality, sexual diversity, sexual and reproductive health rights, responsible parenthood and sexual behaviour and violence prevention."² To ensure accessibility to all adolescents, including those with disabilities, the information should be available in alternative formats.³ Furthermore, states should ensure this information reaches out-of-school youth.⁴ The European Court of Human Rights has also determined that sexuality education must not reinforce stereotypes or prejudices and or include discriminatory information on sexual minorities.⁵ For more information on developing comprehensive sexuality education, see UN Educational, Scientific and Cultural Organization's International Technical Guidance on Sexuality Education.⁶

V. Realizing Adolescents' Right to an Effective Remedy

In addition to the right to access sexual and reproductive health services, minors are also entitled to the right to an effective remedy when their human rights are violated.¹²³ Where children's rights have been violated, states must provide appropriate reparations, including compensation, measures of non-repetition and, where needed, measures to promote physical and psychological recovery.¹²⁴

Barriers

Adolescents face numerous barriers in accessing effective remedies for violations of their human rights, including:

- **Lack of information:** Adolescents may not recognize that certain actions constitute a violation of their rights or may lack know how to report such violations.¹²⁵
- **Lack of avenues for redress:**
 - Laws and procedures about how adolescents should be treated or their ability to participate in proceedings may not be suited for the realization of adolescents' rights and may even discriminate against them based on age or gender.¹²⁶ For example, where the law does not explicitly recognize adolescents' right to sexual and reproductive health services, they may not have an avenue for challenging denials of access to such services.
 - Additionally, adolescents may be legally precluded from seeking redress through the judiciary or other mechanisms based on minimum age requirements which would require a parent or other adult to act on their behalf.
- **Inadequate resources:** Adolescents are also frequently dependent on adults to be able to seek an effective remedy, as they may not be able to afford the costs associated with legal proceedings or be physically unable to travel to where the nearest court is located.¹²⁷
- **Intimidation and stigma:** Judicial mechanisms can be intimidating for adolescents, and filing complaints could expose them to harassment or stigmatization.¹²⁸ Adolescents may also doubt that a complaint will be taken seriously or assessed fairly.¹²⁹ In some places, it may be considered socially or culturally unacceptable for an adolescent to file a complaint and seek redress for a human rights violation.¹³⁰

All of these barriers may be seriously exacerbated in light of the stigma surround-

ing sexual and reproductive health services, which can make children less likely to voice their concerns, file a complaint or seek redress. Furthermore, certain groups of children, including girls, those belonging to marginalized racial and ethnic groups, migrants, indigenous children, children living in poverty, and children in conflict situations, may face additional barriers in accessing an effective remedy, in part due to intersectional discrimination and stigmatization.¹³¹

Child-friendly Remedies

In recognition of the unique barriers that children face in seeking remedies for human rights violations, it is paramount that states put in place child-friendly redress mechanisms.¹³² The CRC has made clear that states must ensure that children have access to child-sensitive procedures to access an effective remedy,¹³³ including by providing “child-sensitive information, advice, [and] advocacy, including support for self-advocacy.”¹³⁴ The CRC has further urged states to provide “access to independent complaints procedures and to the courts with necessary legal and other assistance.”¹³⁵ OHCHR has called for states to adapt their remedies to take into account the special vulnerabilities of children,¹³⁶ such as by putting in place structural and proactive interventions to enable all children to have access to an effective remedy.¹³⁷

For such mechanisms to be effective, adolescents must have information about their rights, in order to enable them to recognize human rights violations.

- For this reason, it is critical that states enshrine the right to access sexual and reproductive health services into laws and policies and disseminate information to adolescents about this right.¹³⁸
- Adolescents must further have knowledge about their rights and available mechanisms of redress to access remedies for human rights violations and how to go about doing so.¹³⁹ Information about adolescents’ rights, including their right to an effective remedy, must be “conveyed in language children are able to understand and which is gender- and culture-sensitive, and supported by child-sensitive materials and information services.”¹⁴⁰

In addition to providing information on remedies to adolescents, legal systems must also have the authority to **adjudicate claims** from adolescents and filed on their behalf.¹⁴¹ This is particularly critical for sexual and reproductive rights violations, as adolescents may be unwilling to seek assistance from a parent or other adult. The CRC has noted that entitlements, such as adolescents’ right to sexual and reproductive health services, should be set forth in sufficient detail by states for remedies surrounding non-compliance to be effective.¹⁴² To this end, the right to access sexual and reproductive health services should be **enshrined in law and be justiciable**.

