



CENTER  
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RIGHTS

December 8, 2005

The Committee on the Rights of the Child (CRC)  
8-14 Avenue de la Paix  
CH 1211 Geneva 10  
Switzerland

Re: Supplementary information on Lithuania scheduled for review by the Committee on the Rights of the Child during its 41<sup>st</sup> Session

Dear Committee Members:

This letter is intended to supplement the periodic report submitted by Lithuania, which is scheduled to be reviewed by the Committee on the Rights of the Child (the Committee) during its 41<sup>st</sup> Session. The Seimos Planavimo ir Seksualines Sveikatos Asociacija (The Lithuanian Family Planning Association-LFPA) and the Center for Reproductive Rights are independent non-governmental organizations that hope to further the work of the Committee by providing independent information concerning the rights protected in the Convention on the Rights of the Child (Children's Rights Convention). This letter highlights several areas of concern related to the status of the reproductive health and rights of girls and adolescents in Lithuania. Specifically, it focuses on discriminatory or inadequate laws and policies related to the reproductive rights of girls and adolescents in Lithuania.

Reproductive rights are fundamental to adolescents' health and equality, thus, states parties' commitment to ensuring them should receive serious attention. Furthermore, adolescent reproductive health and rights receive broad protection under the Children's Rights Convention. Article 24 of the Children's Rights Convention recognizes girls' and adolescents' right "to the enjoyment of the highest attainable standard of health and to

facilities for the treatment of illness and rehabilitation of health.” It also requires states parties to take appropriate measures to develop “family planning and education services.” Yet, despite these protections, the reproductive rights of girls and adolescents in Lithuania continue to be neglected and, at times, violated.

We hope to bring to the Committee’s attention the following issues of concern, which directly affect the reproductive health and rights of girls and adolescents in Lithuania:

## **I. The Right to Reproductive Health Services (Article 24 of the Children’s Rights Convention)**

The Committee has regularly expressed concern in its Concluding Observations where adolescents have limited access to reproductive health services and has asked states parties to increase women’s and adolescents’ access to such services.<sup>1</sup> It has frequently highlighted the need to address unsafe or illegal abortion<sup>2</sup> and teenagers’ lack of access to reproductive health services.<sup>3</sup> In its General Comment on Adolescent Health and Development, the Committee urges governments “to 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, [and] adequate and comprehensive obstetric care and counselling.”<sup>4</sup> Furthermore, the Committee on the Elimination of All Forms of Discrimination against Women (CEDAW Committee) has recommended governments, including Lithuania, to strengthen family planning programs and access to contraceptives in light of high rates of abortion among women and lack of access to family planning.<sup>5</sup>

### **A. Access to Affordable Modern Contraception**

Adolescents must have access to contraceptives and dual protection methods to prevent unwanted pregnancies and sexually transmissible infections (STIs). The Committee has regularly expressed concern in its Concluding Observations where adolescents have limited access to family planning services and contraceptive use is low, and it has recommended that states parties work toward making family planning services more widely available.<sup>6</sup>

Half of all women worldwide, ages 15–44 have experienced at least one unintended pregnancy,<sup>7</sup> but only 31% of women in Lithuania use modern methods of contraception.<sup>8</sup> The teen pregnancy rate in Lithuania of 21 births per 1,000 women is above the average for Europe.<sup>9</sup> Part of the inaccessibility of contraceptives stems from the high costs of available contraceptives. Oral birth control can cost up to USD 60 per year,<sup>10</sup> while in comparison the cost of an early termination abortion is about USD 28.8 for in-patient, clinic abortion.<sup>11</sup> All abortions performed for medical reasons are free of charge.<sup>12</sup> And although abortion is not necessarily considered a method of family planning, the number of abortions performed each year in Lithuania indicate that it is probably one of the primary methods of family planning. Lithuania performs three times as many abortions every year as any other Scandinavian country.<sup>13</sup> Approximately twenty-six out of every

1,000 women in Lithuania have undergone an abortion,<sup>14</sup> and one third of Lithuanian adolescent pregnancies end in induced abortion.<sup>15</sup>

