CENTER FOR REPRODUCTIVE RIGHTS

September 28, 2012

Hon. Navanethem Pillay
United Nations High Commissioner for Human Rights
Palais des Nations
1211 Geneva 10, Switzerland

Re: Response to Call for Submissions for OHCHR Study on Children's Right to Health

The Center for Reproductive Rights (the Center) appreciates the opportunity to provide this submission to the Office of High Commissioner for Human Rights to inform the upcoming report on children's right to the enjoyment of the highest attainable standard of health. The Center, an independent nongovernmental organization based in New York, with regional offices in Africa, Asia, and Latin America, uses the law to advance reproductive freedom as a fundamental human right.

In accordance with international human rights standards, everyone, including children and adolescents, has the right to the enjoyment of the highest attainable standard of physical and mental health,[1] including "the right to control one's health and body, including sexual and reproductive freedom."[2] Under international human rights law, in order to effectuate children and adolescents' right to health, States are obligated to establish and implement laws and policies that guarantee access to comprehensive and appropriate sexual and reproductive health services.[3] Adolescents' right to health "is dependent on the development of youth-friendly health care, which respects confidentiality and privacy…"[4] and the full realization of this right requires "removal of all barriers interfering with the access to health services, education and information, including in the area of sexual and reproductive health."[5] A comprehensive understanding of sexual and reproductive health is essential for adolescents to make informed decisions. As such, under international human rights law, adolescents must have access to confidential and non-discriminatory sexual and reproductive health education, information and services.[6] Such information and services are also crucial to reducing and preventing unwanted pregnancies, unsafe abortions,[7] maternal mortality,[8] and the transmission of sexually transmitted infections and HIV/AIDS.[9]

In this submission, the Center will highlight the following issues regarding the sexual and reproductive rights of children and adolescents: barriers to accessing sexual and reproductive health services, mandatory and coercive pregnancy testing of school girls and expulsion of pregnant school girls, sexual violence against adolescents, and child marriage.

I. Adolescents as a particularly vulnerable group

Despite the aforementioned affirmative State obligations, there are large gaps in access to reproductive health services for adolescents. Although adolescent girls account for one-fifth of all women of reproductive age, they have been widely underserved by reproductive health services worldwide.[10] Every year, approximately 16 million adolescent girls between the ages of 15 and 19 give birth,[11] with harmful results for their health; complications from pregnancy and childbirth are the leading causes of death for 15 to 19-year-old girls in the developing world.[12] In South Central and South East Asia and in sub-Saharan Africa, the unmet need for contraceptives

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among adolescents who are sexually active but want to delay pregnancy is 68 percent.[13] In part due to this unmet need for contraceptives, nearly half of the deaths resulting from unsafe abortion worldwide occur among women and adolescents below the age of 25.[14]

In addition to services, adolescents also face various challenges in accessing sexual and reproductive health information. In many societies, lack of evidence-based sexuality education hinders the ability of adolescents to make informed decisions about the use of contraceptives, which may lead to high incidences of unintended pregnancy[15] and abortion.[16] Stigma associated with adolescent sexuality may also deter them from seeking such services or may result in denial of services by providers.[17] The cost of services and distance of health facilities can also be an obstacle, as adolescents frequently do not have their own source of income.[18]

International human rights norms dictate that States should "develop and implement programmes that provide access to sexual and reproductive health services, including family planning, contraception and safe abortion services where abortion is not against the law…"[19] Reproductive health services must be available, accessible, accessible and of good quality; as such, services must be economically, physically and socially accessible to all adolescents, and must be scientifically and medically appropriate.[20] Furthermore, States must "ensure that adolescents have access to the information that is essential for their health and development,"[21] without requiring parental consent.[22] The numerous barriers adolescents face in accessing quality, comprehensive reproductive health services compound and reinforce one another, exacerbating their impact and hindering adolescents from enjoying the highest attainable standard of health. As a result, adolescents constitute a particularly vulnerable group in regards to reproductive health services and States must take targeted measures to ensure that their human rights are respected, protected and fulfilled.

II. Adolescents' access to reproductive health services: select issues

Further exacerbating the barriers that adolescents face in accessing reproductive health services, access to contraceptives and abortion are frequently restricted by laws specifically targeting adolescents.[23] Two such policies are requirements for a prescription for emergency contraception (EC) and for parental consent for abortion. Such restrictions may make adolescents reluctant or unable to access these services and may result in adolescents foregoing EC following unprotected sex or in adolescents turning to unsafe abortion to terminate an unwanted pregnancy.