States must ensure that adolescents participating in judicial, legal or other proceedings are guaranteed the right to **non-discrimination**, which requires states to actively identify both individual and groups of adolescents who may require special measures of protection.¹⁴³ For example, girls seeking redress for sexual and reproductive rights violations may need to be guaranteed a female arbiter, as they may be uncomfortable

discussing the incident with a man. For adolescents who seek redress through the judiciary, states should ensure that they have access to **subsidized or free legal services** to assist them in this process.¹⁴⁴ States should also ensure children are provided with **other appropriate assistance**, such as social workers and psychologists, as needed.¹⁴⁵

Preventative redress mechanisms

A number of international human rights cases on the right to access reproductive health services have reflected the need for a preventative mechanism where individuals can assert their right to access such services.¹⁴⁶ States have an affirmative obligation to adhere to a due diligence standard in ensuring that non-state actors recognize, respect, and fulfill children's rights,¹⁴⁷ including ensuring that health services providers "do not deny children any services to which they are entitled by law."¹⁴⁸ Due to the immediate and preventative nature of the need for sexual and reproductive health services, it is critical that states implement **effective, immediately accessible, rapidly-responding processes** by which individuals, including adolescents, can assert their rights to treatment and receive an authoritative response from an independent body when they are denied access to reproductive health services.¹⁴⁹

In accordance with international human rights standards, the mechanism must:

- be compelled to take up the case in a ***timely fashion and issue a rapid decision***, due to the time-sensitive nature of reproductive healthcare.¹⁵⁰
- protect women and girls' ***physical and mental health***,¹⁵¹
- take into account their ***opinion***;¹⁵²
- and provide a ***well-founded, written decision***.¹⁵³

The mechanism should further guarantee the patients' **confidentiality** and **meaningful participation** and should consist of **independent decision-makers** who do not face the threat of backlash or criminal charges for authorizing reproductive healthcare services. Furthermore, there must be a right to **appeal** the decision.¹⁵⁴ The European Court of Human Rights has noted in the context of reproductive health services that procedures which only review decisions about whether an individual has the right to access such services *post factum* do not fulfill human rights standards and can amount to a failure of the state to comply with its positive obligations in ensuring the right to respect for private and family life.¹⁵⁵

Furthermore, any health care provider who denies an adolescent sexual or reproductive health services, should be **required to do so in writing** and to provide information about how the minor can seek review of the denial and appeal the result of the review. To the extent possible, health clinics should have staff members who are specifically charged with assisting adolescents and who can explain these processes to them in an understandable manner.

Alternative Redress Mechanisms

Furthermore, the Convention on the Rights of the Child mandates that states must develop alternative mechanisms in the context of juvenile justice, such as mediation and community-based programs.¹⁵⁶ Similarly, states should put in place alternative, child-friendly mechanisms for children seeking redress for human rights violations, in order to supplement their ability to access effective remedies through the judiciary. In accordance with the CRC, states should establish national human rights institutions (NHRIs) and ombudspersons for children, “with the authority to receive individual complaints submitted by or on behalf of children, carry out investigations, and secure effective remedies for breaches of children’s rights.”¹⁵⁷ NHRIs tend to be more accessible than the judiciary, as their complaints mechanisms are generally free of charge, are less formal and easier to use, and do not require a lawyer.¹⁵⁸ In addition to providing a mechanisms to lodge complaints, NHRIs can also disseminate information and raise awareness about children’s rights and empower children.¹⁵⁹ Yet, to be effective, they “require adequate resources, institutional cooperation with other actors... independence in the performance of their mandate” and the trust of young people.¹⁶⁰ OHCHR also recognizes that group litigation, also known as combined cases or class action, can enable minors and their representatives to challenge widespread or systematic violations of children’s rights, particularly where identifying an individual petitioner may be difficult or problematic.¹⁶¹

*KL's Story*¹

At age 17, KL learned that she was pregnant with an anencephalic fetus – meaning that the fetus was developing without parts of its brain or skull and had no chance of survival after birth.

Upon the advice of her doctor, who recognized that the pregnancy was also posing a risk to KL's life, KL decided to terminate the pregnancy. Despite Peru's law permitting abortion where pregnancy poses a risk to the woman's life or health, the hospital staff refused to administer her abortion services. Although KL successfully obtained the support of a social worker and a psychiatrist, who certified that being compelled to continue the pregnancy was significantly harming KL's mental health, Ministry of Health medical staff refused to intervene. After giving birth, KL was forced to breastfeed over the course of the four days her baby survived, ultimately leaving KL in a deep state of depression. KL was ultimately unable to access effective recourse in the Peruvian legal system due to the lack of administrative and judicial remedies which would function rapidly enough to enable her to assert her right to termination in a timely manner. Without any domestic recourse, KL brought her case before UN Human Rights Committee, which found that Peru violated her right to private life, by arbitrarily intervening in her decision to terminate a pregnancy, and her right to be free from cruel, inhuman and degrading treatment, by exposing her to mental suffering by failing to provide her abortion services.² Finally, the Human Rights Committee found that the state failed to afford KL special protections based on her status as a minor, as she did not receive the necessary medical and psychological support that was required during and following her pregnancy.³