In several sets of concluding observations, the Committee has expressed its concern over the lack of contraceptive alternatives and adolescents' use of abortion as a primary method of contraception.<sup>16</sup> The Human Rights Committee has also commented on issues involving contraception. The HRC has stated that high costs are an obstacle to women's access to contraception<sup>17</sup> and are a violation of the non-discrimination provisions of Article 3 of the Civil and Political Rights Covenant.<sup>18</sup> The HRC has remarked that ensuring access to contraception will help secure women's rights to life, protected under Article 6<sup>19</sup>. Furthermore, the HRC has directly related high rates of abortion with lack of access to contraception.<sup>20</sup>

### **B. Access to Safe, Comprehensive Abortion Services**

One of the significant problems concerning safe abortion is the lack of the possibility for women and adolescent girls to choose freely between abortion procedures. Lithuanian Teenage women aged 15-19 procure abortions at the rate of 9.8 abortions per 1,000 women.<sup>21</sup> In Lithuania, the possibility of adolescents to choose medical abortion, as a safe and effective method of terminating early pregnancy, does not exist. In 2002, the Lithuanian National Committee on Biomedical Ethics rejected both the application for clinical trials for medical abortion and approval of the drugs.<sup>22</sup>

Medical abortion, however, is a proven early, safe and effective non-invasive alternative to surgical abortion that involves the use of two types of medicine to end a pregnancy. The most common regimen calls for an oral dose of mifepristone, an antiprogesterin that acts to weaken the attachment of the fertilized egg to the uterus, followed 36 to 48 hours later by an oral or intravaginal dose of a prostaglandin analog—either misoprostol or gemeprost—that causes contractions of the uterus, helping to expel the fertilized egg.<sup>23</sup> This regimen, which can be initiated as soon as pregnancy is confirmed,<sup>24</sup> is approximately 95% effective for abortion up to 49 days' gestation,<sup>25</sup> but has been approved for up to 63 days' gestation in some countries.<sup>26</sup> Many abortion providers will not perform some types of surgical abortion until at least the sixth week of gestation.

Medical abortion is the result of decades of medical research conducted to develop and perfect a safe and perhaps more acceptable alternative to surgical abortion, with the larger goal of benefiting women and adolescent girls' health and access to health care services. As a safe method of pregnancy termination with the potential to reduce maternal health risks for thousands of women adolescent girls, medical abortion is an important component of reproductive health care to which all women adolescent girls should be entitled. Because medical abortions can be initiated as soon as pregnancy is confirmed up to the first few weeks of gestation, the availability of medical abortion may allow women to obtain earlier, and thus safer, abortions.<sup>27</sup> The availability of medical abortion can improve women and adolescent girls' access to safe abortion services and thus help reduce abortion-related mortality and morbidity. It has the potential to reduce the number of abortion complications, such as uterine perforation and cervical lacerations, as well as

those associated with anesthesia and infection.<sup>28</sup> Some studies suggest that the availability of medical abortion can lead to an increase in the number of health care providers who offer abortion services, thereby improving women and adolescent girls' overall access to safe abortion.<sup>29</sup>

Since the introduction of medical abortion, research on patients' evaluations of medical abortions found that the majority of women—often more than 90%—were satisfied with the procedure and would opt for the same method if a future termination were necessary.<sup>30</sup> Studies also show that 57–70% of women prefer medical abortion when presented with a choice between medical and surgical abortion,<sup>31</sup> and the safety and efficacy of this method has been consistently demonstrated in nearly every region of the world.<sup>32</sup> For adolescent girls who wish to avoid a surgical procedure for reasons of health, culture, privacy or convenience, medical abortion provides a more acceptable option of pregnancy termination.

For over a decade, women and adolescent girls in almost all member states of the European Union seeking an abortion have had the option of either a surgical or medical procedure.<sup>33</sup> While these countries' positions on the legality of abortion differ, their legalization of medical abortion reflects a common effort to expand women's options with regard to pregnancy termination and reasoned consideration of the proven safety and efficacy of the regimen involved.<sup>34</sup> The decision of the Lithuanian Committee on Biomedical Ethics to reject medical abortion as an option in Lithuania has denied women and adolescent girls' access to a proven safe modern health care option, thus compromising their right to life, health, reproductive autonomy and right to benefit from scientific progress.