In a number of States, a prescription is required for EC for adolescents, constituting a barrier to their access to EC. In the United States, for example, levonorgestrel-based emergency contraceptives – which are the most common[24] – are only available to women under 17 with a prescription, while women age 17 and older are not required to have a prescription.[25] These requirements are particularly perilous due to the time-sensitivity of EC – it must be taken within five days of intercourse and is more effective the sooner after intercourse it is taken.[26] Furthermore, emergency contraception is included in the World Health Organization's Model List of Essential Medicines,[27] indicating that the World Health Organization (WHO) considers it a requirement for basic health care systems.[28] There is no medical evidence to justify this restriction, as WHO considers EC to be a safe, convenient and effective means of contraception,[29] which can be self-administered with low risk of abuse and overdose.[30] For

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adolescents, the prescription requirement creates a heavy burden, as adolescents are less likely to have access to reliable transportation and be able to afford a doctor's visit.[31]

Laws requiring parental consent for abortion are also particularly harmful to adolescents. Adolescents who are unable to legally terminate unwanted pregnancies without the consent of a parent or guardian may choose to delay abortion, which can increase the risk and costs of the procedure,[32] or may seek illegal and unsafe abortion services.[33] Parental consent requirements may put some adolescents at risk of physical danger at the hands of their parents.[34] Adolescents also may fear telling their parents because they might be forced to carry the pregnancy to term.[35] Given that unsafe abortion is a leading cause of maternal mortality and morbidity,[36] the "[d]enial of services or of confidentiality may be a matter literally of an adolescent girl's death, or severe and enduring injury."[37] Under international human rights norms, "the obligation to respect rights requires States parties to refrain from obstructing action taken by women in pursuit of their health goals…States parties should not restrict women's access to health services or to the clinics that provide those services on the ground that women do not have the authorization of husbands, partners, parents or health authorities."[38] Under these norms, references to "women" include girls and adolescents.[39] Barriers such as parental consent requirements and prescription requirements constitute an obstruction to adolescents' access to comprehensive reproductive health care.

III. Mandatory pregnancy testing of school girls and expulsion of pregnant girls from school

International human rights norms recognize that "[e]ducation has a vital role in empowering women, safeguarding children from exploitative and hazardous labour and sexual exploitation, [and] promoting human rights…"[40] States must make education "accessible to all, especially the most vulnerable groups, in law and fact, without discrimination on any of the prohibited grounds,"[41] including de facto discrimination.[42] Despite these requirements, however, a number of States have passed laws and policies which permit or mandate pregnancy testing for school children and expulsion of pregnant girls from school,[43] thereby restricting their access to education and subjecting them to stigma and discrimination.

In Kenya, for example, the 2009 National School Health Policy imposes "voluntary" pregnancy tests on female students once per term, as a way of addressing teenage pregnancy.[44] However, condoning voluntary testing may be seen as an endorsement of mandatory pregnancy testing.[45] Furthermore, lack of clarity among implementers as to the "voluntary" nature of the testing leads to violations of the rights of adolescent girls. For example, one Health Ministry official in Kenya said it would be evident that the girls who do not volunteer are most likely pregnant,[46] which exposes them to stigma and discrimination. Another Ministry of Education official suggested that the test is not voluntary for school girls, but rather that the school administrators have discretion to test girls upon "suspicion" of being pregnant.[47]

Exacerbating the stigma associated with mandatory pregnancy testing, girls are often expelled from school if it is discovered that they are pregnant.[48] This practice interferes with their education and commonly terminates their education entirely, as they are frequently not permitted to return to school.[49] Lack of education minimizes their economic prospects, and girls with little or no education or training are more likely to enter into high-risk practices, including sex trafficking and sex work, and are more likely to be abused or exploited.[50] The practice also

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perpetuates the stigma of teenage pregnancy and the idea that the presence of pregnant schoolgirls will corrupt "innocent girls" and cause a "domino effect."[51] Furthermore, this practice likely leads to greater numbers of girls seeking unsafe, clandestine abortions,[52] in order to protect themselves from shame and discrimination, and to preserve their educational futures.