Endnotes

- 1 See UNITED NATIONS POPULATION FUND (UNFPA), MOTHERHOOD IN CHILDHOOD: FACING THE CHALLENGE OF ADOLESCENT PREGNANCY 37 (2013) [hereinafter UNFPA, MOTHERHOOD IN CHILDHOOD].
- 2 *Id.*, at 1.
- 3 *Id.*, at v.
- 4 See Committee on the Elimination of Discrimination Against Women (CEDAW Committee), *General Recommendation No. 21: Equality in marriage and family relations*, (13th Sess., 1994), para. 21, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008); CEDAW Committee, *General Recommendation No. 23, Political and Public Life* (16 Sess., 1997), para. 10, U.N. Doc. HRI/GEN/1/Rev.6 (2003).
- 5 See CENTER FOR REPRODUCTIVE RIGHTS, FORCED OUT: MANDATORY PREGNANCY TESTING AND THE EXPULSION OF PREGNANT STUDENTS IN TANZANIAN SCHOOLS 25-26 (2013), available at http://reproductiverights.org/sites/crr.civicactions.net/files/documents/crr_Tanzania_Report_Part1.pdf.
- 6 UNFPA, MOTHERHOOD IN CHILDHOOD, *supra* note 1, at 26-28.
- 7 See Changu Mannathoko & Heather Milkiewicz, EMPOWERING ADOLESCENT GIRLS THROUGH EDUCATION ELIMINATING EXCLUSION AND DISCRIMINATION 8 (2012) (noting that “Direct costs of schooling (for instance: school fees, exam fees, uniforms, books and stationary supplies) diminish opportunities for children to access and/or remain in school. This contributes to the high number of girls being pushed out of school, especially in favor of boys for whom education is accorded higher priority in many societies. Indirect costs (such as the opportunity cost in terms of lost income or household labor from girls) further diminish girls’ participation in education.”), available at www.worldwewant2015.org/file/290405/download/31481; INTERNATIONAL LABOUR OFFICE, GENDER EQUALITY AT THE HEART OF DECENT WORK 61-65 (2009), available at http://www.ilo.org/wcmsp5/groups/public/@ed_norm/@relconf/documents/meetingdocument/wcms_105119.pdf.
- 8 See UNFPA, MOTHERHOOD IN CHILDHOOD, *supra* note 1, at iv.
- 9 UNFPA, MARRYING TOO YOUNG: END CHILD MARRIAGE 11 (2012) [hereinafter UNFPA, MARRYING TOO YOUNG].
- 10 See UNFPA, MOTHERHOOD IN CHILDHOOD, *supra* note 1, at iv.
- 11 CENTER FOR REPRODUCTIVE RIGHTS, CHILD MARRIAGE IN SOUTH ASIA: INTERNATIONAL AND CONSTITUTIONAL LEGAL STANDARDS AND JURISPRUDENCE FOR PROMOTING ACCOUNTABILITY AND CHANGE 16 (2013), available at http://reproductiverights.org/sites/crr.civicactions.net/files/documents/ChildMarriage_BriefingPaper_Web.pdf.
- 12 CENTER FOR DISEASE CONTROL AND PREVENTION, TEEN PREGNANCY IN THE UNITED STATES (2016), available at <https://www.cdc.gov/teenpregnancy/about/>; Press release, World Health Organization, WHO Issues New Guidance on How to Provide Contraceptive Information and Service (Mar. 6, 2014), available at <http://www.who.int/media-centre/news/releases/2014/guidance-contraceptive/en/>.
- 13 For example, a number of countries’ abortion laws explicitly require parental authorization for minors seeking abortion services. See Ministry of Health, Order No. 50 of 28 January 1994 on Procedures for Performing a Surgical Termination of Pregnancy, annex no. 1, art. 1.6 (Lithuania) (“The written consent of one of the parents, foster parents, guardians, caregivers, or persons actually raising the child is mandatory in cases of a termination of pregnancy to be performed on a minor girl under the age of 16”); Law of Jan. 7, 1993 on Family Planning, Human Embryo Protection, and Conditions of Legal Pregnancy Termination amended as of Dec. 23, 1997, art. 4a.4 (Pol.) (“In the case of a minor or fully incapacitated woman, the written consent of her legal representative is required”); Zákon . 73/1986 Zb. o umelom prerušení tehotenstva v znení zákona . 419/1991 Zb. [Act No. 73/1986 Coll. on Artificial Termination of Pregnancy as amended by the Act No. 419/1991 Coll.] (1986), sec. 6 (1-2) (Slvk.) (“(1) In the case of a woman who has not yet reached the age of 16, artificial interruption of pregnancy in accordance with Section 4 may be performed with the consent of her legal representative or of the person who has been assigned responsibility for raising her. (2) If artificial interruption of pregnancy in accordance with Section 4 has been performed on a woman between 16 and 18 years of age, the health facility shall notify her legal representative.”); see also INTERNATIONAL PLANNED PARENTHOOD FEDERATION (IPPF), QUALITATIVE RESEARCH ON LEGAL BARRIERS TO YOUNG PEOPLE’S ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES 13 (June 2014) [hereinafter IPPF, Legal Barriers to Young People’s Access to SRH Services].
