

**Comments from the Center for Reproductive Rights in response to the call for submissions from the Office of the High Commissioner for Human Rights study on youth and human rights**

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1. **Introduction**

The Center for Reproductive Rights (the Center)—an international non-profit legal advocacy organization headquartered in New York City, with regional offices in Nairobi, Bogotá, Kathmandu, Geneva, and Washington, D.C.—uses the law to advance reproductive freedom as a fundamental human right that all governments are legally obligated to respect, protect, and fulfill. Since its inception twenty-five years ago, the Center has advocated for the realization of women and girls’ human rights on a broad range of issues, including on the right to access sexual and reproductive health services; preventing and addressing sexual violence; and the eradication of harmful traditional practices, including female genital mutilation and child marriage. We are pleased to provide this submission to the Office of the High Commissioner for Human Rights on youth and human rights.

This submission sets forth the barriers adolescents face in realizing their sexual and reproductive health and rights (SRHR). It discusses recent critical developments in the human rights framework underpinning these rights. It outlines how the international community can assist states with guaranteeing all adolescents the full exercise of their sexual and reproductive health and rights.[[1]](#endnote-1)

1. **Challenges faced by adolescents trying to exercise their right to reproductive health and services**

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 levels. Despite increased attention to this issue over the past decade, signiﬁcant gaps remain in adolescents’ knowledge about their sexual and reproductive health and rights and ability to access essential sexual and reproductive health services.

1. 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 services. Such laws may restrict adolescents’ independent access to health services. For instance, some states have laws that require parental notification or authorization for service access.[[2]](#endnote-2) Such restrictions may apply to all minors or specifically to those under a certain minimum age. For example, parental consent is required for before a young person can access contraceptive goods and services in Argentina (under 14), Lithuania (under 16), Peru (under 18), Poland (under 18), and Slovakia (under 15).[[3]](#endnote-3) 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.[[4]](#endnote-4) 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.[[5]](#endnote-5)

In some instances, in lieu of parental authorization, judicial authorization may be required to access specific sexual and reproductive health services. Judicial authorization requires an adolescent to file a petition and appear before a judge.[[6]](#endnote-6) Judicial authorization requirements are problematic overall[[7]](#endnote-7) and are particularly challenging for adolescents, due to the range of barriers they face in accessing formal judicial mechanisms and the stigma surrounding adolescent access to sexual and reproductive health services.[[8]](#endnote-8)

Even when there are clear laws that allow adolescents to independently access sexual and reproductive health services, service providers may simply choose to ignore them. Consider the story of P, who was nearly prevented from having an abortion after Polish hospitals failed to provide P with the services to which she was legally entitled. When P was 14, she became pregnant after she was sexually assaulted by a classmate. With the support of her mother, P obtained a certificate from a prosecutor, which is required for abortions in the case of rape. Despite that P had the support of her mother and was able to obtain the certificate from the prosecutor, three hospitals gave P distorted information, which nearly prevented her from having an abortion before reaching the 12-week gestational limit for abortion in cases of rape. Only after the Ministry of Health intervened was P able to obtain an abortion a few days before the limit.[[9]](#endnote-9)

1. Practical barriers

In addition to legal obstacles, there are a number of practical barriers that can prevent adolescents from seeking sexual and reproductive health information and services. One significant barrier is the stigma surrounding adolescent sexuality, which 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.[[10]](#endnote-10) 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.

Other barriers exist where adolescents do not understand their sexual and reproductive health needs, and they are unable to take measures to prevent unwanted pregnancy or sexually transmitted infections or disease. This may be due to difficultly in accessing comprehensive sexuality education or information on sexual and reproductive health.[[11]](#endnote-11) Often, it is a combination of obstacles that prevent girls from receiving appropriate reproductive health care. For example, if adolescents do not know how to prevent unintended pregnancies, such situations, combined with stigma related to adolescent sexuality, can be disastrous for their futures. Consider the story of Rahema, who did not receive any sexuality education, including pregnancy prevention, when she was growing up in Tanzania. As a result, her entire life was interrupted when she became pregnant at age 16. Formal expulsion of pregnant schoolgirls is rampant throughout Tanzania, and thus Rahema was pressured to drop out of school. 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. Rahema indeed dropped out of school and even though she wanted to go back after giving birth, she was unable to do so. Rahema currently lives with her parents and works part-time as a cook.