To effectuate the fundamental rights to education and to be free from discrimination, States must take measures to ensure that adolescents are not coerced to undergo pregnancy testing in schools and that those who become pregnant are not expelled from school. UN treaty monitoring bodies have recommended that states "put in place measures, including monitoring mechanisms and sanctions, to ensure that pregnant students stay in and return to school during and after pregnancy,"[53] take measures to combat attitudes and stigma which may prevent girls from continuing school[54] and sanction those responsible for the expulsion of pregnant schoolgirls.[55]

IV. Sexual violence against adolescents and lack of services for victims of sexual assault

Sexual violence against women and adolescents has a devastating effect on their health and overall wellbeing. Victims of sexual abuse may suffer from various physical injuries[56] and may face a variety of psychological impacts, including rape trauma syndrome, post-traumatic stress disorder, depression, anxiety and suicidal behavior.[57] Furthermore, victims of rape face higher risk of unwanted pregnancy, unsafe abortion, and sexual transmitted infections including HIV/AIDS.[58]

Adolescents are particularly vulnerable to sexual violence, as they may face such violence both in the public and private spheres.[59] Institutions that are often regarded as nurturing, such as schools, clinics, workplaces and homes, often become venues for violence.[60] The fear of sexual violence in schools may prevent female adolescents from continuing their education, resulting in lower educational levels, fewer options for their futures and lower socioeconomic status.[61]

To address the issue of sexual violence against children and adolescents, States have an obligation under international law to take "all appropriate legislative, administrative, social and educational measures."[62] They should also put in place "social programmes to provide necessary support for the child and those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment."[63] States also must "provide appropriate health and counselling services to adolescents who have been sexually exploited,"[64] including ensuring victims' access to a full range of reproductive health services such as EC and safe abortion.

i. Access to emergency contraception

Emergency contraception is a safe and effective method for preventing unintended pregnancy,[65] and is the only method of effectively preventing pregnancy following a failed contraception method. However, a number of barriers prevent adolescents from accessing EC. Such barriers include lack of awareness of the availability of EC,[66] legislative or policy restrictions on the provision of EC,[67] and regulations requiring a doctor's prescription,[68] parental consent and minimum age requirements.[69] In accordance with WHO standards, it is critical that following a sexual assault, adolescents are offered and provided with EC in order to prevent against unwanted pregnancy.[70] See above for more information on barriers adolescents face in accessing EC.

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ii. Access to safe abortion

According to the WHO, "victims of sexual assault require comprehensive, gender sensitive health services in order to cope with the physical and mental health consequences of their experience and to aid their recovery from an extremely distressing and traumatic event."[71] The WHO specifically identifies safe abortion as one of these services.[72] However, laws, policies and attitudes of medical providers towards abortion impede adolescent's access to safe abortion worldwide. A number of States, such as Chile, Ireland, the Philippines, Tanzania, and Uganda, do not explicitly permit abortion when the pregnancy results from rape.[73] Even where abortion is legal when the pregnancy results from rape, adolescents face resistance when trying to access abortion services. In the case of *Paulina Ramirez v. Mexico*, a 13-year-old became pregnant after she was raped by an intruder at home.[74] Although abortion is legal in Mexico when the pregnancy results from rape, when Paulina sought an abortion, public officials intentionally impeded her access to an abortion, forcing her to carry the pregnancy to term.[75] The Mexican government admitted responsibility for the human rights violations that Paulina experienced as a result of the denial of access to a legal abortion.[76] As stated by the WHO, "[t]he protection of women from cruel, inhuman and degrading treatment requires that those who have become pregnant as the result of coerced or forced sexual acts can lawfully access safe abortion services."[77] A number of treaty monitoring bodies, including the Committee against Torture, the Committee on the Elimination of Discrimination against Women and the Human Rights Committee have urged States to permit abortion and guarantee its accessibility in instances of rape.[78] States must implement laws and policies in order to effectuate this right.

V. Child Marriage

Child marriage is a harmful traditional practice that has grave physical, economic, social, and psychological consequences for young girls. Despite a concerted international effort to eradicate child marriage, the practice remains prevalent in many countries. In Tanzania, about 40 percent of girls are married by the age of 18.[79] Nepal has the second highest rate of adolescent childbearing in South Asia, due in part to the prevalence of early marriage.[80] Sixty percent of women marry by age 18,[81] and 41 percent of 19-year-olds have already had a child or are pregnant.[82] The practice contributes highly to the country's high rates of maternal mortality and morbidity.[83]

Under international human rights norms, States should not give legal effect to child marriages and must specify a minimum age for marriage.[84] States should "adopt effective and appropriate measures to abolish harmful traditional practices affecting the health of children, particularly girls, including early marriage."[85] States should take "comprehensive, effective and stringent measures" aimed at eradicating child marriage and effectuating the human rights of girls.[86] The Committee on the Rights of the Child has urged States to implement legislation prohibiting early marriage,[87] and to raise the legal marriage of girls to age 18.[88]