- 14 For example, Croatia’s abortion law only requires parental authorization for minors under the age of 16. Contraception, sterilization, abortion, and artificial insemination, Law No. 1252-1978 of April 21, 1978 on health measures to implement the right to a free decision regarding the birth of children (Narodne Novine, May 4, 1978, No. 18 at 423-426), Art. 18 (Croatia).
- 15 See, e.g., Ilene S. Speizer, David R. Hotchkiss, et al., *Do Service Providers in Tanzania Unnecessarily Restrict Clients’ Access to Contraceptive Methods?*, 26 GUTTMACHER INSTITUTE INTERNATIONAL FAMILY PLANNING PERSPECTIVES 16 (MAR. 2002), available at <http://www.guttmacher.org/pubs/journals/2601300.pdf>; Lisa M Calhoun, Ilene S Speizer, et al., *Provider imposed restrictions to clients’ access to family planning in urban Uttar Pradesh, India: a mixed methods study* 13 BMC HEALTH SERVICES RESEARCH 532 (2013), available at <http://www.biomedcentral.com/content/pdf/1472-6963-13-532.pdf> [hereinafter *Provider imposed restrictions to clients’ access to family planning in urban Uttar Pradesh, India: a mixed methods study*].
- 16 See Rachel K. Jones & Heather Boonstra, *Confidential Reproductive Health Services for Minors: The Potential Impact of Mandated Parental Involvement for Contraception*, GUTTMACHER INSTITUTE, 36 PERSPECTIVES ON SEXUAL AND REPRODUCTIVE HEALTH 5 (2004), available at <http://www.guttmacher.org/pubs/journals/3618204.html> [hereinafter Jones & Boonstra, *Confidential Reproductive Health Services for Minors*].
- 17 See Melanie Zuch, Amanda J Mason-Jones, Catherine Mathews, & Lesley Henley, *Changes to the law on consent in South Africa: implications for school-based adolescent sexual and reproductive health research*, BMC INTERNATIONAL HEALTH & HUMAN RIGHTS (April 10, 2012), available at <http://www.jstor.org/discover/10.2307/25593915?uid=3739832&uid=2129&uid=2&uid=70&uid=4&uid=3739256&sid=21102632486033> (noting that “discussions surrounding sexuality are often shrouded in stigma and parent-child communication with regards to sex and sexuality is often limited. An adolescent therefore may not feel comfortable confronting a parent or guardian about participation in a sexual and reproductive health research study or may face disapproval if he or she chooses to do so”); see also Derek A. Kreager and Jeremy Staff, *The Sexual Double Standard and Adolescent Peer Acceptance*, 72 SOCIAL PSYCHOLOGY QUARTERLY 2, 143 (2009), available at <http://spq.sagepub.com/content/72/2/143.abstract> (exploring the “sexual double standard” wherein boys are praised while girls are stigmatized for engaging in sexual activity).
- 18 See Martin Donohoe, *Parental Notification and Consent Laws for Teen Abortions: Overview and 2006 Ballot Measures*, MEDSCAPE (Feb. 9, 2007), available at <http://www.medscape.com/viewarticle/549316> (noting that a significant portion of minors not revealing their abortion to a parent had experienced or feared violence or feared being forced to leave home).
- 19 Judicial authorization requirements can also appear as a requirement imposed on both adults and minors to access abortion services where restrictive abortion laws are in place.
- 20 IPPF, LEGAL BARRIERS TO YOUNG PEOPLE’S ACCESS TO SRH SERVICES, *supra* note 13, at 13.
- 21 In re Petition of Anonymous 5, a minor, 838 N.W.2d 226 (Neb. 2013), No. S-13-510009, 28 Neb. 642-643, Nebraska Supreme Court, Oct. 4.
- 22 *Id.*, at 649.
- 23 See UNFPA, MOTHERHOOD IN CHILDHOOD, *supra* note 1, at 37.
- 24 See Jones & Boonstra, *Confidential Reproductive Health Services for Minors*, *supra* note 16; WORLD HEALTH ORGANIZATION (WHO), SAFE

- ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS 95 (2d ed. 2012).
- 25 ADVOCATES FOR YOUTH, BEST PRACTICES FOR YOUTH FRIENDLY CLINICAL SERVICES, *available at* <http://www.advocatesforyouth.org/publications/publications-a-z/1347--best-practices-for-youth-friendly-clinical-services>.
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 - 27 Australian Human Rights Commission, Surgery on Intersex Infants and Human Rights (2009), *available at* <https://www.humanrights.gov.au/surgery-intersex-infants-and-human-rights-2009>.
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 - 53 CRC Committee, *Gen. Comment No. 20, supra* note 28, para. 39.
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 - 55 CRC Committee, *Gen. Comment No. 20, supra* note 28, para. 31.
 - 56 *See* CRC Committee, *Gen. Comment No. 15, supra* note 35, para. 70 (urging states to guarantee access to a broad range of contraceptive options); Committee on the Elimination of Discrimination against Women, *Concluding Observations: Cyprus*, para. 30(b), U.N. Doc. CEDAW/C/CYP/CO/6-7 (2013) (urging the state

- to guarantee women and girls a comprehensive range of contraceptive methods).
- 57 See CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 45, para. 28; UNFPA, *ENGAGING MEN AND BOYS: A BRIEF SUMMARY OF UNFPA EXPERIENCE AND LESSONS LEARNED* (January 2013).
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- 59 These considerations were devised to be specific to adolescents seeking sexual and reproductive health services and the particular barriers and risks they face. They are drawn from broader principles on human rights and medical practice.
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- 64 *Id.*
- 65 CRC Committee, *Gen. Comment No. 3*, para. 11.
- 66 *Id.*
- 67 See, e.g., Human Rights Committee, *Concluding Observations: Peru*, para. 14, U.N. Doc. CCPR/C/PER/CO/5 (2013).
- 68 CRC Committee, *Gen. Comment No. 15*, *supra* note 35, para. 56.
- 69 UNFPA, *MOTHERHOOD IN CHILDHOOD*, at 26-28.
- 70 For example, the effects of uterine prolapse and obstetric fistula can last throughout girls' entire lives.
- 71 See CRC Committee, *Gen. Comment No. 15*, *supra* note 35, paras. 8-9.
- 72 CRC Committee, *General Comment No. 4: Adolescent health and development in the context of the Convention on the Rights of the Child*, (33rd Sess., 2003), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, para. 6, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CRC Committee, *Gen. Comment No. 4*].
- 73 CRC Committee, *Gen. Comment No. 5*, *supra* note 63, para. 12.
- 74 CRC Committee, *Concluding Observations: Namibia*, para. 57(a), U.N. Doc. CRC/C/NAM/CO/2-3 (2012); ("The State party's punitive abortion law and various social and legal challenges, including long delays in accessing abortion services within the ambit of the current laws for pregnant girls. In this regard, the Committee notes with concern that such a restrictive abortion law has led adolescents to abandon their infants or terminate pregnancies under illegal and unsafe conditions, putting their lives and health at risk, which violates their rights to life, to freedom from discrimination, and to health").
- 75 *L.C. v. Peru*, CEDAW Committee, Commc'n No. 22/2009, para. 8.15, U.N. Doc. CEDAW/C/50/D/22/2009 (2011) [hereinafter *L.C. v. Peru*].
- 76 See *Convention on the Rights of the Child*, *supra* note 61, art. 12 ("States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law"); see also Committee Against Torture (CAT Committee), *Concluding Observations: Greece*, para. 6(m), U.N. Doc. CAT/C/CR/33/2 (2004) ("All decisions affecting children should, to the extent possible, be taken with due consideration for their views and concerns, with a view to finding an optimal, workable solution"); Special Rapporteur on the sale of children, child prostitution and child pornography, *Rep. of the Special Rapporteur on the sale of children, child prostitution and child pornography, Najat M'jid Maalla – Addendum – Mission to Latvia*, para. 84(c), U.N. Doc. A/HRC/12/23/Add.1 (2009) ("The participation of children should be strengthened on all issues concerning them, and their views should be given due weight").
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- 86 *Convention on the Rights of the Child*, *supra* note 61, art. 19(1).
- 87 CRC Committee, *General Comment No. 13: The right of the child to freedom from all forms of violence*, 56th Sess., para. 4, U.N. Doc. CRC/C/GC/13 (2011) [hereinafter CRC Committee, *Gen. Comment No. 13*].
- 88 *Id.* para. 20.
- 89 *Id.* para. 20(c).
- 90 *Id.* para. 22(a).
- 91 *K.L. v. Peru*, Human Rights Committee, Commc'n No. 1153/2003, U.N. Doc. CCPR/C/85/D/1153/2003 (2005) [hereinafter *K.L. v. Peru*].
- 92 *P. and S. v. Poland*, No 57375/08, Eur. Ct. H. R. (2008) [hereinafter