Other practical barriers to sexual and reproductive health services further prevent adolescents from obtaining these services. For instance, where sexual and reproductive health services are too far away, adolescents may be unable to access or afford the required transportation.[[12]](#endnote-12) Moreover, adolescents may also decide not to obtain services because they are uncomfortable with how the services are provided, especially when services are not provided in an adolescent friendly way.[[13]](#endnote-13) This may also occur where adolescents do not believe that their right to confidentiality will be maintained, they may forego sexual and reproductive health services.[[14]](#endnote-14) Even if adolescents are able to obtain the services, adolescents may not be able to afford the services or products.[[15]](#endnote-15)

1. Cultural practices - child marriage

Cultural practices can also hinder girls’ ability to access sexual and reproductive rights and services. Child marriage is one such practice. Though child marriage is criminalized in many countries, the practice remains widespread through certain regions.[[16]](#endnote-16) Child marriage affects both boys and the girls, however, it disproportionately affects girls’ ability to enjoy their rights and freedoms, especially due to the serious risks of sexual and reproductive harms associated with this practice.

Child marriage triggers a continuum of reproductive and sexual harms and violations by exposing girls to forced initiation into sex and unprotected sex, as well as early, unplanned, and frequent pregnancies. Girls subjected to child marriage are likely to face slavery-like practices such as servile marriage, sexual slavery, child servitude, child trafficking, and forced labor.[[17]](#endnote-17) Girls married as children are often denied educational[[18]](#endnote-18) and employment opportunities, which undermines their self-development and negatively impacts their lives, leaving them economically dependent, vulnerable, and disempowered.[[19]](#endnote-19) The harmful consequences of child marriage are exacerbated by married girls’ lack of access to reproductive health information and services, including contraception[[20]](#endnote-20) and safe abortion services.[[21]](#endnote-21) Patriarchal norms and unequal power dynamics further limit their ability to negotiate safe sex and contraceptive use. The compromised ability to determine the number and spacing of their children places them at a heightened risk of early and frequent pregnancies,[[22]](#endnote-22) resulting in high rates of maternal mortality[[23]](#endnote-23) and morbidity,[[24]](#endnote-24) and increases their exposure to sexually transmitted infections such as HIV.[[25]](#endnote-25)

States are taking a variety of means to address the issue of child marriage. Nepal is one such country. The 2015 Constitution of Nepal explicitly prohibits child marriage[[26]](#endnote-26) as a punishable offence and establishes the right to compensation for violations from the perpetrator.[[27]](#endnote-27) The Government of Nepal also adopted a National Strategy to End Child Marriage in Nepal, 2016, which provides an overarching policy framework to combat child marriage and promote legal accountability. It aims to end child marriage in Nepal by 2030.[[28]](#endnote-28) The Strategy calls for revising laws and policies related to child marriage to be in line with constitutional and international human rights standards, and harmonizing child marriage laws with other areas of law including property rights, gender-based violence, divorce, annulment, marital rape, dowry, birth registration, and citizenship.[[29]](#endnote-29) Initiatives such as those taken by Nepal could help reduce child marriage, which will also eliminate some of the obstacles to sexual and reproductive health care created by child marriage.

1. **International Human Rights Standards**
	1. Adolescents’ right to sexual and reproductive health services.

International law affirms the importance of providing adolescents access to sexual and reproductive health services.[[30]](#endnote-30) The Committee on the Rights of the Child (CRC Committee) has been at the forefront of establishing these international human rights norms. The CRC Committee has urged states to “ensure that health systems and services are able to meet the specific sexual and reproductive health needs of adolescents.”[[31]](#endnote-31) In this regard, the CRC Committee has made clear that adolescents should have access to the full range of sexual and reproductive health services,[[32]](#endnote-32) including maternal health care; contraceptive information and services; safe abortion services and post-abortion care; and information and services to prevent and address sexually transmitted infections.[[33]](#endnote-33) Further, the CRC Committee has urged state to “decriminalize abortion to ensure that girls have access to safe abortion and post-abortion services.”[[34]](#endnote-34)