Despite these condemnations of child marriage under international law, in circumstances in which it still occurs, husbands may be required to consent to medical services for their wives,[89] thus undermining the married girl's autonomy to make decisions about her reproductive health in a confidential setting. Contraceptive use among married youth is low,[90] as high bride prices place immense pressure on young girls to begin childbearing.[91] Young adolescent girls

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experience significantly more pregnancy-related complications than adult women; girls younger than 15 are five times more likely to die in childbirth than women in their twenties.[92] Child brides are immersed into the role of an adult at a very young age and are often seen as property paid for by their husbands. As a result, physical abuse is common, and the instability of these marriages often leads to separation or divorce, leaving a young mother, with limited or no education, to support herself and her children.[93]

The Center for Reproductive Rights hopes that the information provided within this submission assists the Office of the High Commissioner for Human Rights in its study on children's right to health.

Should the Office of the High Commission for Human Rights have any questions or require any further information on any issue raised therein, please contact Lilian Sepúlveda, Director of the Global Legal Program at the Center for Reproductive Rights, at lsepulveda@reprorights.org or at +1-917-637-3650.

Sincerely,

Lilian Sepúlveda
Director, Global Legal Program
Center for Reproductive Rights
120 Wall Street
New York, NY 10005

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[1] International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, at 49, Art. 12(1), U.N. Doc. A/6316 (1966) (*entered into force* Jan. 3, 1976).
[2] Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14*: *The right to the highest attainable standard of health*, ¶ 8, U.N. Doc. E/C.12/2000/4 (2000) [hereinafter CESCR, *General Comment No. 14*].
[3] Committee on the Elimination of Discrimination against Women (CEDAW Committee), *General Recommendation No. 24 (Article 12): Women and Health*, ¶ 29, U.N. Doc. A/54/38/Rev.1 (1999) [hereinafter CEDAW Committee, *General Recommendation No. 24*]; CESCR, *General Comment No. 14*, *supra* note 2, ¶¶ 12, 14, 21, & 22.
[4] CESCR, *General Comment No. 14*, *supra* note 2, ¶ 23.
[5] *Id.* ¶ 21.
[6] Convention on the Rights of the Child, *adopted* Nov. 20, 1989, G.A. Res. 44/25, annex, UN GAOR, 44th Sess., Supp. No. 49, Art. 24(1), U.N. Doc. A/44/49 (1989) (*entered into force* Sept. 2, 1990); CESCR, *General Comment No. 14*, *supra* note 2, ¶ 12; CEDAW Committee, *General Recommendation No. 24*, *supra* note 3, ¶ 31(e).
[7] *Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, Sept. 5-13, 1994, ¶¶ 7.44 (a), (b), 7.47, U.N. Doc. A/CONF.171/13/Rev.1 (1995) [hereinafter *ICPD Programme of Action*]; *Key Actions for Further Implementation of the Programme of Action the International Conference on Population and Development*, U.N. GAOR 21st Special Sess., June 30-July 3, 1999, ¶¶ 35(b), 73(c), (e), U.N. Doc. A/S-21/5/Add.1 (1999).
[8] *See*, e.g., CEDAW Committee, *Concluding Observations:* Nigeria, ¶¶ 33-34, U.N. Doc. CEDAW/C/NGA/CO/6 (2008); CESCR, *Concluding Observations*: Bolivia, ¶ 43, U.N. Doc. E/C.12/1/Add.60 (2001).