## **II. The Right to Education on Sexuality and Family Planning (Article 24 of the Children's Rights Convention)**

The Committee, in evaluating state party compliance with the Children's Rights Convention, has recognized states' duty to ensure access to sexual and reproductive health education. In its General Comment on Adolescent Health and Development, the Committee has stated:

States parties should provide adolescents with access to sexual and reproductive information, including on family planning and contraceptives, the dangers of early pregnancy, the prevention of HIV/AIDS and the prevention and treatment of sexually transmitted diseases (STDs). In addition, States parties should ensure that they have access to appropriate information, regardless of their marital status and whether their parents or guardians consent.<sup>35</sup>

In numerous Concluding Observations, the Committee has recommended that states parties strengthen their reproductive health education programs for adolescents in order to combat adolescent pregnancy and the spread of HIV/AIDS and other STIs.<sup>36</sup> In its

most recent Concluding Observations for Lithuania, the CRC noted progress in the area of Adolescent Health, but expressed “concern at the increase of cases of Sexually transmitted diseases (STDs) and HIV/ AID”<sup>37</sup> and “the frequency of unplanned pregnancies and abortions among youth.”<sup>38</sup> The committee also “notes the limited availability of programmes and services in the area of adolescent health including...prevention and information programmes, especially on reproductive health, at school.”<sup>39</sup>

The Human Rights Committee, in its most recent concluding observation to Lithuania, expressed its “...concern at the high rate of unwanted pregnancies and abortions among young women between the ages of 15 and 19, and the high number of these women contracting HIV/AIDS, with consequent risks to their life and health”<sup>40</sup>, which implicates Article 6 of the ICCPR. The Human Rights Committee recommends that Lithuania “take further measures to help young women avoid unwanted pregnancies and HIV/AIDS, including strengthening its family planning and sex education programmes.”<sup>41</sup> The Human Rights Committee identifies state obligations in preventing unwanted pregnancies and transmission of HIV/AIDS by placing an obligation on Lithuania to strengthen its sex education programmes.

Furthermore, CEDAW Committee, and the Committee on Economic, Social and Cultural Rights (CESCR) have also noted in Concluding Observations on Lithuania their concerns about the high rate of unwanted pregnancies and abortions among young women and the high number of women contracting HIV/AIDS.<sup>42</sup> They recommended that the Lithuanian government strengthen its sex education programs and promote awareness of sexual and reproductive health.<sup>43</sup>

Currently, sex education in Lithuanian schools does not adequately address the needs of Lithuania’s youth. Sexuality education is not provided at school on systematic basis. Sex education is integrated into different disciplines in school curricula. However, curricula on sex education does not give adequate attention to topics of contraception, protection from STIs, as well as the promotion of safe sex practices and equitable gender relations. Teachers frequently do not have adequate training in the field of modern sexuality education. Manuals present stereotypical attitudes to human sexuality and gender roles. Lithuanian universities have not trained teachers to teach sex education, although in 1998, the Lithuanian Pedagogical University created an elective program for health teachers that will qualify them to teach sex health classes. The Catholic Church and certain influential educators oppose the teaching of sex education in schools.<sup>44</sup>

The Ministry of Education and Science has recently refused to support a Baltic states project for training of teachers on HIV/AIDS prevention. Government support to this voluntary sex education plan whose aim was to provide youth in schools with unbiased, balanced information, was withdrawn in 2004 due to campaign to distort the facts about this project and manipulate the public and politicians of the dangers of sexuality education. This situation has left most youth with little knowledge and tools to protect themselves from sexually transmitted infections.

Lack of access to sexuality education is troublesome especially considering the increasing rates of HIV infections amongst youth, especially among young women. 26.5% of all infected women are between the ages of 15–18.<sup>45</sup> In Lithuania, the 72 new HIV cases detected in 2001 increased more than five-fold in 2002.<sup>46</sup> In addition, the rates of adolescent unwanted pregnancies and abortions remain high. In 2004, the average number of births per 1,000 women aged 15–19 was 26, which is about two to three times more than Western European countries.<sup>47</sup> Of all abortions in 1998, 7.2% were performed for women under the age of 19.<sup>48</sup>

The Family Planning and Sexual Health Association, founded in 1995, is the only NGO working in the field of sexual-reproductive rights and health of the public, especially adolescents. The Association initiated a program to found youth centers in six towns, where specially trained young people inform their peers about sexual and reproductive health issues. Through peer education methods, these centers provide information about reproductive health, family planning, relationships and disease prevention. The Association also provides adolescents with information about family planning service providers. In addition, it works on the development of legislation, reproductive health programs and policy, training and sexual/reproductive rights. Adolescent Health Promotion Centers (founded by the Association) also offer lectures, lead discussions, and inform their peers about sexual and reproductive health, safe sex, and reproductive rights.<sup>49</sup> However, the government currently provides no funding support for these projects.