- P. and S. v. Poland].
- 93 See WHO, WORLD REPORT ON VIOLENCE AND HEALTH: SEXUAL VIOLENCE 149 (2002), available at http://www.who.int/violence_injury_prevention/violence/global_campaign/en/chap6.pdf.
- 94 See, e.g., CRC Committee, *Concluding Observations: Argentina*, para. 59, U.N. Doc. CRC/C/ARG/CO/3-4 (2010); CAT Committee, *Concluding Observations: Peru*, para. 15, U.N. Doc. CAT/C/PER/CO/6 (2012).
- 95 See, e.g., CRC Committee, *Concluding Observations: Cape Verde*, para. 40(e), U.N. Doc. CRC/C/15/Add.168 (2001); CAT Committee, *Concluding Observations: Kenya*, para. 28, U.N. Doc. CAT/C/KEN/CO/2 (2013).
- 96 CAT Committee, *Concluding Observations: Kenya*, para. 28, U.N. Doc. CAT/C/KEN/CO/2 (2013).
- 97 WHO, *Adolescent Pregnancy*, Factsheet No. 364 (Sept. 2014), <http://www.who.int/mediacentre/factsheets/fs364/en/>.
- 98 CAT Committee, *Concluding Observation: Sierra Leone*, para. 17, U.N. Doc. CAT/C/SLE/CO/1 (2014); see also *El Salvador*, para. 23, U.N. Doc. CAT/C/SLV/CO/2 (2009); *Peru*, para. 23, U.N. Doc. CAT/C/PER/CO/4 (2006).
- 99 ICCPR, Art. 24(1); ICESCR, Art. 10(3); CRC, GC 4, para. 1.
- 100 Convention on the Rights of the Child, *supra* note 61, art. 19(1).
- 101 CRC Committee, *Gen. Comment No. 4*, *supra* note 72, para. 12.
- 102 CRC Committee, *Gen. Comment No. 13*, *supra* note 87, para. 13.
- 103 K.L. v. Peru, *supra* note 91, para. 6.5.
- 104 L.C. v. Peru *supra* note 75, para. 8.15.
- 105 P. and S. v. Poland, *supra* note 92, para. 161.
- 106 *Id.*, para. 162.
- 107 CRC Committee, *Gen. Comment No. 12*, *supra* note 77, para. 101.
- 108 CRC Committee, *Gen. Comment No. 13*, *supra* note 87, para. 34.
- 109 *Id.*, para. 42(b).
- 110 *Id.*, para. 44.
- 111 CRC Committee, *General Comment No. 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration (art. 3, para.1)*, 62nd Sess., para. 4(d)(i), U.N. Doc. CRC/C/GC/14 (2013) [hereinafter CRC Committee, *Gen. Comment No. 14*].
- 112 *Id.*, para. 4(d)(ii).
- 113 See, e.g., CRC Committee, *Gen. Comment No. 15*, *supra* note 35, para. 52; CEDAW Committee, *Concluding Observations: Vanuatu*, paras. 35, 55, U.N. Doc. CEDAW/C/VUT/CO/3 (2007).
- 114 SR Health, *Report on the health of adolescents* (2016), *supra* note 44, para. 30.
- 115 SAVE THE CHILDREN AND UNFPA, ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH TOOLKIT FOR HUMANITARIAN SETTINGS 75-76, available at http://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_ASRHtoolkit_english.pdf [hereinafter ADOLESCENT TOOLKIT]; see also WHO, QUALITY ASSESSMENT GUIDEBOOK: A GUIDE TO ASSESSING HEALTH SERVICES FOR ADOLESCENT CLIENTS 2-3 (2009), available at http://whqlibdoc.who.int/publications/2009/9789241598859_eng.pdf [hereinafter WHO QUALITY ASSESSMENT GUIDEBOOK].
- 116 WHO QUALITY ASSESSMENT GUIDEBOOK, *supra* note 115, at 2.
- 117 *Id.*
- 118 CEDAW Committee, *Concluding Observations: Georgia*, paras. 30-31, U.N. Doc. CEDAW/C/GEO/CO/4-5 (2014).
- 119 WHO QUALITY ASSESSMENT GUIDEBOOK, *supra* note 115, at 3.
- 120 ADOLESCENT TOOLKIT, *supra* note 115, at 76; CRC Committee, *Gen. Comment No. 15*, *supra* note 35, para. 52.
- 121 WHO EUROPE, YOUTH-FRIENDLY HEALTH POLICIES AND SERVICES IN THE EUROPEAN REGION 24 (2010), available at http://www.euro.who.int/_data/assets/pdf_file/0017/123128/E94322.pdf.
- 122 ADOLESCENT TOOLKIT, *supra* note 115, at 18.
- 123 CRC Committee, *Gen. Comment No. 5*, *supra* note 63, para. 24.
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- 125 OHCHR, *Access to Justice for Children*, *supra* note 138, para. 14.
- 126 *Id.*, para. 14.
- 127 *Id.*, para. 16.
- 128 *Id.*, para. 15.
- 129 *Id.*, para. 15.
- 130 *Id.*, para. 15.
- 131 *Id.*, para. 17.
- 132 See Office of the High Commissioner for Human Rights (OHCHR), *Report of the United Nations High Commissioner for Human Rights, Access to Justice for Children*, para. 10, UN Doc. A/HRC/25/35 (2013) (citing HRC, GC 31, para. 15) [hereinafter OHCHR, *Access to Justice for Children*]; Human Rights Committee, *General Comment No. 31: The Nature of the General Legal Obligation Imposed on State Parties to the Covenant*, (44th Sess., 1992), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, at 243, para. 15, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008); CRC Committee, *Gen. Comment No. 5*, *supra* note 63, para. 24; Special Representative of the Secretary-General (SRSG) on Violence against Children, *Safe and child-sensitive counseling, complaint and reporting mechanisms to address violence against children* (2012) [hereinafter SRSG report on violence against children].
- 133 CRC Committee, *Gen. Comment No. 5*, *supra* note 63, para. 24.
- 134 *Id.*
- 135 *Id.*
- 136 OHCHR, *Access to Justice for Children*, *supra* note 132, para. 10.
- 137 *Id.*, para. 8.
- 138 See *id.*, para. 9 (noting that states must “ensure that their domestic legal framework is consistent with the rights and obligations provided [under human rights treaties], including the adoption of appropriate and effective legislative and administrative procedures and other appropriate measures that provide fair, effective and prompt access to justice.”).
- 139 SRSG report on violence against children, *supra* note 132, at 11.
- 140 OHCHR, *Access to Justice for Children*, *supra* note 132, para. 19 (citing SRSG report on violence against children, *supra* note 132, at 7).
- 141 See *id.*, para. 21.
- 142 CRC Committee, *Gen. Comment No. 5*, *supra* note 63, para. 25.
- 143 OHCHR, *Access to Justice for Children*, *supra* note 132, para. 52 (citing Committee on the Rights of the Child, *General Comment No. 5*, para. 12).
- 144 *Id.*, para. 40.
- 145 *Id.*, para. 41.
- 146 See L.C. v. Peru, *supra* note 75, paras. 8.17, 12(b)(i); Tysiac v. Poland, No 5410/03, Eur. Ct. H. R., para. 118 (2007); see also SR Health, *Report on the health of adolescents* (2016), *supra* note 44, para. 66.
- 147 See CRC Committee, *Gen. Comment No. 15*, *supra* note 35, para. 76.
- 148 *Id.*, para. 27.
- 149 See P. and S. v. Poland, *supra* note 92, para. 99; L.C. v. Peru, *supra* note 75, para. 8.17.
- 150 L.C. v. Peru, *supra* note 75, para. 8.17 (“It is essential for this legal framework to include a mechanism for rapid decision-making, with a view to limiting to the extent possible risks to the health of the pregnant mother, that her opinion be taken into account, that the decision be well-founded and that there is a right to appeal.”).