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[9] *ICPD Programme of Action*, *supra* note 7, ¶¶ 8.29(a), 8.31, 8.32; *See also Further Actions and Initiatives to Implement the Beijing Declaration and Platform of Action*, U.N. GAOR, ¶ 44, U.N. Doc. A/Res/S-23 (2000).
[10] *ICPD Programme of Action*, *supra* note 7, ¶ 7.41.
[11] WORLD HEALTH ORGANIZATION (WHO) AND UNITED NATION POPULATION FUND (UNFPA), PREVENTING EARLY PREGNANCY AND POOR REPRODUCTIVE OUTCOMES AMONG ADOLESCENTS IN DEVELOPING COUNTRIES: WHAT THE EVIDENCE SAYS (2012).
[12] SAVE THE CHILDREN, CHILDREN HAVING CHILDREN: STATE OF THE WORLD'S MOTHER 2004 4 (2004).
[13] GUTTMACHER AND INTERNATIONAL PLANNED PARENTHOOD FEDERATION, IN BRIEF: FACTS ON THE SEXUAL AND REPRODUCTIVE HEALTH OF ADOLESCENT WOMEN IN THE DEVELOPING WORLD 2 (2010).
[14] WHO, UNSAFE ABORTION: GLOBAL AND REGIONAL ESTIMATES OF THE INCIDENCE OF UNSAFE ABORTION AND ASSOCIATED MORTALITY IN 2003 19 (5th ed. 2007).
[15] *See* CEDAW Committee, *Concluding Observations: Bosnia and Herzegovina*, ¶ 35, U.N. Doc. CEDAW/C/BIH/CO/3 (2006).
[16] *See* CEDAW Committee, *Concluding Observations: Greece*, ¶ 207, U.N. Doc. A/54/38/Rev.1 (1999).
[17] *See* CENTER FOR REPRODUCTIVE RIGHTS, THE REPRODUCTIVE RIGHTS OF ADOLESCENTS: A TOOL FOR HEALTH AND EMPOWERMENT 8 (2008).
[18] For more information on cost as a barrier to reproductive health care for adolescents, *see* CENTER FOR REPRODUCTIVE RIGHTS, CALCULATED INJUSTICE: THE SLOVAK REPUBLIC'S FAILURE TO ENSURE ACCESS TO CONTRACEPTIVES 35 (2011). *See also* SUSHEELA SINGH ET AL., GUTTMACHER INSTITUTE & UNFPA, ADDING IT UP: THE BENEFITS OF INVESTING IN SEXUAL AND REPRODUCTIVE HEALTHCARE 12 (2009), *available at* http://www.guttmacher.org/pubs/AddingItUp2009.pdf.
[19] Committee on the Rights of the Child (CRC Committee), *General Comment No. 4*: *Adolescent health and development in the context of the Convention on the Rights of the Child*, ¶ 31, U.N. Doc. CRC/GC/2003/4 (2003).
[20] *Id.* ¶ 29.
[21] *Id.* ¶ 39(b).
[22] *Id.* ¶ 28.
[23] WHO, ADOLESCENT FRIENDLY HEALTH SERVICES: AN AGENDA FOR CHANGE 8 (2002).
[24] U.S. Pharmacist, *Emergency Contraception, An Update of Clinical and Regulatory Changes*, http://www.uspharmacist.com/continuing_education/ceviewtest/lessonid/106417/.
[25] Press release, Center for Reproductive Rights, CRR Blasts Health and Human Services Secretary's Intervention to Block FDA Approval of Plan B One-Step for Over the Counter All Ages Use (July 12, 2011), *available at* http://reproductiverights.org/en/press-room/crr-blasts-health-and-human-services-secretary%E2%80%99s-intervention-to-block-fda-approval-of-pl.
[26] WHO, EMERGENCY CONTRACEPTION, FACT SHEET N°244 (2012), *available at* http://www.who.int/mediacentre/factsheets/fs244/en/.
[27] WHO, WHO MODEL LIST OF ESSENTIAL MEDICINES 26, *available at* http://whqlibdoc.who.int/hq/2011/a95053_eng.pdf.
[28] *Id.* at Introduction.
[29] WHO, EMERGENCY CONTRACEPTION, A GUIDE FOR SERVICE DELIVERY 7 (1998).
[30] *See* Citizen's Petition, Food and Drug Administration, Department of Health and Human Services, Petition to make EC available OTC (Feb. 14, 2001) at 3. (The petition was filed by the American Public Health Association, the American Medical Women's Association, the Association of Reproductive Health Professionals, the National Asian Women's Health Organizations, the National Black Women's Health Project, the National Family Planning and Reproductive Health Association, the Planned Parenthood Federation of America, the Reproductive Health Technologies Project, and 58 other organizations, by their counsel, the Center for Reproductive Rights.). *See also* BIXBY CENTER FOR GLOBAL REPRODUCTIVE HEALTH, SHOULD EMERGENCY CONTRACEPTION BE AVAILABLE WITHOUT PRESCRIPTION?, *available at* http://bixbycenter.ucsf.edu/publications/files/ECwithoutPrescript_2008.pdf.
[31] LIZ C. CREEL AND REBECCA J. PERRY, POPULATION COUNCIL AND POPULATION REFERENCE BUREAU, IMPROVING THE QUALITY OF REPRODUCTIVE HEALTH CARE FOR YOUNG PEOPLE 4, *available at* http://www.prb.org/pdf/NewPerspQOCAdolRepro_Eng.pdf.
[32] Center for Reproductive Rights, *Parental Involvement Laws*, *http://reproductiverights.org/en/project/parental-involvement-laws* (Jan. 1, 2009).