**We hope the Committee will consider addressing the following questions to the Lithuanian government:**

1. What legislation and policies have been adopted to address the barriers that women and adolescent girls face in accessing comprehensive reproductive health and family planning services including medical abortion, as well as information about these services?
2. What is the unmet need for contraception among adolescents and what governmental efforts are being made to increase public awareness about and access to contraceptive methods?
3. Unbiased and accurate sex education is still not systematically offered in the schools. Given this reality, what specific measures have been taken to institute government-sponsored programs such as public awareness campaigns and sexual education in schools, and to distribute contraception to adolescents?

There remains a significant gap between the provisions of the Children's Rights Convention and the reality of adolescents' reproductive health and lives. We appreciate the active interest that the Committee has taken in the reproductive health and rights of adolescents and the strong Concluding Observations and recommendations the Committee has issued to governments in the past, stressing the need to take steps to ensure the realization of these rights.

We hope that this information is useful during the Committee's review of the Government's compliance with the provisions of the Children's Rights Convention. If you have any questions, or would like further information, please do not hesitate to contact the undersigned.

Sincerely,

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Lithuania Family Planning Association

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Legal Adviser for Europe  
Center for Reproductive Rights

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<sup>1</sup> See e.g., *Concluding Observations of the Committee on the Rights of the Child Central African Republic*, U.N. Committee on the Rights of the Child (CRC), 25<sup>th</sup> Sess., 669<sup>th</sup> mtg., paras 60–61, U.N. Doc. CRC/C/15/Add 138 (2000); *Concluding Observations of the Committee on the Rights of the Child Benin*, CRC, 21<sup>st</sup> Sess., 557<sup>th</sup> mtg., para. 25, U.N. Doc. CRC/C/15/Add 106 (1999); *Concluding Observations of the Committee on the Rights of the Child Cambodia*, CRC, 24<sup>th</sup> Sess., 641<sup>st</sup> mtg., para. 53, U.N. Doc. CRC/C/15/Add 128 (2000); *Concluding Observations of the Committee on the Rights of the Child Mexico*, CRC, 22<sup>nd</sup> Sess., 586<sup>th</sup> mtg., para. 27, U.N. Doc. CRC/C/15/Add.112 (1999); *Concluding Observations of the Committee on the Rights of the Child Kyrgyzstan*, CRC, 24<sup>th</sup> Sess., 641<sup>st</sup> mtg., paras 45–46, U.N. Doc. CRC/C/15/Add 127 (2000); *Concluding Observations of the Committee on the Rights of the Child Lithuania*, CRC, 26<sup>th</sup> Sess., 697<sup>th</sup> mtg., para. 40, U.N. Doc. CRC/C/15/Add 146 (2001); *Concluding Observations of the Committee on the Rights of the Child Spain*, CRC, 30<sup>th</sup> Sess., 798–799<sup>th</sup> mtgs., para. 39, U.N. Doc. CRC/C/15/Add 185 (2002)

<sup>2</sup> See e.g., *Concluding Observations of the Committee on the Rights of the Child Chad*, CRC, 21<sup>st</sup> Sess., 557<sup>th</sup> mtg., para. 30, U.N. Doc. CRC/C/15/Add 107 (1999); *Concluding Observations of the Committee on the Rights of the Child: Colombia*, CRC, 25<sup>th</sup> Sess., 669<sup>th</sup> mtg., para. 48, U.N. Doc. CRC/C/15/Add.137 (2000); *Concluding Observations of the Committee on the Rights of the Child Guatemala*, CRC, 27<sup>th</sup> Sess., 721<sup>st</sup> mtg., para. 40, U.N. Doc. CRC/C/15/Add 154 (2001)