- 151 *Id.*, para. 9(b)(i).
- 152 *Id.* para. 8.17.
- 153 *Id.* para. 8.17; *see also* Tysi c v. Poland, No. 5410/03 Eur. Ct. H.R., para. 117 (2007) (“In such circumstances such as those in issue in the instant case such a procedure should guarantee a pregnant woman at least a possibility to be heard in person and to have her views considered. The competent body should also issue written grounds for its decision.”).
- 154 *L.C.*, No. 22/2009, para. 8.17.
- 155 *Tysi c*, para. 118 (“...the very nature of the issues involved in decisions to terminate a pregnancy is such that the time factor is of critical importance. The procedures in place should therefore ensure that such decisions are timely so as to limit or prevent damage to a woman’s health which might be occasioned by a late abortion. Procedures in which decisions concerning the availability of lawful abortion are reviewed *post factum* cannot fulfill such a function. In the Court’s view, the absence of such preventive procedures in the domestic law can be said to amount to the failure of the State to comply with its positive obligations under Article 8 of the Convention.”).
- 156 *See* Convention on the Rights of the Child, *supra* note 61, art. 40; OHCHR, *Access to Justice for Children*, *supra* note 132, para. 23.
- 157 OHCHR, *Access to Justice for Children*, *supra* note 132, para. 25 (citing CRC Committee, *General Comment No. 2*, para. 13).
- 158 *Id.*, para. 25.
- 159 *Id.*, para. 25.
- 160 *Id.*, para. 25.
- 161 *Id.*, para. 25.

Endnotes for Boxes

P’s Story¹

- 1 P. and S. v. Poland, No 57375/08, Eur. Ct. H. R. (2008).
- 2 *Id.*, para. 166.
- 3 *Id.*, para. 109.

Younger Adolescents

- 1 UNITED NATIONS POPULATION FUND (UNFPA), MOTHERHOOD IN CHILDHOOD: FACING THE CHALLENGE OF ADOLESCENT PREGNANCY 24 (2013).

Provider-Imposed Restrictions on Sexual and Reproductive Health Services

- 1 *See, e.g.*, Ilene S. Speizer, David R. Hotchkiss, et al., *Do Service Providers in Tanzania Unnecessarily Restrict Clients’ Access to Contraceptive Methods?*, 26 GUTTMACHER INSTITUTE INTERNATIONAL FAMILY PLANNING PERSPECTIVES 16 (MAR. 2002), available at <http://www.guttmacher.org/pubs/journals/2601300.pdf>; Lisa M Calhoun, Ilene S Speizer, et al., *Provider imposed restrictions to clients’ access to family planning in urban Uttar Pradesh, India: a mixed methods study* 13 BMC HEALTH SERVICES RESEARCH 532 (2013), available at <http://www.biomedcentral.com/content/pdf/1472-6963-13-532.pdf> [hereinafter *Provider imposed restrictions to clients’ access to family planning in urban Uttar Pradesh, India: a mixed methods study*].
- 2 Nina Ehrle & Malabika Sarke, *Emergency Contraceptive Pills: Knowledge and Attitudes Of Pharmacy Personnel in Managua, Nicaragua*, 37 GUTTMACHER INSTITUTE INTERNATIONAL FAMILY PLANNING PERSPECTIVES 2, 70 (2011), available at [HTTP://WWW.GUTTMACHER.ORG/PUBS/JOURNALS/3706711.PDF](http://www.guttmacher.org/pubs/journals/3706711.pdf).