Moreover, the CRC Committee 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.”[[35]](#endnote-35) 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.”[[36]](#endnote-36)

The CRC Committee and the Special Rapporteur emphasize that all adolescents have the right to access confidential, adolescent-responsive sexual and reproductive health information, irrespective of age and without the consent of a parent or guardian.[[37]](#endnote-37) These normative developments reinforce the Committee on the Elimination of Discrimination Against Women’s (CEDAW Committee) recognition that parental authorization requirements constitute a barrier to health services.[[38]](#endnote-38)

In the CRC Committee’s general comment on rights of the child during adolescence, for the first time, the Committee 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.”[[39]](#endnote-39) This approach is endorsed by the Special Rapporteur on Health.[[40]](#endnote-40) Adolescents’ right to sexual and reproductive health services also includes their right not to have such services forced upon them.[[41]](#endnote-41) The CRC Committee 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,[[42]](#endnote-42) and has called on states to ensure that the voluntary and informed consent of adolescents for all medical treatments and procedures.[[43]](#endnote-43)

These standards have been reinforced by other treaty monitoring bodies, such as the CEDAW Committee, the Committee on Economic, Social and Cultural Rights (ESCR Committee), and the Human Rights Committee.[[44]](#endnote-44) For example, these bodies have called on states to ensure girls access to safe abortion services;[[45]](#endnote-45) affordable modern contraception, including emergency contraception;[[46]](#endnote-46) and proper care during pregnancy and childbirth.[[47]](#endnote-47)

* 1. Adolescents’ right to make decisions about their sexual and reproductive health and 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 right to life, survival, and development; the right to equality and non-discrimination; and the right to be free from all forms of violence and cruel, inhuman, and degrading treatment. The denial of any of these rights can constitute a human rights violation.

The treaty monitoring bodies have long affirmed the interdependence of these rights.[[48]](#endnote-48) Consider KL’s story, which was a case that was heard by the Human Rights Committee. At age 17, KL discovered 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. As the prospect of carrying a non-viable pregnancy to term exposed KL to severe mental suffering, emotional instability, and symptoms of depression, she sought to terminate the pregnancy. Although Peru’s law permits abortion where pregnancy poses a risk to the person’s life or health, the hospital staff refused to administer abortion services to KL and the Ministry of Health refused to intervene on her behalf. KL was compelled to carry the pregnancy to term and breastfeed the baby over the course of the two days it survived, ultimately leaving her in a deep state of depression. In hearing the case, the Human Rights Committee found that Peru violated her right to private life, by arbitrarily intervening in her decision to terminate a pregnancy, and her right be free from cruel, inhuman and degrading treatment, by exposing her to mental suffering by failing to provide her abortion services.[[49]](#endnote-49)

1. **Facilitating and Supporting Adolescent-Friendly Sexual and Reproductive Health Services**

The primary responsibility to facilitate and support adolescent-friendly sexual and reproductive health services belongs to states. The international community must call on and support states in fulfilling their obligations under the human rights conventions.

* 1. Ensuring accessibility of health services and information

In accordance with international human rights norms, treaty monitoring bodies must help states ensure that sexual and reproductive health services for minors are youth-friendly,[[50]](#endnote-50) 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 be encouraged to enable adolescents to access sexual and reproductive health services.[[51]](#endnote-51) Where adolescents are unable to autonomously access these services, they may resort to unsafe methods to try to prevent pregnancy or to terminate an unwanted pregnancy, posing serious threats to their lives.[[52]](#endnote-52) Accordingly, states should ensure that reproductive health services are geographically accessible and are open during convenient hours for adolescents. States should also develop a core package of interventions, including sexual and reproductive health services, that will be available free of charge.[[53]](#endnote-53)

* 1. 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 adolescents’ rights. Specifically, states must ensure that providers have accurate information on adolescents’ right to access sexual and reproductive health services. Furthermore, states should ensure that health care workers:

* do not discriminate against adolescents, including on the basis of age, sex, or social status, among others.[[54]](#endnote-54) This includes overcoming prejudices against adolescent girls’ sexuality;[[55]](#endnote-55)
* are respectful of adolescents, meaning that they be non-judgmental, friendly and considerate of their needs, and do not criticize them;[[56]](#endnote-56)
* administer adolescent-friendly sexual and reproductive health services, including on client privacy, confidentiality and respecting minors’ needs;[[57]](#endnote-57)
* provide scientifically-accurate and comprehensive information on adolescents’ sexual and reproductive health and rights;[[58]](#endnote-58) and
* communicate effectively with adolescents to ensure they understand their sexual and reproductive health needs.[[59]](#endnote-59)
	1. Meaningful participation of adolescents

States must also guarantee adolescents meaningful participation in the design, implementation, monitoring, and evaluation of youth-friendly sexual and reproductive health programs.[[60]](#endnote-60) 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.

* 1. Ensuring an effective remedy when their rights are violated

Finally, both the international community and state governments must ensure that adolescents can access effective remedies when their rights are violated[[61]](#endnote-61) The CRC Committee has made clear that states must ensure that children have access to child-sensitive procedures to access an effective remedy,[[62]](#endnote-62) including by providing “child-sensitive information, advice, [and] advocacy, including support for self-advocacy.”[[63]](#endnote-63)

For such mechanisms to be effective, adolescents must have information about their rights, 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.[[64]](#endnote-64) 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.[[65]](#endnote-65) 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.”[[66]](#endnote-66)

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.[[67]](#endnote-67) This is particularly critical for sexual and reproductive rights violations, as adolescents may be unwilling to seek assistance from a parent or other adult.