<sup>3</sup> See e.g., *Concluding Observations of the Committee on the Rights of the Child Cambodia*, CRC, 24<sup>th</sup> Sess., 641<sup>st</sup> mtg., para. 53, U.N. Doc. CRC/C/15/Add 128 (2000); *Concluding Observations of the Committee on the Rights of the Child Dominican Republic*, CRC, 26<sup>th</sup> Sess., 697<sup>th</sup> mtg., para. 37, U.N. Doc. CRC/C/15/Add 150 (2001); *Concluding Observations of the Committee on the Rights of the Child Guinea*, CRC, 20<sup>th</sup> Sess., 531<sup>st</sup> mtg., para. 27, U.N. Doc. CRC/C/15/Add.100 (1999)

<sup>4</sup> Committee on the Rights of the Child, *General Comment No. 4 Adolescent health and development in the context of the Convention on the Rights of the Child*, 33<sup>rd</sup> Sess., para. 31, U.N. Doc. CRC/GC/2003/4 (2003) [hereinafter *General Comment No. 4*]

<sup>5</sup> *Concluding Observations of the Committee on the Elimination of Discrimination Against Women Lithuania*, CEDAW, 23<sup>rd</sup> Sess., paras 158–159, U.N. Doc. A/55/38 (2000)

<sup>6</sup> See *Concluding Observations of the Committee on the Rights of the Child Central African Republic*, U.N. Committee on the Rights of the Child (CRC), 25<sup>th</sup> Sess., 669<sup>th</sup> mtg., paras. 60–61, U.N. Doc. CRC/C/15/Add 138 (2000); *Concluding Observations of the Committee on the Rights of the Child Cambodia*, CRC, 24<sup>th</sup> Sess., 641<sup>st</sup> mtg., para. 53, U.N. Doc. CRC/C/15/Add 128 (2000); *Concluding Observations of the Committee on the Rights of the Child Kyrgyzstan*, CRC, 24<sup>th</sup> Sess., 641<sup>st</sup> mtg., paras 45–46, U.N. Doc. CRC/C/15/Add 127 (2000); *Concluding Observations of the Committee on the Rights of the Child Lithuania*, CRC, 26<sup>th</sup> Sess., 697<sup>th</sup> mtg., para. 40, U.N. Doc. CRC/C/15/Add 146 (2001);

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*Concluding Observations of the Committee on the Rights of the Child: Spain*, CRC, 30<sup>th</sup> Sess., 798–799<sup>th</sup> mtgs., para. 39, U.N. Doc. CRC/C/15/Add.185 (2002).

<sup>7</sup> Family Planning and Sexual Health Association, *Unintended Pregnancy and Emergency Contraception Information for Women*, at <http://www.spa.lt/en/adults.phtml> (last visited Nov. 15, 2005).

<sup>8</sup> UNITED NATIONS POPULATION FUND (UNFPA), *THE STATE OF WORLD POPULATION 2004*, at 104 (2004) [hereinafter UNFPA, *STATE OF THE WORLD*]. Modern methods include male and female sterilization, IUD, the pill, injectables, hormonal implants, condoms and female barrier methods. *Id.* at 114.

<sup>9</sup> UNITED NATIONS POPULATION FUND (UNFPA), *THE STATE OF WORLD POPULATION 2005*, at 109 (2005).

<sup>10</sup> *Developing Effective Laws and Policies in Lithuania*, 3 MAKING THE CONNECTION (SIECUS Int'l, New York, N.Y.), Winter 2002/2003, available at <http://www.siecus.org/inter/connection/conn0030.html> [hereinafter MAKING THE CONNECTION].

<sup>11</sup> INTERNATIONAL HELSINKI FEDERATION FOR HUMAN RIGHTS (IHF), *WOMEN 2000 – AN INVESTIGATION INTO THE STATUS OF WOMEN'S RIGHTS IN CENTRAL AND SOUTH-EASTERN-EUROPE AND THE NEWLY INDEPENDENT STATES 282* (2000), available at [http://www.ihf-hr.org/documents/doc\\_summary.php?sec\\_id=3&d\\_id=1467](http://www.ihf-hr.org/documents/doc_summary.php?sec_id=3&d_id=1467).