LC’s Story¹

- 1 *L.C. v. Peru*, CEDAW Committee, Commc’n No. 22/2009, U.N. Doc. CEDAW/C/50/D/22/2009 (2011).

The Right to Confidentiality and Mandatory Reporting Requirements

- 1 CRC Committee, *General Comment No. 4: Adolescent health and development in the context of the Convention on the Rights of the Child*, (33rd Sess., 2003), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, para. 11, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CRC Committee, *Gen. Comment No. 4*] (indicating that adolescents’ medical information “may only be disclosed with the consent of the adolescent, or in the same situations applying to the violation of an adult’s confidentiality.”); CEDAW Committee, *General Recommendation No. 24: Article 12 of the Convention (women and health)*, (20th Sess., 1999), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, at 358, para. 12(d), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CEDAW Committee, *Gen. Recommendation No. 24*]; P. and S. v. Poland, No 57375/08, Eur. Ct. H. R., para. 128 (2008) [hereinafter P. and S. v. Poland]; *See* Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The right to the highest attainable standard of health (Art. 12)*, (22nd Sess., 2000), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, at 78, para. 23, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) (“The realization of the right to health of adolescents is dependent on the development of youth-friendly health care, which respects confidentiality and privacy and includes appropriate sexual and reproductive health services.”).
- 2 CRC Committee, *Gen. Comment No. 4*, para. 11.
- 3 CEDAW Committee, *Gen. Recommendation No. 24*, para. 12(d).
- 4 P. and S. v. Poland, para. 134.
- 5 *Id.*, para. 128.
- 6 For example, the CRC has urged states to require all professionals, including health professionals, working with minors to report instances, suspicion, or risk of violence and sexual exploitation. *See* CRC Committee, *Concluding Observations: Benin*, para. 47(b), U.N. Doc. CRC/C/BEN/CO/2 (2006); *Denmark*, para. 24(a), U.N. Doc. CRC/C/OPSC/DNK/CO/1 (2006); CRC Committee, *General Comment No. 13: The right of the child to freedom from all forms of violence*, 56th Sess., para. 50, U.N. Doc. CRC/C/GC/13 (2011).
- 7 *See* Patricia Donovan, *Caught Between Teens and the Law: Family Planning Programs And Statutory Rape Reporting*, 1 GUTTMACHER INSTITUTE 2, 5 (1998), available at <https://www.guttmacher.org/gpr/1998/06/caught-between-teens-and-law-family-planning-programs-and-statutory-rape-reporting>; BREAK THE CYCLE, BALANCING OBLIGATIONS: SERVING TEEN VICTIMS AND MANDATED REPORTING OF STATUTORY RAPE (2008), available at <http://www.breakthecycle.org/sites/default/files/pdf/ta-issue-brief-08-08.pdf>.
- 8 *See* The Protection of Children from Sexual Offences Act, No. 32 of 2012, art. 2(d), INDIA CODE (2012) (defining a child as anyone under the age of 18, without any exceptions for consensual sexual conduct).
- 9 CRC Committee, *General Comment No. 20 on the implementation of the rights of the child during adolescence*, para. 40, U.N. Doc. CRC/C/GC/20 (Dec. 2016).

Rahema’s Story¹

- 1 CENTER FOR REPRODUCTIVE RIGHTS, FORCED OUT: MANDATORY PREGNANCY TESTING AND THE EXPULSION OF PREGNANT STUDENTS IN TANZANIAN SCHOOLS (2013), available at http://reproductiverights.org/sites/crr.civicactions.net/files/documents/crr_Tanzania_Report_Part1.pdf.

Comprehensive Sexuality Education

- 1 CRC Committee, *General Comment No. 20 on the implementation of the rights of the child during adolescence*, para. 61, U.N. Doc. CRC/C/GC/20 (Dec. 2016).
- 2 *Id.*

- 3 *Id.*
- 4 *Id.*
- 5 See INTERRIGHTS v. Croatia, No. 45/2007 European Committee of Social Rights (2009).
- 6 UNITED NATIONS EDUCATIONAL, SCIENTIFIC AND CULTURAL ORGANIZATION (UNESCO), INTERNATIONAL TECHNICAL GUIDANCE ON SEXUALITY EDUCATION (2009).

KL's Story¹

- 1 K.L. v. Peru, Human Rights Committee, Commc'n No. 1153/2003, U.N. Doc. CCPR/C/85/D/1153/2003 (2005)
- 2 *Id.*, paras. 6.4-6.5.
- 3 *Id.*, para. 6.5.

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