1. In 2017, the Center published *Capacity and Consent*, which details the reproductive rights of adolescents. For additional details on the rights discussed in this submission, *see* Center for Reproductive Rights, Capacity and Consent: Empowering Adolescents to Exercise their Reproductive Rights (2017). [↑](#endnote-ref-1)
2. 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 č. 73/1986 Zb. o umelom prerušení tehotenstva v znení zákona č. 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]. [↑](#endnote-ref-2)
3. *Id*. at 9. [↑](#endnote-ref-3)
4. *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*]. [↑](#endnote-ref-4)
5. *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](http://spq.sagepub.com/search?author1=Derek+A.+Kreager&sortspec=date&submit=Submit) and [Jeremy Staff](http://spq.sagepub.com/search?author1=Jeremy+Staff&sortspec=date&submit=Submit), *The Sexual Double Standard and Adolescent Peer Acceptance*, 72 Social Psychology Quarterly 2, 143 (2009) (exploring the “sexual double standard” wherein boys are praised while girls are stigmatized for engaging in sexual activity). [↑](#endnote-ref-5)
6. 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. [↑](#endnote-ref-6)
7. Judicial bypass acts as a barrier for women to access services, particularly abortion. The process is overly burdensome, and by the time authorization is granted, the pregnancy is normally past the gestational limit. *See* Center for Reproductive Rights, *Supplementary information on Rwanda scheduled for review by the Committee on the Elimination of Discrimination against Women during the Pre-Session of the 66th Session*(June 10, 2016), *available at* http://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/RWA/INT\_CEDAW\_NGO\_RWA\_24267\_E.pdf. [↑](#endnote-ref-7)
8. IPPF, Legal Barriers to Young People’s Access to SRH Services, *supra* note 1, at 13. [↑](#endnote-ref-8)
9. This case was taken to the European Court of Human Rights. In finding that P’s rights to respect for private and family life, liberty and freedom from ill treatment were violated, the Court emphasized that throughout the ordeal, there was not proper regard for her “vulnerability and young age and her own views and feelings.” 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.” P. and S. v. Poland, No 57375/08, paras. 166, 109, Eur. Ct. H. R. (2008). [↑](#endnote-ref-9)
10. *See* United Nations Population Fund (UNFPA), Motherhood in Childhood: Facing the Challenge of Adolescent Pregnancy 37 (2013) [hereinafter UNFPA, Motherhood in Childhood]. [↑](#endnote-ref-10)
11. *See* United Nations Educational, Scientific and Cultural Organization, Comprehensive Sexuality Education: The Challenges and Opportunities of Scaling UP 8 (2014). [↑](#endnote-ref-11)
12. *See* World Health Organization (WHO), Making health services adolescent friendly: Developing national quality standards for adolescent friendly health services 8 (2012). [↑](#endnote-ref-12)
13. *Id*. [↑](#endnote-ref-13)
14. *See* Jones & Boonstra, *Confidential Reproductive Health Services for Minors, supra* note 3; WHO, Safe Abortion: Technical and Policy Guidance for Health Systems 95 (2d ed. 2012). [↑](#endnote-ref-14)
15. Cost can be an especially large barrier for adolescents, as they may not have an income stream or be independently insured to afford the services. [↑](#endnote-ref-15)
16. For example, though child marriage is a criminal offense in Nepal, it has been practiced for generations. Nepal has one of the highest rates of child marriage in the world—37 percent of Nepali women ages 20 to 24 were first married by age 18 and 10 percent by age 15. The Muluki Ain (General Code), part 4, ch. 17, no. 2 (1963) (Nepal); UNICEF, EARLY MARRIAGE IN SOUTH ASIA: A DISCUSSION PAPER 2 (2009); UNICEF, State of the World’s Children 151 (2016), *available at* https://www.unicef.org/publications/files/UNICEF\_SOWC\_2016.pdf. [↑](#endnote-ref-16)
17. Anti-Slavery International, Out of the Shadows: Child marriage and slavery 7, 28, 29 (2013). [↑](#endnote-ref-17)
18. Govt. of Nepal, Nepal Adolescents and Youth Survey 42 (2010/11), *available at* http://nepal.unfpa.org/sites/default/files/pub-pdf/NepalAdolescentandYouthSurveyHighlights%282%29.pdf. [↑](#endnote-ref-18)