<sup>12</sup> *Id.*

<sup>13</sup> H.E. Dr. Gediminas Serksnys, Statement to U.N. G.A. 56<sup>th</sup> Sess., Comm. on Population and Development 35<sup>th</sup> Sess., *Reproductive rights and reproductive health, with special attention to human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS)* (April 2002), at <http://www.un.int/lithuania/CPD-35-56.HTM>.

<sup>14</sup> MAKING THE CONNECTION, *supra* note 9.

<sup>15</sup> Youth Peer Education Electronic Resource, *Lithuania – Country Overview*, at <http://www.youthpeer.org/default.asp?Page=CountryOverview> (last visited Nov. 12, 2005).

<sup>16</sup> See THE CENTER FOR REPRODUCTIVE RIGHTS AND UNIVERSITY OF TORONTO INTERNATIONAL PROGRAMME ON REPRODUCTIVE AND SEXUAL HEALTH LAW, *BRINGING RIGHTS TO BEAR 127* (2002).

<sup>17</sup> See *id.* at 129.

<sup>18</sup> See *id.*

<sup>19</sup> See *id.*

<sup>20</sup> See *id.* at 130.

<sup>21</sup> *Lithuanian Health Information Center*, Information on file with the Family Planning and Sexual Health Association of Lithuania.

<sup>22</sup> Information on file with the Family Planning and Sexual Health Association of Lithuania.

<sup>23</sup> Mitchell D. Creinin, *Medical Abortion Regimens: Historical Context and Overview*, 183 AM. J. OBSTETRICS AND GYNECOLOGY S3, S5 (2000) [hereinafter Creinin, *Medical Abortion Regimens*].

<sup>24</sup> Rachel K. Jones & Stanley K. Henshaw, *Mifepristone for Early Medical Abortion: Experiences in France, Great Britain and Sweden*, 34 PERSP. ON SEXUAL AND REPROD. HEALTH 154 (2002) [hereinafter Jones & Henshaw, *Mifepristone for Early Medical Abortion*].

<sup>25</sup> Creinin, *Medical Abortion Regimens*, *supra* note 21, at 44–45.

<sup>26</sup> Mifepristone has been approved for early abortion up to 63 days in Great Britain and Sweden. Jones & Henshaw, *Mifepristone for Early Medical Abortion*, *supra* note 22, at 154.

<sup>27</sup> See *id.* at 156.

<sup>28</sup> See ROYAL COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS (RCOG), *THE CARE OF WOMEN REQUESTING INDUCED ABORTION* (2000), available at <http://www.rcog.org.uk/guidelines.asp?PageID=108&GuidelineID=31> (last visited Mar. 5, 2004) [hereinafter RCOG, *THE CARE OF WOMEN REQUESTING INDUCED ABORTION*]; see Elizabeth Pirruccello Newhall & Beverly Winikoff, *Abortion with mifepristone and misoprostol: Regimens, efficacy, acceptability and future directions*, 183 AM. J. OBSTETRICS AND GYNECOLOGY S44 (2000) [hereinafter Newhall & Winikoff, *Abortion with mifepristone and misoprostol*].

<sup>29</sup> In the United States, studies conducted after FDA approval of mifepristone but before the drug was released on the market indicated that the availability of mifepristone as an abortifacient would increase women's access to abortion services in the U.S., primarily by increasing the number of health care providers who offer abortion services. Bonnie Scott Jones & Simon Heller, *Providing Medical Abortion: Legal Issues of Relevance to Providers*, 55 AM. MED. WOMEN'S ASS'N, INC. 2 (2000).

<sup>30</sup> Jones & Henshaw, *Mifepristone for Early Medical Abortion*, *supra* note 22, at 57.



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<sup>31</sup> *Id.* at 58.

<sup>32</sup> Newhall & Winikoff, *Abortion with mifepristone and misoprostol*, *supra* note 26, S50–S51.

<sup>33</sup> See Jones & Henshaw, *Mifepristone for Early Medical Abortion*, *supra* note 22.

<sup>34</sup> See RCOG, *THE CARE OF WOMEN REQUESTING INDUCED ABORTION*, *supra* note 26; see Newhall & Winikoff, *Abortion with mifepristone and misoprostol*, *supra* note 26.

<sup>35</sup> *General Comment No. 4*, *supra* note 4, para. 28.