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[33] WHO, SAFE ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS 28 (2012); Center for Reproductive Rights, *Parental Involvement Laws, http://reproductiverights.org/en/project/parental-involvement-laws* (Jan. 1, 2009).
[34] Center for Reproductive Rights, *Parental Involvement Laws, http://reproductiverights.org/en/project/parental-involvement-laws* (Jan. 1, 2009).
[35] *Id.*
[36] WHO, UNSAFE ABORTION: GLOBAL AND REGIONAL ESTIMATES OF THE INCIDENCE OF UNSAFE ABORTION AND ASSOCIATED MORTALITY IN 2008 27 (6th ed., 2011).
[37] R. Cook and B.M. Dickens, *Adolescents' 'evolving capacities' to exercise choice in reproductive healthcare,* 70 INTERNATIONAL JOURNAL OF GYNECOLOGIST AND OBSTETRIC 13, 17 (2000).
[38] CEDAW Committee, *General Recommendation No. 24, supra* note 3, ¶ 14.
[39] *Id.* ¶ 8.
[40] CESCR, *General Comment No. 13: The right to education*, ¶ 1, U.N. Doc. E/C.12/1999/10 (1999) [hereinafter CESCR, *General Comment No. 13*].
[41] *Id.* ¶ 6(b)(1).
[42] *Id.* ¶ 37.
[43] *See* CENTER FOR REPRODUCTIVE RIGHTS, SUPPLEMENTARY INFORMATION ON THE REPUBLIC OF TANZANIA SUBMITTED TO THE PRE-SESSIONAL WORKING GROUP OF COMMITTEE ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS DURING ITS 47TH SESSION, DECEMBER 2011 (2011), *available at* http://www2.ohchr.org/english/bodies/cescr/docs/ngos/CRR_TanzaniaWG47.pdf; Cynthia Vukets, *Testing School Girls for Pregnancy Not Likely to Cut Number of Teenage Mothers*, DAILY NATION, Dec. 22, 2009, *available at* http://www.nation.co.ke/News/-/1056/829400/-/view/printVersion/-/rmhek5z/-/index.html.
[44] Cynthia Vukets, *Testing School Girls for Pregnancy Not Likely to Cut Number of Teenage Mothers*, DAILY NATION, Dec. 22, 2009, *available at* http://www.nation.co.ke/News/-/1056/829400/-/view/printVersion/-/rmhek5z/-/index.html.
[45] *Id.*
[46] *Id.*
[47] *Id.* Suspicious signs include "girls sleeping in class, being choosy about food or vomiting."
[48] CENTER FOR REPRODUCTIVE RIGHTS, IN HARM'S WAY: THE IMPACT OF KENYA'S RESTRICTIVE ABORTION LAW 53 (2010).
[49] *Id.*
[50] United Nations Children's Fund (Unicef), *Millenium Development Goals, Achieve Primary Education*, http://www.unicef.org/mdg/education.html (last accessed Sept. 27, 2012); UNICEF, FACT SHEET, CHILD TRAFFICKING, *available at* http://www.unicef.org/protection/files/ipuglobaltrafficking.pdf; UNICEF, HANDBOOK ON THE OPTIONAL PROTOCOL ON THE SALE OF CHILDREN, CHILD PROSTITUTION AND CHILD PORNOGRAPHY ix (2009).
[51] Interview with high level official at the Ministry of Community Development, Gender, and Children (Jan. 13, 2011) (on file with the Center for Reproductive Rights); *see also* Interview with right to education NGO in Tanzania (Jan. 21, 2011) (on file with the Center for Reproductive Rights) (describing these attitudes as extremely widespread); Interview with teachers at private secondary school (Jan. 19, 2011) (on file with the Center for Reproductive Rights).
[52] Interview with official at the Ministry of Education and Vocational Training (Jan. 15, 2011) (on file with the Center for Reproductive Rights).
[53] CRC Committee, *Concluding Observations: Saint Lucia*, ¶ 28, U.N. Doc. CEDAW/C/LCA/CO/6 (2006).
[54] CEDAW Committee, *Concluding Observations: Kenya*, ¶ 32(a), U.N. Doc. CEDAW/C/KEN/CO/7 (2011).
[55] CRC, *Concluding Observations: Uruguay*, ¶ 58(e), U.N. Doc. CRC/C/URY/CO/2 (2007).
[56] WORLD HEALTH ORGANIZATION (WHO), GUIDELINES FOR MEDICO-LEGAL CARE FOR VICTIMS OF SEXUAL VIOLENCE 12 (2003), *available at* http://whqlibdoc.who.int/publications/2004/924154628X.pdf.
[57] *Id.* at 13-14.
[58] *Id.* at 12.
[59] CENTER FOR REPRODUCTIVE RIGHTS, THE REPRODUCTIVE RIGHTS OF ADOLESCENTS: A TOOL FOR HEALTH AND EMPOWERMENT 11 (2008).