19. The Demographic and Health Surveys Program, Nepal Demographic and Health Survey 84 (2011) [hereinafter NDHS 2011]. [↑](#endnote-ref-19)
20. *Id*., at 104-105. [↑](#endnote-ref-20)
21. *Id*., at 137, 139. [↑](#endnote-ref-21)
22. *Id*., at 79. [↑](#endnote-ref-22)
23. Government of Nepal, Ministry of Health and Population, Department of Health Services, Family Health Division, Nepal Maternal Mortality and Morbidity Study: 2008/09 6 (2009) [↑](#endnote-ref-23)
24. NDHS 2011, *supra* note 17, at 143. [↑](#endnote-ref-24)
25. Office of the United Nations High Commissioner for Human Rights, *Preventing and eliminating child, early and forced marriage*, para. 23 U.N. Doc. A/HRC/26/22 (2014). [↑](#endnote-ref-25)
26. The Constitution of Nepal (2015), art. 39(5). [↑](#endnote-ref-26)
27. *Id.*, art. 39(10). [↑](#endnote-ref-27)
28. Govt. of Nepal, Ministry of Women, Children and Social Welfare, National Strategy to End Child Marriage in Nepal 8 (2016). [↑](#endnote-ref-28)
29. *Id*. at 13. [↑](#endnote-ref-29)
30. *See* CEDAW Committee, *Concluding Observations: Argentina,* paras. 34-35, U.N. Doc. CEDAW/C/ARG/CO/7 (2016); CEDAW Committee, *Concluding Observations: Thailand,* para. 39, U.N. Doc. CEDAW/C/THA/CO/6-7 (2017); CEDAW Committee, *Concluding Observations: Congo*, para. 36(f), U.N. Doc. CEDAW/C/COG/CO/6 (2012); CRC Committee, *Concluding Observations: Central African Republic*, para. 55, U.N. Doc. CRC/C/CAF/CO/2 (2017); CRC Committee, *Concluding Observations: Nigeria*, paras. 37-38, U.N. Doc. CEDAW/C/NGA/CO/7-8 (2017); ESCR Committee, *General Comment No. 16:* *The equal right of men and women to the enjoyment of all economic, social and cultural rights (Art. 3)*, (34th Sess., 2005), para. 29, U.N. Doc. E/C.12/2005/4 [hereinafter ESCR Committee*, Gen. Comment No. 16*]; ESCR Committee, *Concluding Observations: Namibia*, para. 65 (a), U.N. Doc. E/C.12/NAM/CO/1 (2016). [↑](#endnote-ref-30)
31. CRC Committee, *General Comment 15: The right of the child to the enjoyment of the highest attainable standard of health*, (62nd Sess.), para. 56, U.N. Doc. CRC/C/GC/15 (2013) [hereinafter CRC Committee, *Gen. Comment No. 15*]. [↑](#endnote-ref-31)
32. *See, e.g,* *id.*, paras. 56 & 69-70. [↑](#endnote-ref-32)
33. *See generally* *id.* [↑](#endnote-ref-33)
34. Committee on the Rights of the Child, *General Comment No. 20 on the implementation of the rights of the child during adolescence,* para. 60, U.N. Doc. CRC/C/GC/20 (Dec. 2016) [hereinafter CRC Committee, *Gen. Comment No. 20*]. [↑](#endnote-ref-34)
35. *Id*. [↑](#endnote-ref-35)
36. Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Rep. of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of health, Dainius Puras*,para. 59, U.N. Doc. A/HRC/32/32 (2016) [hereinafter SR Health, *Report on the health of adolescents* (2016)]. [↑](#endnote-ref-36)
37. *Id*. at para. 60; CRC Committee, *Gen. Comment No. 20*, *supra* note 33, paras. 39, 59. [↑](#endnote-ref-37)
38. 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. 21, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008). [↑](#endnote-ref-38)
39. CRC Committee, *Gen. Comment No. 20*, *supra* note 38, para. 39. [↑](#endnote-ref-39)
40. SR Health, *Report on the health of adolescents* (2016), *supra* note 40, para. 60. [↑](#endnote-ref-40)
41. *See* Committee on the Rights of the Child, *General Comment No. 9: The rights of children with disabilities*, (33rd Sess., 2003), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at 497, para. 60, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008)(expressing concern about and urging states to prohibit the forced sterilization of children on the basis of disability). [↑](#endnote-ref-41)
42. CRC Committee*, Gen. Comment No. 15, supra* note 35,para. 21. [↑](#endnote-ref-42)
43. CRC Committee, *Gen. Comment No. 20*, *supra* note 38, para. 39. [↑](#endnote-ref-43)
44. Human Rights Committee, *Concluding Observations: Paraguay*, para. 13, U.N. Doc. CCPR/C/PRY/CO/3 (2013); CEDAW Committee, *Concluding Observations: Bolivia*, para. 29(b), U.N. Doc. CEDAW/C/BOL/CO/5-6 (2015); *Poland,* paras. 36, 37(e), U.N. Doc. CEDAW/C/POL/CO/7-8 (2014); ESCR Committee, *Concluding Observations: Lithuania,* para. 22, U.N. Doc. E/C.12/LTU/CO/2 (2014). [↑](#endnote-ref-44)