<sup>36</sup> See *Concluding Observations of the Committee on the Rights of the Child: Lithuania*, CRC, 26<sup>th</sup> Sess., 697<sup>th</sup> mtg., para. 39, U.N. Doc. CRC/C/15/Add.146 (2001); *Concluding Observations of the Committee on the Rights of the Child: Argentina*, CRC, 8<sup>th</sup> Sess., 177–179<sup>th</sup> mtgs., para. 19, U.N. Doc. CRC/C/15/Add.35 (1995); *Concluding Observations of the Committee on the Rights of the Child: Egypt*, CRC, 26<sup>th</sup> Sess., 697<sup>th</sup> mtg., para. 44, U.N. Doc. CRC/C/15/Add.145 (2001); *Concluding Observations of the Committee on the Rights of the Child: Georgia*, CRC, 24<sup>th</sup> Sess., 641<sup>st</sup> mtg., para. 47, U.N. Doc. CRC/C/15/Add.124 (2000); *Concluding Observations of the Committee on the Rights of the Child: Latvia*, CRC, 26<sup>th</sup> Sess., 697<sup>th</sup> mtg., paras. 39–40, U.N. Doc. CRC/C/15/Add.142 (2001); *Concluding Observations of the Committee on the Rights of the Child: Russian Federation*, CRC, 22<sup>nd</sup> Sess., 586<sup>th</sup> mtg., para. 48, U.N. Doc. CRC/C/15/Add.110 (1999); see also, CRC, *General Comment No. 3: HIV/AIDS and the rights of the child*, 32<sup>nd</sup> Sess., para. 16, U.N. Doc. CRC/GC/2003/3 (2003).

<sup>37</sup> *Concluding Observations of the Committee on the Rights of the Child: Lithuania*, CRC, 26<sup>th</sup> Sess., 697<sup>th</sup> mtg., para. 40, U.N. Doc. CRC/C/15/Add.146 (2001).

<sup>38</sup> *Id.*

<sup>39</sup> *Id.*

<sup>40</sup> *Concluding Observations of the Human Rights Committee: Lithuania*, HRC, 80<sup>th</sup> Sess., para. 12, U.N. Doc. CCPR/CO/80/LTU (2004).

<sup>41</sup> *Id.*

<sup>42</sup> *Id.*; *Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Lithuania*, CEDAW, 23<sup>rd</sup> Sess., para. 159, U.N. Doc. A/55/38 (2000); *Concluding Observations of the Committee of Economic, Social and Cultural Rights: Lithuania*, CESCR, 22<sup>nd</sup> Sess., para. 28, U.N. Doc. E/C.12/1/Add.96 (2004).

<sup>43</sup> *Concluding Observations of the Human Rights Committee: Lithuania*, HRC, 80<sup>th</sup> Sess., para. 12, U.N. Doc. CCPR/CO/80/LTU (2004); *Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Lithuania*, CEDAW, 23<sup>rd</sup> Sess., para. 159, U.N. Doc. A/55/38 (2000); *Concluding Observations of the Committee of Economic, Social and Cultural Rights: Lithuania*, CESCR, 22<sup>nd</sup> Sess., para. 50, U.N. Doc. E/C.12/1/Add.96 (2004).

<sup>44</sup> See CENTER FOR REPRODUCTIVE RIGHTS, *WOMEN OF THE WORLD: EAST CENTRAL EUROPE* § IV(E), at 94 (2000).

<sup>45</sup> See LITHUANIAN AIDS CENTRE, *PRELIMINARI SITUACIJA APIE SITUACIJA LIETUVOJE* (on file with the Center for Reproductive Rights).

<sup>46</sup> JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS (UNAIDS) & WORLD HEALTH ORGANIZATION, *AIDS EPIDEMIC UPDATE*, DECEMBER 2003, at 16 (2003).

<sup>47</sup> UNFPA, *STATE OF THE WORLD*, *supra* note 8, at 104. For example, in France, the average number of births per 1,000 women aged 15–19 was 9 in 2004. *Id.*

<sup>48</sup> See CENTER FOR REPRODUCTIVE RIGHTS, *WOMEN'S REPRODUCTIVE RIGHTS IN LITHUANIA: A SHADOW REPORT TO THE CEDAW COMMITTEE* 140.

<sup>49</sup> See *Id.* at 29–30 (2000).