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Tel. 917 637 3600 Fax. 917 637 3666
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[60] *See generally* CENTER FOR REPRODUCTIVE RIGHTS, REPRODUCTIVE RIGHTS IN THE INTER-AMERICAN SYSTEM FOR THE PROMOTION AND PROTECTION OF HUMAN RIGHTS, *available at* http://www.reproductiverights.org/pdf/pub_bp_rr_interamerican.pdf; HUMAN RIGHTS WATCH, SCARED AT SCHOOL: SEXUAL VIOLENCE AGAINST GIRLS IN SOUTH AFRICAN SCHOOLS (2001), *available* at http://www.hrw.org/reports/2001/safrica/.
[61] UNICEF, FACT SHEET: YOUNG PEOPLE AND FAMILY PLANNING: TEENAGE PREGNANCY (July 2008), *available at* http://www.unicef.org/malaysia/Teenage_Pregnancies_-_Overview.pdf.
[62] Convention on the Rights of the Child, *supra* note 6, Art. 19(1).
[63] *Id.* Art. 19(2).
[64] Committee on the Right of the Child, *General Comment No. 4: Adolescent health and development in the context of the Convention on the Rights of the Child*, ¶ 37, U.N. Doc. CRC/GC/2003/4 (2003).
[65] *See* WHO, EMERGENCY CONTRACEPTION: A GUIDE FOR SERVICE DELIVERY 7 (1998).
[66] ELISA WELLS & MICHELE BURNS, CONSORTIUM FOR EMERGENCY CONTRACEPTION (ICEC), EXPANDING GLOBAL ACCESS TO EMERGENCY CONTRACEPTION: A COLLABORATIVE APPROACH TO MEETING WOMEN'S NEEDS 4 (2000).
[67] *See* International Consortium for Emergency Contraception, *Policy Statement: Improving Access to Emergency Contraception* (2003).
[68] *Id.*
[69] *See, e.g.*, CEDAW Committee, *Concluding Observations: Australia*, ¶ 404, U.N. Doc. A/49/38 (1994); *see also* Committee on the Rights of the Child, *Concluding Observations: Austria*, ¶ 15, U.N. Doc. CRC/C/SR.507-509 (1999); Committee on the Rights of the Child, *Concluding Observations: Barbados*, ¶ 25, U.N. Doc. CRC/C/15/Add.103 (1999); Committee on the Rights of the Child, *Concluding Observations: Benin*, ¶ 25, U.N. Doc. CRC/C/15/Add.106 (1999).
[70] WHO, SAFE ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS 69 (2nd ed. 2012).
[71] WHO, GUIDELINE FOR MEDICO-LEGAL CARE FOR VICTIMS OF SEXUAL VIOLENCE 2 (2003).
[72] *Id.* at 63.
[73] For a complete list of countries that completely prohibit abortion or only contain exceptions to save the woman's life, refer to CENTER FOR REPRODUCTIVE RIGHTS, THE WORLD'S ABORTION LAWS MAP 2011, *available at* http://reproductiverights.org/en/document/the-worlds-abortion-laws-map-2011.
[74] Paulina del Carmen Ramirez Jacinto v. Mexico, Inter-Am. Ct. of H.R., Case 161-02, Report No. 21/07, OEA/Ser.L/V/II.130 Doc. 22, rev. 1 (2007).
[75] *Id.* ¶¶ 11-13.
[76] *Id.*
[77] WHO, SAFE ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS 92 (2nd ed. 2012).
[78] Committee Against Torture, *Concluding Observations: Nicaragua*, ¶ 16, U.N. Doc. CAT/C/NIC/CO/16 (2009); Committee Against Torture, *Concluding Observations: Paraguay*, ¶ 22, U.N. Doc. CAT/C/PRY/CO/4-6 (2011); Report of the Committee on the Elimination of Discrimination against Women, U.N. Doc. A/55/38, ¶ 181 (2000); CEDAW Committee, L.C. v. Peru, ¶ 9(b)(iii), U.N. Doc. CEDAW/C/50/D/22/2009 (2011); Human Rights Committee, *Concluding Observations: Dominican Republic*, ¶ 15, U.N. Doc. CCPR/C/DOM/CO/5 (2012).
[79] International Center for Research on Women, *Child Marriage Facts and Figures*, http://www.icrw.org/child-marriage-facts-and-figures.
[80] AJIT PRADHEN ET. AL., NEPAL MATERNAL MORTALITY AND MORBIDITY STUDY 2008/2009 18 (2010).
[81] GOVERNMENT OF NEPAL, MINISTRY OF HEALTH AND POPULATION, POPULATION DIVISION, NEPAL DEMOGRAPHIC AND HEALTH SURVEY 2006 102 (2007), *available at* http://www.measuredhs.com/pubs/pdf/FR191/FR191.pdf.
[82] GOVERNMENT OF NEPAL NATIONAL PLANNING COMMISSION & UN COUNTRY TEAM NEPAL, NEPAL MILLENNIUM DEVELOPMENT GOALS PROGRESS REPORT 2010 51 (2010), *available at* http://www.undp.org.np/pdf/MDG-Layout-Final.pdf.
[83] GOVERNMENT OF NEPAL, MINISTRY OF HEALTH AND POPULATION, POPULATION DIVISION, NEPAL DEMOGRAPHIC AND HEALTH SURVEY 2006 102 (2007), *available at* http://www.measuredhs.com/pubs/pdf/FR191/FR191.pdf; AJIT PRADHEN ET. AL., *supra* note 80, at 18.
[84] Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), *adopted* Dec. 18, 1979, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, 1249 U.N.T.S. 13, Art. 16(2), U.N. Doc. A/34/46 (1979) (*entered into force* Sept. 3, 1981).
[85] CESCR, *General Comment No. 14*, *supra* note 2, ¶ 22.