45. CEDAW Committee, *Concluding Observations:* *Denmark*, para. 32, U.N. Doc. CEDAW/C/DNK/CO/8 (2015); ESCR Committee, *Concluding Observations: Romania,* para. 22, U.N. Doc. E/C.12/ROU/CO/3-5 (2014). [↑](#endnote-ref-45)
46. CEDAW Committee, *Concluding Observations:* *Ecuador*, para. 33(d), U.N. Doc. CEDAW/C/ECU/CO/8-9 (2015); CEDAW Committee, *Concluding Observations*: *Eritrea*, para. 35(d), U.N. Doc. CEDAW/C/ERI/CO/5 (2015); CEDAW Committee, *Concluding Observations:* *Gabon*, para. 35(c), U.N. Doc. CEDAW/C/GAB/CO/6 (2015). [↑](#endnote-ref-46)
47. CEDAW Committee, *Concluding Observations: India*, para. 31(a), U.N. Doc. CEDAW/C/IND/CO/4-5 (2014); *Bangladesh*, paras. 34-35, U.N. Doc. CEDAW/C/BGD/CO/8 (2016); ESCR Committee, *Concluding Observations: Indonesia,* para. 33, U.N. Doc. E/C.12/IDN/CO/1 (2014); Human Rights Committee, *Concluding Observations: Peru*, para. 14(b), U.N. Doc. CCPR/C/PER/CO/5 (2013). [↑](#endnote-ref-47)
48. *See, e.g.,* CRC Committee*, General Comment No. 5, General measures of implementation of the Convention on the Rights of the Child, (34th Sess., 2003),* para. 12, U.N. Doc. CRC/GC/2003/5 [hereinafter CRC Committee, *Gen. Comment No. 5*]; Human Rights Committee, *Concluding Observations: Peru*, para. 14, U.N. Doc. CCPR/C/PER/CO/5 (2013); CRC Committee, *Concluding Observations: Namibia,* para. 57(a), U.N. Doc. CRC/C/NAM/CO/2-3 (2012); CAT Committee, *Concluding Observations: Kenya*, para. 28, U.N. Doc. CAT/C/KEN/CO/2 (2013). [↑](#endnote-ref-48)
49. K.L. v. Peru*,*Human Rights Committee, Commc’n No. 1153/2003, paras. 6.4-6.5, U.N. Doc. CCPR/C/85/D/1153/2003 (2005).  [↑](#endnote-ref-49)
50. *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). [↑](#endnote-ref-50)
51. CRC Committee*, Gen. Comment No. 15, supra* note35, para. 56. [↑](#endnote-ref-51)
52. UNFPA, Motherhood in Childhood, supra note 9, at 26-28. [↑](#endnote-ref-52)
53. SR Health, *Report on the health of adolescents* (2016), *supra* note 40, para. 30. [↑](#endnote-ref-53)
54. *Id*. [↑](#endnote-ref-54)
55. CEDAW Committee, *Concluding Observations*: *Georgia,* paras. 30-31, U.N. Doc. CEDAW/C/GEO/CO/4-5 (2014). [↑](#endnote-ref-55)
56. WHO, Quality Assessment Guidebook: A Guide to Assessing Health Services for Adolescent Clients 3 (2009), *available at* http://whqlibdoc.who.int/publications/2009/9789241598859\_eng.pdf. [↑](#endnote-ref-56)
57. Save the Children and UNFPA, Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings 76, *available at* http://www.unfpa.org/sites/default/files/pub-pdf/UNFPA\_ASRHtoolkit\_english.pdf [hereinafter Adolescent Toolkit]; CRC Committee, *Gen. Comment No. 15, supra* note 35, para. 52. [↑](#endnote-ref-57)
58. *See* CEDAW Committee, *Concluding Observations: Italy*, para. 36, U.N. Doc. CEDAW/C/ITA/CO/7 (2017); *Nigeria,* paras. 33-34, U.N. Doc. CEDAW/C/NGA/CO/7-8 (2017); Ireland, para. 39 (c), U.N. Doc. CEDAW/C/IRL/CO/6-7 (2017); CRC Committee, *Concluding Observations: Antigua and Barbuda*, para. 45(a), U.N. Doc. CRC/C/ATG/CO/2-4 (2017); ESCR Committee, *Concluding Observations: Benin*, para. 42, U.N. Doc. E/C/12/1/Add.78 (2002). [↑](#endnote-ref-58)
59. 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>. [↑](#endnote-ref-59)
60. Adolescent Toolkit, *supra* note 60, at 18. [↑](#endnote-ref-60)
61. *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 51, para. 24; Special Representative of the Secretary-General (SRGS) on Violence against Children, *Safe and child-sensitive counselling, complaint and reporting mechanisms to address violence against children* (2012) [hereinafter SRSG report on violence against children]. [↑](#endnote-ref-61)
62. CRC Committee, *Gen. Comment No. 5*, *supra* note 51, para. 24. [↑](#endnote-ref-62)
63. *Id*. [↑](#endnote-ref-63)
64. *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.”). [↑](#endnote-ref-64)
65. SRSG report on violence against children, *supra* note 64, at 11. [↑](#endnote-ref-65)
66. OHCHR, *Access to Justice for Children*, *supra* note 64, para. 19 (citing SRSG report on violence against children, *supra* note 64, at 7). [↑](#endnote-ref-66)
67. *See* *id.*, para. 21. [↑](#endnote-ref-67)