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New York, New York 10005
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[86] CEDAW Committee, *Concluding Observations: India*, ¶ 57, U.N. Doc. CEDAW/C/IND/CO/3 (2007).
[87] CRC, *Concluding Observations: Sierra Leone*, ¶ 57, U.N. Doc. CRC/C/SLE/CO/2 (2008); CRC, *Concluding Observations: Djibouti*, ¶ 56(a), U.N. Doc. CRC/C/DJI/CO/2 (2008).
[88] CRC, *Concluding Observations: Pakistan*, ¶ 27, U.N. Doc. CRC/C/PAK/CO/3-4 (2009); CRC, *Concluding Observations: The Democratic People's Republic of Korea*, ¶ 26, U.N. Doc. CRC/C/15/Add.239 (2004).
[89] International Women's Health Program, *"Til Death do us Part": Understanding the Sexual and Reproductive Health Risks of Early Marriage*, http://iwhp.sogc.org/index.php?page=early-marriage&hl=en_US (last accessed Sept. 27, 2012).
[90] GUTTMACHER INSTITUTE, FACTS OF THE SEXUAL AND REPRODUCTIVE HEALTH OF ADOLESCENT WOMEN IN THE DEVELOPING WORLD 2 (2010) (noting that "on average, about one-third of married adolescents in low and lower-middle–income countries who want to avoid pregnancy use a modern method"); Ann K. Blanc et. al., *Patterns and Trends in Adolescents' Contraceptive Use and Discontinuation in Developing Countries and Comparisons with Adult Women*, 35 INT'L PERSPECTIVES ON SEXUAL AND REPRODUCTIVE HEALTH 63, 63 (2009) (noting that contraceptive use among married adolescents in Nepal and Pakistan are as low as 6 percent).
[91] Iben Madsen, *Tanzania: Is Child Marriage a Neglected Problem?*, DAILY NEWS, DEC. 2, 2009, *available at* http://allafrica.com/stories/200912020746.html.
[92] USAID, *Child Marriage: Overview*, http://transition.usaid.gov/our_work/cross-cutting_programs/wid/dg/child_marriage.html (last accessed Sept. 27, 2012).
[93] Iben Madsen, *Tanzania: Is Child Marriage a Neglected Problem?*, DAILY NEWS, DEC. 2, 2009, *available at* http://allafrica.com/stories/200912020746.html.

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